Capillaries

The Undergraduate Journal of Narrative Medicine

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Letter from the Editor

Welcome to the first edition of Capillaries: The Undergraduate Journal of Narrative Medicine. We are a new publication facilitating dialogue between the sciences and the humanities and aspire to create a more empathetic community. Our chosen name Capillaries embodies our mission: just as capillaries are sites in the human body where the exchange of nutrients and gases takes place, our journal is a site for the exchange of stories and ideas.

Traditionally, narrative medicine is a field for healthcare providers and patients to reflect on their experiences in medicine by using art. This process fosters respect for diverse healing processes and appreciation for the inherent humanity in all people. This is especially of importance today. In a time of great technological advancements, we must not lose sight of the essence of medical care: to understand our fellow human beings and their unique circumstances, and to thus treat the patient and not simply the disease.

While the roots of narrative medicine exist in the healthcare profession, it is a movement applicable to all members of the community. On our own campus, thousands of undergraduates are currently involved in healthcare, either as students in the health sciences, medical volunteers, and/or recipients of treatment. Our aim is to collect and curate stories and ideas about health from students of all majors, backgrounds, and interests. Specifically, we wish to provide undergraduates a forum to express themselves and become familiar with narrative medicine. Moreover, we hope to give voices to stories that may otherwise go unheard and to share a positive message that healing is possible for all of us.

Thank you to those who shared their ideas, stories, and vulnerabilities with us. We are deeply honored to provide a home for your prose, poetry, and reflections, and we invite readers to join in the dialogue on narrative medicine as well.

Sincerely,
Alice Ranjan
Audrey Immel
Fleur Anteau
Gal Snir
Maddy Bennett

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School of Nursing
Department of Gender, Women and Sexuality Studies

The Body

Jack Ferguson ‘18

I'm there now
standing at the top of the stairs
hesitant to walk down, I could just
fall down, to the cracking cold storage basement

The anticipation
is nearly unbearable, nerves shaking body and blood
rushing to head allowing me to float down
the last few steps and into the room

There it is
The waxy contraption covered
by silk smooth cloth and a gleam
off of fluorescent light reflections; the rolling
smoky steam and ended dreams

I reach out my arm to touch it
A cold layered ice cream cake of suspended decay and
nightmares of the worst possible moment of the worst possible choice
It could have melted under those lights
and revealed the mechanisms of life

I hold his hard hand in mine
It feels like an apple from the fridge
but brings to me a peace that only pain can bring
A calming repose rarely felt

I notice he didn't shave that week
and that his eyebrow isn't where it should be
I wanted to open his eye to catch a glimmer of something there
But he wasn't there, not at all, not any of him
This wasn't the same brother I knew
This was just a body

The Door Keeps Turning

Veena Pillalamarri ‘18

A lady in her late 40s, let’s call her Jane, comes running through the door of the Emergency Department. She is followed by two Emergency Medical Technicians (EMTs). It’s 12:30pm, I had just started my shift and observed that she was frantic as she tried to understand her surroundings. The EMTs stand with her while explaining to a nurse that the patient had called them and had asked to be admitted to the hospital voluntarily because she was having visions of people chasing after her. Jane was suffering from schizophrenia, a condition which affects how a person thinks and behaves. Symptoms include delusions, agitated body movements, and thought disorders[1]. She hadn’t taken her medication since a few days and knew that she needed to be treated.

In the United States, healthcare providers aren’t allowed to treat patients against their will[2]. A course of treatment can only be followed if the patient consents to it. When Jane voluntarily walked through the hospital doors, we as healthcare providers were only allowed to treat her with her consent. I started taking her vitals while a nurse proceeded to ask her about her previous medications, allergies, and why she decided to come to the hospital today. After completing our initial assessment of the patient, the nurse and I left the room upon telling her that a physician would be in to see her soon. A few minutes later, the patient came out of the room and informed us that she no longer wanted to be seen by a physician and refused any care we could give her. Since she came in voluntarily, we were required to allow her to leave.

3 PM: The front desk phone rings loudly. The coordinator is on the phone for about a minute before she hangs up and announces that an ambulance is five minutes out. I was exiting a patient’s room when an EMT asked me to help with the incoming patient. I rushed out to the unloading dock to find a group of two nurses, two EMTs, a physician and two police officers assembled outside. This kind of team is usually protocol for patients who are in an emergent condition such as having an ongoing stroke. Most patients are admitted before a nurse or physician meets with them.

