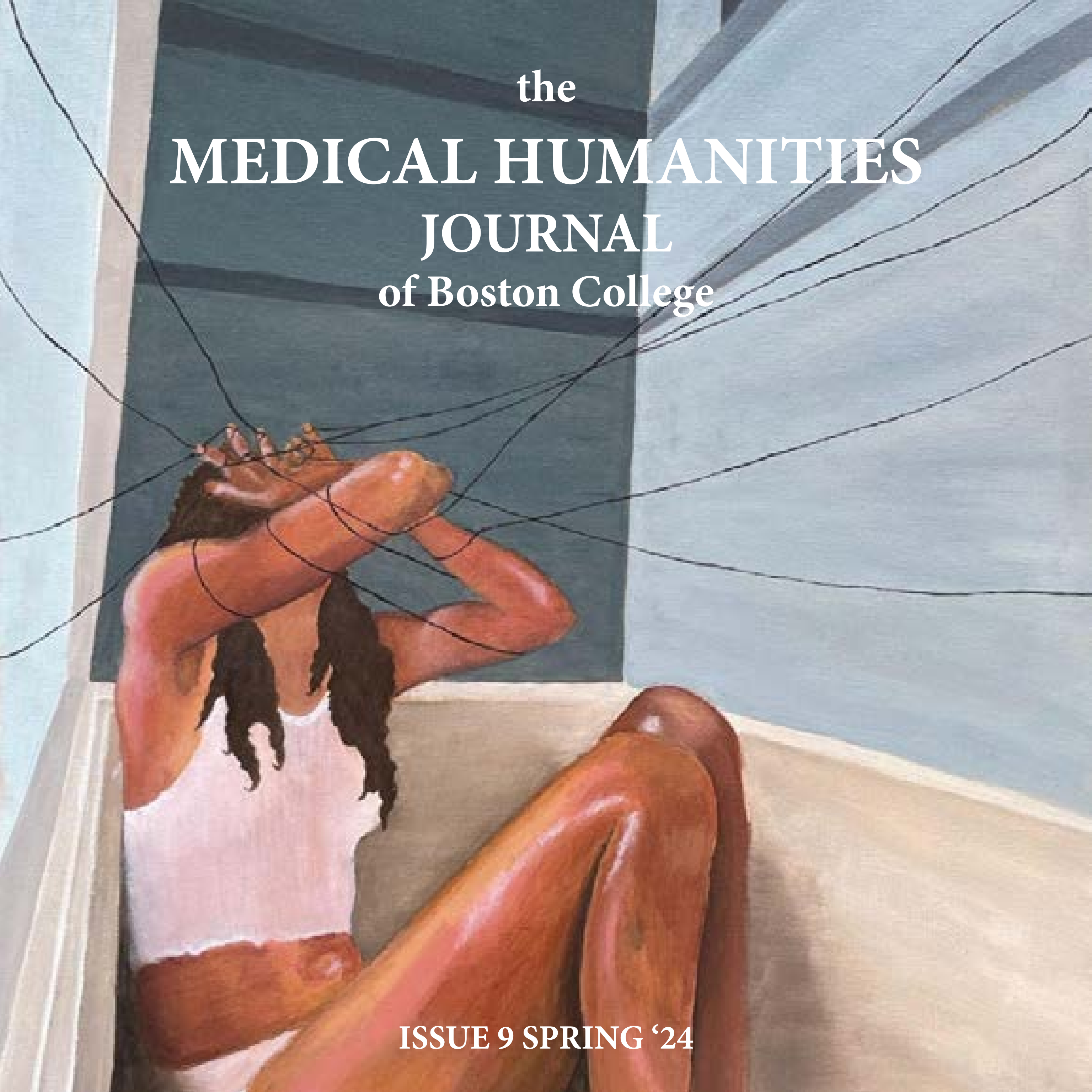
the
MEDICAL HUMANITIES
JOURNAL
of Boston College



ISSUE 9 SPRING '24

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.

ACKNOWLEDGEMENTS

Editorial Staff
Co-Editors-in-Chief
Jenny Zeng ‘24
Tristan Leitz ‘24

Layout Manager
Morgan Costa ‘25

Website Design and OJS Coordinator
Dhiman Shahid ‘25

Outreach and Publicity
Taylor Barbee ‘27

Treasurer
Ella Richards ‘25

General Editors
Talin Deukmejian ‘24
Julia Rose ‘24
Suzanne Has ‘25
Raquel Cohen ‘25
Emily Barnabas ‘26
Jess Julian ‘26
Malia Robinson ‘27

Cover Artist
Jada Tuffin ‘27

Logo
Joanna Tomsick

Advisors
Amy Boesky, Department Chair, Professor of English and Director of the Medical Humanities, Health, and Culture Minor

Grace Gerrish, Ph.D Candidate in the Department of English and Graduate Assistant to the Medical Humanities, Health, and Culture Minor

THANKS and CONTRIBUTIONS

Funding for this publication is provided by the Institute for Liberal Arts at Boston College
Susan Dunn, Director of Center for Centers
The Medical Humanities, Health, and Culture Minor

Very special thanks to Grace Gerrish, Graduate Assistant in the Medical Humanities, Health, and Culture Program

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

The Medical Humanities Journal of Boston College, Volume 8, Spring 2023
Mailing Address: 10 Stone Avenue, Chestnut Hill, MA 02467

EDITOR'S NOTE

We are often asked by those who want to submit to this Journal, "What should I write about?" After all these years, it's still not an easy question to answer.

Sitting in front of a blank page, oftentimes we find ourselves looking for something to hone in on. A prompt, a question, maybe an issue we've been grappling with or are facing at this very moment. But with a Journal that combines the three largest pillars of academic subjects—the arts, sciences, and humanities—what is there not to write about? After those blank pages are filled up, and cut down, and perhaps filled up again, the end result is something unique to each author. Every work of writing is—in some way, shape, or form—a reflection of a person's beliefs, values, and thoughts. As editors, especially for a journal that attracts intimately personal stories, we must treat each story with the utmost care. In "Sambal Ikan Bilis," Emily Barnabas invites us into her grandmother's kitchen where "the window by the kitchen sink [is] lined with painkillers" but "it was really the little bottles of turmeric and coriander powder that kept her going." In "Proctor Two," Rachel Ruggera shares her journey with mental health and writes about a week spent in a psychiatric hospital with moving honesty and lyrical metaphor. Sadia Tanzem challenges us to think about the power our words and the connotations they carry, and the lasting effect they can have on another's psyche in "The Medicine of Language." Every story is special. We are grateful to each author for sharing their stories with the world, and applaud them for their courage in setting their words free.

For others, the innermost feelings of the human condition are expressed not with words, but through the visual form with colors, shapes, and lines to blank canvas. In the claustrophobic cell of the bathtub depicted in Jada Tuffin's *Strings Attached*, we feel a suffocating sense of closing in, of dead ends. The subject's face is covered, perhaps suggesting that it could represent anyone. We have all lived in our own self-imposed cell at some point. Even if we are unable to fully understand the intent of the work as the artist intended, we are somehow able to understand what they might have been feeling at the time of the work's creation.

This year, we had the wonderful opportunity to meet the founders of the Journal. Although it has been ten years since the Journal's founding, their lasting commitment to and interest in the medical humanities strengthened our belief in the power of writing our stories, and sharing them with the world. It is our hope that the editors who succeed us carry on the Journal's mission to bring awareness to the field of medical humanities, word by word, line by line, page by page.

This submission also marks a few monumental steps forward for the Journal. We joined Boston College Libraries' Open Access Journals page. After many long hours of planning, sending emails, making phone calls, and meetings, we also organized an event in collaboration with the McMullen Museum to commemorate the tenth anniversary of the Journal, which included a reading event with authors published in the Journal, an art gallery, film screenings, and arts and crafts. We could not be more proud or thankful for our general editors and executive board members who rose up to each challenge and made this event possible.

To those who ask, "What should I submit to the Journal?," we say, "Write your story, the one you want to tell."

Also, from Tristan, I'd like to give a personal thank you to Jenny. In our work together, she is the epitome of a partner-in-crime. Her dedication, flexibility, and commitment to this Journal are second to none. Through all of the trials and tribulations that we faced together, there is no one else I would have rather led this Journal with. From the bottom of my heart, I am so proud of everything we have accomplished together, and the hands we are passing the Journal off to. Thank you, Jenny.

From Jenny, I'd like to extend a personal thank you to Tristan. We both joined the Journal in our freshman year (seems so long ago!) during the Covid-19 pandemic when meetings were held over Zoom. Even when things started to return to "normalcy," leading the Journal was not easy. There were more moments than I would like to admit when I doubted myself, when we both struggled to push the Journal forward. I'm immeasurably grateful for Tristan's steadfast support through the thick and thin. I am proud of how far we have come. The Journal would not be where it is today without him.

