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Masthead

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Disclaimer

We seek to give voice to unheard experiences of illness, foster empathetic dialogue between patients, clinicians, and the caring communities, and create a sense of community between patients, clinicians, medical students, writers, artists, readers, and scholars. As such, we hope to be a platform for new voices, a proving ground for new ideas, and a forum for the difficult but necessary conversations to transform healthcare. However, the perspectives, thoughts, and opinions conveyed in any materials published by The Brown Journal of Medical Humanities belong solely to the author and do not represent those of The Brown Journal of Medical Humanities, the Cogut Institute for the Humanities, or Brown University. In addition, the information featured on our website or print journal is not to be interpreted as professional or medical advice by The Brown Journal of Medical Humanities, its authors, or any affiliates.

Foreword

“Wherever the art of medicine is loved, there is also a love of humanity.”

— Hippocrates

We, the members of the Executive Board, proudly present the second issue of the *Brown Journal of Medical Humanities*. We are honored to have been able to continue the excellent work of our founding members and produce an issue pursuing the journal's mission to bring the medical humanities to the Brown community and elsewhere. In moving towards the future of the journal, we focused on expanding our teamwork with both the local and medical humanities communities; we did so by increasing our editorial and design staff, incorporating further collaboration throughout the editorial process, and opening our call for submissions to an even wider group of contributors. We recognize the medical humanities, broadly defined as the interdisciplinary, humanistic, and cultural study of illness, healthcare, and the body, to be an essential element to the art of providing care and healing those who suffer. In this frame of mind, we constructed this issue to provide space for narratives expounding upon the way that human beings interact with medicine, the medical field, and illness. Our journal explores these topics from the points of view of family members, care providers, sufferers of illness, and those experiencing grief. We strongly believe that in a time of great polarization, instability, and loss for the Brown and wider global community, these stories hold a particular power to unite and heal. The power of the written word and of sharing one’s narrative should not be underestimated in the medical realm, and we hope that in each individual’s expression within these pages you are able to relate to the common ties that hold us as humans together.

We are exceedingly grateful to the students, medical trainees, doctors, authors, and artists from various institutions who contributed to this issue for sharing their stories and talents with us and our readership. To our dedicated editors and designers, we thank you for your essential work towards this publication. The Brown Journal of Medical Humanities is published with the generous support of the Cogut Institute for the Humanities. We are incredibly grateful for their partnership, which has been essential to the success of our journal. We would also like to thank the individuals at Brown University and the Rhode Island School of Design who serve on our Advisory Board, providing critical feedback on the editorial process and sage insight across their many areas of expertise. It has been an incredible privilege to work with such talented individuals and to bring this issue to you, our readers, without whom we would not be able to continue to bring the *Brown Journal of Medical Humanities* to life.

With gratitude,

Samantha Alzate, Byron Butaney, Adeline Allen, and Amrik Eadara
BJMH Executive Board

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By Adithri Pingali

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and call for help.

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rhythm.

don't wonder if
your hands would
shake
in reality,

if you'd even be able to act
quickly enough.

just
breathe
and

3. keep going

Deference to Difference

By Ria Mulherkar, MD

Note: All names and personal identifiers have been changed for the purpose of this narrative.

When I was in medical school, I met a 35-year-old Cambodian man named Ley. He and his mother Nari lived in a small flat in Chinatown above the grocery store they owned. Ley spoke some English, but Nari did not understand a word of it. She relied heavily on Ley's English skills to navigate existence in the United States.

One day, Ley had a grand-mal seizure. He lost consciousness, foamed at the mouth, and began shaking in a way Nari had never seen before. She was able to get him to a hospital, but when he came to, Ley was not at all himself. Nari revealed he had been increasingly confused and had lost a lot of weight in the last few weeks. His workup in the emergency department revealed a brand-new diagnosis of extensive stage small cell lung carcinoma. It was an aggressive form of cancer that had started in his lungs, but ultimately spread to multiple other areas, including several sites in his brain. At the time, I was a medical student on a radiation oncology rotation. My team was consulted on Ley's case to discuss the role of radiation therapy for the tumors in his brain. I tagged along behind our resident and attending radiation oncologists. We happened to arrive at the patient's room simultaneously with the medical oncologist. A translator was also present, and she informed us that Nari did not yet know anything about Ley's diagnosis. This would be her first time hearing the results of the scans and the biopsy.

Upon entering the patient's room, I quickly surmised that this would be a challenging conversation. Ley was extremely confused, and although he spoke English, he was not able to respond to our commands or convey any sort of understanding. His mother Nari was crying profusely at his bedside.

We first introduced ourselves to Nari in English, and the translator subsequently conveyed our words to Nari. Nari nodded, eying us all warily through a sheen of tears. And then it began. One sentence at a time, the medical oncologist told Nari, via the translator, that her son had stage IV metastatic lung cancer. His disease was very advanced, and the condition could be treated, but never cured.

Nari's cries were heartbreaking. I could only imagine what was going through her mind each time the medical oncologist spoke, and she had to wait for the translator to speak before she could understand. How much fear lived in those moments? As the conversation continued, Nari's demeanor gradually began to change. The news had started to sink in. She asked a question in her native language. The translator repeated in English, "How much time does he have to live?"

The medical oncologist sighed, as if she answered this question often. "Fifty-fifty, one year."

Throughout this encounter, I had been an observer, a mere medical student among much more powerful resident and attending physicians. I continued to observe, as the translator conveyed her interpretation of the oncologist's answer, and Nari closed her eyes and nodded. In that moment, I felt that something was off. I cannot explain what struck me — was it the translator's relatively ambivalent demeanor, or was it Nari's lack of immediate despair? I had an indescribable instinct that something had quite literally been lost in translation.

Still, I stayed quiet. The medical oncologist had moved on, and I did not want to rudely interrupt. I did not feel it was my place. I was, after all, only a medical student, the lowest-ranking member of the healthcare team in the room. Besides, no one else had noticed anything wrong. Maybe I had misunderstood.

My instinct continued to nag at me, however. After another ten or fifteen minutes, when we exited the room, the translator came with us. My attending announced that we would bring Ley to our department later in the afternoon for a whole brain treatment planning scan. At this point, I found a pause to respectfully interject.

"Sorry, Doctor, but I have a question." I looked at the translator. "When Nari asked how much time Ley has left, did you tell her that he will live until he is fifty to fifty-one years old?"

The translator nodded, wide-eyed and suddenly afraid.

I looked at my resident, and then at my attending. "I was afraid of that." Again, I looked at the translator. "I think when the medical oncologist answered that question, what she was trying to say was there is a fifty percent chance that he survives even one year."

The translator gasped, her fears confirmed. "Oh dear. I did not translate that correctly. I said fifty, fifty-one years, so his mother thinks he has fifteen years left."

There was a bleak silence. "We should correct that," the resident noted. "We need to tell her there was a mistake."

The attending smacked his lips irately. "And this is why I never tell my patients exact timeframes."

"When should we tell her?" I asked.

The attending glanced at his watch, and the growing list of patients he needed to see. "We can tell her this afternoon, when he comes for the planning scan."

Again, a knot twisted in my stomach, and my instinct was to protest. Nari deserved to know now. We could not leave her with a false sense of hope until this afternoon. But, my training had allowed me to become somewhat deferential. I did not want to contradict the attending, so I stayed quiet.

"No," the translator objected, rather vehemently.

"We need to tell her now. This is a big deal."

The attending reacted as if he had snapped out of a reverie. He shook his head, as if to say *'What was I thinking?'* "You're right. I was wrong. Let's fix this now."

And so we did. We reentered the room, and the translator corrected Nari's understanding of Ley's life expectancy. There was the cry that I had expected, the complete despondency. It hurt to witness, but it is what needed to happen.

It has been years since this encounter, but I will never forget the lessons it taught me.

Differences in rank within the healthcare system can often silence our better instincts. Especially as a student, but sometimes even down the road, it is tempting to stay quiet and observe, out of respect for and sometimes fear of our superiors.

I am so glad I thought to say something that day, even if not at the correct moment. My instinct had been right, and somehow, I had caught a miscommunication. However, in a second opportunity to advocate for Nari, I stayed silent and almost let us delay the righting of our wrong. That day, the translator showed the courage to respectfully contradict our attending, and at once, she changed his perspective.

You Speak Softly on X-Rays
By Priya Amin

A death receptor in apoptosis,
Passing a gentle understanding from another cell
To whisk away one's proteins
To be judged by the bones of its framework,
To be juried by the cell's lifespan,
rendered powerless by executioner caspases.

A quiet war waged by a single-cell
Knows no bounds but the silence
of auto-antibodies in search of peace:
To grow, to spread, to be ill-defined,
Boundlessly into its own destruction
An ancient understanding of all life,
Lost to decay with each mutation
As the body may scream a tumor to die.

Stickout
By Maya J. Sorini

I should be most clamped
by the cords of brain against
the pillow, the step off
bone where his skull
ends, the crushed helmet iced
in blood, his scorched
skin, the unnamable
smell, his yellowish
feet, his being so
young, his gaping
mouth, the places the road ate
to bone, that once he had
a mother who grew his heart,
but all I can marvel at are the handfuls
of gravel in the body bag,
they teem.

cpr
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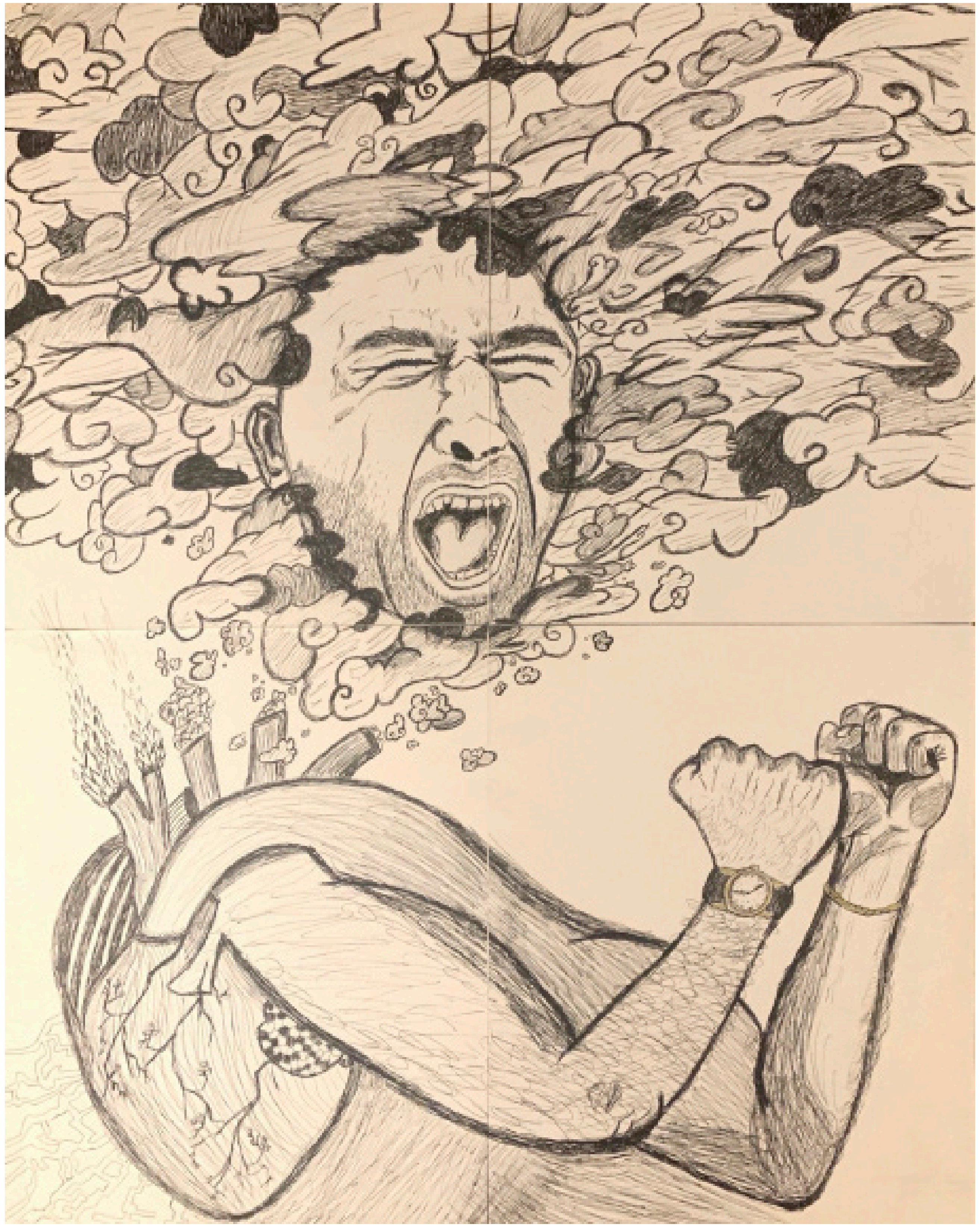
Undiagnosed
By Raphel Awa



