The Word Made Flesh:

That Time I Gave Cancer to a Character, Who was Me

BEN REED

1. EXPOSURE

After nine years of putting my English degree to work in the service industry—as a bartender, mostly—I decided to enroll in graduate school at a nearby public university, in what I'd been told was a very good but underpublicized MFA program.

In my third year, I took a course titled "First Novels." Among several debuts, we read Eric Puchner's *Model Home*, in which a teenager named Dustin watches as his girlfriend's sister Taz strips off her clothes and intentionally dives into a beautiful but undoubtedly carcinogenic reservoir of industrial waste. Through a shocking act of detached fatalism, she was probably giving herself cancer—roughly equivalent to committing suicide on an installment plan.

I contributed to my classmates' various expressions of unease and critical skepticism about Taz's toxic swim, but internally her act did not

seem wholly alien to me. I had been diagnosed with cancer the year before, and I had recently come to believe that I had caused it.

Let me step back.

Before graduate school, there was this short story I tried to write. It never came together, and I'm now certain I know why: because it was an *idea* story. The conventional understanding is that writers come by good stories through epiphany, some otherworldly or uncontrolled event. A rogue sentence appears before them, fully formed, out of the ether; through happenstance they overhear a compelling bit of dialogue between two strangers; they're told an anecdote and instinctually perceive a way to make the narrative more compelling. The point is, starting a short story is supposed to be an organic and vaguely magical process. The writer who takes a pet topic and clinically constructs a narrative around it is dooming himself to a boring and facile story. For *good* stories, there is a prerequisite quantity of mystery. I learned this the hard way.

As an English major who wanted to be a writer, I quickly maxed out on creative writing and modern literature courses. After that, cultural anthropology became my overriding focus. The area that interested me most was medical anthropology, specifically, culture-bound syndromes—what are sometimes alternately called culture-specific diseases, or folk illnesses.

There are a number of distinct culture-bound syndromes. There is koro, endemic to some Chinese and Southeast Asian cultures, in which the afflicted become convinced that their genitals are withdrawing into their body and will soon disappear. There is latah, also observed in Southeast Asia, where individuals who experience an emotional shock succumb to fits of jumping and hysterical laughing or shrieking. Dhat, in India, affects men who believe they are becoming impotent and are passing semen in their urine. There is brain fag, noted in Nigeria, in which stressed-out students come down with intense but medically inexplicable pain in their head, neck, and eyes. Similar to this is Ataque de nervios, which afflicts people of Iberian descent in the Caribbean, causing them to experience dissociative fits of screaming and shouting and crying.

To the day-tripping undergraduate anthropologist ca. 2001, the conventional attitudes seemed to indicate that culture-bound syndromes were exotic curiosities, proto-religious occultism, a residue of something pre-Axial. The West often thinks itself inoculated to culture-bound syndromes by virtue of our belief in empirical science, and our less rational yet doggedly dualist approach to the mind-body problem—perceiving the mind to be fundamentally distinct from the body, in this case presupposing a conceptual firewall between psychological complaints and somatic illnesses of the brain. Except of course that there are all manner of Western phenomena that could quite easily qualify as culture-bound syndromes: demonic possession, speaking in tongues, Morgellons, and Electromagnetic Hypersensitivity (e.g., people who believe they're allergic to Wi-Fi).

My big idea was that even though culture-bound syndromes are understood as singular and exceptional pathologies, they are also indicators of group identity. Illness can signify membership.

2. ENTER: PATEL

Around the time I started writing my *idea* story, this middle-aged man became a new member at my gym. He was balding and overweight, and apparently from India, though none of these details were why he stood out. For one, he didn't wear conventional exercise apparel. He was almost always in the same pair of old trousers and an ill-fitting terrycloth polo that would ride up his belly while he exercised. Except that "exercising" wasn't precisely what he was doing. He used all the machines incorrectly and inelegantly, to an almost comical degree, wandering between each inscrutable device with the feckless indifference of someone who has been ordered by his doctor to lose some weight. What this man did with the pull-down bar was more akin to postmodern narrative dance than a concerted attempt to train his *latissimus dorsi*. And yet, at least as often as I did, this man gamely enmeshed himself into the hypothetically beneficial

American ritual of sweating into delirium while lifting up and setting down pieces of rubberized metal, as Matchbox Twenty or Gwen Stefani blared from overhead speakers.