TABLE OF CONTENTS

TABLE OF CONTENTS

Abecedarian Endings

Kathryn Gilmore

Asthmatic breaths come first—
Before the biopsies and ER trips.
Cutting through storybook narrations,
Dragging out lullabies, stuttered
Exhalations— a soundtrack
Familiar to me as the strums of his
Guitar, echoing through out
Home. It was a faint worry,
In time, enhanced by the blooming
Jaundice across his skin,
Kindling a fear that had always been
Lurking there with the cancer in his liver.
Months of surgeries,
Numbly listening to
Offers of
Palliative care,
Questions of comfort in final days,
Realizing nightmares that
Soaked being a
Teenager in grief.
Undulating pulses,
Virulent infections,
White hospice blankets turned crimson,
X-rays of a liver, trying to prepare for some kind of future— a girl in a
Yellow school uniform
Zealously studying for the ACT next to her father's deathbed.

Alleyway Overdose

Lizzy de Foy

"Cardiac arrest in an alleyway – fat fucking chance," Dylan said, flipping on the lights and sirens.

Luke laughed, and the ambulance jolted as he began to weave through the traffic we'd been stuck in. "That's firefighters for ya."
I leaned towards the separation window excitedly. "You mean it's an overdose?" I'd never had an overdose patient before.

"Yeah, probably," Luke said. "Patient's passed out in an alley. We'll let you give the Narcan." I grinned. After a few sleepy days spent at a firehouse in the suburbs, my first ride-along with the city fire department was quite the change of pace. Cyndi Lauper filled the ambulance as we swerved onto the highway, blaring lyrics and sirens alike.

"Oooh, girls just wanna have fun…"

***

It was not an overdose. Firefighters swarmed the scene. The patient came into view as I passed around a parked truck: an older black woman with thick silver-gray hair was lying on her back in a driveway. A firefighter was bent over her, doing compressions. As I got closer, I saw unnaturally blue eyes, wide open and staring at the sky.

Luke tossed me the glucose kit. "Get a sugar on her, would you?" I knelt next to her in the debris and took her limp hand in mine to get the reading.

Luke drilled into her tibia – *intraosseous infusion*, my mind supplied – and administered the first dose of epinephrine. Up by her head, a firefighter was pushing breaths into her with a bag valve mask. As the compressions and the BVM forced air into her stomach, she began to vomit. It pooled in her mouth.

"You wanna suction her?" Luke asked. I took the suction catheter from him and knelt by her head, heart racing. My EMT textbook flipped open in my mind's eye. *Place the rigid suction catheter into the patient's mouth only as far as you can see.* I placed the hard plastic tube into her mouth and sucked out the vomit, making wide circles.

Luke peered into her mouth and shook his head. "Nah, go deeper." I forced it down her throat, and thick orange vomitus shot up through the plastic tubing. In and out, I pushed the catheter until the vomit stopped coming. It occurred to me that suctioning *only as far as you can see* was fairly useless. Had that textbook's author ever been in the field?

The patient continued to vomit: keeping her airway clear was rapidly becoming an issue. Luke took the breathing tube Dylan handed him, turning back to me. "Wanna place the i-gel?"

"Absolutely." I looked down at the thick rubber tube and hesitated. *Never place a supraglottic airway without first administering lubricant.* "No lube?"

"Nah, just stick it in," he said. *Okay…* It was surprisingly easy to push the i-gel down her throat once I'd pulled her lip back from her teeth. I wondered how badly her throat would be bruised later. As I adjusted its placement, I heard the words "stage four colon cancer" from a firefighter behind me. Would she be awake to feel the tube? To feel any of this? I knew the stats for cardiac arrest. I knew we were unlikely to succeed. And even if we did, for a terminally ill patient… I focused on the airway placement, pushing recovery data out of my mind.

Luke attached the bag to the protruding top of the i-gel and handed it off to me to continue respirations. I put my hands around the ballooned rubber, careful not to push too hard. Squeeze, *one, two, three…* In class, I'd often rush my counting while practicing on our beat-up manikin. Now, I counted slowly, methodically. I felt a thrill for a moment – was I really breathing for my patient? My hands felt unnaturally steady on the bag.

I continued to bag her as the firemen lifted the backboard up and onto the stretcher. A man had been watching from the sidelines, and as we brought the woman out to load her into the ambulance, he came up beside her. He leaned down, and he took her face in his hands very gently, ignoring the streaks of vomit on her cheeks. He pressed a kiss to her forehead.

My hands faltered on the bag. Would this man lose his love today? How long had he been preparing for this moment? Heartache rose in my chest, but I forced it down, blinking hard.

Focus. I shook myself and resumed counting. In the ambulance, we shocked her several times. I tried to close those blue eyes, but they rolled back open. I worried that they'd dry out. I wondered why I worried – such an inconsequential thing for a woman with no heartbeat.

Dylan repositioned from where he crouched at her neck, feeling for a pulse. "Luke? Think I got one." I hadn't expected a pulse. Now, I was afraid. I'd read too much of Gawande's writing. What state would she be in if she woke up? I was afraid that she'd never go home: that she'd die in the hospital, a long, drawn-out, painful death. I wanted to revel in the thought that we'd resuscitated her. I didn't want to wonder whether we were doing the right thing.

We dropped her off at the hospital, and a host of medical personnel piled around her bed. I squeezed into a corner of the room, watching from afar. Once she'd been settled, I slipped out of the room. I stripped the stretcher and loaded it back into the ambulance. I stared for a moment at the remnants of medical paraphernalia littering the floor of the ambulance. *He took her face in his hands…* I threw away the bits of paper and plastic and tubing, meticulously checking corners, and then I sat down heavily on the bench. I stared at the empty stretcher, at the flecks of vomit on my boots. After a bit, Luke was back. He climbed in and sat next to me.

"So, kinda cool, right?"

I looked up from the stretcher. "Yeah," I said quietly. "Pretty cool."

Water Soluble Oil on Cnvas *Jada Tuffin*

Beyond Biology: Exploring the Mental Well-being of Non-Gestational Mothers in Same-Sex Partnerships

Tess Chernauskas

Many couples that aspire to start a family face various challenges from pregnancy planning to parenthood. However, there are also specific challenges that lesbian parents have to navigate due to our societal norms and the heteronormative expectations exhibited within our legal and healthcare systems. This affects the social and personal dynamic between the partners themselves, society, and even their future children (Morse, 2013). We can again perceive the negative implications of societal norms through the negative experiences communicated by these couples, making it a pertinent issue within our society that must be examined and directly addressed (Gregg, n.d.). The formation of parental identity for non-gestational parents in lesbian relationships is hindered by societal heteronormative standards, necessitating interventions to advance social, biological, medical, and legal inclusivity.

The first significant factors affecting the mental health of the non-gestational lesbian parent is stigma and social exclusion. As reiterated by Vázquez (2020), social stigma regarding same-gender relationships affects the perceived competence of each queer parent individually. While the biological partner tends to receive less scrutiny from the general public due to her "maternal instincts," the non-gestational partner does not have biology to fall back on. Due to this stigmatization, fissures often form within LGBTQ+ relationships due to the perception that one parent is more valuable than another. From a broader familial standpoint, non-biological mothers reported that extended family was more likely to make an effort to connect with the child if it was biologically related to their daughter (Paldron, 2014). These heteronormative "master narratives" (Farr and Vázquez, 2020) that define our society leads to non-gestational or adoptive lesbian parents not being perceived as "real moms." This lack of acknowledgment leads to a sense of invisibility, therefore negatively affecting the mental health of these moms (Abelsohn, 2013).

Lesbian mothers have also reported feeling as if the questions asked of them as parents are much more invasive than those asked of heterosexual parents (Hope, 2019). These comments usually target the non-gestational mother's role in the procreation of their child, as shown through the classic question regarding who the "real" mom is. Not only does this create tension between the couple and those asking, but also creates an awkward dynamic between the mothers and how they decide to approach answering such a question (Abelsohn, 2013). Another question that many couples find themselves hearing incessantly regards who is playing the role of "mom" and who is playing the role of "dad." According to qualitative research, many non-gestational mothers feel themselves being compared to the "dad" in their relationship due to the fact that they are not carrying (Hope, 2019). This is specifically harmful to their mental health because it is subliminally invalidating their identity as lesbian women.

Another factor impacting the mental health of non-gestational lesbian parents is biological connectedness, which influences identity formation regarding "fatherhood." From a broader societal context, many people try to discern whether the donor is the "father" or "not the father" which can have detrimental effects on the creation of parental roles (Lingiardi et al., 2016). The implications of this are decreased significance of genetic ties between the parents and children, and increased importance of an intentionally structured, connected relationship (Lingiardi et al., 2016).

However, societal norms still poke through, even as lesbians foster these connected relationships. As Lingiardi (2016) states, many non-biological mothers feel as though they are third in line in their importance as a parent, after the biological mother and donor. This not only disrupts their sense of equality as co-parents but also may incite feelings of invalidity in relation to the biological mother and donor (Lingiardi, 2016). The use of assisted reproductive technology ignites other psychological problems within some non-gestational mothers. For example, the language used to describe the donor as the "missing" or "extra" piece in the creation of a family perpetuates the idea that the lesbian familial structure is lacking due to the absence of a father.

