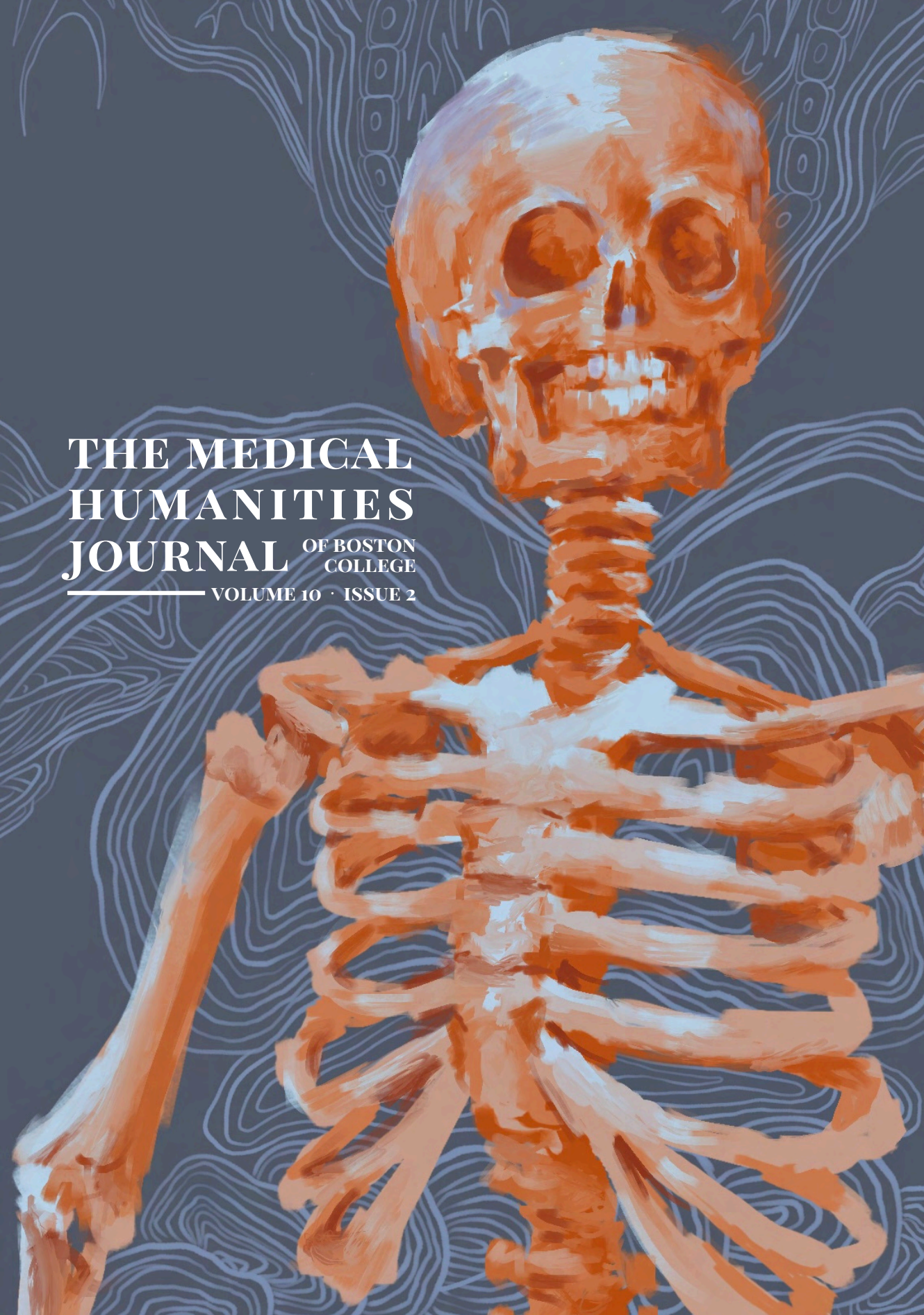

THE MEDICAL HUMANITIES JOURNAL

OF BOSTON COLLEGE

VOLUME 10 · ISSUE 2

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 engage in conversation beyond Boston College.

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

The Medical Humanities Journal of Boston College, Volume 10, Issue 2, Fall 2025.

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Before You Read...

Hey there! Here's a quick note before you dive in.

The Medical Humanities Journal of Boston College explores the messy, beautiful intersection of bodies, minds, and meaning. Sometimes that means confronting the uncomfortable. Some pieces in this issue touch on heavy themes like:

- Illness, death, or grief
- Trauma or loss
- Mental health struggles
- Inequity, identity, or systemic harm

We trust our readers to approach these stories with empathy, and also to step back if something feels too close. Take a walk, drink some water, talk to someone you trust. We invite you to read slowly, and to rest when the work asks too much.

If you need someone to reach out to, please contact:

- Boston College University Counseling Services:
  (617) 552-3310
- Boston College Murray Center for Student Wellness:
  (617) 552-9900
- 24/7 Crisis Text Line: Text *HOME* to 741741
- National Suicide Prevention Lifeline (US): 988

Our mission is to foster dialogue around the human dimensions of medicine and health. We recognize that such conversations can be both illuminating and emotionally challenging. The inclusion of these works does not reflect endorsement of all views expressed, but rather our commitment to giving voice to diverse and often difficult human experiences.

Thanks for reading bravely.

With care,
The Medical Humanities Journal of Boston College

Editor's Note

JESSE JULIAN, EDITOR-IN-CHIEF

I came to BC as a Neuroscience major, but I realized I liked the *idea* of medicine more than *doing* medicine. I skipped my chemistry lectures to foster my passion for writing. Now I'm here, leading a journal that embraces both disciplines. I'm curious about science and the stories surrounding it. I read research done by authors like Jack Keaney and Rachel Herschbein, impressed by the depth they display when investigating diagnostic challenges in case studies, or the intriguing trend of "bathing" in Georgian health culture. Why do we read and research, dedicating hours of our lives to the lab? Why do we memorize the bones in our bodies and the diagnoses for every disease?

It starts with narratives that cut deeper into the heart and brain than the scalpel can reach. I am opting to share a heavy one with you here. I began this semester with the unexpected passing of my father. I am too familiar with the limbo we call the waiting room, the tension in a patient-provider dynamic, and the sterile language of medicine. While I could tell you the technicalities of what occurred, what sits with me now is not his patient chart, vital stats, or his cause of death—it's his tightly-squeezed hand, his head turning to hear me, and the last "Good morning" in that hospital room. I struggle to find words that encompass what happened. All I know is that it's pulled me closer to the mission set forth by the Medical Humanities—to remind us of our *own humanity* in the medical field. To see patients and providers as *people*. The Medical Humanities reminds us that the patient is always a loved one—a friend, or a brother. A father.

MHJ provides a space to articulate the feeling of being human in an often life-changing environment. It's grown to include works from beyond campus. These sensitive, provocative, and engaging pieces provide an understanding of our humanity through the lens of another. Jessica Hwang's "Waiting Room"

observes seemingly contradictory ideas in medical spaces—our silence and noise, fears and hopes, and the ordinary and extraordinary. We suffer from complications that bring us to death, but also make our lives so potent and *alive*. The people of *MHJ* delineate the tension of giving and receiving healthcare. Nick Huempfner shows an emergency responder repeating their chaotic routine of rescue. Nicoletta Gianopulos exposes a history of research gaps failing mothers. Andrea Cruz and Halle Ashenafi examine the denial of human rights, exacerbating illness. Elani Scott depicts the patient squeezing their Pillow Pet hippo while counting pricks, their inner child sobbing. Each effort towards interpreting medicine reflects an added part of an ever-growing body of interwoven stories—breathing in unison, inching closer to understanding medicine as *humans*.

I'd like to extend my personal gratitude to our editorial team, who read these works with focused care; our Lead Editors, Malia, Jessica, Tay, Angela, and Emma, who carry forward the wisdom and ideas for this journal a decade after its conception; Vincent, our Deputy Editor who consistently excels in leadership and reliability when the going gets tough; Alyssa, *Gusto*'s Editor-in-Chief yet informally known as my best friend; my dad, who mutually knew that words cannot transcend what we could possibly mean to say, and that's the beauty of failing to write—we keep trying anyway.

I sincerely thank you for reading the Fall 2025 edition of *The Medical Humanities Journal of Boston College*.

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Waiting Room

JESSICA HWANG

Someone coughs,

and the clock answers with its own hollow throat.

Magazines lean on the table,

their covers promising

the ideal life—smooth skin,

a new diet,

a kitchen flooded with sun.

Across from me,

a child clings to her mother's hand,

small fingers braiding themselves

into larger ones.

Neither speaks.

They don't need to.

What is medicine,

if not this—

to sit in the ordinary light of morning,

where fear presses against hope,

and both somehow fit

in the same chair?

I think of the body,

how it waits for us,

how it endures

our silence and our noise,

how it still insists on breathing.

And I wonder if holiness

is not a miracle at all,

but the sound of a mother

and a child

exhaling together

in a room that smells of coffee

and antiseptic,

while the clock ticks on

as though nothing

were extraordinary.

