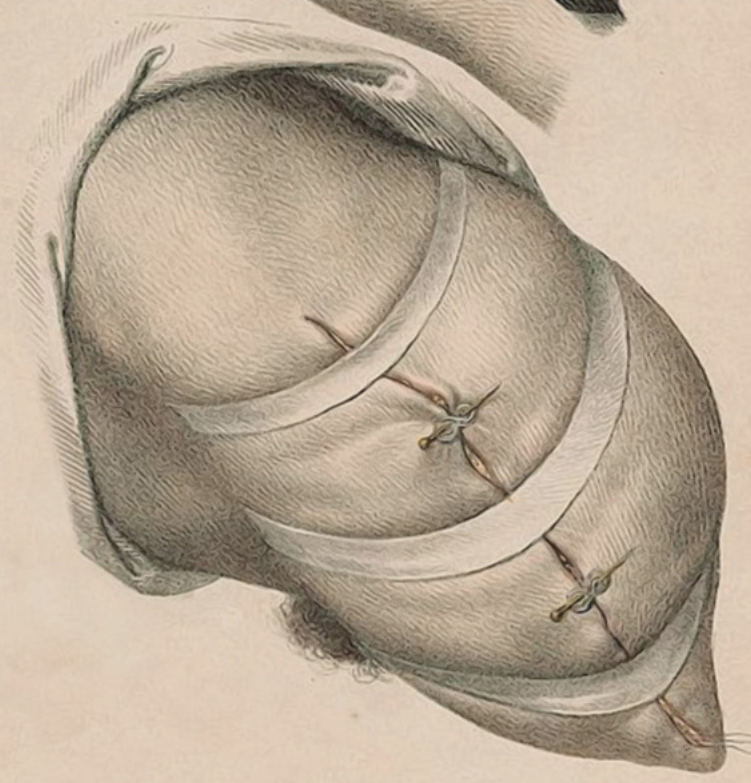


THE NEW INQU.

SICK



Cover and following images: *Traité complet de l'anatomie de l'homme: comprenant la médecine opératoire*, 1839



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SICK

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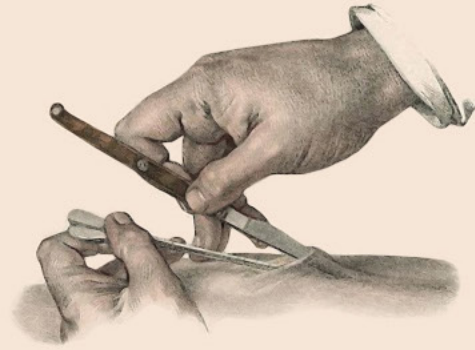
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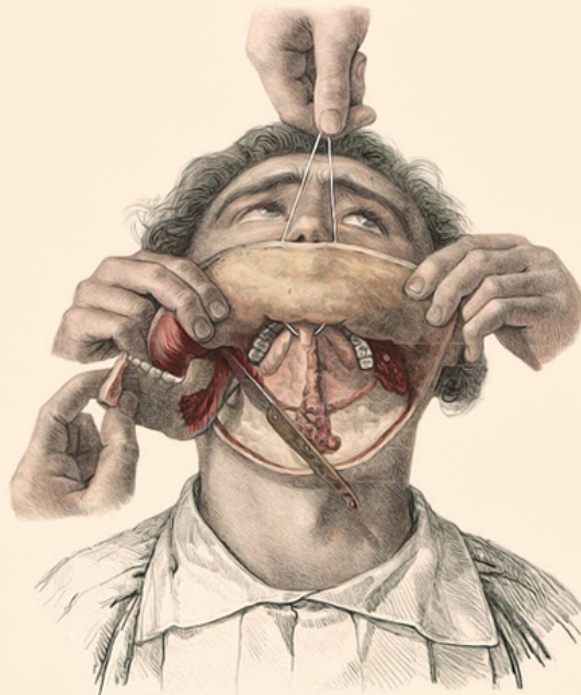
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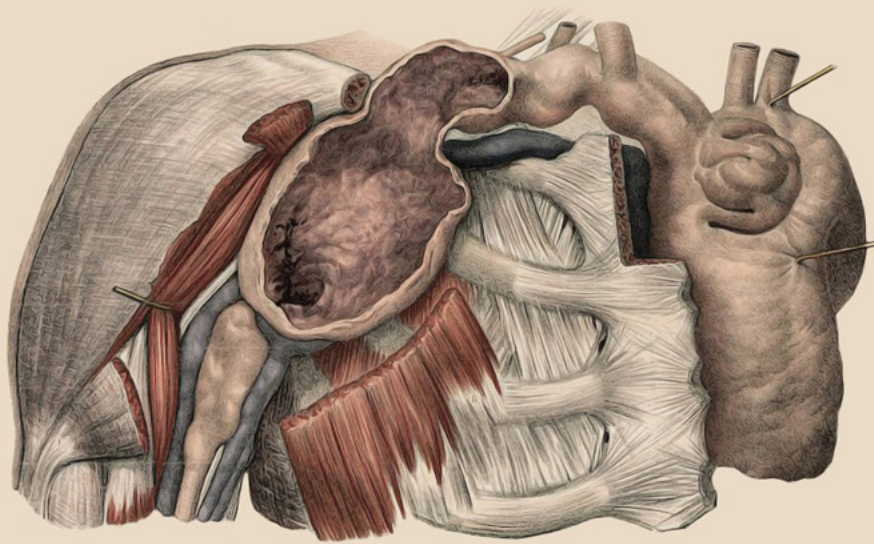
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BEING sick changes your relation to your body and how you inhabit it. As an experience, it is stubbornly untheoretical, even though it oozes theory, infecting concepts of cleanliness, system, and body with its disorder. Mutated understandings proliferate from sickness that lance falsely clear categories, revealing the orderliness of the world to be a form of disease. What is clear is that clinically treating biological pathogens as the sole source of corporeal trouble is an efficient way to wipe clean the structures that weigh on our lives.

