lect it and study it. Disease, however, is invisible and intangible, and it's had 20 years to grow and spread and get stronger. The truth is, we have no idea what health effects we're truly dealing with, and we won't know until people come seeking help. The question is, will those with the power to right this wrong allocate more money to the Victim Compensation Fund so that we can help these human beings when they do?

Damon Tweedy Critical Review

Cailin MacQuarrie

During Dr. Damon Tweedy's Park Street Lecture, which centered on his novel Black Man in a White Coat: A Doctor's Reflections on Race and Medicine, he widened the scope of the discussion to something much broader than just the issue of race and medicine: the systematic issue of ongoing racism in our society. Tweedy skillfully argued that the racially-centered issues he describes in his book, and the problematic racially-motivated instances in our society as a whole, are merely indicators of a much more deeply entrenched problem of racism in our society, one that we continue to combat half a century after the end of the Jim Crow Era.

Tweedy began the evening's conversation by not focusing on his own personal experiences with race and medicine, but by examining the larger issue at hand. Specifically, Tweedy discussed the semi-recent surfacing of Governor Ralph Northam's racist 1984 Eastern Virginia Medical School yearbook photos. The reasons that these photos are problematic were immediately evident and numerous, yet there were still those who raised the notion that, "He's a good person having a bad day." Tweedy introduced the point that when racist events surrounding an individual emerge, the debate always ensues of whether or not the person is a "bad person" because of the other seemingly "good things" the person has done. The question of whether all of the "good things" the person has done can be overshadowed by a single event arises. Tweedy correctly states that while it's imperative that we condemn these incidences for what they are, hateful, racist acts, we also can't be so focused on the individual in these situations. Rather, we must turn our attention to the larger problem which is that a number of people obviously saw these photos, didn't see anything wrong with them, and approved them to be published. This example perfectly encapsulates Tweedy's argument that we can't just view individual instances of racism as isolated events, but that we must look at racism as a whole and the group that it stems from.

Throughout his lecture, Tweedy emphasized the power of our words, urging the audience of students, faculty, and socially conscious citizens to continue the narrative he incited with his novel and lecture, imploring us to have real conversations with real people. Undoubtedly, Tweedy came to Boston College to spark conversation, stating "For me to come here and talk and for that to be the end of it is no good." From this single conversation that was had during the Park Street Lecture, he wanted innumerable different conversations to emerge and for all of us to be more aware. He called on us to recognize how much weight our words, written or spoken, carry, citing the specific example of the inherent bias that's present in medical charting. "Your words have tremendous power", he stated, referencing how often he's come across unnecessary and racially-focused bits of information in patients' medical charts, which can skew the way the patient is perceived, potentially impact the care given, maintain "durable stereotypes", and sustain the false narrative that "being black is a risk factor for getting sick". Tweedy was correctly vehement in how critical it is that this changes. He generously shared with us some of his more awkward experiences as a doctor, in which he was made to feel like the "other" and served as "reminders of being different". One instance in particular that he described was when he was working the night shift and his patient told him that she was worried about him working the night shift and having to get up in the morning to go to basketball practice. Tweedy jokingly stated that the woman thought he was "a basketball player moonlight-

ing as a doctor" and that he was "Clark Kent except with a white coat and a basketball jersey underneath." While his delivery was comical, it didn't take away from the fact that assumptions such as the one that Dr. Damon Tweedy is a basketball player and not a physician are problematic and indicative of a systematic issue.

Dr. Tweedy concluded his lecture with a quote from Dr. Martin Luther King Jr.: "If I cannot do great things, I can do small things in a great way." This applies to everybody in Dr. Tweedy's audience, and everybody at Boston College, in that we're all responsible to at least do the small but great thing of continuing the conversation he began. As university students we may feel that we're at the bottom of the totem pole, that we don't have a voice, that we don't have the power to spark change, but Dr. Tweedy assured us that the opposite is true. The fact is that we're in an incredibly unique and privileged position as college students in that we're celebrated for sharing what we think and feel and there are ample opportunities for us to do so. We applaud Dr. Damon Tweedy for bringing to light that all it takes for us to incite change is to recognize the power of our words, and then use them to start a new narrative.

"Placebo and Nocebo" Effct - Explaining the Divergent Impacts of HIV/AIDS Initiatives

Derek Xu

As of 2017 36.9 million people were living with Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) worldwide, and today the disease remains one of the most notorious global health challenges. Developments in therapeutics and diagnostic testing have allowed for HIV/AIDS to be managed without significant consequence. As of 2017, only 75% of people living with the disease were aware of their HIV status and only 59% of those living with HIV (21.7 million people) had access to antiretroviral therapy (ART). The resilience of this disease in the face of global health initiatives can be explained by two distinct but interconnected conundrums: the negligence of HIV/AIDS's pervasive impact on all sectors of life (personal, career, and societal), and the unintended consequences of punitive societal condemnation. Neither of these challenges directly relate to the biological efficacy of medicinal treatments, but pose challenges to providing patients with the treatments that they require.

Many of the policies and plans today implemented by public health programs revolve not around the physiological efficacy of treatments, but instead around the relationship between the HIV/AIDS afflicted population and the healthcare system as a whole. Many of the policies approach the epidemic in a way similar to how a garden is "pruned and weeded;" following the logic that improving the health of the HIV/AIDS positive population will limit the spread of the disease. The goal is to provide prophylactic measures and symptomatic treatments which, when managed well, could slowly improve the overall health of the community. While many of these approaches have demonstrated success, some end up facilitating more harm than good.

This harm is often psychological rather than physiological, allowing fear and to invade and pervade throughout the HIV/AIDS population. Severe poverty, punitive condemnation by both society and the legislature, and mental health issues within the HIV/AIDS community are fueled by the failure of global outreach programs. The concept of the "Placebo Effect" and its lesser-known but implicitly more notorious counterpart, the "Nocebo Effect", characterize how certain global healthcare approaches are being carried out and provides a lens into how future initiatives should be orientated.

The concept of the "Placebo vs Nocebo Effect" is unique in its suggestion that something which is "physically inert" could have a significant impact on the health of individuals living with HIV/AIDS without directly interacting with the biological mechanisms of disease. The "Nocebo Effect" posits that a patient's negative expectations can lead to an increase in and intensification of the negative aspects of their treatment, both perceived and physiological. Such a phenomenon can be attributed to the concept of "somatization," the tendency to experience and communicate psychological distress in the form of somatic symptoms. With regards to HIV/AIDS, a patient's seemingly morbid prognosis and resulting decrease in quality of life can be partially attributed to the extremely negative and harmful stereotypes associated with the disease, particu-