Lifeline
By Deeya Prakash

Content warning: This piece discusses suicide and suicidal thoughts and behavior.

To mourn is to be ambushed. One moment I am walking my small dog on the summer street of my hometown, and the next I am in a riptide so strong I can feel it in my spine. It tugs me under as my dog barks at some leaf in the grass. I have nothing keeping me afloat, so I let myself drown to remind myself it happened. Grief holds hands with water, currents like steel.

Six weeks after I meet Caitlin Alexander, I feel it stir underneath me, the wave threatening to take me under. I close my eyes and accept my fate because grief waits for nobody, leaning against a lamppost and smoking a joint because it knows me already. But this time, someone's hand shoots out. I grab onto it and we tumble into the sea together, water rushing down our throats.

***

Caitlin holds my hand as she walks. Not in a loving way, but with urgency, as if to let go is to lose the on thing tethering her to the ground. We are at the medical school and have just sat through hours of panels, legs bouncing under the table, eyes darting to the clock. Pen and paper in hand we approach professors and physicians and advocates, nodding and smiling as they gesture and speak and laugh. One of them asks us if there is a specific reason we are here. We look at one another and laugh the question away, old habits burning red on our tongues as we explain that we are just happy to learn anything we can. Light peeps in through the ceiling window like it knows it will shortly be asked to leave. Caitlin and I take our seats near the rear, our presence largely unnoticed—young premed students attending a symposium. Business attire crunched and unpressed. Smiles waning.

The organizer stands and thanks us for coming, and explains the candle-lighting that will occur next, unlit tea lights arranged on a table, wicks at the ready. We watch in stony silence, as participants, volunteers, and panelists approach the stage one by one, walking confidently, invisible hand at their back. Some are quick and others take their time. There are matches and candles. There is a mic.
And then, after a raspy inhale, a moment of silence, or a combination of the two, there is a name.

***

Suicide is one of the leading causes of death for young people but you don't realize that until the hospital report is in your left hand, note in your right hand.

Caitlin corrects me: school resource sheet in your left, police memo in your right.

***

My mother holds my hand as we look side to side, my fingers trembling in the purple mittens we bought from the neighborhood yard sale. I am four, and no one has yet taught me how to express my emotions. So instead, I bounce with anticipation, fingers slipping in my mother's grasp because there is a lake across the street and we are going to feed the ducks, heels of Kroger-brand bread fisted in my mother's free palm. Small waves lap at the edges, and I simply cannot wait to go. I wiggle but she holds firm. She gives me a stern look and I stop.

I'm just keeping you safe. Hold on tight, she says.

We cross, and I let go as soon as I can, legs pumping towards the water.

***

Caitlin is jittery, legs jumping underneath desks and fingernails rapping on the table like something is trapped within her. When we meet, she is climbing a tree in the quad of our freshman-year dorm because *it helps with the stress*. I stand underneath her as she climbs higher and higher, unafraid of the fall.

We spend time together in the coming weeks, brushing at our surfaces and finding the same type of roots beneath. Ties grow like vines and we laugh at the same jokes, stare at the same people, whisper in the same tone. Once, we are studying at a rooftop cafe, and Caitlin threads her hair in her fingers, sighing and slamming her laptop closed. We are preparing for our organic chemistry final, and the sun glints off of the Ohio River as we turn the pages of our notebooks, eyes straining with the glow. Caitlin huffs, exhaustion painting her face like lines on a palm. We haven't slept properly in days.

This shit is so hard. I want to kill myself, she says, glancing out the window.

Her comment hangs in the air and I stiffen for a moment, pencil floating. *Don't say that*, I mutter, resuming my scribbling as I flip the pages of my notebook.

Caitlin looks at me, expression unreadable. She's somewhere else in her mind, and her eyes reveal nothing as she says *I'm sorry*, brushing my hand with hers before turning back to her notes. Her apology rings like a confession, and it shocks me with its suddenness. I gape at her, crushed with the weight of our latest tie.

We go back to studying and leave only when the sun has disappeared, quietly slipping below the water.

***

Caitlin calls me on the phone and says it's urgent, her voice laced with shame and fuck I've messed up and I'm so sorry. I ask her where she is and she does not answer, the trembling of her lip and the rattling of her heart palpable through the line. I hear the river, drop everything, and run.

***

When I am younger, my mother calls me into our living room, patting the couch cushion next to her. She is wearing a red sweater and blue jeans, her hair done in a loose knot with the hairclip that I used to toy with as a child, clamping the teeth around my fingers and watching them turn white in fear. She asks me to sit and I do, telling her to please make it quick because I have homework to finish and interruptions are not helpful in the slightest. She looks at me with so much pain in her eyes that I find my hand settling on hers, worry lining my voice. *Are you okay, mom?*

No, beta. *Just promise me you will be, okay? Just say you'll be okay.*

My eyebrows crease and she turns her hand to grip mine. I tell her that she's starting to worry me and it is then that she finally says it. The riptide rushes in my ears. I ask her to say it again. And again. I ask her to explain what a noose is.

It has been six years and I still will never forget the way I held her hand, shock and confusion and sadness running through our skin like water in the stream.

***

When it happens to Caitlin, it is her school counselor. He doesn't even call her into the hallway. He marches into her classroom, bends down to her level, and tells her that the police found him in a shed in the woods with rope and a chair. She is left gaping in his wake, a silent scream caught in her throat that she still harbors underneath her chipper grin. She begins to say something when the calculus teacher asks her if she can pull herself together to continue or if there's somewhere else she'd like to be.

She tells me this a few months into our friendship and I'm horrified, the scene overlapping with my memory as if they were meant to go hand in hand. Her blond hair falls in her face and her fingers make elaborate shapes in front of her as she sits in the aftermath, our breaths collecting in a pool. Eventually, our eyes meet, and I can't help but unravel. When I'm finished, Caitlin is crying. The only thing I can do is hold her hand.

***

Caitlin's knuckles are white against mine. Fingers laced, we breathe like it is the last one we will take. It seems like hours pass as we make our way to the stage, the banner boasting "Suicide in Healthcare Conference" in blue and purple letters. The mic is too low for our mouths so we bend, our eyes to the ground because these memories feel private, clutched to our chest and warm between our palms. Caitlin inhales, and looks over at me, blue irises soft and ready. I squeeze her hand. We stand like that for a moment, eyes resting calmly on each other before looking up at the crowd.

For Xavier, she whispers finally, stepping aside. I inhale, and trade places with her, our hands fused together.

For Laine, I say, voice cracking so badly that I am not sure anyone understands the words that come out of my mouth. But Caitlin nods, and we both move to the table and light our candles, hands flying back to each other as we disembark, our seats miles away. There are tears in our eyes, but we don't go under.

We stay afloat.
We pass the river on our walk home, gulls screeching above us as if they too have something important to say.

***

Woodside Cemetery is quiet on weekdays. I go there sometimes, when the wind plays hopscotch in the air and my mother isn't home yet.

***

The waves in the Ohio River are subtle, lazy ripples mixed with sunlight shine. I find Caitlin there, knees hooked over the railing on the bridge. I approach her with fists in my pocket, face ashen. She thanks me for coming so quickly but doesn't move to leave. We sit there together for a while, gulls flying above us.

You miss them? She asks it like a question but it is a statement, one that we have both rolled over our tongues but never had the desire to say out loud. I nod anyway, settling next to her and breathing the salty air, setting my hand on her thigh as it stops jumping up and down. I look up at the buildings, and land on Caitlin's hair, caught between my eyes and the skyline above. I brush it from her face and catch her hand in mine.

Were you going to jump, Caitlin?

She looks at me and my heart tightens because we are both just barely above water, legs beating the current, fighting the riptide with young bodies and grieving hearts. She gives my hand a squeeze.

Not anymore, she says.

Flowers

By Ciprian Buzila

Only When the Time Was Right
By Baani Minhas

It began as a relatively unspectacular day, but a
content end to this first semester.
After lugging haphazardly packed suitcases
from the dormitory and into the back of the car,
we feasted on ceremonious french fries and barbeque
sauce,
the only way we liked them. Fuel for the soul.

Traffic littered the freeway, stop and go
as the holidays lured families back home.
Daily video calls left no room for catching up,
so we flirted with the idea of rearranging
the living room furniture and
trying our hands at that new recipe.

And suddenly, road trip ramblings were over.

I felt the moment fizzle out
when she told me that the doctors had found
something suspicious, a nodule.
And a seed of doubt was planted in my stomach,
much bigger than any nodule, no scans necessary.

Not much to worry about anymore, she said gently.
They had been monitoring it over time.
Odds were that it was no big deal.
And I felt the seed slowly deflate,
but doubt needs no watering.
The questions you ask matter, I found out rather
quickly,
when I asked how long she had known.
A little over 3 months. She hadn't wanted to be a
distraction.

Seed no more, bindweeds erupted from my skin,
taking root under my seat and wrapping around my
body,
strangling me until it was impossible to breathe.
Perhaps that was actually the anger, of knowing
that she didn't put enough salt in last night's
lentil soup,
and that she'd slept in a whopping
extra hour last week.

But not this.

There could have been worse news with more harrowing
endings.
The type where parents tell the kids right
before they figure it out for themselves.
Where the patient doesn't even find
out until it's too late.
When they have no choices to make.