Earlier this year a report found indigenous Americans suffer PTSD at the same rate as Iraq and Afghanistan war veterans. This year too, Eric Garner was choked to death by a NYPD officer, but chalking his murder up to either banned maneuvers or chronic asthma is to ignore the sickness of the social order that brought Garner and his murderer Pantaleo

into such predictably lethal contact. The past hundred days or so have seen the deadly toll of the social order, which steals lives as steadily as a heartbeat. That order has come under revolt by people immune to the political delusions that take such a body count to be an index of civic health.

It's easy to say that capitalism makes us sick, white supremacy makes us sick, misogyny makes us sick, and mean it quite literally. What and where it hurts is another question, and why may be beyond our scope. But in this issue of *The New Inquiry*, our contributors attend to their illnesses. Hannah Black writes of the toll of losing someone to schizophrenia, of the death-in-life that you have to accept when it dawns on you that you no longer exist in a shared world. Caring for a person with a mental illness forces you beyond all measure, she writes, which is why it often falls to women, who live partly outside of measure, and often makes them crazy too.

Another kind of crazy-making death-in-life is living with the knowledge that you have tried to kill yourself, as Natasha Lennard writes in “On Suicide.” Questions of intent are necessarily hazy in this act, which confounds the subject-object split beloved of philosophy but doesn’t make it any easier to put to rest. Trying to die, but in a state that means you can’t really mean it, means you’ll struggle with coming to terms even with your failure—as if there even are terms to come to.

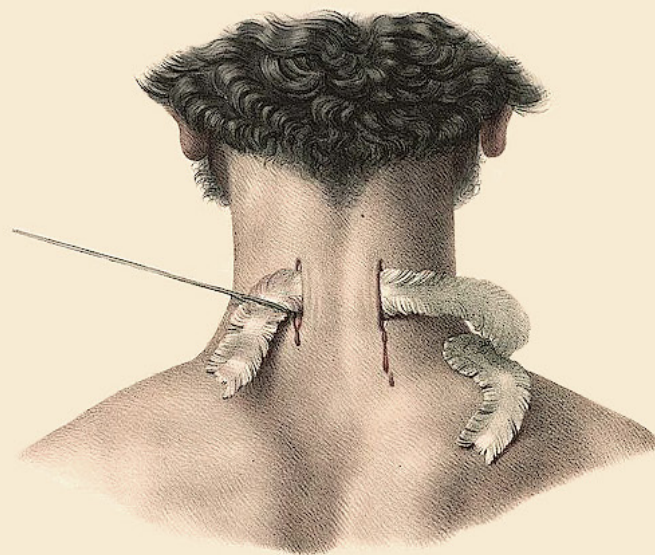
Evan Calder Williams writes of the experience of diabetes as a transformation of your body into a siphon through which the world pours itself. Historically, diabetes has been understood through its liquids—insulin, urine, blood that must be constantly drawn and read. Diabetes is the condition of no longer being able to take what’s supposed to be good for you, but it forms subjects whose existence depends on the same circuits of production that made them sick from the start. Trapped between

refusal and fidelity, of course they are targets of shame.

In “Weight Gains,” Willie Osterweil examines the equally shame-ridden problem of obesity, though its medical status isn’t nearly as stable as that of diabetes. Instead, he finds it to be a product of capitalist agriculture’s need to find a place to store its glut, which it resolves (as always) with the bodies of workers. If anything about obesity is a sickness, he writes, it’s that the global food market is structured precisely like an eating disorder, sending consumers spinning from diet pill to subsidized corn.

In “Taking Shit From Others,” Janani Balasubramanian writes of that most shameful substance, shit, and the miraculous cures it promises, if only the FDA would get past its squeamishness and let a thousand transplanted microbiomes bloom. The digestive system, like a body within a body, is the where the world flows through us.

Racialization is another way the world gets inside us. Yahdon Israel takes a serious look at the racial ramifi-



cations of cooties, turning the playground malady into a lens through which to examine the level of light required for passing a black body as a white one. For a black child trying to understand how the world sees him, cooties signal the racist threshold between “good” and “bad” bodies.