This new and conspicuous member at the gym precipitated my understanding that if I was going to write about culture-bound syndromes as systems of inclusion, I should probably work backward from some issue of intercultural conflict. I would write about a recent immigrant—no, better yet, an immigrant *family*. A small, story-sized unit of characters who have just traversed a series of national and cultural boundaries, landing in an unfamiliar conceptual geography. I decided they'd be Indian, the nationality I'd presumed to be that of the middle-aged man I saw at the gym.

I named the family Patel—provisionally, after a childhood friend—and decided the father would be the proprietor of a motel, or store, or gas station, one of a chain managed by a network of cousins and uncles and aunts. He becomes fervent that his family try harder to adopt the cultural norms of their new home. At all turns, this desire is thwarted. While the Patel patriarch is perfecting his English skills and American idiom, his wife has fallen into a deep, homesick depression. She refuses to learn English beyond what is minimally required of her. Their son is doing well at school, but despite his height he refuses to try out for the basketball team. Instead he watches cricket on cable TV, and when asked describes his American classmates as ugly, facile, and lazy. Their daughter refuses to eat American food and spends her afternoons conversing with her Indian friends on MySpace[1]. She turns fourteen and pleads to be sent back to Gujarat, to her corrupt high school administrators and problematic, cigarette-smoking girlfriends—in order, her father suspects, to find a husband, and thus a permanent purchase in their native country. Of course, Patel refuses. After this his daughter almost stops eating altogether.

After an interval, it's clear the daughter is ill. She's wasting away. An American doctor refers them to a specialist in eating disorders, who tells

1 This would be ca. 2007-2008.

them that she has anorexia nervosa, and explains that her eating disorder can be considered a "culture-bound syndrome," one fairly common among young women in America and parts of Europe. Though of course Patel is concerned for his daughter's health and wellbeing, *he is also privately elated*. His daughter has a Western cultural disease! Despite his family's subtle but constant mutinies, they're finally fitting in!

So, you see the problem. I had an already arrived-at sense of meaning going into the process, artificially scaffolding the overarching conceit—and to what end? So a basic plot could unspool into a punch line for a perverse version of a laugh-track sitcom. And then there was the potential effrontery toward both South Asian immigrants and people with eating disorders. But there was also no ruddy and urgent aboutness, nothing true I could make new for the reader. Also, the Patel in my story was unlike the man at the gym who had inspired him. My Patel was an eager adopter of new tropes and isms, whereas "the real Patel"—as I had begun to think of him—nightly presented a more nuanced, if shipwrecked, attitude at the gym, an expression of good-natured incredulity.

3. REVISION

Some nights, the real Patel didn't show up and I had an opportunity to study other members at the gym. Once, while I was stripping down in the locker room, I happened to look at the naked back of a man who was undressing a few feet away from me. He had a large and disquieting lump on his upper back, a discolored growth about the size of a halved plum, though not quite as purple. Plausibly it was a tumor. I was a bartender, not a dermatologist, but that's how scary this thing looked; it was obviously and disconcertingly unnatural. I wondered if I should say something. What if he didn't know? What if he lived alone, with no partner who saw him undressed often enough to say, "Uh, Herb, you really ought to get that thing checked out." Or what if he already knew everything about it? Maybe he hadn't gotten it removed due to some reason that was sad, or shameful.

Gradually, the man with the lump on his back began to merge with my Patel. In a flash, I realized I'd have Mr. Patel join a gym—like the real Patel—where he is painfully out of context, in a way that hurts his pride of nativization. One afternoon he's approached in the locker room by another gym member, a man about his own age who turns out to be a dermatologist. He asks Patel if he is aware of the disconcerting lump on his back. Patel is not. Sexual transactions with his wife have lately become terse and functional. The dermatologist has Patel visit him in his office and subsequently schedules him for surgery to remove a stage-one tumor that could have become a fatal mass. Later, as a show of gratitude, Patel has the dermatologist over for dinner, where the doctor immediately notices that the daughter—temporarily forgotten during her father's cancer scare—is alarmingly thin. He takes Patel and his wife aside to explain what he believes is happening to their daughter. *This* is how Patel would have his epiphany.

