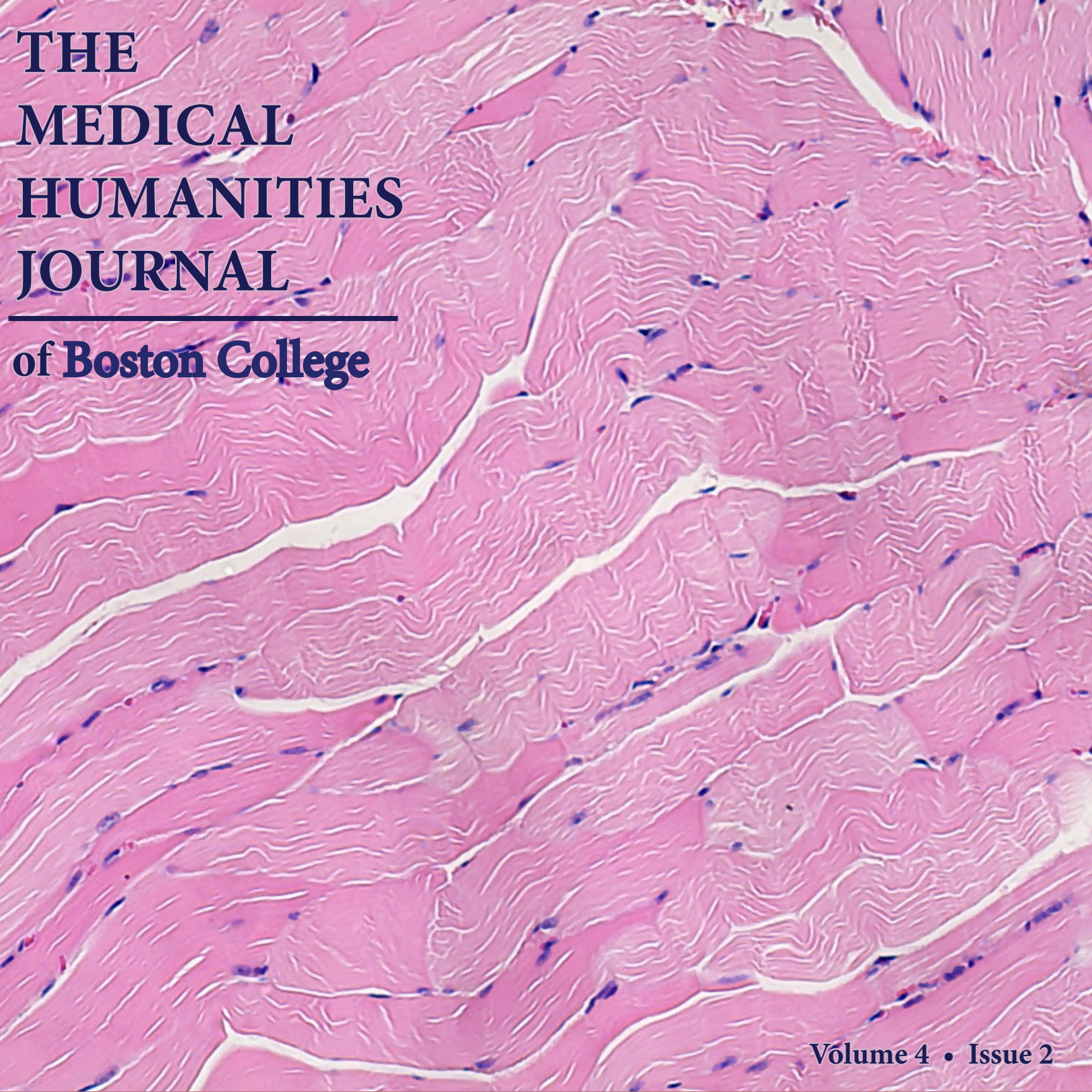
THE MEDICAL HUMANITIES JOURNAL

of **Boston College**



Volume 4 • Issue 2

MISSION STATEMENT

The Medical Humanities Journal of Boston College **seeks to:** • Initiate and engage in conversation in the Boston College community and beyond about the emergent field of Medical Humanities, Health and Culture. • Provide students at Boston College with the opportunity to publish original work. • Feature a variety of work from several disciplines. • Examine critically and represent creatively ideas of health, illness, caregiving, and medicine. • Connect students with alumni, professionals, and other Medical Humanities programs to extend and to engage in conversation beyond Boston College.

EDITORIAL STAFF

COVER
"Peritoneal Wall 24 Hours Post Injection"
Kashviya Suri

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To read the journal online or find out more information, please visit us at **www.mhjbc.org**. Please direct questions or submissions to **bc.mhj.1@gmail.com**.

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EDITORS' NOTE

We are thrilled to be publishing our second issue as an editorial board. It is exciting to hear the voices of the Boston College community as we engage in the rich conversation of the medical humanities. Whether through topics of medical education, patient experiences, epidemics, or policy, these subjects provide us with a chance to reflect on ourselves and the communities around us.

The pieces published in this edition form a truly interdisciplinary conversation around health and illness, clustered around four major themes: mind, body, bearing witness to others' experiences, and societal considerations in our global landscape. Topics of mental health and emotion lead into discussions of physical experiences and the body. Beyond one's own skin and psyche, one can view the impact of health and illness through the human relationships of family or medical care. The conversation is expanded to a global scale through which we learn about health systems and the professional careers of healthcare personnel, among others.

Our authors have written about personal setbacks and triumphs, disheartening observations and hopeful outlooks, family struggles and global problems.

"Please Help If You Care: A Narrative" by Karissa Mokoban is a story of acknowledging, understanding, and overcoming depression. Her narrative sheds light on a personal struggle with mental illness and the importance of seeking help. Mental health, though invisible, touches all of our lives, and it is important to understand its present role in the human experience.

"Stares" by Laura Perrault discusses a journey of acceptance. The narrative includes various aspects of Perrault's identity and how they intersect with each other to form her definition of her self -- including her experience of body and physical appearance.

Another short narrative, "Después de la Tormenta" by Eleanor Brown, shares the story of a caregiver's comforting of a young patient. Her experience demonstrates the importance of empathy and the role of the caregiver in helping those who are ill or facing health challenges to take each day by day.

We are very grateful that these authors and artists have shared their work with us, and for the time and care they have put into their pieces. We would like to extend a thank you to our editorial board and advisors for all of their hard work and guidance that made this Journal possible. Finally, thank you especially to our readers who have supported us and who continue the conversation of the medical humanities beyond our pages.

Kaylie Daniels and Gayeon Lee
Editor-in-Chief and Managing Editor

THE MIND

THE BODY

BEARING WITNESS

A GLOBAL LENS

The "Therapeutic" hour

Joely Cetraccio

50 MINUTES.

HOW WILL I TELL MY STORY TODAY,
HOW LONG UNTIL THE TORRENT OF TEARS DAMPENS THE NECKLINE OF MY SHIRT,
HOW SOON WILL I BE TOLD THAT HOW I AM FEELING IS TEMPORARY,
AND HOW QUICKLY CAN I RETURN TO NORMALCY?

40 MINUTES.

I HIDE BEHIND THE FORTRESS OF MY HANDS,
IMMOBILIZED BY FEAR AND PANIC,
FINDING SOLACE IN THIS MAKESHIFT ENCLOSURE,
I ORIENT MY BODY TOWARD THE WALL,
TO AID IN MY SEARCH FOR THE WORDS I DO NOT HAVE.

30 MINUTES.

BARRIERS BETWEEN US,
REINFORCED BY LOOMING DIPLOMAS AND MANUALS,
CAUSE ME TO ACHE FOR HUMAN CONNECTION,
AND THOUGH YOUR EYES ARE FIXATED ON MINE,
YOU WILL NOT COME TO SEE ME AT ALL.

20 MINUTES.

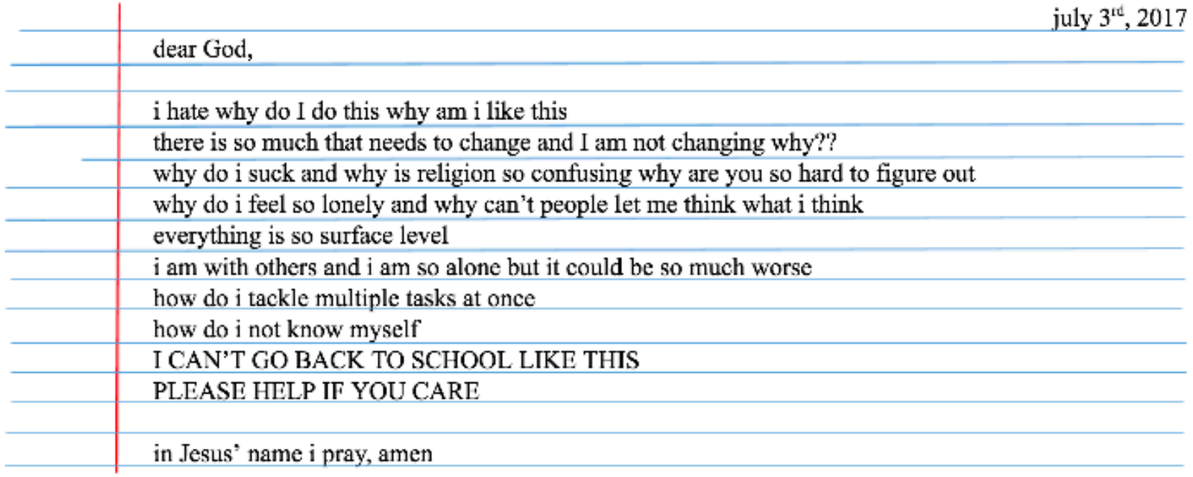
I DO NOT WANT TO SCAN MY BODY NOR FEEL MY BODY AGAINST THE CHAIR,
BECAUSE NOTHING IS CURRENTLY FELT.
LONGING TO BE GRACED WITH SECURITY,
AND TO KNOW I WILL BE OKAY.

5 MINUTES.

A SUBTLE SHIFT IN GAZE TOWARD THE CLOCK,
SIGNALS THAT THE MOST DREADED QUESTION IS TO COME.
MY WEIGHT SHIFTS IN THE CHAIR,
BREATHING UNSTEADILY WITH ALARM,
AND UNPREPARED TO REENTER LIFE'S ARENA WHEN ASKED,
"ARE YOU FEELING BETTER NOW?"

Please help if you care: A narrative

Karissa Mokoban



july 3rd, 2017

dear God,

i hate why do I do this why am i like this
there is so much that needs to change and I am not changing why??
why do i suck and why is religion so confusing why are you so hard to figure out
why do i feel so lonely and why can't people let me think what i think
everything is so surface level
i am with others and i am so alone but it could be so much worse
how do i tackle multiple tasks at once
how do i not know myself
I CAN'T GO BACK TO SCHOOL LIKE THIS
PLEASE HELP IF YOU CARE

in Jesus' name i pray, amen

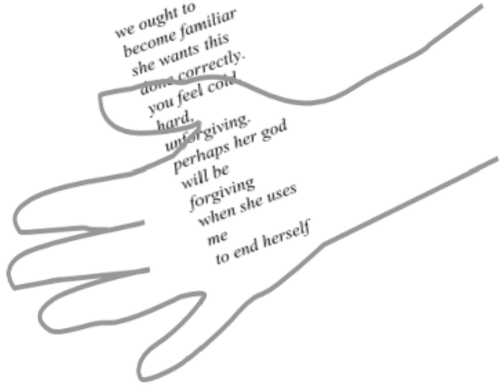
How was she supposed to pray
when her own brain trespassed against her
come, lord jesus
she is fading quickly

A year after writing that letter, I knew myself enough to know I had severe depression. I could ignore the poor hygiene and overwhelming fatigue, but the insidious train of thought screeched too loudly to dismiss. Some passengers drafted meticulous plans: minimizing the clean-up for my roommates, personalizing each letter to family and friends, donating my savings, and asking my boss to take me off payroll. Other passengers painted explicit scenes: the Red Line train pulverizing my body, an image of myself gulping down a Tylenol-and-bleach cocktail,

or a familiar figure hanging limp in the basement of my apartment. At first this train of thought followed an irregular schedule, but before long it ran twenty-four seven in a relentless craze.