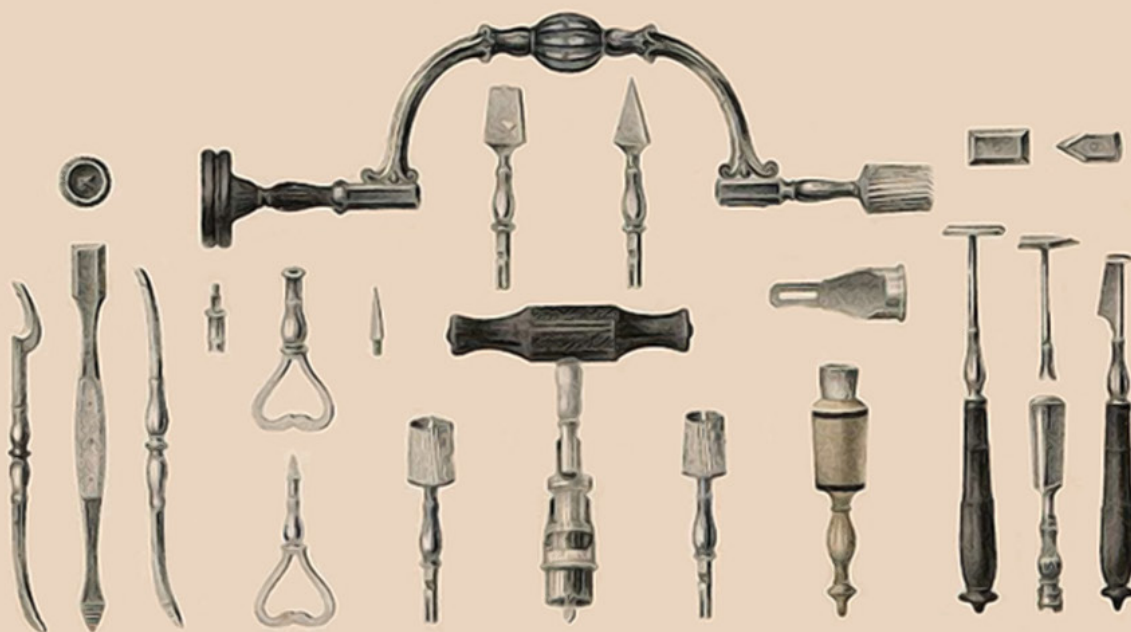
In “Who Cares” Laura Anne Robertson writes of the gendered infrastructure of care work, reading her job as a nurse in a mental health-care facility through feminist theories of the relation between gender and labor. Anne Boyer writes of breast cancer as a uniquely destructive force in women’s intellectual history. If women do not die for each other, she writes, they die of being women.

In our reviews section, Derek Ayeh assesses Atul Gawande’s *Being Mortal*, recently a presidential pick for the First Daughters. American medicine fails the dying, he writes, and makes examples of deliberately chosen death, like Brittany Maynard’s, appear as relief from industrially extended sickness. He finds Gawande’s critique of med-

icalized death to be compelling, and even more, his recommendations of what doctors should do instead to be practically and applicable advice.

Reviewing Eula Biss’s new book *On Immunity*, Sara Black McCulloch finds that the divisions immunity relies on (host, body; sick, well) has given rise to a whole host of sick programs: eugenics, miscegenation laws, and forced sterilization of genetically “undesirable” mothers. But this obsession doesn’t even have a clean starting point—we’re born impure. Instead, a real understanding of immunity would take its true lesson to heart, that both the threat and the treatment must come from inside the body we all share.

Sickness, as treated in these pages, becomes a name for the ways the world makes individual bodies bear its weight. Illness is either rebellion or submission, our bodies rejecting a foreign pathogen or succumbing to a weakness in our defenses. Examination can’t always diagnose, but perhaps it can prompt healing. **TNI**



Crazy in Love

By HANNAH BLACK

Caring for someone with a mental illness forces you beyond all conventional measures of worth or meaning



B was born in a caul, so fate paid him special attention from the start. He was descended from pharaohs and brought up in darkness inside a pyramid, but escaped and was adopted by my family, who pretended to be his family. For years, an army of spies dressed in white followed him around everywhere. Doppelgängers impersonated his ex-girlfriend, and friends conspired to kill him. Here are the careful phrases with which I learned to respond to this extraordinary life story: *That's not my understanding of what happened, or, That's not how I remember it.*

The phrase “mentally ill” feels euphemistic. It was not an illness; it had no etiology, no prognosis, probably no cure, and apparently no end. It had few external signs: Well into the depths of B’s decline, or, put another way, the heights of his ascent, people would grab my arm and whisper, “He’s so handsome!” I told them, “Yes, but he’s crazy.” *What is crazy?* people would ask, or, *Aren’t we all crazy?*, trying to be kind, and I would say, “You’ll know it when you see it.”

As soon as a doctor even mentioned the word

schizophrenia, I used it like a talisman to ward off well-meaning dismissals. I allowed that frightening word to stand in for the uncanny sensation of death-in-life I experienced as it dawned on me that B could no longer fully recognize me or our shared life except through the most labyrinthine thought procedures, complex constellations of metaphor and association that I could only sometimes follow. No one dared to insist *but what is crazy* once I had invoked that magic word. Meanwhile, others who cared about B prayed against it, as if a less terrifying name would bring back whoever we imagined B had once been, in the capacious space for optimal, fantasy Bs left by his disappearance.

