THE MEDICAL HUMANITIES JOURNAL

of Boston College

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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. • Critically examine and creatively represent 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.

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To read the journal online or find more information, visit us at www.bcmhj.com. Please direct questions and submissions to **bc.mhj.1@gmail.com**. Submissions are also collected via Google Form each semester.

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A Note from the Editors

When Dhiman and I joined the Medical Humanities Journal our sophomore year, we feared for its future. As we now celebrate the 10th issue anniversary of our publication, we found ourselves overwhelmed by the support and recognition that has been fostered between our team, allowing us to continue spreading our mission to the Boston College community. Founded on the purpose to support student work, believing that everyone can add to the ever-evolving conversation, we have worked closely with the minor to continue the exploration into an interdisciplinary, humanistic, and cultural study of illness, health, healthcare, and the body.

In our first edition, Christopher Kabacinski and Emilee Herringshaw wrote: "Medical science contends that what gives life matter are genes and atoms and strings. Medical humanities contends that what makes life matter are stories." From working in the medical field, taking care of family members, sharing fears and insecurities, a global pandemic, and even what it in itself means to be human, we have shared stories that engage the self and medicine through artistic expression. But more than that, we have been able to write our own stories that we will carry with us long after graduation. The Medical Humanities Journal was the first student organization that I joined at Boston College, and the first place where I felt accepted. Jenny and Tristan were like our impromptu parents, and I feel so lucky that we were able to collaborate with them for two years. That being said, we knew it would be a big transition for the journal and ourselves, but we hope that we have led you in a way that makes you as proud of us as we are of you.

Our goal for this journal is to give voices to the common experiences we have so that we might build empathy between one another. Medicine is a field overflowing with immovable statistics. Yet, until we understand that a human being is behind each number, a number is what they will remain in our minds. My sophomore year roommate once told me that literature is the most powerful and intimate form of communication, an outpouring of the soul of the writer to the reader. Our journal is a year-long, collective effort—a dive into the *soul* of medicine. It is our duty and honor to share it with you.

Morgan Costa and Dhiman Shahid
Co-Editors-in-Chief

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Proof of Pain

Jesse Julian

PROOF OF PAIN

Written by

Jesse Julian

ACT I

> *During the years when I found it necessary to revise the circuitry of my mind I discovered that I was no longer interested in whether the woman on the ledge outside the window on the sixteenth floor jumped or did not jump, or in why.* ***I was interested only in the picture of her in my mind: her hair incandescent in the floodlights, her bare toes curled inward on the stone ledge.***
>
> —Joan Didion, *The White Album*

REVISION OF Scene 1

SETTING:

EXAMPLES

We are in Room 802 of [redacted], a public high school in the suburbs of Southern California. This office belongs to [redacted], a guidance counselor. Framed prints straight from Etsy fill the walls with decorative catchphrases in a friendly, pastel font. A desk divides a cushioned swivel seat from a plastic

COMFORT VS.

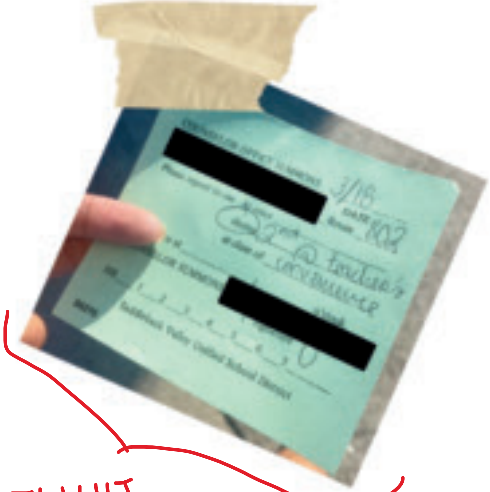
*SAFE SPACES are designed w/ SUFFERING in mind

DISCOMFORT

blue chair. The dim, golden glow of a hexagonal IKEA lamp offers the ILLUSION of warmth and security. The setting's effect is ~~comforting~~ TENSE. STRANGE.

AT RISE:

[redacted], a student, sits in the plastic chair with upright posture. Her left hand holds a mound of tissues and her right hand holds a green call slip. Tears of eyeliner mark her face; they're like claw wounds from a hard-fought battle of sobs. Yet confusion holds her face still. MRS. [redacted] maintains welcoming body language. Her eyebrows bend with concern, though she shares a sympathetic smile.



SPOTLIGHT

getting called to the front is never any good!

MRS. [redacted]

*CASTING NOTE: STRAINED & DRAINED, in her 30s. ill-equipped

A couple of people have expressed their concern for your wellbeing. Let's discuss what your friend said the other day—he believes that you attempted to self-harm.

[redacted]

ZONED-OUT, DISORIENTED

(muttering)

I just said I wanted to drive my car off the freeway.

MRS. [redacted]

(MRS. [redacted] perks up. She sifts through her head, considering her response.)

~~Let's dive deeper into what that means.~~

~~Talk me through what that feeling felt like.~~

~~Can you explain what you mean by that?~~

~~I'm sorry that you felt that way.~~

what should she have said?.....

It happens. I mean, this feeling of not having control, or of thinking things might be better, that the world might be better without you in it—sometimes those bad thoughts really do get in our heads. I mean, just two weeks ago, my husband stood at the edge of a building, asking me why he suddenly wanted to jump. He stood there on that ledge and I stood right behind him, not sure how to save him, or answer. Sometimes we don't know the answer!

She was right.

Sometimes we don't know the answer, and I sure as hell didn't know the answer, because what the fuck am I supposed to say to that?

I left this unwanted interaction with this image of a stranger. He teeters on the edge of my consciousness as a frigid breeze rocks him back and forth. He stares into an obsidian night that craves to swallow his unsteady body, aimlessly falling like a fisherman's rod casted into an unlit ocean. An entire life—decisions, dreams, actions, ailments—all come down to his fatal surrender to gravity. Behind him stands his wife—employed by my school to "help"—struggling to help him.

Here she sat, struggling to help herself as excruciatingly theatrical details rolled off of her tongue via the Trojan Horse of shared experience, subtly ready to wage war with my mind. She unveiled her corny sayings, reciting,

MRS. [redacted]

(hands flailing, shrugging her shoulders)

And it's okay! It's okay not to be okay. *You are not alone*.

I’ve come to question what theatrical script these school counselors rehearse prior to pulling the velvet curtains back, revealing their audience: an ideal caseload of 250 students, sitting together in the strange darkness of shared breath and sustained silence. With cliché catchphrases and cringy attempts at trauma bonding, the short-term emotional support of K–12 counseling staff falls flat into comical redundancy.

Take her entertaining delivery for example. Each syllable bounced out of her mouth with uncanny joy, like the predictable yet perfect timing of a comedian after hours of practice. It is nearly humorous to see that she was ready to spit out lines assuring me that it isn’t *only* me. The butt of the joke: it is *awful*ly great, *terribl*y fantastic, and *horribl*y outstanding that someone else *really* wanted to kill themself. Bonus points for standing on the ledge merely ready to jump! The punchline: I sure am thankful I’m not alone.

The American School Counselor Association (ASCA) advises counselors like her to promote a continuum of care with a focus on empathy. This ability to understand and share the feelings of another exists at the core of social-emotional learning. My counselor might have logically reached this conclusion: if empathy resolves loneliness, and loneliness correlates with suicidal behavior, then empathy reduces these suicidal tendencies. Her storytelling utilizes the cognitive dimension of empathy to walk in my shoes—innocent proof that she understands.

But she walked me up to that ledge where he stood, piquing my interest in the picture of him in my mind. Not that I was interested in whether he jumped or did not jump, or why. I must feel grateful that he was *there*, and that someone was *ready* to jump. How selfish and silly do I look, sitting at a steering wheel with only thoughts and tears—someone else has done the harder job of readying themself for the dive into the unknown! The punchline, again: although I certainly am not alone, my problems can’t be as bad as that.

It seems like we've accepted that as long as there's always something worse going on, then your problems aren't that bad. The existence of the worst guarantees the better. People constantly understand the subjective quality of their life through comparison. American psychologist Leon Festinger observed this more than half a century ago in his Theory of Social Comparison Processes, theorizing that self-evaluation comes from the comparison of oneself to others.

Festinger's theory evolved into Buunk and Ybema's Identification/Contrast Model to involve the key features of *direction* and *perceived similarity*, which gives us the phrase "downward contrast"—recognizing one's dissimilarities with someone who is downward, or "worse off." Downward contrasts should foster positive feelings, as it reassures the individual about their superior standing. As I look down at those spiraling toward rock bottom, I should reassure myself that I *must* be good up here—at least I am not falling. My counselor likely believed that she provided comfort and ease through the knowledge that there are others struggling even more than I am. The existing literature that addresses social comparison theory and mental health arrives at fairly unanimous conclusions: upward contrasts lead to feelings of insecurity, and downward contrasts can temporarily boost self-esteem.

Yet I argue that downward contrasts invalidate the individual experience of suffering. Is it always wrong to suffer if someone has it worse? Research professor Dr. Brené Brown broke down the term *comparative suffering* by connecting it to scarcity in culture amidst the COVID-19 pandemic. She explained that "we start to rank our suffering and use it to deny or give ourselves permission to feel." People began to strip themselves of the right to feel pain, because the scarce resources of sympathy belong elsewhere: the higher ranks on the scale of suffering. For every time that you are hungry, there is someone hungrier; for every time that you are sick, there is someone sicker; for every time that you are struggling mentally, there is someone on a ledge, ready to jump—and if it's not you, then you must do more to prove it.

ACT II

TELEPHONED PRESCRIPTION Rx NUMBER

NAME SUFFERING DATE

ADDRESS

PHONED BY TIME DELIVER WILL CALL

ORIGINAL Rx NO. DO NOT REFILL ☐ REFILL ∞ TIMES

℞ Fluoxetine Paroxetine Escitalopram Duloxetine Citalopram Trazodone Lithium Bupropion Esketamine Sertraline Venlafaxine Clomipramine Mirtazapine Brexpiprazole

LABEL ☐ Sig: TAKE UNTIL THEY NOTICE

M.D.

PHARMACIST DR'S PHONE DOCTOR

DR'S ADDRESS DEA NO.

Casual reading has nurtured my interest in stories with angsty protagonists drowning in tumultuous chaos—fighting for survival in a world unfit for them. I curated a melodramatic, pessimistic perspective by diving into Sylvia Plath's narration from *The Bell Jar*, or witnessing the breakdown of Kate Chopin's protagonist in *The Awakening*. Reading these experiences brought true empathy for me. I'd like to think that this differs from my counselor's performance—while she *responds* to my experience, these written works do not demand pity. I felt different, yet not alone. I was a willing participant in the crowd, watching scenes unfold before my eyes.

Recently, I finished reading Ottessa Moshfegh's *My Year of Rest and Relaxation*, expecting the same trope of societal suffocation. But I struggled to enjoy this book. Moshfegh's unnamed protagonist watches her world flood with tragedy (her parents' death, a demeaning romance, an unfulfilling career), but she does not struggle to float—she bathes and basks in it. Instead of grappling with her problems, she avoids them. The story follows her hibernation attempts through pounds of sleeping medications prescribed by a ridiculous doctor.

Scene 1

PROTAGONIST

So I filled the prescriptions for things like Neuroproxin, Maxiphenphen, Valdignore, and Silencior…

While her witty and snide remarks carry the novel's sardonic tone, her lifelessness lends to a boring plot. The reader clings onto the sole entertainment: her annoying attitude.

Scene 2

PROTAGONIST

I took a cab home, filled the new prescriptions and refilled the old ones at Rite Aid, bought a pack of Skittles, and went home and ate the Skittles and a few leftover primidone and went back to sleep.

She maintains this elusive pride for using a myriad of medications, which she hides under a façade of simplicity and uncaringness. *Oh, whatever, I'll just pop another of this and another of that*, her tone conveys.

Scene 3

PROTAGONIST

I opened the medicine cabinet and took two Valiums and two Ativans, guzzled water from the tap.

Her drug use does not appear as dry swallows between sobs, or tear-soaked tablets gripped by a shaky hand. She is *casual, collected, intentional,* and because of this, frustrating. We have no collective witnessing of catharsis. She's quite happy to "rest" and "relax."

Am I an asshole for thinking that she's annoying? I criticize her for processing her depression this way, but must we always perform breakdowns in offices or spectacles on ledges? Despite her apathy for life, the reader understands that her abusive habits contribute to her meticulous plan to escape misery, despite her apparent pleasure in dosing away and dozing off. Our sympathy for her stems from her never-ending name-drops of drug after drug, each product of medical nomenclature eliciting solace. Perhaps the protagonist creates a physical manifestation of suffering others can see. These piles of pills are her proof of pain.

It's easier to doubt the truth of mental illness; we're witnessing a rise of self-diagnosis and incessant labelling, exaggerated expressions for emotions, and the pathologization of every touch of sadness. Also, mental illnesses fall under the category of *invisible disability*; it does not have a particularly tangible form, which makes it difficult to secure assistance. Prescription medication, however, seemingly resolves both of these: it possesses a physical form and the validation of a licensed psychiatrist, forcing one's pain into visibility.

With the scarce amount of attention society can afford for tragedy, people treat a person on prescription medicine with more serious regard than the unprescribed. The dominant biomedical model of mental health leads us to deem medication as not only a resolution, but a sign of legitimacy. A commercialized pharmaceutical industry pushes practitioners to increase the economic demand for psychotropics through marketing. Thus, health care providers enlarge the diagnostic boundaries of disorder and pathologize all of human suffering.