Hypotheticals suddenly hailed on my world, shattering
my foolish assumptions.
Had there been an option, I now know that she
wouldn't have told me — that she did not consider it
my burden to bear.
Not about a minor pain, not a follow-up appointment,
not even a diagnosis.
Not that holiday season, anyway, with so
much on my plate. Certainly not now.
As if crisis would reference my calendar
before striking.

She does not recognize her shields would become a
prison.
To keep me in the dark, she would eventually need
to shove me into a cage fight
cornered against reality
with no time to process
the barrage of sucker punches.
Memories would become corrupted with hindsight,
seeing with double vision as my perception detaches
from the truth.

That conversation in the car freshman year
could have gone a million ways,
been more painful than the frustrating answers to
my what-ifs.
In that paralyzing moment,
all I could do was listen. And watch, as the past unfolded.
Like starlight finally reaching me.

Gross Anatomy
By Adithri Pingali

You don't see them—
The eyes—and, somehow,
That makes it easy.

Better to stare at the pieces
Of preserved flesh,
Devoid of life's signature pinkness,

Without knowing the whole story.

But then,
The white sheet
Is ripped off.

Now,
you see them.

You see

Her.

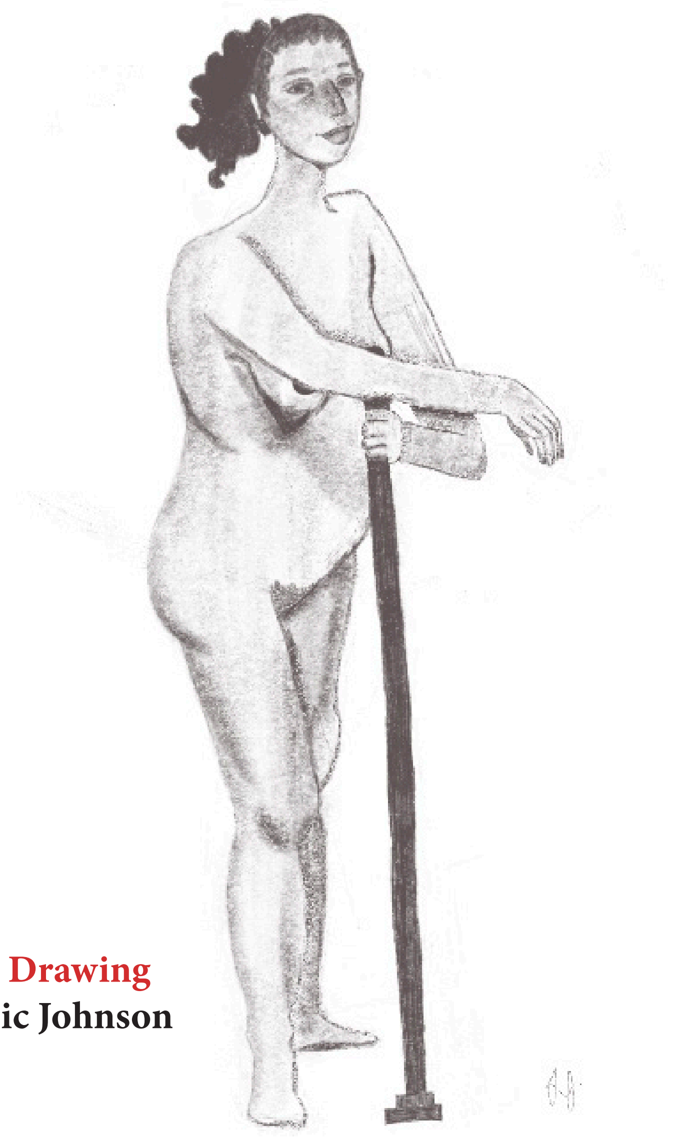


Figure Drawing
By Lyric Johnson

Some Yellow

By Jaehun Seo

I had to clear my nose before I could write this sentence. Even then, it continues sniffling as I write this one, and I'm expecting a sneeze to interrupt the next sentence. The culprit? Well, these sentences were written exactly halfway through April, the midpoint of an otherwise beautiful season.

Every spring without fail, a class of minute particles awaken from their slumber in the dormant trees, grass, and weeds, and crawl out into the warm sun. They jump into the air, playfully riding the winds and small creatures, embarking on an adventure to find the friends they've missed during the winter.

These particles are diverse in character, depending on the plant they call home. Many different ridges, grooves, and bumps decorate their granular surfaces, creating microscopic versions of potatoes, planets, and sea urchins. According to research studies, only 10% of these designs are symmetrical and reproducible using computer simulations[1] .The rest of them are asymmetrical or smooth with no pattern. Each of these particles also has its own unique odor, depending on who they are wooing[2]. But from my experience, they are indistinguishable in taste and all one shade of yellow or another.

Their name comes from the Latin word for "fine flour", but the modern eye would describe them more as "lemon chalkdust." What is their identity? Plant sperm, to be precise. This is the package of DNA produced by the anthers—the male part of the flower—and shipped off to another flower's stigma—the female part. The namesake process is what allows for fertilization and eventually fruit production.

Of course, to a 7-year-old, none of this means anything, and the particles hardly existed in my world at the time. I mean, they were practically invisible, and I was far more preoccupied with Pokémon cards than plant reproduction. This all changed that year when I moved from Ann Arbor, Michigan to Atlanta, Georgia. That first spring in the American South, I noticed a clear distinction from my previous home: the yellow dust was harshly visible. It was shocking to see how pervasive these species were, noticeably covering every surface exposed to the outer world. Parked cars and windshields, asphalt roads, apartment walls, playgrounds—they would all turn completely citrine, as if someone ran an enormous highlighter across the face of this corner of the planet. The only thing that appeared the same as before the impact of the saffron tsunami was the golden school bus.

With this slight environmental change, I suddenly became acutely aware of the particles' existence, but not in the most positive light. I remember going crazy the first Sunday of Georgia spring. I was playing outdoors after church as usual, but that day, they ambushed me. My nostrils were flooded by an unstoppable torrent, and my eyeballs were set ablaze on a fire unquenchable by any amount of rubbing. Alarmed at how red and watery my eyes got, my parents frantically asked around the church cafeteria as to what was happening. Every suburban resident knew exactly what my symptoms meant: I had seasonal allergies.

Gathering as much intel as they could, my parents jotted down some common medicines and rushed to the nearest CVS, bringing back cherry-flavored Claritin dissolving tablets (I couldn't swallow pills at that age) and Opcon-A eye drops. To a family that just moved to the States four years ago, this pharmaceutical jargon was a foreign world in an already foreign language. That day, I learned a new personal meaning of the word "allergy." From then on, it was a constant war—fighting battles against congestion, excessive fluid secretion, and the burning itch, all day and night.

As a kid, I always wondered why I had to suffer so much from this lemon chalkdust that reappeared every spring. Did Adam and Eve quarrel with the same mischievous entities? Why do they exist anyway, if they're such a nuisance to everyone? And then, I watched the cinematic masterpiece that is called Bee Movie. So these particles do have a purpose, a life's mission: to bring back flowers every season and propagate these flower-bearing plants. After learning that, I felt a little better. I wasn't enduring all this torment for nothing, and there was some good that came out of all this. But then, I started to wonder why this burden was unfairly borne by certain individuals and not everyone.

Later in a college course in immunology, I learned about the Hygiene Hypothesis—the theory that individuals with less early exposure to "germs" could lead to the development of Type I hypersensitivities such as allergies due to the imbalance of TH1 and TH2 cells. These T helper (TH) cells are responsible for protecting our body against intracellular and extracellular pathogens, respectively, and without the proper ratios, our immune system may overreact to innocuous foreign materials like plant sperm. I guess this hypothesis makes sense, considering I was an only child growing up in urban or suburban areas with no pets or animal exposure. What I find ironic is that I was born in Jinhae, South Korea on April 4th, right when and where the largest cherry blossom festival in Korea takes place with over 350,000 trees on blooming display. My eyes and nose wouldn't let me attend the festival if I tried to go today.

Sometimes I wonder if the reason boogers can appear yellow is because of these tinted particles. But, the yellow of our dried mucus is much deeper and duller, like decay, compared to the bright color of these particles. It's hard to describe the actual hue Georgia plant dust takes on. Some days it feels greener; other days more orange; but most days, just pure-but-not-average yellow. Retrospectively, I think seeing all that yellow has rubbed off on me because today, I gravitate towards objects of the shade I'm trying to describe. The Hydroflask water bottle I own was labeled "pineapple" when I purchased it. The pair of crocs I wear was called "sulfur" online. Even my Vans hoodie, which doesn't have a named color because I found it in a yard sale, is a pale yellow. None of these words seem right though, and the only way I can capture this hue so real yet so imaginative is in the made-up word, pollen-yellow.

This unique color is produced by flavonoids which are polyphenolic compounds found in many parts of a plant, including the flower and its canary children grains[3]. Their aromatic rings create a potent chromophore capable of absorbing harmful UV-B radiation that could damage the DNA contained in the plant sperm. This version of yellow is a shield. Thus, the few exceptional plants with non-yellow sperm are usually night-flowering plants that rely on nocturnal pollinators, which don't require protection from the daytime sunlight. There is a reason for this bright hue of the enemy, other than the cautionary message it conveys.

Allergies aren't the only disease associated with this color though. Jaundice is the yellowing of one's skin, eyes, and mucous membranes due to the buildup of bilirubin, and it can be caused by hepatitis, Epstein-Barr virus, gallstones, and Yellow Fever. I remember learning about the latter in my 8th grade English class with the book An American Plague: The True and Terrifying Story of the Yellow Fever Epidemic of 1793. According to the book, what the residents of Philadelphia did not know at that time was that the disease was spread by mosquitoes, a creature that first brings to mind its mocking buzz. I imagine the yellow particles engaging in a similar teasing: "Oh silly giant, can't even handle us?"

To be frank, I half-expected my allergies to magically disappear when I came to New England for college. I thought I had successfully escaped the intimidating amber swarm of Georgia flowers when I saw no sign of yellow enveloping everything. But as the weeks passed, I felt the fluids moving, secreting, flowing out of my nose and eyes. My allergies weren't going anywhere.

Today, I still use antihistamines (Zyrtec) and corticosteroids (Flonase). These tiny particles continue to wreak havoc on my physiological balance every spring, even as I write these concluding sentences. I don't think I will ever make peace with them, yet I can acknowledge the ways they influenced me. They have made me rethink my definition of home (where tissues are in safe supply), become ever-so aware of the nanoscopic world (yellow dust can be beautiful under a microscope), and grow my empathetic capacity to care for the sick (no matter how minor my symptoms may be compared to theirs). They remind me that not all interactions with nature are favorable (and with good reason, considering all that humans did to nature), but not all interactions have to be favorable to affect me and shape my identity. Of course, I still wish plants would keep their sex more private, but who knows, maybe it was their destiny to introduce me to pollen-yellow.