Another important variable that may have a significant effect on the non-gestational parent's mental health is legal factors. Ehrensaft (2008) raises the point that the vast majority of the time, the non-biological lesbian mother holds no rights over their child unless she formally adopts him or her. Therefore, you can imagine how this may feel as a partner who has been involved in the entire pregnancy and birthing process—extremely invalidating (Ehrensaft, 2008). This is not even mentioning the adoption process, which in itself is very rigorous. While all states support "marital presumption," or asserting the father as an automatic legal parent, nowhere in the United States does the same presumption apply to lesbian mothers. Wald (2016) also raises the point that this can be both emotionally and financially devastating for all parties involved, illustrating a factor of discrimination against same-sex couples. Additionally, if a lesbian couple were to file for divorce and adoption was not yet asserted, the non-biological mother would have no grounds for custody as a father would in a heterosexual relationship. Therefore, equal parental legitimacy is directly affected by genetic participation (Lingiardi, 2016). This idea of queer rights was highly disputed in the case Obergelfell v. Hodges, which asserted an array of equal protections for the gay community. However, legislation is still extremely unequal regarding parental rights, a statue not protected by the Equal Protection Clause of the Constitution (Farr et al., 2001).

Intervention needs to be instituted in the areas of therapy, the medical field, and our government. To begin, it has been proven that socializing is positively correlated with better mental health outcomes. This underscores the necessity for increased accessibility to therapy, particularly for non-gestational mothers. Therapy is typically offered to the biological mother during postnatal check ups due to higher rates of postnatal depression; however, the non-gestational mother is not afforded this same opportunity for screening since she did not carry the child (Abelson, 2013). Therefore, resources such as LGBTQ+ Counseling and Therapy Services (NGB) in California have to be more widely employed and accessible. This form of intervention actively combats the manifestations of stigmas regarding non-biological parents in our society by offering LGBTQ+ Counseling and Therapy Areas for a wide array of obstacles that come with being a part of the LGBTQ+ community. They explore niches such as dating, relationship, and marriage issues; divorce and healing; parental alienation; and of course, non-biological parent therapies.

Inspired Birth Pro, an organization striving to promote inclusivity through online childbirth education, is leading efforts to a more welcoming maternal community. This organization believes there is a lack of education within the medical community and coaches massage therapists, chiropractors, doulas, midwives, doctors, nurses, lactation consultants, childbirth educators, and all other pregnancy/birth/postpartum professionals on these ever-so-important identities. For example, one aspect of educating these medical professionals is teaching them the difference between gender identity, gender expression, physical attraction, and emotional attraction, and how this may equate to an individual's identity and relationship status (Bauta, 2020). This relates to the non-gestational parent's mental health by spurring more sensitive and accepting dialogue among the biological mother, the clinician, and the non-gestational mother.

The most significant legislative advancement needed is the establishment of marital presumption of parentage. This legal concept would grant equal rights to same-sex couples by presuming their legitimacy as parents based on their shared living arrangements. In reality, however, marital presumption is applicable only to heterosexual couples and not to lesbian couples, consequently affecting child rights of the latter group (Krimmer, 2016). The majority of the time the non-biological mother is not listed as the other parent on the birth certificate. Often they must go through a legal process that confirms the mother's intent to raise the child, a step that no birth parent would have to complete (Wald, 2016). This flaw in the United States' legal and medical systems must be corrected to affirm the rights of the LGBTQ+ community as parents.

There needs to be a clear statute written within federal law (not just state law) that allows same-sex partners the same rights as heterosexual couples. A Rhode Island lesbian couple reflected upon the necessity for this legislation. The non-gestational mother stated that for the first eight months of her son's life (the time it takes for the adoption to be processed), she could not pick him up from daycare, authorize vaccines, or even add him to her insurance (Moreau, 2020). This couple is actively involved in the Movement Advancement Project for assisted reproduction and de facto recognition, a legal intervention currently supported by thirteen states (MAP, n.d.). De facto recognition makes the non-gestational lesbian parent an automatic legal guardian over their child, just as male non-gestational parents have this same right.

In conclusion, the lack of systemic support for the non-biological mother in a lesbian couple has detrimental effects on both her, her partner, and their child. Additionally, we see broader societal implications, revealing our prioritization of traditional families over non-traditional ones through our actions. To address this, we must intervene on a variety of fronts, including addressing social, biological, medical, and legal inclusivity.

References

Abelsohn, K. A., Epstein, R., & Ross, L. E. (2013). Celebrating the "other" parent: Mental health and wellness of expecting lesbian, bisexual, and queer non-birth parents. Journal of Gay & Lesbian Mental Health, 17(4), 387–405. https://doi.org/10.1080/19359705.2013.771808

Bauta, D., MacAuley, Goldman, D., Swan, C., Brooke, & Darlene MacAuley. (2020, December 18). LGBTQIA inclusive pregnancy and birth care. Inspired Birth Pro. Retrieved November 23, 2022, from https://www.inspiredbirthpro.com/lgbtqia-inclusive-pregnancy-birth-care/

Ehrensaft, Diane. (2008). Just Molly and Me, and Donor Makes Three: Lesbian Motherhood in the Age of Assisted Reproductive Technology. Journal of Lesbian Studies, 12(2-3), 161-178. DOI: 10.1080/10894160802161331

Farr, R. H., & Vázquez, C. P. (2001, January 1). Stigma experiences, mental health, perceived parenting competence, and parent–child relationships among lesbian, gay, and heterosexual adoptive parents in the United States. Frontiers. Retrieved November 20, 2022, from https://www.frontiersin.org/articles/10.3389/fpsyg.2020.00445/full

Gregg, I. (n.d.). The Health Care Experiences of Lesbian Women Becoming Mothers. Retrieved November 23, 2022, from https://www.nwhjournal.org/article/S1751-4851(17)30333-1/fulltext

Hope, A. (2019, June 4). 7 things you should never say to lesbian moms. SheKnows. Retrieved November 23, 2022, from https://www.sheknows.com/parenting/articles/2044377/7-things-never-say-to-lesbian-moms/

Krimmer, Christopher. "And Baby Makes Three: Marital Children of Same-Sex Spouses." Our Lives, 1 Mar. 2024, ourliveswisconsin.com/article/and-baby-makes-three-marital-children-of-same-sex-spouses/.

Lingiardi, V., Carone, N., Morelli, M., & Baiocco, R. (2016, June 24). 'it's a bit too much fathering this seed': The meaning-making of the sperm donor in Italian lesbian mother families. Reproductive BioMedicine Online. Retrieved November 20, 2022, from https://www.sciencedirect.com/science/article/pii/S1472648316303789#bib0100

Moreau, J. (2020, August 1). Changes to state parenting laws help fill gaps for same-sex couples. NBCNews.com. Retrieved November 21, 2022, from https://www.nbcnews.com/feature/nbc-out/changes-state-parenting-laws-help-fill-gaps-same-sex-couples-n1235517

Morse, A. B. (2013). Learning from lesbian non-gestational parents: contributions to a changing world. Retrieved November 21, 2022, from https://scholarworks.smith.edu/cgi/viewcontent.cgi?article=2023&context=theses

Other parental recognition laws. Movement Advancement Project. (n.d.). Retrieved November 21, 2022, from https://www.lgbtmap.org/equality-maps/other_parenting_laws

Paldron, M. F. (2014). The Other Mother: An Exploration of Non-Biological Lesbian Mothers' Unique Parenting Experience. Retrieved November 21, 2022, from https://conservancy.umn.edu/bitstream/handle/11299/167423/Paldron_umn_0130E_15263.pdf?sequence=1

Wald, D. H. (2016, November 28). Do lesbian mothers still have to adopt. The Wald Law Group. Retrieved December 14, 2022, from https://www.waldlaw.net/faqs/do-lesbian-mothers-still-have-to-adopt/

Beyond the Body: Finding Liberation in Basquiat's Lines

Madighan Crowley

It did not occur to me at the time, but looking back on my experience, I imagine that every twelve year old is uncomfortable in his or her body. On the other hand, not every twelve year old can so intensely locate this discomfort to such a specific, tangible place on their body--though, again, perhaps it does feel that way to many kids. Still, my anxiety told me I was different, and that only magnified my embarrassment. It was not until later that I discovered my discomfort had a name: pectus carinatum.

"It's not a medically concerning condition, but…," the doctor began--and my shame had long since familiarized me with where this sentence was going-- "...many patients feel uncomfortable about it and want it addressed." The doctor's choice of "uncomfortable" struck me as a gentle euphemism for the depth of awfulness I felt.

"You have three options: undergo surgery, wear a twenty-four-hour brace, or choose to deal with it." Those choices replayed in my mind as my mother and I left the surgeon's office. "Mom, I need this thing gone," I exhaled.