I liked this cancer angle a great deal. Giving Mr. Patel a tumor created an idiopathic counterpoint to his daughter's illness, underscoring the suddenness and inexplicability of both. But I needed to find a specific type of cancer to give Patel. Something serious, but nothing that would require chemotherapy or radiation, as I needed the doctor to visit the Patel home fairly soon after the surgery. I found *Dermatofibrosarcoma protuberans*, or DFSP. It's a rare and serious sarcoma, but not necessarily mortal in any imminent way. I plugged all these details into a new draft and continued to work on "the Patel story" until it inevitably died on me. Draft after draft failed to develop into anything I found compelling enough to see through to the end.

4. THE EMERGENCE

Years later, when I was a graduate student, my wife noticed a strange bump on my upper back. It was a hardened sebaceous cyst, maybe—I'd had one of those before, on the back of my neck. I agreed that I should have it checked out, but put off actually doing so. The lump grew larger. Then it took on a bluish tint. Finally, I made an appointment to see my doctor.

Mostly, my feeling was one of disbelief. I couldn't have *cancer*. I was only thirty-four. But there was no more plausible category for what my wife had discovered.

"It's probably nothing," said my doctor, a pragmatic Midwesterner who also owns and oversees a large working farm. Nearly every time I've inquired after different drugs or interventions, he has successfully deflected me with his old standby: "Give it some time. The body has a habit of healing itself." When I asked for cortisol injections for my aching and inflamed ex-football knees, he told me what I really needed was to lose some weight. Such exchanges reaffirm his value.

My doctor said he was going to refer me to a dermatologist, but tried to encourage me with the information that he'd only diagnosed malignant skin cancer twice in his entire career. He added, "And one of them was my brother in-law." I didn't know how to respond to that.

By the time I got in to see the dermatologist a week later, the lump on my back had risen even higher while a depression had sunk around it, the way a moat rings a castle. The dermatologist also affected a tone of disregard, dismissing outright the likelihood of malignancy. But this time I detected an underlying tremor of concern. Either my dermatologist did not have my doctor's poker face, or he was just better at spotting tumors. When his scheduling admin called a week later, to confirm my follow-up appointment, she told me, No, she could not give me my biopsy results over the phone. This revealed what I most wanted to know. Years before, when I'd had the sebaceous cyst taken out of my neck, the surgeon called me at home to give me the cheery news that everything was totally benign. No cancerous cells at all were detected. This you can say over the phone. When it comes to diagnoses, only good news travels fast. Bad news requires your presence.

5. THE IMPECCABLE WORD

Long before this—back in the halcyon days of benign neck cysts—I got married. A few days after Christmas my wife and I honeymooned in Portland, Oregon, the farthest city from ours where we could still afford to live it up for a week. We spent New Year's Eve at The Jupiter, one of the progenitors of the hipster hotel phenomenon.

Instead of Gideons Bibles in the nightstands, The Jupiter provides copies of *The Four Agreements*, by don Miguel Ruiz. (An insert encouraged us to take it with us when we left; the hotel would add it to our bill.) I flipped through our copy while my wife was taking a shower. The book is resonant with Carlos Castaneda's *The Teachings of Don Juan*, and Eckhart Tolle's *A New Earth*, in that the Toltec-inspired wisdom Ruiz offers hews to recognizable tropes of spiritualist New Age self-guidance books, all of them basically instructing the reader in the ways she might dissolve the egoic and dreamlike veil of misconceptions enshrouding her foundational reality.

The Four Agreements are really imperatives, and they're actually quite reasonable:

1. BE IMPECCABLE WITH YOUR WORD
2. DON'T TAKE ANYTHING PERSONALLY
3. DON'T MAKE ASSUMPTIONS
4. ALWAYS DO YOUR BEST

Ruiz writes that the first agreement—the commitment to impeccable speech—is the most important of the four. This is because speech, written or spoken, is our primary creative force. Words come from God, and it is in our words that we are most godlike. Only through language do we seem to create something out of nothing—an idea not entirely unknown outside of the Toltec tradition[2].

2 "In the beginning was the Word, and the Word was with God, and the Word was God" (John 1:1).