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The Patients I See

By Wesley Peng

Note from the artist: This piece portrays individuals the artist has met while volunteering at Phoenix Children's Hospital. He often attempts to lighten patients' moods by painting with them: "I love seeing a kid's face beam up with happiness when they have a paintbrush in their hand. Keeping a little piece of every interaction, I painted their faces to highlight the idea that we become stronger when we are with others".

The Child Protection Center
By Nina Mondero

Content warning: This piece discusses abuse, child abuse, sexual abuse, and sexual abuse of a minor.

Entering the halls of the Child Protection Center was like stepping into a world I had never known existed. A world where the weight of sadness and the urgency of hope intermingled in every patient's story. Despite the warnings of the center's heavy caseload and the emotional toll it could take, I knew I had to be there. Little did I realize, that decision would ignite a passion within me, shaping my aspirations to become a pediatrician dedicated to serving vulnerable populations such as those we help at the Center.

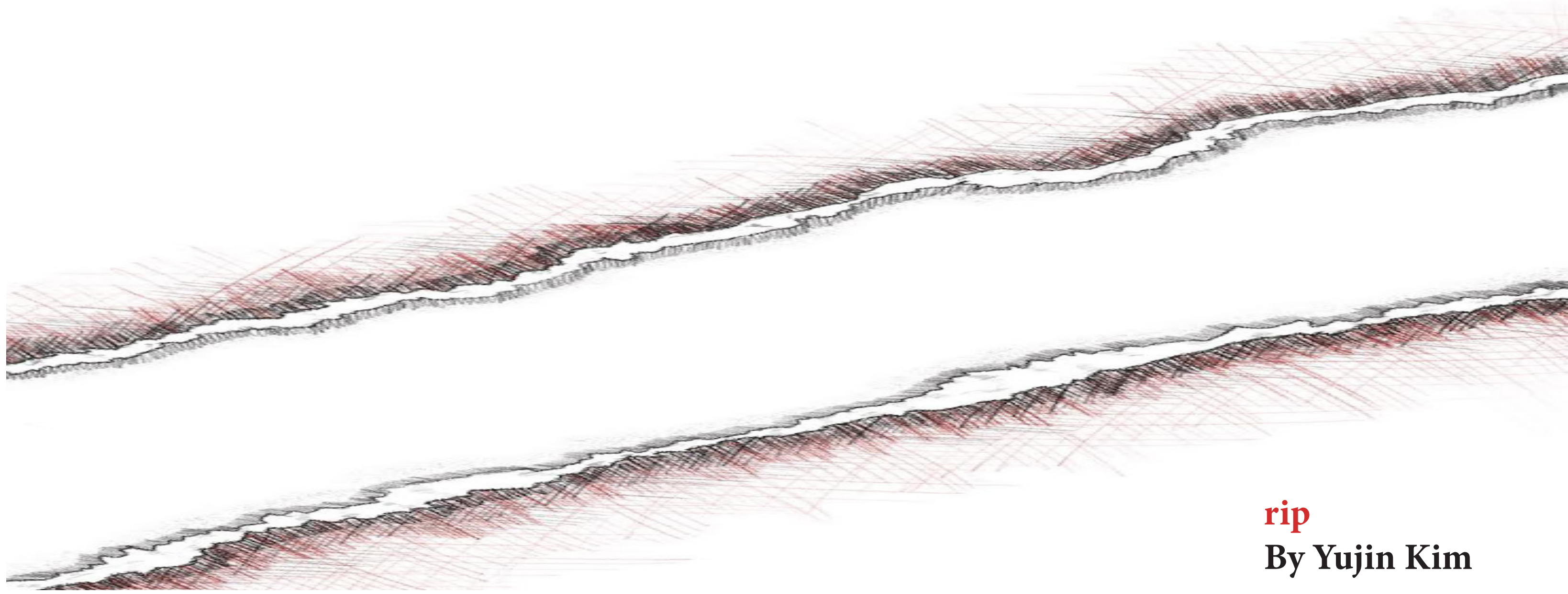
At the Child Protection Center, we work as a team, an assembly line that focuses on one patient at a time to assess, evaluate, treat, and secure a child in their home or caregiving situation. Today a four-year-old, let's call her Lily, has come to the clinic chaperoned by social workers. My job is the first in line: I get to take the children and "warm them up" before they go for their interview and exam. I take Lily into the playroom and ask her what she likes to do. She is very shy at first, not wanting to interact with me. I pull out a dollhouse and a pretend tea set and begin pouring the dolls some "tea" and inviting Lily to join our tea party. Ten minutes later, she is the most talkative little girl I have ever met, chatting about parties, books, dogs, and candy in an adorable baby-New England accent.

When the doctors are ready, they enter the playroom to begin the next phase of the appointment: the interview. One doctor takes Lily into a closed conference room and begins to ask her questions about her life, her parents, and her school. As they go off to the interview room, I go to the "Homeroom" where all the other doctors, social workers, and nurses are watching Lily's interview being streamed on a big television. Simultaneously, another doctor is interviewing the social worker chaperone about Lily in a different room. In this room, I learn the reason why Lily is in today: her guardian has had several abusive partners who have possibly physically and sexually assaulted Lily. She is accompanied by a social worker who is working with the doctors to determine if she needs to be placed in foster care.

As we watch Lily's interview, we all chuckle as she makes adorable, four-year-old responses to questions like, What do you like to learn in school? What is your favorite food to eat for breakfast? How do you like your house? With no additional context, her responses would sound normal for any other toddler. However, everything changed when the doctor's questions got a bit deeper. They asked Lily, Who lives with you in your house? What do these people do in your house? and Have you ever been hurt in your house? With every question, the little ball of energy I was having tea with in the playroom disappeared until her affect was nearly emotionless. Suddenly all of Lily's responses were "I'm done tawking" over and over again. The doctors got what they needed.

The Afterbirth
By Blessed Sheriff

It does not have to be hidden.
Not even when
your hand trembles from some
invisible draft of oxytocin and lidocaine.
Not even when
the mystery of touch compels a curious
fist to seek out its new share of existence at your chest.
Between you and yourself,
another act of God emerges into the light –
and the debt of life collects between your thighs,
handfuls at a time
while all poetry turns away, blushing and burnt in the cheeks
while the room spins on, and coos, and awaits your bloodless
smile
while a body that knows what you do not
about letting go
saves you –
almost unnoticed
except for the testimony of blood,
thick with the memory of creation.



rip
By Yujin Kim

Environmental Health Preparedness
By Anne-Emilie Rouffiac

To the Louisiana State Department of Health, New Orleans Health Department, and all insurance carriers with business in the state:

From jambalaya to beignets, New Orleans is known for its eclectic mix of tastes that enraptures tourists and locals alike. Now, you can top it off with a glass of extra salty water!

Jokes aside, the Orleans Parish has spent the past few months anticipating significant saltwater intrusion into its water supply. There has been too little rainfall to sustain the flow of the Mississippi River, allowing denser saltwater to move inland. Citing WHO guidelines, local authorities affirm that, for the average person, tap water remains safe to drink[1]. Potential risks, however, pushed local authorities to declare a state of emergency[2, 3]. One group is of particular concern; people living with hypertension and/or cardiovascular disease could see their health quickly deteriorate if they drink water with salt levels above 20 ppm[1].

Thankfully, some of these folks already have the necessary support to manage their conditions. Just last year, Tulane researchers received over $7 million in NIH funding to assess the effectiveness of church-based hypertension monitoring programs built by retired nurses and community health workers (CHW). These congregations are primarily African American, underlining how - due to structural inequities - this demographic disproportionately bears the state's significant CVD burden[4]. The grant covers the costs of counseling, medication, and self-measured blood pressure devices (SMBP) to address barriers to care[5]. These resources could not come at a better time as such patients face the looming challenges of saltwater intrusion.

Yet, most people with hypertension are not part of the Tulane study. What do they do? They are told to evaluate the water quality in their homes, and their blood pressure, tune into news alerts, and contact their physicians[1, 6]. But how can they follow these instructions without a sodium hydrometer? What if they cannot afford to stock up on bottled water? What if their physician has no availability until two months from now?

While it is critical for patients to take responsibility and make healthy choices, such individual-level mitigations will not effectively curb the risk of emergency CVD events throughout the saltwater intrusion crisis or any other extreme environmental event. This situation demands a structural plan. Consider the congregations that saw a need for local health outreach, meeting patients where they're at. CHWs are key components of such efforts. Yet, funding their work remains a challenge. A state survey of CHW employers revealed that over two-thirds rely on grants like Tulane's[7]. But, funds dry up and new grants are not always secured, making them unreliable sources of long-term investment in community health.

Instead, if insurers got involved, local hospital systems and agencies could better incorporate CHWs into their care teams. This would reduce costlier episodes of care, particularly during emergencies like saltwater intrusion, which could land at-risk patients in the ER. When leveraged for potential long-term care patients in disadvantaged areas of Arkansas, the use of CHWs was associated with over $2 million in net savings for the state's Medicaid program[8]. There is also evidence that CHW-based interventions are more impactful than changes at the healthcare system level[9]. And, based on the programs' sustainability before the grant, I would not be surprised to see Tulane's research further affirm the benefits of health outreach. I, myself, have met dedicated CHWs who served formerly incarcerated patients and helped them forge new paths; I've also worked with physicians who care about social determinants of health but consistently lack the time to address them. CHWs respond to the system's need for a link between medical treatment and healthy living, all while being more likely to gain patients' trust.

Still, some may view insurers' engagement of CHWs as redundant, considering that Louisiana has already integrated them into Federally Qualified Health Centers (FQHC)[7].Why not just send workers to visit hypertensive patients until the saltwater issue has ended? The reality is that they already have enough on their plate, as highlighted in a report by Louisiana State's Center for Healthcare Value and Equity. Even when they focus primarily on uninsured individuals, they are overexerted and probably underpaid[7]. That's a problem for the federal government (the primary funder of FQHCs).

Regarding regional emergencies, insurers, and Medicaid programs must form their own response networks. It would be most effective to direct CHWs' skills toward specific beneficiaries who become eligible for outreach services during high-risk periods. For instance, when the New Orleans mayor declared a state of emergency, coverage would have kicked in. Healthcare payers must establish a reimbursement/payment scheme for providers and/or health departments that identify at-risk patients and connect them to CHWs.

We should also ponder the importance of care continuity. It would be counter-productive to end CHW financing as soon as a natural disaster ends. Payers can smoothen the transition back to regular care by offering limited outreach coverage for some time after the high-risk period. In this 'buffer zone,' as I'll call it, CHWs can check that the patient's tap water has been deemed safe, for instance, or that they have scheduled a future appointment with their physician.

Incorporating such services into emergency response measures improves our ability to prevent harm. Climate change will increasingly pose health threats to our communities, particularly to individuals with cardiovascular disease. It's time for both public and private payers to tune into what works for such folks. While MDs remain essential, CHWs maximize patient engagement and tackle barriers to healthy living. When deployed for specific objectives and health outcomes, they can decrease the number of care episodes (from physician visits to hospitalizations) and save lives, the after-effect of which involves considerable cost savings. Let's challenge the assumption that emergencies are always life-threatening. By pairing disaster preparedness with public health innovation, we can enhance protection, survive the storms (or salty water), and restore the bustle of our vibrant communities.