"And would you prefer the painful brace or the metal bar screwed into your chest?" she asked. My heart raced under the protrusion on my chest, knowing she was right. felt as if a repulsive parasite had invaded my body, fed by my anxiety. So began my long struggle to come to terms with my pectus carinatum. "Deal with it" was an easy option for a doctor to list, but a seemingly impossible task to accomplish. For years my motto was: hide, ignore, forget, repeat. Until I encountered Jean-Michel Basquiat.

I saw Basquiat's *Horn Players* for the first time in Art History class: three panels connected by scrawled white words: "DIZZY," "ORNITHOLOGY," and "ALCHEMY." The painting's figures are jarring, uncanny, and disproportionate: one a head atop a spine of music, one with a phantom shadow of an arm, and one a disembodied head disrupted by incongruous lines appearing from nowhere. I was captivated. Basquiat dissolved the coherence of bodies, leaving strange and vibrant figures in their place--fragments, shapes, chaotic lines, pulsating colors. Feeling my long-held anxiety dissipate, I sensed Basquiat freeing his bodies from their restrictions, unleashing the power of their raw physicality. I felt myself exhale. Entranced by Basquiat's style of physicality, I realized my repulsion at my pectus carinatum had deep roots in my understanding of bodies as having a simple composition, defined with averageness as virtue. This understanding melted away in the face of the strange gift of Basquiat's bodies and the possibilities for embodied life they showed me.

This engagement with Basquiat left me with a transformed understanding of the meaning of academic work. I was often intrigued by my school work, but studying *Horn Players* revealed that a curriculum could speak directly to my sense of self, my uncertainties, and my great bodily insecurity. We learned that Basquiat grappled with his physicality after a car accident, and that, after the removal of his spleen, he worked through his art to visualize the human body differently — bringing out its vitality by deconstructing its form. I came to see Basquiat's art as an expression of his struggle to comprehend his body and life with it. The stakes of struggle are real to Basquiat in his art, which made the stakes of Art History concrete for me. My time with Basquiat revealed a significance to academic study beyond the abstract accumulation of knowledge, one that led me to appreciate Art History as a series of stories about human beings who grappled with their bodies, selfhood, and encounters with the world. I felt the presence of art as an expression of human uncertainty and insecurity, an expression that I felt in myself as well. Looking to my undergraduate studies, I yearn to deepen this understanding of intellectual work, pursuing it in Art History and finding it anew in other disciplines.

Jean-Michel Basquiat, Horn Players, 1983, acrylic and oil stick on three canvas panels mounted on wood supports, 243.8 x 190.5 cm (The Broad Art Foundation) © The Estate of Jean-Michel Basquiat

A Conversation with Dr. David Duong, MD, MPH

Mehdi Kayi

As an aspiring physician and global health practitioner, you can imagine how delighted I was to interview Dr. David Bao-Long Duong and learn from his insights and perspectives. To provide context, Dr. Duong earned his undergraduate degree in Anthropology and Political Science from the University of Michigan Ann Arbor, his Master's in Public Health from the University of Michigan, and his MD from the Harvard Medical School. He currently serves as the Director of the Harvard Medical School Program in Global Primary Care and Social Change. He has served on the World Economic Forum's Global Future Council on Health and Healthcare, and he was also named a World Health Organization's Young Leader in Primary Healthcare. During our conversation, Dr Duong reflected on his journey to medicine and global health, the effects of the pandemic on these domains, and why we observe such disparities in healthcare access and quality.

Reflecting On Our Healthcare Systems

Although Dr. Duong is a primary care physician at heart, besides working with patients during well-visits at the illustrious Brigham and Women's Hospital, he also enjoys helping patients overcome critical health conditions in the intensive care unit (ICU). Due to the preventable nature of many of the ailments patients face in the ICU, Dr. Duong asserts that much can be done from a system level in primary care to mitigate these risks and proactively keep people healthy. This systems-level approach has also influenced Dr. Durong's public health work in a global context. In rural or otherwise under-resourced places (such as Dorchester, much of Uganda, and parts of West Virginia for example), primary care is neither accessible nor culturally appropriate. There are overarching social, economic, and political structures, frameworks, and policies that can either support or damage health. Also, because we have a patchwork medical system here in the United States, the majority of people here are not receiving acceptable care. The status quo involves reacting to illness when it manifests, as opposed to focusing on primary and primordial prevention measures to limit the potential for illness. This is especially unfortunate considering that other socio economically developed nations are much more committed to keeping their populations and citizens from becoming ill and requiring more advanced tertiary care. Thus, we must strive to improve the systems so that care is easy, accessible, and convenient for all of our community members and the general population.

How the Pandemic has Affected Clinical Practice and Global Health Efforts

According to Dr. Duong, the most important lesson gleaned from the pandemic is that we are much more interconnected than we ever believed we were prior. This pandemic demonstrated that pathogens and other disease-causing agents do not recognize state or national borders, and thus, require a truly cohesive and collaborative effort on an international scale to ameliorate their effects. What began in Wuhan very easily spread to our own backyards across the globe, and remarkably quickly as well. As a result, we must be attentive to the importance of data sharing and communication. Also, we must shift our thinking to view people not as static, but instead as dynamic individuals who were influenced by various factors before presenting at the hospital, and who will continue to be affected by such conditions after leaving.

Interestingly, apart from the countless consequences experienced during the pandemic, Dr. Duong expressed that the pandemic has allowed us to rapidly innovate ways of delivering healthcare. For example, we have been forced to develop and improve telemedicine, other modes of virtual care, and hospital-at-home models. Medical education has also been transformed in similar ways, and I have heard that virtual interviewing for medical school admissions has made the process much more equitable as well. As Dr. Duong described, another effect of the COVID-19 pandemic is that overall health literacy among the populace has increased. Thus, what resulted was a more empowered and knowledgeable patient population. However, this is a double-edged sword and has led to some downsides as well. The fact remains that true health literacy is a skill that requires much time to develop. Due to the prominence and prevalence of misinformation, the general population requires further education to discern legitimate from illegitimate information, or genuine science from pseudoscience.

This process of delineation is difficult, and thus, people are becoming less trusting of healthcare professionals. Dr. Duong shared a powerful anecdote that illustrates the issue. Despite helping many of his patients endure heart attacks, diabetes, and cancer, and despite building long-lasting and trusting relationships with these patients after years of visits, when Dr. Duong recommended that his patients receive the COVID-19 vaccine, he was met with hesitancy. In fact, many of his patients refused because of false information they encountered on platforms like Facebook that planted an idea that the vaccine was ineffective or otherwise dangerous. Dr. Duong advised his patients out of an honest and heartfelt concern for their well-being, yet this was usurped by maleficent propaganda.

As Dr. Duong explained, we also cannot oversimplify or reduce the factors that contribute to a lack of trust. In places like India, for example, where British colonial rule allowed for the weaponization of medicine, a lack of trust in Western technological and scientific advancements may be justified. Our beliefs are all rooted in and cannot be divorced from our culture, history, and social contexts. This all connects back to Dr. Duong's assertion that our primary care and public health efforts should be socially and culturally competent, acceptable, and appropriate.

The Causes of Under-Equipped Healthcare Systems and Potential Responses

Given my Moroccan heritage, and having heard stories about the inaccessibility of healthcare in even large metropolitan cities in my parent's country of origin, I was interested to hear from Dr. Duong about what causes this lack of robustness. Speaking from a plethora of experiences, Dr. Duong shared that the main culprit is a lack of resources. When examining why we have such limited resources, looking at a nation like Sierra Leone for example, this can be attributed to colonial rule, abuse, and war. These perils have disallowed Sierra Leoneans from building robust medical infrastructures and systems.

We see a similar deficiency in places like Dorchester and Blue Hill Ave. in Boston, where there's a majority of black and brown people who are disproportionately affected by a lack of access to medical care. Dr. Duong affirmed that people in positions of power and influence hold faulty social perceptions that prevent them from investing in these neighborhoods, because they may be inclined to argue that whatever they build in such neighborhoods would be vandalized anyway. Such perceptions have had deadly ramifications. The data shows that black and brown people were more likely to be exposed to COVID-19, contract it, experience long-Covid, and die from the disease.

Dr. Duong's Inspirations for Pursuing His Career of Impact and Reflections on Modern Medicine

Given the rigors of pursuing a medical education and becoming a physician, I was curious to hear what has motivated Dr. Duong throughout his journey, and even currently as an accomplished researcher and healthcare professional. Dr. Duong shared that, while he was an undergraduate student at the University of Michigan, he read one of Dr. Paul Farmer's books, and became deeply interested. He also took medical anthropology during this time, and completed summer internships in Vietnam, Haiti, and inner-city Detroit. All of these first-hand experiences led to Dr. Duong completing a Master's in Public Health, followed by a consultancy job working on developing health systems right after his graduate program. While working in Uganda for an American firm, Dr. Duong realized that while he gained much expertise in drafting plans and budgets for ministries and clinics, he did not fully understand how these budgets and policies translated into how a patient receives care. A desire to learn what the downstream effects of these efforts entail fueled Dr. Duong's pursuit of medicine.

