The Medical Humanities Journal of Boston College seeks to:

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

We all enter university eager to become specialists in our own fields of interest, be it chemistry, economics, nursing, or art history. We are often driven by our passions, which prompt us to take separate paths towards the attainment of our goals. In light of our individualized engagements, we tend to forget what keeps us interconnected; one of our shared experiences is that of health and illness.

The Medical Humanities Journal of Boston College seeks to bring all of our experiences to light in an effort to communicate the breadth of the medical humanities. Through pieces like Calin MacQuarrie’s op-ed on the expansion of the Victim Compensation Fund for 9/11 victims, Ivelisse Mandato’s reflection on the stigma against physical illness, and Matthew Davis’s comparison of the healthcare systems in Ireland and Scotland, we hope that our journal helps readers see that despite our differences, we are connected through our losses, our desire to be loved and supported, our internal struggles, and our celebrations of life.

While health is a topic that is pertinent to all of us, it is highly individualized. Health is on a continuum, characterized by personal progresses and setbacks. We seek to expand the definition of health to include physical, mental, emotional, spiritual, and social wellbeing. Healing for some might represent a cure. Healing for others might mean eternal peace. Different outcomes generate different responses in individuals and in their loved ones.

Spring of 2019 was distressing, complex, and difficult for our student body. Being faced with the passing of our peer Patrick Gregorek has prompted grief, puzzlement, and heartache across campus. Some of us knew him personally as a close friend, a roommate, a group member, and a classmate. All of us know him as a peer at Boston College.

Coping can be an especially difficult process to undergo alone. For this issue, we have collectively decided to dedicate our publication to Patrick, and to encourage members of our community to address the topics of death, dying, loss, and grief. We hope that these pages serve as an outlet for our emotions, and work to make this experience less isolating. Our journal has always aimed to foster an open space for interdisciplinary conversations. Loss is often devastating. The more we talk and the more we reflect, we begin to make sense of events in our lives that are difficult to come to terms with. Through the touching words of Patrick’s friends and through words about loss from BC professors, the themes of love, support, and togetherness unfailingly emerge. This publication has reinforced our belief in the healing powers of expression.

We extend our deepest gratitude to the talented authors and artists who contributed to our journal. Thank you to members of our board for pouring their hearts into compiling a moving publication. Thank you to our readers for participating in these conversations, and for helping us sustain our overarching goals. MHJBC is committed to giving others a voice, and aims to remove stigma that exists around certain topics. All in all, we hope that this journal does justice to our efforts of delivering feelings of comfort, strength, care, and love.

Aleksa Qilleri and Heena Nissaraly
Co-Editors-in-Chief
<table>
<thead>
<tr>
<th>Title</th>
<th>Author</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Love Blurs Borders</td>
<td>Kathryn Giordano</td>
<td>6</td>
</tr>
<tr>
<td>Lost in the White Dust: Forgetting 9/11 Too Soon</td>
<td>Cailin MacQuarrie</td>
<td>9</td>
</tr>
<tr>
<td>Damon Tweedy</td>
<td>Cailin MacQuarrie</td>
<td>11</td>
</tr>
<tr>
<td>HIV/AIDS Piece</td>
<td>Derek Xu</td>
<td>13</td>
</tr>
<tr>
<td>Jan. 13th, 1990</td>
<td>Jenna Santos</td>
<td>16</td>
</tr>
<tr>
<td>Fearful Response</td>
<td>Mitchell Lavoie</td>
<td>19</td>
</tr>
<tr>
<td>Comparative Healthcare</td>
<td>Matthew Davis</td>
<td>27</td>
</tr>
<tr>
<td>And, Finally, I Cried</td>
<td>Ivelisse Mandato</td>
<td>33</td>
</tr>
<tr>
<td>Glasses</td>
<td>Matthew Davis</td>
<td>35</td>
</tr>
<tr>
<td>Changing Tides</td>
<td>Sydney Shugrue</td>
<td>36</td>
</tr>
<tr>
<td>At Home</td>
<td>Carol Dickinson</td>
<td>39</td>
</tr>
<tr>
<td>In Memory of Patrick Gregorek:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Showdown Words for Pat</td>
<td>Alexander Gardiner</td>
<td>42</td>
</tr>
<tr>
<td>Words for Pat</td>
<td>Alexandra Moran</td>
<td>43</td>
</tr>
<tr>
<td>Corduroy Blue</td>
<td>Matthew Davis</td>
<td>45</td>
</tr>
<tr>
<td>Amy Boesky</td>
<td></td>
<td>46</td>
</tr>
<tr>
<td>Sara Moorman</td>
<td></td>
<td>47</td>
</tr>
<tr>
<td>Anne Elizabeth Pluto</td>
<td></td>
<td>48</td>
</tr>
</tbody>
</table>
“¡Tiralo a mí!” Throw it to me. My fingers clumsily clutch the at the seams of the baseball as I attempt to wind my hand back like the pros I’ve seen in the MLB. My hand glides forward. The mandatory baby blue scrubs adhere to the sides of my arm, providing just enough restriction for the ball to land at the feet of my playmate. Her gap-toothed grin is reserved and her eyes tinted with an unfocused gloss. I can feel the corners of my mouth fall as the baseball leaves the tips of my fingers and her eyes struggle to focus on the object flying towards her.

“KGI!” The trip leader’s voice rings in my ears and I turn my head. Her mouth is moving but her words become lost in the chatter of patient families discussing current maladies and excitement over the possibility of receiving a hygiene pack. Realizing I’ve probably spent more time at this clinic playing with younger patients than packing medications or taking vital, I jog over to the coordinator.

“Did you hear what I said?” I shake my head. “I can always help translate.” I nod my head and walk into the consultation room.

It’s a small classroom, concealed with silver metal roofing and walled with thin, dorm-like concrete. My scrubs cling to my body, uncomfortably latching onto my legs and arms with every movement. I plop down in an empty school-sized desk and kick my legs out. This was nothing like the crankly white sanitizing paper I sat on back home. The chairs crunched under my weight, providing just enough restriction for my legs to榥

Love blurs borders

If anything, I should have embraced them, but the clinching of my toes and the hardened grimace on my face said otherwise. “This minimizes the contraction of serious diseases like yellow fever, malaria...” the doctor’s voice trailed off. “I don’t care! I don’t want the shot,” I whined.

“Kathryn, suck it up and take the needle.” My mom sat in the corner, failing to lift her gaze from her iPhone, which beeped with new emails and Amazon Prime offers every five minutes. “You’re not going to Panama without the proper vaccinations. You don’t want to get something serious. You’ll get something worse and with your luck lately, you’ll come back... I don’t know... blind for all we know. Now take the damn shot!”

The rapid Spanish subsides and the doctor lifts herself from the desk school. She wraps her fingers around the sides of her iPhone, using her opposite finger to tap the touchscreen. A bright, blinding light comes on. She walks towards the little girl and uses two fingers to pull up her chin. The doctor moves the light across her eyes, back and forth. The little girl’s head swings with the movement of the light. From my angle, I watch as her left eye follows, glancing periodically at the doctor’s face. No expression. She turns the light off, guides the little girl’s chin down and walks back to the desk beside me. The little girl fidgets, forcibly straightening one leg. Her arms stretch to the sides of the chair, attempting to hang them over, but only her fingers reach the end. Without showing teeth, she smiles at me.

The Spanish picks up again. This time, it goes so fast I retain “no voz,” “no se,” and “no puedo ayudarte.” The older woman’s eyes swell with small tears as her contemplative stare shifts towards the little girl. The child is kicking her feet now, just as unaware as I am to the current situation at hand. The little girl, with eyes wide, turns slowly. “She’s blind in her right eye. I do not know what illness caused it and I do not know how to fix it. She needs surgery and her mother cannot afford it. There is nothing I can do.” The shocking words spin in my mind and I pause, attempting to find any possible solution. I had no difficulty interpreting the interaction before, but now, I was stalled. There was nothing. Slowly, I adopted the same gaze she held. “Cómo lo hizo soy todos” peeks out the corner of my vision. I think back to my visit with the travel doctor before leaving on the trip. It was a routine check-up with supplemental vaccinations required by the US to leave and return home. My visit was smooth, my doctor was thorough and when it was all over, she handed pamphlets titled “Common Allergic Reactions to Vaccinations” and “What Does this Vaccination Do?” into my hands and ushered me out the door.

At that moment, I felt distant. I made sense of the situation, but I did not understand. I will never understand.

I never had a life-altering diagnosis nor been in a situation where financing treatment was the first priority. I thought of the phrases I translated from the doctor and mother’s dialogue in that consultation session: she can’t see, I don’t know, and I cannot help you. Never have I heard those words from a practicing physician: so motivated by desire yet so constrained by their environment. I still regret it to this day, but without realizing, my mind fell prey to the classic issue plaguing the medical field. The rich lead healthy lives while the quality of life for the poor dwindles. My thoughts, thankfully, broke off with the sound of the baseball bouncing across the concrete floor, followed by the patter of feet. Our previous patient rushes in, picks up the ball and looks at me. Her right eye no longer struggles to connect with mine, but contently sits at the
side. Slowly a smile forms, revealing a wide, gapped-tooth smile. The skin around the edges of her eyes sinches as she pushes her chin out, showing the space between her teeth with a proud innocence. She removes one hand from the ball, tucks all fingers but one and points at me. Her diagnosis was untreatable, not due to the complexity but to social and economic factors. Most people would shut down, finding every excuse to pity their life itself was trickling along like normal. As people would signify that we are only now beginning to face. Those toxic particles have had ample time to incubate, transforming a historical atrocity into an emerging, modern day public health dilemma.