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Cartoon Anatomy

By Lyric Johnson

Note from the artist: Lyric Johnson, a visual artist from Gary, Indiana, uses their artwork to explore the awkwardness and discomfort of the human experience. This has transitioned from an exploration of surrealist artwork to captivating depictions of illness through medical illustrations. Through their work, Lyric invites viewers to confront the physically uncomfortable experiences of being human through depictions of illness and creative rendering of eerie perspectives, pushing artistic boundaries and embracing shared humanity.

The Paradox of Emotions in the Emergency Department

By Anisha Baktha

"Patient in Room 5B is in stable condition. She came into the emergency department for injuries she sustained when her ex-boyfriend broke into her house and choked her."

My eyes widened and my mouth opened in awe. How could anyone ever imagine doing that to another person? I looked around me to see if anyone else had a similar reaction. Nothing. The resident giving the briefing on the patient was stone-faced, and he had already moved on to discussing the next patient. The doctor I was shadowing, Dr. Becker, reacted similarly. The clear focus on communicating patient information in a professional and effective manner, rather than allowing personal emotion to seep into the situation, immediately stood out to me. I quickly observed this paradox of emotions: although these doctors have high levels of emotional intelligence when connecting with their patients, they must keep their emotions composed and handle stressful situations calmly to not affect their communication with other physicians or the care they provide.

After getting the patient briefing in the B Pod, I navigated to the critical care unit, which is where I spent most of my shadowing shift. Dr. Becker ushered me into a room where a woman (I'll call her Megan) was getting an ultrasound. The doctors were examining a collapsed lung she had experienced after receiving a lung biopsy, which occurs in about 25% of cases[1]. Unfortunately, her biopsy had also indicated the presence of metastatic colorectal cancer. During the ultrasound, the resident (I'll call him James) attempted to strike up a diverting conversation with the patient, but it was challenging for her to demonstrate any optimism.

"Oh no, how did you end up with a collapsed lung?"
"They screwed it up in the biopsy they took," Megan responded with defeat in her eyes.
"I'm so sorry to hear that."
"And guess what? The biopsy showed that I have metastatic colorectal cancer! Great!"
"Oh wow, I'm so sorry."

An awkward silence ensued before James, persevering in his effort to distract the frustrated patient, asked, "So, what do you like to do in your free time?"

"Not be in the hospital."
"I know, you'll be out soon. I'm sorry. Well, what do you like to do besides that?"
"Travel."
"If you could go anywhere, where would you go?"
"Out of this hospital."
"I know, I'm so sorry again. Where's the last place you traveled to?"
"Jamaica in 2014. Nine years ago. Ever since then, I've been taking care of my mother and my ex-husband. And now, I have this cancer."
"I'm so sorry to hear that, but that's very nice of you to take care of them."
"Well, now look at the karma I have!"

James, recognizing that his patient had no plans to engage in his optimistic conversation, thanked Megan for allowing me in the room while he showed me how to perform an ultrasound.

I felt slightly uncomfortable while this conversation took place, mainly because I felt awful for the patient: how could this happen to such a kind-hearted woman? And, as if getting colorectal cancer after taking care of your family members for nine years wasn't enough, she also had a collapsed lung thanks to her bad news biopsy. Despite this situation, I was very impressed by James' ability to separate himself from these emotions, perform the ultrasound, maintain a calm composure, provide empathetic conversation, and generate a teaching moment for me despite the circumstances. I immediately thought about the conversation between the resident and Dr. Becker earlier in the day – here it was again: the paradox of emotions.

After the ultrasound, I made my way to another critical care room, where an older woman (I'll call her Jane) in her seventies was in severe pain after falling and breaking several of her ribs. The residents and nurses worked together to give her a pain exam, which involved moving her on her side to check her spine. Each time they touched her, Jane screamed in pain, which was quite tough to hear. Despite this, the care team achieved the perfect balance of sensitivity and empathy to her pain, keeping their own emotions in check while successfully carrying out their exam. It's not easy to hear someone screaming in pain, especially when you know you're the one causing the pain, yet at the same time, these individuals seemed to recognize they were simply doing their job: at the end of the day, these steps are necessary to help Jane recover.

Following the pain exam, the surgical resident (I'll call him Matt) approached the patient, saying he was going to ask her a few questions for her chart. He remained calm as he asked her one of the most difficult questions someone in her position could hear.

"If your heart was to stop, would you want us to bring you back to life?"
"What?"
"Again, I'm not saying this is going to happen during your stay in the hospital, but we need to have an answer in case of emergencies. Do you think you would want to be given CPR if your heart were to stop?"

She grappled with the question for a few moments before speaking. "Well…my husband is still alive…and I wouldn't want to leave him…so… hmm…"

Matt talked out these thoughts with Jane, and the conversation began to move in a different direction before he pulled back the reins. "These are all very important considerations, but going back to my original question, do you think you would want us to restart your heart if it stops?"

Jane finally had her answer – "yes" – and Matt documented her wishes in her chart. I was moved by how he was able to look out for her needs and make sure she felt heard, while also ensuring a productive conversation that resulted in a clear answer to his difficult question.

My reflections were interrupted by a call over the loudspeaker: "Trauma code blue! Arriving in 10 minutes! Critical care room #4!"

"You are going to want to see this!" one of the nurses called out to me.

I entered room four, where nurses, residents, attendings, and other ER staff were awaiting the arrival of an 88-year-old man whose heart had stopped after he fell down the stairs.

I stayed in the corner of the room, observing everyone's facial expressions and reactions. This was going to be my first time seeing CPR being performed on a patient, but that wasn't the case for anyone else in the room. One of the nurses looked at me and smiled,

"Sorry to break it to you, but this probably won't be too exciting. The EMTs have been doing CPR for a while with no luck. Because of his age and condition, they will probably call it once he gets here."

I was soothed yet taken aback by her calm demeanor as she spoke such harrowing words. This is someone's dad, husband, brother, friend – how could it be so easy to speak of his death? How was she able to apologize to me for the lack of excitement in the room when a man was about to die? Someone called out "ROSC!" (which I later learned meant "return of spontaneous circulation"). 4 minutes before he had arrived at the hospital, the patient had finally gotten a heartbeat.

I don't know what I expected to see when the patient was wheeled into the room, but for some reason, I associated "gotten a heartbeat" with "back to normal life". This was not the case. His eyes were open but unreactive, his body was stiff, he was cut up from his fall, and it was clear he had a long road to recovery. It was challenging for me to witness, but for the rest of the staff in the room, it was a common sight – they knew they had to go straight to work. Over the next twenty minutes, the patient was intubated, X-rays were taken, a catheter was inserted, medication was provided, and the patient was wheeled to a CT scan.

I returned to the critical care unit, where I was greeted by another patient who had coded. This time, the patient was found in his car on the highway, slumped over his steering wheel with no pulse. The EMTs had no luck resuscitating him, so it was up to the nurses and physicians in the ED to bring him back.

I had already primed myself for this visual because of the earlier patient, so I felt pretty comfortable observing the nurses alternating giving manual CPR, seeing the use of the LUCAS chest compression machine for the first time, and watching the attending physician use the defibrillator. After about twenty minutes, the patient had a stable heartbeat and vitals. I was in awe. In such a high-stress environment, with an unidentified patient on the brink of death, the staff in the ER were able to come together, collaborate, and bring his body back to life.

Smiles, hugs, high-fives, and pride filled the room. For a split second, I wondered what the reactions would have been if the patient had never gotten a heartbeat, but I tried not to think about this too much and instead focused on the positives. Maybe I was starting to understand the balance of emotions that I had been seeing the nurses, residents, and physicians maintain all day, I thought.

My newfound sense of emotional balance didn't last long. A screaming 28-year-old (I'll call her Mia) with a head wound and a history of bipolar disorder was wheeled into the empty room that was once occupied by the 88-year-old man who had fallen down the stairs. The ER is really just a cycle of pain, I thought before I tuned back into her screams.

"I NEED TO GO TO THE BATHROOM! LET ME GO!"

"I DON'T WANT A BEDPAN. YOU'RE GOING TO MAKE ME HUMILIATE MYSELF IN FRONT OF ALL THESE PEOPLE IF YOU DON'T LET ME GO PEE," she sobbed, "YOU DOCTORS ARE EVIL."

Mia tried to fight back, and she was restrained. It was already painful to watch, but my heart dropped even more when she began screaming about her son.

"I'm sorry!!! I'm sorry!!! I just want my son back!!! And YOU EVIL DOCTORS WON'T EVEN LET ME USE THE BATHROOM!"

Through sobs, she managed to explain that her son had been taken away from her by the Department of Children, Youth, and their Families (DCYF), and all she wanted was to get him back. The residents were compassionate and understanding of her situation, but firm in their stance that she could not get up to use the restroom. When she fought back, they tightened her restraints and gave her some medicine to calm her down. I'm sure they felt bad, but again, here was another situation where the emotions needed to be put to the side and the job had to be done.

I found the whole situation overwhelming to watch, so I excused myself and spent the last thirty minutes of my shadowing shift back in the B pod, shadowing Dr. Becker in a much calmer environment.

These reflections directly relate to a concept discussed extensively in the medical community: physician burnout. According to a 2023 report by Medscape[2], emergency medicine physicians had the highest rates of burnout at 65%. This rate was likely exacerbated by the COVID-19 pandemic, during which a large portion of the burden on hospitals fell onto the shoulders of physicians in the emergency department.

This relationship was examined in a study by Michael Mong and Kenji Noguchi, where ER physicians reported high levels of burnout despite no clinical symptoms of anxiety and depression. Further, they found that ER physicians who exhibited higher levels of coping skills were associated with lower levels of psychological distress, while those with "maladaptive coping strategies such as self-blame, denial, disengagement, venting, and substance abuse, were related to lower overall mental health" [3].

Clearly, the paradox of emotion can only go so far. Yes, being able to separate your true emotions from the way you practice as a physician is important to ensure you are providing the most effective, objective care. But at the same time, it is also important to recognize your limits and take the time to comprehend and express your emotions, rather than ignore them.

As I look to the future, I see myself working in a fast-paced environment similar to the emergency department. I appreciate the notion of caring for all patients who come in, no matter their situation, and I want to incorporate these ideals into my profession. That being said, I also recognize the importance of taking care of oneself: the emergency department is a stressful place, and it's pivotal to maintain a strong personal balance amidst the paradox of emotions.

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Vanity

By Natasha Khalid, MD

During my internal medicine residency, I rotated through various subspecialties, but the one that left me with the most thought-provoking perspectives at the end of the day was dermatology. I was very excited to work in derma and learn how to treat basic clinical conditions like acne, hair fall, and dermatitis. However, my daily clinics opened my eyes to a new plethora of issues that I was oblivious to.

1.

I see a five-year-old girl losing her forehead hair and developing skin scars. As we try to dig deeply into the trigger, we discover that she has moved away from her family and into a nuclear space. She has lost friends and a deep connection that she shared with her grandma. The girl had been grumpy and now experiences extensive hair loss for which she needs topical immunosuppressants.