Ruiz writes, "The word is a force; it is the power you have to express and communicate, to think, and thereby to create the events in your life."

He continues,

"All the magic you possess is based on your word. Your word is pure magic, and misuse of your word is black magic…One word is like a spell, and humans use the word like black magicians, thoughtlessly putting spells on each other…We cast spells all the time with our opinions. An example: I see a friend and give him an opinion that just popped into my mind. I say, 'Hmmm! I see that kind of color in your face in people who are going to get cancer.' If he listens to the word, and if he agrees, he will have cancer in less than one year. That is the power of the word."

6. DIAGNOSIS

My wife is a math professor. She had to teach on the day I was to return to the dermatologist for my biopsy results, so I had to take our one-year-old son with me, even though he wasn't so great at things like sitting still or waiting or being quiet.

The dermatologist was grim when he arrived holding a manila folder. He regarded me as I tried to keep Henry occupied with a hybridized version of peek-a-boo, which incorporated random objects I'd found in the diaper bag. I made the perfunctory apology, but the dermatologist said, "No, it's probably good that you brought your baby."

It's safe to say he had my attention.

"So—it's bad?" I wasn't really surprised. Since the biopsy the lump had grown noticeably larger and become a much deeper shade of red. Healthy tissue doesn't do that in response to a few very small surgical excisions.

He sat down and told me that the raised lump on my back was indeed a malignant tumor. "What you have is very rare. It's called a *Dermatofibrosarcoma protuberans*. That's a mouthful, I know. Why we usually just call it 'DFSP.' To be honest, I haven't seen one in person since medical school." He held up his manila folder. "I actually had to

go online and do some research." He went on to explain that DFSP is a very rare type of sarcoma. I was not quite one in a million; I was four in a million. I kept it to myself that the odds we were dealing with were actually far more astronomical—really, what are the chances a writer will become afflicted by the very same super-rare disease he gave to one of his characters? One in a billion? A trillion? The likelihood was so unthinkably miniscule, random chance felt impossible.

The dermatologist said my situation was serious, though not necessarily life-threatening. Still, I was to be referred to a surgical oncologist. "You can live with a DFSP for several years before metastasis. Most likely, no radiation or chemotherapy will be required. Just the surgery." I nodded. I already knew all this, from my own research. I tried to get a look into his folder, wondering if he and I had read some of the same articles.

"I must say," the dermatologist said. "You're taking this rather well."

I shrugged. I picked up my son and gently bounced him on my knee.

"What am I supposed to do? Cry? Freak out?"

"Well, yes," he said, stammering a little. "That's generally what people do."

I didn't know what to say. I felt that I was being perfectly reasonable.

7. MAGICAL CONSIDERATIONS

God help the writer who is not a skeptical, scrutinizing, and critical person by nature. Writing something worthwhile almost always requires at least some exposition of the gears and levers normally cordoned off from our mental landscapes, or hidden behind society's tasteful curtains. However, a typical writer's understanding of causation is not necessarily scientific.

In John Gardner's *On Becoming a Novelist*, he writes the following in a chapter titled "Faith":

"…the single question most often asked [of me] during question-

and-answer periods in university auditoriums and classrooms is: 'Do you write with a pen, a typewriter, or what?' I suspect the question is more important than it seems on the surface. It brings up magical considerations—the kinds of things compulsive gamblers are said to worry about: When one plays roulette, should one wear a hat or not, and if one should, should one cock it to the left or to the right? What color hat is luckiest?"

It has also been my own experience that writers, as a class, are devoutly ritualistic and superstitious people. Like professional athletes, many of us cling to charmed instruments and religious performances that we imbue with the mystical power to ward off creative slumps and blank paper. We develop a preference for a brand of pen, or notebook, or a type of chair, or set time of day in which to work. Preferences easily become dependencies. It is said that Carson McCullers always wore her lucky sweater to write, and that John Cheever would write without pants. Truman Capote refused to begin or end a piece of writing on a Friday. Friedrich Schiller kept rotten apples in his desk drawer, unable to work without the odor of their decomposition. The poet Edith Sitwell would lie in a coffin before writing. Isabelle Allende only commences new novels on January eighth. Charles Baxter has said, "I don't like to spill salt. I throw it over my left shoulder…if I spill salt in the morning, my day is fucked." A number of writers I know have championed the totemic power of a house cat. Many of us avoid discussing works in progress, for fear that speaking of them while *in utero* might bring upon miscarriage, or will enervate or exorcise some fundamental creative motivation.