During his time in medical school, Dr. Duong was still interested in learning more about global health. Fortunately, he had many opportunities to do so. At Harvard, he connected with mentors who had worked in Vietnam and established projects there. This ultimately led to Dr. Duong developing his own initiatives in Southeast Asia and Vietnam. Being Vietnamese-American, Dr. Duong has found that he has the cultural competency required to build, grow, and nurture relationships with members of the population. As he emphasized, relationships and trust are truly at the core of public health efforts, and his heritage allows him to gain that trust because his fellow countrymen and women see Dr. Duong as one of their own. Due to the time, energy, and effort required to establish these relationships, it can certainly be tiresome and frustrating at times. Yet, it is deeply rewarding, and the potential for impact is immense.

As one of the late Dr. Paul Farmer's students, Dr. Duong feels as if learning under him ingrained in him a belief in the importance of relationship-building and trust. Also, it inspired in him an appreciation for the social sciences and the intersection of human health and the humanistic disciplines. This humanistic approach is too often lost. A common issue faced in our age of medical education is that the rigors of the curriculum and the training cause students to be too tired for compassion. The long hours may cause trainees to simply wish to "check the boxes" so that they may go home and rest. Also, fledgling students and seasoned professional practitioners face the problem of a profit and efficiency-focused medical system. When pressured to see so many patients, the short appointment times do not allow enough time for conversing with the patients and genuinely engaging with them. Also, much time is spent documenting patient visits and updating patients on lab results, and this work is often off-hours and unpaid. Our "sick care", damage-control system does not just apply to the patients: it also applies to the providers. It is the antithesis of a humanistic system.

When asked about whether there have been improvements in any of these areas, Dr. Duong left me with a profound sentiment. Although there has been a greater focus on self-care and wellbeing on the education side, nothing is concretely being done to ameliorate the shortcomings of our system. Thus, we are at a pivotal point in medicine and healthcare, because we must now decide what will drive us. Will it be profits, or will it be an authentic concern for the greater good?

If we begin treating healthcare as a basic and common good, such as a K-12 education, clean water, and paved roads, this will prevent the death of humanism, lower the risks of burnout and quitting, and minimize the injustices of inequitable care. However, to accomplish this systemic, moral conversion, we must strive for Medicare for all and universal healthcare. Once we lose our focus on profits, we can open our eyes to ways in which we can protect and promote the social, physical, and psychological well-being of our loved ones, friends, neighbors, and fellow human beings.

The First Biopsy

Kathryn Gilmore

The night before, he sat at the kitchen table
writing letters to each of us— notes for his

daughters in case he didn't survive the next
twenty-four hours. He explained the ten percent

likelihood of fatality after the others had gone
to bed, confiding in me as the oldest. I asked

what exactly would happen. He told me they
were going to reach a metal rod into his flesh,

cut off a piece of his liver, and pull it out.
If they hit the wrong blood vessel during

the extraction, he would bleed to death.
I didn't know what to do with this. I had

a calculus test the next day. I did what I
never did alone— I prayed. He lived

through the surgery, and I thought I'd done
something right. I thought that maybe God

did exist, and he listened to teenage girls in the
suburbs. I thought it was over. We celebrated

as if we'd made it out of the flames unscathed,
as if the yellow spreading across his skin was

nothing but friendly fire.

Morgan Costa

I Never Stopped Walking Once I Stepped Out of that Hospital

Kathryn Gilmore

I walked through riverbank fog thick as grief
and rising waters swallowing the city whole.
I walked down a graduation aisle
in an empty church, polyester on my face,
faux flowers between my hands.
I walked through New England streets
older than anyone I've known,
bricks stained with snow and dirt.
I walked across quads teeming
with children drunk on freedom
from the people who raised them.
I walked into dimly lit rooms with bass
that commands the heart to its war drum;
I moved through convulsing bodies
churning to music in an imitation of prayer,
over aluminum and sweat on a concrete floor.
Across the ocean, I walked
down cobblestone labyrinths,
Mediterranean sun warming stone and skin.
I walked the same moors and isles
that generations before left behind;
I walked into pubs and drank two-pound cider.
I walked through a desert at night
and looked up at the terrifying stars.
I walked until my ankles swelled
and the skin of my heel flapped and bled,
then I kept walking on damaged limbs,
slugging through blizzards and heatwaves,
because if I stopped, I would fall back into
that waiting room chair and never stand again.

In My Bones

Aspen Fain

I grew up believing that Saturdays were created for cross country meets and that October is the best month in the year. It's the act of pushing off the Earth with each long stride, losing the air in my lungs, and seeing the long path ahead that feels the most natural to me. I've felt this way about running for most of my life, but this passion wasn't always present. It began in a grassy field as my older sister practiced with her cross country team. I sat in the grass, refusing to get up while my mom pulled me by my arm. She was trying to get me to run with her, but knowing my younger self, that was the last thing I wanted to do. I don't remember how, but she convinced me to join the team when I entered second grade. It was this decision that led to eleven years of running beside my best friends.

Society seems to be in agreement that running is healthy for the body. For me, however, running was the only way I knew to quiet my mind. There was something about pushing my body to its limits that made everything else feel minor. It was almost as if the further I ran, the further I could get from the clutter of everyday life. With every step, I crushed the anxieties and trials of my day. It was my meditation, my drug. Gradually, my mental condition became reliant on my ability to feel the rhythm of my stride beneath me. I was literally chasing happiness. I wasn't aware of this dependence until the day I couldn't run.

I got my first stress fracture early in my freshman cross country season. I remember being shocked upon finding out that the pain I had been experiencing in my foot for weeks was my bones slowly cracking under pressure. Who knew bones got stressed like the rest of us? I felt the loss of my first high school cross country season, but with this being the first one, I remained optimistic. There was always next season, right?

My second stress fracture hit a little harder. I had struggled with pain for weeks, but stayed in denial of any serious injury. It was close to halfway through the state cross country meet that my leg finally cracked under pressure. I remember the feeling of defeat when the doctor pointed to the cracked fibula displayed on the x-ray sheet illuminated by the fluorescent lights of the exam room. This time I didn't feel as optimistic.

The third and fourth stress fractures appeared during my senior year. A fractured femur from cross country, a fractured hip from track. I could feel hope slipping away with each MRI report. It felt like the thing that brought me the most joy was the one thing my body wouldn't let me do. Each injury was followed by months of recovery and many of high school's biggest moments spent leaning on a pair of crutches. Mostly, I spent these recovery periods behind the ropes of cross country race courses, wishing I could be the one crossing the finish line. I couldn't understand why the activity I loved to do most in this world was taken from me again and again.

My body kept breaking down and I was perplexed as to why. I refused to accept the simple answer. Instead, I visited multiple doctors, tested my bone density, checked my vitamin levels, analyzed my gait – everything just looking for a reason. There had to be some reason my body denied me the one thing I wanted to do most. When the tests came back normal, I was forced to return to the most obvious conclusion. I was doing it all wrong.

Recently, the running community has been flooded with stories of young female runners with this same experience. They call it the female athlete triad: "prolonged periods of low energy availability and undernutrition due to mismatch of nutrition intake and exercise expenditure leads to amenorrheic state, estrogen deficiency, and the dysfunction of other hormones required for bone health (cortisol, leptin), and result in impaired bone health" (Curr Rev Musculoskelet Med Basically, the bodies of many young female athletes are struggling for survival. With limited research concerning the female body in sports, too many high school girls are overtraining on unsustainable diets, ultimately leading to injuries and other medical complications. In a study published by the International Journal of Women's Health, female athletes with any of these three risk factors were 2.4-4.9 times more likely to experience a bone stress injury (Int. J Womens Health). It took four fractures for me to finally understand this.

I realized that I had refused my body the resources it needed to function correctly. For years, I denied it proper nourishment and essential rest, pushing it beyond its limits, until it broke. There were signs, but I refused to see them. I accepted the weakness I felt everyday. I told myself that it was completely normal to go months without having my period. I ignored the pain until it was too late. The desire I felt to run was so strong that I put it before my physical needs. Eventually, my body was forced to compensate by stealing minerals from my bones and energy from my hormonal processes.

With each fracture, I began to feel frustrated with my body. I despised my own bones for their weakness. I had no appreciation for what my body was doing for me; all I knew was that I couldn't run. It was one of my favorite professional runners who challenged this attitude. Allie Ostrander is a long-distance runner who has recently vocalized her struggle with an eating disorder and injuries. I remember reading her essay, "Dear Body, I Love You", and being amazed at the honesty with which she acknowledges her role in the collapse of her body. She ends the apology to her body by saying, "You kept me alive" (Ostrander). I remember being struck by that. Through it all, my body has taken care of me even when I refused to take care of it.