From this experience, I learned that depression is a serious disease and can manifest differently in children than it does in adults. Here, it triggered the alopecia areata and caused the hair loss that was seen. One needs to be exceptionally good at communicating and taking notes to read the subtle clues. Although we might be able to solve her hair condition temporarily, she will continue to show up with other problems until her underlying issue is addressed.

2.

A teenager walks in with a painful skin lesion covering her eye. What at first glance appears to be an acid burn victim, turns out to be a beauty hack gone wrong. The girl injected herself with vitamin C at home, thinking this would make her skin fair.

Let this be a warning to everyone who mindlessly follows beauty hacks: Use caution and consult with a doctor first before experimenting. Before this case, I never considered how dangerous misinformation could be and how it could be detrimental to one's health.

3.

I encountered another case in which a girl of a darker complexion desired a lighter complexion. She can't decipher what we're explaining. She is tired, struggling to get married, and living in a failed shell just because she does not meet the definition of beauty in Southeast Asian culture. She is willing to go to the extreme to change the color of her skin; to get expensive glutathione intravenous injections in high doses despite data showing risk of liver damage; to apply a cream that contains steroids and agents with known dangerous implications.

Our society has concrete ideas about what the definition of beauty and success is. This girl failed to see her achievements of being a successful, inspiring teacher and longs for a change in skin color, as many people have rejected her as a suitor for marriage. Her family keeps dropping subtle hints on how to improve her skin color. Yet, our features are inherited and there's not much we can do to change them, especially safely.

4.

A young guy walks into the clinic with severe acne, and when questioned about the cause, he talks about getting a facial at a local salon before his brother's wedding. While this is a treatable condition, it is also a learning lesson to be aware of the places you go to when concerning your skin. It's likely that the things used were not sanitized, leading to the acne.

This persistent pursuit of perfection is something I observe every day as I treat patients. The need for fair skin, flawless skin, more hair, more volume, more texture, goes on forever! I couldn't help but realize our dissatisfaction with our current condition. Our skin tone is genetically determined and uncontrollable by us. We don't have bald spots and fine hair; we just want to look like the celebrities we admire.

Our perceptions of life in lower-middle-income nations are mobilized, transformed, and challenged by the experiences of our patients. These stories make us aware of the common complexes people possess, how they affect their behavior, and how they contribute to illness. These stories have given me a better understanding of how individuals view beauty and are persuaded to go above and beyond to achieve the pinnacle of perfection.

Exploring Conventional Medicine's Approach to Chronic Digestive Illnesses

By Anisha Baktha

Alyssa sits in her pediatrician's office impatiently awaiting her test results. For the last few months, she has been experiencing symptoms of fatigue, lethargy, and poor digestion, which have prevented her from going to school, hanging out with her friends, and engaging in her normal daily activities. But no test comes back conclusive. Instead, she's given a firm diet plan that cuts out many of her favorite foods – too strict for a ten-year-old who can't fathom the idea of not enjoying pizza and cake at the long list of birthday parties she is scheduled to attend. All Alyssa wants is to go home, eat until her heart is content, and feel better.

Unfortunately, this never exactly happens for her. During an interview I conducted with the now 21-year-old Alyssa, she shared that she never received a conclusive diagnosis or an effective treatment plan that helped to alleviate her chronic digestive illness. These dead ends with the conventional medical system eventually led Alyssa to a place where she felt frustrated, alone, and desperate for any answers that could help her cope with her illness and allow her to lead a healthy, functional life. Alyssa isn't alone, as at least twenty million individuals in the United States experience these issues daily. Alyssa's story, similar to that of other chronic illness patients, demonstrates how medical treatment that focuses on fixing one's illness rather than caring for the whole person leads to patients with chronic issues taking on the burden of their illness, forcing them to take sole charge of their own healing processes. Conventional medicine's response to chronic digestive illnesses needs to become a more collaborative, holistic process that focuses on caring for, not just fixing, the whole person.

However, before analyzing the potential solutions to such a thorough, multidimensional issue, it is important to first understand the context of the problem that exists between the conventional medical system and patients with chronic digestive illnesses. This context is clearly demonstrated in Alyssa's experiences with conventional medicine, which mainly include her interactions with her pediatrician and the gastrointestinal specialist.

Prior to her chronic digestive illness, Alyssa and her family had a deep-rooted trust and comfort associated with conventional medicine. According to Alyssa, this trust was developed through positive interactions and relationships with her physicians. During her interview, Alyssa shared that her pediatrician was always "warm, insightful, and easy to talk to", while her GI specialist "came with professional energy and seemed like she had a lot of experience, which made [Alyssa] feel very safe". The presentation of this type of physician demeanor is developed during the ritualized procedures of medical training, especially as younger medical interns learn from the traditions and qualities that are maintained by the experienced medical professionals above them. This phenomenon is known as embodied learning, and it can lead to the routine development of rituals and skills that are key to gaining patient trust and establishing authority, as they did in the case of Alyssa and her family[1]. For Alyssa, the consequence of this innate trust in the conventional medical system was that she and her family were more willing to go through the extensive cycle of tests and physician visits without any questioning, as they sincerely trusted that Alyssa's physicians would eventually figure out what was wrong and find a cure for her suffering.

Unfortunately, the core emphasis of conventional medicine on "fixing" Alyssa's illness led to a constant, never-ending cycle of tests, unclear diagnoses, and vague treatment plans. In her interview, Alyssa described her interactions with her GI specialist as solely focused on what tests to run or what medications to prescribe: in her words, "every test was looking for an illness that they could then prescribe medication for." This pattern of medical care and treatment is associated with the idea of the medical gaze, a perspective that leads many physicians to "see patients not as whole persons, but as medical objects"[2]. Within this perspective, physicians tend to separate the patient's biological systems and disease processes from the patient's identity and personal nature. This view, known as biological reductionism, contributes to the tendency of physicians to consider the biological explanation as the most valid explanation behind a patient's disease, therefore making them less likely to seek out the possible social or psychological explanations for disease associated with the patient[3].

A more holistic model of care that incorporates these external factors with the relevant biological factors in the context of a patient's disease is known as the biopsychosocial approach. This approach specifically integrates aspects such as the patient's internal biological processes, individual behaviors, and social and cultural environments to better understand the patient as a whole and treat them in the context of their independent circumstances3. Specifically, a study found that in the context of gastrointestinal disorders, often coexisting with psychological and affective disorders, it is important for physicians not only to address the disease-related factors in the patient, but also the relevant therapeutic-related factors, such as the patient's accessibility to treatment, the individual factors, such as the patient's confidence in medicine, and the psychopathological factors, such as the patient's experience with affective disorders like anxiety and depression4.

Alyssa's overall experience with the conventional medical system left her with no concrete answers. She had no diagnoses, besides vague "irritable bowel syndrome" and "chronic digestive illness" labels, and no evidence-based treatment or cure. Most significantly, she was still dealing with the same, if not more severe, digestive ailments that brought her to the physician in the first place. The conventional system was so focused on finding the perfect "fix" for Alyssa's condition, that when it failed to find it, Alyssa was left alone with no solution for her suffering, no direction forward, and the full burden of illness on her shoulders.

During her freshman year of college, Alyssa was especially desperate for help, as she was experiencing severe anxiety and flare-ups of her chronic digestive illness in a new environment away from her usual support system. At this point in her life, she also expressed frustration that no solution proposed to her by conventional medicine had helped at all. Alyssa truly felt that her only option was to take responsibility for her health and independently explore other sources of support and care.
In a desperate attempt to find some answers and alleviate the severe discomfort and helplessness she was experiencing, Alyssa decided to explore forms of alternative medicine. She quickly realized that although many of these non-conventional methods were accepted in other countries, they were often looked down upon within the United States healthcare system. Consequently, she was left with essentially no structured guidance or support from her community or the conventional medical system as she navigated the vast, wide-ranging field of medical therapies known as alternative medicine.

Despite these challenges, Alyssa found success in alternative medicinal methods when she tried a gut reset diet plan created by an online blogger with severe IBS. Although this plan was not created as a sustainable way to eat in the long run, Alyssa said it "definitely reset her gut and cleansed it" and she "felt better than she had in many years" after completing it. She also reflected on how this experience gave her more confidence in her ability to cope with her chronic illness. Today, Alyssa follows a thorough, intentional daily routine that focuses on enhancing her mental, emotional, digestive, and physical well-being. She has curated each aspect of this routine– which includes tongue scraping, oil pulling, meditating, exercising, cooking, and journaling– to improve digestion, relieve stress, and overall minimize associated pain and problems.

In general, Alyssa still deals with effects associated with her chronic digestive illness, but says these alternative strategies have led to noticeable differences and better results than "any sort of traditional medical advice she has ever followed." However, despite this relative success, Alyssa continuously expressed that dealing with this illness entirely on her own is extremely overwhelming and stressful, especially on days when her illness flares up and she doesn't have anyone to turn to for objective and effective help. Research has identified a relationship between these feelings of anxiety and increased severity of digestive illnesses and symptoms[5], so it is possible that Alyssa's experience carrying the burden of disease resulted in a more negative presentation of her chronic digestive illness.

Just as important as it is to listen to individuals and empathize with their stories, it is also important to pave the way forward, elicit positive change, and ensure that future chronic illness patients have improved illness experiences. Given Alyssa's story, as well as other stories of patients with chronic illnesses, I propose a solution: an interdisciplinary approach to treatment that emphasizes physician communication and holistic care.

Research has demonstrated that timely, effective collaboration between primary care physicians and specialists is associated with better outcomes for patients experiencing chronic diseases such as dementia, liver disease, and kidney disease[6]. In Alyssa's case, better communication between her pediatrician and GI specialist would have enabled discussion regarding the connection between Alyssa's anxiety and digestive issues. Alyssa's pediatrician was aware of her extensive history of mental illness, but her GI specialist was either unaware or chose not to integrate this history during her encounters with Alyssa. However, if the relationship between Alyssa's affective disorders and digestive issues had been jointly discussed by her physicians, this could have been identified as a potential causal mechanism leading to stronger diagnoses, more effective care, and better-tailored treatment earlier in Alyssa's life.

Moving forward, studies have suggested that telemedicine is a highly plausible approach to improve inter-physician communication. Recently, a study reported that the telehealth model implemented during the COVID-19 pandemic was widely accepted and had high satisfaction rates among gastrointestinal specialists and patients[7]. Innovative technology that allows for improved, real-time collaboration between providers should be explored as an achievable way to enhance communication between medical professionals and their patients.

In addition to improving physician communication, a holistic approach to Alyssa's chronic digestive issues that emphasized caring for Alyssa as a whole person could have also reduced her burden of disease. Alyssa expressed that she would have appreciated her physicians walking her through self-care and self-management strategies, rather than running endless tests and prescribing medications to try and fix her condition. If Alyssa had this holistic support, she would not have felt as isolated in her recovery process, which would have reduced her feelings of helplessness and uncertainty.