Counting Pricks

ELANI SCOTT

Mixed Media: Bristol, Watercolor, Digital

The Things They Don't Tell You

NICK HUEMPFNER

They don’t tell you how quickly it becomes routine: how the tones drop and your body moves before your brain does, fingers stretching wrinkled gloves over sweaty palms, gloves that you forget are there until they tear at the thumb while you’re wrist-deep in someone else’s blood, which is always darker than you remember, thicker, and stickier too—

How the blood stains everything it touches, streaking down stretcher straps and hospital linens, drying in little specks on the cheap boots you cinch tight each morning, the ones that squeak on hospital tile and leave footprints in kitchens where the food is still warm, down hallways lined with photos where the family is still smiling, in that tiny bedroom where you crouch down to lift someone’s grandma off the floor—

How you'll curse every time the radio squeals, the static-laced chatter slicing through your thoughts mid-bite, mid-laugh, mid-sentence, and suddenly you're flying down the street again, the pulse of the sirens bleeding into your bones as you wonder what you will find when you open that front door, stepping over plastic toys and nosy pets, past the fridge littered with crayon drawings and the Christmas tree still dropping pine needles, just to kneel beside a man face-down in the tub, the water tinged red, your fingers slipping as you pull him onto the cold tile and the surprise that comes with just how easily his ribs crack like twigs under your hands as you press, and press, and press, and squeeze an artificial breath into his lungs—

How you won't recognize the voice that leaves your lips, the one your preceptor built in your mouth, the one that says *ma'am, I need you to step back*, and *sir, can you hear me?*, and *yes, we're doing everything we can* even when you're not sure it's true, the voice that you use when you lie to the child you cradle in your arms, the one you pulled from the backseat of the overturned car, whispering *you're going to be okay* over and over and over until you almost believe it, even when her legs are bent like wire, even when her big brown eyes glaze over, her pulse fading underneath your fingertips—

How you lie again and again because what else can you do when you know the miracle isn't coming, how it's all you can do to comfort the grieving father that hides his sobs, how you hide the panic in your eyes from the mother who watches you in the doorway clutching the baby blanket she doesn't yet know she won't need it, how you kneel when you speak to the child that watches you say something he won't understand but will carry with him forever—

How you will remember the weight of the infant that lies limp in your arms, skin already losing color as his tiny head lolls heavy against your wrist, the coldness creeping in through your gloves and lingering long after you let go, how you will be asked to *keep going, please, just a little longer* by the desperate mother even when there's nothing left to save, but you do anyway because pretending that there's hope is still easier than admitting there's not—

How you'll realize death isn't like the movies but more like a room exhaling, suddenly emptier than it should be, and how you won't be able to escape its smell, which settles in your clothes, your hair, the grooves of your steering wheel, following you down grocery aisles and into restaurants, finding you in your sleep—

How when its all said and done the mother will still wail like someone is carving the grief from her throat, screams that ring in your ears long after you leave the scene, long after you're back in the truck eating cold leftovers in vomit-stained pants, laughing too hard at your partner's bad joke just to keep the silence from creeping in, the silence that doesn't feel quiet any more, the phantom sirens that plague you in your sleep so you'll leave the TV on some nights just to drown them out—

How you'll fall asleep sitting up and wake with your fists clenched, the dreams looping and blending, and your partner says you've been grinding your teeth again, the same teeth you bare in a gas station mirror forcing a smile you don't recognize, noticing the line between you and your patients is wearing thin, and you'll press two fingers to your own wrist—feeling for its steady pulse—a reminder that you are still here, even if everything inside you feels like it's quietly, slowly, constantly falling apart.

The Human Right to Health Care: Upholding Ethics Beyond Borders

HALLELUJAH FIKIR ASHENAFI

Abstract

The ethical duty of medical professionals to provide healthcare extends to all individuals, regardless of their immigration status. Yet, undocumented immigrants in the United States continue to face significant discriminatory barriers to accessing medical care, despite their economic contributions and protection under international human rights standards. This paper argues that healthcare is a fundamental human right that cannot be denied based on legal status. Drawing on medical ethics, international legal frameworks, and cultural representations such as the film *Gattaca*, the analysis challenges common counterarguments related to cost and legality. Denying healthcare to undocumented immigrants not only undermines core ethical principles of justice and beneficence central to medical ethics, but also endangers collective public health and weakens the broader commitment to human dignity at the heart of healthcare.

Keywords: healthcare access, undocumented immigrants, medical ethics, human rights, health equity

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As migration numbers in recent years have surged, the debate over healthcare access for undocumented immigrants has

intensified. According to data from the U.S. Customs and Border Protection, over two million individuals crossed the border without legal authorization just in 2022 (Alarcon, 2022). This growing population highlights the urgent need to address the ethical and human rights implications of healthcare denial based on immigration status. Upholding this inherent right of undocumented immigrants to receive medical care reflects the ethical responsibilities of healthcare professionals and a commitment to human rights and the public health interests of society. Although the question of healthcare access for undocumented immigrants is highly polarizing, it should not be a point of contention, as medical professionals have a fundamental responsibility to care for all human beings; their oaths prioritize their duty to humanity over legal or immigration status. Therefore, one's legal status should never be a barrier to receiving necessary medical treatment, as it is a breach of the values that define the medical profession. Healthcare access is not only about legality or cost; it is about basic human dignity and the obligations of society. In this light, the effects of legal status on healthcare access for undocumented immigrants extend beyond issues of legality or financial burden; at its core, it reflects a society's commitment to human dignity and the ethical foundations of medicine.

Given that healthcare access is fundamentally tied to human dignity, it is critical to examine the ethical responsibilities of those entrusted with safeguarding public health. The obligations outlined in the professional oaths taken by medical practitioners, known as the Hippocratic Oath, provide clear guidance on how care should be delivered—without bias, discrimination, or regard for legal status. While this text is rooted in an ancient Greek tradition, the oath's enduring relevance lies in its commitment to treat all patients without discrimination, regardless of their social, political, or legal

standing (National Library of Medicine, 2002). The oath requires doctors to affirm: "Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption, including the seduction of women or men, whether they are free men or slaves" (National Library of Medicine, 2002). This early declaration established the ethical framework that physicians have a professional and moral duty to care equally and without exploitation for every individual in need, irrespective of their status. This, in turn, illustrates that the principles at the core of the Hippocratic Oath and all medical practice require prioritizing human life and well-being over politics and documentation. Although undocumented immigrants may face legal challenges within the broader society, none of these legal barriers should extend into the realm of medicine.

Access to healthcare is not only a professional ethical obligation but a universally recognized human right that must extend to all individuals, regardless of immigration status. American providers professed commitment to human dignity directly aligns with international standards on this principle, like the United Nations' International Covenant on Economic, Social, and Cultural Rights (ICESCR), which demands medical service and attention for all individuals in the event of sickness (United Nations OHCHR, n.d., Article 12). However, the United States was notably the only nation to refuse endorsement of the UN Global Compact reaffirming healthcare rights for migrants (Gostin, 2019), thus violating both the fundamental human rights highlighted by the ICECSR and the United States' own commitment to upholding human dignity. Although the nation's medical ethics and humanitarian values claim to prioritize life without discrimination, America continues to fall short in the practice of international norms.

Despite the clear ethical mandates guiding the medical profession, the reality of healthcare access for undocumented immigrants reveals a stark contradiction between principle and practice. The imperative to provide care without discrimination stands in sharp contrast to the harsh realities undocumented immigrants face within the U.S. healthcare system, where access is often determined not by medical need but by immigration status. Undocumented immigrants have extremely limited access to healthcare despite their substantial contributions to U.S. society (National Immigration Forum, n.d.). A persistent misconception among critics suggests that undocumented individuals impose an unsustainable financial burden, as they do not contribute financially, and that offering them healthcare drains resources from citizens. However, in reality, "undocumented immigrants contributed $20.1 billion in federal taxes and $11.8 billion in state and local taxes" in one year, continuing to support the nation through both labor and fiscal contributions (National Immigration Forum, n.d.). Although one's economic contributions should be irrelevant to whether they receive healthcare—especially from the perspective of a healthcare provider, whose duty it is to administer care to all patients without bias—addressing this truth is important to further expose the deeper inequities embedded in current healthcare practices. This inequity is highlighted further by the fact that "undocumented immigrants are largely barred from federal healthcare programs like Medicaid and Medicare, except for emergency situations" (National Immigration Forum, n.d.). However, even access to emergency care is minimal; in fact, healthcare services for undocumented immigrants accounted for less than 1% of total Medicaid expenditures in 2016 (National Immigration Forum, n.d.). Together, this evidence emphasizes how the

exclusion of undocumented immigrants from regular medical services is not an issue of protecting government resources but rather represents the deeply unethical and unjustified practice that ultimately serves no benefit to anyone.

The consequences of inequitable care are so deeply ingrained in society that they have even been explored through popular media. The pervasiveness of such inequity is captured in Andrew Niccol's *Gattaca*, which portrays a dystopian society where genetic composition predetermines an individual's worth and access to opportunity (Niccol, 1997). The film highlights the dangers of discrimination based on arbitrary classifications, such as genetic status—a reality that mirrors how undocumented immigrants are often treated within the healthcare system (Niccol, 1997). In the world of *Gattaca*, individuals labeled as "invalid" are systematically denied opportunities and medical care based solely on their genetic profile (Niccol, 1997). While it is easy for audiences to recognize the injustice portrayed in the film, there remains a troubling disconnect when similar inequities arise in real life. Just as *Gattaca* exposes the ethical and moral failures of genetic discrimination, denying healthcare based on immigration status similarly undermines the principles of ethics, equality, and justice. The parallel between Gattaca and the real-world treatment of undocumented immigrants underscores a universal truth: any system that conditions access to care on status—genetic or legal—rather than need, erodes the ethical core of both medicine and humanity itself.

Healthcare is not a reward for legal status; it is a human right essential to protecting life, dignity, and public health. Medical ethics demand that care be administered without discrimination, and international human rights standards reinforce the obligation to treat all individuals

equally. While the principles of medicine, the demands of human rights, and even practical concerns about cost all support the extension of healthcare to undocumented immigrants, arguments based on legality or financial burden fail to justify the denial of basic medical care. Through its portrayal of a society fractured by genetic discrimination, Gattaca reinforces the ethical warning against allowing status to determine access to care, reflecting the very injustices confronted in reality. Providing healthcare to all individuals, regardless of immigration status, is not simply a compassionate choice—it is a necessary act of justice, and one that affirms the collective commitment to human dignity and ethical responsibility.