The combination of the already dwindling source of funding and the rapidly increasing rates of 9/11-related cancer only mean one thing: innocent people are going to continue to suffer and more lives are going to be lost as a result of the events that took place on a single day two decades ago. Those who are ignorant and uninformed will falsely state that because the Fund hasn’t run out yet, it isn’t a pressing issue. Anyone who states this is gravely incorrect. In fact, the need to secure more funding has never been more urgent than it is right now. The clearly unsatisfactory $2.8 billion left to be divvied up has resulted in cuts in compensation to 9/11 victims by as much as 70% in an effort to stretch the remaining balance of the fund as thin as possible. Rupa Bhattacharyya, the administrator for VCF, stated that as of October 2018, 8,000 more claims had been made with the fund. At a monetary dead end, Bhattacharyya has exhausted every option and is left with no choice but to cut the compensation given to the victims of this catastrophe.

I implore you, why should anything less than 100% compensation be acceptable, especially to those first-responders who gave their 100% on that day? Why should those who were lucky enough to narrowly cheat death have to face this reinincarnated horror, and why should they have to face it without support? Just as the white plume of dust and debris billowed out across lower Manhattan, expand- ing and tainting everything it touched, so has 9/11-related disease. We were in a better position with the white dust, though, for it was visible and palpable, and we could col-
During Dr. Damon Tweedy’s Park Street Lecture, which centered on his novel Black Man in a White Coat: A Doctor’s Reflections on Race and Medicine, he widened the scope of the discussion to something much broader than just the issue of race and medicine: the systemic issue of ongoing racism in our society. Tweedy skillfully argued that the racially-centered issues he describes in his book, and the problematic racially-motivated instances in our society as a whole, are merely indicators of a much more deeply entrenched problem of racism in our society, one that we continue to combat half a century after the end of the Jim Crow Era.

Tweedy began the evening’s conversation by not focusing on his own personal experiences with race and medicine, but by examining the larger issue at hand. Specifically, Tweedy discussed the semi-recent surfacing of Governor Ralph Northam’s racist 1984 Eastern Virginia Medical School yearbook photos. The reasons that these photos are problematic were immediately evident and numerous, yet there were still those who raised the notion that, “He’s a good person having a bad day.” Tweedy introduced the point that when racist events surrounding an individual emerge, the debate always ensues of whether or not the person is a “bad person” because of the other seemingly “good things” the person has done. The question of whether all of the “good things” the person has done can be overshadowed by a single event arises. Tweedy correctly states that while it’s imperative that we condemn these incidences for what they are, hateful, racist acts, we also can’t be so focused on the individual in these situations. Rather, we must turn our attention to the larger problem which is that a number of people obviously saw these photos, didn’t see anything wrong with them, and approved them to be published. This example perfectly encapsulates Tweedy’s argument that we can’t just view individual instances of racism as isolated events, but that we must look at racism as a whole and the group that it stems from.

Throughout his lecture, Tweedy emphasized the power of our words, urging the audience of students, faculty, and socially conscious citizens to continue the narrative he incited with his novel and lecture, imploring us to have real conversations with real people. Undoubtedly, Tweedy came to Boston College to spark conversation, stating “For me to come here and talk and for that to be the end of it is no good.” From this single conversation that was had during the Park Street Lecture, he wanted innumerable different conversations to emerge and for all of us to be more aware. He called on us to recognize how much weight our words, written or spoken, carry, citing the specific example of the inherent bias that’s present in medical charting. “Your words have tremendous power”, he stated, referencing how often he’s come across unnecessary and racially-focused bits of information in patients’ medical charts, which can skew the way the patient is perceived, potentially impact the care given, maintain “durable stereotypes”, and sustain the false narrative that “being black is a risk factor for getting sick”. Tweedy was correctly vehement in how critical it is that this changes. He generously shared with us some of his more awkward experiences as a doctor, in which he was made to feel like the “other” and served as “reminders of being different”. One instance in particular that he described was when he was working the night shift and his patient told him that she was worried about him working the night shift and having to get up in the morning to go to basketball practice. Tweedy jokingly stated that the woman thought he was “a basketball player moonlighting...
ing as a doctor” and that he was “Clark Kent except with a white coat and a basketball jersey underneath.” While his delivery was comical, it didn’t take away from the fact that assumptions such as the one that Dr. Damon Tweedy is a basketball player and not a physician are problematic and indicative of a systemic issue.

Dr. Tweedy concluded his lecture with a quote from Dr. Martin Luther King Jr.: “If I cannot do great things, I can do small things in a great way.” This applies to everybody in Dr. Tweedy’s audience, and everybody at Boston College, in that we’re all responsible to at least do the small but great thing of continuing the conversation he began. As university students we may feel that we’re at the bottom of the totem pole, that we don’t have a voice, that we don’t have the power to spark change, but Dr. Tweedy assured us that the opposite is true. The fact is that we’re in an incredibly unique and privileged position as college students in that we’re celebrated for sharing what we think and feel and there are ample opportunities for us to do so. We applaud Dr. Damon Tweedy for bringing to light that all it takes for us to incite change is to recognize the power of our words, and then use them to start a new narrative.

As of 2017 36.9 million people were living with Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) worldwide, and today the disease remains one of the most notorious global health challenges. Developments in therapeutics and diagnostic testing have allowed for HIV/AIDS to be managed without significant consequence. As of 2017, only 75% of people living with the disease were aware of their HIV status and only 59% of those living with HIV (21.7 million people) had access to antiretroviral therapy (ART). The resilience of this disease in the face of global health initiatives can be explained by two distinct but interconnected conundrums: the negligence of HIV/AIDS’s pervasive impact on all sectors of life (personal, career, and societal), and the unintended consequences of punitive societal condemnation. Neither of these challenges directly relate to the biological efficacy of medicinal treatments, but pose challenges to providing patients with the treatments that they require.

Many of the policies and plans today implemented by public health programs revolve not around the physiological efficacy of treatments, but around the relationship between the HIV/AIDS afflicted population and the healthcare system as a whole. Many of the policies approach the epidemic in a way similar to how a garden is “pruned and weeded,” following the logic that improving the health of the HIV/AIDS positive population will limit the spread of the disease. The goal is to provide prophylactic measures and symptomatic treatments which, when managed well, could slowly improve the overall health of the community. While many of these approaches have demonstrated success, some end up facilitating more harm than good.

This harm is often psychological rather than physiological, allowing fear and to invade and pervade throughout the HIV/AIDS population. Severe poverty, punitive condemnation by both society and the legislature, and mental health issues within the HIV/AIDS community are fueled by the failure of global outreach programs. The concept of the “Placebo Effect” and its lesser-known but implicitly more notorious counterpart, the “Nocebo Effect,” characterize how certain global healthcare approaches are being carried out and provides a lens into how future initiatives should be orientated.

The concept of the “Placebo vs Nocebo Effect” is unique in its suggestion that something which is “physically inert” could have a significant impact on the health of individuals living with HIV/AIDS without directly interacting with the biological mechanisms of disease. The “Nocebo Effect” posits that a patient’s negative expectations can lead to an increase in and intensification of the negative aspects of their treatment, both perceived and physiological. Such a phenomenon can be attributed to the concept of “somatization,” the tendency to experience and communicate psychological distress in the form of somatic symptoms. With regards to HIV/AIDS, a patient’s seemingly morbid prognosis and resulting decrease in quality of life can be partially attributed to the extremely negative and harmful stereotypes associated with the disease, particu-
larly its presence in a plethora of other controversial issues. The severity of the HIV/AIDS epidemic as a whole stems from the unproductive and erroneous world view on the issue and resulting erroneous public health policies, not the prevalence and transmission of the disease itself.

Many of the concerns of issues living with HIV/AIDS, such as fear of stigmatization and loss of “health integrity,” are psychological and societal in nature, encouraging a global health emphasis on issues beyond the biology of the disease. It is important, however, that the global health community avoid unfairly de-emphasizing the physiological concerns surrounding HIV/AIDS maintenance. This could lead to unfairly de-emphasizing the physiological concerns of issues living with HIV/AIDS, and transmission of the disease itself.

It is important, however, that the global health community recognize that the unproductive and erroneous world view on the issue and self-reflection need to refine these two juxtaposed issues with regard to future research/treatment, political, and public perceptions.

In December 2004, the leading Ugandan newspaper published a headline proclaiming that “Flawed Uganda AIDS Research Misleads World.” This report recapitulated the revelations posed by Associated Press reporter John Solomon, who claimed that a Kampala-based study, which evaluated the prevention of mother-to-child HIV transmission, “may have underreported thousands of severe reactions, including deaths” due to in part by the study drug, nevirapine. The study, identified as HIVNET 12, decried the “unfair” stories circulating among its participants suffer due to experimental design. These scenarios can both be critically analyzed under the Doctrine of Double Effect, a Christian method of exploring the morality of an action that brings about good while also causing serious harm. This doctrine assigns relative value to the different actions at play and stitches together the best narrative out of all the ethical conditions. 1) The nature-of-the-act condition, in which the action must be either morally good or indifferent, 2) The means-end condition, in which the bad effect must not be the means by which the good is attained, 3) The proportionality condition, in which the bad effect must not be disproportionate to the good effect. Edmund Tramont, the NIH’s AIDS Research Chief, rewrote the HIVNET12 report in a way that affirmed the study’s scientific findings while down-playing concerns about the safety and quality of the research, attempting to force the narrative of this research to fit within the four conditions for an acceptable “double effect”.

These trials of less effective treatments in poor countries are controversial and troublesome. Conducting research that is useful to “developing” countries often entails testing treatments that, while still helpful, are nonetheless substandard. While the relative low cost of these treatments may ensure more widespread accessibility, they are often less effective or have an increased chance of side effects when compared with treatments provided in wealthier countries like the United States. This brings up a moral dilemma: Is research that is conducted in countries with fewer resources justified in falling short of the standards set in “first world” countries? Given the limited access to resources in these countries, sometimes the only alternative to this lower standard is to not conduct the research at all. This would essentially bar doctors in poor countries from conducting locally relevant research which might save or improve their patients’ lives. These debates explore the criteria upon which scientific inquiry is vetted as well as the intractable international inequalities that pervade the scientific landscape. To sum up and to quote Johanna Crane, “the debate is not merely about ‘right’ and ‘wrong,’ but about how science travels, and about how to forge useful and humane scientific knowledge across terrains of difference and inequality.” For a supposed leader like HIVNET 012 researcher Francesco Minto to assert that “the doctrine of ‘utility’ ascribes serious side effect in Kampala” is a seriously problematic statement in that it encourages those benefit from such findings and those who seek to conduct further research to use superficial determinations of severity. In order to avoid this ethical misstep, all those involved in scientific and medical research must reflect on the consequences of their actions and work in a way that avoids perpetuating low standards and human mistreatment. For every step of the process there should be reflection and reevaluation to ensure that something beneficial, such as a public healthcare initiative, is oriented solely towards the good while avoiding the bad.