Those struggling must validate their pain through medication. But this sparks an invalidation of those who do not use prescribed medication, as their severity of illness appears incomparable to those who need chemical alteration. Plenty have exercised their bragging rights over medication on social media, leading to a rise in the glamorization of mental illness. This, I believe, is what annoys me about Moshfegh's protagonist; the laundry lists of medication feel awfully reminiscent of people parading around with their pills.

It breeds unhealthy competition. For every time I cannot focus, my coworker reminds me that she needs Vyvanse to do so; for every time I am upset, my friend says only Prozac solves the problem. The trend of medicating hinders my permission to feel the full intensity of emotion, because I ought to remember that I am relatively fine compared to those with a certified diagnosis. Raw, individual suffering is ultimately diminished unless supported by its physical embodiment: the orange bottle.

ACT III

Reva was gone. I watched the videotape over and over to soothe myself that day. And I continue to watch it, usually on a lonely afternoon, or any other time I doubt that life is worth living…Each time I see the woman leap off the Seventy–eighth floor of the North Tower—one high-heeled shoe slipping off and hovering up over her…I am overcome by awe…not because Reva and I had been friends, or because I'll never see her again, but because she is beautiful. ***There she is, a human being, diving into the unknown, and she is wide awake.***

—Ottessa Moshfegh, *My Year of Rest and Relaxation*

Arthur Frank, a sociologist from the University of Calgary, recently came to Boston College to discuss polyphonic suffering within the context of Shakespeare's plays. He described suffering as a "space"; a physical location we arrive at. This space contains a multiplicity of voices; melodies roaming across a stage through different scenes that complicate the experience. "Suffering is always, and irrevocably, a mess," he says. The actors constantly affect each other into incoherence.

We should desire to leave this space. To persevere past suffering and escape that mess. To heal. To draw the curtains, turn off the spotlight, and leave the theater.

Yet why do we feel the need to witness the suffering of others to better understand our own? Is the stage play cathartic?

No matter how much exposure we have to pain, our individualized suffering feels like one big, stupid question mark. Even those professionally trained to help us end up botching the show. No script can prove that we truly understand each other.

No prescription can prove that one is ill enough to deserve care and attention. Processing the severity of suffering reaches no resolution, regardless of how many stories high you are.

Competitive suffering evokes a dangerous, masochistic pleasure. It wears a mask of empathy, and a disguise of diagnosis. "You are not alone" translates to "you are not as alone as I am."

I don't mean to villainize anyone, though. This competition does not come from malintent of the individual—it comes from a system that has succeeded in drawing profits from diagnosis rather than providing proper treatment. If the individual wishes to validate their suffering, they look to the person who has it better and reassures themself that they have it worse. We've reached a problematic point in understanding mental illness: one is supposed to feel reassured of their own life's comforts so long as they can watch others jump off the ledge.

Society should never compare suffering in the first place. No more gold stars or Olympic medals awarded for pain. No Oscar for the best performance. Varied perspectives can create a shared and complicated experience, but to feel pain and emotion in any capacity? That is proof enough.

FADE OUT.

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END.

The End of an Era: One and a Half Years of Solitude

Raquel Cohen

My soul was a silent empty cavity.
I was a robot, Zooming in, and Zooming out.
I was a black screen against a background of a dozen more black screens.
I was a voice that was not a voice;
only empty words that echoed through a speaker
until that day.
The day the sun came out.
The day I left my house.
It was warmth radiating from every direction.
It was remembering what it means to smile at someone and
remembering how it feels to be smiled at.
The feeling was a symphony of tingles restringing my heart
and elevating my soul.
Life was a flight of freedom for the first time in what felt like
forever, I remember this feeling
forever, I realize that presence is a gift.

Inequities in Clinical Trials: Impact on Women

Carrie Kandall

You fall and scrape your knee. Naturally, you clean the cut and put on a band-aid. Because of the band-aid, you continue with your day, feeling confident that the band-aid will protect your cut. This is a remedy to a small, but real, problem.

Of course, medical issues can get far more elaborate than this and require more complicated solutions. We are made up of trillions of cells and 11 major organ systems that must interact daily (Cooke, 2023). Due to the complexity of these systems, there is no simple band-aid for many of the diseases, illnesses, or disorders that affect millions of people every day, especially the chronic ones. As a result, many people with complex medical needs enter periods of trial and error, where they experiment with different medicines until they find one that works best for them.

I was one of those individuals.

When I was nine years old, I was diagnosed with Crohn's Disease, but my complications got more severe in high school. For a few years, I kept trying different medications, dealing with unexpected side effects, and then facing defeat. This cycle felt endless. Going through this experimental trial made me wonder why my trillions of cells were failing me; why were my organs not communicating and working together like everyone else's? Eventually, I found a medicine that appeared to work. However, I only felt relief for a split second. This medicine controlled my disease but created new, unexpected side effects, requiring me to seek care from another specialist. When I asked my provider why this was the case, she did not have an answer.

The medicine for me—the one that was made to provide my relief—was not created with women in mind. Historically, women have been underrepresented in clinical trial testing in the U.S. This disparity means that women are more likely to experience adverse effects from medications and inequities in their treatment.

Clinical trials are important in healthcare because they provide a structured opportunity for researchers to innovate, learn about possible new treatments, and ensure that all medications are safe and effective before entering the market. Clinical trials are conducted in four phases. In Phase I, 20 to 80 people participate to judge the drug's safety. In Phase II, researchers recruit more participants and begin to evaluate efficacy, along with safety. In Phase III, the study expands to hundreds and thousands of participants, allowing researchers to study different populations and dosages. At this point, if researchers can prove that the drug is safe and effective in addressing a specific health concern, the FDA will approve it. Researchers will still engage in Phase IV testing to monitor the drug's use in diverse populations and uncover possible side effects from long-term use (NIA Scientists, 2023). The nature of the clinical trial process allows those involved in testing to drastically impact how researchers understand a drug and its interactions within the human body. Yet, the majority of study participants are biologically male, even though 51% of the population are biologically female (Balch, 2024). This means that we have significantly less knowledge on how drugs in the market react in a biologically female body, compared to a male one.

This pattern is something we have seen throughout history, though it worsened from 1957 to 1961. In Europe and Australia, thousands of women took Thalidomide to manage morning sickness. Later, it was revealed that the drug caused severe birth defects in over 10,000 children (Unachukwu, 2021). As a result, policy makers capitalized on this fear to justify excluding women from clinical trials. In 1977, the FDA introduced regulations to prohibit all women of childbearing age from participating in clinical trials, unless they had a life-threatening condition. The objective of this was to protect women's fertility; in reality, researchers wanted to test medications without thinking of or unintentionally harming any woman's reproductive system (Jakubek, 2024). This perpetuated the mindset that the biologically male body was the easier one to work with and that the female's reproductive system was a burdensome complication. This gave researchers permission to cater their studies toward males, without adapting research to females too.

It took until 1993 for the NIH to identify and attempt to reverse this injustice. The NIH Revitalization Act of 1993 required all clinical trials that receive federal funding to include "women and minorities" (Mazure, 2015). Even though this is a positive step forward, there are still significant barriers in improving equity in clinical trials. For example, the government funds most clinical trials, but approximately 40% of clinical trials in 2017 were funded by private, for-profit companies (Hokoum, 2017). This means that not every drug that enters the market must follow these equity standards. Additionally, while the provisions of this act apply to all future testing, it does not change the past. Many prescribed drugs on the market now were approved by the FDA before 1993, and do not need to undergo retesting. Even though there have been significant strides forward, especially with better female representation in Phase III clinical trials, we must recognize that there is still underrepresentation, especially in Phase I and Phase II studies (Fultinavičiūtė, 2022). Dosing regimens used in Phase III are based on pharmacokinetic data from Phase I and Phase II, meaning exclusion from any phase of the clinical trials is harmful.

Despite efforts to increase the enrollment of women in clinical trials, progress has stalled. A study by Contemporary Clinical Trials looked at federal data covering over 300,000 participants. Despite being the leading causes of death for women, only 41.9% of participants in cardiovascular research and 41% in cancer research identified as women. The disparities are even worse for mental health: 60% of people with psychiatric disorders are women, but women only make up 42% of clinical trial participants. This signifies an improvement from the late 1900s, but still shows opportunity for growth (Blakemore, 2022).

Because of this history, women are more likely to be overmedicated or face adverse side effects from medicines in the market. Males and females metabolize medicine differently due to differing sex hormones. These hormones, which can be impacted by menstruation, pregnancy, menopause, or oral contraceptives, affect how the body breaks down medicine. Without equivalent testing, there is no definitive way of knowing how a biologically female body may react to a medicine. For example, Irving Zucker, a professor emeritus of psychology and integrative biology at UC Berkeley, and Brian Pendergast, a professor at the University of Chicago, conducted a study on the sleep medication Ambien. They revealed that women experienced stronger side effects than men in over 90% of the cases and experienced adverse effects at twice the rate of men (Pratt, 2020). Additionally, Zucker and Pendergast found that there were sex differences in how the body broke down 86 different medications, including aspirin, morphine, and sertraline (Lerner, 2020).

These shortcomings in research contribute to inequities in health access. Consider cardiovascular disease: the number one cause of death for men and women in America. Women die at higher rates from cardiovascular disease than men, but the warning signs are analyzed through a male perspective (Unachukwu, 2021). During a heart attack, both men and women will likely identify chest discomfort. However, women are more likely to also identify nausea, fatigue, and breathlessness. Since heart attacks are a condition more commonly studied on men, people who present these other symptoms are thought of as “unusual cases.” In other words, the way a heart attack manifests in a woman is “unusual” compared to a man’s presentation, which is the socially constructed norm. As a result, in an emergency room, women with chest pain wait 11 minutes longer than men to receive treatment, are less likely to receive an electrocardiogram, and are less likely to be hospitalized. With this information, it is not surprising to learn that between 2010 and 2017, women made up only 27% of research participants in studies concerning coronary artery disease (Corliss, 2022).

Our understanding of the human body and medicines has grown tremendously, but that knowledge is not spread equitably. We know that there are differences between biological males and biological females, and instead of embracing and learning more about these differences, researchers have attempted to ignore it. I am still enduring the impacts of taking a medicine that was not tested on women; I still hold onto the helplessness I felt in high school, the feeling like no medicine was made for me; I still hold onto the frustration I had at my provider when my new symptoms appeared, but now an understanding that she had no studies or trials to reference. Without equitable access and participation in clinical trials, women will continue to face adverse impacts. We must work to ensure that clinical trial access is available to all people, regardless of sex, gender, race, religion, and socioeconomic status.

There is no easy band-aid for more complicated medical problems, and that is okay. But it would be better if the band-aids we gave women to cover their cuts did not give them bruises too.

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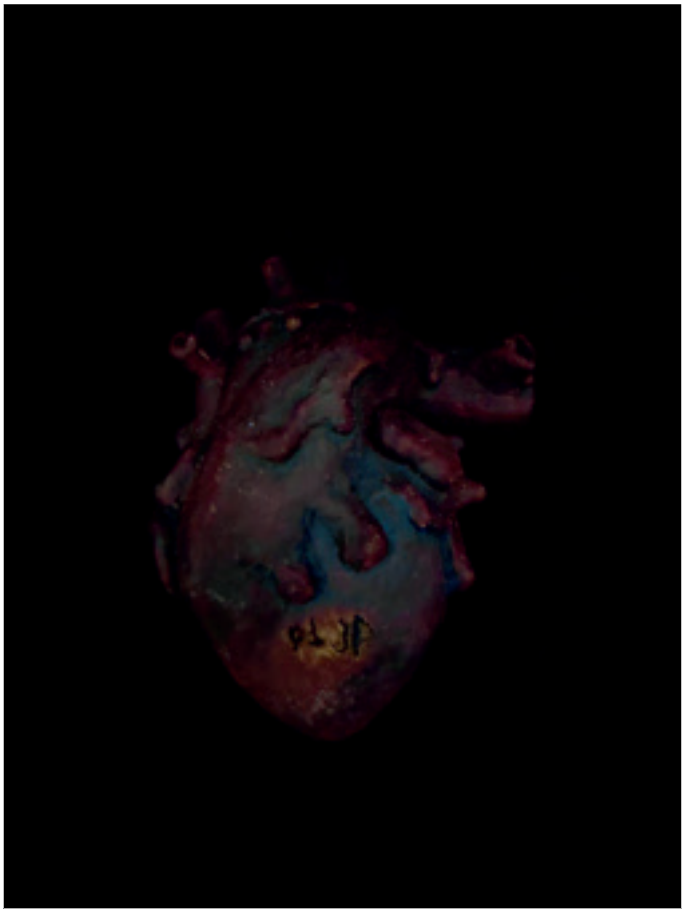

Hand Holding Melting Heart

Jeremy Park

It Used to Be My Lavender

Liv Absey-Allen

Once she was finally here, I knew no better way to care
For her exhausted parents on Sunday afternoon than my lavender
Bread rising in the oven, defrosted lasagna on fresh dishes
Cleaned with my distant childbirth memories, the pain that trampled my own body
Five times, but once I saw their faces all suffering was forgotten.
As soon as this new sweet face grew older

We too would scrounge the blistering hillside, looking for older
Bushes that crawled and trellised, too enchanted by their beauty to care
About the peacock that ate our sandwich, the dead flowers we forgot
To water. I would tell her to *clip the stem here*, bags of lavender
Taller than my granddaughter's own tip-toed body.
From the house, we smelled panettone, whiffs of yesterday's dishes

Because I couldn't remember the little things, like the dishes,
Or why the children lost interest in the ladybug puzzle as they grew older
And the hillside grew colder. The harvest became too hard on my body,
It wilted, maybe instead I could ask someone if they cared
Enough to trim back my canyon of rambunctious lavender,
While I went to the store instead, we had no bread, I must have forgotten.