The ambulance arrives and a white stretcher is pulled out. High pitched screaming fills the air but all I can see are white blankets. Hands from under the blankets struggle to pull the blankets off.

I rush forward to help when I hear one of the EMTs telling us that the patient was found naked on the street a few blocks away from the hospital screaming about people chasing her. A nearby resident had called the police who brought her to the hospital. The patient kept kicking and screaming trying to pull the blankets off her. The nurses and I succeeded on getting her into a gown when I finally had the chance to notice her face. The patient was none other than Jane from earlier in the afternoon. Now, she had scratches running down her arms and the side of her face. After we secured her gown, the police officers came in to place restraints on her. Since the patient presented as a threat to others and didn't seem of sound mind, the physician on the case made the call to restrain her from hurting herself or others around her.

Having placed restraints on Jane, most of the people in the room started leaving to allow some space for the physician and a psychologist to work together to help the patient. One of the department's EMTs worked at a station which looked directly into the room to continue monitoring the patient. I left the room still feeling intrigued by everything that was going on. The physician walks out of the door and lets us know that the psychologist will be working to calm the patient down before any course of treatment can be pursued because we still must obtain consent from Jane before administering any form of care.

I wait patiently, sitting next to the EMT and inquire about similar cases he has seen having worked so many years in the ED. Fifteen minutes later, the psychologist comes out to let the physician know that Jane has calmed down and would like to talk about courses of treatment. The rest of my shift passed by without any incidents. Before I left, I asked the psychologist and physician about Jane's progress. Jane had agreed to take the medication provided to her and was kept under observation until she seemed more stable. The treatment plan was to send her to a mental health facility where she could recover.

Following this experience, I wanted to learn more about mental health facilities and their functions in the United States. I took a class at the University of Washington taught by a professor who does research on accessibility and affordability of health facilities including psychiatric clinics and large hospitals. Through that class, I got insight regarding the kind of care patients received at health facilities. Approximately 43.8 million adults experience mental illness every year within the U.S. However, only 41% received mental health services[3].

Due to lack of resources, patients can obtain these services until they qualify as being of sound mind. After being declared fit to be able to function by themselves, patients stop receiving their medication that helps them control their illness. Many try to find jobs but due to the history of their illnesses, it becomes very hard for them to gain employment. Without steady employment, many people don't have insurance or the money to afford medication, causing them to revisit a hospital and have medication administered for another brief period of time. This is true in Jane's example as well. The health facility that the hospital placed her into will offer their services for a short amount of time, then they will release her at which point the cycle will start again since the progress she makes at the facility will deteriorate without the medication she needs.

After this experience, I have gotten involved with various organizations across Seattle which support National Health Programs and rally for more resources for the uninsured demographic. I have worked with physicians in trying to reach out to Senators and Representatives of Washington. I hope reading this article will give the readers insight into some of the aspects of the healthcare system in the United States.

[1] "Schizophrenia." *National Institute of Mental Health,* U.S. Department of Health and Human Services, Feb. 2016.

[2] Boudreaux ED, Niro K, Sullivan A, et al. Current practices for mental health follow-up after psychiatric emergency department/psychiatric emergency service visits: a national survey of academic emergency departments. Gen Hosp Psychiatry. 2011;33(6):631-633.

[3] "NAMI." *NAMI: National Alliance on Mental Illness,* 2015.

A Specimen Lies There

Kevin Andrew Nguyen ‘20

A specimen lies there
Oh so vulnerable, so compliant
In the cold, non-contaminated air.
A lax breath emerges,
Both by the patient and the doctor
Thereby creating a field of tranquility, and allowing
A healing aura to settle on the near horizon.

Chemicals lathered, skin tinted with a deep orange,
Liberally applied to eliminate any trace of contamination.
A small frame of the surgical area is revealed
With all else draped in morning sky blue sheets.

Incision!
Scalpel’s edge, sharp as the wielder’s focus
Gliding through the skin, flawlessly and precisely,
The slight pressure is combined with a massive exposure.
Layers of muscle unveiled
Causing the internal maroon sea to flood the site,
And an elegant maroon waterfall to result
Time is now of the essence.