Bibliography
January 13th, 1990

January 13th, 1990. It was an icy Saturday night when my dad was a passenger in his cousin Arthur’s car. My dad was spending time in Arthur’s new apartment after a long syllabus week. You could say he was enjoying the calm before the storm. His forebears how his life would be bombarded with the struggles of a wintry commute to Chestnut Hill, the complexities of Father McGowan’s business statistics course, and the challenge of making time for his girlfriend, Anna, an education student at Salem State. But what was about to happen could have never crossed his mind, for the storm my dad was about to weather was much greater than he could have ever predicted. January 13th would mark the transition from Mike before the accident to Mike after the accident.

When this is usually true, it is not always the case: accidents, depression, terminal illness, are just a few of the many things that can throw a wrench in the plans. I think my dad understood the anticipation and the uncertainty of life in a very basic sense.

January 13th, 1990. The call to reach my mom at Loon Mountain. “Judy, Mike was in a very bad accident, Mike’s mother is calling for Anna. It is very important that you get down there as soon as possible. Don’t tell her what happened, it’s too devastating to tell her bluntly, he might not make it by the time you get back.”

When the body reaches the lower quartile of the homeostatic range, it is common to break into reservoirs of ions and proteins or use the build-up of some gradient that sums the activation energy to move on to the next stage in a biological mechanism. During survival mode, our body does anything and everything to maintain life. As a response to lower quartile conditions, the body produces a stimulus that activates biological processes that aim for a return to the interquartile range, the normal range. My biochemistry professor, Dr. Folker, explains biological processes as a glorified game dominated by probability. Our cells do not have a greater likeness or affinity to one process or another, we cannot personify our cells, but rather, given a set of conditions within a microenvironment, it is likely the cells will respond when conditions are more favorable.

Even when the conditions are favorable and the probability of a return to normalcy is likely, there is always that minuet chance that things will not return within their normal range. Murphy’s law expresses that if something can go wrong, it will go wrong. Sometimes things just happen that way.

February 8, 1990. “Your fever isn’t going away. The seizures will go wrong. Sometimes things just happen that way.”

The cells will respond when conditions are more favorable. A return to the interquartile range; the normal range. My biochemistry professor, Dr. Folker, explains biological processes as a glorified game dominated by probability. Our cells do not have a greater likeness or affinity to one process or another, we cannot personify our cells, but rather, given a set of conditions within a microenvironment, it is likely the cells will respond when conditions are more favorable.

When the mind cannot find a logical pathway to make sense of the inexplicable, the mind tends to place blame on itself, or a higher power. Fate is the idea that there is an invisible acting force that has some part in the agency of individual lives. Lia Lee’s parents believed that she contracted “the spirit catches you and you fall down” from the slamming of a door. My Vavo thought she induced my dad’s seizure because she was in the hospital room. Sometimes when moments in time pile up to the point of incomprehensibility, the mind tends to search for a loophole, an explanation, a meaning behind it all. Sometimes there isn’t an explanation. As humans, we have a natural inclination to understand our condition; but sometimes we simply can’t.

February 18, 1990. “Uncle JoJo would drive me to Lowell at 5 in the morning so I could be with dad before any of his family got there. They were all so angry all the time, fighting with the nurses and doctors, not pushing dad in the right ways. It was frustrating to watch, and I was a fragile shell of a human. One morning I was so out of it, I forgot to wash the shampoo out of my hair and I walked out to the car and Uncle JoJo told me I had white suds everywhere...I asked Uncle JoJo to go in and talk sports to dad while he was in a coma because I know dad loved sports. Uncle JoJo would tell him all the stats, then I would go in and play his favorite music. Who knows if he could fly out of the passenger door? But instead, the question should have been, what is the true meaning of suffering? Before Boston College, I believed that suffering is a direct result of God’s will and therefore the wicked. After reading the Bible for myself, I have come to learn a new face to faith and suffering; suffering is the damming condition all finite creatures must face, but faith is the acceptance that suffering is mysterious and blind. I wish my family could have recognized this during the months following my dad’s accident. I wish they could recognize this today.

February 28, 1990. “Uncle JoJo would drive me to Lowell at 5 in the morning so I could be with dad before any of his family got there. They were all so angry all the time, fighting with the nurses and doctors, not pushing dad in the right ways. It was frustrating to watch, and I was a fragile shell of a human. One morning I was so out of it, I forgot to wash the shampoo out of my hair and I walked out to the car and Uncle JoJo told me I had white suds everywhere...I asked Uncle JoJo to go in and talk sports to dad while he was in a coma because I know dad loved sports. Uncle JoJo would tell him all the stats, then I would go in and play his favorite music. Who knows if he could fly out of the passenger door? But instead, the question should have been, what is the true meaning of suffering? Before Boston College, I believed that suffering is a direct result of God’s will and therefore the wicked. After reading the Bible for myself, I have come to learn a new face to faith and suffering; suffering is the damming condition all finite creatures must face, but faith is the acceptance that suffering is mysterious and blind. I wish my family could have recognized this during the months following my dad’s accident. I wish they could recognize this today.

Andrew Solomon said, “To be creatures who love, we must be creatures who can despair at what we lose. I think about my parents when I read this quote. My mom often talks about “growing up quick.” One day her youth completely vanished before she had time to tug on the
few remaining strings. My dad's accident, unforeseen and sudden, led my mom to make lots of decisions that were no longer solely about her. When I think of strength and sacrifice, I think of my mom. I could never imagine going through what she endured at 18 years old. I cannot fathom the intensity of my mom's pain when she found out her best friend would never be the same.

My dad is a fully functioning adult with college degrees and unsteady employment. His recovery was truly a miracle. Despite what veneer is exposed to families experiencing the fallout of an accident, or any major life-altering event, there is no sugar coating the before and after version of each person. My mom loved Mike before the accident, and she loves Mike after the accident. They are partly the same Mike, but no one in my family will deny that he's never returned back to who he once was. With the amount of brain damage he sustained, how could he? What they all may fail to notice is their own lack of return to how they once were. Love is powerful; its unconditionality ignites a glimmer of hope that love will always prevail in the darkest of times.

March 25, 1990. "Our long awaited day has finally arrived. You're coming home today. Your memory is improving, so is your speech. The past months have been long and unbearable at times. You are a fighter, Mike. Welcome home!"

March 25, 2017. My 18th birthday. "Ien, do you want a PB&J for lunch?" I respond calmly, "No thanks Dad, I'm allergic to peanuts." I've been allergic to peanuts for 18 years.

So where does this leave me? Looking back on a story that only became mine 9 years after it began is a difficult feat. How can I do justice to a narrative, with so many perspectives, so much pain, but yet so much hope and triumph? How do I live a life of my own, when the one I lead is deeply influenced by the events that came before me?

The dynamic answer that continues to change is complex: this narrative is only partly mine, it leaves me at Boston College, on the precipice of the past and the future. Boston College is a place where I am forging my own path, but also walking the same lanes my dad walked when his life was forever changed. I believe F. Scott Fitzgerald could offer some form of hiatus to a narrative currently in action, one unfinished, "Gatsby believed in the green light, the orgastic future that year by year recedes before us. It eluded us then, but that's no matter...So we beat on, boats against the current, borne ceaselessly into the past!"

A
FEARFUL RESPONSE: HEALTHCARE WORKERS AND EBOLA
M itchell Lavoie

In 2014, the extremely fatal Ebola virus ravaged through the countries of Sierra Leone, Guinea, and Liberia, killing over 11,000 people and infecting even more. This outbreak led to a significant response mounted by the Centers for Disease Control and Prevention (CDC) of the United States. Many healthcare workers from the United States answered the call to serve and were initially appalled for their heroic actions abroad. They eventually landed a spot in Time Magazine's prestigious Person of the Year issue, honoring all of the Ebola fighters as "the ones who answered the call" ("TIME Person of the Year"). However, this warm U.S. response was not consistent for healthcare workers Dr. Craig Spencer and nurse Kaci Hickox, Ebola workers who spent time in Guinea and Sierra Leone respectively. Instead, they were greeted at America's borders with hostility and utter fear. The media narrative only fueled this fear, further vilifying their image. Their image was not one that resembled other healthcare workers in TIME as the U.S. met their return with hasty public health policy and negative public opinion. These two healthcare workers were presented as the "superspreader" as discussed in Priscilla Wald's Contagious, representing a major characteristic in the outbreak narrative which helped drive the fear: The fear has even deeper roots, though, resulting from previous outbreak narratives of Ebola and hemorrhagic fever, such as Richard Preston's 1994 novel The Hot Zone which, in an effort to find meaning out of an epidemic, only caused mass hysteria and fear (Rosenberg, Quammen). As a result, the initial positive U.S. response towards the Ebola workers in 2014 was replaced by stigma and poor treatment for many of these same individuals.
those countries, a much more stringent policy at the border was put in place, where pre and post travel screenings were mandated, isolating all ill travelers who entered the country. While the screenings may seem warranted, it was the mandatory quarantine of healthy travelers coming from areas of high SARS transmission that had damaging effects (Cetron et al.). It is through the comparison to these policies that makes evident that healthcare workers returning to the United States were treated far better than those in other countries, with a nation that rightfully respected the civil liberties of individuals by not thrashing healthy individuals into quarantine.