What is crazy? In practice, madness is defined functionally rather than with reference to some absolute cognitive distinction. You can be as unhappy as you like if you can still make rent. You can be convinced that every streetlight is an angel as long as you walk past them and to your own door. If you have a lot of money, you can go on being crazy without consequence for longer than if you have only a little. Despite all these gradations, it is not as if there are two kinds of things, really real things and merely socially constructed things: The conditions of reality are socially determined, and *crazy* is one of the names for a life that falls outside value.

The schizophrenic person is a special figure, wilder than the hysteric or the depressive, more remote, certainly easier to make a metaphor of. The word implies something split or broken and lends itself to fantasies of schizophrenia sufferers as multiple, or in flight from themselves. But medically, it's a baroque accumulation of symptoms hinging around language and relationship: hallucinations, delusions, failures of meaning. In Deleuze and Guattari, it stands for both a reaction to present brokenness and some possible future orientation to the world, where different forms of meaning will be allowed to disperse freely. The term *schizo-culture* is not meant to refer to the actual disease, which renders people unglamorously confused and incapable of basic self-care, but to the alluring possibility of

remixing and transforming the ways we relate to each other.

Because of the many years I lived by proxy with schizophrenia, I—stubbornly, untheoretically—dislike its use as an image, even when well meaning. The idea of schizophrenia as an extreme materialization of the pain of our present social form, and therefore as perhaps its overcoming, is hard to accept because it's also the name for a certain kind of real experience. And yet of course I also read my long encounter with it, via the person I am here calling B, as a judgment on the world, and on me.

PARANOID thinking is apparently incapable of self-critique, can never fault itself. It's as if the psyche is externalized, so that reality mirrors its vicissitudes. Meanwhile, the inner life is full of worldly intrusions: Thoughts are implanted, dreams are monitored. The structural antecedents of B's psychosis, I thought, were in the melancholic/paranoid histories that both he and I were bathed in as children: black nationalist readings of a world antithetical to blackness, on one side, and the post-apocalyptic (rather than Zionist-reparative) strand of European Jewish mourning, on the other. I did different things with the same material, preferring to locate the world's brokenness in my own brokenness, to find fault with myself. B was completely the opposite. At the height of his illness, it was as if everything that might be subjective and inside the self had been projected out into the world, where objects and events formed complex chains of meaning, all conveniently proving whatever was going on inside B's head. Romantic talk of madness often skips over how *annoying* its stubborn logic can be.

B was not my first encounter with paranoid thought. In my father's house, intense young men pontificated at length about white devils and black ancestors. The symbolism and codes of this strand of black radicalism make up an elaborate structure of thought that is partly a mocking parody of academic "paranoid readings," and partly a serious effort to interpret a world, this world, that appears

from the perspective of blackness as formally insane. The everyday beliefs and activities of what we could call white supremacist capitalism, or perhaps less precisely *life as we know it*, are all, from this perspective, more deeply disturbing than the craziest fantasy you'll find on a high-security ward. But how is a person supposed to *live* this knowledge? Unlike me, B was quiet, absorbing everything. Could a white-passing boy even picture the black world that animated his father's dreams? By the time they all settled down to a quieter middle age, we had spent years steeped in this atmosphere of pain and conspiracy.

At the end of the worst time, in a high-security ward, B's brown eyes shone with enormous impossible truths

In psychosis, no event or thing is small enough to escape the tightly woven net of personal significance. A clock means a bomb, a sunset is a message, and so on. But how do you live in a world in which everything signifies? How do others who live in this shimmering, terrifying world treat you? One time B was found cowering in the restroom at a café, too afraid to leave, and was arrested.

Just as much as they are implacably hostile to blackness, for reasons both mysterious and self-evident, the police are also structurally fated to hate the mad. Arrests, harassment, and lucky escapes punctuated the acute phases of B's illness. Now, every so often, another story of police hurting or killing a mentally ill person surfaces, and I am momentarily gripped by the kind of intense, helpless pain that must be what people mean when they talk about *being triggered*. Still, it's important to not overindulge in other people's trouble, even where it affirms your own. The duty of a crazy person's friends and family is far more practical: Our duty is to appear, as much as possible, not crazy, so that our loved one will be allowed to live.

We had to act a certain way in the hospitals, to show the doctors that B was not trash. I would put on the smooth neutral suit of sanity, which is smiling politely, listening carefully, and in all ways acting as bourgeois as possible. Those times when my mother forgot her armor, when she begged and cried, I saw how the doctors looked at her, as if she were the really crazy one. But B too knew how to put on the smooth and neutral suit; he knew how to answer the doctors' questions with enough of an appearance of sanity to escape imprisonment, even when he was in desperate need of help. In an emergency ward, my mother cries and B shouts. We would be a spectacle if anyone cared. I adjust my dress and smooth down my hair, momentarily wishing myself whiter so as to be better able to resist the implications of the doctor's sneer, which is on the verge of becoming impossible to ignore. I see we are all in danger of falling out of the hole in the skin of the world. *Come on let's go, let's just leave.* I remember my mother crying in the car but I don't remember what we did next.