I thought I needed running to be happy, so I refused to accept that anything was wrong. I justified the damage I was doing to my body by saying it was beneficial for my mind. It's not often that what we need mentally is at odds with what we need physically. For four years, I thought it was one or the other, and I always made the same decision. Until finally, I couldn't do it any more.

I decided that I needed a break. Letting go of running felt like leaving the life I had lived for the past 11 years, but it was time. I knew I couldn't keep repeating this cycle of breaking and healing. I had to find a way to suppress this passion, keep it from controlling my life like it had for so many years. I had to learn how to listen to my body, how to take care of it. I had to find something else to quiet my mind, something that wouldn't tear me down at the same time.

However, this isn't a perfect success story. I have decided that I'll never be able to let running go. Six months after my last stress fracture, I returned to the trails. This was my homecoming. Feeling my heart beat against my chest, the burn in my legs, the clearness of my head, I was hooked again. I'm told by family members that I'll never learn my lesson, and maybe that's true. Every day I struggle with finding a balance between running and listening to what my body has to say to me. I'm still figuring it out today, because it's not easy when your mind is telling you one thing and your body another. Every day feels like a decision between stress on my mind or stress on my bones.

I have been able to find a silver lining from this experience. I now know what I did to my body, and I know that it did what it had to do to protect me. Our bodies are magical entities that love us and will always try to support us, no matter how we treat them. They are deserving of our appreciation and care. That being said, I think it's time I return the favor.

References

Chen, Yin-Ting, et al. "Update on Stress Fractures in Female Athletes: Epidemiology, Treatment, and Prevention." Current Reviews in Musculoskeletal Medicine, Current Science Inc., June 2013, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3702771/.

Mallinson, Rebecca J, and Mary Jane De Souza. "Current Perspectives on the Etiology and Manifestation of the 'Silent' Component of the Female Athlete Triad." International Journal of Women's Health, Dove Medical Press, 3 May 2014, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4014372/.

Ostrander, Allie. "Dear Body, I Love You." MileSplit United States, 10 Oct. 2022, https://www.milesplit.com/articles/313574/allie-ostrander-dear-body-i-love-you.

The Medicine of Language

Sadia Tanzem

Language is as essential to medicine as doctors are to the healthcare field. But too often, language is brushed aside as simply a means to an end. Usually overlooked, language builds a narrative beyond a diagnosis, creating the difference between patient care and patient empowerment. Both articles “Wounded by the Language of War” by Paula Span and “Reconsidering the Role of Language in Medicine” by Berkeley Franz and John Murphy recognize the influential role of language in healthcare contexts. However, Span does not offer a solution to the problem she highlights in her article: war metaphors in a healthcare setting. But when taken in context with Franz and Murphy’s article, their research compliments Span’s work by offering a strategy that could lessen the emotional impact of culturally imposed war metaphors on patients.

“The war on cancer.” “He’s a fighter.” “She’s a survivor.” These are all commonly used phrases when referring to chronic illnesses. In “Wounded by the Language of War,” Paula Span highlights the use of war and combat metaphors to regard those afflicted with disease. Span interviewed Dr. Daniel Johnson, a palliative-care physician in Denver. He acknowledges that “Society sees death as the enemy, so it’s not surprising we turn to language that references war” (Span). This view of death as an “enemy” connotes a fearful relationship between today’s culture and a natural event in the cycle of life. This overarching fear pressures patients and their families to continue receiving often intrusive and exhausting treatments that may only prolong life expectancy by a few months. Since this language is so readily available, many patients view these terms as the only way to communicate.

This culture of characterizing illness as a battle imposes not only fear but an assortment of other emotions for a patient to cope with. Dr. Johnson admits that “patients have taken him aside to confess that they dread another round of chemotherapy but fear disappointing those who expect them to ‘fight’” (Span). The use of the word “fight” to describe a patient’s journey with a disease implies that they “give up” if they choose to no longer pursue treatment. This can lead to emotions of shame, guilt, and weakness. Additionally, the feeling of fear grows as an individual may be afraid of disappointing loved ones. The psychological impact of these strong emotions can add stress to a patient already dealing with a difficult illness. These war-related metaphors in healthcare contribute to patients feeling dehumanized and disempowered as they no longer feel in control of their medical treatment. Rather, they are pressured to pursue a socially acceptable outlook on terminal illness.

These metaphors, pushed by society, erase the stories patients want to write about their life. Span’s own cousin suffered from heart failure and accepted that “She didn’t want to die, bloodied and exhausted, on a battlefield. She wanted peace” (Span). The contrast between these two sentences implies that wanting peace is not as valid as dying in exhaustion after a long fight. Finding peace in letting death come naturally is just as courageous as holding off death with treatment. The vital distinction is honoring the patient by allowing them to decide how to die just as they decided how to live. But Span does not propose any intervention to allow for this type of conversation between patients and doctors. Rather, she ends her essay by stating “[others] might feel freer to make them if they were released from the language of war and the expectations that accompany it” (Span). Allowing patients to be released from the shackles of war language will require a systemic change across society and medicine, which Span fails to acknowledge in her conclusion. It would be difficult for a patient to communicate that they want to die peacefully if never given the chance to engage in meaningful dialogue.

However, a perspective provided by Franz and Murphy could counteract these preconceived war metaphors. Their article “Reconsidering the Role of Language in Medicine” brings awareness to narrative medicine, “a strategy to improve doctor-patient communication and integrate patient perspectives” (Franz and Murphy). Narrative medicine draws on the study of art and literature to both enhance providers’ listening and observation skills and expand their view of patients to encompass more than just medical histories. This practice should be brought to awareness and taught to medical providers so they can implement the time and space necessary to have such conversations that promote patient stories. This can be fostered through implementing medical humanities classes in medical school, providing a space for doctors-in-training to analyze published literary works of patient narratives in a constructive learning space. Since the average person does not have medical training, speakers with experience communicating their journey with illness and disease could be brought in to teach medical students how the average patient uses everyday diction to communicate their symptoms.

In an environment where diagnoses and treatments rely on data, statistics, and complex medical terms, it is easy to overlook the patient’s ability to communicate their story. Additionally, many patients may not know how to feel after receiving a life-altering diagnosis, thus turning to the convenience of war metaphors because of society’s expectation for them to “fight” illness. The combination of war metaphors and overwhelming medical information limits meaningful dialogue, because when patients use words provided to them by society and doctors, they may not expand on their situation using their own words. Thus, as a corrective, the framework of narrative medicine encourages physicians to truly listen to their patients (Franz and Murphy). Critical to narrative medicine is that both patients and clinicians bring perspectives to the clinical encounter that are relevant to patient care, rather than convenient language. This can be accomplished with longer appointments and doctors who are willing to ask questions about the patient’s background and goals for their quality of life.

By improving communication, patient stories can be explored and better guide a care plan and ease the pressure of continuing to “fight” a disease. Medical practice then shifts and has a special aim — patients are allowed to speak and be heard in their own voices, not with the articulation of a doctor or society. With the awareness and implementation of the narrative medicine perspective by doctors, a space for open dialogue is created, filling the void that war metaphors occupy as patients can express and be heard if they choose to pursue physically and emotionally draining treatments or if they prefer to live out the rest of their life without treatment.

Language plays a role in determining the outcome for a patient's healthcare. With medical providers being willing to take on the perspective of narrative medicine and allow the time for open conversations during consults or appointments, patients can look to their own language as a remedy for improved patient-provider relationship rather than being stuck in the cycle of fighting unwanted or detrimental battles. The center of health care communication needs to shift to patient narratives. At the end of the day, they know their story best.

References

Franz, Berkeley, and John W. Murphy. Reconsidering the Role of Language in Medicine." BioMed Central, 5 June 2018, . https://doi.org/10.1186/s13010-018-0058-z

Span, Paula. "Wounded by the Language of War." The New York Times, 11 Apr. 2014, archive.nytimes.com/newoldage.blogs.nytimes.com/2014/04/11/wounded-by-the-language-of-war/.

Jasmine Yu

Proctor Two

Rachel Ruggera

Spring was boiling over into summer, the week I was in the mental hospital. Two police officers escorted me to the cruiser and spoke through the opaque divider separating me from where they sat up front. The one driving had a stutter and walked beside me with a crooked gait. In the passenger's seat sat another officer with thin, dark hair, Asian features, and a thick Boston accent. The man with a stutter asked me about myself, what year of college I was in, what I was studying, and if I was looking forward to graduation. I answered pleasantly, but my voice was muffled through the plastic. I stared out the barred windows until we reached the intake building.

Two paramedics wheeled a woman on a stretcher through the door. She lay back silently, strapped into the bed at her legs and waist with her arms unmoving on top of the white sheets. How do you go on living with razors, pills, and tall buildings on the mind? How do you make a cup of coffee, tie your shoes, walk to class? As I approached the entrance, I knew I was about to find out. I was taken away from the world of smiling faces and pleasant conversation. I was removed like a bruised fruit on a supermarket display. I was grateful. I would return when I was fixed, when everything bitter and sharp inside of me was cut away and I could return to real life. I know now that the self can be undone in an instant.