SARS, however, was an outbreak somewhat different than the Ebola outbreak in West Africa in 2014. SARS traveled rapidly and many healthcare workers became patients because of the work they did (Singler et al.). This characteristic is not consistent with the Ebola outbreak in 2014. Much of this can be attributed to the more stringent usage of PPE, as personal protective equipment in West Africa versus relatively less intense equipment in nations like Canada and China, with gloves and an N95 respirator masks for SARS (Cetron et al.). Due to the large volume of SARS patients in hospitals, many healthcare officials became infected. Even in the wake of their infection or the potential to be infected, about 80% of healthcare workers noted that they did not feel stigmatized because of their work in a hospital (Yamei et al.) (Nickell et al.). This was different than the Ebola outbreak in West Africa, where both healthcare workers Dr. Spencer and Nickell et al. noted that they did not feel stigmatized because of their work in a hospital (Cetron et al.). Due to the large volume of SARS patients in hospitals, many healthcare officials became infected. Even in the wake of their infection or the potential to be infected, about 80% of healthcare workers noted that they did not feel stigmatized because of their work in a hospital (Yamei et al.) (Nickell et al.). This was different than the Ebola outbreak in West Africa, where both healthcare workers Dr. Spencer and Nickell et al. noted that they did not feel stigmatized because of their work in a hospital (Cetron et al.). Due to the large volume of SARS patients in hospitals, many healthcare officials became infected. Even in the wake of their infection or the potential to be infected, about 80% of healthcare workers noted that they did not feel stigmatized because of their work in a hospital (Yamei et al.) (Nickell et al.). This was different than the Ebola outbreak in West Africa, where both healthcare workers Dr. Spencer and Nickell et al. noted that they did not feel stigmatized because of their work in a hospital (Cetron et al.). Due to the large volume of SARS patients in hospitals, many healthcare officials became infected. Even in the wake of their infection or the potential to be infected, about 80% of healthcare workers noted that they did not feel stigmatized because of their work in a hospital (Yamei et al.) (Nickell et al.). This was different than the Ebola outbreak in West Africa, where both healthcare workers Dr. Spencer and Nickell et al. noted that they did not feel stigmatized because of their work in a hospital (Cetron et al.). Due to the large volume of SARS patients in hospitals, many healthcare officials became infected. Even in the wake of their infection or the potential to be infected, about 80% of healthcare workers noted that they did not feel stigmatized because of their work in a hospital (Yamei et al.) (Nickell et al.). This was different than the Ebola outbreak in West Africa, where both healthcare workers Dr. Spencer and Nickell et al. noted that they did not feel stigmatized because of their work in a hospital (Cetron et al.). Due to the large volume of SARS patients in hospitals, many healthcare officials became infected. Even in the wake of their infection or the potential to be infected, about 80% of healthcare workers noted that they did not feel stigmatized because of their work in a hospital (Yamei et al.) (Nickell et al.). This was different than the Ebola outbreak in West Africa, where both healthcare workers Dr. Spencer and Nickell et al. noted that they did not feel stigmatized because of their work in a hospital (Cetron et al.). Due to the large volume of SARS patients in hospitals, many healthcare officials became infected. Even in the wake of their infection or the potential to be infected, about 80% of healthcare workers noted that they did not feel stigmatized because of their work in a hospital (Yamei et al.) (Nickell et al.). This was different than the Ebola outbreak in West Africa, where both healthcare workers Dr. Spencer and Nickell et al. noted that they did not feel stigmatized because of their work in a hospital (Cetron et al.). Due to the large volume of SARS patients in hospitals, many healthcare officials became infected. Even in the wake of their infection or the potential to be infected, about 80% of healthcare workers noted that they did not feel stigmatized because of their work in a hospital (Yamei et al.) (Nickell et al.). This was different than the Ebola outbreak in West Africa, where both healthcare workers Dr. Spencer and Nickell et al. noted that they did not feel stigmatized because of their work in a hospital (Cetron et al.). Due to the large volume of SARS patients in hospitals, many healthcare officials became infected. Even in the wake of their infection or the potential to be infected, about 80% of healthcare workers noted that they did not feel stigmatized because of their work in a hospital (Yamei et al.) (Nickell et al.). This was different than the Ebola outbreak in West Africa, where both healthcare workers Dr. Spencer and Nickell et al. noted that they did not feel stigmatized because of their work in a hospital (Cetron et al.). Due to the large volume of SARS patients in hospitals, many healthcare officials became infected. Even in the wake of their infection or the potential to be infected, about 80% of healthcare workers noted that they did not feel stigmatized because of their work in a hospital (Yamei et al.) (Nickell et al.). This was different than the Ebola outbreak in West Africa, where both healthcare workers Dr. Spencer and Nickell et al. noted that they did not feel stigmatized because of their work in a hospital (Cetron et al.). Due to the large volume of SARS patients in hospitals, many healthcare officials became infected. Even in the wake of their infection or the potential to be infected, about 80% of healthcare workers noted that they did not feel stigmatized because of their work in a hospital (Yamei et al.) (Nickell et al.). This was different than the Ebola outbreak in West Africa, where both healthcare workers Dr. Spencer and Nickell et al. noted that they did not feel stigmatized because of their work in a hospital (Cetron et al.). Due to the large volume of SARS patients in hospitals, many healthcare officials became infected. Even in the wake of their infection or the potential to be infected, about 80% of healthcare workers noted that they did not feel stigmatized because of their work in a hospital (Yamei et al.) (Nickell et al.). This was different than the Ebola outbreak in West Africa, where both healthcare workers Dr. Spencer and Nickell et al. noted that they did not feel stigmatized because of their work in a hospital (Cetron et al.).
Dr. Spencer. Dr. Spencer was a U.S. healthcare worker stationed in Guinea to help fight Ebola in 2014. In October of 2014, he returned to New York City where he attempted to assimilate back into everyday life. He stated that “I slept long hours and had a hard time connecting with old friends” (Spencer). Dr. Spencer chided those who encouraged this stigma, stating that “after my diagnosis, the media and politicians could have educated the public about Ebola. Instead, they spent hours retracing my steps through New York and debating whether Ebola could be transmitted through a bowling ball” (Spencer). The fear that Ebola could be transmitted this way so easily was a major player in the fear of the disease. What is more is that in the typical outbreak narrative, as defined by Wald, as well as in Spencer’s specific case, the carrier and the disseminator are social representations of “bodily interconnectedness” in the city of New York could easily transmit a disease through shared spaces, such as a bowling alley (Wald 70). Spencer’s violation of this social contract cast him as a villain and outcast for not upholding his responsibility as a citizen and subsequently threatening the health of many (Wald 70). His work in Guinea was nowhere to be mentioned, but his Sunday afternoon at the bowling alley was all over the news. This fear further exacerbated negative public opinion through outlandish media headlines such as “Ebola: the ISIS of Biological Agents?” (Spencer). This only contributed more to Spencer becoming a pariah as well as the general public fear of maintaining that perception implies explanation. Certainly this is the case during epidemics, when fear and anxiety create an imperative need for understanding and thus reassurance” (Spencer). Furthermore, after the midterm elections on November 4, 2014, Spencer noted that to politicians “the ebola epidemic ended,” bringing light to the lack of public attention after the elections (Spencer). Rosenberg also clearly characterizes these actions through his work in framing disease, stating that “perception implies explanation. Certainly this is the case during epidemics, when fear and anxiety create an imperative need for understanding and thus reassurance” (294). Politicians played off of the opportunity to reassure the public that they were safe. Therefore, the institution of fear and taking advantage of it to enforce their executive power and implemented strict 21-day quarantine laws even if said worker wore their personal protective equipment (PPE) when in contact with Ebola patients in West Africa (Caebeeten). These policies were not based in scientific fact, ignoring the CDC’s recommendation of personal monitoring or monitoring by public health officials, stating nothing of a mandated quarantine recommendation (“Public Health Professionals Gateway”). This then begs the question of why such stringent public policy was instated. It is important to note the proximity of Dr. Spencer’s quarantine, late October 2014, with the impending midterm elections in early November. Spencer eluded to politicians utilizing public fear to institute strict quarantine laws, stating that “We all lose when we allow irrational fear, fueled in part by prime-time ratings and political expediency, to supersede pragmatic public health preparedness” (Spencer). The Narratives of Fear: Nurse Kaci Hickox Dr. Spencer’s narrative to influence public fear and took advantage of it to enforce their executive power and implemented strict 21-day quarantine laws even if said worker wore their personal protective equipment (PPE) when in contact with Ebola patients in West Africa (Caebeeten). These policies were not based in scientific fact, ignoring the CDC’s recommendation of personal monitoring or monitoring by public health officials, stating nothing of a mandated quarantine recommendation (“Public Health Professionals Gateway”). This then begs the question of why such stringent public policy was instated. It is important to note the proximity of Dr. Spencer’s quarantine, late October 2014, with the impending midterm elections in early November. Spencer eluded to politicians utilizing public fear to institute strict quarantine laws, stating that “We all lose when we allow irrational fear, fueled in part by prime-time ratings and political expediency, to supersede pragmatic public health preparedness” (Spencer). Furthermore, after the midterm elections on November 4, 2014, Spencer noted that to politicians “the ebola epidemic ended,” bringing light to the lack of public attention after the elections (Spencer). Rosenberg also clearly characterizes these actions through his work in framing disease, stating that “perception implies explanation. Certainly this is the case during epidemics, when fear and anxiety create an imperative need for understanding and thus reassurance” (294). Politicians played off of the opportunity to reassure the public that they were safe. Therefore, the institution of fear and taking advantage of it to enforce their executive power and implemented strict 21-day quarantine laws even if said worker wore their personal protective equipment (PPE) when in contact with Ebola patients in West Africa (Caebeeten). These policies were not based in scientific fact, ignoring the CDC’s recommendation of personal monitoring or monitoring by public health officials, stating nothing of a mandated quarantine recommendation (“Public Health Professionals Gateway”). This then begs the question of why such stringent public policy was instated. It is important to note the proximity of Dr. Spencer’s quarantine, late October 2014, with the impending midterm elections in early November. Spencer eluded to politicians utilizing public fear to institute strict quarantine laws, stating that “We all lose when we allow irrational fear, fueled in part by prime-time ratings and political expediency, to supersede pragmatic public health preparedness” (Spencer). In this moment of uncertainty and fear, public officials instituted policy to further isolate the heroic fighters of disease, using Dr. Spencer’s narrative to influence public health measures. At the time of Dr. Spencer’s quarantine, Governors from New York and New Jersey gave into public fear and took advantage of it to enforce their executive power and implemented strict 21-day quarantine laws even if said worker wore their personal protective equipment (PPE) when in contact with Ebola patients in West Africa (Caebeeten). These policies were not based in scientific fact, ignoring the CDC’s recommendation of personal monitoring or monitoring by public health officials, stating nothing of a mandated quarantine recommendation (“Public Health Professionals Gateway”). This then begs the question of why such stringent public policy was instated. It is important to note the proximity of Dr. Spencer’s quarantine, late October 2014, with the impending midterm elections in early November. Spencer eluded to politicians utilizing public fear to institute strict quarantine laws, stating that “We all lose when we allow irrational fear, fueled in part by prime-time ratings and political expediency, to supersede pragmatic public health preparedness” (Spencer). The Narratives of Fear: Nurse Kaci Hickox Dr. Spencer’s narrative to influence public fear and took advantage of it to enforce their executive power and implemented strict 21-day quarantine laws even if said worker wore their personal protective equipment (PPE) when in contact with Ebola patients in West Africa (Caebeeten). These policies were not based in scientific fact, ignoring the CDC’s recommendation of personal monitoring or monitoring by public health officials, stating nothing of a mandated quarantine recommendation (“Public Health Professionals Gateway”). This then begs the question of why such stringent public policy was instated. It is important to note the proximity of Dr. Spencer’s quarantine, late October 2014, with the impending midterm elections in early November. Spencer eluded to politicians utilizing public fear to institute strict quarantine laws, stating that “We all lose when we allow irrational fear, fueled in part by prime-time ratings and political expediency, to supersede pragmatic public health preparedness” (Spencer). The Narratives of Fear: Nurse Kaci Hickox Dr. Spencer’s narrative to influence public fear and took advantage of it to enforce their executive power and implemented strict 21-day quarantine laws even if said worker wore their personal protective equipment (PPE) when in contact with Ebola patients in West Africa (Caebeeten). These policies were not based in scientific fact, ignoring the CDC’s recommendation of personal monitoring or monitoring by public health officials, stating nothing of a mandated quarantine recommendation (“Public Health Professionals Gateway”). This then begs the question of why such stringent public policy was instated. It is important to note the proximity of Dr. Spencer’s quarantine, late October 2014, with the impending midterm elections in early November. Spencer eluded to politicians utilizing public fear to institute strict quarantine laws, stating that “We all lose when we allow irrational fear, fueled in part by prime-time ratings and political expediency, to supersede pragmatic public health preparedness” (Spencer).
public safety through an “abundance of caution,” of which they will use when a “healthcare worker who came into contact with Ebola-positive individuals returns soon from New Jersey” (Miles 1). This policy was tailor made to Ms. Hickox, as seen in the blatant referral to her return from New Jersey. Priscilla Wald points that there is a “conflict arising from the state’s obligation to safeguard both civil liberties and public health and well being” (70). The civil liberties of Hickox, she claimed, were violated and the mandatory quarantine policies in Maine, New Jersey, and New York are a flagrant utilization of public fear to implement hasty public policy that is not based in scientific fact or evidence but for political expediency at the expense of an individual’s “personal civil rights” (Miles) (“Matt Lauer and US Nurse Kaci Hickox”).