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Curanderismo: A Philosophy and Practice of Healing

ANDREA CRUZ

Curanderismo: A Philosophy of Healing

A system born of ancient tribes,

Aztec, Mayan, and Incan wisdom interwoven.

It is syncretic and holistic,

A belief in the natural and supernatural

Philosophy of balance

Each sickness, a story of imbalance.

Emotional, physical, or social

In a search for harmony

The mind and body,

inseparable.

Where anguish of heart,

unfolds as aches in the flesh.

To refer to illnesses as malevolent forces

An intrusion or attack

But not an invincible one.

Curanderismo: A Practice of Healing

Curandera

A holistic healer

Of body, mind, and spirit

To treat the soul first,

Then the vessel that holds it

Healing often beginning in the unseen,

A gentle moment shared,

of understanding and empathy.

Illness

A disruption of the mind and body

Treatment based on restoration.

Family, too, becomes the cure

Interdependence woven

Into the fabric of health,

Their care as essential as the healer's touch.

Healing–

A ritual of connection,

To earth

To spirit

To one another.

Access to Healthcare

Mothers and Fathers,

Undocumented alike,

Hesitate at the threshold,

Fear of being turned away,

Fear of the questions

That cut deeper than illness.

Worries linger in their minds,

Questions unspoken,

Accents carrying stories

that deserve to be heard.

To build a relationship with your physician

Is to understand one another

To share your story

But what if my story reads in Spanish?

How can I put my words,

And be vulnerable

In a language I am unfamiliar with?

How can I be sure,

I am not being lost in translation?

How can you be sure,

You can diagnose and treat

A person whose essence you cannot fully know?

How do I say,

My pain is here,

In the split of my identities,

In the weight of two worlds I carry,

longing to be understood.

To be healed as a whole

The role of representation in healthcare

To see a familiar face,

In a moment of vulnerability.

To be unsettled,

Then meet eyes with someone who understands.

A silent connection,

An unspoken bond,

Sharing the emotions across the space between us.

The ease with which I breathe now,

Even if just briefly.

To be a pillar of light

And a beacon of hope

In spaces heavy with worry,

Uncertainty,

And the unknown.

For it is much more than acknowledging the hurt—

It is seeing the person,

Honoring the shared experience,

And understanding what it means to be

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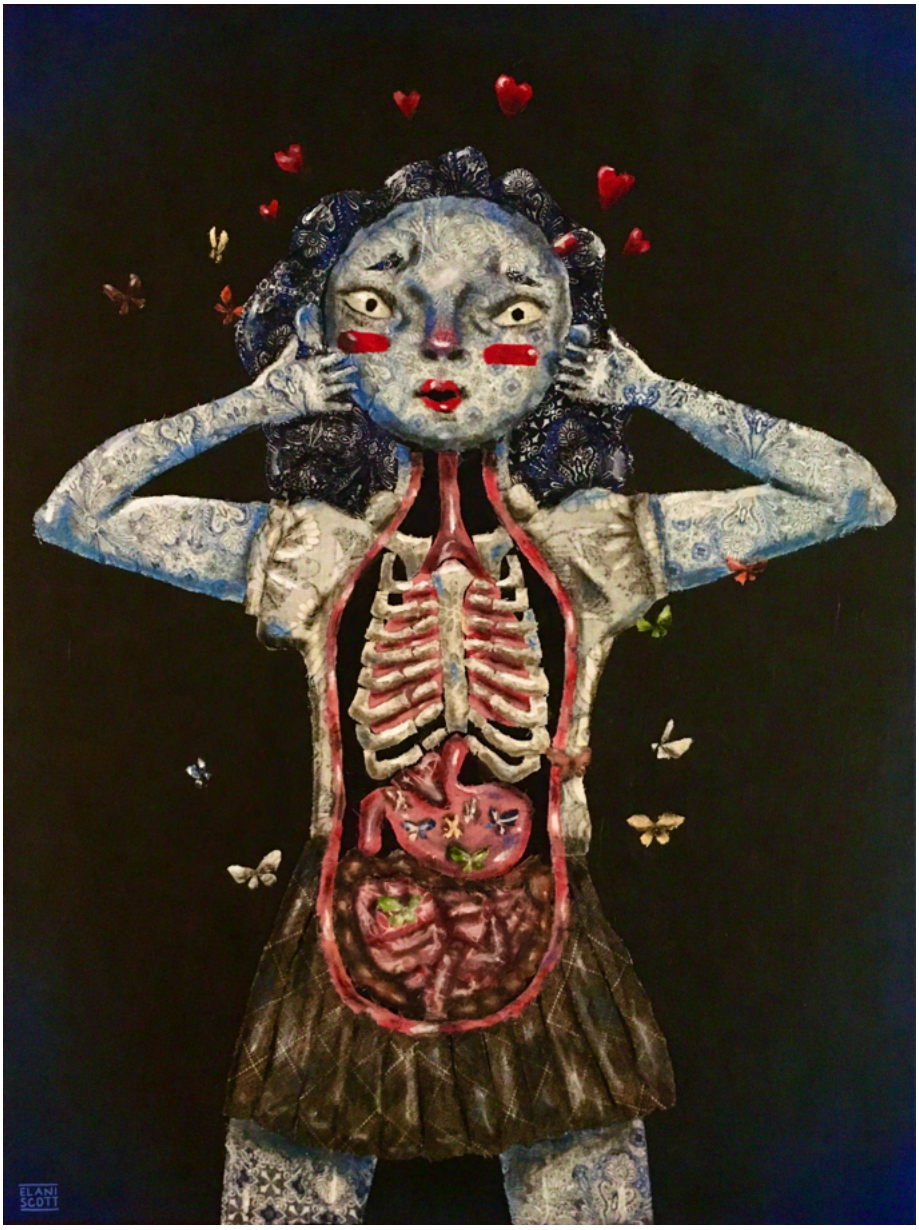


Butterflies In Her Stomach

ELANI SCOTT

Mixed Media: Canvas, Fabric, Acrylic, Chalk Pastel

Beyond Increased Muscle Tone: Co-Occurrence of Stiff Person Syndrome and Idiopathic Parkinson's Disease

JACK KEANEY, DUARTE G. MACHADO, ANKUSH MAHESHWARY

ABSTRACT

Background and Objectives

Stiff Person Spectrum Disorder (SPSD) is a rare neuroimmunological disorder primarily associated with the GAD65 autoantibody. Stiff Person Syndrome (SPS) is a classic subtype characterized by increased rigidity, triggered muscle spasms, and hyperlordosis. Idiopathic Parkinson's Disease (IPD) has been reported to co-occur with autoimmune conditions; however, significant overlapping symptomatology can pose diagnostic challenges. The purpose of this study is to describe two rare cases of SPS co-occurring with IPD, highlight the diagnostic complexity, and explore whether GAD65 autoimmunity may contribute to synuclein-related pathology.

Methods

We report two clinical cases of SPS co-occurring with IPD, discussing diagnostic, immunological, and therapeutic challenges, while exploring possible immunopathological

intersections informed by recent cohort data on GAD65-related syndromes.

Results

A 71-year-old man presented with a 2-year history of gait instability, bilateral leg stiffness, and loss of hand dexterity. Initial examination showed bradykinesia and symmetrically increased tone in all extremities, hyperreflexia, shuffling gait with short stride length, and normal base. Imaging investigations were unremarkable, including an MRI brain scan and cervical spine, DaT-SPECT brain, and PET CT brain. Laboratory analysis revealed elevated cerebrospinal fluid GAD65 levels (0.41 nmol/L) and serum GAD65 antibodies (>250 IU/ml), leading to the diagnosis of SPS.

A 71-year-old woman presented with a constellation of symptoms including tremors, muscle weakness, fatigue, balance issues, numbness, difficulty catching breath, and tight muscles. Per her PD history, she was diagnosed on the basis of clinical symptoms and positive DaTSCAN. Per her SPS history, she receives IVIG treatment weekly.

Discussion

These cases illustrate the potential overlap between autoimmune and neurodegenerative diseases, emphasizing the diagnostic and therapeutic challenges posed by coexisting SPS and IPD. Despite their rarity, such cases emphasize the need for heightened clinical awareness of overlapping motor phenotypes, particularly within SPS and IPD. Skin biopsy and antibody testing were essential in delineating dual pathology of the diseases.

INTRODUCTION

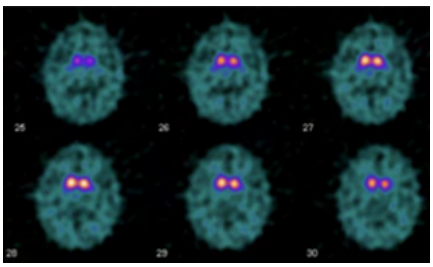
SPS manifests with increased rigidity, spasms, and gait disturbances, with GAD65 antibodies often present at high titers. The relationship between high GAD65 levels and specific neurological phenotypes remains controversial, especially regarding its role in neurodegeneration. While IPD is a neurodegenerative synucleinopathy without a

known autoimmune basis, its overlapping motor symptoms with SPS raise important diagnostic considerations.

METHODS

In this report, we describe two clinical cases, both consisting of clinical features suggestive of the co-occurrence of Stiff Person Syndrome (SPS) and Idiopathic Parkinson's Disease (IPD). Clinical data were retrospectively reviewed, including symptom progression, neurological examinations, laboratory results, and neuroimaging. Diagnostic evaluations focused on identifying autoimmune markers, neurodegenerative indicators, and therapeutic response over time.