Next week they said *you need to move mom, you are starting to forget*
They took me to a new place, where some people barely moved and others did the
dishes.
Those ones who told me *this is your room, we know you like lavender.*
The sheets smelled good, a little bit of home, and next to my old
Bed I saw my boogie board, for writing in the redwoods, but I didn't care
For the topiary garden outside my window or all the unfamiliar bodies.

One by one, I learned each of their stories, some of these bodies
Spoke of lives of birdwatching and beach cabins, some had already forgotten
But they all treated my rock collection with care.
One of them worked at the library each Wednesday, the rest of us never did the
dishes
Because compared to the people that did, we were much older.
They would never tell me where they put my lavender.

I soon asked *what's that smell?* To a room full of faces. *It's lavender,*
They said, and we looked down at the sheets, but I only saw my body,
A total stranger. I wasn't sure if I knew these people, I knew they were older
This time, kind, I'm sure, although they had clearly forgotten
Basic manners, since they kept trying to feed me from these dishes
Like I was a baby, grabbing my hand as if they didn't even care.

The family that bought the house didn't grow lavender, but the stories were never
forgotten
She sank into the sheets, out of her body, losing sight of the plastic dishes.
I'm so happy it's time for me to be older, she thought, and she knew they cared.

Old Sparky: The Electric Chair as Spectacle, Symbol, and State Power

Jane Zafran

Introduction

In 1964, acclaimed artist Andy Warhol began commissioning a series of one of America's most infamous creations: the electric chair. His portfolio highlights the death chamber at New York's Sing Sing prison. The canvases show a vacant electric chair in an empty room, emerging slowly from the shadows in the background. The series reflects Warhol's preoccupation with violent death; he observes, "when you see a gruesome picture over and over again, it doesn't really have any effect" (Buchloh and Warhol). Such is the attitude of most Americans flooded with media accounts of violence, whose desensitization have allowed for the prominence of the electric chair in popular culture. This paper provides a multidimensional analysis of "Old Sparky," the nickname given to many of the country's electric chairs. Outlining the chair's history, symbolism, and legal properties, I highlight the power relations at work in capital punishment via electrocution in the United States, which are deeply intertwined with notions of capitalism, American exceptionalism, and biopower. Ultimately, these forces suggest a dark side to the American creed of democracy, equality of opportunity, and justice, drawing into question the legitimacy of such values in American government and culture at large.

The Road to Hell is Paved with Good Intentions: The History of the Electric Chair

The electric chair was born partly in response to growing public aversion to hanging, reflecting changing notions of modernity and civilization in America in the early 1800s. Long considered the preferred method of execution, hanging offered a few advantages: it requires little equipment and allows the body to be displayed postmortem as a deterrent to others (Galvin 19–20). However, the suspension drop involved must be calculated precisely so that the victim is not decapitated, which U.S. law considers “cruel and unusual punishment” (Galvin 21). This proved challenging to the era’s executioners, as several botched executions widely publicized in newspapers helped turn the tide of public opinion against hanging. In 1866, the Cork Examiner reported that onlookers “find appalling the spectacle of common criminals being publicly hanged in front of the jail” (Galvin 29–30). Framing this past methodology as barbaric, the Supreme Court would eventually write in 1958 that the Eighth Amendment, prohibiting cruel and unusual punishment, “must draw its meaning from the evolving standards of decency that mark the progress of a maturing society” (Varland 313). Such standards of decency would serve as the test for the gallows’ replacement: the electric chair. During its first use in 1890, death by electricity proved humane enough.

Scientific advances in the mid-19th century seemed to answer the public’s call for greater conscience. After observing an accidental electrocution, which killed the victim instantly, Alfred Southwick began lobbying in favor of electrocution. His occupation as a dentist, where patients were seated when operated on, gave him the idea to use a chair for electrocutions. Governor David Bennett Hill recommended the idea to the New York legislature in 1885, declaring, “the present mode of executing criminals by hanging has come down to us from the dark ages…it may well be questioned whether the science of the present day cannot provide a means for taking the life of such as are condemned to die in a less barbarous manner” (Brandon 49). His statement reflects the perceived brutality of past executions and intended transition to a new Gilded Age, where “science” can provide a dignified death. Electrocution, which sanitized the killing process through its veneer of technological perfection and achievement, was the answer. While abolitionists still called for the end of the death penalty, the discourse of Southwick's humane methodology of execution helped justify and perpetuate capital punishment in America, which remains one of the few industrialized countries who endorse it today. Seeking a "scientific alternative" to hanging, the public soon rallied around electrocution, with the *New York Tribune* claiming that "there is no reason to doubt the ability of modern science to devise a mode of swift and really painless execution. Electricity would certainly furnish the means" (Brandon 49). However, these sentiments reveal a seemingly unbreakable faith in "modern science," which as a discipline is by nature experimental and, at times, unreliable. A reasonable level of doubt and willingness to ask questions is fundamental to the scientific method. Like its predecessor, hanging, the electric chair would endure its share of malfunctions, which I will explore later in this paper.

To manufacture a working electric chair, Southwick turned to the expertise of Thomas Edison, inadvertently embedding the device in the war of the currents as Edison and his rivals sought to standardize their preferred type of electric power. Losing the battle for America's electricity, Edison used this opportunity to try to smear rival George Westinghouse by linking alternating current—associated with Westinghouse—to executions. Edison's profit motives and competitive ambitions not only cast doubt on the legitimacy of the "humane" defense of electric execution but reflect an abuse of power. His misleading account of the workings of electric power reflects scientific hubris at its worst, showing wanton disregard for the lives at the mercy of his creation. It also draws into question the credibility of scientific expertise as a source of knowledge, tarnishing the reputation of the "scientific expert" far and wide. Thus, by politicizing how electric power would be delivered during execution—Edison for direct current, Westinghouse for alternating—the electric chair became embroiled in a commercial battle for dominance. Moreover, prisoners became pawns in what was ultimately a corporate and political dispute; neither Edison nor Westinghouse even supported the death penalty. But Edison had already unleashed Pandora's box; in 1886, Senator Daniel MacMillan of New York appointed a commission to investigate the most humane method of capital punishment, including electrocution (Brandon 51). Edison's testimony was crucial to the Gerry Commission's report, which ultimately endorsed electric execution. Speaking at a public hearing about the commission's findings, committee member Elbridge Gerry "testified that he thought Edison knew more about electricity than anyone else in the United States and that Edison's endorsement was the major factor in persuading him" (Brandon 58). These findings prompted new legislation, and on June 4th, 1888, Governor Hill signed the Electrical Execution Bill into law (Galvin 65). Thus, Edison leveraged his status as an expert, manipulating information for commercial advantage in a demonstration of knowledge as power. The war of the currents continued as New York's first electric chair began construction, with Westinghouse determined to prevent alternating current from being used. The New York Legislature consulted the Medico-Legal Society of New York to help ensure the chair's mechanics facilitated a quick and painless death. The society's chair, Dr. Frederick Peterson, and engineer Harold Brown began experimenting with different currents to determine lethality, using small animals for test subjects and Edison's laboratory as facilities. They soon moved their demonstrations to the public arena, experimenting on larger animals in front of reporters, doctors, and government officials. The spectacle paid off; after frying a 1,230-pound horse with alternating current, the *New York Times* declared, "the alternating current will undoubtedly drive the hangman out of business in this State" (Galvin 82). The society followed suit, recommending electrocution with alternating current a few days later. As with hanging, which was driven out by public disenchantment, the theatrics of execution remained a strong force in maintaining the integrity—and support—of execution method, regardless of the scientific or medical processes at work. Still, as Brown began gathering the physical materials for the chair, he encountered resistance from Westinghouse, who refused to sell him the generator needed to power the apparatus (Galvin 83). His efforts to prevent alternating current from being used confront the politics of ownership in science. The conflation between a person and a technology—Edison and direct current, Westinghouse and alternating current—suggests an ownership between creator and creation. This legacy is what inspired Edison to smear Westinghouse, so that alternating current would be synonymous with lethality and criminality. It seems that whoever "owns" the property (physical or intellectual) or data bears some responsibility for its use in public imagination. Yet if inventors struggle to gatekeep their inventions—Brown eventually secured Westinghouse generators on the second-hand market—can they still be held accountable for consequences of their use? Hindsight is 20/20. The science and innovation of the past few centuries seems to have opened a Pandora's box. Edison sparked a myth—the lethality of alternating current—and a monster was born.

An Eye for an Eye: The Electric Chair as a Symbol of Retributive Justice and American Exceptionalism

The electric chair's prominence in the American cultural imaginary reflects a clash of morals, amplified further by the public's morbid fascination with death. Having become a symbol for the death penalty itself, the electric chair holds a contentious narrative position in public discourse. In its defense, advocates for capital punishment evoke phrases like "an eye for an eye." Others contend, "let the punishment fit the crime." These popular sayings convey the principle of retributive justice: "a system by which offenders are punished in proportion to the moral magnitude of their intentionally committed harms" (Carlsmith and Darley). Retributive justice operates under the notion that people deserve punishment and must pay accordingly for their crimes. The more serious the crime, the more serious the punishment. Criminology, an art more than a science, then boils down to a simple equation: balancing the moral magnitude of the crime with the punishment. This logic seems almost common sense; there is a basic human instinct for retribution when wronged. However, transcending such primal instincts may in fact be the hallmark of a civilized society. Though killing a murderer may be "just" under this framework, the question of civility is different altogether. Jeffrey Reiman, faculty at the John Jay College of Criminal Justice, offers the following remarks: "though the death penalty is a just punishment for murder, abolition of the death penalty is part of the civilizing mission of modern states" (Reiman 115). Though the electric chair was conceived of as humane, the evolving standards of decency today—where laws are no longer inscribed in stone—demand abolition in accordance with the development of the modern state. The nickname "Old Sparky" suggests a barbaric relic of the past, seemingly at odds with the supposed dignity capital punishment prescribes. On one hand, "old" emphasizes how the electric chair remains entangled in its controversial history, which had different standards for notions of modernity, civility, and justice than today. Holding onto this history through references to "Old Sparky" (sometimes abbreviated as "Ol' Sparky") suggests a fondness for it, an approval of the way we unveiled our killing machine outside the Jackson state capitol in 1940, displaying it in a show of strength— "tough on crime." While "old" is often synonymous with powerful—reinforcing the state's authority as executioner—it also describes something antiquated and run down. The image of broken power lines emitting sparks (“sparky”) comes to mind. The electric chair has malfunctioned numerous times over the years; in recent times, convicted murderer Pedro Medina’s head burst into flames during his execution in 1997. These botched executions draw into question the chair’s efficacy in providing an instant and painless death. Some even champion its brutality as a supposed deterrent to crime. In response to Medina’s death, Florida attorney general Bob Butterworth warned, “people who wish to commit murder…better not do it in the state of Florida because we have a problem with our electric chair” (Brandon 2). Such willful ignorance frames “Old Sparky’s” defects as an advantage, making it a symbol of not only vengeance but deterrence. However, relying on the “old” also suggests rejecting the “new”: advances in medicine and technology that might offer a more humane alternative to electric execution, like lethal injection. Moreover, new forensic methods, like DNA testing, reveal that the electric chair is not the only institution that malfunctions. The criminal justice system itself falls victim to wrongful convictions, uncovered by organizations like the Innocence Project, which uses DNA testing to exonerate wrongfully convicted individuals. Rather than reckon with these failings, nostalgia for “Old Sparky” uncovers neglect in the criminal justice system. The chair’s nickname also personifies the technology, using flippant humor in an ironic portrayal of the device as a familiar friend. This affectionate discourse sanitizes the execution process, effectively making references to “Old Sparky” euphemisms for the death penalty and desensitizing the public to the chair’s lethality. With a long history of public execution as spectacle, the American public was a natural audience for death by electrocution. However, the Gerry commission recommended that executions be held in secret, free from news observers. The report’s authors feared press broadcasts to the public would feed a “vicious and morbid appetite” for horror (Galvin 63). In his critical commentary “American Exceptionalism and the Death Penalty,” sociology professor Tony Poveda argues that capital punishment is embedded in the cultural ethos of the American Dream, justifying punitive sentiment. A supposedly meritocratic society, America champions equality of opportunity. However, the “double-edged sword” that prizes individual achievement inevitably tolerates extremes of inequality, where “the cultural emphasis on winning and getting ahead also requires “losers” and “failures” (Poveda 255). It is these “losers” and “failures”— overwhelmingly the poor and racial minorities—who pay the ultimate price of competition. As an eager spectator, the victorious American becomes executioner, upholding the values of exceptionalism in its perverted notions of liberty, egalitarianism, and individualism.