"today we discuss Descartes" you say as you begin class
giving space to one of your students
tears streaming down her face as she writes
furiously attempting to convince herself
she deserves to live

Three weeks into July, I shuffled over to the parking garage and reached the top floor. On either side of the elevator lies significant room to fall seven stories down onto the cement below—a detail I carefully stored away much earlier. When I got to the edge,* I clenched the metal barrier and tried to be brave.



*The amount of time I stood and wept there evades me.

But the more I looked down, the more I doubted a certain death. I dug out my phone, searched the Internet thoroughly, and discovered that I needed eight more floors to succeed. Tempting as it was, living permanently injured attracted me even less than living fully intact. I stepped away, still clueless as to how to crawl out of hell. Campus police drove me home that Saturday night. I have no memory of Sunday.
According to the CDC, four thousand six hundred young people in America end their lives each year. This makes suicide the third leading cause of death for people aged ten to twenty-four.

That night, and every night this summer, would have played out much differently without the resources that my school provides. If Boston College had police officers I couldn't trust, I might have resorted to walking home knowing full well I might leap in front of a car. Without an emergency psychologist available day and night, I might have spent the rest of Saturday night plotting my next move. If my school's mental health services had a fee, I most likely would not have sought help at all. And if the emergency psychologists and full-time psychologists didn't communicate with each other, I might have gotten away with multiple attempts until it worked. I certainly would t have been the only college student in any of those situations.

The Monday morning following my pseudo-attempt, my therapist called me unexpectedly, as we originally scheduled our appointment for 3:00pm. The emergency psychologist had told her what happened, so she urged me to accept help far beyond our weekly sessions. Knowing how quickly the depression had progressed, I let campus police transport me to the nearest psychiatric hospital, which happened to be a reputable one. For ten days I swallowed antidepressants and sleep medications, created art with other patients, and dutifully participated in group therapy. After learning the daily cost of staying there, I tried be as honest as possible when offered individual therapy.

do you know what it feels like to no longer exist?
no, because you cannot feel
you are but dust returned

When the doctors determined I was no longer a threat to myself, I departed with goodbye notes, a folder stuffed with documents, my belongings, and a revived will to live.

Early on during the hospital stay, I recognized the need to stay in the staff's good graces. Our unit was quite the drama scene; patients would bend the rules, staff members would respond sternly, and patients would retaliate against their authority in return. Childish as that may sound, the tense environment made lashing out understandable. The rules were strict: you could only stand outside on the patio if the nurses had determined you weren't suicidal, you weren't allowed to hug anyone, staff checked on you every fifteen minutes (even when you were showing or sleeping), you couldn't have your phone charger, and staff had to watch you if you wanted to shave…anywhere. The power dynamic became especially clear at 5:00pm, when the day staff could leave and we could not. The physical environment induced stress as well, as very little natural light entered our rooms while

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If I could return to a simpler time, I would tell myself a few things:

- You are beautiful.
- You are a normal child in an unfriendly place.

you are loved

- They may seem cool, but those girls don't want to be your friend. Their loss.
- Thick thighs are very much okay.
- Dad isn't trying to be mean. He just doesn't know how to avoid hurting your feelings.

you are loved

- You are so much more than your grades.

you are loved

- Quit letting them touch your hair. I know it's hard, but you don't want that kind of attention.

you are loved

- You are allowed to tell Mom you don't like it when we go to Auntie's house and he touches you like that.

you. are. loved.

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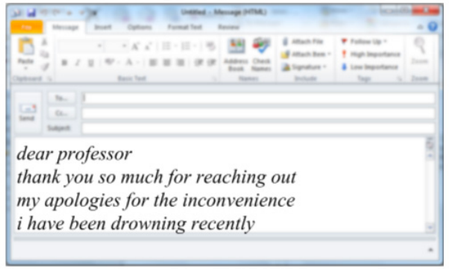
the hallway lights glared continuously. Some of us handled it better than others.
I relapsed in mid-October. Since the beginning of junior year, stress and imbalance triggered depressive and/or anxious episodes that paralyzed me for hours at a time. It seemed that I failed in at least one aspect of life every day, whether it was in studying, exercising, sleeping, or being a good friend. As a diehard perfectionist who once took great comfort in "going above and beyond" (as my secondary school teachers would phrase it), watching myself struggle to perform basic academic tasks pained me the most.



To make matters worse, a man I had been talking to sauntered out of my life at random. This new loss triggered the familiar thought pattern that (a) I'm always losing someone and (b) a life spent alone is not one I want to stick around for. The worldview I constructed back in the hospital to keep me safe backfired; if I alone hold the responsibility to have a wholesome life, what happens if I am too broken to navigate the loss and instability that seem to characterize it?
The emergency psychologist, as lovely and helpful as she was, couldn't answer that one for me.

Please write your <u>name</u> / <u>date of birth</u> / and <u>identification number</u>

how polite of you to ask
these letters and numbers arranged in English
will mean nothing very soon

Suicidal depression had flung out its pole, snatched me, and reeled me in again. My off-campus therapist and I are still trying to yank me back to safety.*

*There was once a time I would have sugar-coated that episode. At this point, I have run out of sugar.

On an especially bright afternoon back at the hospital, the staff invited interested patients on one of their "fresh air walks." Most of us joined in, and as we wandered around the property we glimpsed what appeared to be glamorous townhouses only yards away from our building. When I asked what they were for, our guide told me that they were actually one interconnected facility for wealthy clients and celebrities. We moved on, but for the rest of the excursion I daydreamed of me and my new friends being treated there.

Recently, The Boston Globe published an article entitled "Exclusive Psychiatric Care, For a Price." The author discussed how many psychiatric hospitals across the country offer exceptional treatment programs solely to those who can pay thousands of dollars out of pocket per day. Within these programs, "clients" (as opposed to "patients") reside in living spaces meant to resemble home while receiving ample individual psychiatric attention. The author describes how economically disadvantaged people, with or without insurance, cannot take advantage of any of the amenities available to their rich, uninsured counterparts. This illuminates the strict binary system

we are operating with; either people pay thousands for a luxe mental health package, or they get shuffled into regular facilities that do not provide nearly the same experience.

As my social theory professor once said, healthcare in America is a consumer good rather than a right of citizenship. If we're going to treat mental health care as something people can buy as opposed to something people inherently deserve, we could at least diversify the marketplace so anyone can choose a high-quality program within their price range.
No one invites mental illness to come in and disturb their lives. So what makes a wealthy woman from Queens deserve excellent care more than depressed, black college kid or a homeless, schizophrenic man chasing pigeons in Boston Common?
The mind does not discriminate in betraying someone, neither should we in helping people heal.

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let this be a gentle reminder
you can't wait for life to bloom for you
you have worlds to conquer in the meantime

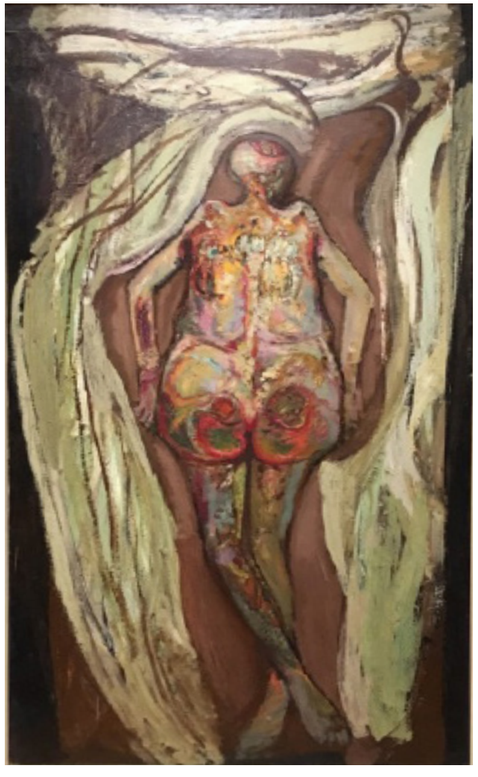
PROUD

Abigail White

A Beautifully Grotesque View of Death

Lauren McKenna

Hyman Bloom was a Boston-based painter during the middle of the twentieth century. A 1943 trip to Kenmore Hospital began his artistic fascination with skeletons and corpses. Bloom's 1947 painting, Female Corpse, Back View, is oil paint on canvas and depicts one of the dead bodies that Bloom observed in the Kenmore Hospital morgue—an unnamed female body positioned with her back towards the artist, observed as if from above with gaping rainbow wounds throughout her viewable frame due to decomposition (Female Corpse). Bloom presents the dead body in a nontraditional fashion, blending the decrepit and horrific equally with beauty and luminescence through the use of unconventional body posing, background imagery, and color choice.



Traditional views of death in society are often clean, clinical, and impersonal as the thought of confronting our ultimate passing challenges human nature; however, Bloom steps into this uncomfortable space, stripping away part of the decrepit nature of morbidity to reveal a combination of contrasting beauty and horror. The first impression of the picture begins with the title, a cool and detached description of the scene, a female corpse, viewed from behind, and this portrayal is immediately contrasted with the more personal image presented in the work, with its bright colors, draped background and humanistic depiction of a body. This juxtaposition of emotional elegance and clinical stoicism is especially apparent in the posture of the cadaver. In modern society, bodies are strategically posed, face-up, with individuals often in their finest clothing, faces shrouded in makeup to hide the pallor that accompanies death. But Bloom rips away this safety net used by people to protect themselves from their imminent fate by painting the body bare and vulnerable, turned away from the audience, her gaping wounds of decay checkered across her skin. The shocking image leaves audiences uncomfortable with this unconventional portrayal of a corpse; however, Bloom infuses this horrific image with the contrast of the delicate positioning of the body: the woman's legs carefully crossed towards the bottom of the painting as if she was standing, rather than laying down, with her arms resting by her sides casually, unlike the stiff way the dead are often posed in their caskets.

Furthermore, a backdrop of draped white linen surrounds the decomposing corpse, and this deliberate choice by the artist both softens the harsh reality of the women's death and contrastingly makes it more clinical. Bloom uses the background to enmesh both the traditionally dispassionate and surprisingly sensitive aspects of death by choosing a backdrop that resembles a fabric, a blanket of warmth and comfort in the wake of the woman's surprising decomposition, while the white color touches upon the stark side of the hospital reality in a clean and clinical color, which offers little warmth. The fabric also encircles the woman's head, as if it were a halo, creating an angelic, calming image of the grotesque body. Lastly, the body is painted non-traditionally, her gaping wounds of decomposition creating craters of rotting flesh and mountains of protruding bone not hidden by clothing or shading, but on display in a harrowing state of death. In sharp contrast to the decomposition is the rainbow array of colors used to paint the scene. The spectrum of reds, greens, yellows, purples and blues used to fill in the crevices stand in contrast not only with the grim outlook of the decomposition, but also with the traditionally darker blacks and greys associated with the depressing occurrence of death. The colors add a beauty to the body, livening the image and welding together the horrifying with the illuminating. The painting effectively combines shocking images of death with gentle, pearly colors and imagery to provide a unique vision of the dead body.

Bloom explores his fascination with the body throughout varying aspects of his painted portrait, countering the grotesque with the delicate in order to portray death in a nontraditional fashion. The conflict is surprising and shocking to audiences as society firmly grasps at life, struggling to confront not only the death of oneself, but the passing of those who are most important to them. The artist attempts to encourage viewers to face the eminence of death, shocking them with his blunt and unashamed portrayal of a body alone, while showing the beauty through color choices and body positioning. Facing death can be a harrowing and emotional journey. But the self-realization and actualization can be a liberating experience, and through the painting Female Corpse, Back View, the audience members can experience the juxtaposition of grace and shock, confronting their initial ideas and feelings about death.

Citation and Photograph of Painting
"Female Corpse, Back View." Museum of Fine Arts, Boston, College Art Association, Feb. 2015, www.mfa.org/collections/object/female-corpse-back-view-35040.

Catharsis

Shirley Lin

Stares

Laura perrault

I am confident. I parade into my first-grade classroom, a Hello Kitty backpack gripped tightly against my shoulders and a genuine smile plastered across my face. My hot pink leggings are matched with a loose-fitting tank top covered in vibrant sunflowers that bobs up and down with each fearless stride. My mother shields her face behind the hallway window in hopes of hiding the tears slowly dripping down the side of her cheek, but she knows that I am ready to take on the world. I am beautiful. I am unique. I am powerful. That is what my parents always told me, at least.