Figure 1: DaTSCAN Imaging



Imaging was performed following intravenous administration of 5.5 mCi of I-123. Revealed abnormal study, with reduced uptake of radiopharmaceutical within the striata bilaterally, consistent with loss of presynaptic dopaminergic terminals. Activity is presented within the bilateral caudate. Imaging results support a clinical diagnosis of Idiopathic Parkinson's Disease (IPD).

Neuroimaging included MRI and DaTscan (where applicable) to assess dopaminergic function. Therapeutic interventions included intravenous immunoglobulin (IVIG), rituximab, and dopaminergic agents.

RESULTS

Case 1 Report

A 71-year-old man presented initially with gait instability and bilateral leg stiffness. His medical history showed a history of bipolar disorder previously treated with olanzapine. Neurological examination showed bradykinesia, hyperreflexia, and a shuffling gait. Elevated GAD65 antibodies were noted in both serum and CSF; laboratory studies revealed elevated GAD65 antibodies in both serum (>250 IU/mL) and CSF (0.41 nmol/L).

The patient was treated with IVIG and rituximab. Over time,

the patient exhibited more pronounced asymmetrical Parkinsonism; he developed action and resting tremors (right > left), micrographia, and hypophonic speech. Bradykinesia and rigidity were predominantly worse on the right side. A Syn-One biopsy was subsequently performed, which revealed abnormal phosphorylated deposition in the posterior cervical region, leading to the initiation of carbidopa-levodopa therapy and the co-diagnosis of IPD.

Case 2 Report

A 71-year-old woman with a history of Stiff Person Syndrome (SPS) presented with bilateral stiffness, fatigue, and tremors. Her SPS diagnosis was supported by positive GAD65 antibody testing, with a serum titer exceeding 265 IU/mL. The patient had been receiving regular weekly infusions of IVIG.

The patient experienced worsening tremors and motor symptoms over time. Confirmed by DaTscan in 2018, the patient was diagnosed with IPD. She was bedbound due to multiple spinal fractures, unable to twist or bend. She denied experiencing hallucinations, and no cognitive decline was noted. While mild changes in memory were presented, there were no RBD symptoms and no constipation.

Figure 2: History of Progression

Figure outlines diagnostic evaluations, immunologic findings, and treatment interventions over three years. Initial symptoms included memory changes and symmetric Parkinsonism. Despite elevated serum and CSF GAD65 antibodies and partial improvement with IVIG and Rituximab, the patient developed persistent asymmetric Parkinsonism. Alpha-synuclein was later detected on skin biopsy, suggesting overlapping synucleinopathy.

DISCUSSION

These cases underscore the diagnostic and therapeutic challenges posed by the co-occurrence of Stiff Person Syndrome (SPS) and Idiopathic Parkinson's Disease (IPD). Despite being etiologically distinct—SPS being autoimmune and IPD being neurodegenerative—both disorders share overlapping motor features, complicating clinical interpretation.

To our knowledge, this is the first reported evidence of co-occurrence between SPS and IPD. Approximately 6% of GAD65 antibody-positive cases have been reported to exhibit signs of hemiparkinsonism. While previously reported cases relied on clinical examination and DaT SPECT study, these cases highlight the importance of obtaining further objective evidence, such as skin biopsy, in challenging diagnoses.

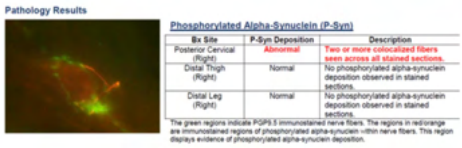
The parallel between these unique cases suggests that SPS may trigger an autoimmune cascade that accelerates phosphorylated alpha-synuclein accumulation, a hallmark of synucleinopathies like IPD. Increased T cell reactivity, suggesting underlying autoimmunity, has been observed up to 10 years before IPD motor symptoms.

However, it is important to note that this report may be limited by a small sample size (two patients). Future studies are needed to determine whether a mechanistic link exists between GAD65 autoimmunity and synucleinopathy and to define optimal treatment strategies.

CONCLUSION

This case emphasizes the significance of maintaining a wide differential diagnosis and considers the possibility of other neurodegenerative conditions when treatment responses are inadequate. Further research is essential to elucidate the potential immunobiological link between SPS and the synucleopathies.

Figure 3: Syn-One Skin Biopsy



Immunofluorescence staining revealed abnormal P-Syn deposition in the right posterior cervical skin sample, with two or more colocalized fibers identified across all stained sections. No phosphorylated alpha-synuclein was observed in the right distal thigh or distal leg samples. The green signal represents PGP9.5-immunostained nerve fibers, while red/orange signals indicate phosphorylated alpha-synuclein within those fibers. These findings are consistent with peripheral synucleinopathy, supporting the diagnosis of Idiopathic Parkinson's Disease (IPD).

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Circulation

EMMA SU

Digital Illustration

Taking the Waters: Georgian Medicine in Bath, England

RACHEL HERSCHBEIN

When studying an era before the advent of germ theory or pharmaceuticals, it is not difficult to understand why natural phenomena, such as a hot spring, were heralded as medicinal. The tradition of using the waters of a hot spring for curative purposes was centuries in the making, and the waters at Bath, England, were no exception. Early examples of "doctoring" in Bath stretch back through the medieval period, but an explosion of health culture in the city occurred during the beginning of the eighteenth century, ushering in the oft-glorified English Georgian period, which lasted from about 1714-1837.

As early as the fifteenth century, there are records of analyses of the waters which sought to determine the element that supposedly "cured" bathers who visited the city's spring.[1] Sulphur (S), an especially fragrant component of the waters at Bath, was suspected first to heal by "penetrating the most intimate recesses of the body in general, and the lungs in particular."[2] In the eighteenth century, the identification of carbon dioxide (CO_2) in the waters was theorized to be the source of its curative properties; in turn, this revelation encouraged the development of "artificial mineral waters,"[3] or as it is known today, carbonated water, or seltzer. The bottled mineral water industry in Bath, though never overwhelmingly popular, persisted in England

[1]Roger Rolls, *Diseased, Douched and Doctored: Thermal Springs, Spa Doctors and Rheumatic Diseases* (London Publishing Partnership, 2012), 11.
[2]Thomas Guidott, *An Apology for the Bath: Being an Answer to a Late Enquiry in the Right Use and Abuses of the Baths in England, so Far as May Concern the Hot Waters of the Bath in the County of Somerset. With Some Reflections on Fresh Cold-Bathing in Sea-Water, and Dipping in Baptism.* (London, 1705), 8, Burns Library Boston College.
[3]Rolls, *Diseased, Douched and Doctored*, 22.

until after World War II. During the nineteenth century, the focus of chemical analysis of the waters centered on the presence of dissolved helium (He), though chemists remained perplexed on how this "curious" element could have "such beneficial results as are undoubtedly produced by 'taking the waters.'"[4] By the twentieth century, the city of Bath was heavily publicizing the presence of Radium (Ra) in the waters, an element which actually seemed, for the first time, to justify its efficacy.[5] One of the most common afflictions for which Georgian visitors sought the baths was gout, a condition caused by a buildup of uric acid in the joints. The waters' concentration of Radium, in conjunction with heat up to 115°F, was theorized to dissolve uric acid out through the skin, and not only decrease symptoms, but lower the future risk of a flare-up as well.[6]

Bathing was prescribed both as a treatment for active illness as well as a preventative measure for healthy people. In any case, the heat of the water caused the bather to sweat, the clearest marker of an effective bathing treatment.[7] Doctors at Bath theorized that conditions such as arthritis and rheumatism could be sweated-out,[8] and in one testimony from 1906, a treatment with "super-heated" water kept at 180°F is broadcast, a temperature which most certainly would instantly scald the patient.[9] The term "treatment" must also be taken with a grain of salt in this context. According to the Royal Mineral Water Hospital in Bath, from 1742 to 1888, out of 39,137 patients who were admitted, 11,535 were entirely "cured" and 19,293 "relieved" of their

[4]Sir William Ramsey, Notes on the Therapeutics of Radium in the Bath Waters (Bath Corporation with the approval of the Bath Medical Committee of the British Medical Association, 1912), 1, Bath Record Office.
[5]Peter Borsay, The Image of Georgian Bath, 1700–2000: Towns, Heritage, and History (Oxford University Press, 2000), 266.
[6]Bath Branch; British Medical Association, "Radio-Activity as a Factor in the Efficacy of the Bath Mineral Waters," in *Notes on the Therapeutics of Radium in the Bath Waters* (Bath Corporation with the approval of the Bath Medical Committee of the British Medical Association, 1912), 2, Bath Record Office.
[7]Bath Branch; British Medical Association, "Radio-Activity as a Factor in the Efficacy of the Bath Mineral Waters," 2.
[8]W. Lewis & Son, *The Original Bath Guide* (1906), 35, Bath Record Office.
[9]W. Lewis & Son, *The Original Bath Guide*, 25.

symptoms.[10] Interestingly, the hospital gives no report on the 8,309 patients who left with no relief from their condition. While a nearly 79% success rate sounds good, the "relieved" category is ambiguous in what it entails, yet it composes a majority of the cases. It is most likely that these patients experienced a temporary remission and would require further treatment. The Royal Mineral Water Hospital (RMWH) was founded in 1738 as a more medicinal counterpart to the homeopathic bathing practice. Within the RMWH's walls, however, the prioritized methods of treatment remained based in the hot springs, from immersion baths to pumping water onto the affected limb or area. Above all else, the RMWH emphasized that it was "open to the sick poor of every part of the world; to whose cases the Waters are applicable."[11] Critically, though, it is noted in parentheses that the sick poor population who already lived in Bath did *not* qualify for treatment.[12] This institution not only served the function of a hospital, but also as an advertisement for the city; there was no interest in serving the local poor, as the goal was primarily to draw out and serve the needs of invalids from around Europe. If treatment seemed effective –even temporarily– Bath had just earned itself a new annual consumer.