We can call these beliefs and rituals by less weighty labels—like *methodology*, or *practices*—or we can call them what they are: superstition, the belief that a specific action will instigate a specific outcome, without any natural and objectively verifiable process.

I understand the utility of writerly superstitions. Writers work long and diligently, to exacting standards, without the promise of readership, publication, or payment. This despite the fact that we are constantly con-

structing plots—which is to say, we are constantly constructing causalities. One thing must lead to another.

8. THE GOOD KIND OF CANCER

The dermatologist explained that my sarcoma wasn't so terrible, all things considered. It was not a melanoma, for example. But it did need to come out, as there was always the possibility of metastasis.

"To where? My scapula?" I clearly remember saying "scapula" instead of "shoulder blade." For some reason I'd wanted him to know that I knew the word "scapula."

"No, not your—scapula. Your lung." Then he told me that the moat-like depression around my back lump was where the tumor had been diverting my blood to feed itself.

This was about the time everything started to feel serious.

I removed my T-shirt so he could survey the site post-biopsy. "Whoa!" he said. "This thing looks a little angry, doesn't it?" My tumor had not only redirected blood from the rest of my body, but suddenly it had gained a personality, capable of both irrigation and emotion. Except that my punctured and provoked protuberance didn't look angry. At home, in the mirror, it was wine-red and throbbing, flushed and engorged. It didn't look angry; it looked fucking *furious*.

9. THE MIND-BODY PROBLEM

If culture-bound syndromes were purely psychological, we could instead classify them as culturally unique expressions of universally human neuroses. But there are also somatic symptoms—different manifestations of biologically and clinically significant distress that have no clear organic origin or physiological mechanism. They almost seem factitious, or like voluntary performances, except that they are neither.

I never told any of my medical interventionists what I suspected: like one of don Ruiz's thoughtless practitioners of black magic, I had placed a spell on someone, only in this case it was myself. And it goes without saying that I never mentioned Patel—neither his actual nor fictitious manifestations—to any of the three doctors I now saw regularly. There's no way they could have understood why I believed that I had given myself cancer. They would have said my assertion was absurd, fantastic, or simply specious. But what could they offer besides pure, random chance? Randomness is not an explanation. It is the absence of an explanation.

10. EXCUSED ABSENCES

After I spent a day and night fasting, my wife drove me to the hospital. I was put under and operated on by a surgical oncologist and discharged later that day. I had been told the whole procedure would be relatively simple and straightforward, but I soon realized this would not be the case. I continued to bleed after I got home, at a surprising rate and with no apparent recession. Twice I had to visit the surgeon's office to have my back cauterized with what my wife said looked like liquid mercury. Three times I had to see him to replace the clear plastic bandage he had affixed over the bloody rectangle on my left thigh, where he had removed a reticulated swatch of skin to graft over the very large divot in my upper back. The plastic bandage on my leg was intended as a sterile occlusive wrap good for up to two weeks, but it kept filling with blood, like a pouch. After the surgeon replaced it for the fourth time, he told my wife where she could buy the plastic bandages herself, as it would be impossible for him to see us every time I needed a replacement.

Every day, my wife changed the bandage on my back, using mounds of sterile gauze and more cloth tape than a heavyweight boxer needs to wrap both hands. The bandage made me look like a hunchback. I ruined several T-shirts with stains from blood and betadine and topical antibiotics. I slept on my stomach, unable to roll or bend or move very much at

all, my head turned to one side and then the other. My body smelled like sleep and medical products.

The administrators at my MFA program were sympathetic. My instructors were excessively accommodating. My siblings and in-laws helped out by watching my son and running small errands when my wife was too busy or too exhausted. Friends brought food so she wouldn't have to cook—mostly my wife's friends, not mine. I had changed jobs three times in four years and at that point most of the people I interacted with were other graduate students whom I was just getting to know, and who were all several years younger than I. Honestly though, I didn't mind being left alone. I turned down any offer of company that came to me personally. All I wanted to do was lie in the air conditioning, letting my skin grow. I hadn't known serious depression since my twenties, but I could sense its proximity, a familiar density tugging at me from just beyond the periphery of my painkiller fog.