At the end of the worst time, in a high-security ward, B's brown eyes shone with enormous impossible truths. He had unraveled completely over the course of a year during which he refused to see us. To save him, we had inflicted a terrible betrayal on him, allowing social services to send cops into his home to forcibly hospitalize him. For a while,

he would repeat stories of how the police had insulted and abused him, and I couldn't say much in response, because at that moment, between B's freedom and death and his unfreedom and continued life, we had colluded with the enemy; we chose life for him, with all its attendant conditions of abuse and domination. In the hospital I was so happy to see him again that the work I thought I'd done to kill my hope of his return revealed itself as a convenient lie. Love is one name for a certain kind of susceptibility to sorrow, but I'm pretty sure I already knew that before B went crazy. Leaving the ward after our reunion with B, we met an older woman in tears. She had a bandage around her wrist. "They told me today that my son will never get better," she said. Her son was the one we heard yelling NO over and over again from behind a locked door. The building next door was a special psychiatric mother-and-baby unit. This was a secret place, a backstage place, the hidden, true home of the family.

IT would be better if that man yelling NO or that woman's cut wrist or B himself could describe psychosis, from inside psychosis's own perspective. Like the kind of dog that can be beaten into a killer exactly because they have been bred to love humans, the insane person's hypersensitivity to experience makes them the most vivid register of its real character. Not only can they not participate in society, often unable to work for long periods, or to be charming, or to smell nice, and so on, but they are an implicit critique of the infrastructure of working, the charms and nice smells with which people survive the painful world. So loving a crazy person forces you beyond all conventional measurements of worth or meaning. That is why it often falls to women, who live partly outside measure, and often drives them crazy too. As for me, I could not deal with the day-to-day maintenance of B; I found ways to avoid him, told myself lies about tough love and so on. But my love for him followed me around everywhere.

It could be that, when I insisted on a clear distinction

between (my) sanity and (B's) insanity, I was doing exactly what others implicitly accused me of: lying about the world to protect myself or make myself exempt from it. It's true that I was sometimes troubled by the curious links between my worldview and B's; we had shared so much. There was the time when I had a meeting right after visiting B in hospital, to discuss a video I was making. At the hospital B spent hours describing a world in which everyone had been replaced with an imperfect copy, an imposter. Then at the meeting I laid out my confused research, and my colleague said, "You seem to be interested in substitution..." I was always so tired after seeing B when he was really sick; my body ached, it was hard to breathe. Every time, right after I saw him, my faith in the distinction between us was at its lowest ebb; it felt possible that I belonged with him in the hospital or whichever tiny filthy apartment he was living in. The difference between us was that I knew what I could and couldn't get away with, and I cared what people thought of me, or I cared to share my structure of thought with others, to live in a shared world. I could not bring B there with me. Every time I had to leave him behind.

As B became increasingly socially unacceptable, as people began to cross the street to avoid him or call the cops on sight of him, the place of my tenderness for B was like a gateway I had to keep open even as other forms of pain streamed through it. Unable to fully turn away from B, I could also not defend myself against the sadness of the many other evidently crazy people who I saw every day wandering in the street or riding the train, who had also probably once been cute and inventive children. My desire that B be treated kindly, against all reason, committed me to a hopeless and helpless kindness against reason. Unable to do anything for B or myself, I trembled with useless love for whoever shuffled with the distinctive gait of the medicated mad, whoever spoke to themselves under their breath, whoever was desperately trying to appear normal.

I was not sure if I had chosen citizenship in this wounded world, or if B's madness was the sign that I

belonged there all along. Even as B's daydreams morphed into delusions, I could fill in the missing links between one thought and another apparently unrelated thought with the detritus of our shared life: a movie we watched over and over as kids, an ancient Egyptian symbol, a recycled anxiety, all stitched together in his thoughts and universally applicable. After listening to one of my breathless explanations of how B's thought processes were unusual but fundamentally comprehensible and therefore not mad, a social worker said, not unkindly: *Okay, but the main diagnostic we use for mental illness is suffering.* Yet B's madness was also a protection from suffering. He withdrew into a private realm of significations and left me to try to explain. It was like it had been when we were small; I was the ambassador to the world, and he was the planet I came from. But I liked the job, how could I not? We were made partly of each other.

There's a Jewish fairy tale where a couple lose their son and pray for him to come back, only for him to return as a walking corpse: They forgot to say they wanted him to come back alive! Maybe I forgot something in my disavowed prayers for B's full recovery; I forgot to say that the B who I wanted to return to me was not the inevitably scarred former madman but the hypothetical healthy adult who would otherwise have grown out of the funny, charming kid he was right before he got sick. But over the progression of a long madness, the material of a life coarsens, sinks to the level of survival. My father said once that B was like someone submerged in water, who now and then came up to the surface, only to sink back down again. Now his medicine allows him to spend more time above air. He is sweet, kind, funny, vague, strange, frustrating. As for the years that his delusions tore a hole in the skin of the world, those are not his problem; he wasn't really there for them. Here he is now, smiling, childlike, impatient with our anxieties, as if none of it ever happened. But, for all my loving intentions, my desire to write this disposable past overwhelms my solidarity with his silence.

What is crazy? The world is a bag and the water inside the bag is all the sense of power, joy, and possibility in the

world, but there are holes in the bag: each wounding experience or painful loss is its own hole. Everyone carries their own world-bag and sometimes the bag gets so ragged with holes that all the water of possible joy runs out of you and you are left with a collapsed and empty bag that once held everything. That is crazy!