It is important to remember that the human body's internal processes were still largely mystical during the Georgian period, even to medical professionals. Humoral medicine (the balancing of blood, yellow bile, black bile, and phlegm) was used to understand the body and heal the sick until the mid-nineteenth century throughout Europe, but it seems to have persisted even longer in the city of Bath. Guides for the city of Bath as late as 1843 warned that "due preparation is necessary" before bathing can be safely engaged in; "the blood vessels should not be too full, and the primæ viæ should be cleansed; without which cautions, bathers are liable to headache, fever, &c."[13] The diagnostic criteria of

[10]Anthony Beaufort Brabazon, *History of the Royal Mineral Water Hospital, Bath* (1888), 75.
[11]Meyler and Sons, *Bath Guide* (1843), 31, Bath Record Office.
[12]Meyler and Sons, *Bath Guide*, 31.
[13]Meyler and Sons, *Bath Guide*, 39.

the Georgian period was quite limited, resulting often in misdiagnosis and ineffective treatment. As mentioned above, one of the most commonly diagnosed afflictions was gout, appearing in countless advertisements, correspondences, and satirical illustrations about Bath. However, the diagnosis of "gout" was also an oversized umbrella term encompassing many ailments which have absolutely nothing to do with uric acid in the body. For example, "flying gout" referred to a burst blood vessel, whereas the symptoms of "head gout" seem to reflect a sinus infection, and "stomach gout" could be anything from indigestion to a stomach ulcer.[14] The danger of this misunderstanding cannot be understated, and yet there was no way that doctors of the 18th century could have diagnosed more accurately: they worked off of what they knew. In recruiting the waters to be a cure-all formula, on the other hand, the Bath doctors of the 20th century likely knew the snake oil they were selling.

Treatment with the waters was far more than simply just bathing, though this was undoubtedly the most popularized method. The waters were so ubiquitous with medicine in Bath that an 1843 guide remarked that "if any of the preceding disorders fail of relief by the Bath water, it is because the patients will not allow enough time for their cure," or are unable to ingest as much water as was prescribed daily.[15] At the same time, favor for public and mixed-gender bathing declined and was replaced with an overwhelming Victorian modesty campaign. The city recognized its shrinking consumer market, and thus, rather than the "ancient way of Bathing," proponents of hydrotherapy encouraged drinking the waters, substantiating with claims of wildly beneficial health effects.[16] The rebrand was successful, and by the end of the Georgian period, drinking the waters at Bath had emerged as a premier

[14]Elizabeth Burton, *The Pageant of Georgian England* (Scribner, 1968), 240–45.
[15]Meyler and Sons, *Bath Guide*, 45.
[16]Guidott, *An Apology for the Bath*, 15.

treatment for most gastrointestinal and circulatory problems. Seasonal visitors took the Bath Road, "the earliest of all the great public roads in the kingdom," which stretched over 100 miles (172 km) of English country to reach the western city.[17] There, they could take lodgings, visit the baths, and take the waters at the Pump Room daily. The benefits of the waters abounded, according to local legend, and one particularly ambitious scientist speculated that drinking Bath water could heal a damaged liver and alleviate an alcoholic's cravings for liquor.[18] The substitution of alcohol for the Bath waters was championed by the Bath Temperance Association, which erected a statue, the Rebecca Fountain, in 1861. Clearly inscribed are the words, "Water is Best," and when functional, a public tap from which passersby could collect fresh spring water to drink. The attribution of spontaneous curative abilities to the waters was only just beginning with the Georgians, and as the city struggled to maintain its popularity, claims became even more wild. Drinking water hot from the Pump Room's tap was the most direct and curative method to acquire the waters, but as England industrialized in the Victorian period, it was also aerated and bottled, so as to be served at room temperature without the minerals in the water precipitating out. This "cure" was prescribed to be taken three to four times per day in copious amounts, so as to flush the stomach first, and second, purify the blood.[19] Rectal and vaginal douching was another method by which invalids in Bath were cured, but this process was generally reserved for special cases.

As medical technology developed, doctors at Bath experimented further with the waters, developing ear and eye drops which could be purchased and taken away from Bath.[20] Bath Guides of the twentieth century identified an element

[17]R.E. Peach, *Street-Lore of Bath:* (LEGARE STREET PRESS, 1893), 113, WorldCat.
[18]Meyler and Sons, *Bath Guide*, 43.
[19]Bath Branch; British Medical Association, "Radio-Activity as a Factor in the Efficacy of the Bath Mineral Waters," 4.
[20]Dr. S.S. Aubermann, "Radium Emanation and Physiological Processes," in *Notes on the Therapeutics of Radium in the Bath Waters* (Bath Corporation with the approval of the Bath Medical Committee of the British Medical Association, 1911), 2–3, Bath Record Office.

called Niton –the now-obsolete name for Radon (Rn)– in the gases emanating from the baths, a by-product of the dissolved Radium's decay. Contemporary medical journals ponder a Niton nasal spray, which patients could purchase to continue treatment at home.[21] At the RMWH, techniques like the "Electric Hot Bath" and hypodermic injections of Bath water persisted into the mid twentieth century, and these methods were suspected to have even greater effects than simple bathing or vapor inhalation.[22] In their advertisement of an electric bath with "Niton water," the RMWH claimed that the current would "ionize the cells," so as to allow the waters to better penetrate the body.[23] Whether a component of the waters had actual health benefits or if bathers experienced simply the placebo effect was quite irrelevant, many scholars argue, since ingestion of the waters was so faithfully believed to act as a shield to prevent the drinkers' infection with plague, or even circumvent death.[24] This miraculous quality was summarized in lilting rhyme, proclaiming:

> The mineral steams which from the baths arise,
>
> From noxious vapours clear the neighboring skies: –
>
> When fevers bore an epidemic sway,
>
> unpeopled towns, swept villages away: –
>
> While death abroad dealt terror and despair,
>
> The plague but gently touched within their sphere.[25]

It seems that the waters were definitely effective in some cases, yet by no means predictable. Relying on the theory of four humours deep into the eighteenth century, doctors at Bath hoped that immersion in hot water would "thicken the serum" of the blood.[26] It seems that physicians failed to foresee the effects of overheating on the body, and this was an often

[21]Ramsey, *Notes on the Therapeutics of Radium in the Bath Waters*, 21.[18]Meyler and Sons, *Bath Guide*, 43.
[22]Aubermann, "Radium Emanation and Physiological Processes," 2–3.
[23]Ramsey, Notes on the Therapeutics of Radium in the Bath Waters, 20.
[24]Rolls, Diseased, Douched and Doctored, 218.
[25]Meyler and Sons, *Bath Guide*, 4.
[26]Guidott, *An Apology for the Bath*, 27.

unpleasant surprise. For example, in a “sanguinous, healthy subject,” the waters may actually have caused the bather to become flushed and develop a “violent headache,” which reveals the waters as the opposite of an invigorating preventative measure.[27] In fact, a guide to the city remarks that bathers who were not careful could not only lose the benefit of the waters, but “return to their home much worse than they came,” nodding to the public health crisis that inevitably came to Bath.[28] As the health center gained popularity, people seeking a cure arrived in abundance, bringing with them an array of infections, chronic illnesses, and potentially contagious diseases. Nonetheless, popular literature of the time reaffirmed the city as the paramount center of health, mythologizing the hot spring and the city’s past as a health resort: “Each human lip, that drinks of this bright wave,/ Drinks to a temporary triumph o’er the grave.”[29] This dramatization is typical for advertisements from Bath, which only became more fervent by the end of the nineteenth century. A 1906 Bath Guide encapsulates the city’s desperate attempts to sell their health cure: the waters may not be a "panacea" for “all ills that flesh is heir to,” they admit, but it *is* effective to treat gunshot wounds.[30] There is no explanation as to why or how this magical cure is possible. It is doubly unlikely that the victim of a gunshot wound would be able to survive the long journey to the southwest of England, especially before the introduction of the Great Western Railway system in 1833.

Not all people were completely sold on the waters, though, especially considering the city’s reputation as a place of gambling, drinking, carousing, and spending money. A 1767 collection of letters from Bath reveals skepticism over the Bath doctors, who seemed to be more concerned with Bath as a sociopolitical city than a health center, a quality distinctly ironic coming from the medical

[27]Reverend G.N. Wright, *Historic Guide to Bath* (1883), 101–2, Bath Record Office.
[28]Meyler and Sons, *Bath Guide*, 39.
[29]Reverend G.N. Wright, *Historic Guide to Bath*, 95.
[30]Lawrence Wilson, *Bath as a Health Resort* (Bath Corporation, 1906), 37, University of Michigan.

community.[31] As stated in a poetical epistle, one patient "Declar'd she was shock'd that so many should come/ to be doctor'd to death such a distance from home."[32] The seasonal visiting trend in the city throughout the Georgian period meant that most doctors were only present there during the months of October to March, when Europeans began to come down with seasonal colds or viruses and travelled to Bath for a cure.[33] With an increasingly interconnected print and media culture in Europe, the number of visitors to Bath steadily rose each year, as did the prices for use of the bathing establishments. The suite of baths in the city went through major developments, including apartments devoted to the application of massage, inhalation, pulverisation, &c." so as to make the experience as luxurious as possible for those able to afford it.[34] Other than within the RMWH, standardization of "treatment" in Bath was nonexistent, as revealed in contemporary discourses between medical professionals which reveal methods and theory of treatment. One eighteenth-century physician complained that the waters were being heated and cooled at will for pleasure bathing, rather than keeping the temperature steady in accordance with the treatment plans of the people who were actually ill.[35] This critique marks a split in the city of Bath, one for pleasure and one for health, two avenues which grow further and further apart as Georgian England grows in splendor. While Bath maintained its main purpose to be "the search for health," it also sought to cater to other interests, particularly those of a healthy visiting population, "whether or not acting as companions of the sick.[36] Bath, the city of health, was put face to face with a rising trend of leisure, which favored Bath's transformation into a vacation destination.