Stares

I am comfortable. It wasn't long before I made friends within my elementary school bubble. These friends weren't the type who just hung out with me at recess because my house was remembered as the best 6th birthday party in Mrs. McGlynn's entire class (the secret is a bounce house, that always wins them over). Instead, they were my friends because we giggled nervously at the back of the classroom when the teacher made a mistake, passed notes about this week's crushes, and stayed up way too late at sleepovers talking about how we wished that the school cafeteria served pizza every day instead of only Fridays. I had found my place with the people I was meant to be with, and nobody could take that away from me. That was until a little twerp approached me at recess, spitting ferocious fire out of his hateful mouth, "what is wrong with your face?!" The words sliced through my skin, leaving a trail of blood dripping down my body as my whole world crumbled between pursed lips. My friends stood in silence. What does he mean? My mom told me I was beautiful. I thought I was unique. I was supposed to be powerful. Have my parents been lying?

Stares

I am puzzled. I stare deeply into the mirror, desperately hoping to get rid of the foreign face glaring back at me. It has been added to my nightly routine that as I lay in bed, I pray to God that He can fix this broken doll to look like all of the others, perfectly pursed lips delicately placed upon sun kissed skin. I used to yearn to be picked out of a crowd first for intense games of kickball or tag. Now I wished nothing more than to blend into the painting, my body spreading outwards until I slowly begin to fade into a sea of hues that you can't tell apart from the others. My mother attempted to soothe me with the idea that He chose me to be different because He knows that of all people, I have the determination and compassion to handle it. I can only imagine the laughter erupting from my classmates when I tell them this the next time they make fun of me.

Stares

I am lost. My brain finally comprehends the fact that what I look like is not normal, but does knowing this reality make it any easier? Defect. The word has become my only definition, throwing me in a box placed in the back of the room to be returned. Defect. It becomes the sole topic at endless doctors' appointments and awkward conversations with family members and close friends. It pierces my ears when it is said aloud, making my face burn with embarrassment and rage. Defect. I retract until the lack of light allows me to fade into eternal darkness; the word can't reach me here. There is no cure for this.

Stares

I am improving. Slowly, I take one courageous step out of the darkness at a time. My knees tremble with the weight that they are forced to carry, but I beg them to stand up straight and propel my body forward. I started as the timid freshman that hid behind dorm room walls, avoiding social interactions that went beyond stating my name, major, and hometown. I looked fear in the eye as I practiced my introduction in front of the mirror, perfecting the way my name escaped my mouth with assurance. "I am Laura Perrault." I stick out a firm hand, stronger than ever before, and my hand meets theirs and knows exactly what to do. Three seconds, then let go so that they don't think you're clinging on to their presence. "It was nice to meet you, we should get lunch sometime." Do they really want to get lunch with me, or is it out of pity? We get lunch on Monday at 12pm, and days later those lunch dates turn into Monday, Wednesday, and Friday. I sit beside them again at dinner at 5:30 pm sharp. We're regulars now, and there is a sense of comfort in their presence. I am given a new introduction, "this is my friend, Laura," and the word never tasted so sweet. Friend.

Stares

I am beautiful. There is no way to erase the years that I allowed my birth defect to take the reins of my life and eliminate all happiness. Along the way, I met people who challenged my improvement, and encountered situations that made it almost unbearable to regain my balance to keep moving forward. However, in those darkest moments, I found others that stood by my side, building up my army to protect the castle inside that lay defenseless. They built up my walls and then slowly tore them down until my vulnerability was something that I was no longer afraid of. Sister. Daughter. Chemist. Academic. Researcher. Friend. The name Laura Perrault is sculpted by these words, making a definition that overpowers any other that once plagued the name. This new definition is added to the dictionary, making it permanent in the ink that bleeds the pages. This confidence is here to stay.

Blood Test

GABRIELLE LATORRE

Blue Button

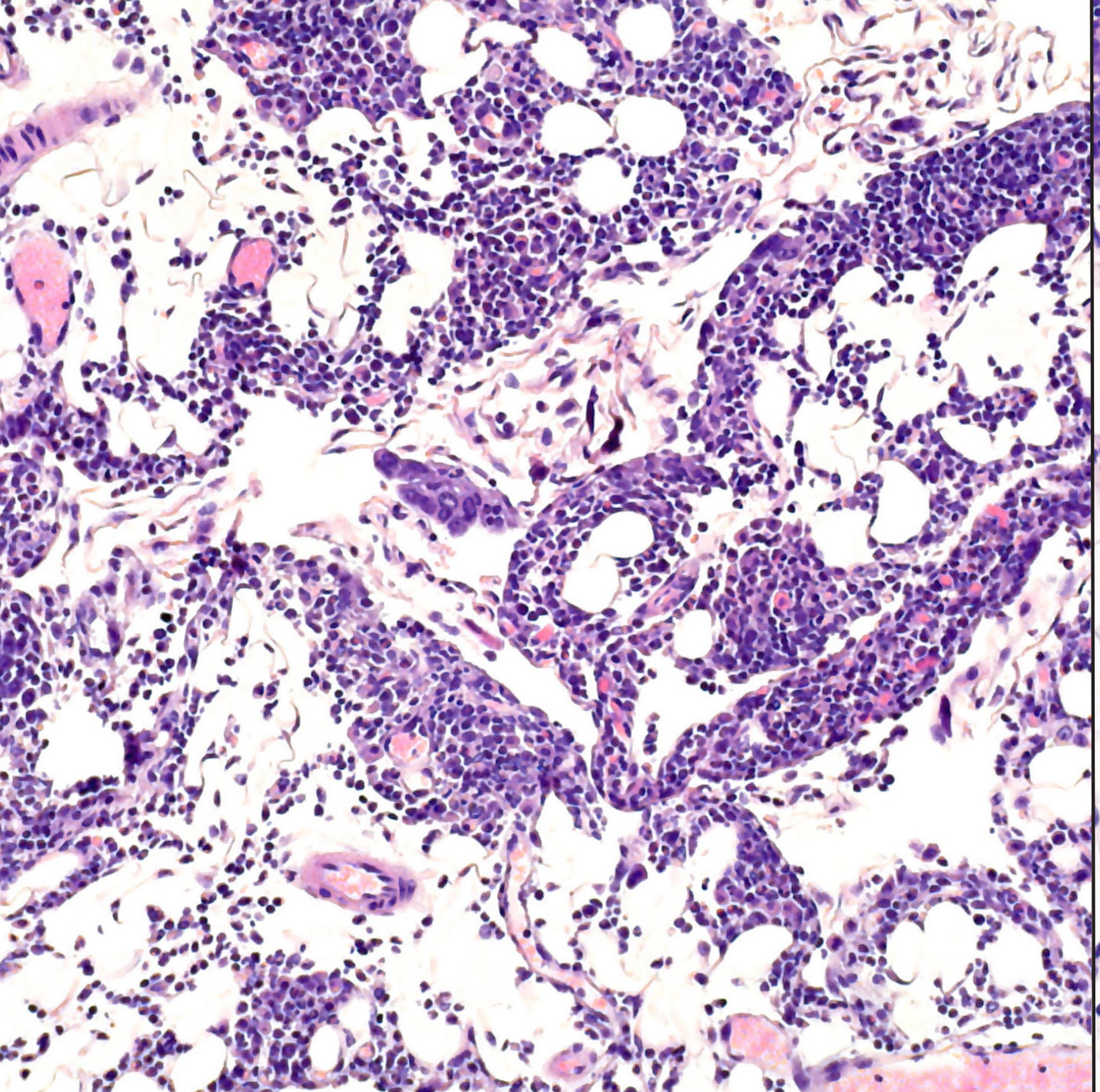
It was a routine blood test. Results were negative. She spends the next night writhing under pale pink, sweat-soaked, polyester sheets. Beads of perfumed perspiration drip trails and tributaries down her damp skin. A sharp, pointed pain shoots through the crook of her arm between forearm and bicep, lurching her awake. She brushes her fingers over the spot, feeling a distinct, cold swelling. Frantically, she fumbles for the light switch and sits up with a start. Her mouth gapes in horror as she watches what appears to be an iridescent blue button the size of a dime fight its way to the surface of her skin. She swallows a panicked, garbled scream, certain she must be dreaming, delirious with fever. Covering her eyes, she peaks cautiously through partitioned fingers, holding her jagged breath. It's still there. A deep, hot jolt of fear courses through her veins like molten lava. Thoughts swirl in her mind, a cacophonous frenzy, clamoring over and crashing into one another, each vying for attention. She forces herself to take a deep breath, but it comes out shaky and she can't steady it. Fingers twitching, itching to push the button, yet she refrains. She reflects on yesterday, yearning for clues, anything to latch onto. The quick, white swish of fresh ironed lab coat, the melodic clicking and scribbling of felt-tipped pen on clip board, the hushed tone and quiet arguing outside her hospital room. Too terrified to bend her arm lest the button get pressed, heart beating in rhythm with the swift hooves of a racehorse, she finishes the night with eyes stapled wide open.

Pressed

She felt her veins expand to heavy tubes through her once sun-soaked skin, now a translucent milky white. They pulsate with her heart, a steady thrum like the beat of an ominous marching band, processing into darkness. The blue tubes snake through her body and emit a dull glow, muted by clusters of cells. Blood swirls through them, like water through an enclosed amusement park slide. She can almost hear it sloshing through her. The urge to cut herself open and investigate what's inside consumes her.

[This isn't some warped sci-fi movie, this is her life. They told her the clinical trial might have unknown side effects, but nothing like this. It was supposed to save her, not ruin her.]

[The unknown is simply too deadly, a potential trapped door to fall through, never to recover.]



O Mental Fat Pad, 7 days post injection

KASHVIYA SURI

Counting to Thirty

Eleanor Brown

I am with people when they are most vulnerable: in the hospital, stripped of their clothes, with nothing on but a thin gown that has been worn by many bodies before. My role is a constant balance between "human" and "robot".

T-minus 3 minutes. The room is ready; the positions are assumed, the monitors are set. We look at the clock as the seconds slowly pass. We stand in silence to conjure up the stillness before the storm.

It is an inhumane act that no amount of training on plastic man kins can prepare you for; the anxiety in the room that is masked by delegations, the rush of adrenaline coursing through your veins, the assertive movement of your hands over the body, the crack of a fractured rib, the two possible outcomes rushing through your mind, the fear of failure, the fear of guilt.

As we stand quietly, waiting, I remember my first time.

"Mary Doe," room 19: a woman I grew to appreciate during the morning hours of my shift. She had four children, nine grandchidren, and every time I walked past her room, she showed me pictures of her adoring husband. She liked tea; in fact, she loved tea. Between the hours of eight and twelve, she had 7 cups. I was busy; she was one of sixteen, but, I always made sure she had enough hot water to soak her tea bags and someone to show off her family to. She reminded me of my grandmother.

The following day, I arrived back and was on the same assignment as the day before. I made my rounds, but first I went in to see Mary. She refused her tea, which I found to be unusual, but I did not think anything of it and continued with my rounds.

13:43: the cardiac monitor for room 19 at the nursing station was blaring. She was having a cardiac arrest. I sprinted down the hallway and was followed by the code team; I was the first one in the room. Mary was lying still in her bed, with her purse tucked by her side, her beige knitted blanket covering her shoulders, and the first thing that came into my mind was that she looked so peaceful. How is so much havoc occurring inside of her frail body at this very moment? Was this the end?

As the code team arrived, they confirmed there was no pulse, and they put a durable board beneath her fragile body. The same blouse I gently dressed her in a few hours prior was the same top I was stripping her of. There was so much commotion in the room: the respiratory therapist was getting ready to intervene and the cardiologist was giving orders to push meds. I put down the side rail, laid my right hand over my left, straightened my arms, and began. The same bed I neatly tucked her into the day before was the same bed I was undoing.

It felt different. I was trained with objects that did not have thick thoracic cavities, soft delicate skin that smelled of pomegranates, a warm and familiar body, or a bona fide reason to fight for a successful resuscitation. Mary was a daughter, a wife, a mom, and a grandmother. She was loved. And as I hovered over her vulnerable body and pressed my sweaty palms aggressively against her bare chest, the image of her family was at the forefront of my consciousness.

It was challenging for me to obscure my humanity and be a strict healthcare professional, but it was in that moment I realized how critical it was to find a balance between the two.