There are several species of insects known to kill themselves. The sting of a honeybee, a self-destructive defense mechanism, is lethal to the insect as the stinger detaches from the body pulling most of the abdomen out with it. A species aptly named the "exploding ant" can spontaneously rupture an internal sac releasing a caustic chemical to deter other insects and predators. Worker ants have been shown to self-sacrifice by abandoning the colony, a way to ensure certain death, when infected with a lethal fungus to protect their nestmates from a similar infection. The psychologist Thomas Joiner writes that there is a necessary habituation to death before suicide. There is a death-worth-more-than-life calculus at play. The combination of alienation and burdensomeness makes an action that seems incomprehensible feel inevitable. Death is a fearsome prospect. There's something fearless about the honeybee that terrifies me. Maybe he should be more afraid, more selfish. Joiner asks the honeybee, "What is fearlessness like?"

What makes you think I wasn't afraid?

I knew him when he still went by Nora. We gathered in the dance studio, laid down our mats, and muddled through the required yoga class each week. We met in the late afternoon, after a day of running between classes, and settled into the stillness of the room. The P.E. teacher drew the blackout curtains across the floor-to-ceiling windows. We put our mats next to each other, flush against the wooden floor, creaking slightly when we shifted our weight. I closed my eyes, peaking over at him from time to time to see if he had his eyes closed too. The smell of eucalyptus drifted through the air. The teacher liked to dab the scented oil on her hands and wrists near the end of class. This smell made its way into my clothes even when we stood to leave, changing out of our blue P.E. shorts and gray t-shirts printed with the school's mascot.

When we came back the next school year, he went by Emmett. I'll never know how he chose the name. We weren't close enough for me to ask. In truth, we weren't friends at all. He was just another quiet kid who floated between friend groups, never spoke in class, didn't call attention to himself. When his parents held the funeral, I didn't go. I felt like I didn't know him well enough. No one ever said it out loud, but it was whispered with heads bent together and eyes darting back and forth. It was understood that he killed himself. Someone made rubber bracelets with his name on them and passed them out to the kids in our grade. We never spoke about him again.

It was years ago now, but I swear I can still hear him breathing. I lay on the floor, staring at the ceiling, counting as I breathed in—*one two three four*—holding my breath with my lungs full to bursting, then breathed out—*one two three four*—praying for calm to return to my body. I felt the heaviness of the past like a stone on my chest. I squeezed my eyes shut tighter until I saw flashes of color and red-tinged darkness behind my eyelids. I imagined Emmett lying on the floor next to me. We were flat on our backs with our eyes closed. Corpse pose, our teacher called it. But in the mind of a high-schooler, we would live forever. I saw his belly rise and fall gently as if he had fallen asleep. I heard his breathing, steady and measured, effortless.

The door to the common room slammed closed, trembling on its hinges as a draft from the window pushed and pulled through the suffocating heat. In the lopsided circle of chairs, ten faces stared at their socks, at faded posters with quotes and affirmations, paintings taped up against the blank white walls, or simply at nothing at all. A young girl with brown, matted hair down to her waist. A woman in a wheelchair with a thin, nasal voice. A middle-aged man who never changed out of his hospital gown, the green checkered robe coming up to his knees.

A woman shook her foot, leg, and entire body with her eyes glued to the door. It slammed shut again and we both flinched. She was a racehorse in its box, terror in her eyes, nostrils flaring, just waiting to bolt, and I couldn't take my eyes off of her. There was something about her fear that quieted mine. There was something about her unashamed display of anxiety that expressed my own unspoken fear. She was losing her mind so I didn't have to.

As we sat in the common room, we were like children again. Burying ourselves with sand up to our chins in an elementary school sandbox. The sand was cool to the touch, shaded from the afternoon sun. It shifted and moved with me as I breathed. I wiggled my fingers and toes just to make sure they were still there. The sand was clean. It flowed over our bodies, into our clothes, into our homes as we tracked it into the house, sitting on the floor pulling off our shoes, pouring a day's worth of sand into a little pile on the ground. Unmoving in the sand, I was dormant, resting, and full of potential. I felt a buzzing energy beneath my skin knowing that at any moment I could stand up, the sand would fall away, and I would be made anew.

I've always been able to dig my way out. But now, I've fallen into something I can't seem to write myself out of. It is something that keeps the sand trickling back in from all sides no matter how fast I dig. I was afraid if I kept at it I'd find my own bones buried there. I was afraid of what might happen if I stopped digging for even a moment. If I let the sand fill my eyes, ears, nose, and mouth. I could rest here, letting the cool sand brush against my cheeks, kiss my eyelids, and settle over me with finality.

I woke up early the next morning and stripped the sheets from my bed. It was the day of my discharge. It was the day of my college graduation. Walking through the hallway, I felt the beaming faces of the patients around me, faces I mistakenly thought were empty, now smiling at me and my second chance. These were the faces I sat across from at breakfast sipping their decaf coffee, complaining about the food, sharing bits and pieces of their lives. They had known me for only a week and yet remembered my face, my name, and cared about my future outside of the hospital. They congratulated me on my way to the med line and stopped to say their goodbyes while waiting for their vitals. They were happy for me even when they struggled to be happy themselves. When I walked across the stage that day with my diploma, I thought back to them.

I stood on the curb in front of the hospital holding all my belongings in a brown paper bag. I imagined my family out there sitting on the bleachers shading their eyes from the sun. My friends, draped in black and parading around the stadium, held their heads high. I only looked back once while I was getting into the car. I read the side of the building. *Proctor Hall. Floor Two.* I was glad to know where I had been.

I was late to the ceremony. While thousands of students sat on folding chairs listening to the commencement speaker give some rousing address, I was back in my dorm room draping my black robe over my head, attaching the hood, gold at the throat, and sitting silently on the bare mattress of my bed. The dorm was empty now. My roommates had packed the week before. A few hours ago, I had been on fifteen-minute safety checks restricted to the ward. Now, I was about to step out onto the field, squinting in the sunshine, wandering through a mass of black robes and searching for a chair with my name on it. I could almost forget I had even been gone at all. I could return to who I was before all this craziness happened. I could wash away the past year from my mind, from the minds of my friends and family, and restore their happy version of me. No, I want to remember.

I must grapple with the fact that I have changed. That I will never be who I once was or thought I should be. I must be who I am now, and that is the hardest part. I thought when I finally emerged from that hospital room with its cafeteria trays and paper-thin sheets, I would be transformed. I would see things for how they truly were and feel the weight fall from my shoulders. I would dust off the sand from my clothes and walk out of this life into something better, someplace with clarity, and tree-lined avenues, and no pain. The writer Natalie Goldberg wrote that anything we do fully is an alone journey. I was caught on those words—an alone journey. Sometimes I am unhappy. I try to make peace with myself for my unhappiness. I try to forgive myself. Maybe I am omitting details even now in fear that you will turn away in disgust or contempt. Maybe I am framing this story to cast myself in the most sympathetic light. Maybe I am forcing a happy ending because that's what I think you want. But the truth is crawling up my throat threatening to be spoken.

Sambal Ikan Bilis

Emily Barnabas

Then

My grandmother's wok clanged as it hit the stove grates. Effortlessly, she carried over an overflowing dekchi with little bowls of ingredients: colorful chopped chilis, pungent shrimp paste, and cloves of garlic shifted as she proceeded towards the oil-scorched pot. I sat quietly to the side of her, teetering on the kitchen stool as I watched her cook. Savoring both the time spent with her and the ever-familiar scene of her cooking, I became full of admiration for my grandmother.

Watching my grandmother move around in the kitchen has always been captivating: the way her arms tirelessly chopped vegetables, her hands skillfully gutted fish and meat, and her legs tranced effortlessly across the kitchen floor. While she tolerated company in the kitchen, my grandmother never wanted help cooking her meals. Instead, she showed her love through soupy sampling spoons and countertops crowded with snacks so the family would never starve.

When it was finally time to eat, my grandmother systematically carried each dish she prepared to her shabby, food-stained buffet table. The walk from the kitchen to the table was a process in itself, each step methodical and measured. The rest of the family, forced aside by her steadfast devotion, watched as she put the final touches on the meal. I wondered why my own parents and relatives helped minimally during this process, only assisting by laying serving spoons and unplugging the rice cooker.

When my grandmother finally decided to sit down, she slightly winced, slowly bent her knees, and sunk into the thick couch cushions. Setting her plate down on the floor, she proceeded to rub slow circles on her knees, breathing deeply as she recuperated. When I caught her eye, it seemed as if she was overcome with relief. The sight made me unusually weary as it was generally uncharacteristic of my grandmother. At that moment, I wondered if my grandmother's Sambal Ikan Bilis would always taste the same. While it scared me to think about a time when my grandmother wouldn't be able to cook and care for us, I knew deep down that soon we'd have to learn to master her dishes for ourselves.