[31]Christopher Anstey, The New Bath Guide: Or, Memoirs of the B--r--d Family : In a Series of Poetical Epistles. (London, 1767), 28, Burns Library Boston College.
[32]Anstey, *The New Bath Guide*, 30.
[33]Rolls, *Diseased, Douched and Doctored*, 133.
[34]Wilson, Bath as a Health Resort, 23.
[35]Guidott, *An Apology for the Bath*, 69.
[36]Sylvia McIntyre, "Georgian Towns as Health and Pleasure Resorts," *Georgian Group Symposium*, Life in the Georgian Town, 1985, 44.

Doctors in the city were a strict necessity, considering the immense public-health risk caused by the flocking hordes of invalids whose number grew every visiting season. The Georgians were not oblivious to the idea of contagion, though they may not have quite defined it in relation to germ theory. However, there were some provisions to attempt to protect bathers from catching a new ailment; patients in the "inflammatory stages of disease" were forbidden from bathing, pumping, or even drinking the waters, on the basis that it is "not merely improper, but unsafe."[37] This unfortunately contradicts the reason that an ill person might come to Bath, and the diagnostic criteria for determining the likelihood of disease transmission were not always accurate, resulting in premature exposure of the public to a contagious infection. British historian Peter Borsay describes Bath as a "magnet" which collected "a high concentration of the aged, sick, and suffering."[38] As the most vulnerable populations of England gathered together, it not only brought together disease from elsewhere, but also potentially sent visitors home with a new disease they caught in Bath. The Rural Sanitary Authority of the Bath Union, formed in 1872, was well aware of the urgency in this matter and put several safeguards in place to reduce the risk of transmission, such as requiring an open-air construction on the Roman Bath, despite it not reflecting the original classical architecture they hoped to recreate.[39] The Sanitary Authority also hosted inspections in Bath, but the frequency and efficacy of these visits are unclear. It is known, however, that the 1882 inspection deemed some buildings in the bathing establishment to be "unfit for human habitation," which is far from a shining endorsement.[40] Despite the circumstances it operated under, the Rural

[37]Reverend G.N. Wright, *Historic Guide to Bath*, 103.
[38]Borsay, *The Image of Georgian Bath, 1700–2000*, 22.
[39]Rural Sanitary Authority. Bath Union., *Bye-Laws for the Parishes of Bath Easton, Bath Ford, Bath Hampton, Charlcomb, Dunkerton, English Combe, Moncton Combe, South Stoke, Swanswick, Walcot, Wellow, : With Respect to (1.) New Streets and Buildings. (2.) The Cleansing of Footways and Pavements, the Removal of House Refuse, the Cleansing of Earth Closets, Privies, Ash Pits and Cesspools. (3.) Common Lodging Houses. (4). Slaughterhouses (Bath Easton Only.)* (1882), 30, Bath Record Office.
[40]Bath Union., *Bye-Laws for Bath Parishes with Regard to Rural Sanitation*, 41.

Sanitary Authority can be credited for keeping a large component of visiting invalids alive as the population in Bath boomed like never before.

The city of Bath offered holistic care in many ways to accommodate its population during their stays, developments which legitimately contributed to the lessening of illness. One of the most iconic Bath images is that of the sedan chair, a vehicle invented for the transport of invalids from their apartments to the baths.[41] Debuted in 1630, the sedan chair was a single-person compartment with long handles on front and back. The invalid would sit inside the compartment, while two attendants lifted in synchrony and walked to their destination. The sedan chair maintained popularity until the 1850s, though it came to be colloquially known by then as a vehicle taken by women in large dresses, who had not the energy to walk to the Assembly Rooms. Regardless, reducing the distance walked by a feeble population was beneficial, as the journey to and from Bath for the average visitor was more than likely long and arduous.

Modern historians of Bath have begun to speculate that the waters of Bath may not have been necessarily curative, but time away from home certainly could have been. Scholar Roger Rolls notes the common exposure of people before 1900 to lead daily, whether that be in their home or workplace. By simply leaving those environments, to Bath or elsewhere, the quantity of lead in the body lessens, thus alleviating symptoms of conditions such as plumbism, saturnine gout, or Devonshire colic.[42] Logically, this is the simplest answer for why the spa seemed so effective. In a similar way, Rolls also notes the power of close attention and human touch as a healing tool: visitors step away from work to be cared for by trusted professionals, and much of the beneficial effects of bathing or massage could come from an improved psychological state.[43] The nature of treatment at Bath was commonly more stable and

[41]Maria Joyce and Mary H. Wills, *Bath in Old Picture Postcards* (European Library, 1990), 24, Bath Record Office.
[42]Rolls, Diseased, Douched and Doctored, 35.
[43]Rolls, *Diseased, Douched and Doctored*, 45.

healthy than the typical day-to-day life of many visitors, who likely did not have the regular opportunity of seeing new places or meeting new people. On top of these psychological impacts, patients at Bath were required to adhere to a regular diet and routine, which may have provided more nutrients and food security than typical in the country.[44] Put together, it is clear that the *lifestyle* at Bath was far more curative than any single product or remedy, and potentially even better than what contemporary medicine of the Georgian period had to offer.

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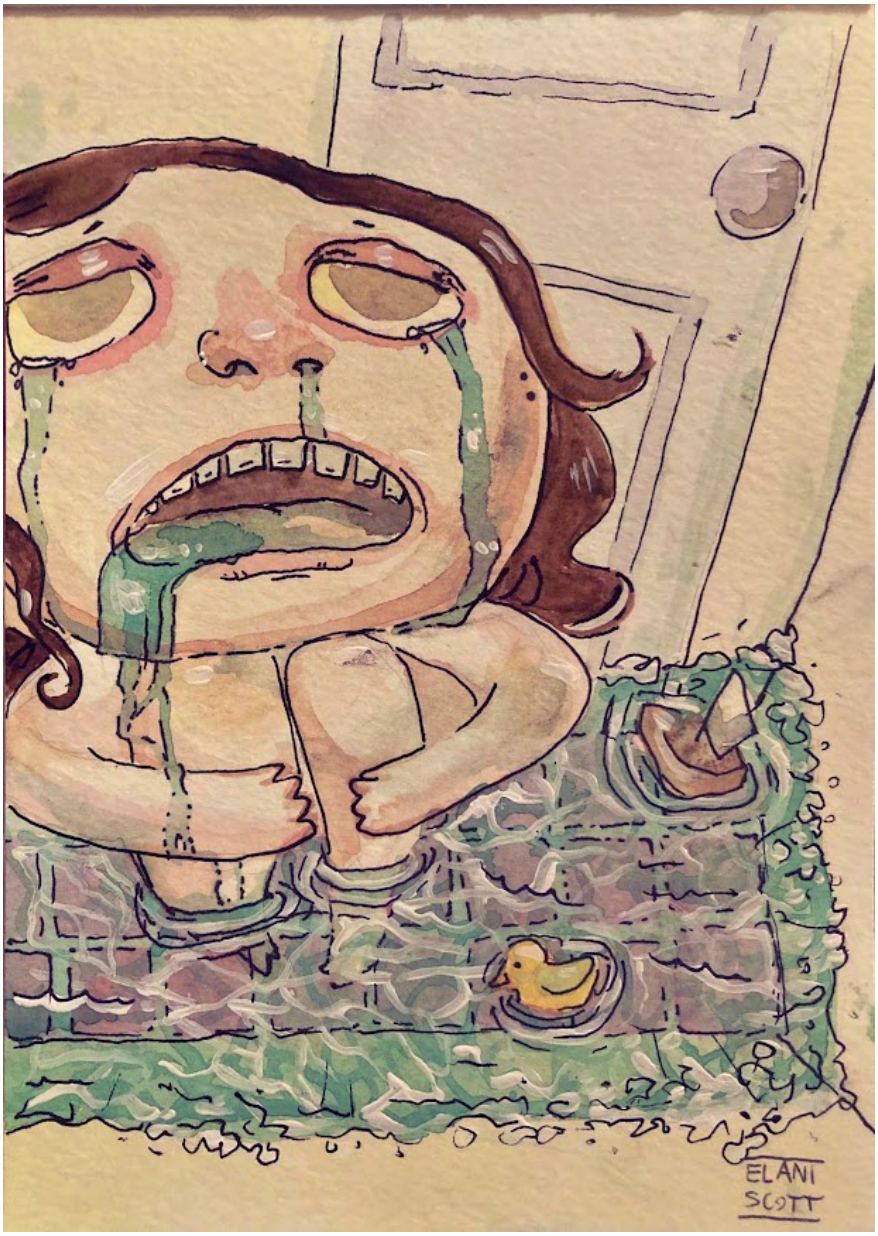

Drowning in Sickness

ELANI SCOTT

Mixed Media: Bristol, Watercolor, Acrylic, Pen

“How’s Work?” I Asked.