A woman almost died that day but she didn't because we followed strict medical protocol: patient was confirmed unconscious and pulseless, 30 chest compressions were followed by 2 breaths with oxygen and airway adjuncts, pads were applied. Once we found a shockable rhythm, we used a defibrillator to bring her back into a normal rhythm. In these moments, I become part of the machinery that functions to sustain the breath and the beating of the heart. While it is important to be an empathetic caretaker and predict the silent needs of patients, I have learned the importance of masking emotional engagement when I care for patients in critical situations that require precise medical attention, such as providing life support.

I awake from my memory to the sound of a stretcher rushing down the hallway. "We have a sixty-seven-year-old male in a cardiac arrest. We have been doing compressions for seven minutes; he is unresponsive," yells the medic carrying the chart. I take over the compressions for the medic and begin counting to thirty.

Después de la tormenta

Eleanor Brown

She lay curled in the corner of a musty, humid space. Underneath the window sits a puddle of water; the afternoon storm had just passed. She is dressed in a light blue gown decorated in red stains.

I approach her. My mind is translating English, so that the words I speak are understood.

Oh, María, ven aquí.

I kneel beside her so that we are at the same level. I wrap my arms around her small body; I hold her like the child she is. I feel her skin from the back of her open gown. Her head buries into my chest. Her skin is warm. Her hair is dark and combed with sweat. Her body is shaking. She smells of earth.

Estás bien, María. María, todo está bien.
Martín está en un lugar mejor. Él está en un lugar mejor.

As we sit quietly in the room, I think of what it is that I have just experienced. I am in a rural clinic in Sumpango, Guatemala. We delivered a baby, a baby boy named Martín. But due to the limited equipment for ventilation, we were unable to find an airway for the newborn; he died of hypoxia. Maria, the mother, is a twelve-year-old girl. I am holding her in my arms. I don't want to let her go. I continue rocking her back and forth, convincing myself that I can make this moment just a little bit better.

I close my eyes and listen to our asynchronous breaths.

Alcoholism: a familial contagion

Anonymous

In fifth grade, Ms. Huebsch told our class that drinking a glass of red wine every night was healthy for the heart. For my classmates, my teacher's irrelevant fact went in one ear and out the other, but for me, it was monumental. At that time, it was a beacon of hope. I suddenly became the bearer of precious information that would solve my family's problems. My relief grounded my excitement in this newfound information, thinking that maybe, just maybe, the addiction that cast a dark shadow over my family might have an unforeseen health benefit. Instead of bringing my father closer to death, his problem was actually adding years to his life. That day, I counted down the seconds until the last school bell rang, leaped out of my desk and gathered my books from my locker. I could not wait until I got to slide into my mom's minivan to tell her the good news. I contemplated the best way to relay the cure for my mom's sleepless nights––do I gloat that my extensive fifth-grade knowledge could save my parents' marriage? Should I throw in an "I told you so! He doesn't have a problem!"? Or do I reveal my insecurities, conveying my secret hope that my childhood hero was not the fraud we all thought he was?

The moment that followed solidified the rift in my relationship with my parents for the rest of my childhood. Like many other insolent children, I chose to gloat, or rather, play into my middle-child syndrome. Naturally, I smart-mouthed my mom. But instead of chastising me for my tone, my mother softened, held my hand, looked deep into my anticipating eyes and said: "It's not healthy when you drink three bottles a night."

Today, I still grapple with this moment; I reflect on the losses I have suffered over the years and the hopes that were shattered in this interaction. Despite the negative feelings it brings, this memory compels me to acknowledge the things I've gained from it––by no means did it bandage the wounds in my familial ties, nor did it absolve my resentment, but it laid the groundwork for me to complicate my distorted relationship with two fundamental concepts in my life: alcohol and my father. I am drawn to investigate my experiences, explicate my feelings and analyze my thoughts in order to uncover the crucial tension inside of me: What does it mean to wholeheartedly aspire to be like my father, a world-renowned doctor who is also struggling immensely with alcoholism?

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I remember the first time I was carried home after drinking too much. Well, let me rephrase––what I truly remember is the feeling of a million gymnasts doing a vault and bar routine in my stomach the next morning. The night before, my sister had found me overwhelmingly intoxicated at a concert, and quickly brought me home, where she thought I would feel safe.
While I was no longer able to publicly embarrass myself, in no way did I feel the security my sister had sought to obtain for me in my childhood home. I knew I had to face my parents. Though it was not a surprise to my mom and dad that I drank in high school, they (ironically) did not approve of unhealthy, let alone underage drinking habits. When I was forced to address that evening's events, I felt like our home simultaneously flooded with emotions: you could see disappointment in my mother's eyes and undeniable anger painted on her face. I had anticipated a severe reprimand on the dangers of uncontrolled drinking, and maybe even a couple days without car privileges, but the words exchanged between us after she had entered my room surprised me. Instead of following my predictions, my mother sat on the edge of my bed and said: "Do you want to end up like your father?"

This moment highlights one of many collisions I've had with alcohol. At times, I speculated that my mom had her own addiction––dependent, no––devoted––to covering up my father's problem. In this case, she was able to redirect my teenage rebellion right back into those familiar feelings of shame, embarrassment and guilt. I was astounded, and honestly impressed, that she found the verbal footing to contort my bout with social drinking into a personal attack, insinuating that I could follow in his footsteps. Ultimately, I found myself questioning the potential truth behind what any child of addiction would consider the ultimate insult, which for me was a debilitating blow, sending me spiraling into self-inspection.

Children of alcoholics hear the statistics loud and clear: alcoholism spreads like a persistent weed through generations. The genetic weight of alcoholism is undeniable; in fact, I can easily see the pathways of addiction sprouting in my family. Each of us regard, interact and stigmatize alcohol from a different perspective. My mother and sister are addicted to control, a feeling that slipped out of their grasps for so many years during the worst of my father's struggle. My brother is stuck in denial––allowing his famous one-liner, "let's be grateful that he's healthier now," blur the consequences of years of suffering in the shadows of my father's disease. I, on the other hand, still question, struggle and falter on what my relationship with addiction should be. I find myself constantly taxed by feelings of hypocrisy.

Even many years later, as a college senior who is legally allowed to imbibe, the words of my mother still creep into my conscious thoughts. For a few seemingly endless moments, I'll spiral into the questioning, loathing and genuine discomfort related to each of my encounters with alcohol. I resent my friends who enjoy a glass of wine with their parents at dinner. I feel guilty drinking socially as a college student. And worst of all, I despise the fact that I am consciously battling against the looming possibility of history repeating itself.

As the daughter of an alcoholic, I find myself writing a unique context for myself and alcohol. Instead of forcing myself into the frame inhabited by most college students, I choose to expand the bounds and acknowledge the sprouting weeds of addiction as they continue to grow. By adopting this mindset, I gain a sense of perspective––an appreciation that my past, present and future will continue to be complicated by alcohol. Though I may never feel comfortable around alcohol, my negative experiences with it bring me closer to understanding what role I want it to play in my life, instead of the role it was assigned by my parents. Reflecting on my past, my mother's harsh words on that brutal Sunday morning demonstrated how unpredictable, triggering and truly explosive alcoholic interactions are in my family. Thus, instead of conforming to how alcohol is situated in society, I shift my focus to a curiosity of mine––one that allows me to move away from resentment and toward control, taking me one step closer to answering: What relationship should an alcoholic's daughter have with alcohol?

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I was eight years old when I first acted out against my father's addiction. The Minnesota Twins were up to bat in the bottom of the ninth, my mom's famous Bolognese sauce bubbled on the stovetop, and his stemless wine glass gleamed on the counter. I sat at the edge of the breakfast bar, watching him gulp down the ruby red Cabernet like water. The brand was Bogle. I remember the logo because I helped my mom pick it out at the liquor store earlier that day. A trip to the liquor store was an unhealthy, weekly tradition for my mother and me––we went after we got groceries next door; she pushed the cart while I ran along the aisles, pointing out his favorite brands and making her grab three of each. I liked certain varieties more than others (mainly for their colorful and ornate labels), but sometimes she would let me pick a new bottle. After years of performing this obligation with my mom, I observed that some of the wines looked darker than others when they were poured into a glass. I preferred the dark purple wines, mainly because the red ones looked more like blood when he spilled them on the carpet. At the time, these moments were nothing more than the thirty-minute span between camps and playdates; it would take many years before I noticed them influencing my daily life. Thus, I carried on, twirling my angel hair pasta as the Twins hit a home run, ending the game. My father set down his wine glass, clapped his hands in excitement and walked out of the kitchen. My thoughts raced––this was my chance to stop him once and for all. I darted around the kitchen table, grasped the wine glass with nervous hands, and poured its contents down the sink, naively hoping the shame, trauma, memories and consequences of his drinking would drain with the alcohol. Years passed before I thought about this moment again––and this time, I did not benefit from the youthful innocence that had previously numbed my pain. Fast-forward thirteen years, and I find myself walking down the familiar aisle of a liquor store in search of a perfect wine to pair with the red sauce served at a dinner party later that night. Merlots from California dominated the section to my left, and I found myself overwhelmed by the sea of deep red. My eyes surveyed from left to right, and each bottle looked the exact same––except for one. Among the multicolored wax covers, hourglass-shaped bottles and thin stems, I spotted the familiar label that enabled so many of my family's problems over nearly two decades. Suddenly, I was overwhelmed by much more than just the bottle of wine. I felt the burden of the memories associated with its content on my shoulders, warning me of the temptation it contained, and ultimately making me recall its insurmountable powers: to make a doctor abandon his oath to medicine, neglect the health of his body, and most importantly, forget his duty as a father.

It took me a long time to think of my father's struggle with addiction as a disease. It seemed wrong to group alcoholism alongside chronic illnesses like Alzheimer's, Cystic Fibrosis, or even cancer. My implicit biases dictated that individuals struggling with addiction made choices that perpetuated their behaviors; in my mind, classifying addiction as a disease made a mockery of those who were simply helpless victims of genetic anomalies. In fact, I watched for years as my father poured another glass; I remained silent when he drove my siblings and me while noticeably intoxicated; and most importantly, I felt the immense shame when he chose alcohol over his career, friends and family.

Even as a grown adult, I hear that familiar sound of a wine pour when a friend, professor or classmate refers to alcohol-

ism as a disease. My lived experiences situate me directly in the frame of addiction, leaving me entangled by contradictory and complicated feelings. While the scientific knowledge from my pre-medical education provides me with logic and research that outline alcoholism as an innate mental and chemical imbalance, I still find it difficult to diagnose my lived experiences in terms of something so matter-of-fact. At times, it seemed like this identification excused my father's actions, took away the traumatic narrative of my childhood and invalidated my ongoing struggle with its repercussions. It is in these moments that I feel the tension and resentment toward my father and alcohol most. I am left to grapple with a dichotomous feeling that waded in the shadows of my sheltered youth, and conversely, bombards me daily in my adult life: How much weight should the context of my childhood have on my father's medical diagnosis as an alcoholic? At what point should the choices he made, the symptoms he portrayed and their downstream effects on my family outweigh his classification as a victim of a disease?

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As I plan for my own career in medicine, I find myself contextualizing all of my thoughts and actions around my father's relationship with addiction. Despite the ways in which he has tainted my childhood, I grew up admiring the idea of my father––a person I had only heard about, and seldom met––allowing me to idealize how he could have been, instead of what he lacked. As a coping mechanism, I clutched onto memories of him that were revealed to me through anecdotes from the past––the doting physician that I read about in stories from thank you cards that patients mailed to my house, or the adventurous and bright teenager that my grandparents described who joined the Peace Corps to teach high school science in Kenya, or even the loving husband who knew he would marry my mother on their first date. During the worst times, this man sounded like a stranger who went missing during crucial moments of my childhood. I would only meet this beloved person after my father went through extensive in-patient treatment, where he was reminded to mend his relationships with those he hurt, and fill in the blanks for that which he missed. Yet, I still find myself unsatisfied. Although it is almost three years since the resurrection of my thoughtful, curious and dedicated father, I continue to boil over with intense resentment, and I find myself fantasizing about what could or should have been. In these moments, I am caught in the crossfire of ambivalent emotions towards two completely different people: my father (the alcoholic), and my father (the recovered alcoholic).