The environment as still as the patient
Whose peacefully quiet and under,
Respiring the sterile air,
Observed is no phase of shock and no abnormalities,
The scaffold of muscle and ligaments appear perfect
But the foundation has crumbled,
A bone violently fractured into two
Yielding the entire joint holistically weaker.

Maroon-stained, ivory-white shards scraped away
And collected for a later graft,
A robust steel plate is inserted and sits beautifully
Resembling the horizon as the sun sets on the ocean,
The interface of natural and artificial
Structural steel and fragile bone become a unified foundation,
Yielding an unprecedented strength for future articulation
And an endurance that will last a lifetime.

Bone graft inserted, a slurry of maroon and white
Saline flushes the site, strengthening the maroon waterfall
Still present in the background.
Range of motion tested, and the rotations exceed expectations.
Slowly the layers are brought back,
First the tissue scaffold: the muscle and any supporting ligaments
Cover the steel-plated bone,
Encasing it like armor.
Then the skin returns as a blanket for the site,
And stitches are weaved back and forth
By a credence for natural regeneration,
Of a successful procedure,
And of a full healthy recovery.

The maroon waterfall has been hindered by the closing skin
The dynamic sea is fully restored and content,
And now fully within.
Within the frame surrounded by sky blue sheets,
There appears a new picture
Valiantly showing
A new strength, and a new phase of life,
For the specimen that lies there.

America: The Land of the Free and Home of the Short Lived

Neha Krishnam

Ever since 1990, Americans are dying faster and younger. Our life expectancy has dropped from 79.3 years to 78.6 years-0.1 from last year according to reports from the National Center of Health Statistics. Our maternal mortality has increased. Homicide rates are rising. We have some of the highest rates for adolescent mortality. A fifteen year old girl from Sri Lanka has a better chance of living to 60 than a 15 year old American girl. We spend approximately 3.2 trillion dollars on healthcare yet we are dying younger by the years. We rank 35th amongst other rich countries. Why?

The United States. One of the richest countries in the world. The only country asides from Papua New Guinea that doesn't offer paid maternity leave. And the rate—which we call the maternal mortality ratio, or MMR—is increasing in the U.S., whereas it's declining in most other countries. It's currently between 17 and 28 per 100,000 live births-more than double the rate 30 years ago. In Michael Moore's "Where to Invade Next", Moore travels to other countries and explains America's norms while the Europeans stare in astonishment. Across the world, it is expected for a mother to rest and spend time with her child after giving birth. Birth being one of the greatest moments in a parent's lifetime is a big deal and treated just as so in the majority of the countries. As research shows, early child life programs around 70% of adult health. Early child life is influenced from the womb and thus, the mother should not be under any stress or critical situations. Stress includes worrying about financial issues while pregnant. This is why most countries offer paid maternity leave as they recognize the importance of a mother creating special bonds with her child without the stress of money. Some countries even offer paid parental leave to encourage that the father participates in the early years of raising a child. However; in the United States, some mothers go straight to work a week after giving birth.

There is a serious lack of funding from the government for maternal services. This results in a lack of emphasis on maternal health when compared to fetal health. Previously, there used to be specialists in maternal health who could provide adequate care for women when complications arose. However; now many providers are trained to diagnose fetal issues yet still work in the labor/delivery unit and thus are not educated in the maternal problems. Another factor that contributes to this is systemic racism Statistics show the disparities in maternal mortality. Black women, regardless of socioeconomic status, dying in much higher rates than white women which indicates that our healthcare is not reaching all people of different races equally.

On the topic of race, modern day society has seen more than enough mass shootings. Homicide rates and adolescent mortality rates have been on the rise. The United States has the highest rates of traffic accidents and violence as well as suicide which are reasons for the rising adolescent mortality rates. Violence plays an important role in the increasing homicide rates as well. The United States ranks third highest for homicide rates - ranking around a 5 per 100,000 deaths. This has to do with the role of the government and again, economic inequality. Due to the lack of control on accessibility to weapons such as guns, violence is rising. Eighteen year olds are allowed to purchase guns but are not allowed to rent a car due to the laws. Statistics also show that poorer places have higher homicide rates because of the lack of education and increase in shootings and drug use. Children are growing up around gang members and friends/family getting shot. They are able to recognize at such a young age, that racism still exists - more than fifty years after Martin Luther King Jr. The number of mass shootings has doubled over the past few years and for every 50 guns, there are about 40 deaths due to accidental shooting, murders, and people handling guns who should not be doing so. Children from the age of 4 have been victims of gun abuse yet the government has not done anything about it.