JESSE JULIAN

I hastily plugged in my second AirPod while I boarded the T. I heard the muffled announcements before I tuned them out: “Express to Washington St.” and “No Smoking Please.” The monotone words blended into the beat of commuting passengers brushing shoulders in distant intimacy and squeezing past one another to hop on and off the platform. I imagined we were all en route to work, from work, between work. Work serves as the kinetic energy motivating all frenetic movement in the city. Aspiring adults in the workforce pollute every street of Boston, which ranks as one of the highest concentrations of employment in the United States—I’m not sure if that should be impressive or not (Boston.gov). All heads bowed down as we marched to the rhythm of a cold Monday morning in March.

I don’t call my aunt often. Only in moments like this, in transit, where I have an excuse to hang up once I have arrived at my destination. It’s only fair, since I know she’s just as busy as I am. We’ve maintained an unspoken, mutual agreement that we’re both too preoccupied with work and school and whatnot. She’s tired and I’m tired. We must preserve all facades of friendliness for the heavy mask of service roles. We don’t have the time nor energy for small talk—especially when the only topic is work.

“One of my coworkers passed away. *Shit*,” she said.

Okay! Fuck. This was great. Why did I even call? I stumbled through condolences, awkwardly feigning shock and suppressing my apathy. It’s difficult to care about the death of a stranger when I feel so engrossed in my

own self-absorbed world. My cluttered mind could only see papers strewn on desks and deadlines dragging my calendar down.

"Wow, I'm so sorry," I forced out.

I used my left hand to steady myself on the train during the sudden stops. The thumb of my other hand rapidly searched up polite phrases to say when someone you don't really know dies.

"What was her name?" I asked.

She gave no useful details to paint a precise image, besides this: "She worked at the front desk, remember? During nights. She had another job in the morning, so I always closed with her." I could only conjure the image of a fifty-something-year-old woman hunched over a computer, eyebags swallowing her sight while wrinkles pulled at her droopy frown. I wasn't sure how this woman spent her mornings, but moonlighting as a nurse seemed lethal.

My main questions regarding work seemed to go awry here. I did intend to ask my aunt about her work experiences in healthcare. She seemed like an appropriate interviewee for this piece; long, grueling shifts and the demanding hospital setting increase the odds of nurse burnout, as seen by the 31.5% of nurses in the US who left the profession due to burnout in 2018 (Shah).

I cringed at the scripted list of interview prompts in my Notes app, which now seemed offensive if I bothered to ask them: "What makes your job difficult?" "Would you consider yourself burnt out?" "How often do you and your coworkers work?" Although I was dressed in my work uniform, I did not expect the all-black dress code to manifest this surprise funeral eulogy.

"When did you last see her?" I asked.

Apparently, her coworker had been diagnosed with stage four cancer back in November. Just before the holidays, she

disappeared from work, only sending a vague email to the staff regarding her decaying state. While they all wished her well and asked to see her, she *insisted* that no one come until she felt better—the last thing she wanted to think about was work.

She died in February—no visitors from my aunt's clinic.

"Now what?" I asked.

My aunt took a deep breath. "Well. We'll just keep working," she said.

I'm not surprised she came to this conclusion. She delivered this mortifying statement with ease. When faced with morbidity, we'll just keep working, turning the gears until we're someday forced to stop. My aunt prides herself on this high-functioning, socially acceptable addiction. The grind has pulled her into a tiresome, repetitive loop of sunrise starts, 16-hour shifts, and impractical bedtimes. Everyone who knows my aunt knows her main value: hard work. When Facebook asked her to describe herself using 101 characters, she only needed ten to brazenly spell out "Workaholic."

The Oxford English Dictionary traces the North American origin of the colloquial term "workaholic" back to 1947 (OED). Canada's *Toronto Daily Star* referenced Alcoholics Anonymous by creating a punny alternative: "Workaholics Synonymous." Workaholism, also referred to as work addiction, unsurprisingly involves an excessive devotion to one's work. This often entails overwhelmingly long hours and intense commitments. However, workaholics often experience a compulsive desire to continue working, even if and *especially* if they do not like their work. By entrenching themselves, they may attempt to relieve their insatiable appetite for varying positive rewards: a monetary bonus, a promotion, a flimsy certificate stating "Employee of the Month" (Sussman). It creates a self-nurturing addiction rather than sensation-seeking behavior, though it could do both. The workaholic finds themself addicted to the "drug" of

compulsive behavior (Holland). Realistically, about 10% of the United States adult population may suffer from workaholism, a similar rate to cigarette or alcohol addiction (Sussman). Specifically, 10.9% of US adults suffered from alcohol addiction in 2023 (National Institute on Alcohol Abuse and Alcoholism). These growing negative consequences amount to the obvious consideration of workaholism as a harmful addiction, despite the cultural perpetuation of its positive effect on work productivity.

Our capitalistic society thrives on hustle culture, encouraging us to outwork and outrun one another by sprinting through life. It rarely allows us to enjoy the present, let alone maintain the pressures of one job. But the art of hustling emphasizes and requires multiplicity; you must multitask, hold multiple side hustles and responsibilities, and be in multiple places at once. One job is no longer good enough. You *must* push beyond these maximum limitations and create more unattainable objectives and standards. *The New York Times* traced the root of the phrase "hustle" through the centuries (Diamond). In the 20th century, a "hustle" denoted the aggressive pursuit of a beneficial activity, oftentimes a money-making scheme. It then developed into a word describing the reality of Black people in poverty trying to financially support themselves. In the 21st century, hustle culture described an inescapable pursuit of success at work. A term previously possessing negative connotations now graces the screens of Gen-Z's social media in hopes of motivating them to outhustle each other. We are trained to desire those 3 a.m. yoga routines, the 5–9 after your 9–5, and the relentless effort of living your "best" life—at least, according to the standards of rich person perfectionism.

This all seemingly relies on the notion of an attainable American dream: opportunities are within your reach if you're willing to sacrifice yourself to them. In 2024, the Pew Research Center found that out of a

representative sample of 8,709 adults in the United States, about half of them believed the dream was still possible (Borelli).

I often wonder if my aunt believes she's living the dream (although "living" is a generous term here). After all, she spends little to no time sleeping with her 12 a.m. bedtime and 4 a.m. alarms. Is this her way of daydreaming? They say, "the early bird gets the worm." Besides the literal sense, is all this work keeping her fed?

What I fear, though, is that the exhaustion has made her a little less human. Nurses already suffer from issues regarding compassion fatigue; notably, exposure to traumatized individuals can decrease empathy and motivate *absenteeism*, or calling out of work constantly (Wolotira). Yet workaholics likely encounter the opposite problem of *presenteeism*, in which the employee should not physically be present due to illness or work-related stress. The high rate of nurse presenteeism possibly indicates an addiction to their work, or at least an inability to cut it out of their lives. Whenever my aunt is suffering from a fever, she simply slaps a mask onto her face and insists that her work "*needs*" her. She rejects the process of healing for the sake of being a good employee and healing others.

Besides compassion fatigue, nurses are plainly fatigued. The experience of sleep deprivation often aligns with mistakes in patient care and the development of burnout (Shah). I recall that my aunt's most common phrase would be, "I'm so tired." I used to brush this phrase off, mentally responding, *We all are!* But there exists a particular weight to the words of someone who seems to have chosen a life of work for themselves with an outstandingly difficult schedule but cannot escape this nightmare. It almost seems like her chase and hustle are aimless, solely a quick speed run through life. Her eyes are shut tight from seeing the present right in front of her. But perhaps it's not just her. Are we hopelessly sleepwalking through our lives

before we're suddenly woken up? We're expected to put our heads down, shrug, and just keep working. But I ask: how's work?

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The Complex

JESSICA HWANG

My mother once confessed
she hated the bumpy constellations
etched across her skin—
as if her body were a map
charting a disease no one asked to read.

Doctors leaned in
with eyes bright as scalpels.
Not to soothe,
but to name.
Not to heal,
but to harvest her sorrow into words
they could claim as new.

“Do not walk the path of medicine,” she told me.
Her voice trembled like gauze,
a shield against the hunger of doctors
who treated her as discovery,
not daughter, not woman.

But how can I turn away?

When I have seen the insomnia

folded in her eyelids,

the midnight pacing

between questions and despair.

If I study the body,

it will be to build lanterns

for her sleepless corridors,

to stitch answers

into the silence she learned to bear.

She fears I will inherit

the arrogance of medicine.

I fear I have already inherited

her skin,

her shame,

her complex.

Yet let even these be my compass.

Let me walk the long corridor of medicine

not as a collector of suffering,

but as one who returns

what was stolen:

dignity, tenderness,

a night without fear.

Not to write her down as rare,

but to write her back

into the language of care—

where her bumpy skin

is no longer anomaly,

but mother.

But story.

But flesh worthy of rest.

Finding a Therapist

ELANI SCOTT

Mixed Media: Cardboard, Pen, Prismacolor Pencils

Field Notes

NICK HUEMPFNER

I was taught to write in shorthand,
scribbled across the back of latex gloves.
Stories etched in hurried strokes
that curl across the contour of my hand.
An entire life confined
to the space between wrist and thumb.

It's a language born in urgency,
a shorthand for survival.
You learn to write without looking,
as you count the rhythms of a fading breath.
The marks smudge before they settle,
a promise meant to last
only as far as the ER doors.

Yet I quickly learned that this language erases
more than it records.
"Distressed" cannot capture the shrill of a mother's scream
as you pull her limp child from the wreck.

“Apneic” is hollow beside the sight of blue-tinged lips,
as you imagine how they once parted for breath.
“Unresponsive” never comes to mind,
while you cradle the weight of a body too young to die.

Such a language fails me in the field.
Its edges are too smooth for broken glass,
too sterile for the blood that cakes my sleeves.
It fails me when I must take a mother’s hand,
and search for words wide enough to hold her grief.