What is different about Hickox’s situation, as opposed to Spencer’s, was that she did not in fact have Ebola. Her subsequent quarantine was enabled through a lack of coordination and a sense of public fear that surrounded the Ebola epidemic. The Maine court system that rejected Governor LePage’s court order recognized this public fear and the lack of scientific evidence for taking an “abundance of caution,” stating that “the court is fully aware of the mandate however and in 2017 filed a lawsuit against Governor Chris Christie for his violation of her civil liberties (Sanctor). Ms. Hickox did not take the money in an effort to effect change in the way to which she belonged no where near the American public. Not all outreach narratives are the same however, and Hickox was plagued with pronounced neglect of civil liberties while Spencer was shamed for his actions. As a result of their hard work and efforts, governors from New York, New Jersey, and Maine instituted strict 21-day quarantine laws that went against CDC recommendation of simple self monitoring, the practice that Dr. Spencer underwent when he reported himself to the board of health (Spencer). Fear drove a response that was a public opinion which culminated in public health policies that could, as Hickox mentions, “have a chilling effect” on future generations of workers in their willingness to fight disease (“Matt Lauer and US Nurse Kaci Hickox”). These mandatory quarantine laws essentially cast returning aid workers as pariahs and hazards to greater public health. Spencer argues that this negative response will have debilitating effects on the decision of future aid workers to help fight Ebola and other diseases.

Public health policy was then informed by the politics of fear as and Spencer mentions “if the U.S. public policy response undermined efforts to send more volunteers to West Africa, and thus allowed the outbreak to continue longer than it might have, we would all be culpable” (Spencer). This could undermine the ability to fight disease effectively and the response of the United States could have put many lives at stake (Spencer). The negative response driven by Hickox and Spencer and Kaci Hickox’s heroic actions were met with intense and turbulent public fear that they would be Wald’s “superspreader” that brought Ebola back to the United States. In the 2003 SARS outbreak, there was a clear line in the sand that the United States would not cross, the violation of civil liberties. It would not institute the mandatory quarantine policy that would alienate her and cast her as a health hazard for “political expediency” (Miles).

Conclusion and Implications

The debilitating quarantine policy implemented by politicians during the Ebola outbreak in 2014 was a novel response to epidemic among healthcare workers in the United States. In the 2003 SARS outbreak, there was a clear line in the sand that the United States would not cross, the violation of civil liberties. It would not institute the mandatory quarantine policy that would alienate her and cast her as a health hazard for “political expediency” (Miles). This policy sparked by Hickox achieves many things. First, Quarantine or isolation will be imposed only when “medically and epidemiologically necessary to prevent the spread of Ebola,” however they must be carried out in the “least restrictive measures to prevent the spread of Ebola,” and after less restrictive measures have been explicated (Harrison). Finally, there must be a comprehensive order documenting information such as the legal authority under which the order is issued, the medical basis, and a statement explaining the right to hold an attorney and appeal (Harrison). While this is only one policy change since the disastrous display in 2014, it is a step in the right direction, one that “upholds the values of liberty and due process” (Sanctor).

Change in Policy Since 2014

Kaci Hickox did not stand for this abhorrent treatment however and in 2017 filed a lawsuit against Governor Chris Christie for his violation of her civil liberties (Sanctor). She initially sought compensation in the amount of $250,000 but dropped the suit under the agreement to create a “Bill of Rights” for “individuals subject to possible quarantine or isolation in New Jersey” and this “sets a model for other states to replicate” (Harrison). This policy response by Hickox achieves many things. First, Quarantine or isolation will be imposed only when “medically and epidemiologically necessary to prevent the spread of Ebola,” however they must be carried out in the “least restrictive measures to prevent the spread of Ebola,” and after less restrictive measures have been explicated (Harrison). Finally, there must be a comprehensive order documenting information such as the legal authority under which the order is issued, the medical basis, and a statement explaining the right to hold an attorney and appeal (Harrison). While this is only one policy change since the disastrous display in 2014, it is a step in the right direction, one that “upholds the values of liberty and due process” (Sanctor).
While the fear and the U.S. response reduced the humanitarian crisis, the form of these policies varied. The Beveridge model, which is based on the Beveridge, Bismarck, National Health Insurance model, primarily found in Canada and South Korea, uses private-sector providers with government funding. The Out-of-Pocket model is seen in less developed countries. In this system, if one can afford medical care, they will purchase it. If they cannot afford the proper medical attention, they will be forced into staying sick or dying.

All citizens of the countries of Ireland, Northern Ireland, and Scotland are entitled to receive public health care. However, with different systems set in place in each country, the treatments and processes involving this care fluctuate. Even citizens in the same country are often victims of issues with their respective healthcare systems. Irishmen and women who live on Inis Oirr, the smallest of the three Aran Islands – part of the greater Republic of Ireland – must suffer through great difficulties in times of medical need. A representative from the island, while claiming that their health services are “on par” with that of the mainland, also admitted that elders and pregnant women need to travel to the mainland – with all expenses paid out of their own pocket – just to have access to this mainland healthcare. Similarly, a study involving the Scottish Social Attitudes Survey also feel that emergency coverage is significantly weaker in rural areas, once more putting at-risk groups such as the elderly in an unsafe situation. Despite these policies containing vast differences between each country and severe disparities between groups and locations within the countries, healthcare is still seen as essential within the major nations of the British Isles. This paper will go further into detail concerning the specific healthcare systems of Ireland, Northern Ireland, and Scotland, and will explore how these differences affect the citizens of each respective country.

**Overview of healthcare and its importance**

There are many different types of healthcare systems that countries choose to utilize. While each country creates their own variation, forming the vast differentiation of policies, there are four basic models which all healthcare systems is based on the Beveridge, Bismarck, National Health Insurance, and Out-of-Pocket Model. The Beveridge model, which is observed in states such as Great Britain and Spain, provides medical services to their citizens through governmental taxes. In theory, most hospitals are owned by the government. The Bismarck model, seen in Germany, France, and Japan, for example, utilizes an insurance system with privatized hospitals. The National Health Insurance model, primarily found in Canada and South Korea, uses private-sector providers with government funding. The Out-of-Pocket model is seen in less developed countries. In this system, if one can afford medical care, they will purchase it. If they cannot afford the proper medical attention, they will be forced into staying sick or dying.