As I continue to uncover new and old emotional scars, I accept that my lived experience with the duality of addiction affects my interactions, motivation, memories, and relationships. Instead of giving into the pressure to pick from the two father figures, I choose to love and hate, acknowledge and ignore, and forget and remember each simultaneously. Rather than focusing on one way to interact with alcohol, I choose to see the paths to both overbearing intoxication and complete abstinence, removing the veil that clouded many of my previous decisions, and making my own route down the middle. And most importantly, I choose to allow my longstanding relationship with alcoholism to shape a healthy way for its incorporation in my life.

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Yet, even with these conclusions, I still find myself lingering on the question: How can I still want to be a doctor like my father? There is no simple answer to this question. I cannot deny that the collisions, broken memories and distorted relationships I have with alcohol, addiction and my father influence (and sometimes cloud) my perspective on the world. Nevertheless, they simultaneously compel me to challenge the overwhelming amount of hypocrisy I feel when I socially interact with alcohol, and reform its frame to include the context of my childhood. My father shaped, for better or for worse, who I am. His disease encouraged me to love medicine despite its flaws and its failure to rid him of his addiction, and allowed me to understand that a disease cannot be simply understood by its biology––a lesson I will carry with me as I pursue a degree in science and healthcare. In turn, I find ways to appreciate the stories of his compassion and ambition––true character traits that were veiled for many years underneath the cloud of his disease. Consciously, I choose to welcome the uncomfortable notion of remaining emotionally torn. With the odds stacked against me, I intend to become a doctor for reasons that I have fought for––ones that incorporate the lessons I have learned from my father, and most importantly, those that commend, exemplify and unravel my tenacious, ever-curious pursuit of understanding a disease that I never asked for, but cannot seem to get away from. .

Sympathy, Empathy, and Compassion

Rose Mahoney

Empathy, sympathy, and compassion are often enveloped in conceptual and semantic confusion. The three are frequently used interchangeably in literature and conversation, conflated and boiled down to a bare-bones definition of "feeling bad" for someone. Recent studies suggest that a patient's perception of their healthcare provider as empathetic correlates with better outcomes. These studies have serious implications for clinical practice, medical education, and research., Physician education has shifted to emphasize the importance of empathy, particularly in instances of palliative care. This transition towards medicine rooted in empathy is made difficult by the lack of a clear practical and conceptual definition of empathy.

The Importance of empathy in healthcare

In 2013, a group of researchers in the Netherlands screened 964 original clinical studies available on PubMed, EMBASE and PsychINFO published in English between 1995 and 2011. The studies were evaluated based on their empirical data about patient experience and General Practitioners' empathy. Researchers defined empathy as "the competence of a physician to understand the patient's situation, perspective, and feelings; to communicate that understanding and check its accuracy; and to act on that understanding in a helpful and therapeutic way." The study found a "good correlation between physician empathy and patient satisfaction… [and] direct positive relationship with strengthening patient enablement." The study concluded that in most cases, a physician's expression of empathy was found to "lower patients' anxiety and distress and deliver significantly better clinical outcomes." In their conclusion, the authors warned about a systematic movement away from good patient-physician communication and towards the technological aspects of care and productivity in general practice. They suggested that in the future, efforts should be made to draw the attention of policy makers and health insurers to these aspects of empathy.

A 2012 study of almost 900 diabetic patients and their primary care physicians in Parma, Italy found that physicians with high empathy scores had patients develop acute metabolic complications at a significantly lower rate. The physicians' empathy scores were determined using the Jefferson Scale of Empathy, a validated instrument developed at the Center for Research in Medical Education and Health Care at Jefferson Medical College which measures empathy based on "understanding of experiences, concerns, and perspectives of the patient, combined with a capacity to communicate this understanding with the intention to help." Patient outcome was measured as a function of acute metabolic complications, which are common among diabetic patients, including diabetic ketoacidosis, hyperosmolar state, and coma. For patients with high empathy scores, the rate of acute metabolic complications per 1,000 patients was 4.0, differing significantly from the 6.8 patients per 1000 for physicians from the moderate and low empathy score category. The report concludes empathy plays an immense role in a trust-based physician-patient relationship, which leads to optimal clinical outcomes through mechanisms of better communication and greater compliance with treatment plans.

The difference between sympathy, empathy, and compassion

In June of 2018, a report was published in the Journal of Palliative Care in which 53 advanced cancer patients in large urban hospitals were interviewed on their experiences with physician sympathy, empathy, and compassion. Upon coding and analyzing patient responses to questions such as, "In your experience are compassion and sympathy related, are compassion and empathy related?" the following table was constructed.

	Sympathy	Empathy	Compassion
Definition	A pity-based response to a distressing situation that is characterized by a lack of relational understanding and the self-preservation of the observer.	An affective response that acknowledges and attempts to understand an individual's suffering through emotional resonance.	A virtuous response that seeks to address the suffering and needs of a person through relational understanding and action.
Response to Suffering	Acknowledgement	Acknowledgement, understanding, and emotional understanding	Acknowledgment, understanding, and emotional resonance linked with action aimed at understanding the person and the amelioration of suffering
Patient-reported Outcomes	Demoralized Patronized Overwhelmed Compounded suffering	Heard Understood Validated	Relief of suffering Enhanced sense of well-being Enhanced quality of caregiving
Examples	"I'm so sorry" "This must be awful" "I can't imagine what it must be like"	"Help me to understand your situation" "I get the sense that you are feeling …" "I feel your sadness"	"I know you are suffering, but there are things I can do to help it be better?" "What can I do to improve your situation?"

While patients spoke to the many similarities between compassion and empathy, they were quick to identify sympathy as distinctly unhelpful and superficial, rooted in a pity and perceived as a coping mechanism used by healthcare professionals in situations that they feel unable to address. Empathy and compassion rooted in acknowledgment of, understanding of, and emotional resonation with a suffering person, were valued by interviewed patients. Some of their responses are recorded below.

"Sympathy, I think is you're feeling sorry for that person. I don't Want somebody to feel sorry for me, I want you to help me." – Patient 48

"That's because empathy is, for me, empathy is that personal conection…whereas sympathy doesn't have to be personalized, it can just be, you know it's just all those comments, my thoughts are with you, blah, blah blah." – Patient 49

"When you empathize with people you, you've crawled. Right into their moccasins." – Patient 44

In differentiating between empathy and compassion, patients emphasized the importance and effectiveness of response rooted in action. While both empathy and compassion acknowledge and attempt to understand another's suffering, compassion adds an active response.

"Compassion is actions… sympathy are thoughts and Well wishes" – Patient 14

"Sympathy are words and you know, "jeez I hope you feel better" and "it's terrible you got this" and compassion is running over and getting a barf bag." – Patient 13

Barriers to compassion and empathy in the medical profession

Many healthcare providers are drawn to the healthcare field because they desire to provide compassionate care; but this can be emotionally taxing in challenging environments where loss and suffering are common and patient throughput is high. A series of one-on-one, semi-structured interviews of healthcare providers including physicians, registered nurses, social workers, hospice psychologists, and palliative care unit employees, were performed in an attempt to pinpoint barriers to compassion and empathy in healthcare. From these interviews the following table was created.

Challenges to compassion	
Theme	**SubThemes**
Personal challenges	Egotistic caregiving Individual differences in HCPs innate virtues
Relational challenges	Stigmatization and prejudice towards patients Perceived lack of patient and family receptivity to compassion.
Systematic challenges	Competing system demands Time constraints
Maladaptive responses	Treating challenges to compassion as excuses for not being compassionate

Participants described personal internal factors as a major challenge to compassion, particularly focusing on egotistic caregiving in which healthcare providers overemphasize their role and unique ability in caregiving. This egotistic caregiving leads a healthcare provider to place all praise and blame on their own shoulders. It leads to stress, depression and burnout, creating a dangerous environment for the patient.

"Sometimes we can be barriers ourselves. As nurses sometimes, we think we know best on what to do or how to control symptoms." –Participant 33

"[You think] 'I'm the only one who can care for this person because we have such a close relationship', so you're the one who comes riding in on the white horse with the white hat to save the day… And so, I think that muddies the road of compassion… because it becomes less about that person and becomes more 'I feel better because now this person relies on me'." – Participant 7

Participants also spoke to the challenges that come about in an unsupportive healthcare system and culture of practice that is perceived as lacking compassion. While compassion often arises as a spontaneous response, it can be stifled by restrictive institutional policies, on overly task-oriented approach and an overly biomedical focus to care. Short-staffing, inflexible schedules, and limited resources were also labeled as barriers to compassion.

"You have all these other obligations and duties and how do you have those moments and still get your job done and all the tasks that you have in front of you for that day. That's a struggle for me." – Participant 4

Conclusion

These studies reveal to us something very intuitive: that a healthcare provider who is empathic is more readily appreciated, accepted, and valued by patients. These positive relationships, rooted in empathy, have been shown to correlate with better patient outcomes and improved healing experience overall. Qualitative studies like these are difficult to perform on such an elusive and ill-defined concept as empathy. Various researchers have taken perspectives of both patients and healthcare providers to create a working definition of clinical empathy as a response that acknowledges and attempts to understand an individual's suffering through emotional resonance, and takes active steps to alleviate pain or suffering. This work provides a scaffolding upon which qualitative data can be collected and used to inform policy, health insurers, healthcare educational facilities and healthcare providers. This research is especially important now as physicians face mounting demands on their time. Increased emphasis on efficiency and administrative requirements for health care delivery encroach on time that could be spent developing a patient-healthcare provider relationship.

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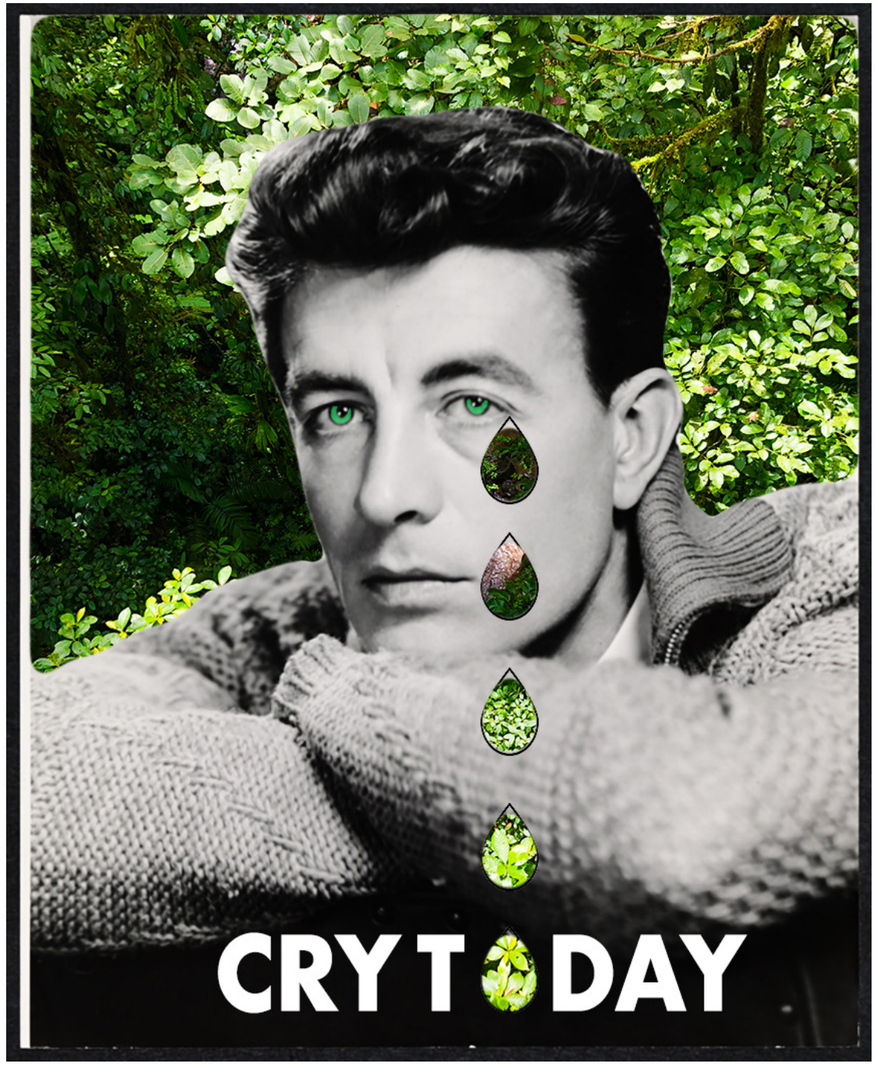
Cry Today

Fernando Mote



Autism Causing Vaccines are Fake News:

A Need for Federal Vaccination Laws

Kathleen Paterson

Every state mandates that children get immunized for measles, rubella, diphtheria, pertussis, tetanus and polio before enrolling in kindergarten. However, all 50 states allow medical exemptions, 47 states allow religious exemptions, and 17 states allow philosophical exemptions. These exemptions, permitted on the basis of our nation's First Amendment, give parents the choice to not vaccinate their children, which leads to serious and dangerous consequences. For instance, the 2015 Disneyland measles outbreak was linked to an unvaccinated child visiting the crowded park.