Another major factor for our decreasing health status is our health. Cardiovascular disease is the number one leading cause of death for Americans. Among these factors of death include obesity, cancer, alcoholism, and drug abuse. The food we eat is filled with extreme fat, lots of sodium, and excess sugar. Healthy habits are taught in school but not encouraged through the food served. Cafeterias and dining halls serve food that mimic slob- a hamburger or a hot dog with a side of fries and a shake or sodium filled soup sitting in packets stored in the back. Compared to other countries, our food is a main reason as to decreasing life expectancy. Another issue is our portion size. Americans are served twice to almost thrice portion size of food that we should be eating in a day. If one wants to be healthy, they have to spend an excessive amount of money to do so. Inequality also plays a role in this yet again. Places of lower income have food deserts with markets filled with basic produce and stocked with junk food. Places of higher income have lots of variety and choice of where they can shop whether it be Trader Joe's, Albertsons, Ralphs, Whole Foods or Sprouts. These places have larger varieties of what they sell and have healthier options as well. This is also notable in dining halls. For example, UCLA is known to have the healthiest food in their halls. Food is freshly made and made out of ingredients that benefit the body and students. However; here at UW, food is stored in the back for months and filled with ingredients that increase our risk for diabetes and obesity.

While a majority of our taxes go to healthcare, it doesn't seem as though this is doing our nation much of a benefit. America, being one of the wealthiest nations, ranked 35th in the global "olympics" when compared to countries of similar wealth using health indicators such as maternal mortality and life expectancy amongst other statistics. The United States could really take note of how these other countries are functioning. For example, countries such as Poland provide 26 weeks of 100% paid maternity leave and even have introduced paternity leave to help the nurturing of the newborn child and to reduce stress on the new parents. Sweden puts most of its money into education and early life to enhance mental health and program adult health of a child.

Canada has universal healthcare for all of its people - of different races and different socioeconomic status. In France, school cooks consult with the teachers, dieticians, and even the mayor to make sure the children are getting the necessary nutrients and eating healthy food. Food is prepared daily and made from fresh ingredients. Their food is made with healthy ingredients and portion sizes are controlled unlike American portions. Japan has low homicide rates due to their laws and regulation when it comes to guns and other weapons. These are just words and a few statistics. It depends on changing our policies, laws, proper organization of society, but most of all, striving for greater equality to change the health of this country of ours.

Social Anxiety: My Best Friend

Madeline Kushnadi ‘19

I love when people tell me to stop being shy, embarrassed, or embarrassing. It’s like telling me to stop breathing. You don’t tell people with cancer to stop having cancer. Why is it any different? Why shouldn’t I chew on my nails, my hands, my self-esteem and entire existence? Why should I stop just because it’s the first day of school in a completely unfamiliar place with all these strangers who I don’t know won’t know can’t know send help someone please wait no don’t come…

“Hi! My name’s Jason,” a man wearing black converse shoes held out his hand towards me.

OH MY SWEET JESUS…a person.

“Oh

Well Ummmm H-

Hi Nice to me

Meet

Meet yo YOU. you…”

“Sorry, what was that?” freaking Jason…please be my friend…

“Uh hahah.. I
I said

It w- was

Nice…

TO MEET YOU”

I looked up to see that of course, Jason, normal, black converse-wearing Jason, has walked away by then. I bit down hard.

No blood, just tears.

Death's Call (A Sestina on the Limits of Scientific Medicine)

Maddy Bennett '20

We whipped and turned about the square

Interlocking our functions like the gilded clock,

The one in the emporium window that Arthritia could never trust

And so sat gathering dust unsold, a burden

Regardless, she had no need of such a wheel

It was her final breath-hour and her son sounded the clarion call

A haggard courier arrived at my door—this was no social call

With hastily assembled tools and tinctures, I followed him into the hills beyond the familiar square

And came upon an outpost of settler shacks where the road had scarcely been graced by a wagon wheel

There was nothing more complex than a plow in the hamlet, save the distant spire of the town clock