And so I write.

I write beyond the confines of that clinical code,
beyond the clipped acronyms and rigid charts.
I write in all the words that are left behind.
Words that breathe and pulse,
that dance unrestrained across the page.
Words that give life to my patients,
beyond what can be recorded on a glove.

I write to hold onto that flicker of hope,
that exists beneath two fingers at the neck;
to remember the grief as it seeps in,
when the skin finally cools beneath my gloves.
I write to rinse the blood from my hands,
to lace up my boots day after day,
to prepare myself to hold the weight
when the adrenaline finally fades.

It is only then that I find the world becomes bearable,
if even for just one line.

Understudied and Undersupported: How Gaps in Research and Bedside Care Harm Maternal Mental Health

NICOLETTA GIANOPULOS

You've likely heard people say that women's health research has been historically underfunded or overlooked. But what does "historically" really mean, and how does that history continue to shape the quality of reproductive and mental healthcare today? Many assume that while early research focused primarily on men, women were gradually included in studies over the next decade or two. In actuality, however, it wasn't until 1993 when the inclusion of female participants in clinical trials became a requirement in research. This disparity is recent enough to affect the care people receive right now across every stage of the reproductive lifespan.

With around half of the global population being female, it is deeply worrisome to find that there is a significant divide in how much female bodies have been represented in clinical research compared to male bodies. A 2022 study by Alexandra Sosinsky and colleagues examined the proportion of female participants in research about diseases such as cardiovascular disease, cancer,

and psychiatric disorders. These diseases affect women equally as often, if not more than men. They found that women made up only 41.2% of participants in clinical trials about these diseases in 2019, despite the fact that women represent 51% of cancer patients and 60% of psychiatric patients. Additionally, the healthcare system has long operated under the mistaken assumption that there are no significant differences in the way that male and female bodies experience certain health disorders, in terms of treatment type, effectiveness, and symptoms, which is inaccurate. This results from an assumption made based on a body of research with a disproportionately large number of white, male participants.

Another widespread issue in the maternal healthcare system is the inconsistent quality of bedside manner, largely due to a lack of standardized, comprehensive education on compassionate communication in medical school curriculum. Quality bedside manner can be as simple as eye contact with patients, acknowledgment of patient feelings and concerns, being receptive to patient questions, and explaining diagnoses or treatments in a way that patients are able to understand. The way that doctors interact with patients has an impact on patients' feelings about treatment, and thus their attitude towards continuing self-treatment at home if prescribed. Cardiologist Dr. Bernard Lown argued in his *The Lost Art of Healing* (1996) that bedside manner among practicing physicians worsened in quality as technology advanced and the healthcare system became more reliant on it. Whether it is a lack of training in bedside manner or a side effect of an increasingly screen-reliant society, proper bedside care is necessary for positive patient outcomes, both mentally and physically.

Tying this back to women's health, medical schools do not always require students preparing to become OB-GYNs to receive comprehensive training

in how to break unfortunate news to their patients, despite this being something that these providers must do frequently. A study conducted in 2022 by Luísa Silva de Carvalho Ribeiro and colleagues revealed that provider education—involving lectures, patient simulation, feedback/debriefing, and protocols specifically surrounding reproductive health bedside manner—was beneficial in physicians' ability to communicate hard news to patients and couples. While this study is helpful in empirically identifying this problem, there is a deficit in literature specifically related to how to break bad news to patients.

The psychological impact of poor communication by providers during the perinatal period can often be harmful to many patients during such a vulnerable period of life. In some cases, poor bedside communication on the part of OB-GYNs and other women's reproductive healthcare providers can exacerbate or even cause PTSD, unintentionally. For example, in individuals who experienced childhood trauma related to feelings of helplessness and abandonment, poor bedside manner like dismissiveness and lack of expression of care can contribute to trauma during pregnancy. Survivors of sexual assault may also be triggered by examinations by doctors before, during, or after pregnancy. It has been found that communities with a predominantly Black population have had higher rates of PTSD, and it is possible that these higher rates might be influenced by discrimination, human rights violations, and unequal treatment and access to healthcare. Without an understanding of health trauma and mental health, doctors serving these populations are unable to provide holistic and effective care to their patients, potentially even harming their mental wellbeing.

These points of struggle are often not an individual-level issue on the physician's part, but rather reflect systemic issues. It may be possible that providers are overwhelmed with the

number of patients that they must communicate clearly with in a single day, or simply do not know how to best approach these conversations interpersonally. The emotional demands required for consistently practicing empathy in a career in which patients are often deeply struggling mentally as well as physically could likely take a negative toll on the physician, and sequentially, their ability to focus on their work in an unattached manner. This emotional load may lead to burnout and thus the physician may avoid continuing to exercise substantial empathy towards their patient. It is important to understand both perspectives of empathetic perinatal medical treatment, as medicine is not simply about science, but also about care.

For many of these providers' patients, the family-building stages are times of high emotional intensity, especially when there are complications during the process of becoming pregnant, during pregnancy, or while giving birth. We as a society should strive to fill the gap that exists in attending to the mental wellbeing of individuals as they navigate these stages, creating opportunities for happier, healthier women and families. We must understand mental health during the reproductive life stages not only from empirical research, but from providing women the opportunity to be heard and validated through compassionate attention and care for the whole person.

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Evening Song

JESSICA HWANG

The kettle hums in the kitchen,
and steam curls upward
like a prayer too small for heaven.

Outside, children's laughter
fades with the light.
Somewhere a dog barks,
then falls silent.

I hold my cup
and feel the warmth
seep into my palms.
How brief a thing—
this comfort,
this body that remembers both sorrow and joy.

They say death comes like a shadow.
But tonight the air is gentle,
the stars are unhurried.

If tomorrow never arrives,

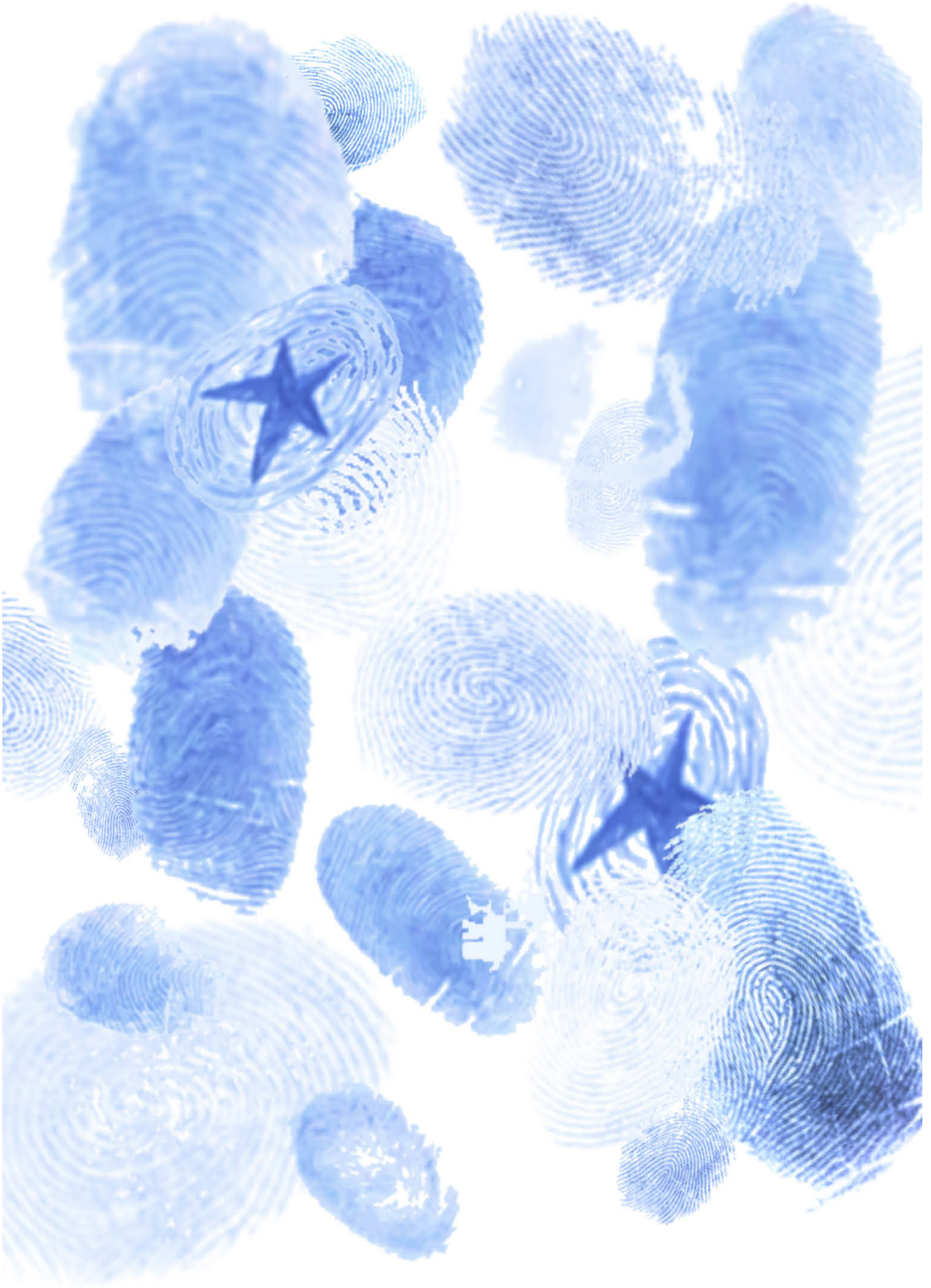
let this be enough:

to have sipped tea,

to have listened to cicadas,

to have lived one evening

without fear.



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