It is a major irony of existence that recovery can be the hardest part of having a disease.

My lowest moment came when I first looked under the bandage. I'm not normally squeamish, yet I had put off looking for almost two weeks. My wife had been warning me, conditioning me for the shock—she saw the damage every time she changed the bandage; I had heard her sharp inhalations. Still, I was unprepared to see how much of me had actually been removed. The concavity in my back was about the width and depth of a small saucer. When I moved my arm as I stood hunched over in front of the bathroom mirror, I could clearly see my shoulder blade sliding beneath a translucent layer of fascia. Doing this made me nauseous, but I kept at it, making strange contortions before the mirror. It's strangely compelling to witness your own skeletal workings.

Draped across the new depression in my back was the reticulated mesh of skin grafted from my thigh—its diamond pattern less like a fishnet stocking, as my wife had described it, and much more like the white Styrofoam lattice you see in grocery stores, snugged around the Asian pears. I had been told that the surgical excavation of my back would eventually

fill itself in and heal over, leaving little more than a wide scar—a pink slick interrupting a constellation of freckles. But looking at the hole, you would doubt such a space could ever recover. The dermatologist had said the tumor was probably about the size of an almond, and yet the surgeon had left a blast crater wider than a grapefruit.

Since the surgery I have walked through airport body scanners dozens of times, and at every occasion I have been asked to step aside so I can be patted down. When I turn to look at my avatar in the monitor, I can see that my scar has been flagged, indicating that this part of my geography might be worthy of closer inspection.

The best part of my recovery—even better than taking my first hot, full-blast shower, after weeks of standing at the bathroom sink to take what my wife referred to as "whore baths"—was getting the results from the post-surgery biopsy: my pound of flesh had clear margins of one to two centimeters along the surface perimeter, and one to two millimeters along the tissue that formerly lay against my scapula. Medically speaking, I could exhale.

II. AFTERLIFE

As a graduate student I had discovered that I enjoyed teaching, so I remained at my university after graduation, becoming a full-time adjunct lecturer of English. Two years into my new career, a fellow adjunct and poet named S. was diagnosed with an advanced and metastatic melanoma that had already spread throughout her pelvic area and inflamed the lymph nodes around her femoral artery. She was only twenty-nine, and her outlook wasn't good.

S. was aware that I had dealt with some kind of cancer a while back, and reached out to me through Facebook Messenger. We had never been friends, but that didn't matter. We both now belonged to a group described by a diagnosis.

Mostly, S. was seeking advice and commiseration. I told her what I

could, and put her in touch with a friend's sister, a young woman who had survived a potentially deadly melanoma. Our correspondence was sporadic, as S. didn't want to communicate when she wasn't feeling well. Whenever I did hear from her, she was upbeat:

"I'll be joining you in the scar club soon enough. I'll have an eight incher on my right outer [thigh], four to five inches on my inner thigh, and a series of small ones across my pelvis. Plus a med-port scar [. . .] my skin is starting to look like the surface of the moon with all the biopsies my derm has taken. Sorry, I haven't gotten this down to a concise description yet. I process it each time I share."

It wasn't surprising to me that a poet and fellow English teacher would focus on descriptive visual detail and the efficacy of her own provisional metaphor to gauge her attempts to describe and thus *understand* her illness. What did surprise me was that she had also initially identified herself as a guilty party:

"I think I'm finally coming out of the blame-stage, trying to figure out which sunburn it was, which lapse on my part caused it. That's been harder than thinking of my prognosis."

As it turns out, blaming oneself is an almost unfailing consequence of a cancer diagnosis. I think this is partly because most of what the average person knows about cancer relates to theoretically avoidable environmental hazards, like second-hand smoke, UV radiation, heavy metals, and asbestos—and partly because it's natural to blame yourself when something goes wrong with your body. You locate internal hazards, like poor diet, lack of sleep, negativity, and chronic stress. Facing a scary prognosis, the mind-body problem is easily eschewed. *Of course* it's my fault. Whose else could it be?