A hand at my back and I was inside the house of burden

Soft oil-light lined deep valleys in an old woman's face eroded by trust

In a new land—we had all come here with intent to trust

In the abundance of nature and in the clamor of civilization's call

But now the elders were expiring and I would not take on their burden

I wicked moisture from Arthritia's forehead, heard her ragged breaths, traced the perfect square

That I had been taught at the collegium as I learned to proselytize the way of the clock

My leather bag spilled its contents and I searched for the perfect fiber, knife, wheel

Her cataracted eyes refracted with terror at the sight of the sharp wheel

Even she knew being cut would alter her, put her into my trust

Though to extract the bad thing, it needed doing—remember the clock

Arthritia's daughter shielded her own small daughter's eyes, and possibly her ears to prevent her hearing the call

Of Death, the one who is said to look us square

In the face and tell us when it is time to relinquish our burden

But he does not do this, because there is no Death spirit, and that is the real burden

Which falls to me, the doctor, the one who will dispel their belief in a great wheel

Or some such nonsense. A circle will never be a square

Yet as I am about to make the incision, Arthritia violates my own trust

By sending for the Old Ones, telling her daughter to make the call

The Old Ones will come if one stands out in the field and yells, for they have never seen a clock

Three Old Ones drift down from the mountains, faces as blank as those of a clock

They wear only black robes and carry no implement or burden

A sunflower in each hand is all they have brought to respond to the call

They dance and sing around Arthritia in their own wheel

I am cast aside as the daughters join the song and Arthritia's face gleams with joy and trust

She died that way, and I returned unpaid and unneeded to the town square

To some of the people both in and outside of the square, I was not an aid but a burden

A clock doesn't measure the way light plays across a face, does not provide the trust

That some want as they die, the trust that the wheel will not leave them behind, that the Old Ones will be there to soothe while they hear death's call

A Matter of Life and Death: Asian Americans Towards Terminal Illness

Ai Che'19

I read the patient's profile many times while waiting in the hospital's lobby to prepare for my speech: taking notes of medical terms I was about to use; speculating the family's responses, etc. It was a typical day working as a medical interpreter at Seattle Cancer Care Alliance. My session today was for an elderly Vietnamese woman whose blood test results required the presence of family members. As grim as it may sound, I reminded myself not to get too involved with the patient's ordeal and keep my professionalism intact.

The patient was an 80-year-old accompanied by a middle-aged woman, presumably her daughter. The woman, wearing business formal clothes carefully helped her mother got to her feet and talked to her in courteous, clear voices. She had a wary look I knew so well from my days in palliative care interpreting sessions. She knew what to expect of the test result. I came and greeted them, starting a pre-session by introducing myself. The hospital assigned me to their case because the patient – her mother – couldn't speak English, but her daughter could. Before the doctor came, she pulled me to a corner and spoke urgently: "I know you aren't allowed to do this but this is very important to my family. My mother must not know she had cancer! She wouldn't want to live for fear of becoming a burden. Whatever the doctor said, please don't use the word 'cancer'. You understand that, right?" she demanded. Judging by her tone, she was used to having her request obeyed. I tried to refrain from saying "yes, ma'am" and recounted the first code of ethics I was taught – A for "Accuracy". I was obliged to interpret everything the health care providers said. But, as someone who grew up in Vietnam for eighteen years, it put me in a difficult situation. Traditionally, we believed that cancer diagnosis is a death sentence without cure in sight. An elderly woman would be less likely to opt for chemotherapy treatment or palliative care. In their mind, a prolonged death is the worst way to go and put a financial burden on their families.

The woman sensed my wavering resolution and lowered her voice. "We will send her back to Vietnam so she could spend her final years with friends and relatives. She would be well-cared for and happy, as long as you don't say the word," she added with an assuring smile. Protecting her parent from the truth is considered a noble duty she was trying to embrace on her own. The doctor soon approached us and plunged right into the topic. I was thankful to take my mind off the matter and interpreted what he said. My words flowed naturally and the patient nodded contentedly. The daughter eyed me closely when the doctor finalized the blood test result. It was indeed staged 4 cancer. I decided to play my last card. "Sir, as an interpreter, I would like to clarify the serious mental effect of the word cancer to an elder patient from my culture. She may not be able to handle the news." I pleaded.
I was cut short and explained immediately that he was following the hospitals very explicit policy of informing all patients of the formal diagnosis. The young woman heard this and glanced at me sharply. Her body language conveyed unmistakable disagreement. "I'm sorry, I'm just doing my job," I thought to myself. I would comply with my training and honor my profession. Before I uttered the "c" word, I suddenly remembered a useful piece of information that may defend my case. I made the judgment on the spot and used the word "serious illness" with a grave expression, hoping to emphasize the solemnity of the situation. The session continued with some follow-up questions about the treatment plans but from her reluctance to discuss the matter, they were unlikely to accept treatment.