Now that the worst time seems to be over, telling the story of it is like trying to tell a dream, full of implausible jumps from one scenario to the next, invented fake continuities, people masquerading as others: that kind of boring dream. At times I bent the story of B's madness to my own ends, using it to justify what I wanted to do anyway, which was to hurt myself. B couldn't be happy, therefore I wasn't allowed any happiness either. For years I minimized the impact of B's illness: *It's not sad, it's just how it is!* With this phrase I dismissed the leaden feeling in my chest, the grief of his quasi-disappearance. I have yet to unlearn this defensive position. Even if the couple in the fairy tale had gotten their son back fully alive, how long would it have taken them to relax into loving him again, now that they knew what it was like for him to die?

It's not sad, it's just how it is. In real life madness is not romantic or even especially interesting, which is why this writing is another kind of crazy. In a café back when it was all just beginning to be over, my beautiful B, still edging into his recovery, waddles across the room. He's heavy with medicine, bumping into tables, apologizing sweetly, apparently or deliberately indifferent to the assessing glances of strangers, the assessing and then discarding glances of strangers. Fuck you, is what I'm thinking of the café customers, but despite myself I'm embarrassed in front of them, I'm cringing inside as he sits back down and shows me a website he likes, shows me his threadbare inbox. Rattled by love, rancid with love, I stroke his beloved arm. There is nothing with which I can justify our lives. But as long as crazy is nothing and means nothing—I mean until we begin the abolition of intolerable conditions—then the crazy will go on bearing the burden of meaning. **TNI**

The Honeyed Siphon

By EVAN CALDER WILLIAMS

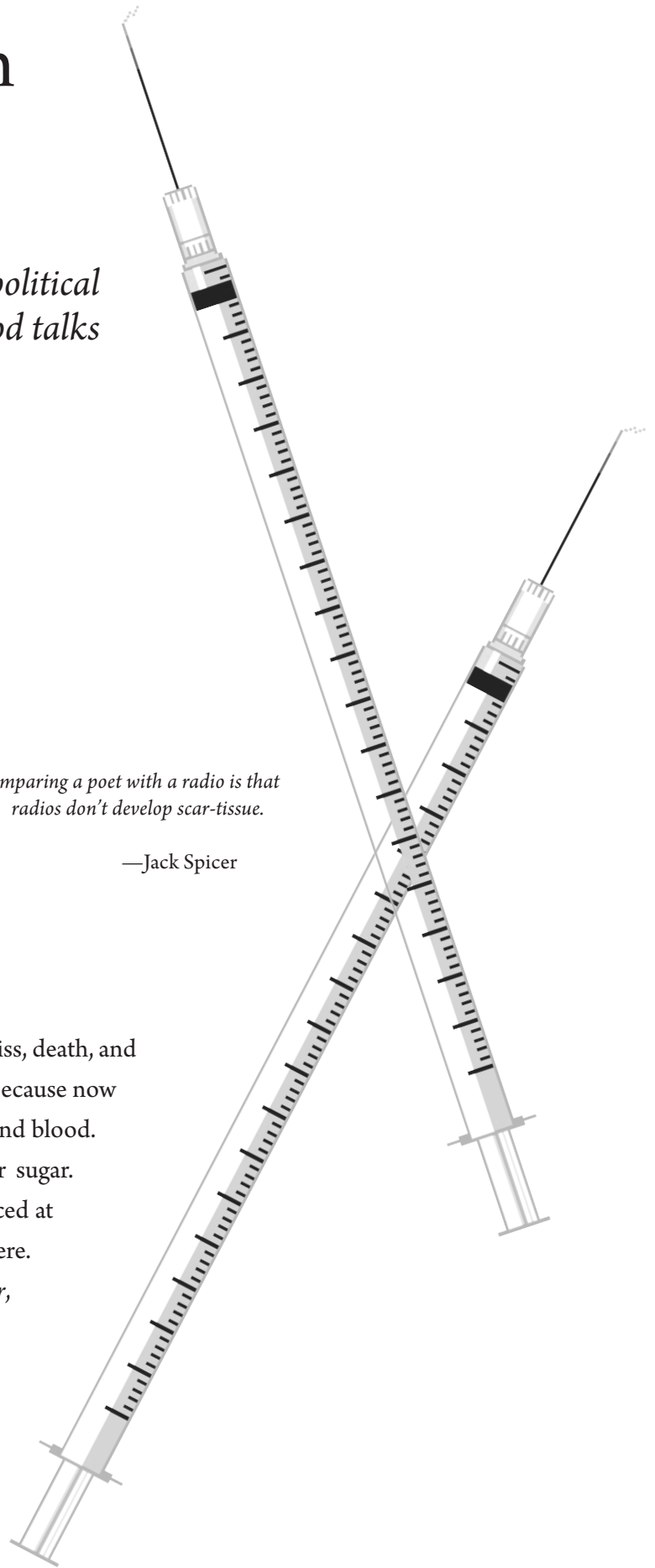
For 14 years I have lived a hamfistedly biopolitical life, in which all food is quanta and my blood talks in numbers.

The trouble with comparing a poet with a radio is that radios don't develop scar-tissue.