12. IPSO FACTO

It is no accident that humanity has developed language and mathematics and music. Perceiving and recreating patterns may be our fundamental

advantage. Long before early modern humans had to become expert at the cycles of seasons and meteorology in order to raise crops, their predecessors had to understand the wheel of the heavens in order to navigate strange lands, the migrations of game in order to hunt, the rotation of tides in order to fish and scavenge protein-rich crustaceans, and the patterns of illness in order to nurse the sick. Eons later, all of philosophy and science was predicated on a single structure: *If this then that*. Finding patterns—adducing the relationship between an effect and its cause—is what we do. And there is no causality scarier than its absence, no meaning more terrifying than meaninglessness. In some ways it's actually comforting to understand that a lifetime spent smoking and getting sunburns will probably result in getting cancer. And yet there was my grandmother, who lived in the desert and smoked dozens of cigarettes a day from her early twenties until my mother made her quit at eighty-three—she died at ninety-one, from simple old age. Conversely, we are not always to blame for the cancer that ravages our body, just as we aren't responsible for the color of our eyes, or the luck of the sperm that impregnated the egg that became us.

Organizations like the American Cancer Society and the National Cancer Institute reiterate the consensus that there is no clearly established link between mentality and carcinogenesis. Not in regard to attitude, personality, or stress. These issues *do* have an observable effect on wellness in a number of ways; however, a positive outlook and attitude has no effect whatsoever on a cancer patient's odds of survival, nor on anyone's ability to ward off cancer in the first place. Perpetuating the misconception that one can better parry a cancer that has taken root by eating raw organic vegetables—or practicing yoga, or meditating toward a Buddhistic mindfulness—allows those who fail to get better to blame themselves for the full arc of their disease. Our human reflex to perceive causality doesn't just make us place stock in our horoscope, or leave us prone to superstition; it causes some cancer patients to die thinking that they were somehow the responsible party, hampering their ability to meet death with calm and dignity

We in the West are not immune to culture-bound syndromes. We are

simply immunized to the types of culture-bound syndromes that are endemic to developing and colonized nations—places that, not accidentally, are decades or centuries behind the technological literacy of Leipzig, Tokyo, or Austin. And yet, despite our supposed sophistication, cancer remains only partially explicable. All we can say with certainty is that cancer is what can happen when a cell is made or remade imperfectly. We are only now just beginning to understand how these imperfections come about, how these typos find their way into the story of our genome. The second-most common cause of human death remains partly mysterious to our best minds and our fastest computer processors. Here, space is created for the only true black magic out there: our need to perceive order, meaning, and causality, even where it does not exist, or when it cannot be known.

Deciding whether or not I *actually* gave myself cancer does not depend on my understanding of carcinogenesis, or whether or not I am a superstitious person. It depends on where I draw and redraw the boundary that both separates and connects my environment and myself, and how I rationally perceive my mutable self in the cause-and-effect existence of the empirical world. It is therefore ironic that fruit is so often the universal scale of cancer prognosis—my tumor was the size of an almond, but yours may be a pea, or a cherry—because the fundamental conflict that arises from trying to fingerprint cancer causation is, essentially, a problem of apples and oranges. We understand human biology very well, and we understand what elements comprise our environment. But one doesn't necessarily reveal the other, and in some senses we have yet to catch these conspirators in the act of inciting cellular mutiny. Until the next breakthrough, we must tolerate this mystery, walking a tightrope anchored to faith on one side, and instinct on the other.

13. THE END

Almost exactly four years after my surgery, the chair of the English Department emailed the faculty to inform us that S. had died two days

before, on a Thursday at the end of March. This was about 250 days after her diagnosis.

It would be false to say that talking to S. about her illness had made us close. Beyond saying hello to her at work, and seeing her out a few times at one of the bars adjacent to our campus, a handful of Facebook messages were the entirety of our relationship. However, it would be equally false to say I did not feel affected. Since my diagnosis, S. was the first person in my social vicinity to die from the disease I had eluded, and despite everything I now understood about cancer—and about how badly the human mind needs to adduce causality—I still felt her death must *mean* something.

Ultimately, this is how we as writers find our membership—not to a group composed of other writers, hoping some magical process will help us find the right words—but as human beings, believing against reason that whatever strange or terrible thing comes our way, there must be some explanation.