I took a bite of white rice and my grandmother's sambal, letting the flavors infuse into my mouth for as long as I could.

Now

My grandmother asked me to pull the kitchen stool next to the stove so she could rest her knees while cooking. I saw her grimace as she rested on the stool, stifling her excruciating discomfort. This was a type of ache I couldn't understand; the creeping agony of aging. Over the last few years, her osteoarthritis had worsened: she only could stand independently for short increments of time, shooting pains dashed across her palms, and her knees became unbearably stiff. Her osteoarthritis made her function like a marionette puppet; only allowing her to painfully move one limb at a time with limited mobility. The rest of my family stood cautiously to the side of my grandmother instead of mingling and chattering in the kitchen. It appeared like they were waiting for her arthritis to strike in the form of her dropping a ladle or slipping on a kitchen mat.

Bravely, they would ask her if she wanted help; only for her to repeatedly respond with a stern "No."

My grandmother's brazen independence reverberated through the silence of the kitchen, making my stomach churn uneasily. I was waiting for something to go wrong; for something to burn, for her to slip, for things I didn't even know. Uncertainty began to consume me: while my grandmother's self-sufficiency had always been admirable to me, I now wished she would've accepted our help.

"You know", my grandmother sighed, "I like to do this. I want to do this. I have to cook for you all. You all don't know my recipe anyway," she said pointedly, breaking the stagnant silence in her kitchen.

No one said a word, mainly because everyone knew it was true. While it hurt us to see her suffering while standing at the stove, we knew that it was keeping her alive. Although the window by the kitchen sink was lined with painkillers, it was really the little bottles of turmeric and coriander powder that kept her going. For her, butchering meat and slicing vegetables was physical therapy. It became increasingly clear that time in the kitchen, surrounded by her family, was the best rehab that we could offer my grandmother.

When she finished up in the kitchen, my grandmother grasped my arm and slowly made her way to her favorite spot on the couch. I felt her frail hands against my skin: small and determined, they trembled lightly against my own skin. It was difficult to digest that I was now providing stability to the woman who had supported me my whole life. In those moments, the reality of aging overwhelmed me. I tried to stifle the emotions bubbling inside of me by mindlessly spooning food into my mouth. My tastebuds exploded: the chili oil coated my tongue, the little pieces of anchovy releasing a fishy tang, and slices of garlic and onion tying the umami together. It tasted like slow summers with my grandparents, like a room full of my aunts and uncles laughing, like a simpler time. I wondered if there would always be my grandmother's Sambal Ikan Bilis at family gatherings and if the same family members would be there to share it.

My grandmother's face caught the corner of my eye: still rubbing slow circles on her small knees, the corner of her mouth turned upwards into a faint smile. She simply sat back and watched us with our clean plates and emotive conversations, her eyes shimmering with contentment and pride.

Morgan Costa

What would I do if she was gone?

Ashley Valenzuela

January 14, 2017
Dear Diary,
I went with Grandma to the doctor's office today. They told us she has cancer.
-Ashley

I still remember it clear as day.

My mom was working so my grandparents brought me along with them to my grandma's annual check-up. The sky was partly cloudy and the air was crisp. I wore a yellow sweater and my grandma wore her signature bright pink lipstick that she wore to every appointment. We walked into the office and sat in the small blue chairs along the wall for a while. My impatience grew by the second: "Why is this taking so long? I want to get out of here and eat lunch" I thought. As I watched the hour hand of the clock continue to move my thoughts of lunch dwindled and a pit in my stomach formed. After what was hours, they later called my grandma into the room and sat me, my abuela, and my abuelo down. "Colon Cancer Stage 3" he said. For some reason I didn't cry at that moment, it was like the color had drained from the earth as time came to a stop. I might have been young but I knew what cancer meant. Who would I be without her? What would I do if she was gone?

My grandma is like a second mother to me. She is my grandma goose and I am her nina de mis ojos (apple of my eye). She is the only one who will listen as I rant about books she's never read, the only one who will tag along as I stay up all night watching Bridgerton. She is some of my dearest memories, the familiar silhouette I remember making empanadas in the kitchen. What would I do if she was gone?

When we walked back to the car it was raining. It seemed even the sky was mourning my grandma, water sprinkled down my cheeks as I walked and I couldn't distinguish the rain from my tears. We got inside the car and didn't speak the rest of the way home. When we got home, something in me finally returned to earth. I gave my grandma the biggest hug I could and sobbed in her arms. There I was crying as if I myself had been the one diagnosed with cancer, and still, she consoled me.

"I am not going away that easily. I am going to live, I am going to live for you mi vida", she said.

While she didn't shed a tear once that day, I knew she was still scared by the way she looked at my mom and I with a small gaze, as if she was saying goodbye. It tore me apart inside but I had to have faith: in god, medicine, anything really that would stop me from feeling so incredibly helpless. What would I do if she was gone?

February 25, 2017
Dear Diary,
Grandma went back to the doctor today. They told her she might be able to have a surgery that would take out the tumor but she would have to poop in a

bag for the rest of her life. Grandma and Mom keep telling me to have faith and pray but how can I when it's been a month and we are just now hearing the following options? Where is God now? What if she dies during surgery? Everyone told me that she won't but I know they'll just tell me things to make me feel better. I am too young to know anything. I fear I'll be kept in the dark until she reaches her grave. I hate it.
-Ashley

The morning of my grandma's surgery was a hard one. My mom, grandparents, and I all drove in the same car at 3AM. to the hospital. I was shaking the whole way there and the car, once again, filled with silence. *Was today the day I lost one of my favorite people?* My grandma has diabetes and some heart condition that I can't remember the name of. *What if she bleeds out? What if she lives but now a part of her never the same because of the bag attached to her stomach?* Can things ever return to normal? My mind rambled with all these questions as I waited for my grandma to come out of surgery. After 8 hours of sitting in a chair and pacing around the hospital halls, the doctor approached my mom. My stomach tightened with fear and I felt like I was going to collapse or throw up, maybe both.

"She did great, we cleaned her out and moved things around, she's cancer-free," he said.

My entire body released the anxiety I was feeling and I began to cry. She was going to live. *We are out of the worst of it right?* What would I do if she was gone?

March 18, 2017
Dear Diary,
Grandma had her surgery yesterday. She looked really sick when we saw her, they said she can't leave for another week. You can tell she's in pain. Her body but her feelings too. She puts on a smile and a brave face but I can tell she's sad. I'm happy she's alive. I tell myself this because I'm reminded that she could very well not be. But I can't help but worry about the future. What if it comes back? I heard that happens a lot with cancer, that it's even harder the second time. I could barely handle it the first time around. What if I have to do this again? If she has to do this again?
-Ashley

A week had passed after my grandma's surgery and she still wasn't out. My mom kept telling me day after day "just one more day." After the second or third time she repeated that phrase, I knew something was wrong. Did the cancer come back already? Something called "sepsis" had happened when they moved her intestine.

Septic: a widespread infection through the bloodstream damaging organs in its path. Sepsis is deadly if untreated or detected late.

Where did my grandmother fall in that? I cried the entire day I found out. A hole in my chest grew where hope originally dwelled. What would I do if she was gone?

March 26, 2017
Dear Diary,
Grandma isn't getting better so they have to do another risky surgery. I think I have cried more in these last couple of months than others cry in their whole lives. I keep asking a lot of pessimistic questions and my mom hates it. I can't help but worry but all she responds is "pray and have faith." How could I have faith when she was still sick the entire month of praying. If it's not one thing it's the next. I can't talk to Grandma about this anymore. I don't want to add my fears to her own. I am completely alone.
-Ashley

My grandma lived through the surgery. My heart once again started to ease its pain. It took her two more weeks before she was finally discharged from the hospital. On that day, sunny skies shone brightly. My grandma was able to walk once again and eat normally. As the weeks went on my anxiety eased more and more. She was alive and she was here to stay. I finally talked to my grandma about everything she had gone through, I told her how alone I felt and how I mourned her even though she wasn't gone. She said she felt much the same and yet she still fought. When I asked what she meant she responded,

"God has let me live so that I may bring happiness and comfort to all my kids but most of all you. Even though life will be different now, I know I can do anything because I am surrounded by love. I am not nearly as alone as I felt in the hospital and I remind myself that every day. And even when I am gone one day you will live too for the people who love you".

Every day I remind myself of my grandma's perseverance near death. How stubbornly she clinged to hope and life. My grandma has been been cancer-free since then and continues to live with a colostomy bag. Even though I wasn't diagnosed with cancer, there is a journey of illness that is experienced by both the patient and their family. I still fear the cancer that could come back. Still fear the complications that can and already have arrived. But for now, I let my grandma's words quiet my anxious voice whispering, *What would I do if she was gone?*

The Medical Humanitities Journal of Boston College

Chestnut Hill, MA 02467