—Jack Spicer

FOR most of its history, diabetes has been about piss, death, and shame. Especially piss. Things are marginally different now, because now the primary metrics and metaphors of diabetic life turn around blood. Blood as number or proportion. Blood as an occasion for sugar. Blood over the long term. Blood to be tested and slowly placed at the heart of all affect, like a concept. Blood that gets everywhere.

I've found that I no longer say *I have low blood sugar*, like I did at first. I just say, *I'm low*, which doesn't mean sad or blue. It means <70 mg/dL, as opposed to <55 mg/dL, which itself means *I am a fever made of glass* and on the way to *a buzzing nullity in place of symbolic thought* (35 mg/dL). There's a basic synecdoche to diabetic life, where our blood not only stands for the whole enterprise of a body across time,



but also winds its way into every pocket¹ of that body's life. "Like a sponge, soaking up the personal," in the apt words of Alice Alcott, herself a diabetic. Indeed, few things crumble illusions of mental autonomy and free will faster than realizing that the creep of anxiety about the state of a friendship is, in fact, just 174 mg/dL. That fact of blood can only find a response in another quantity in a different scalar system, 2 ml of Humalog, which is manufactured by Eli Lilly in Puerto Rico and comes to me in 300 ml pens, dark blue for smooth transition between daywear and formal, complete with pocket clip.

For my own experience at least, it is not sickness that sops up the personal, the incidental, and the private. We ourselves become the substance of illness, a sponge into which busy paths of world are drawn in and squeezed out. A substance full of holes, teeming mid-point for a set of processes that far exceed us. That is my most constant tactile experience: The sensation of being permanently porous, a surface from which small beads of blood are squeezed at least four times a day, and through which is injected a liquid that smells like pig leather². And it would be wrong to set the borders of this surface where the skin ends. Like everyone, diabetics are always cyborg and sprawl, always in relation to our technical extensions. We are just more obvious about this than most of the population, with our little blood-fed computers, followed by trails of dead test strips like bread crumbs.

1. And beneath that is a dead-end index: the failed organ of the pancreas, which does not hurt or make itself known beyond the initial frenzy, in type 1 diabetics, of its autoimmune self-destruct sequence.

2. And yet, of also being *meat*, an inanimate substance spurred through those injections into something resembling life. A diabetic criticism, a minor task if ever there was, would open up certain odd avenues. Kobo Abe's *The Ruined Map*, for instance, is the best version I've read of the megalithic torpor of high blood sugar, wherein one becomes a bag of guts sluggishly humping down the stairs, yet with an insect-like buzzing of nerves. Though in that book, Abe was talking about being drunk. Still, I carry in my wallet a card that my old doctor gave me. It reads, *I AM NOT DRUNK, I AM DIABETIC*.

This property is there in the word itself: *Diabetes* comes from the Greek word for *siphon*, in the sense of "that through which is passed." It means something that is not itself a vessel, not a container, merely a medium of circulation. But the conditions of experience I've described are themselves extremely recent, as insulin injections emerged in 1922, and blood-based glucose testing came to market in 1970. Before the blood test, testing meant measuring or examining urine, and before insulin injections, being diabetic meant a death sentence of variable length. Type 1 diabetics, like me, died fast, our coma breaths reeking of rotten hay. Type 2 diabetics died more slowly, some surviving due to food scarcity imposed either by diet or war and famine. And given that there was no operative treatment, diabetics pissed all the time: They were siphons through which water and their own bodies poured, gallons a day.

The reason is simple enough. Insulin is the hormone that regulates cellular absorption of glucose. Type 1 diabetics have no insulin production, because of an autoimmune attack that destroys the responsible cells. Type 2 diabetics have diminished insulin production or sensitivity. When too much glucose remains in the blood and is not absorbed into cells, the kidney cannot reabsorb that glucose. It gets pissed out. The increased sugar ramps up the osmotic pressure of the urine, which makes it all the harder for the kidney to reabsorb any liquid, which spurs on increased urine production and so the cycle begins. You develop a "fatal thirst," as the body pours out all its moisture into upwards of fifteen liters of urine a day. You waste away, because unable to get energy from sugar, the body starts consuming all of its energy reserves, its fat. Things get worse from there. Untreated, you die. If you manage to hold on for a while, you go blind, your organs fail, you cease being able to heal any sores. Your limbs turn first numb, then necrotic, and require amputation.

Frequent urination is therefore not cause but symptom, an indication of failure on a far more microscopic level. Still, it was visible and specific, and hence, it became

the index for the illness, which was treated for most of its history as a variant of polyuria (excessive urination) in general. Therein the name, the “passing through,” given by Apollonius of Memphis in 230 BC, before getting its unique qualification from British physician John Rollo in 1797: *mellitus*, meaning “honeyed,” because the urine of untreated diabetics tastes, in the words of Avicenna, “wonderfully sweet.” Etymologically at least, to be a diabetic is to be a honeyed siphon. The earliest known medical description of the disease came from the Ayurvedic tradition, in Sushruta’s sixth century BC *Sushruta Samhita*, where diabetes appears as *madhumeha*, or “sweet urine.” So for most of its history, this combination of constant urination and unbearable thirst—Zhang Zhongjing termed diabetes “the malady of thirst”—was grasped as the condition itself. It was “the pissing evil” (Thomas Willis), an evil that appears especially potent in the writings of Aretaeus, the West’s first extended account of the illness. There, what pours through the siphon is not just excess (and excessively sweet) urine but also the patient herself: Aretaeus sees a “melting down of the flesh and limbs into urine.” In Galen, it’s a “urinous diarrhea,” for which he prescribed the first of medical history’s truly terrible proposals for diabetic relief: vigorous horse-riding. *Oh, you cannot stop making water, to the point that it feels like your body exists as a mobile spout through which the world is poured? You should get on a horse. Make it bounce around a lot.*