Often described as “peculiar,” America’s electric chair is apt for comparison to that other “peculiar institution”: slavery. The cruelty of slavery also seems at odds with America’s supposed egalitarian and democratic values. However, a strong cultural logic perpetuates slavery as a tradition of social exclusion, with the same forces at work to continue justifying capital punishment today. Poveda describes the historically disproportionate share of executions on minorities, particularly African Americans, that occurred in the South in the “regionalization of the death penalty” in the post-Furman era (Poveda 257). The administration of capital punishment thus became embedded in the legacy of slavery, especially in the South. In a national study of Texas executions in the 20th century, James Marquart “argued that a ‘cultural tradition of exclusion,’ deriving from slavery and its legacy of racial discrimination, accounted for the disproportionate lynchings and executions that occurred in the South” (Poveda 258). Linking slavery as a precedent to disproportionate lynchings and state executions of minorities, Marquart’s “tradition of exclusion” values the elite white body, providing the cultural basis in America for the death penalty.

Conclusion

Conceived of as a shining “city upon a hill,” America champions itself as a beacon of hope for the world, helping to promote democracy across the globe. However, the multidimensional analysis of the electric chair outlined in this paper reveals a darker history underpinning American exceptionalism, drawing into question the legitimacy of its claims to justice, equality of opportunity, and modernity. The capitalist forces that propelled the electric chair’s construction, and the American government’s enthusiasm to put it to use, reveal perverse motivations for power at odds with the democratic ideal. Moreover, the American public’s morbid interest in “Old Sparky” reflects broader cultural values less concerned with life and rehabilitation than punishment and retribution—even when culpability remains doubtful. First carved out of an oak tree by prisoners in 1923, Florida’s electric chair has killed more than 200 people (Brandon 1). Reflecting nearly a century later, it seems our labor might be put to better use elsewhere.

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From Hesitation to Healing

Sadia Tanzem

I've never faced a health emergency alone before. Throughout my childhood and adolescence, my parents were always there to take me to the ER or doctor's office, whether I was severely ill or had an injury from track and field. However, this past fall semester marked one of the first times I had to confront a medical emergency without the support of an adult. Suddenly, I found myself in a role once occupied by my parents: the responsible decision-maker, tasked with determining whether to seek medical attention or hope that my symptoms would resolve on their own. As someone who struggles with indecision, making this choice challenged me to confront my uncertainty and trust my judgment.

One Wednesday morning, I began my day and went to the bathroom as usual. After completing my morning routine of brushing my teeth, getting dressed, and applying makeup, I was ready to head to my 9 a.m. class. However, as I was leaving my dorm, I felt the sudden urge to urinate again. Initially, I didn't think much of it. Still, I found it odd, considering my tendency to be perpetually dehydrated and forgetful about drinking water throughout the day.

As the day progressed, my symptoms worsened, despite my reluctance to acknowledge that something was wrong. The constant urge to urinate intensified, and each trip to the bathroom brought an intense burning sensation. The discomfort became unbearable, and fearing the worst, I turned to Google. My symptoms aligned with a UTI, confirming my suspicions. Still, I decided to tough it out, hoping it would pass in a day or two.

It wasn't until the next morning, during a Behavioral Neuroscience exam, that I realized the progressing severity of my discomfort. Unable to focus on my exam due to the extreme urge to urinate, I rushed through the test, only to find that

I had little urine to expel. Yet the urge persisted, and when I finally managed to relieve my bladder, I was horrified—it was cloudy, streaked with specks of blood. Fear gripped me, and panic set in. It was then that I finally accepted the reality: I had a UTI and needed to schedule an appointment with UHS immediately.

Ironically, as a pre-med student, I wasn't applying the very principles I hope to uphold as a future doctor—promoting proactive and preventive healthcare through patient advocacy and education. I needed to trust myself and advocate for my own well-being. Ultimately, I realized that having agency over my body meant seeking help when necessary, despite any discomfort or fear. Further research underscored the dangers of untreated UTIs, making me acknowledge the urgency of getting medical attention.

Later that afternoon, as I walked to UHS, I felt a wave of anxiety. Would I be judged? How would they treat me? Would it be a lengthy and inconvenient process? Fortunately, the experience was straightforward. After providing a urine sample for testing and discussing my symptoms with the doctor, I was diagnosed with the typical UTI. I was shocked at the brevity of the whole encounter. In less than 10 minutes, my suffering transformed into a treatable disease. The doctor prescribed antibiotics, and within a few hours of taking the first pill, I felt considerable relief.

Nearly two months later, I experienced a familiar sensation. Waking up with a persistent urge to urinate but unable to produce urine, I again hesitated to accept that I had developed another UTI so soon. However, I recognized that prolonging seeking medical help would only lead to more suffering. This time, I promptly called UHS while my discomfort was still manageable, and received antibiotics without delay, averting another crisis. I was proud of myself for listening to my body and not letting myself endure agony for no good reason.

This experience taught me an invaluable lesson about the importance of proactive healthcare and trusting my ability to recognize when something isn’t right with my body. While I may have once viewed seeking medical attention as a last resort, I now understand that prioritizing my well-being is a responsibility I must act on as soon as I realize I may be unwell. As a future physician, I hope to carry this understanding forward—encouraging patients to trust their bodies, seek help as soon as possible, and embrace their agency over their health. Through this experience, I became not only a stronger advocate for myself but also a more compassionate future caregiver, better equipped to support others facing similar moments of uncertainty and fear.

Back for the Summer

Olivia Emerick

Beams of sunlight
refracting through my window,
witness my rotting.

My body is not decomposing in
the dark dank underground,
where the dead lay peacefully.
Mine is a body crumbling,
in the room it was raised,
because it couldn’t endure the return.
Bugs crawling on a tongue
that hasn’t been used in days;
cotton growing in ears that have tuned out
familial voices and the whirring AC;
vultures circling glazed eyes
that have only perceived the four walls
of my bedroom-turned-crypt.

Returning to familiar patterns,
my limbs sink in my queen-sized coffin
where I question why I returned to
die in a house I once called home.

The Scale

Meghan Cabral

The doctor's office is never inviting. Every medical assistant smiles when I walk in, to no avail. The walls of the combined pediatric and adolescent medicine wing are dotted with gentle reminders and animal paintings, but they just make me feel small.

I am not complex here. I am just a body, identified by numerical code. A white, plastic bracelet around my wrist has reduced me to numbers: my birthdate, my medical record number, my appointment date. In the corner, the flat black box on the ground stares back at me. The scale. There, the number that matters most will appear. That number defines me as unhealthy or healthy, determines how many more appointments I will need, decides how I perceive myself. I am that number.

The scale was not invented to weigh people; it was invented to weigh goods. Thousands of years ago, balance scales were made of limestone and leather rather than metal. You could find one in an Ancient Egyptian marketplace: an odd, T-shaped beam with two plates, one on either side. One scale plate would cradle grain, while the other would be slowly filled with weight standards, polished cubes of stone. When the plates became balanced with each other, the grain was priced accordingly. It would be a practice of patience: scooping cups of spelt onto the scale, choosing each weighted cube with intention, watching the beam oscillate until the plates were equal. It was a tool of economy, a tool engineered to exhibit balance.

But the thought of stepping on the scale made me feel unsteady. I fiddled with my hospital bracelet. The pre-visit questions remained the same as always.

Are you in pain right now? No, not really. I hope my face does not betray me. The scale awaits my return. It has been a blissful month of not knowing.

In 30 BCE, the Roman Empire conquered Ancient Egypt. The next iteration of the scale was the steelyard scale, invented in the Roman Empire during the Common Era, decades after the fall of the Pharaoh. The steelyard scale was invented independently in China as well. It is an astonishing thought: two parallel needs resulting in respective creations of a similar design thousands of miles away from each other.

In all honesty, the steelyard scale looked more like a torture device rather than a scientific tool. It has the same T-shape, but no plates are to be found on this scale. Instead, one branch of the “T” has chains with hooks to hold up the object to be weighed and the other has hanging copper weights. The object would dangle from the hooks while someone would slide the copper along the other branch, until the branch was parallel with the ground. Just like the balance scale, the steelyard scale searches for equality of both sides.

Somehow, the lack of hooks on the electronic scale on the floor did not alleviate my anxiety. On the exam table, a blue gown is folded neatly, expectantly. I am instructed to strip down to my underwear and swathe my body in the cloth. My winter clothes add a few pounds. I take a deep breath and grab the hem of my sweater.

The intentional act of finding weight manually using balance ended during the Renaissance. After centuries of adding up polished stones and copper weights, Leonardo da Vinci invented the first self-indicating scale. It is hard to imagine its exact shape; something that was new, but also incorporated old elements of previous scales. The idea sounds outlandish: Leonardo da Vinci played a part in the ritual I was about to partake in. I wonder if he foresaw how his invention would lead to emotional turmoil and churning stomachs. The scale used to just be a tool for quantitative analysis of items, of goods. I try to remind myself that I am more than an item, more than a body, but the scale makes me forget myself.

I shiver as the cold air hits my skin. The gown covers my front, but leaves my back exposed. Open to attack. I try my best to tie it around my body, but the ties are too flimsy. I peek my head out of the room to signal that I am ready for the weighing. I try to shield myself, contorting around the door to hide the gown, my pale legs, the exhaustion in my body.

Over time, scales became more and more complicated, just as life did. In 1770, Richard Salter created the spring scale, which no longer required weight standards. Instead, it relied on the physics of spring tension to determine weight, a simple yet effective design. The spring scale became popular within multiple areas of the economy; they can still be found today hanging from grocer's ceilings to weigh produce. Yet another scale that was not made to weigh a person, but rather to determine the economic value of goods. During the Industrial Revolution, platform scales grew in popularity. One patent created by Thaddeus Fairbanks allowed a wagon to be driven onto the platform for weighing collected crops, especially helpful for the agricultural sector.

It was my turn to be directed to the platform of the scale. This was always the worst part. The medical assistant changes the units to kilograms so I cannot decipher my weight in pounds. Then, she asks me in a quiet voice to turn around, to face away from the scale. I am required to step onto the scale backwards. I feel as if I am going to fall, like I am taking a step off of a cliff.

In the middle of the 19th century, European military examinations included weighing potential soldiers. A simple balance scale would be used and, eventually, an average weight for selection for service was established. This practice permeated into medicine for everyone in the late 19th and early 20th century, as doctors began to focus more on body measurements. If they could not quantify the person, they could at least quantify parts of the person, the body. The scale made everything more scientific, more numerical. It simplified the analysis of the body, forgetting the soul residing within it.

I feel the scale underneath my feet. I cross the fingers of my left hand and hold my breath, like a child wishing on a star. I find myself praying to a god that I barely believe in. *Please remind me that I am more than just a body and a number.*

The first public weighing scale in America was installed in Chicago City Hall in 1922. According to historical accounts, people were fascinated by it. Weighing your body became a novelty, a pastime. Penny scale popularity boomed; for a penny, a person could weigh themselves in the market, in the department store, in the train station, out in public. Did they watch the pointer oscillate until it stopped on a number? Did they feel the dread?

Dread expands in my stomach, spreading to the tips of my fingers. I am on the scale for a total of 60 seconds, but it feels like a lifetime. Standing on the creaking metal, I am scared of my center of gravity. I feel frozen. Then, I am told to step down. Surreptitiously, I turn my head to see the number; I can search up the conversion while I am waiting for the doctor. When I look, the screen is blank. Defeated, I dress myself, avoiding my own gaze in the mirror.

Bathroom scales began to be marketed to the American public as a way to maintain beauty standards. Advertisements boasted that scales were “beauty in figure or scale” and “the *weigh* to hold beauty and health,” accompanied with pictures of women smiling. Suddenly, weight had become an aspect of life, something to check every day. Scales were in the public, in doctor’s offices, in people’s homes. It feels like that type of scale has never really left the public eye.

I see it now in front of me: a ubiquitous flat platform scale, with an indicator of weight on the wall above it. A surface with the ability to measure my every molecule, but not my essence. A number that defines my health. A culmination of thousands of years of development and invention that pierced my heart with every use.

The scale is meant to be a tool, a way of quantifying things. It was a way for trade to be fair, where items were assigned a monetary value based on their weight. Lady Justice holds a balance scale in her hands, a symbol of equality. Yet, the scale has become something in our culture that perpetuates inequality. You are assigned a number deeming you healthy or unhealthy, desirable or objectionable. You are stereotyped based on your weight, your eating habits, and your exercise ability. Weight is everything.

The exam room is quiet. I have been underweight, I have been overweight, I have never been of the proper weight. It's either the waistband of my jeans or my restriction of food intake or my favorite breakfast or my bloated stomach. It is never enough and it is more than enough, every single day. A way of measuring burden has become my burden.

I take a deep breath. I have to remember where it began. Grain spilling onto a plate, intricate statuettes placed with care to create evenness, apples at the grocery store pulling down a spring, the light touch of fingers to find balance in an uneven world. *I am more than a body. I am more than what the scale says I am. I am intentional, too. I rise above the scale.*

Nathan et al., 2027

Daniel Strickland

The Cytoskeleton-Associated Protein *NVR1* Prevents and Reverses Death in *Escherichia coli* and *Caenorhabditis elegans*

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ABSTRACT

The *NVR1* gene codes for a protein which binds to the cytoskeletal protein lokiactin in hydrothermal vent archaebacteria. Here, we demonstrate via a fluorescent reporter that *NVR1* shows binding affinity to the actin-based cytoskeleton of *Caenorhabditis elegans* and the bacterial homolog in *Escherichia coli*. While bound in bacteria, the *NVR1* protein prevents cell division while ensuring the cell survives thermally and chemically lethal conditions. In *C. elegans*, *NVR1* protein is distributed throughout the body and permits cell division to repair tissue damage, but ceases body growth and sexual (gonad) function. *NVR1*-expressing *E. coli* and *C. elegans* do not appear to have a fixed duration on their lives. In addition, transfection of an active *NVR1* gene into heat-killed *E. coli* cells or deceased *C. elegans* specimens restores the life-functions of these organisms via an unknown cytoskeleton-associated pathway. These results were repeated numerous times in a variety of conditions (including heavy physical damage, such bisection of the worm), except nutrient starvation, which ensures permanent death. Deceased specimens as old as five years were also resurrected. The widespread genetic difference between the tested species implies that *NVR1* genes may be able to restore life to any deceased species in the kingdom of life.