Despite there being only four basic models, when it comes to healthcare policy nearly every country has distinct variations. Jacob S. Hacker, an expert of healthcare policy from Yale University, explains that the form of these policies “depends on the market structures, policy ideas, interest group strategies, and public views.” In other words, each nation has its own history, political ideologies, and economic abilities. These differences in the political institutions of each nation “influence the…enables the kinds of policies that countries adopt.” This is how a country like the United States can have a healthcare system with aspects from all four models; or how two countries with aspects from all four models.
The Irish National Health Service (Irish NHS) was launched on January 1, 2005, after the Health Act of 2004. Under this act, all citizens are covered under the HSE. Health spending by the government is significantly better, as shared through documentation from Senator Ruile Enda. Done by public healthcare. The only slight exception to this “universal” method is called “Sláintecare.” Sláintecare, similar to UHI, is a plan for a “universal, single-tier public health service where care is provided on the basis of health rather than ability to pay.” This ten year plan is the first time in Ireland all of the major parties have come to a political consensus to create a one-tiered system, where they also can fix many of the problems that cause this lack of trust. The newest method is called “Sláintecare.” Sláintecare, similar to UHI, is a plan for a “universal, single-tier public health service where care is provided on the basis of health rather than ability to pay.” This ten year plan is the first time in Ireland all of the major parties have come to a political consensus on a health reform plan. Not only will Sláintecare accomplish all of the positives that the Fine Gael set out in the UHI, but it will also provide services such as maximum waiting times guaranteed, earlier and better access to mental health services and a new and improved HSE board. A recent snag in this process has revealed, however, that this ten year process could take longer, mainly due to concerns over cost. The Taoiseach, Leo Varadkar, explains how difficult it is to start new and expensive healthcare programs: While we accept the Sláintecare report, at the moment health spending is already running about 8.6 per cent ahead of last year, so we’re already spending a lot of additional money on healthcare, and when you are increasing spending by 8.6 per cent per year already, it is difficult to find even more money on top of that to implement other programs. While Varadkar and the rest of the Irish government are in support of Sláintecare, the need of additional money – especially with the looming economic concern regarding Brexit – is going to significantly slow down the process of reform. Ireland has a lack of “single-tier care” as it is the part of the United Kingdom. Just like the Beveridge model states, the majority of healthcare in Northern Ireland is from the public sector. The Northern Irish healthcare system is often referred to as the National Health Services, as it is in the rest of the United Kingdom and Ireland as well. More accurately, though, its proper name is Health and Social Care (HSC). As it is one of only two countries in the United Kingdom that also provides social care. It is fully funded by the Northern Ireland Executive, under the Department of the Health, in Stormont, Belfast. However, since Northern Ireland is a part of the United Kingdom, taxes from any citizen of the UK can be charged for it. The Public Health Agency is responsible for regulating all health and social care laws and policies. It was created in 2009 in an attempt to reform the health systems in the area. The key functions of this agency are improving health and social wellbeing, protecting the health of the people of Northern Ireland, creating and commissioning policy, and research. It is also their purpose, and the purpose of the HSC in general, to try and reduce, and ultimately eliminate health inequalities.
Despite this attempt at lessening social inequalities, there are many negatives that Northern Irish individuals need to overcome when it comes to their health care. This care that most Northern Irish healthcare system does not adequately cover is mental health, despite being one of the only countries in the United Kingdom to cover social health. Mental health, specifically post-traumatic stress disorder, or PTSD, is very common in Northern Ireland. Loyalist Jim Watt explained that both loyalists and nationalists are struggling with severe mental health issues due to their involvement in the fighting between one another. Close to 30% of Northern Irish citizens have admitted to having long-term mental illnesses, and 25% more people with mental health issues than England and Scotland. The HSC, even though there is a great need for it, does minimal to help those who have suffered greatly and have mental diseases because of it.

Scotland’s healthcare system is very similar to Northern Ireland, since it is also a member of the United Kingdom. It is likewise run under an NHS system, however as is true for all UK countries, it is only one of its social care. It has been devolved in 1999 and since then was operated under its own management and administration. It is funded through West- minster through a block grant, and spends approximately £12 billion a year on healthcare. Similar to Northern Ireland, Scotland is the only other country to also cover social care in its policies. While the vast majority of citizens utilize the public healthcare system, around 8.5% use some other form of private insurance, mainly for the use of dental or fertility care. Scotland also has a new organization, the Healthcare Improvement Scotland, or HIS, which is responsible for reviewing and examining the healthcare facilities of the country.

The attempt to monitor and combat against these health inequalities that Brexit could bring on the area of Northern Ireland. These inequalities often lead to dangerous health behaviors such as “smoking, obesity, lack of physical activity, poor nutrition, [and] abuse of drugs and alcohol.” Therefore, the HSC created programs such as “Investing for Health,” in 2002, the “Health and Social Care Improvements Monitor System,” the “Family Nurse Partnership” for teenage mothers, and “Roots of Empathy” to reduce levels of stress and aggression in school children. The HSC also created educational strategies to encourage positive physical behavior, such as alcohol consumption, reducing the amount of smoking, increasing the levels of breastfeeding and encouraging physi- cal activity, and many more. Even though health inequalities still are prevalent in Northern Ireland, the citizens have many opportunities through the HSC to get help and proper social care. Despite this attempt at lessening social inequalities, there are many negatives that Northern Irish individuals need to overcome when it comes to their healthcare. First, similar to their neighbors of the south, Northern Ireland struggles greatly with accessibility for their patients. Northern Ireland has, by far, the highest average percentage of patients out of all of the countries in the United Kingdom, despite spend- ing the second most on health services. Even with receiving reviews stating the need for a major healthcare transforma- tion, specifically when it comes to accommodation, it has remained essentially stagnant, with little progress being made. One cause for this difficulty in alteration is that, as explained, the HSC is funded and run through the North- ern Ireland Executive, which currently has been shut down due to the lack of political backing and two years of no money from Westminster, under the United Kingdom’s ruling, and decisions for the well-being of the Northern Irish citizens are often no longer put as a major priority.

While Scotland’s healthcare system seems similar to the Northern Irish system, there are many differences. Scotland, while similar to Northern Ireland, devolved in 1999 and since then was operated under its own management and administration. It is funded through West- minster through a block grant, and spends approximately £12 billion a year on healthcare. Similar to Northern Ireland, Scotland is the only other country to also cover social care in its policies. While the vast majority of citizens utilize the public healthcare system, around 8.5% use some other form of health services such as personal hygiene, maintaining proper food and diet, any personal assistance, and more, and the payment will be covered through the public healthcare system. Despite a very high approval rating from its users, the Scottish healthcare system that still brings many negative ef- fects on its people. As stated earlier, many Scottish citizens feel that there is an inequality in healthcare coverage between those in cities versus those in more rural areas. The same survey that shows high approval also shows that 79% polled believe the level of access to healthcare should be equal throughout the entire country, no matter the location. The majority of the people living in these rural areas are disproportionately elderly – 65 years old and up. They often need more specialized care which they cannot always get. Even in Ireland where access to care is limited in places like the Aran Islands, they still manage to offer a “highly effective offshore medical corps of doctors and nurses.”

It is often difficult for the Scottish government to put new organizations or programs into action, however, due to their funding system. Every year Scotland is granted a lump sum from Westminster to spend on all of their public and social services, healthcare included. If Westminster decides to cut that funding, Scotland has no choice but to cut certain programs, and healthcare is often the one to take the hit. While Scotland does have a say, as they have representatives in Parliament as well as organizations such as the British- Irish Council which help to exchange information, discuss issues, and come up with the best endeavors on how to solve problems and reach agreements, it is ultimately up to the United Kingdom’s decision. This is just one issue that comes with the country not having self-rule.

Conclusion
Healthcare, no matter the type or level, is important and beneficial to the citizens of a country. Whether it be for fighting the price of surgery, simplifying the process of getting pharmaceuticals, or shortening the waiting period, proper health and medical care are becoming seen as a right more than a privilege – especially in the three countries of Ireland, Scotland, and Northern Ireland. Healthcare coverage does not stop at the border of a country. Specifically, in the British Isles, citizens travel from one nation to another for specialized procedures and treatment. Senator Richmond of the Irish political party Fine Gael and export of European Affairs explains that “healthcare in Ireland is largely operated on an all island basis, and you would regularly see patients travel to the UK and indeed from the UK to Ireland for [specialized] care.” While there are many difficulties with the healthcare systems of the countries, Irishmen of both North and South and Scotsmen should ultimately feel grateful for their right to public healthcare.
The bus lurched forward and my stomach churned. No – this couldn’t be happening. I took my medication. I knew I took it. I think I took it… Did I take it? As we continued to roll through the early morning traffic, I came to a conclusion – I didn’t take it. My eyes began to dart around the bus, wondering if anyone could see my panic. This couldn’t be happening. I rapped the window envelope and the frigid, winter air flooded in. “The other people on the bus will understand,” I hoped. With my head halfway out the window, fighting for fresh air, I thought “You can’t do this. You CANNOT do this. You are already the girl with cancer.”

My knuckles whitened as my hands gripped the plastic bag, I made a silent wish. The emotion on their faces always burned. I couldn’t meet her gaze as I choked out, “Basura?” with widened eyes, first startled, then concerned. My face burned. I couldn’t meet her gaze as I choked out, “Basura?”

“Por favor! Lo siento.” She frantically searched the front of the bus before thrusting a plastic bag into my arms. I spent the rest of the bus ride dry heaving into the bag. Too afraid to meet the eyes of the other girls, I stared at the cloudy, yellow liquid until the end of the ride. Breathing in and out, I felt the embarrassment seep in. I was acutely aware of the discomfort I was bringing everyone else by forcing them to listen to my retching. I didn’t need to look up – I could already see their faces. It was the same face that I saw when I walked past them in the hallway. Eyes darted from me to the wall. Back to the wall. Should they ignore me? The emotion on their faces always burned. I didn’t need to look up - I could already see their faces. Eyes darted from me to the wall. Back to the wall. Should they ignore me? The emotion on their faces always burned. I didn’t need to look up – I could already see their faces.

It was the same face that I saw when I walked past them in the hallway. Eyes darted from me to the wall. Back to the wall. Should they ignore me? The emotion on their faces always burned. I didn’t need to look up - I could already see their faces. Eyes darted from me to the wall. Back to the wall. Should they ignore me? The emotion on their faces always burned. I didn’t need to look up – I could already see their faces.