Previous research demonstrates the feasibility and effectiveness of this holistic approach, especially in countries outside of the United States. For example, models like the German healthcare system that integrate a variety of therapeutic approaches that are "patient-centered, intensive, and holistic" are shown to be efficacious in relieving symptoms and improving outcomes in patients with digestive ailments[6]. If the U.S. healthcare system could be modified to incorporate comprehensive care models, such as the biopsychosocial model or the Chronic Care Model[6] , patients with chronic illness could experience symptom alleviation and improved well-being much earlier in their illness experiences.

Unfortunately, many of the rituals associated with the training of medical professionals produce physicians who are less likely to practice in a holistic manner that cares for the whole person. Instead, interns quickly develop a mindset of "fixing" their patients, especially in the context of a fast-paced training environment that commands efficiency and criticizes inaccuracy. Interns closely observe and embody the practices of their attendings and "learn to focus their medical gaze on what medicine values"[1]. As they gain more experience with patient interaction, they learn to hone in on the key details of patient stories that provide insight into the chief complaint, past medical history, and current symptoms, while disregarding many of the seemingly unrelated but often important elements[8]. This patient information is then presented as a case to attendings and contributes to the intern learning to "construct patients into objects of analysis and diagnosis"[1].

To positively alter the outcomes for chronic illness patients, these training processes need to be modified. Currently, social and behavioral topics are sparsely integrated into medical school curriculums before they are suppressed in clerkship and residency training where efficiency is prioritized and integrated into the development of the medical self [8]. In addition, Rita Charon, a Professor of Clinical Medicine at Columbia University, suggests a medical training system that incorporates "rigorous and disciplined training in reading and writing for the sake of their practice"[9]. She discusses how many of the most difficult tasks healthcare workers face, such as listening attentively, critically analyzing texts, embracing new perspectives, accepting uncertainty, and maintaining curiosity, are associated with qualities of a strong reader and writer. In general, medical training should exemplify a comprehensive, integrated, and holistic process because, as quoted by Ecks, "as long as biomedicine splits mental, physical, and social health apart, whole health will remain elusive"[10].

Alyssa's story illustrates the clear hole in care that exists in the approach the conventional medical system provides to chronically ill patients. As discussed in the research article by Thomas, "chronic digestive diseases are causing increased burden to patients and are increasing the United States healthcare spending," so providing resources to help create a stronger support structure of care to these patients will have significantly positive effects in the long run. To accomplish these goals, conventional medicine's response to chronic digestive illnesses needs to become a more collaborative, flexible process that focuses on caring for the person as whole, not just trying to fix the illness presented.

Special thanks to Alyssa, for allowing me to use her name and share her story.

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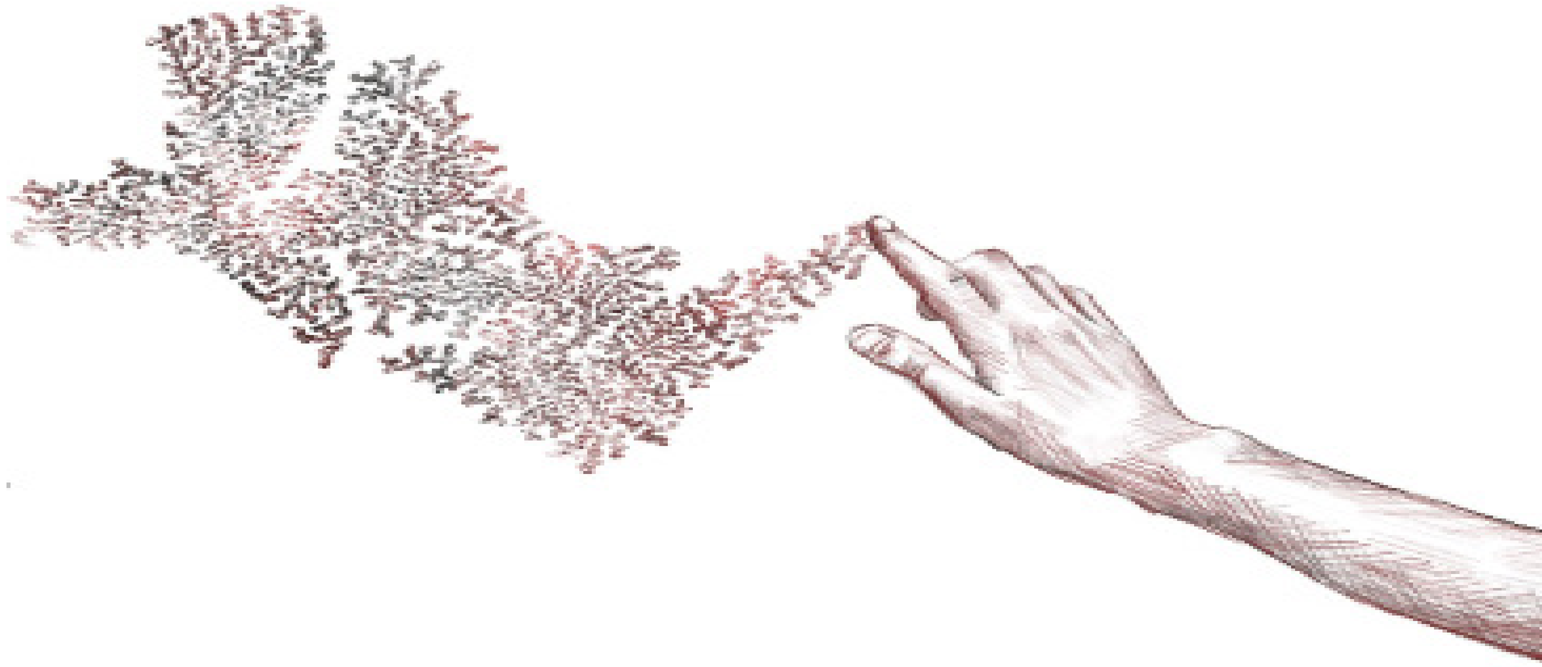
creation

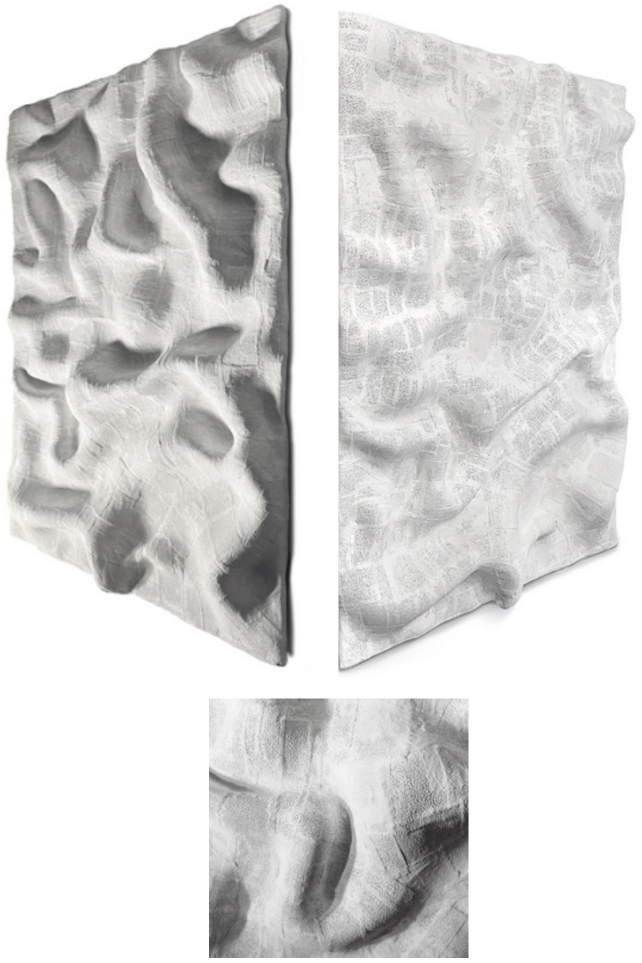
By Yujin Kim



By Kiley Haberkorn

Note from artist: After episodes of uncontrollable psychosis, a cyst was discovered in the center of my brain. The work I made before the cyst formed and the works I make now are very different. Before, there was a lack of focus. Now, I make work that is aware of the brain's functioning, from both artist and viewer perspectives.

My recent abstract expressionist sculptures are sculpted reflections. My interest in Art History, coupled with a deep interest in Science as a patient, a researcher of visual learning and visual representation, an emergency medical technician, and a suicide hotline responder, help me investigate how certain states of the body and mind can impact inner and existential well-being. Size, elevation, repetition, light, and shadow encourage participants to transcend into a meditative and contemplative space. Each sculpture is designed to provoke introspection, emotive responses, and offer a more restorative interpretation of both Surrealist and Minimalist aesthetics; Minimalism and Surrealism are two contrasting artistic movements, as Minimalism emphasizes reduction to the essential elements, while Surrealism explores the irrational subconscious through dreamlike imagery.

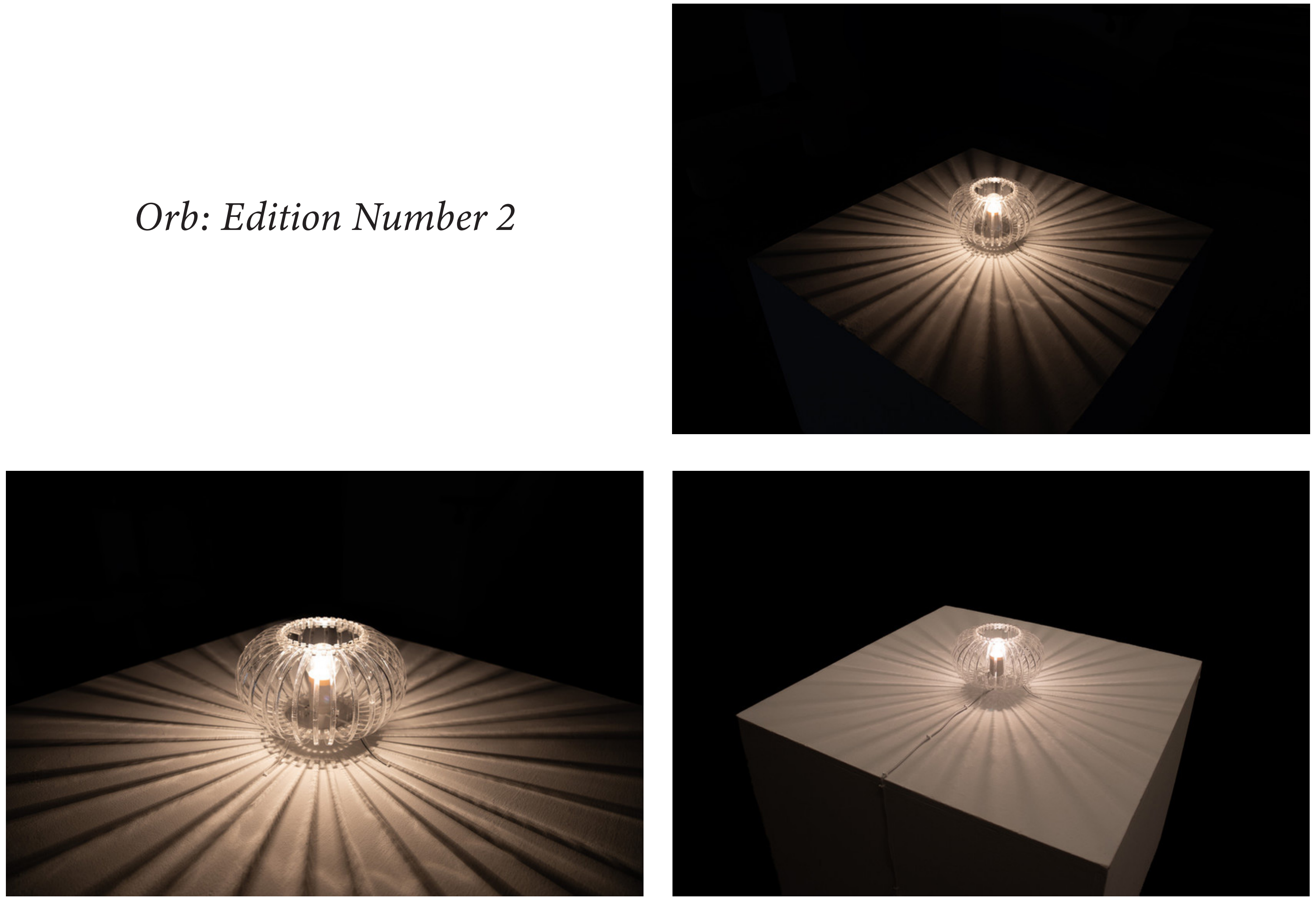


Elevation

Campana Brothers Inspired Chair

Her first solo exhibition, "Spiritual Resonance Sculpture Garden," will debut in Providence, Rhode Island's List Art Center in the spring of 2024.