Do interpreters run into this a lot? Thankfully, not often. Our jobs enjoyed great autonomy but also required self-improvement and high moral standards. Once you get the license
to work, you are on your own, without any supervision or recorded text to present in court. My move was risky on liability term but on cultural point of view, my patient would be at peace in her final days. Even with my vague interpretation "serious illness" instead of cancer and a suitable demeanor, I have captured the urgency of the situation so she could prepare herself. More importantly, I did it in accordance with my training.

By forsaking the first code of ethics, I have complied with the final code. That code reminded us that the people, not the system, are who we serve. My medical interpreting instructor cited that A also stands for "Advocacy"
(Fatland, Barry. Personal Communication. 12 Aug, 2017).

When the patient's health, well-being or dignity is at risk, the interpreter may be justified in acting as an advocate. Advocacy is understood as an action taken on behalf of an individual that goes beyond facilitating communication, with the intention of supporting good health outcomes. Advocacy must only be undertaken after careful and thoughtful analysis of the situation and if other less intrusive actions have not resolved the problem ("A National Code of Ethics for Interpreters in Healthcare" 3).

On some levels, it was the right call because an elderly Asian would be likely subject themselves to family members to make the decisions for them rather than seizing the autonomy of their treatment. Hospice and palliative care were sometimes considered taboo subjects and usually resolved between family members. A survey conducted among 138 Chinese oncology clinicians from Shanghai Medical College recorded only 11 participants (8%) chose to disclose the diagnosis to the patients directly whereas 39.9% would inform the family members (Gu and Cheng). A similar survey was carried out in Singapore, a Southeast Asian country with high-quality healthcare. Only 9% of oncologists chose to disclose cancer diagnosis directly to the patients. They are also more likely to choose non-aggressive treatment and 61% of participants have never consulted geriatricians when making treatment decisions (Pang, Ho, and Lee). The data strongly suggested a correlation between patient's advanced age and treatment approach. In the cases above, 37% of physicians admitted their elderly patients were undertreated. In other words, our cultural belief played a decisive role in matters of life and death and may not comply with doctors' codes of ethics to fully inform the patients.

Limiting communication leads to the patient's inability to make an informed decision for themselves and affect their treatment plans. This practice, though roots of cultural sensitivity, contradicts with the Hippocratic oath of not "causing harm and hurt" and should be avoided because it may cloud the better judgment.

The same attitude was applied towards hospice care for the elderly. In our culture, it was considered a disservice towards our parents if we send them to live their final days away from their loved ones, even if it's for their own good. In short, 'good death' is caused by old age and being surrounded by family members. Other forms of death or life-sustaining methods like palliative care or hospice service discussion should be avoided because it might cause premature death, or lack of will to live from the patients. This is how Chinese, or at a larger scale, the majority of Asian beliefs contrasted sharply with Christian ideology. In the Bible, the fundamental belief that Jesus died for our sins is what compelled someone to become a Christian, and that death is another phase of life, not the ultimate end (Yu 412).

If the patient was fully capable to bear the news, then there is no alternative than to inform them of their illness. However, people tend to approach it with such optimism and a strong conviction that the disease could be won if one "fights" it hard enough. An Asian cancer patient is more likely to receive a "Get well" or "Be strong" cards from well-wishers than a heart to heart
discussion about death, as ironic as it seems. Josh Friedman, a screenwriter, movie producer and cancer survivor, reasoned on Time that courage is a standard that no patient should feel compelled to meet:

> We know the dirty secret: You don't battle cancer. You don't fight it. If cancer wants you, it walks into your room at night and just takes you. It doesn't give a damn how tough you are. The only way you survive is through a mix of science, early detection, health insurance and luck. Courage has nothing to do with it (22).