[**INTRODUCTION**, **RESULTS** and **METHODS** available for access in full article.]

DISCUSSION

There is no phenomenon of life more universal and unpreventable than death. Death occurs in every species of every family of every domain of life. The demand to prevent and reverse death has built every major religion on the planet. The careers of biologists and chemists are often measured by their impact on the battle against death. Here we have clearly demonstrated that death is indeed preventable and reversible. While energy is present, the *NVR1* protein has the capacity to continually rebuild the bodies of the *E. coli* bacteria and *C. elegans* worms tested. The implications for this work are obvious and terrifying. Due to ethical concerns, the protein remains untested in a mammalian system.

We have made the unconventional choice to classify the samples for this experiment. For at least five years after publication, the Olofsson lab will keep all specimens, sequences, and protein extracts isolated and secured while the ‘immortal’ specimens undergo further observation and rigorous testing. The *NVR1* gene’s original species will remain anonymous here as well. No further specimens, bacterial, worm, or otherwise, will be inoculated with the *NVR1* gene or protein until appropriate ethical conversations surrounding the research are conducted and trusted anonymous sources can replicate our findings. All authors will be under the sustained observation and protection of the Kingdom of Sweden. Please respect the authors’ wishes for privacy, security, and continued scientific experimentation.

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CONFLICT OF INTEREST

The authors declare that they are alive, desire to continue to live, and are therefore motivated to publish. Beyond that they declare no conflict of interest.

A Moment of Reckoning: How “The Death of Ivan Ilyich” Redefines Life and Loss

Jane Zafran

Mount Everest, the Burj Khalifa, Hyperion: because of their tall stature, people associate these monuments with power, grandeur, and status. These monuments’ high stature suggests that not only is being tall a good quality, but so is being taller; hence why heaven is above the sky, and hell is below the ground. Height, it seems, is a matter of relativity. Being a little higher means being a little better, and being a lot higher means being a lot better—or stronger, faster, smarter, successful. But height’s relativity also casts doubt on its legitimacy—not only on that of its literal being, but also its significance. Is something actually tall, or is it just tall compared to something else? If height is all a matter of perspective, how can you draw any absolute conclusions about its symbolism? Your deductions may be tainted by self-deception. Something may seem tall to you only because it’s next to something short.

In his novella “The Death of Ivan Ilyich,” Leo Tolstoy wrestles with the traditional notion of tragedy as a fall from height. Though Ivan’s fall off a ladder results in his death, it is hardly his demise. By reckoning with his illness and impending death, he comes to realize what actually matters in life: love and appreciation for meaningful relationships, such as those with Gerasim and his son. This liberates him from his selfishness. Ultimately, Ivan’s fall reveals that height is an illusion, suggesting that death is not only humbling as the great equalizer, but a means of making our lives meaningful—contrary to conventional wisdom, which claims that we do so by living, not dying.

Before Ivan falls ill, in the beginning of the story Tolstoy uses the discourse of height and distance to highlight Ivan’s shallow values and preoccupation with power and social status. For example, Tolstoy writes that “estrangement” is the “goal of [Ivan’s] activity in [his] family” because of how unpleasant he finds spending time with them to be (Tolstoy et al. 53). Work “was rather a cause for joy” which “filled his life” (Tolstoy et al. 53). The pleasure Ivan derives from doing “his work” stems from “the consciousness of his power, the possibility of destroying any man he wanted to destroy,” and “his importance” (Tolstoy et al. 53). Thus, Ivan gets off not only on his self-importance but also by putting others down, in turn lifting himself up and further inflating his ego (not to mention, the cost of his absence to his family). Tolstoy suggests that Ivan has long been power-hungry, writing that “from the earliest age [Ivan] had had this quality of being drawn, as a fly is to light, to the most highly placed people in society, of adopting their manners, their views of life and of establishing friendly relations with them” (Tolstoy et al. 47–48). His comparison of Ivan to a fly buzzing toward the light is rich with symbolism. Flies connote death, disease, and sickness; moreover, as pests, they are killed often, and easily. Just as a fly’s attraction to the light proves often fatal, Ivan’s fall off a ladder ultimately kills him. Symbolically, this reflects Tolstoy’s criticism of Ivan’s attempt to climb up the social ladder of 19th-century aristocratic Russian society. Ivan has long attempted to move into a higher social class, befriending those above him by mimicking their behavior. Yet, the comparison of his ambitions to that of a fly buzzing through the air—headed towards the deadly light—foreshadows his own death.

During a visit to the doctor’s office after his fall, Ivan begins to realize the falseness of his life’s philosophy. As a sick patient, Ivan has only one question: “[is] his condition dangerous or not?” (Tolstoy et al. 63). To Ivan, all that matters is the simple, straightforward, yes-or-no answer to that question. However, his doctor has other intentions. Determined to perform his official work duties in the professional, socially acceptable manner society expects of him, Ivan’s doctor neglects his needs. Ivan is subject to “the waiting and the doctor’s assumed pompousness…and the tapping and the auscultation and the questions requiring predetermined and clearly unnecessary answers” (Tolstoy et al. 62). In other words, the doctor follows the respectable social graces, niceties, and etiquette associated with his profession, maintaining proper bedside manner throughout Ivan’s appointment, even though his overwrought behavior results in poor patient satisfaction. Ivan recognizes that he behaves similarly in his own work, too: “all this was just exactly what Ivan Ilyich himself had performed as brilliantly a thousand times over the accused” in court (Tolstoy et al. 62). However, this kind of performative behavior is problematic because during the appointment, the doctor tries to impress upon Ivan that “[he’ll] fix everything” (Tolstoy et al. 62). By downplaying the severity of Ivan’s illness, the doctor lies. Thus, Tolstoy reveals the bankruptcy of the doctor’s “performance,” with that very word casting doubt on the legitimacy of the doctor’s power. If it’s all just an act, doesn’t that render everything he does insignificant? In this moment, Ivan realizes that the same power he held in his work—which the doctor now holds over him as he “[glances] over his spectacles at the accused” (meaning at Ivan)—is meaningless, inflated with a hollow air of lawfulness, correctness, and decorum (which characterized not only Ivan’s work, but the way he went about living his entire life, dismissing his family, seeking greater social status, etc.). It doesn’t matter that the “doctor performed his summing-up brilliantly, triumphantly, even cheerfully”; despite how good he is at putting on an act, his behavior serves no meaningful purpose. Even the spectacles he wears seem to be for show. As a symbol of perception, glasses typically improve vision, providing clarity. However, the doctor looks at Ivan “over” them, not through them. This highlights the irony of the doctor’s pretense, made even more ironic by the fact that it is his falseness that provokes Ivan’s clarity.

Tolstoy also dismantles deceptive power relations in his portrayal of Ivan's relationship with Gerasim, who helps relieve Ivan's pain by holding Ivan's legs over his shoulders. Though Gerasim, a poor peasant, is financially bound to Ivan, he chooses to hold Ivan's legs "willingly, simply, and with a kindness that moved Ivan" (Tolstoy et al. 75). Offering this physical support simply out of goodwill, Gerasim also acts as an emotional resource for Ivan, serving as a source of strength and comfort that consoles Ivan in his time of need (much in contrast to the doctor, who fails to alleviate Ivan's anxieties). In this way, Ivan comes to appreciate intimate connections with others; whereas "health, strength," and "vigor of life in all other people offended Ivan…Gerasim's strength and vigor of life did not distress but soothed him" (Tolstoy et al. 75). Ivan is also drawn to Gerasim's honesty, a stark contrast to everyone else's minimization of his illness. Ivan is tormented by how everyone else acts as if "he was merely ill and not dying," not "wanting to acknowledge what they all knew and he knew"—the harsh reality of his suffering and imminent death—which they see as "an accidental unpleasantness" and "partly an indecency" that taints the clean air of the social circles in which they operate (Tolstoy et al. 75). Ivan's condemnation of how everyone else disparages his dying "in the name of that very 'decency' he had served all his life" reveals his change in perspective since falling ill (Tolstoy et al. 75). No longer subscribing to the false obligations of decency and decorum he thought were required in work and social life, he has been liberated from the pressure to live his life with such frivolity. Though the life he spent climbing up the social ladder—and fatal fall off of a literal one—is sunk time, he is still able to bond with Gerasim at the end of his life. Making this genuine human connection helps him become less self-centered and gives his life meaning. Similarly, the end of Ivan's life also reveals a shift in his family relations. Whereas Ivan previously believed in the "estrangement" of family life with "his goal [consisting] in freeing himself more and more from" their "unpleasantness" by "spending less and less time with his family," in the final moments of his life he shows his family love (Tolstoy et al. 53). Despite being in pain, he allows his son to hold and kiss his hand (Tolstoy et al. 91), demonstrating that he is capable of giving and receiving love, thus indicating a shift from his previously selfish ways. Instead of being isolated and self-absorbed, he comes to derive meaning in his life through love, thereby truly "freeing himself."

Ultimately, Tolstoy uses Ivan's descent into disease to make a social critique of the frivolity and shallowness of aristocratic social life and the selfishness and self-absorption it encourages. However, killing Ivan is not a punishment, but a blessing in disguise. Grappling with his illness and approaching death prompts Ivan to re-examine his values and philosophies about life, giving him the opportunity to intimately connect with others and find true meaning in life through the process of death itself. While many might consider Ivan's life a waste given what it took for him to experience love, find clarity, and achieve liberation from his selfishness, "The Death of Ivan Ilyich" reveals that sometimes, it is actually through death that we live.

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They Say I Look Like You

Raquel Cohen

For SC

They say I look like you,
round cheeks and dark eyes,
no one knows what is hiding behind.
I always ignore it.
How can I look like a shadow
in a faded photograph from
twenty-two years ago, alone
looking half at the camera, half
at the door ready to run for it?

They say I look like you
with beauty marks in the exact same places
and freckles that decorate our faces.
I refuse to listen.
How can I look like someone who is lost
and can only be found on a sun-
damaged two-dimensional photograph
bleeding an etched time and place
written in ink?

They say I look like you
when the sunlight caramelizes my
skin into a golden yellow, my
hair is bouncing, curling, free
flowing in every direction
like the world belongs to me
or I have found my place in the world
or somewhere in between.
I get annoyed.
How could I look like someone who is caged
in the world of twenty-two years ago, folded
in a photograph, willingly chained to his
demons in ink?

They say I look like you
and you may think so too as
you dig in your bag for the
only thing that sustains you,
clutching whatever is left of a dream.
A drip from the tip and a tear from the eye,
you shoot up for the very last time.

They say I look like you—only without
the twenty-two-year-old prison tattoo.
They see only the first three letters: R-A-Q
before they move you.
Is it weird that I still love you?
I see it now, a memory fading in the distance.
What they say they see in me, I see in you.
I reach out but I am frantically
grasping air and lonely dust particles,
looking at my empty hands,
breathing in smoke from the ashes
of possibilities, eyes watering
from the acrid char of
what could have been,
realizing I will never know
for sure if it's really you.

Elegy to the father I never had.
Elegy to my dead-beat dad.

Your Unforgettably Unwanted Presence

Francesca Geyer

Dear Scoliosis,

When I received your diagnosis, I was told that rather than resembling a straight line, my spine imitates a letter. My spine is shaped like the letter "S" and because of this abnormality, I was subjected to religious bracing and physical therapy. My back brace covered me from my shoulders to my hips and was fastened tightly by velcro, limiting my range of motion. As a result of my bracing and physical therapy, I was fortunate enough to avoid the invasive surgery, where they would have inserted a metal rod to correct my spine. My encounter with you has shaped me, both figuratively and literally.

Are you aware of your effect? Doctors screen children for your identifying "S" beginning at age 10, but they never worry. Your presence is overlooked by most, understood by some, and feared by few.

Prehension

One day my back was exposed. The next thing I knew, I needed extra support. It was as if I no longer had the strength to hold myself together. Soon enough, I was being fitted for your brace. Your brace gripped my torso with the air of necessity. Your brace held me together for well over a year. Before your presence, I did not need to be held together.

Your presence consumed me. Because of you, I thought twice before putting on any outfit, attempting to hide the traces of you. It never worked. Because of you, I would be stopped in security for an extra pat down, as the security guards were suspicious of the bracing you required. Because of you, I lived in fear of the surgery. I lived in fear that, as if you had not affected my life enough for the time being, your presence would become unavoidable for the rest of my life.

I tried my best to ignore you. I tried my best to live my life as if I was never alerted of your presence, as if you had never marked me by way of the long “S” running down my back. Unfortunately, avoiding you was not an option. I could not avoid having to do physical therapy every day and I could not avoid having to wear your brace. All I could do was accept your presence and comply with your regime, hoping for the best. I hoped for your presence in my life to be forgotten. I hoped you would become nothing more than a very distant memory, an interesting story.