Vaccine rates in the United States have been in steady decline since a publication in the 1998 Lancet, which suggested that the measles, mumps, and rubella (MMR) vaccine caused autism in previously healthy children. Although the conclusions from the "study" were almost immediately refuted and then retracted by the journal in 2004, 17 states now have fewer than 90% of children vaccinated for measles. In the age of "fake news media," parents are now emboldened to ignore serious information published by credible news sources and thus choose to opt out of preventive medicine. For instance, in 2012 then citizen Donald Trump tweeted, "Autism rates through the roof--why doesn't the Obama administration do something about doctor-inflicted autism" and then again in 2014 tweeted "Autism WAY UP - I believe in vaccinations but not massive, all at once, shots. Too much for small child to handle. Govt. should stop NOW! "

The most serious risks of vaccines, namely severe allergic reactions, are far more rare than the diseases they protect against. It is in society's best interest that this individual choice be subverted for public good and Federal Laws be imposed to curtail personal and religious belief exemptions. Vaccines work by protecting individuals, but their strength really lies in the ability to protect others, specifically those who are most at risk due to age or a compromised immune system. In upholding the duty to protect its citizens and commitment to public health, the government should intervene when parents, who are often uneducated on the topic, choose not to vaccinate their children and thus confer a serious risk to many innocent people.

Federal mandated vaccination laws would not be unprecedented in terms of the government intervening on behalf of a child's medical well being. For example, in 1989, the Massachusetts State Supreme Court ruled that Jehovah's Witnesses are allowed to reject lifesaving blood transfusions for themselves (on the basis of religious beliefs), but they may not refuse necessary transfusions for minors. The Supreme Judicial Court upheld the lower court's ruling to authorize a transfusion, stating, "We conclude that the child's best interests, and the interests of the state, outweigh the parental and religious rights."

Vaccines are perhaps the most important health intervention in history, but have sadly become a victim of their own success. They have been so effective in eliminating the spread of deadly diseases that people have become complacent with the idea of child contracting measles and instead see the unproven risk of a child developing autism as a side effect of a vaccine as a greater possibility. Vaccines are widely supported by doctors, specifically the American Academy of Pediatrics (AAP). In early 2017, in response to a suggestion of a Federal commission on immunizations, the AAP issued a statement reiterating that vaccines are safe, effective and save lives.

One point that anti-vaccine proponents argue is that autism has become a more prevalent diagnosis in recent years. However, correlation does not prove causation, and although it is true that autism has become more prevalent, the reason is due to a broader definition of autism spectrum disorder, rather than vaccines. Additionally, critics, like President Trump, assert that vaccines should be given over a

longer duration time, as not to tax a child's immune system. Conversely, today's vaccines have fewer antigens than those in the past, conferring immunity without much strain to the immune system. Furthermore, there is no benefit to spacing out vaccines, and doing so leaves a child susceptible to disease for a longer period of time.

There is no scientific evidence supporting claims that vaccines cause autism or any other harm to children. Fortunately, between 80 and 90 percent of kids receive most vaccines. But in some regions in the U.S., growing numbers of parents are opting out. As Jimmy Kimmel noted, "Parents in L.A. are more scared of gluten than they are of small poxes." When people chose not to vaccinate their children due to religious or personal beliefs it puts the whole community at risk. There must be an end to the exemptions of vaccinations to ensure that we continue to live in a disease free country and capitalize on the medical advances being made by hard working and intelligent doctors.

"A Friend who values your dreams:"

International nurse migration from india to the United states from 2003 to 2007

Noella D'Souza

A brief perusal of the 2007 issues of the Nursing Journal of India (NJI) reveals mostly academic articles about nursing practice and case studies in addition to pictures documenting social events for the Trained Nurses' Association of India (TNAI). The back cover for almost every issue from the year 2007, however, features a smiling, confident nurse staring directly at the reader next to a boldface "Nurses to U.S.A. Choose RN India" (Fig. 1). The advertisement then goes on to highlight a checklist of company advantages such as an "international nurse recruitment specialist" and an "in-house immigration team", closing their part of the story with the tagline "When you go with RN India, you don't just choose any agency. You choose an Expert in immigration & a friend who values your dreams...", leaving the reader to complete the story initiated by the company. This advertisement for RN India, an international nurse recruitment agency, is one among fifty-seven related ads published in the 2007 issues of the NJI, publicizing companies that specifically facilitated nurse migration from India to the United States. Looking back through NJI records dating back tot 2003- four years prior, there are no advertisements regarding nurse migration to the U.S. Understanding the significant increase in U.S. recruitment of Indian nurses requires examination of the nursing job market in both countries, as well as the historical associations of nursing in India.

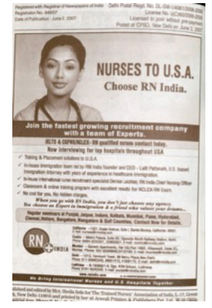


Figure 1: RN India. June 2007. "Nurses To USA".

A Brief Outline of Nursing in India

The Nursing Journal of India is a scholarly publication of the Trained Nurses Association of India (TNAI), India's national nursing association. It has represented Indian nursing since its introduction in the late 19th Century. The TNAI began as an annual meeting of Western nursing superintendents working in colonial British India. Since the first Indian medical institutions were established in the late 1800s by Christian medical missionaries, early Indian nurses were trained in the Western practice of nursing. Medical missionaries frequently used the premise of medical care to enter into communities and try to convert members of the Brahmin caste, the well-respected priestly group in the Hindu caste system. In reality, most eventual converts, and thus, nurses, came from the "untouchable" Dalits, the lowest caste. Additionally, the typical duties performed by nurses were traditionally assigned to the Dalits, as they required close contact with the bodily fluids of others- a ritually unclean task in Hinduism. In this way, the culturally undesirable tasks of nursing work and the social connotations of the Dalit combined to stigmatize the Indian nurse and the Christian work she carried it out. Furthermore, since the initial repositories of nursing knowledge in India were Western medical institutions, this created an implicit understanding that associating oneself with U.S. or U.K.-based medical institutions correlated with a higher level of nursing professionalization. This status-conferring endeavor particularly appealed "to an occupation that, in India, ha[d] been historically status-starved". In contrast, the generally well-received nursing profession in the United States needed India's nurses in the 2000s to supplement the insufficient supply of nurse labor.

An Overview of the U.S Nursing Shortage

The U.S. government's desire for a quick fix to the nursing shortage of the early 2000s and the enthusiasm of recruitment agencies generated the perfect conditions to stimulate international nurse migration. During this decade, the need for nurses was increasing due to the growing U.S. population, particularly of elderly people, and its increasing demands on the healthcare system. The size of the nursing workforce was not increasing to match demand due to fewer nursing school graduates, older RNs in the workforce, a decrease in average earnings per nurse, and the availability of other job opportunities. This shortage only increased leading up to 2003; integrating foreign-educated nurses (FENs) into the U.S. workforce presented itself as a cost-effective, short-term solution. As a result, a 29% increase in the employment of FENs was seen in the years 2003-2007, the period of greatest U.S. international nurse recruitment, with FENs constituting 8% of newly licensed RNs in the U.S.

On the other hand, Indian nurses were drawn to work in the U.S. because of higher salaries relative to their earnings

in India, the respected status of the nursing profession in the United States, and the active recruitment industry that helped place nurses in U.S. medical institutions. U.S. recruitment agencies generally agreed to shoulder the costs of exam preparation, obtaining a U.S. nursing license, and immigration processing while the FEN worked through a one and a half to three year contract with the company. This method of promoting Indian nurse migration during the early 2000s builds on the legacy of previous periods of high nurse migration, most notably from Philippines to the United States in the 1960s during which going abroad was equated with professionalization for nurses. This personal, professional, and cultural status associated with working in the United States positioned the Indian nurse as an ideal target for advertisements marketing the idealized experience of working abroad to recruit FENs to the U.S.

Figure 2: Max HealthStaff. 2005. "Angel of Mercy A".

Interpreting Images

The advertising images and captions used by international recruitment agencies, such as Max HealthStaff and All About Staffing (AAS), utilize the historical associations with Christianity embedded in Indian nursing to elevate the disdained profession and encourage nurses to immigrate. In 2005, Max HealthStaff, an international healthcare staffing agency, started running an ad calling the nurse an "angel of mercy" (Fig. 2). The first version of the 2005 advertisement depicts a youthful looking woman dressed in white scrubs, caringly leaning over a patient who is holding what is most likely a cup of water. While white nurse scrubs are a recognizable characteristic of the profession, the color of her clothing draws parallels with Christianity and its existing association of the color white with angelic purity and holiness. Furthermore, the general scene of a caring woman taking care of a man is reminiscent of many holy women from Biblical stories, like Rachel and Veronica, who give weary men water to drink and/or took care of them. Similar caretaking, bedside nursing images are seen in advertisements from the agencies All About Staffing and Modi Healthcare in 2005 and early 2007.

Drawing distinct parallels with the nurse's work and that of Biblical women reiterates the importance of nursing and confirms the purity of the nurse's work in a culture that historically portrayed that same work as unclean. This is important for the advertisers because elevating nurse's work from the beginning then validates the "angel" nurse's decision to "grow wings" and go abroad to continue this 'holy' and essential work. Interestingly, later in the year, Max HealthStaff slightly changed the image in their advertisement to a nurse in non-white scrubs, a medical mask, and a head cap looking down over a patient while using almost the same caption. The image's primary focus on the figure of the nurse demonstrates a shift in the emphasis from identifying the nurse in relation to her Christian work- "It's time the angel grew wings", to her individual medical competency, "Now it's time you grew wings" (Fig. 3). This paradigm shift is echoed in other aspects of advertisements as the advertising framework shifted away from historical associations of nursing.

Figure 3: Max HealthStaff. 2005. "Angel of Mercy B".

Images from ads run by AAS and RN India closer to 2007 highlight the potential career opportunities of going abroad by emphasizing the experience of living and working in the U.S. and portraying confident, competent individual nurses. Since they first began advertising in the 2005 issues of the NJI, AAS consistently included some reference to the United States in each of their advertisements in versions of the phrase "Opportunity for Indian Nurses... In USA" (Fig. 4). This phrase is accompanied by a happy nurse grinning at the reader behind a button with the outline of the U.S.A, visually streamlining immigration to the U.S., and a logo with an airplane captioned "AAS International". Repeatedly pairing visuals that reference the U.S. or traveling to the U.S. with "opportunity" rhetoric references the existing value placed on migrating to a Western country to advance one's career. Additionally, alluding to "seamless integration" and the ease of pushing a button markets the opportunity by emphasizing the simplicity that comes with working with recruitment agencies. Overall, these messages coalesce to entice the potential nurse to work with a given agency. Notably, a variation of the simple advertising angle is used by Max HealthStaff in their 2007 advertisement which squarely places a U.S. flag next to a photo of Indian nurses studying. This stark contrast paints the professional

opportunity slightly differently, more so as an experience that comes with hard work and dedication, in addition to the company's assistance. Regardless, the allure of going abroad is enhanced by supporting this vision with images of committed, confident women. From 2004 onwards, ads from recruitment preparation agencies ABC Indo-U.S. Academy, AAS, and RN India all feature a bold woman dressed in scrubs with a stethoscope around her neck, ready to become a U.S. nurse. These images establish that nurses who go abroad are both happy, self-assured women and skilled medical professionals (Fig. 1-3, 5). This confidence would be affirmed by living independently in a foreign country or acquired from the experience itself, adding an additional aspect to the marketing of this experience: migration as a financial, professional, and personal opportunity.

Figure 4: All About Staffing. 2005. "Opportunities for Indian Nurses to Live & Work in USA".