Every culture valued courage and weaved it into stories we told to pass on for generations. Cancer surviving stories are no exceptions. But, our default setting when faced with an adversary isn't courage, it is fear of the unknown. To edge a patient in a battle against their own will is to deny them of their most basic emotion and ignore the internal silent struggle they went through when their body betrayed them.

Josh later pointed out in the same article that if we don't acknowledge fear, we won't be able to sympathize or connect with these patients – "the ones who fail, the ones who are afraid and the ones who let themselves and others down" (22). Many a time have I observed the weariness of a patient after their family visits. They had to put on an upbeat attitude to "fight another day" while I recap the doctor's prognosis in our native language; wondering if I was insensitive to their pains from my exposure to medical field or I was a lone voice amidst the crowd. One crucial aspect of quality health care is the provision must accommodate the patients' diverse background. Without understanding and appreciation of the patients' cultural belief, their path to recovery or decision-making process could be severely compromised. The burden of informing the patients of hospice service and palliative care shouldn't be handled by the health care providers alone. For there to be a change, there must be a cooperative support system between family members, chaplains and health care providers to alleviate the news bearing the burden of family members and respect the patient's final wishes. While everyone loves a heroic story of cancer survivors, we must not forget the real people who are doing the fight and their true feelings. That is when we tell a different story: a story of grace, forgiveness, and connectedness (Friedman 22).

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My Shrinking Hippocampus

Jack Ferguson ‘18

“Throughout human history, it has been apparent that few medical maladies are as devastating in their effects as major depression.” (Sapolsky, 2001)

devastating and all encompassing no relief
like we live to suffer and can’t breathe can’t breathe can’t breathe

“A final set of questions swirl around the complex issue of causal links among the correlates uncovered. Which factors contribute to and which are consequences of depression?” (Sapolsky, 2001)

what factors contribute to
engulf you swallow you become you convince
you
consequences contribute to your end

> But findings such as these also support the frequent uphill battle for those who study depression, or suffer from it, namely convincing others that this is a real biological disorder, rather than some sort of failure of fortitude or spirit. (Sapolsky, 2001)

failure

my shrinking hippocampus tells me so

Sapolsky, R. M. (2001). Depression, Antidepressants, and the Shrinking Hippocampus. *Proceedings of the National Academy of Sciences of the United States of America,* 98(22) 12320-12322. doi:10.1073/pnas.231475998

Disorder-Disease

Madeline Kusnadi ‘19

“I’m allergic to water,” I said under my breath.

“You what?” Liliana whipped her head around to face me, both her hands still trying to finish tying up her long, baby blonde hair. Eyes wide and mouth opening to complain, she caught my haha-you-can’t-stop-me grin. I ran passed her and cannonballed into the swimming pool.

“Oh my g– Lilith!” Liliana swiftly dove in to my rescue.

I popped out in front of her, “Relax, girl. Lia, calm down, I’ll live!”

“Then don’t scare me like that, Lili!” She grabbed me by my shoulders. My jade-green eyes meet her sky-blue ones. Mischief and worry don’t usually go together, but we did.

Bios (Meet your editors)

Alice Ranjan is a sophomore studying Microbiology and Molecular/Cellular/Developmental Biology with a minor in English. She aspires to become a physician and to pursue both clinical work and research. When she is not peering at cells under a microscope-she can be found reading classics and modern short stories, writing, and listening to Rachmaninoff's Piano Concerto No. 2 on repeat.

Maddy Bennet is a sophomore majoring in Psychology with an intended double major in International Studies. "Death's Call" is the second poem in her collection and is loosely inspired by the music of Purity Ring. Aside from listening to electronic music, Maddy also enjoys stand-up comedy, knitting, and chilling with friends.

Fleur Anteau is a sophomore intending to study Biology with a focus on Ecology. She is minoring in Environmental Science and History. Passionate about foraminifera (which no one has ever heard of!), she can often be located behind a microscope. When not in the lab she loves to read, garden and be nerdy with friends.

Audrey Immel is a professional student and hopes to keep it that way. While majoring in Public Health and Spanish, her interests range from literature to Chopin to cooking fancy things. Her dream is to be an epidemiologist by day and a stellar Salsa dancer by night.

Gal Snir is a sophomore studying dance. Through the lens of movement, she loves to study how folks connect with each other. She hopes that this first issue of *Capillaries*, with all its wonderful submissions, sparks greater understanding amongst its readers.