In certain moments, I was able to convince myself that the grip of your brace was similar to the feeling of a hug and that living with your brace would only make me more resilient. I tried. I tried so hard and for short, brief moments, it worked. I forgot I even had your brace on. I reassured myself that your grip felt as common and regular to me as putting on my favorite sweatshirt, attempting to equate your tight grasp with the feeling of warmth and comfort. I convinced myself that by wearing your brace I was safe. You held me together and because of that, there was no way that I could have fallen apart. Those 18 months were filled with delusion.

Release

It was halfway through my sophomore year of high school. I was at the doctor's to check up on the damage that you have caused. I was told that I had reached an age where you could no longer harm me. Your presence was no longer a threat. Your bracing was no longer needed, and the physical therapy was now irrelevant.

It was as if I had been holding my breath underwater and I had just come up for air. That day, I took off your brace and gave it to the doctor. I walked out of the office with no layer between my skin and my school uniform. I walked into school that day with a range of motion that I had not felt in oh so long, with the sense of freedom that I had taken for granted before, the sense of freedom that everyone else had. I was able to move my upper body in such a way without restriction, without hearing the familiar sound of your velcro beginning to detach. Undoing the velcro, your grip, for the last time freed me from your airtight grasp. I was then able to take big deep breaths with no thought to my stomach's expansion, as there was no longer anything clutching it.

Meditation

We are encouraged to see our obstacles as opportunities to grow. The things that your presence taught me, I could not have learned anywhere else or through any other experience. You taught me to find comfort in the uncomfortable by relying on myself. I carry this lesson with me each and every day. This lesson grips my torso where you had. This lesson holds me together.

Although I wish you hadn't found me, I am happy that you did. I am, of course, glad that I can wear the outfits I want to wear now. But it is even better that I am able to wear them as someone who has a life in which you are the past and not the present. Someone who no longer needs to rely on the supportive grip of your brace.

This letter that I have written to you is entitled "Your Unforgettably Unwanted Presence." I do not believe there is anything else sufficient to title this epistle. This title perfectly encapsulates the presence you had in my life. You have made a permanent imprint on me, and not just by way of the "S" apparent on my back. I do not believe that I would be the person that I am today if you had never found me.

Yours no longer,
Francesca Geyer

A dance cut short.

Angela Zhang

Ethereal music humming all around me
Tall, illuminated windows to my side
A herd of blurred bodies, shuffling in and out
The foreign and angelic melody dwindles, then wanes
Through my ears to my body to my soul
Hazy limbs, sickled ankles, and a burning abdomen
Above all, an uncontrollable line of fire
Scorching the remnants of my core, arms, and legs

"Get in a line!"
Hollers a tall, thin figure at the front of the studio
I rush, scurry—to the rhythm of the music
A sudden slip of thick, battered and brown shoes
A startled gasp escapes my breath
A desperate arm sticks perpendicular to the ground
Every finger and nerve clawing, crying out
At the excruciating agony devouring all senses

Thud.

Blood fills my vision
Hard, slippery, wooden planes pound into the soles of my feet
An aching, spreading, torturous pain escalates
Suddenly, I'm hot, too hot.

Wrong. Wrong. Wrong.
All of this feels wrong.

Tears escape the folds around my eyes
Spilling over my face and dripping onto the floor
Drip. Drip. Drip. Like blood from a wound.
The contorted image of my arm enters my vision
This isn't real
But it was. Everything.
From the music
to the dance
to the thud
to the tears
to the hospital
to the doctor
to the sling…
Everything was real.

Before the Snow Melts

Abraham Rinehart

Durward LePaysan was not a coffee connoisseur. He drank plenty of it, sure, but it was never high quality. He would have a cup of coffee in the morning to start off his day right—and to take his pills. And he would also have a cup of coffee around lunch. And he would also have a cup or two in the early afternoon. And if it was a tough day, he might have a cup in the late afternoon. In truth, if Durward was near coffee, there was a strong chance he would come to drink it—and this morning was no different.

Outside, the snow that once clung to the dirt roads, naked trees, and sap lines now resided in scattered patches. A week and a half ago the snow was as soft as lamb's wool, mountains of ornate flakes gently balancing on one another and air. Seas of green salt have beaten back the snow that now houses rocks and frozen leaves. Icy clusters are all that remain, hard and unloved and slowly being pushed into smaller and smaller crevices in the ground by each successive spraying of road salt.

Coffee finished, Durward cleaned his dishes and downed a large glass of water before starting his long day. The water was always a bit of a treat. It was well water, as many houses in Vermont have. Alice always said this well produced particularly sweet water.

Durward settled down into the old chair he set beside his door. It creaked with enough violence that a passerby might think a pig was getting slaughtered, but the chair held together. It had been squeaking and squawking for years now—but no significant crack had been seen yet. Lacing up a pair of battered leather boots with tread worn down—to the point of looking more like a painting someone had cunningly put on so that the boots would sell for a dollar more at a yard sale—

Durward noticed a Hermit Thrush bouncing carefully across his porch fence. Every so often it would chance across a loose seed that had fallen from the bird feeder above—which hadn't been filled in months. By this time, most of its brethren have traveled south, as perhaps it should. The south would be warmer, and food would be far less expensive. If it had only joined the rest, the Thrush wouldn't have to desperately fly from porch to porch hoping for a charitable portion of seeds. Still, the Thrush on the porch didn't seem so bothered by the condition others might call hopeless, dancing about on the old wood looking for a kernel more before taking off down the road, further into home.

Stepping at last out of the house, Durward shut the door behind him with a gentle click—and gentle it had to be, as the door was becoming less and less formidable with age. While the house itself had been made near the turn of the 19th century, Durward's father had replaced the door some 40 years ago. Only, the door wasn't 40 years old, it had been salvaged from one of the leaning houses not so far from the town green. Durward's father had thought it solid enough at the time, but now it shuddered distastefully with every swing. The porch too had been replaced by Durward's father, around the same time—from the rubble of one of those same leaning houses, one of the houses that had leaned too far.

The truck started on the first key turn, a welcome surprise to Durward. After letting the engine sort out its sleepiness, he took off toward the town center. New leaning houses lined the dirt road—dirt being the better option between that and cracked pavement. Between the once-lively houses lay well-kept black top driveways stretching sometimes a mile into the woods before they end in richly-adorned double garages.

Durward parked beside a shiny Porsche twenty-something. With a painful hiss he ambled out of his truck and made his way to the Center Store, which itself was the third oldest standing building in town—behind the Community Church and the Daigle's house. Durward had grown up knowing the Daigle kids, and he knew the house well. Folks talked about the age of the house with some reverence, but for all Durward could see it was nothing special. Fairly standard for the older houses of the town, though he did recall that they had a particularly fancy wood stove—newer than the house, of course. But the Daigle kids were long gone now. One was in New York City, one was in California somewhere, and one was just down the road under an engraved stone roof—had been since high school.

The Center Store, on the other hand, was something—groceries, news, clothing, mail, pharmacy, all inclusive. The downstairs had never been living quarters, so it was spacious with a high ceiling. At least, if it was empty, it would be spacious. Half-empty, half-dusted, half-expired shelves made the space a cluttered maze.

Durward strode through the aisles to the register—behind which stood leather-skinned Don Daso, long-time owner. Without a word or thought, Durward grabbed a newspaper and pointed to the tobacco wall. Don shot Durward a curious look as the younger held out twelve dollars.

"That's not enough D—"

"I won't be needing any meds today, Don," Durward cutoff the elder. Don's head tilted slightly as he made a small nod and took Durward's cash before handing over to him a pack of Marlboro Reds. Durward had smoked Golds in high school, as had George. But George wasn't smoking anything nowadays.

"Well…best of luck then," the old man said softly.

Outside, two men sat thoughtfully at either side of a weathered checkerboard. Some might say that the greatest mystery of the town was just how many games of checkers had been played in that spot; some might say it was the most played checkerboard in Vermont. John Roy, who sat with his back to the door, was clearly losing this game. Somewhat a rare occasion it could be noted; John had grown up on the other side of the green and had been playing checkers since the Center Store accepted ration cards. Across from him sat Earl Smith, who had moved from the south of the state back in the ’60s when he married his late wife, whose family had lived in these parts since this state was a Republic.

“I don’t suppose I’ve seen you often enough around here to have you judging my playing from way up,” John spat out the words with half-harshness and half-remorse. It had been far too long since Durward had taken time to idle around the Center Store. Long enough that he had somewhat forgotten how strongly John still held on to the old accent. “I’s” becoming “Oi’s” in a high pitched ramble carefully developed by generations of poor farmers.

“Been busy I s’pose,” Durward grunted. “How’s—” He cut himself off as someone well-dressed came out the store and slid into the shiny Porsche. Durward waited until it turned down the road.

“Who’s that?”

John and Earl both grumbled, a grumble just a bit too long and anger-filled to have to do with the game in front of them.

“Some newcomer—just moved into a new house built by the Wheeler’s old farm. I’m not sure young Jack ever fought for the place when old Henry and Evelyn died. Damn shame. They built a big ugly grey house, I can tell you that. Whole field’s just a big green lawn now—when in the hell do they get the time to mow that?” John answered in a voice that started low and slow, but picked up in volume and pitch as he continued.

“These flatlanders want every bit of this state to be a big green lawn I’ll tell ya,” Earl chuckled as he spoke, but his eyes screamed worry.

“Well why didn’t Bob try to get it? Hasn’t really got much a home now, does he?” Durward asked.

“You’re damn right he doesn’t, but do you know how much that land sold for?” John spared at most a second before continuing, “seven hundred thousand and seven. Dollars! For a house—not even, for land! Land!”

“The Clark’s also sold,” Earl chipped in. “Couldn’t keep up with payments. New house going in there costs over a million! Or will be, once it's finished. A million dollars. I don’t know what I’d do with a million dollars, but I wouldn’t build an ugly house—and so far from town too. Must be two miles of driveway, that’s a right and veritable road.”

Durward shook his head. Both families had been in the town for many generations, at least as long as his had. Worst of all, he wasn’t even sure these newcomers would really live here. They might only come up for leaf peeping or when the snow was deep.

“I think Earl’s got you beat John, and I think I’ve got to go. Too much talk of home to be away from mine.” Durward pushed a smile through his words as he made his way back to his truck. Hoisting himself into the driver’s seat, a flash of pain shot through his back. Durward grunted as he white-knuckled the steering wheel before turning the key in the ignition. It’d been a good number of years since he had hurt his back from felling a tree. He had gone to Dr. Johnson, but that poor woman was snowed in with injuries from the six towns she serviced; it took two months after the incident until he could finally meet with her. Short meeting too at that, as she told him it would heal in time but hurt like hell. She prescribed him Percocets, and while the pain had faded, he soon found the pills couldn’t do the same.

Durward drove down the road to the town cemetery, where he gently got out of his truck and hobbled first to his father. The crash happened not over two years ago, after a long night of drinking and long-winded night-talks.

The sun had reached its peak; from now, the day could only fade. Half-melted snow made walking about the graveyard a muddy affair. But Durward had more stones to see. His grandparents were close enough to his father's grave.

Then came George. He had shot himself back when the two were freshly 18. In the last decade, it had been Durward's habit to say hello to his old friend. Though visits had become rare in the last two years, life had become too blurred.

Mucking it back towards the gate, Durward stopped at a smaller stone, with a flat face at a slight angle. "Alice" was the name it bore, clear and unmarked. Not much could hurt the granite in under a year. Durward knelt, his knee sinking into the frigid mud. But he didn't spare a glance down, or a wince at the biting cold. He extended a hand, slowly, as if he were reaching out to pet a wild animal. Six years ago, Alice had badly hurt her hip and needed treatment—a long-lasting treatment. She wasn't in pain now anymore. Durward sat on his knees as the day dimmed, watering the stone. He wouldn't make any more stops. He couldn't. He only worked his way back to his truck.

Outside the house, Durward surveyed the valley below him. The land tilted slowly downwards for a good hundred yards before dropping sharply into a small stream that trickled far below. Across the valley another mountain rose—taller than the one behind Durward's house, and more striking. A small cliff face reflected the sinking sunlight back to Durward's mountain. While maples, oaks, and birches stood now naked across the base of the mountain, spruce, cedar, and fir adorned the peak with the tenacity of old actors whose hair should've faded years ago.

Durward gazed down the road, framed by stark trees. It held the way to the rest of the world, to every future decision.

Durward opened the old door with considered care and stepped into his home. Sitting down on his old chair, the familiar creak once more sounded about the room. Boots off, he made for the basement.

A few well-gifted bucks lined the walls towards a locked door. Inside, a small collection of hi-vis vests and camo jackets hung besides a shotgun, two rifles, and four pistols. One pistol was more of a collectible than anything, barely the size of his wallet. Two others were somewhat unremarkable. But the fourth was a revolver Durward had gotten from his brother a few years prior. A fine gift, its craftsmanship was unrivaled in Durward's collection. The walnut grip bore a dark finish that brought out thick chatoyancy. Durward popped out the wheel. Two chambers were filled with brass, unmarked.

Durward sat out on the salvaged wood porch and stared down the road ahead. Sat long enough for the sun to start to hide behind the rival mountain, casting a warm glow over the familiar landscape. Not more than a yard away from Durward, the Hermit Thrush landed on the porch fence. It hopped about twice before turning one of its wise eyes towards Durward as if to agree,

Yes, today is a good day for it.