Establishing Agency Credibility

An essential component of persuading the nurse customer was establishing an agency's credentials and its ability to deliver on the promised experience, which was primarily accomplished through relationships with U.S.-based institutions. For example, Maurya Medical Staffing Private Limited (MMSPL), an Indian agency that provided test preparation courses for international nurse licensing exams, partnered with Drexel University in the U.S. and heavily advertised this relationship. The first line of their ad in the May 2004 issue of the NJI directly states that "Maurya Medical Staffing Pvt. Ltd. has teamed up with Drexel University, Philadelphia, U.S.A… With over 22 years of experience Drexel University is a world leader in Nurse Continuing Education and the only accredited University in U.S.A offering NCLEX-RN (State Licensing) courses nationally". In immediately announcing and emphasizing the preeminence of their Drexel University partnership, it is evident that MMSPL, an India-based company, views this connection as a clear advantage of working with their agency. This emphasis acknowledges the value associated with the Western standard of nursing and implicitly elevates Indian nursing through an association. Another example of creating associations between Indian and Western nursing is an advertisement placed by Sterling Hospital, a state-of-the-art Indian medical facility. While they advertised only once in the NJI during the 2003-2007 period, Sterling Hospital listed some of its advantages as "frequent training programs to match the international nursing standards", "Sterling prepares & moulds you to step into any part of the world successfully", and "carry brand name of Sterling Hospital with internationally recognised certification to settle abroad". Sterling clearly acknowledges that many of its trained nurses would leave to go abroad after getting a few years of experience, as had been happening in hospitals across India during the contemporaneous period of increasing recruitment, but they leverage this expectation to position themselves as an ideal training ground for international nurses. This strategy makes international recruitment work in their favor to help attract nurses to their hospital. By putting itself on par with the international nursing standard, Sterling depicts itself in a position to dispense the elite Western medical knowledge and experiences important to professionalization, and in doing so, elevates its status as an Indian medical institution.

Employing U.S.-trained personnel within the agency also conferred credibility to agency programs while ensuring that the nurse would be prepared for work and experiences abroad. In both the April and June 2004 versions of their advertisements, MMSPL highlight their "collaboration with renowned Nurse Educator from U.S.A" and "Faculty selected, trained and monitored by Judith Miller RN MS (Nursing), co-editor of NSNA 'NCLEX-RN review' 4th edition and several other books on nursing", respectively. In one version of this ad, MMSPL does not specifically name said "renowned Nurse Educator", but the instructor's association with the U.S.A. is enough to identify them as a valuable resource for imparting knowledge about U.S. nursing standards, especially as they conduct the "final review of students" prior to the CGFNS and/or NCLEX. Thus, in the same way that Sterling Hospital distinguished itself in India by the international caliber of training it offered, MMSPL distinguishes itself through accessing U.S. experience-based knowledge for the benefit of Indian nurses.

Figure 5: ABC Indo-US Academy. September 2004. "Your Gateway to USA". "Angel of Mercy B".

RN India touts its U.S. affiliations, focusing on the experience of their "In-house immigration team headed by RN India founder and CEO-Lalit Pattanaik, U.S. based Immigration At-

torney with years of experience in healthcare migration" and "In-house international nurse recruitment specialist Denise Leichter, RN India Chief Nursing Officer". Both Leichter and Pattanaik do not just work with the company, but are ingrained in the agency hierarchy itself as CEO and Chief Nursing Officer (CNO), implying a familiarity with nurse migration and accreditation processes that are embedded in the agency's foundation, informing all its decisions.

Comprehensive Services and Personal Support

Recruitment agencies promote their ability to prepare the nurse for certification and immigration processes to reassure her of continual support in the migration process. In previous ads, DB Healthcare, a US-based healthcare staffing company, delineates two main headings discussing their "NCLEX Training" and advantages "As An Employer". However, in later ads, these two sections are consolidated into one to make space for another heading: "Why Join N-CLEX Training?", which lists the various benefits of nursing abroad. These range from the

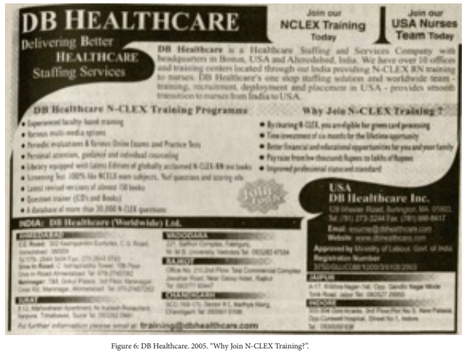


Figure 6: DB Healthcare. 2005. "Why Join N-CLEX Training?".

practical "improved professional status and standard" and "pay raise ... to lakhs of rupees" to the more personal with "time investment of six months for lifetime opportunity" and "better financial and educational opportunities for you and your family" (Fig. 6). Articulating the latter two reasons acknowledges the nurse's personal motivations for migration while entwining them with the agency's NCLEX Training services. The motivation for this accommodation is embedded in a broader invitation for her to work through a given agency. RN India uses a similar approach in their earlier ads with the inclusion of the phrase "When you go with RN India, you don't just choose any agency. You choose an Expert in Immigration & a friend who values your dreams" (Fig. 1). The "friend" rhetoric intentionally paints the recruitment agency as an encouraging confidant and constant companion-two characters who would only be motivated by the nurse's best interests. Even better, this 'friend' is perfectly equipped with all of the immigration and exam preparation services necessary to help the nurse realize her dream. Through this advertising technique, the recruitment agency inserts itself as a fictitious character in the nurse's life who can ease her intangible doubts by encouraging her to work with the very real agency looking for a valuable customer. Once she does make this decision, the agency introduces the nurse to what she can expect when working the U.S.

Services that helped the nurse integrate into U.S. culture and hospitals demonstrate that agencies wanted to paint themselves as occupying a more comprehensive role in the nurse migration and placement process. Both DB Healthcare and Modi Healthcare offered insurance and other benefits for recruited nurses, which sometimes extended to family members as well (Fig. 6). Including long-term benefits in the initial pitch for immigration reassures the nurse that she can reliably support herself and/or her family after being placed in the U.S., and highlighting aspects such as assimilation programs confirms that the recruitment agency will constantly support the nurse through the migration process and beyond. Reaffirming support for all stages of the migration experience assuages anxieties about moving abroad and makes the nurse more receptive to choosing a given agency, knowing that they have already taken these factors into consideration.

Examining advertisements for international nurse recruitment during the mid-2000s reveals how the experience of moving abroad to work in the U.S. was framed as an opportunity for personal and professional growth for Indian nurses. Recruitment agencies marketed this experience to potential customers by appealing to the varied advantages of nurse migration and positioning themselves as the best candidates for facilitating each phase of the migration process. Through leveraging American affiliations, agencies proved their capacity to effectively prepare Indian nurse recruits who could meet the U.S. standard of nursing. Images of smiling nurses paired with the ads imply the rewarding experiences waiting abroad while symbols and logos suggest the continued influence of Western methods and influence in Indian nursing. This paper continues the work of previous studies of U.S. international nurse recruitment but focuses on India as a source country. Qualitatively examining nurse recruitment primarily through advertisements paints a nuanced picture of who were the agencies identifying themselves as 'friends' and what 'dreams' of working abroad they were commodifying and selling to their customers. In doing so, one can understand how the 'value' placed on working abroad was constructed from existing cultural associations implanted in Indian nursing from its inception.

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'Lakh' is a term used in India to refer to numerical quantities of 100,000.

Looking forward:
The Furture of german and greek social security systems

Ted Katsaros

For developed countries, a problem has arisen that may not have been expected 40 or 50 years ago. This problem is the issue of an aging population, and the response to this problem is critical. Two such countries that have shown increased aging populations are Greece and Germany. Both are members of the European Union, and both are rich with history. However, in recent years one of these countries has prospered while the other is in one of the worst financial crises in modern history. Despite these differences, they are bound by the similarity that they must address their aging populations, to ensure that their citizens have the money to live out their lives in retirement.

To fully understand the scope of the issues faced in these countries, one must first look towards their Social Insurance Systems, charged with providing benefits to older citizens, disabled citizens, widows, and orphans. From there it is necessary to look at how these systems have changed over time to adapt to the economic and demographic situations faced by each country, as well as if these changes and systems are effective for their citizens. Additionally, old age care could not be discussed without talking about the healthcare systems the Germans and Greeks offer to their citizens and how costly these systems are to those citizens. Lastly, it is important to look at future challenges faced by these countries when it comes to old age care, as well as to look at how equipped they are to deal with these changes. After compiling all of this information, it is clear that while the Germans have stronger social insurance and healthcare systems in place, both of these countries face significant changes in the near future to their old–age resources.

Germany

How Its System Works

Otto von Bismarck pioneered the world's first social security system when he introduced a system to provide benefits to old age citizens, as well as disabled citizens, in the year 1889 (Social Security Administration [SSA], 2016). Since then the law has undergone numerous changes to reach its current form, which was implemented by the German government in 2002. The German Social Insurance System is a pay as you go (or PAYGO) system, in that citizens are taxed, and these taxes are used to pay out the benefits of already retired citizens. The Germans tax their citizens 9.345% of their monthly income. Companies are also taxed on 9.345% of their payroll, while the self-employed are taxed on 18.7% of their monthly income. The Germans have a tax maximum on incomes of €74,400, or €64,800 for East German citizens; this difference in tax maximums is a result of the merging of East and West German states during the 1990s, and the merging of two tax systems established for two very different economic sectors. As of the 2016 data, the retirement age was 65 years and 5 months, with this age rising to 67 years by the year 2029.

To calculate the benefit these citizens receive, the government has a formula that multiplies individual earnings points by a pension factor and a pension value. Earnings points are calculated by taking lifetime earnings divided by national average earnings, and multiplied by an entry factor, such that if your lifetime earnings were equal to the national average your earnings point would be 1.0. The pension factor for an old-age person is 1.0, and the pension value is calculated as the monthly benefit for a year of average earnings, which amounted to €29.21 in 2016. For those in Germany, deferring benefits beyond the retirement age is rewarded by increasing the entry factory by 0.005 for each month that a citizen is over the age of 65 and 5 months. Conversely, for each month before 65 and 5 months that a person takes his benefits, his entry factor is reduced by 0.003 points. Interestingly, the Germans are increasing the minimum age to 67, while also eliminating the ability to receive an early benefit from the pension system.

Systemic Changes

Relatively speaking, major changes have tended to not occur in German social insurance reform, with several key instances as exceptions to this rule. After its creation the most drastic changes to the system took place between 1945 and 1957 as responses to World War II and its effects on the German nation as a whole. The original system created by Bismarck was a fully-funded, investment-based system, which was able to stay mostly in place until after WWII when the government had far less capital than before the war (Feldman and Siebert, 2002). The investment-based system was not one that could be sustained, and as a result of this the Germans moved for a PAYGO system to gain funds for their retirees. This system was fully implemented in West Germany in 1969, while East Germany remained under the 1949 flat-rate pension system. The Germans then changed their system to reflect more modern times in 1989; however, the system that they agreed upon did not factor in one major event that was just about to happen: reunification. As a result of this, the West German pension system was adapted in the much poorer East Germany, and it was clear that more reforms were needed.

With the challenges brought about from a reunified country, the Germans again adapted their social insurance system in 1999. A major issue that occurred after reunification was the incredibly high unemployment rate in East Germany, which in turn meant that not many people could contribute to the newfound pension system. As an answer to the high unemployment, the German government proposed early retirements and benefits to workers for retiring early in order to get those younger unemployed citizens jobs. While this lowered the unemployment rate from where it was, it placed the burden of supporting the newly retired citizens on the pension system. The 1999 reform kept the PAYGO system in tact, while adding a demographic factor to reduce the overall pension level to correspond with the fact that people now had longer lifespans. Based on the data presented by Bert Rürup in the 2002 book by Feldman and Siebert, this would decrease the pension level from 70% to approximately 64% by the year 2030. Choosing to lower the pension level based on life expectancy allows for a smooth decrease in benefits over time as opposed to more drastic cuts that could have been made. Additionally, the reforms sought to help women, who the government found that outside of the civil sector, where many women were employed, women had very low probabilities of returning to work after having children. To help with this, they encouraged having children by giving women taking care of young children benefits for not working. Lastly, better disability reforms were added to create a stronger relationship between the labor market and the social insurance system.

The German social security system at present is a fairly stable PAYGO system that is able to provide for

its older citizens. However, the changing demographics in the country are threatening this system. As the country looks to push the retirement age backwards further, an additional problem that is presented is the increase in early retirement by those who cannot reach the retirement age. So while the Germans' system remains effective in providing for its citizens, large challenges that the government must address are looming on the horizon.