I didn’t need to look up - I could already see their faces. Eyes darted from me to the wall. Back to the wall. Should they ignore me? The emotion on their faces always burned. I didn’t need to look up - I could already see their faces. Eyes darted from me to the wall. Back to the wall. Should they ignore me? The emotion on their faces always burned. I didn’t need to look up – I could already see their faces.

I didn’t need to look up - I could already see their faces. Eyes darted from me to the wall. Back to the wall. Should they ignore me? The emotion on their faces always burned. I didn’t need to look up - I could already see their faces. Eyes darted from me to the wall. Back to the wall. Should they ignore me? The emotion on their faces always burned. I didn’t need to look up - I could already see their faces. Eyes darted from me to the wall. Back to the wall. Should they ignore me? The emotion on their faces always burned. I didn’t need to look up - I could already see their faces. Eyes darted from me to the wall. Back to the wall. Should they ignore me? The emotion on their faces always burned.
Matthew Davis

Glasses

Quinn was always a troublemaker at camp. Some counselors say that she didn’t get enough attention at home, so she would act out more frequently here. So when another one of Quinn’s crying fits came along one Friday afternoon, only an hour or so before everyone was ready to leave, people were just brushing her off.

I was sitting at the front desk, doing my administrative work when I heard a commotion coming from the back room. It was a first-year counselor – I never got her name, but she was always nice to me and good with the kids – holding Quinn’s hand. They were walking to the nurse’s office, which is right next to the front desk. The counselor said they were outside on the playground when Quinn started to feel dizzy, talking about her grandfather who died over 6 years ago. The little girl just stood there, hysterically crying, on the verge of hyperventilating. She pulled away her hand the counselor was holding to wipe her nose, rubbing the lenses of her pink unicorn sunglasses with her left hand.

At the sign of crying, everyone’s heads turned and worry filled their eyes. But then they noticed the tears came from the eyes of little Quinn, the same eyes who cried 4 out of the 5 days that week. “What is it NOW, Quinn?”, they would say. “Stop crying, Quinn,” “Just. Calm. Down, Quinn.” Usually the attention of adults even noticing her crying was enough to quiet the girl. But with the day being nearly over, even this was too much to attempt to quiet Quinn who often, literally, cried wolf.

Yet I knew this was more than just one of her usual attention-seeking stunts. I saw this before. I knew what she needed. And it was not being told to calm down.

I got out from behind the desk, squatted down to her eye level, and encouraged her to keep breathing. “Inhale deeply. Exhale slowly.” I told her that I was there with her, there for her, telling her that whatever she saw, heard, or thought of, was okay. It will all be okay.

In the face of that little 7-year-old, I saw the face of a boy. Slightly chubby. Thin glasses. Older than I’d like to admit. I shook that thought out of my head and continued my conversation with Quinn.

I told her how much I liked her pink “shades,” as she called them. She started to smile slightly, out of the left corner of her mouth. Within minutes, the nice counselor was taking a now calm, albeit red-faced Quinn back outside to the other kids.

I went back to my desk, adjusted my own glasses, and finished my work.
Sydney Shugrue

2005

Every summer since I was born, my family and I have spent a few weeks during the summer at my grandparents’ house in Avalon, New Jersey. It never truly feels like summer until we arrive down the shore and I feel the salty breeze rustle my hair. This summer is no different, and the moment we arrive I rush up the stairs and into the bedroom, quickly throwing on my bathing suit. I run back outside where my mother spends 10 minutes covering every inch of my body with sunscreen. After she has completed her thorough job, my cousins and I hop on our bikes and speed down the street to the sandy path that will lead us to the promised land: the beach.

After we drop our bikes, we carefully select the perfect spot on the beach: not too far back, but not too close to the ocean that our things will get wet during high tide. We then take off towards the water, making a game out of pretending they are waves pretending they are monsters that will completely soak us and have adjusted to the cold water, my grandpa deciding to join us in the ocean. He slowly wades in, attempting to jump over the waves pretending they are rocks crunching underneath our tires. My grandma opens the door and stands on the landing, smiling down at us as we hop out of the car. As I always do, I rush up the stairs and into the house, stopping to take in the smell of fresh linen and lavender. Instead of heading straight to the beach, I make my way upstairs to say hello to my grandpa. He sits in his old grey reclining chair, watching golf on the television. He doesn’t hear me say hello, and I rush up the stairs and into the living room. Both my grandparents are seated in their respective chairs, golf playing softly in the background. My grandma has thinned out yet again and looks as though she is 85, not 75. I give him a quick kiss on the cheek, and he goes to stand up, bracing his arms on the sides of the chair to push himself up. The first time he tries to stand, his arms give out and he plops back down into his chair. The second time, he is able to get up, but it takes a bit more effort. After he has changed, we make our way to the beach, I on my bike, and my grandpa being driven to the beach alone.

After an hour, I have fully unpacked all my summer clothes and have put on my new bathing suit. This is the first time I have ever really heard my grandfather. He then goes to stand up, making a hard thud on the hardwood floor. My brother runs over to come up. On the last step, he loses his footing and falls, all make our way upstairs, my grandpa being the last one to come up. The second time, he is able to get up, but it takes a bit more effort. After he has changed, we make our way to the beach, I on my bike, and my grandpa being driven to the beach alone.

2010

Another year, another summer down at the shore. Since we are older now, we aren’t spending as many weeks at my grandparents’ house, but I am happy with any amount of time I can get in my favorite place on earth. We pull up into the driveway, the rocks crunching underneath our tires. My grandma opens the door and stands on the landing, smiling down at us at we hop out of the car. As I always do, I rush up the stairs and into the house, stopping to take in the smell of fresh linen and lavender. Instead of heading straight to the beach, I make my way upstairs to say hello to my grandpa. He sits in his old grey reclining chair, watching golf on the television. He doesn’t hear me come up the stairs, and he only notices me after I have called for him a third time. I bend down and give him a hug and a kiss on the cheek. He is thinner than the last time I saw him and his face is more wrinkled. I ask him if he is going to come to the beach with us, and he says yes. After an hour, I have fully unpacked all my summer clothes and have put on my new bathing suit. This is the first time I have ever really heard my grandfather. My aunt rolls her eyes. My grandpa, however, is not amused. Out of nowhere, he slams his fist onto the table and says, “Stop that right now. This is my house and I will not have you behaving that way.” This is the first time I have ever really heard my grandfather yell. When I look up at him, he is still unable to get up.

“Here grandpa, let me help you, these chairs can be difficult to get out of!” I say, looping my arm underneath his arms and slowly pulling him up. He mumbles a thank you and shuffles over to give my mom a hug and kiss on the cheek. I know there is no way he can get to the beach anymore, let alone walk on the unstable sand, so I go downstairs, put my bathing suit on, and head to the beach alone.

2018

We are going to the shore again this year, perhaps the last time we will be here for a while. It is harder to make time to go to Avalon during the summer between all our jobs and school. This year we arrive before my grandparents do, so we get the house to ourselves for a little while. I find myself being happy that we have some time in the house before my grandparents get here, because once they arrive it will be a lot more chaotic.

Eventually, my grandparents arrive at the house and my brother and I help carry their luggage into the house. We make our way upstairs, my grandpa being the last one to come up. On the last step, he loses his footing and falls, making a hard thud on the hardwood floor. My brother runs over and helps lift my grandpa to his feet. He quietly thanks my brother, and then shuffles over to his chair as if nothing happened. My mother and grandmother leave the room, probably going to talk about how my grandpa needs more help than my grandma can provide. My brother retreats downstairs, probably to go play video games. I want to follow
him, because I no longer know what to talk to my grandpa about. Most of the stories he tells are figments of his imagination, remnants of a life he wishes he had. We sit in silence for a few minutes until my grandpa finally says,

“So, when am I going to get to see my grandkids again?”

“Which grandkids?” I ask.

“Your children,” he says, looking puzzled.

“Grandpa, I am Sydney, your granddaughter. My mom is your daughter, Liz, remember?”

“Oh, right,” he says, and turns his gaze back towards the window.

I look at him, sitting in his chair, the warm outside light highlighting his frail body. His face is wrinkled and he looks tired and worn down by life. His hands rest in his lap, and I can see them shaking. After a little while, he turns his face and looks at me. His eyes are empty and lack the light that used to shine within. He turns his attention back to the golf, and I close my eyes, trying to remember how his smile could once light up an entire room.

A at Home

Carol Dickinson

She died peacefully at home. These are words we use so often when talking about death. They offer comfort, something positive to lean into when the pain is immediate and the loss incomprehensible. To know that our loved one was at home, surrounded by the familiar smell their own room, in their favorite pajamas, and in the company of those they held closest provides a small, yet anchoring, sense of peace as we face the challenge of saying a final good-bye.

When a brain tumor began bleeding uncontrollably, there was only one thing remaining to do: to go home. My mom’s journey with cancer was beginning to seem hopeful. While we knew that there was no cure for advanced melanoma, a new treatment promised more time. She was walking and reading again, and plans for the holidays and family vacations replaced conversations about infusions and physical therapy. It seemed like we were just learning how to live again, despite terminal illness. But the journey came to a halt a mere four months after her diagnosis. A headache sent her to the hospital, where scans revealed the problematic bleeding. Over the next 24 hours, her responsiveness diminished rapidly. By the time I got off the plane and to the hospital, she could no longer talk or open her eyes. Arm raises turned to hand squeezes, then small muscle twitches, then nothing.

The decision was obvious. We knew what she wanted. There would be no ventilators or feeding tubes. No futile efforts of emergency surgery or full-brain radiation. After the obligatory meeting with the on-call physician and social worker in the Oncology ICU, the paper-work was finalized and hospice care was arranged. When my dad leaned over and whispered in her ear, “Sweetie, I’m taking you home,” she lifted her arm for a final time to hug him around the neck. Our decision was affirmed and we knew it was time. Led by a medical transport van, we all headed home.