Orb: Edition Number 2



Subtle

Sunday Rx

By Carol Zapata-Whelan, PhD

An incandescent fall morning in the Valley, Sunday after Mass, I was pulling into a shopping center in our BraunAbility Ford Explorer, a sporty gray SUV with a wheelchair ramp. From his power chair on the passenger side, my son Vincent asked me to duck into the pharmacy for a prescription of his.

Before going on, I should explain that my son Vincent has a rare genetic disorder, FOP: Fibrodysplasia Ossificans Progressiva. FOP is so rare it hits one in two million, turns muscle to bone, and can be triggered by trauma as mild as a bump or an injection. Its often overlooked defining feature is a large toe missing a joint. FOP usually rears in childhood and it can cause permanent loss of mobility over time or overnight.

There is no prescription that can be faxed to a pharmacy to fully treat or cure FOP. Not yet.

Vincent, 6'1", dark-haired, brown eyes full of light, now in his thirties, was born with no apparent anomalies. For him at age eight, FOP's first symptom was a limp. Through most of my son's schooling, FOP remained "mild" enough for him to excel, graduate from a UC medical school, train at our children's hospital, and sign on for a pediatric oncology fellowship. But FOP caused catastrophic loss of mobility after he slipped on steps one rainy day in LA., derailing his work with very ill children—and his dreams to help cure them.

I found myself angry at God in those post-fall days of FOP's unrelenting attacks, mystified that God would have allowed my son's life to be upended when he was on his way to save children's lives. (And I remain mystified.) But I eventually understood that I would have to do my best to learn from my son's way of processing upheaval. After retreating and regrouping, he healed, body and soul, in increments, collecting adaptive tools for daily life tasks, easing loss of ability with technology, directing my husband, his father, Walt, and his siblings in the installation of new superpowers. When that catastrophic fall ultimately left my son unable to work in children's hospitals—where he loved to usher in superheroes like Iron Man—he pivoted to pediatrics via Telemedicine from a power chair, upgrading his office with voice-command lights in cartoon colors.

My son's orthopedist—Dr. Fred Kaplan of the University of Pennsylvania, honored in Newsweek—long ago adopted our former "orphan disease." He has led stellar, devoted colleagues in his international research consortium to discover the FOP gene and set up clinical trials in which Vincent takes part, work fueled by FOP family fundraisers. And hope.

With all of the above in my cell and soul memory that translucent Sunday my son needed a random prescription filled, I walked into the supermarket to wait my turn at our pharmacy. Standing idle, in a slow line, I began to imagine the day when I could sashay up to the plexiglass window at the counter with the prescription for a cure for FOP.

But then this—unrelated—thing happened: yanking me back to the reality of a long wait was the angry voice of a brown-haired little boy—three or four years old—in a shopping cart seat, ahead of me in line.

He was shouting an unintelligible refrain punctuated by the word "NO!" while a woman in a rumpled shift and brown messy bun—his mother, I figured—seemed too absorbed by something unseen to address his tantrum.

Before too long, an older woman—the grandmother I decided—wheeled over a baby in a stroller. Wordlessly, she wedged a pack of Pampers into the cart of the shouting boy and rolled away with the baby toward the cereal aisle. The little boy kept shouting.

This all brought up recall of my long-ago pharmacy runs with combinations of my own five kids in sibling rivalry meltdowns, one or another of us belly-flopping on the linoleum. Like the woman with the noisy boy, I did my best back then to act as if we were invisible in public.

"I know why that boy was so angry," I said to the pharmacist when it was finally my turn at the window.

"His life is upended by a new baby." She smiled, nodded knowingly, and went off for the prescription.

Before the pharmacist returned, I saw behind me a display of Hot Wheels superhero cars in reds, greens, blues, on sale. And I could still hear the little boy's angry refrain from across the market. So I decided then and there to buy him a small Hot Wheels, just so he, his mother, grandmother, baby brother— and every soul in the market—could shop in peace.

I found the family in the produce section. The boy's cart was parked near the baby stroller and he was yelling over piles of potatoes in woven sacks.

"New baby?" I asked the family, nodding to the stroller's recesses.

The little boy fixed pale blue eyes on me, bared his teeth, and snarled.

"Six months old," said the grandmother, looking to the sleeping infant. She wore black horn-rimmed glasses and, like her daughter and grandson, was brown-haired, pale, dressed in weekend errand clothes.

Aware that my son was waiting in the car, short on time, I announced— maybe too abruptly: "I thought he might like one." I fished the Hot Wheels from my white pharmacy bag and held it up: a tiny blue Bat Mobile in clear plastic.

The little boy—instantly quiet, beatific—regarded the Hot Wheels car like it was Christmas.

Mission accomplished. In reflex, I handed over the toy.

Mother and grandmother looked at me blankly.

"I remember what it was like for my kids with a new baby at home." I was speaking in a rush, suddenly nervous. "They went crazy!"

The women continued to stare at me.

What if the baby or the boy, or any of them, for that matter, were not related?

The women's stares morphed into frank suspicion. Maybe they didn't care for my use of the word "crazy" in—indirect—reference to their child. I saw them taking in my striped gray Anthropologie jacket and dress pants. The outfit probably made me look as if I were about to ask everyone to sign a political initiative or help me sell Bibles or donate to a charity—and the toy was a hook.

The boy was happy. The women were not.

I could only repeat what I had said, appealing to the grandmother's unblinking eyes behind her horn-rimmed glasses.

I fled the (very quiet) produce section.

Nobody said, "Thank the nice lady."

What had I done, exactly?

I wasn't sure.

Maybe the women saw my gift as an indictment of their childrearing practices. Maybe it was. But who was I to impose a solution?

It wasn't until I sat down to write this account that I asked myself: How could those two women—whoever they were, whatever their roles or relation—have known that maybe I was just trying to make up for my own pharmacy meltdowns back in the day? All those times I couldn't manage upheavals because the filled prescription I needed for my child with the rare disorder was nowhere on those infinitely stocked shelves.

That translucent Sunday after church in a supermarket pharmacy, while my superhero son with a rare disorder waited in his power chair for a prescription, was a day on which I, myself, could not have been expected to know that I was just trying to ease the past, trying to keep the peace, and trying to find the line for the right Rx.

For information on Fibrodysplasia Ossificans Progressiva (FOP): www.ifopa.org

Pandemic Intern

By Ria Mulherkar, MD

Sometimes, there's no time
to feel.

Fishbone labs, diet orders,
pager beeps with a high blood pressure.
Pre-rounds, actual rounds, pager beeps again.
This time, it's a low blood pressure.

Rapid response turns into
a full-blown code blue. Chest compressions.
I find myself hauling coolers of blood
from the blood bank.
We manage to save him.
For now.

I call his wife.
She's not allowed in the hospital,
but we will allow her in today.
I have to write three separate
notes about the incident.
None of them describe how my patient's wife
wailed in my ear on the phone.

I eat lunch in front of my computer.
Click through orders and discharge summaries,
ask questions to busy consultants.
I call and update other patients' family members.
They are also not allowed
to see their loved ones in the hospital.
It's my long day, but I am lucky
to sign out on time.

That night, I watch TV
over a bowl of leftover takeout.
My mind is slow and numb.
A sappy commercial about dog food
makes me cry.

For the first time, I have time
to feel.

Stormy Sunlight
By Teresa Xu

It's happening again.
The first time, I was a whirl of color
and confusion.
Collapse.
Nausea—
sudden, perplexing pain.
Sourceless burning.
A tsunami volcano about to explode.
Clinging to a cracking cobblestone building,
fingers blistering, splintering
as the wind whipped me fearlessly, mercilessly.
And after the wind, rain—
a torrential downpour.
Sleet-snow, blizzard-blow.
How I slipped,
skidded,
stumbled.
I fell into a hole,
face caked with mud,
and found no way out.
Drowning in a deluge,
gasping for breath.
Dark and gray all day.
But even then, somehow—
an eternity later—
the clouds passed.
This, too, shall pass.

Now, like then,
it's an earthquake.
The walls are tumbling down,
sand stuck in my shoes.
My toes protest, shrivel.
Every step is agony.
I can't breathe.
I can't see.
Yet I want—
Something…
Something that can save me.
A lifeboat.
A flashlight.
I need to wade back to shore
and eat more fruits and vegetables.
I need to detoxify my soul,
aloe vera and cucumber eyes
and massages without pain.

It rains harder.
Sleet, vaguely navy
—but I can hardly see.
My eyes drown.
The rain rages.
Too-fast pitter-patter.
There's no light.
But now I know:
like all things,
this too shall pass.

It's the burning of my weak knees
after kneeling for a group photo
far too long.
Blinding pain in the moment,
in the many minutes that add up
to an eternity.
Numbness,
a wax jar.
My body ceases to exist
and exists far too much,
all at once.
But—
Eventually—
my legs can
unfold and stand,
joints cracking in protest, but giving way.
It still burns,
even when I try to walk.
I hobble.
I groan.
I ache.
But more minutes pass by.
Another eternity elapses,
and the burn weakens.
Burning heat becomes
warmth becomes
nothing.
My legs slowly regain feeling.
Eventually,
they can move
and function normally.
Me, too.

The storm clouds pass,
like they were never there.
It's overcast now.
Not perfect,
not a bright blue-gold day
of crisp autumn breeze,
not a rosy, radiant sunrise
gleaming of hope,
but the wind has abated
and I can walk forward again.
To the next street, just a block away.
The next step, just seconds away.
Still jarred, but moving.
Alive.

It's better, now.
Now, I know the storm is temporary.
So, this too passed.
And this too shall pass.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