Meditation: The Past, Present, and Future of Healthcare

Anna Helman

It's been an exhausting day. You have two midterms tomorrow and as you turn off the lights and crawl into bed, the stress comes with you. You lie awake staring at the ceiling and scrolling on your phone. Finally, an hour and a half later, in a last-ditch effort to sleep, you download Headspace: the meditation app you keep seeing ads for on Instagram. You are out within minutes of listening to a guided sleep meditation.

Over 2,500 years ago, a Buddhist monk sits in a quiet space and begins to meditate, too. He eliminates the duality of his body and mind and focuses on feeling aware and at peace, quelling the streams of thoughts that have been—like yours—circulating for far too long.

Five centuries earlier, a yogi silences his mind, focusing on a repeated mantra. Freed from the cacophony of thoughts that often muddle his day, his psyche regains its natural buoyancy toward happiness.

Meditation has evolved and morphed over the centuries, as its motivations, practices, and practitioners adapted the study to their own cultures. While the practice itself dates back to as early as 5000 BCE, meditation began to migrate across countries and religions with the products of the Silk Road, spreading rapidly in 500 and 600 BCE. In the 20th century, the practice moved west, promoted by celebrities and exacerbated by the hippie movement of the 1960s and '70s. Still today, meditation exhibits its roots in reaching across cultures, brought to every corner of our earth via one item that connects us all: cell phones—the very thing you used when you needed to rest before that midterm tomorrow.

Now, meditation is gaining traction in scientific labs, specifically for its benefits surrounding depression and anxiety. Scientists are focusing specifically on advanced meditation, the study of meditative development and endpoints by monitoring the brains of experts, and how they can bring these benefits to everyday people with technology. Massachusetts General Hospital and Harvard Medical School have coupled in their Meditation Research Program. They have been studying the brain activity of experts during Tibetan Buddhist meditation, specifically interested in the feeling of timelessness and the heightened level of awareness that accompanies meditation. Their subjects are experts, many of them having over 20 years of experience with meditation, but the researchers are hopeful they can bring these benefits to the greater population—and they are not alone.

Research centers at the University of Arizona, Harvard, Mass Gen, and Brown have been using electroencephalography (EEG) and magnetic resonance imaging (MRI), combined with subject's descriptions of their experiences while meditating, to research the direct effects of meditation and the induced states' correlations with heart rate, breathing, and alterations in brain waves.

At Harvard and Mass Gen's Meditation Research Program, scientists have been collecting data on advanced concentrative absorption meditation, such as *jhana* from Theravada Buddhism. Practitioners describe feelings of a "distorted sense of time, fewer negative thoughts and an improved ability to detach from their feelings" along with calmness, clarity, self-transcendence, and an opening of their consciousness (Tu). Through the use of new technology, researchers are now able to match their experiences with their brain activity while in deep meditation states. The program collected data from someone who had over 25 years of experience—over 20,000 cumulative hours—meditating. The researchers used a seven-tesla MRI, a machine that uses deep-brain imaging to map the brain stem and cerebellum, among other structures. This allowed them to measure activity previously uncollectible because of the limited scope of a conventional MRI, which is not able to image structures so deeply embedded in the brain. The brain stem in particular plays key roles in controlling breathing and heart rate, making it key in the field of meditation.

A similar study researched practices from the Tibetan Buddhist tradition, where meditators describe feelings of self-transcendence, emptiness, and compassion—experiences that are sometimes disrupted in mental illnesses. Using an EEG, researchers discovered that the density of brain currents was lower in advanced meditation states. Areas of the brain that played a role in referential processing, which are responsible for self-related mental activities and executive control, had particularly less dense brain currents. Additionally, they found that deeper meditation states resulted in increases in high-frequency brain activity in the anterior cingulate cortex, precuneus, and superior parietal lobule. These areas play roles in motivation and decision-making, feelings of agency and first-person perspective, and cognitive, perceptive, and motor-related processes, respectively.

While these individual studies demonstrate both the science and benefits behind advanced meditation states, there remains an obvious obstacle between the practice's application in clinical and nonmedical settings. This research was collected on those whose experience with meditation spans decades, and for many of those afflicted with depression and anxiety, the cost of this time is simply an unreasonable ask. Yet still, the lead researchers of the Meditation Program hope that meditation can serve not only as a beneficial additional treatment to those with depression and post-traumatic stress disorder, but also as an alternative to medicinal or even psychedelic treatment—an area rapidly gaining evidence for its efficacy.

In the United Kingdom, this process is already underway, as the National Health Service has publicly endorsed mindfulness-based therapy for depression.

The organization promotes training people with major depression and generalized anxiety disorder to use meditation to treat negative or repeating thoughts, thereby effectively using the practice as an alternative, or complementary addition, to medication. These meditative states can be induced by a set of verbal instructions, neurofeedback, or brain stimulation, and it is this last trigger that numerous researchers in the United States are particularly excited about.

Understanding the potential of meditation as a treatment, researchers are attempting to fast-track the development of the skill. By applying low-intensity ultrasound waves to brain regions responsible for introspection and mind-wandering, researchers can emulate the states achieved by those who have over two decades of meditation experience. The beams target the default mode network (DMN) in the brain, a group of brain regions that have been observed to be active when a subject disconnects from the world and intensely focuses on the future or past. Abnormalities in DMN function have been linked to anxiety, rumination, and depression, making the structure a key target for meditation treatment. When the wave hits neurons within the brain, the excitability of the cells' ion channels is affected, inducing the meditative states.

The DMN, however, is lodged deep within the brain, making it historically difficult to reach with meditation despite efforts that began in 2001. These previous efforts to reach and stimulate the DMN used magnetic fields and scalp electrodes, which have only centimeter-level precision. Now, with the application of transcranial-focused ultrasound, the targeted waves can achieve *millimeter*-level precision; now perfectly targeting the DMN, offering an alternative to drug therapies, and eliminating the invasiveness of drilling a hole into the brain to achieve a similar effect.

Participants in this ultrasound-induced meditation study at the University of Arizona's Sonication Enhanced Mindfulness Awareness (SEMA) Lab experienced five minutes of stimulation, which inhibited the activity in the posterior cingulate cortex, before reporting their feelings and mental states. The data from the SEMA Lab indicated that participants felt increased "mindfulness" after the stimulation, which, for this lab, was defined as "the ability to be fully present in the moment, without judgment toward others or the self" ("Brain Stimulation Technology - Jay Sanguinetti, PhD"). Additionally, participants reported a "distorted sense of time, fewer negative thoughts, and an improved ability to detach from their feelings" for at least thirty minutes after the stimulation, all of which indicated the treatment's potential to treat mood disorders and depression. Dr. Sanguinetti, a lead researcher at the lab, is hopeful enough to propose that 10 years in the future, a handheld device—possibly even the size of an iPhone—could deliver the ultrasound waves necessary to treat anxiety and depression for individuals on their own.

This hope is not misplaced, and Dr. Sanguinetti and his colleagues are undoubtedly moving toward a very different future for the treatment of anxiety, depression, and PTSD. However, one must also view this innovation from the opposite end. While medicine benefits from the art of meditation, will meditation itself be diminished by the art of medicine? Dr. Sanguinetti is hopeful that a handheld, self-administrable device will, essentially, emulate the meditative states that practitioners have rehearsed for decades to reach on their own, fast-tracking this ancient practice in seconds. For centuries, scientific innovations have diminished the value of their precursors. Electric light bulbs decreased the value of gas lamps, calculators decreased the value of the human profession, and personal phone numbers decreased the value of human operators; but all are, nonetheless, vastly more efficient tools for the modern world. Will this innovation—invaluable in its potential to noninvasively treat serious mental disorders, invaluable in its potential to save hundreds of thousands of lives per year—decrease the value of the art of meditation?

Regardless, the work of the SEMA lab and the Harvard and Mass Gen's Meditation Research Program is undoubtedly exciting. One of the co-directors of the SEMA lab, Shinzen Young, describes himself as a "Jewish-American Buddhist-informed mindfulness teacher who got turned on to comparative mysticism by an Irish Catholic priest who has developed a Burmese-Japanese fusion practice inspired by the spirit of quantified science," and in doing so, perfectly mirrors the journey meditation has made across centuries. From the saddlebags along the Silk Road to popular magazine articles on the lives of celebrities to mindfulness apps in the pocket of a pair of jeans, the art has spread, evolved, and changed the lives of hundreds of thousands of people. And now, coupled with more precise ultrasounds, CT scans, and MRIs, the art has arrived at healthcare, more accessible than ever. This serendipitous intermingling of cultures and science is a reminder that the innovations and achievements of the future may very well be hidden in our past and present. The future of healthcare and communal well-being has a home in learning from a diverse array of cultures, religions, historians, and philosophers—just as Dr. Sanguinetti and Shinzen Young are doing, just as those in Harvard's Meditation Program are doing, and just as you are doing, as you close your eyes, and drift to sleep, a Headspace guided meditation still playing in the dark room.

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About My Guts

Jesse Julian

Split open, spilled over, and spelled out in more than six hundred poems, songs, and essays—I have a gut feeling that there is something wrong with my stomach.

I'm lactose intolerant.

I fainted once due to hunger.

The only time I called out sick from work was because of constipation.

I was on the jumbotron at a baseball game, sweating and smiling through the screen. The unknowing Phillies fans witnessed a severe IBS case unfold as I had been rushing back and forth to the bathroom every inning.

But my conflict pushes beyond just medical.

My stomach resists its job as a digestive organ, boldly asserting itself into a different role. My brain thinks thoughts, as any brain should, but my stomach drags these ideas, fears, and desires downward to my core. Here lies the true issue that bothers me daily: every feeling resides in my gut. I struggle to digest a single thing, as it all continuously comes up through grueling word vomit. I'd almost believe my stubborn stomach was conscious, adamantly fighting comfort or satisfaction by churning my spoiled thoughts and rotten emotions.

While writing this out, my stomach and mind wrestle with restlessness. Each thought braids itself into another tangle of tension. I can't hold it together, anything at all. My insides grumble with anticipation as you trace each word, hungrily awaiting your reaction like a drooling dog begging for praise. I nervously crave to see your face as you read this. To watch your brows furrow in confusion and your face contort with cringe. Or maybe, to see you giggle at my word choice, or grin at my figurative language. I wish I could know what you think without knowing what you think. Do you love it? Or are you bored yet? Whatever your opinion is would probably upset me, and consequently my tummy. And then I'll remind myself, again and again, that there is something wrong with my stomach.

I've hopelessly dreamt of the day I decide to resolve it. I've considered every detail. Here's how my imagination decided it would go: I text my mom. I march to the ER with urgency and hesitancy. I'm laid out on an operating table, with the sterile white lights blinding me. The doctors in blue gowns and blue gloves and blue masks pitifully mutter as they approach the girl who just can't seem to hold it down. "Happy Halloween," one surgeon remarks, a joke I don't find as funny—they're ready to carve me out and ignite my belly, like a jack-o'-lantern.

But instead, they hand me a paper and pen, and I dissect myself. I push them off of me, imploring them to look away. I do most of the work for them. The words spill out, visceral and bloody, appalling and appealing. In conflicted horror and pleasure, I watch myself extract all which lives inside me with painful force.

Yes, this strange scene I envision feels horrifyingly nightmarish. But this captures what my writing career feels like: bulimic. A purging process, unethically pleasurable and equally miserable. I am constantly full of feelings and opinions, reaching the point where I've fried my hunger receptors. My stomach, unable to handle it all, pushes it out on paper with immense disgust—you'd almost mistake it for joyous passion. I write for the sake of the spill, releasing what I cannot stomach in a deeply disordered manner.

Opening myself up and trusting my gut is the challenge I succumb to, facing the process with vulnerable uncertainty. I am never sure of what comes out, but I force myself to watch it take shape. The abhorrent or depressing moments fuel my songwriting and poetry—but this writing rarely sees the light of day, because the perception of others burns straight through my flesh. My thoughts and dreams are held neatly by the palm of my writing, which hands it out into a world destined to destroy them.

All which comes out of me reveals another new part of me. As if my intestines unraveled onto a bare, linoleum floor and spelled out my exact thoughts. And as it's all strung out, I fear that it'll get stepped on, exploding into pink mist through the marching army of a careless audience. It'll mush together into thick incoherency, or twist into unapproachable knots. It'll gather a gallery of eye rolls, exasperated sighs, and tiresome criticism. I cannot seem to bear the thought of my words leaving me, and I cannot seem to bear the thought of them staying in me—a gut-wrenching paradox.

It feels criminal to admit that this is something I do for pleasure. Could you imagine me smiling while I write this? *Because I am*—even after going on an extensive rant, associating my art with puking, and dissection, and disgust, and emptiness. Ironically, the relief after release fulfills me. After what feels like months of morning sickness, I awaken to find that the nausea disappeared. It is like the car has stopped after a long road trip; after endless speed bumps, cracks in need of cement, and twists and turns, my motion sickness rests. Writing is a rollercoaster.

The metaphor finally makes sense, and it feels like I can breathe again. The knot untangles in my stomach. When I identify what torments me through a single stanza, I am at ease. I know that if no one heard me, at least the paper did. When my conclusion reflects exactly what I mean, I step back in admiration. Once this piece—its own wild ride of intrapersonal reflection—finds its stopping point, I will know that I am immortalized. I live for the butterflies; the tumultuous tummy-ache from flapping wings that ache for freedom through words.