Nobody ever tells you what exactly is required to die peacefully at home. There was no warning that a hospital bed may not fit through the interior doorways of our house, or that the hospice nurse would only visit once a day. I had no idea how difficult it would be to administer medicine to someone who was unable to swallow or that a two-hour medication schedule meant I would not sleep for days.

When we arrived home, the transport service situated my mother while I met with the hospice nurse assigned to oversee my mom’s care. In 20 minutes, I received a crash-course in nursing. She explained the uses of and dosages of 13 different medications that I was to administer as needed and made me acutely aware that any confusion or mistake could lead to a lethal dose. My only objective was to minimize any pain. But how would I know if she was in pain? There were no words, no movements, no hints. When I asked, the nurse ominously raised an eyebrow and said, “You’ll know.”

I wanted to run. I had walked through the necessary motions and held it together all day, but this was too much. I frantically tried to absorb every word the nurse said, but the sudden understanding that my family would never look the same again devoured my processing capabilities. She threw out a cloud of cold, clinical symptoms. Terminal fever. Terminal agitation. Dyspnea. Skin motting. My throat tightened in a mix of anger and panic. To her, the woman in the next room was one of many patients. Another person of no consequence that she was to watch die over the next few days. But that was my mother. I wanted the nurse out of our home immediately but was also completely terrified for the moment she would leave.
She finally stopped and took a breath. Looking up from her clipboard for the first time, she said to me, “Remember, you are giving her a gift.”

Sometimes I question if the next four days actually ever happened. When you are waiting for someone you love to die, the passage of time becomes an unfamiliar thing. There is nothing more to hope for and nothing more to be done. All you can do is wait in the strange in-between. Between the desire to hold on and the readiness to let go. Between dread and anticipation. Between life and death.

I occupied myself with the tasks associated with my mom’s care. I wanted to do a good job even though I knew that it would be of little consequence. I had a constant awareness that the worst and best that could happen were, strangely, the exact same thing and precisely what we were waiting for. I grew numb to the high numbers on the thermometer that once caused alarm. Changing compresses that turned warm minutes after being placed her forehead gave me a sense of purpose. I passed minutes by counting respirations, panicking anytime they exceed 26 or fell below 12. I never was able to control the fear that engulfed my whole body every time I approached the door to my mom’s room. Every day, when a nurse visited I unsuccessfully fought the urge to ask the same question: How much time is left? I don’t know if I asked out of fear or a need for assurance that this wouldn’t last forever. Either way, there was never an answer.

The final moment, the one I had anticipated with dread and fear, was probably the easiest of the entire four-day period. It was just the two of us, and I knew, well before the second hand on the clock confirmed it, that it had been her last breath. There was no gasp or vision of spiritual ascension, but somehow, I knew. There was peace, for both of us.

The days to follow would be tiresome and painful, just as the days before, but in that moment, all pain was gone.

I now understand that gift that the hospice nurse mentioned. Dying at home is not easy. It requires immense love and sacrifice. Love to overcome fear and dread. To open the door each time despite not knowing what awaits on the other side, and to provide care when it is entirely hopeless. And sacrifice to surrender to the painful unknowns. To forgo happy final memories for ones of helplessness and confusion, and to bear witness to the entire progression of your own loss. But in the end, there is peace at home. And that peace is a gift, one we both give and receive.
By Alexander Gardiner

As you know, Boston College has lost a dear member of our community. Last Sunday, March 24, God called Patrick Gregorek home. Pat was my friend and roommate. This has been the hardest week of my life but knowing Pat for 3 of his nearly 22 years has truly been a blessing. He was incredibly considerate and purposeful with the most gentle and loving soul. Whenever I would return from practice, he would unfailingly ask me how VIP is going, wondering about our songs and choreo, begging me to reveal our secret Showdown theme. Well, Pat, this year’s theme is about love and family, supporting each other through the good times and the hard. It’s about remembering our loved ones and knowing that even if they aren’t with us anymore, they never leave us. And so tonight, I dance for you, Pat; VIP dedicates our set to you. I bet the seats are pretty good from Heaven, and I hope you enjoy the show.

By Alexandra Moran

I met Pat the second day of our freshman year. I was immediately drawn to Pat and we became fast friends in our shared theology class, sitting next to each other and sticking together during class field trips. Pat would always ask the most thoughtful questions and I found his continual pondering of small and large things alike to be so fascinating. He had the best sense of humor and we’d often just make eye contact and start smiling. I have so many beautiful, joyful moments with Pat, of lunches and conversations, singing with him every Wednesday and Sunday with LAG, and just hanging out laughing. He was so loved by so many people. His smile and kindness and curiosity touched so many. His presence in my life and especially in the LAG community will be so deeply missed. I’m struggling with this feeling of incompleteness, with sitting in rehearsal and in mass and knowing that it’s not right or complete because Pat isn’t there. But despite the grief and sadness, somehow I know that Pat is eternally with us. Pat will forever remain in my heart as one of the most beautiful friendships of my life.
CORDUROY, BLUE

In Memory of Patrick J. Gregorek

He always had a way.

Had a way to make you think.

He was so inquisitive
Always searching for answers
Seeking explanations
Not settling for anything less than truth.

He was so attentive
Listening to every note ring throughout the air
Reading every lyric as they fly across the room
Proving with his eyes that he cares.

He was so strong
Fighting a war without enlisting any soldiers
not wanting to spill anyone else’s blood.

He was loud and proud.
Not caring if he may have been wrong
Standing tall in his navy blazer
Looking for no one else’s approval.

He was funny in the most serious way.
Searching for a laugh both for and from him
Grinning from ear to ear
Spreading his smile like a disease.

He was so bright
Shining the path forward so others could see
in the darkness that he walked through.

He always had a way.

He still does.

He will find his answers and finally understand the truth.

He will sing along to every lyric hitting the perfect note.

He will put down his weapon and put on his jacket and
laugh and smile until we do again.

He is our light.
How does literature help us engage with loss? “About suffering, they were never wrong, the old masters,” W.H. Auden writes in a poem called “Musee des Beaux Arts,” noting the way artists capture both the obduracy of grief and its eruption in the ordinary, the day-to-day. Literature gives grief both outlet and shape. The traditional elegy, with its movement from lament to consolation, helped give expression to the “stages of grief” long before Elizabeth Kübler-Ross wrote her well-known book on that subject. To my mind, there is something about the shape and structure of elegy that is tremendously important to those of us who grieve the loss of a loved one. While “eulogy” lauds the attributes of the individual who has died, “elegy” has its deepest roots in song and ritual, in recognizing both the permanence of loss and what the poet Mary Jo Bang (You Were You Are Elegy) calls “the ineffable sense of continuance.” Scholars of medical humanities and narrative medicine recognize that these organizing frames help us both to remember and to heal. To give shape to loss in art or literature is a way of beginning to order what is profoundly disorienting, a re-membering that is intrinsically important as we resume our shared work of life.

Three weeks after my baby brother’s college graduation, my grandma called my mom.

“I just wanted to let you know that I don’t feel well this morning, and I’m going to the hospital.” Everything was wrong. Kidneys, lungs, cancer everywhere. Her doctor offered treatment.

“Thank you, doctor, but no.” And she was discharged to wait.

I had a trip planned to Scotland the next week.

“Go. I’ll be fine. GO!”

While I was gone, she stopped walking. Eating. Responding. But she breathed evenly.

Landed at Logan, called my mom. My mom entered the bedroom and said, “She’s back.”

By morning, my grandma had left.

Mary Rosenson Moorman, 1918–2012

By Professor Amy Boesky, PhD

By Professor Sara Moorman, PhD
Poetry has always been a force in my life. An echo, a special way to count time, a memory recorder. Before I started first grade my father bought me my first poetry book. He was a man who loved words and could joke in the several languages he spoke. He was man of abundant imagination and perspective. He died at the age of 91 from painful cancer – that had miraculously disappeared for 17 years; my mother – his deep love – died 8 years later at the age of 92. My response to the events of their illnesses and deaths was to write a series of poems which later became a book: Benign Protection (Cervena Barva Press – 2016). The writing process gave space for memory and grief. I would surround myself with talismans – small things that belonged to them, as if to call their ghosts back to me, to feel what I had lost, to let them know they were loved and missed.

I have been to Samarqand
For my father
Two years ago
May now as you made yourself ready for death I wanted to remain, relieve her of her duty and be a good daughter.
You sent me home to die with her alone.
I have been to Samarqand that final time
a journey by water the dream geography more full
than life, the mosque, the church
the covered women singing
the Stations of the Cross
the goblin boat to take me back by morning
I travel by train, north and walk to the park, it’s hot and burning to see the icons at the Met to look into the eyes of each and every opalescent Virgin
in the house of the father she guides the souls in comfort to Samarra.
Her eyes follow me, at home
I present you a gift
war traveler
who prayed
at every house of the father St. Sophia’s in Kiev, the Friday Mosque of Tashkent, the Bucharian Synagogue on Sepyornaya Street the tomb of the Prophet Daniel where his stolen bones grow the stops along the bloody way in Iran, Iraq, in Syria then Lebanon, in Egypt and Palestine, in Bethlehem at the Church of the Nativity where the Ottoman Turks had made the doorways four feet high to keep the wild horsemen out to Jerusalem where they meet God as three a trinity of one almighty city to destroy the houses of the father

Now hear the word of God as the pain goes through you like hot lead as your bones move lengthwise into sleep upon the bed. I have brought your last book in prescience and redemption in secret and in silence open it, alone, look study the compassionate face of Mary the distant face of Christ the icons we cannot escape imprinted on us since baptism, I hear you pray and I pray too for your life that spanned the century let the light hold fast enter Hagia Sophia the final house of the father go then, backwards to Samarra leave your shoes at the door see Christ who never was removed before your destiny is achieved, explore.

A rise, and go Vladimir for the kingdom of Heaven is upon you.
Since Patrick’s passing and the compilation of this journal, we have experienced the loss of another two Boston College students.

Our thoughts, words, and love extend to Alexander Urtula and Saoirse Kennedy Hill.