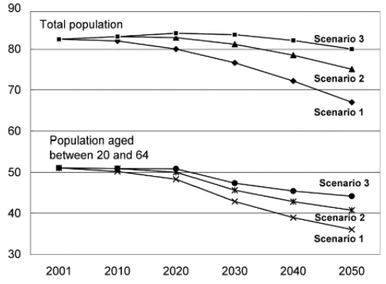
German Healthcare

As with social security, the German healthcare system underwent major reform in the late 1980s after the reunification of Germany. The system in Germany is mandatory for all citizens and is provided through competing, non-profit health insurance groups, and through private health insurance (Blümel and Busse, 2016). As reported by Blümel and Busse, about 86% of Germans receive Statutory Health Insurance (SHI), and 11% go through Private Health Insurance groups (PHI), while military members and other public-sector employees receive their own separate healthcare. In 2016 the value of early contributions paid into the healthcare system was 14.6% of gross wages, split evenly by the employee and the employer, with maximum earnings set at €50,850. All employees earning less than €56,520 are automatically put into the SHI coverage, and non-earning spouses, as well as children, are also covered by the contributions made by the working spouse.

Since 2012 the German system has again undergone changes, namely when addressing the changing demographics in their country. In 2016 the largest piece of reform was introduced in the Second Act to Strengthen Long-Term Care. The first part of this legislation entered in 2016 and significantly expanded support for long-term care for individuals and their families. The second part of this legislation was set for early 2017 and would broaden eligibility for long-term care services, something that had previously been reserved for people with considerably restricted daily functions. To finance this the government is increasing Long Term Care Insurance (LTCI) by 0.2 percentage points up to 2.55% of income for those who have children, and 2.80% of income for those without. This increase will account for 6 billion Euros in revenue for the German government to use to cover long-term care spending by the year 2022.

Going Forward

When looking at the German systems of social security and healthcare, it is clear that they are not hiding from the fact that there are significant issues arising from their demographic situation. The country's new legislature focusing on expanding long-term care is a big first step in recognizing the fact that their demographic situation needs a response. As depicted by the following graph, the population in Germany is drastically changing, and as such they are approaching a point where there will be one working person supporting each retiree, something that in the 1970s was a ratio of three workers for each retiree (Siebert, 2005). Overall, the German government recognizes their issue but needs to take steps to insure that their currently effective system continues to act as such.



Greece

How Its System Works

Following in the footsteps of the Germans, the Greeks instituted their first social insurance system in the year 1934 (Social Security Administration [SSA], 2016). The current Greek system has undergone numerous changes since the 1950s up to the current version that was last touched in 2016. The Greek system has many components to it, and as such is a fairly complicated system to follow. The Greeks tax their citizens 6.67% of their monthly earnings, or 8.87% for what they deem unhealthy or strenuous work. The employer, on the other hand, contributes 13.33%, or 14.73%, of monthly earnings by employees. Self-employed workers, however, must contribute 20% of their monthly earnings to the social security tax. Additionally, the maximum earnings used to calculate a contribution is €5,543.55 per month for employees in Greece. As of 2016 the retirement age in Greece was 67 for men, and 62 for women; to qualify for receiving benefits one must have been a resident of Greece for at least 15 years, while contributing to the system for at least 20.

To calculate the benefits received by Greek citizens, the government has several calculations that they take in to account. First and foremost, a national pension of €384 will be given per month if at least 20 years of contributions have been made. As with many systems reductions are made depending on early claiming, 0.5% per month under retirement age; but the Greek system is unique in that they take 2% off per year under the contributions, as well as 2.5% for each year of residence under 40 years. For contributory old-age pensions, those insured after 1992 have their pensions calculated based on length of coverage and pensionable earnings throughout the last five years. The absolute minimum monthly pension equates to €486.84 a month, with the maximum being €2,373.50. The Greeks apply an earnings test to the pension, by reducing the amount of the pension that exceeds €1,007.10 by 60%, with that threshold increasing by €204.42 per child under the age of 18, or 24 if a student.

Greek Healthcare

Like the German system, the Greek healthcare framework has changed over the years reflecting changes in society, as well as changes economically within the country. Healthcare statistics when it comes to the country of Greece are very important to point out in order talk about changes their social insurance system needs to undergo in order to better care for retired or unemployed old-age citizens. Like with most spending since the 2008 financial crisis, Greece has spent less and less each year on healthcare, down a cumulative percentage of 32% since 2009 (OECD, 2016). As such the share of the population that has public healthcare coverage in 2015 was 85% as opposed to the 100% coverage in the year 2008. This is mainly a result of the fact that the people of Greece currently have less and less disposable income; however, those who are uninsured are covered for any prescribed medications, emergency services in hospitals, and even some non-emergency care as of 2014. This decrease in spending also highlighted larger inefficiencies in the Greek system that had previously been present but were masked by more stable economic conditions. The three main issues were the inappropriate prescribing of prescription drugs by physicians, weak primary care, and imbalances in the mix of health professionals, which mainly affects older citizens needing long-term care.

Looking at how Greek general practitioners over-prescribe, one must simply take a look at the OECD data on volume of antibiotics prescribed. The average OECD country prescribes antibiotics at a volume, defined daily dose, of 20.7, while Greece is at

32.2, this means they are prescribing antibiotics 50% of the time more than in other countries on average. Generally with regards to this statistic, the lower the number the stronger the country's primary care is; Greece's being at such a large number shows the weakness of their primary care system at present. In regard to old age care, Greece faces a problem in the structure of their healthcare system, specifically in staffing. The OECD average for ratio of nurses to physicians is 2.8 as of 2016 data—much higher than the average in Greece of 0.6. This means that while in most OECD countries there are about three nurses for every doctor, in Greece there are about two doctors for every one nurse. This creates a large issue for end of life care, when nursing is such an essential aspect of the old-age healthcare experience.

Greek Economic Issues

Greece was under a military junta from 1967-1974. When this ended it left weaknesses in their economy that would not fully be realized until the economic crisis that occurred at the end of the first decade of the 2000s (Papadopoulos and Roumpakis, 2012). In 2008 following the international crisis in the financial and banking sectors Greece was given $28 billion to help sustain economic growth, help with loans between banks, and boost liquidity. This equated to about 12% of Greece's GDP in 2008 and was added on top of the already incredibly burdened Greek budget that was still dealing with the payments of the 2004 Olympic games. In 2008 Greece was spending more than any other EU member on their military, about 3% of their GDP, and already had a public debt that equaled 110% of their 2008 GDP. By the middle of 2011 Greece had racked up a public debt of €360 billion, of which €75 billion was in loans, with the other €285 billion in bonds. €30 billion of this debt is held in Greek pension bonds, to ensure that those eligible for pensions are still able to receive them.

With that numerical data on the effects of the economic crisis, it is important now to understand where the economic crisis came from. From the Papadopoulos and Roumpakis article, the Greek debt crisis is broken down into several causes that ultimately get to the heart of the economic issues in Greece. Historically, Greece has a history of defaulting consistently, and has declared bankruptcy following global financial hardships in the past. Most notably they declared bankruptcy in 1932 after the Great Depression, following one of the worst financial crises in history. Because Greece relies so heavily on lending, the periods after financial crises where other nations suddenly stopped lending to them presents them with great challenges and sets them on the path to bankruptcy yet again. The Greek government has historically borrowed a lot of money from the public, racking up enormous public debt in terms of GDP (greater than 60%) starting as early as the late 1980s. On top of all of this there is a large underground economy in Greece, wherein the government is trying to impose a move to a plastic system, of debit and credit cards, to stop the corruption of business owners operating under a strictly cash system. These factors, combined with years of corruption in prior Greek governments, all came to a head in the 2008 crisis to start the Greek economy on a downward spiral that they have yet to climb out of.

Comparison

When looking at the two countries presented above, several questions come to mind. The main question is what can these countries do going forward to better help their retired and older populations receive benefits to sustain quality of life? In actuality after researching the two countries, it becomes clear that the differences in their systems are not as much the root cause of economic hardship in old age as overall national economics are. There are, however, some aspects of the German social insurance program that Greece should adapt, as well as overall policy changes that would help the pensioners receive proper benefits. The shift the Germans have made towards ending early benefits would be one way in which Greece could reduce spending on social insurance, especially in a country where so many citizens either retire or are forced out of work at younger ages and need their benefits. Secondly, Greece would benefit from simplifying their system into a PAYGO system as opposed to the contribution-based pension, and the national pension on top of that. Double dipping only adds to the burden of economic hardship by requiring even more funds. The population in Greece would further benefit from higher taxes; the Germans are taxed 9.345% of monthly income, compared to 6.67% in Greece. Changes to the tax structure, while potentially unpopular with the Greek citizens, would bolster funds that are used for retirement pensions, and as such would be able to help cut into the €30 billion debt the pension system faces.

Outside of the social insurance system directly, Greece could benefit from two main political distinctions between themselves and the Germans. For one, the Germans ended military conscription in 2011, and this saved billions of dollars in defense spending. As touched upon from the Papadopoulos and Roumpakis article, Greece spends more on defense than any other country in the EU, and part of this is due to the fact that all men ages 19-45 must serve in Greece. The Greek army is massive in relation to both its size as a country and the frequency in which it enters conflicts, so reducing that spending could help aide the debt in pensions Greece has taken out in bonds.

The German citizens contribute more of their taxes into healthcare, and as such the government was able to move forward with new legislature to ensure better end of life care for the people in the country. As such people in Germany have much better long term care, which is crucial for an aging population. Because of the better-funded healthcare system, the Germans in general show signs of better health than the Greeks. Compared to the rest of Europe, Greeks have incredibly high childhood obesity rates, 44% compared to the average of 24%, and a high percentage of people over 15 who smoke, at 38.9% compared to the average of 19.7% (OECD, 2016). If the healthcare system in Greece were more effective at systematically teaching good health practices, it would reduce costs that come with the long-term effects of obesity and smoking, and any cost reduction in Greece is beneficial.

While the German system does hold firm to being the better system overall, a key facet to the issues faced with the Greek system is the country's economic hardship in general and the immense debt the country faces. Without such debt and hardship, the system in Greece could more easily be changed to adapt to their aging society in ways to better benefit the citizens of the country. All that being said, it is clear as discussed in previous sections that the German system is also far from perfect, and there is still more work to be done there as well to ensure the aging population is properly taken care of. The struggle of aging populations in developing countries is not going to go away any time soon, and looking at what countries like Germany are doing about it can serve as a blueprint for other countries, such as Greece, going forward in dealing with their own aging issues.

Conclusion

As clearly depicted throughout this paper the questions of an aging society, and what to do about them, are serious and must be addressed. In the United States we often do not hear about these issues greatly on campaign trials that focus on taxes, immigration, and national defense. It is shown to be

unpopular to address the fact that by 2034 the United States Social Security trust fund is slated to run out, drastically cutting SS benefits to our retired citizens. While it is politically unpopular to propose any sort of benefit cut, the United States would be wise to learn from some of the steps that the Germans have shown, in combating aging populations.

While the United States is a very different country than Germany on many levels, it should learn from the Germans in regards to the fact that the Germans are striving to make their system work. United States politicians, both liberal and conservative, have proposed plans for higher taxes for Social Security, as well as plans to cut benefits for Social Security. However, by and large the United States is ignoring a problem that is quickly approaching, and doing so are hindering the health and lifestyle of many of America's elderly.

If the United States does nothing about the impending Social Security crisis that is less than 20 years away, many individuals will get to retirement with little to no savings, and little to no retirement income. Social Security is vital to millions of Americans who were not able to privately save enough to retire. As seen in Greece, a poor and aging society ultimately becomes an unhealthy one, and in a country like the United States that values a high level of healthcare, what is happening in Greece should be seen as unacceptable. And yet, if there is no response to the Social Security problem, the situation in Greece could be something that United States healthcare professionals have to find an answer to.

While the United States is staring down the barrel, that is not to say that there is no hope. The biggest issue for the United States is lack of discussion. If the United States is going to tackle its Social Security problems, politicians must more actively make citizens aware of the issues and the possible solutions. Only when people know the full scope of the impending problem, and how it will affect everyone, can politicians propose actual solutions to the problem. The United States has the resources, and the ability, to help fix the issues with Social Security. The question simply remains, will they?

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