To be carved into and hollowed out is an act I do performatively, because I am awfully good at operating on my own self. A surgeon would envy the work I do here. Although I may feel nervous and reserved, I allow my stomach to be bold. My writing stems from an intuitive sixth sense; my words know what they are before they land. What I purge onto paper packs a stronger punch than my immaterial speech ever will; black ink succeeds against thin sounds that vanish into air. What I produce stays present.

The purification of my core feels like a necessity rather than a choice. I envy those who pick up a pencil each morning with a peaceful, little smirk, journaling because they like it. I resonate and sympathize with those who feel a punch to the gut when urged to write, even by their own will. When I write, it is with drastic desire. If I do not get the feeling down, it will certainly explode in my stomach. I do not write to whisper—I write to scream. I write to release guttural expressions of feelings I can never express through speaking. I take on new roles and play with new forms in an effort to command my ravenous needs. I am an editor; a poet; a satirist; a tutor. Every piece I produce is another shard of a mirror, reflecting who I am. It is an X-ray; a biopsy; a transplant; a donation. What I write is who I am, and I cannot be me without it.

And perhaps my stomach isn't so wrong, because I'll admit—I feel a little better now.

To Diagnose or not to Diagnose: An Exploration Into the History Behind the Word "Diagnosis"

Rayann Reese

"It is far more important to know what person the disease has than what disease the person has"—Hippocrates. This idea reflects the deep, patient-centered approach to diagnosis that has been central to medical practice for centuries. The term "diagnosis" refers to the "determination of the nature of a diseased condition" through careful investigation of symptoms and history (Oxford English Dictionary). While this term is central to modern medicine, its historical evolution reveals much about how the practice of diagnosing illness has transformed over time. This essay will explore the history of the term "diagnosis," tracing its origins, shifting meanings, and evolving role in the landscape of medical practice.

The word "diagnosis" has its origins in the Greek language, where it means "judgment" or "discerning." First appearing in English in 1681, it captures the act of interpreting symptoms and medical history to identify the nature of an illness. In early medical practices, diagnosis was made through close observation of symptoms and patient narratives—techniques that relied on a physician's ability to discern patterns and make clinical judgments. Ancient physicians like Hippocrates and Galen laid the groundwork for these methods, emphasizing the importance of understanding the patient as a whole rather than just focusing on isolated symptoms. Their contributions shaped the diagnostic process long before the advent of advanced medical technology.

The 19th century saw the advent of diagnostic tools that revolutionized medical practice. René Laennec's invention of the stethoscope allowed physicians to listen to heart and lung sounds in a more methodical way, moving diagnosis away from mere observation to an evidence-based process. Instruments like the thermometer and ophthalmoscope further expanded diagnostic capabilities, allowing doctors to measure and examine previously unseen aspects of the body. At the same time, medical schools began codifying disease classification systems, such as William Cullen’s nosology, which provided a more structured and systematic approach to diagnosing and understanding diseases. These developments marked the shift from diagnosis as a judgement-based art to a more evidence-based scientific process.

The 20th and 21st centuries brought an explosion of diagnostic technologies that transformed medicine. Imaging techniques like CT scans and X-rays allowed doctors to visualize previously hidden illnesses, enabling faster and more accurate diagnoses. Advances in laboratory procedures, such as blood cultures and genetic sequencing, provided additional insights into the molecular and cellular causes of disease, making it possible to diagnose conditions at earlier stages. These technologies not only improved the precision of diagnosis but also reshaped the role of physicians.

Despite these advancements, diagnosis remains a complex and sometimes problematic process. The growing reliance on technology raises ethical concerns, including the risks of misdiagnosis and unnecessary treatments. Excessive testing can lead to false positives or the identification of conditions that may never cause harm, resulting in unnecessary interventions. As medical technologies evolve, it is essential to maintain a careful balance between impersonal, clinical innovation and the compassionate, nuanced judgment that remains central to effective patient care. Physicians must recognize that while technology offers valuable insights, it cannot replace the need for thoughtful clinical decisions that consider the individual patient's context, preferences, and emotional well-being.

The role of the physician in diagnosis has also evolved significantly. For centuries, medical education focused primarily on lectures and theoretical knowledge, often with little emphasis on direct patient interaction. Sir William Osler, a Canadian physician, revolutionized medical education by introducing the practice of bedside teaching, where students learned to diagnose by observing and interacting with patients. Osler emphasized the importance of taking a thorough medical history, conducting careful physical exams, and listening to the patient’s narrative. These skills remain essential in diagnosis even in the age of high-tech medicine.

The word “diagnosis” carries different connotations for doctors and patients. For physicians, it is often seen as the final piece of the puzzle—the answer to a medical mystery that allows treatment to begin. For patients, however, a diagnosis can be both a relief and a burden. While it provides clarity and an explanation for their symptoms, it also opens the door to a new and often frightening reality. As Barbara Ehrenreich writes in her article “Smile! You’ve Got Cancer,” a woman with breast cancer expresses the emotional toll of repeated diagnoses: “I am positive I am going to beat it, yet it does get harder with each diagnosis to keep a positive attitude” (Ehrenreich 14). This highlights the emotional complexity many patients face when confronted with multiple diagnoses, as they struggle to balance hope with the weight of their circumstances. Physicians must navigate this balance with sensitivity, understanding that their role extends beyond simply identifying a disease. It is their responsibility to consider the emotional impact of a diagnosis and to communicate in a way that supports the patient's emotional well-being, ensuring that the patient feels seen and heard, not just treated.

The term "diagnosis" has evolved dramatically from its origins in observation and judgment to a sophisticated, technology-driven process. While technology plays a critical role in modern medicine, the need for careful, nuanced judgment remains at the heart of diagnosis. Physicians must continue to balance technological tools with their clinical expertise, ensuring that diagnosis remains a holistic, patient-centered process. This approach recognizes that diagnosis is not just about identifying a disease, but about understanding the patient as a whole, considering their emotional, social, and psychological needs. By maintaining a patient-centered approach, physicians can ensure that their clinical decisions not only address the medical issue at hand but also support the patient's overall well-being, fostering trust and improving the patient experience. Technology may provide valuable data, but it cannot replace the empathy, communication, and individualized care that are integral to the diagnostic process. By integrating both technology and compassionate care, physicians can provide more than just a diagnosis; they can offer a path forward that respects the emotional and psychological complexities of the patient's journey.

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Quarantine
Raquel Cohen

To the man I saw dying behind a pane of glass

People are afraid of the big bold letters
like teeth chomping their health and feeding
on their fears as soon as they touch the door.
An orange construction paper taped
like a death sentence, an execution to watch
from a safe distance through a pane of glass.
QUARANTINE

I am afraid of something else.

We have never met but when I
look into your eyes I feel like I see
your lifetime, how you saw the world.
I see your eyes, once dark brown
lightened by your experiences,
flecks of blue and a translucent rim,
your iris, an imperfect circle, elliptical,
forms a small droplet of water
that slides—despite the friction of
beautiful peaks and valleys that come only
with wisdom and experience, battle scars and
triumphs—down your cheeks.

As I draw your blood I feel
like I am stealing
as the droplets are dragged
slowly to the bottom of the vial.
You tell me to lean forward.
You whisper,
“It hurts when I cry.”
The jagged shards of my heart
suddenly feel trivial.
We say goodbye and you are alone.
No visitors allowed except your thoughts,
fears, highs, loves, lows,
sunsets, emotions, memories, regrets.
One last blink, you see cloudy glass
through half-open eyes,
a world beyond,
not ready to say goodbye,
but also cannot go on.

I come back to see you again.
The sign is gone, the bed is made,
the scent of antiseptic and lidocaine.
Your heart stopped but your spirit stayed
in the room and in my thoughts.
Alone in your last moments,
the pain behind glass.

In a few minutes beyond the pane
of glass I am a changed human remembering
through some sort of emotional telekinesis to
never stop moving with my whole soul or putting
my whole heart into everything, knowing
that sometimes it gets broken in the process of
living and loving but it is still beating
ready to come out of its cage again.

Inheritance

Jessica Hwang

they unhook the machines at 4:12 a.m.
I watch the numbers—red, flickering—
count down to nothing.

outside, the street lights blink in slow rhythm,
like lungs filling, exhaling,
filling, exhaling.
someone else's lungs now.

when I was six, I traced my mother's veins
like rivers under thin skin.
asked if blood remembers where it's been.
she laughed, but didn't answer.

they say the body forgets itself,
but someone else will wake up
with his heart thudding in their chest.
a stranger will take their first deep breath in years
and not know the cost.

grief is strange—
it pools in places you wouldn’t expect.
like the hollow of a wrist,
the corner of a mouth.
the silence between
beeping and flatline.

I should go home.
instead, I sit in the parking lot,
watch my breath bloom against the glass,
press my fingers to my wrist,
and wait for the echo.

Whispers of the Unbreathed
Jessica Hwang

Interview with Doaa J. Alareere

Zeyneb Sekin

Translated by: *Iman Kheil*

Can you introduce yourself?

My name is Doaa J. Alareere. I live in an area called Sijaiyyah in Gaza. I have three daughters and three sons. I am 35 years old. My husband and my eldest son were killed on December 18th. My son was seven years old. I am wounded—I lost all 10 toes on my feet, and I have very severe burns on my body up to my knees and on my arms as well. My youngest son, Joud, who is four years old, lost his leg at three and a half years old at the beginning of the war. That is why I am here in the U.S.—for Joud to receive treatment.

We were asked to move from the South to the North, then from the North to the South, relocating multiple times. Before I came to the U.S., I was staying at Al-Shifa Hospital. Al-Shifa Hospital is very well known in Gaza, and while we were there, there were bombings. Before we came to the U.S., we stayed in Egypt for six months because I was in the ICU for 15 days.

Can you describe your experiences with the healthcare system in Gaza before and after the war, and compare the two since they are very different?

Even before the war, the healthcare treatment we received was only 50% of what we needed. During the war, it became even worse—almost nonexistent. Why? Because we lost doctors, we lost hospitals, and even when my son Joud lost his leg after a bombing, it took almost a month and a half for them to amputate his leg and provide some treatment. Then, after about two months, we moved to Egypt for Joud's surgery with the help of the Palestine Children's Relief Fund (PCRF), an organization that helps children in Palestine. They offered us the opportunity to go to the U.S. I was scared and hesitant to come to the U.S., so I initially decided to stay in Egypt. We remained there for six months, but Joud's surgery was unsuccessful on another part of his leg. It was then that I decided to come to the U.S., and I have been here ever since.

What was the relationship between patients and healthcare workers in Gaza during the war?

There is a very strong bond between healthcare workers and patients. The staff and medical personnel are incredibly supportive. When I received treatment, they helped me not only medically but also emotionally. During their shifts, doctors sometimes saw their own relatives, sons, and daughters in need of treatment—or even martyred. We all became like one big family, trying to help and support each other.

How was your access to food, clean water, and electricity in Gaza before and during the war?

Even before the war, Gaza has been under closure for 17 to 18 years. Out of the 24 hours in a day, we had electricity for only two hours. In order to have clean drinking water, we had to filter seawater as much as possible, yet even after filtering, dirt was still visible in the water.

Despite having only the bare minimum, the people of Gaza always support one another. Families help each other and share what little they have. Sometimes, we would store gallons of water for emergencies because we never knew when we would have access to clean water again. We managed with what little we had, but it was only possible because of the support and solidarity among Gazans.

When we had electricity for just two hours a day, we had to cook, clean, and complete all household tasks before it shut down again. Homes felt like they were in a state of emergency, with everyone rushing to get things done. Sometimes, the electricity would come on at midnight or while we were sleeping, and even then, we would wake up to wash clothes, bake bread for the kids, and complete as many tasks as possible before losing power again. The Palestinian people are incredibly resourceful and creative in times of hardship. For example, they found a way to use car batteries with leads to generate electricity instead.

How do you experience healing and cope with the trauma of being displaced by the war? What practices help keep you happy and resilient after everything that has happened?

What helps me cope and heal is *sabr*, or patience. There is a verse in the Quran: "Give good news to those who patiently endure—who say, when struck by a disaster, 'Surely to Allah we belong and to Him we will all return'" (2:156). I also find strength in *yaqeen*, or certainty in Allah, and in the deep belief that my husband and son are in a better place—Paradise. Sometimes, I sit and reflect, and my mind and heart tell me two different things: my mind says that I lost my beloved husband and son, and I begin to cry because my mind cannot accept it. But my heart tells me to be patient, that they will enter Paradise and that they will be the reason I enter Paradise as well.

I am not the only one who lost family in this war. Entire families were killed. My three daughters are still in Gaza, and I have not seen them for a year and a half due to being displaced—first moving to Egypt, then coming to the U.S. for Joud's treatment. I still have family in Gaza, but I must be here in the U.S. to ensure Joud receives the care he needs. With patience and the belief that Allah has something better planned for my future, I am able to endure and move forward through these difficult times.

Is there anything else that you would like to share about your experiences or hopes for the future?

Even though I now live in the U.S., where I am safe, where there are no curfews, and where I have a secure and comfortable life, I still long for my home. To me, home is not just four walls—it is my family.

Even if I had to live in a tent under the conditions in Gaza, I would still go back. Even if I were given a castle in the U.S., I would still return to Gaza. I am deeply grateful to all the people who have helped me and who welcomed Joud and me to the U.S. with warmth and kindness.

Joud dreams of becoming a doctor so that he can return to Gaza and help his people. For now, I am waiting to hear back about my visa so I can return to Egypt and stay there until I am able to reunite with the rest of my family in Gaza.

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