The continual emphasis on urine was hardly unique to diabetes, as it belongs to a wider history of the alternately derided and lauded “pisse prophets,” in the double sense of those who sought to detect all the body’s ills through urine alone and those who were more literally “uromancers,” divining the future through the frothy bubbles of a piss pot. This deep emphasis on uroscopy remains unsurprising, in part because of the continued influence of a Galenic (i.e. “humor-based”) conception of the body, in part because it was a visible, tangible, and tastable symptom (the body’s own “infused liquor,” according to Willis). It could be ex-

amined, measured, and discussed without opening up the infection-prone body through which it had passed.

Such metrics would become more sophisticated, but the plagued lives of diabetics did not change substantively from Sushruta’s diagnosis until the “discovery” of insulin in 1922. “It seems a most hard thing in this disease to draw propositions for curing, for that its cause lies so deeply hid, and hath its origin so deep and remote,” Willis lamented. The link to food was evident early on in this history, so various diets were tried, including, in unfortunate news of medical paths not subsequently followed, one of the most successful pre-insulin injection remedies: a diet consisting primarily of cannabis and animal protein. (The Victorian British threw opium into the mix as well, which at least made the quantitatively brief but qualitatively expansive hell of diabetic life slip free from its sense of time.) A number of physicians did settle on diets that grasped how diabetics do much better consuming as little sugar, starch, or grain as possible, but their suggested replacements tended toward a sort of Atkin’s Unchained. The lunch menu of Rollo’s influential 1797 book *An Account of Two Cases of the Diabetes Mellitus*, for instance, was: “Plain blood puddings, made of blood and suet only.”

But while Rollo’s insight was not rare, it was by no means broadly adopted. In the diabetic equivalent of *Hostel*, French doctor Pierre Piorry pushed a “sugar feeding” diet, based off the idea that diabetics needed huge quantities of sugar to make up for all that was pouring out of them by the pint. The results were as ghastly as one would imagine. The litany of torturous cures is long and bleak. As Elizabeth Jane Furdell sums them up, “the afflicted were bled, blistered, purged, doped, sweated, belted tightly around the waist, submerged in various liquids, and rubbed with disgusting ointments.” John Pechey, a seventeenth-century British physician and extremely nasty piece of work, forced his patients to drink steel filings.

None of this made any difference. Diabetics died as they lived, their bodies feeding on themselves, as open to

the world as unplugged drains. They lived in shame. Aretaeus himself notes that a diabetic's life is not just "painful" but also "disgusting": "But by what method could they be restrained from making water? Or how can shame become more potent than pain?" That's the point precisely: with diabetics, it simply can't. One cannot "hold it," because one becomes siphon. In Liverpool doctor Mat-

I had become an ajar door through which everything came and went, a gap that I could not shut

thew Dobson's case notes, we read of Peter Dickonson, who pissed 15 liters a day. The special quality of diabetic piss, the one that left physicians in wonder, was that when it evaporated, it left behind piles of sugar. The body becomes a small refinery. Dobson tasted the white cake left behind and declared that it could not "be distinguished from sugar." Francis Home made beer from it. A diabetic *Modest Proposal* isn't hard to fathom, yet our history is not that of our busted bodies being put to use processing sweets for those who can consume them, our eyes first

jealous then blind. It is a history of 11 pints of urine a day "stiffening his clothes when it falls upon them," of the "rude crystallization" of diabetic urine left on a woman's dark shoes, of sugar snowflakes on those of men, crusted white on black worsted stockings. Underwear piss-stiffened into candy cane knives. A slop pail beneath the bed, because a bedpan just didn't cut it. That pail being drained in the night, by one without water and so thirsty that he drank his own urine.

WHEN I was 17, I was living on a self-sustaining farm/school in Maine, which made my wholly typical and crippling teenage melancholy, soon to blossom into weapons-grade depression, all the weirder. Listening to Elliott Smith's "Christian Brothers" on repeat while milking a wart-uddered cow at 5:30 AM during a blizzard, already on my second dire epiphany of the day, sums it up plenty. Still, other than a permanent loathing for what was supposed to constitute Saturday night there (enduring a man in a chunky sweater croon James Taylor songs), I was healthier than I'd ever been: straight-edge, vegan, eating food I helped grow myself, and fit as hell from chopping wood.

I was drinking a lot of water, but that entire scene of those who can identify a tufted titmouse by sound alone tends to be obsessed with "hydration." It only slowly dawned on me that this went far beyond that: I was a set of channels through which water was turned into the only marginally different. I relieved myself outside cabins, on them, out their windows. I startled titmice blundering through trees. I was bursting, always. I barely made it, always. But like my wasting away in the same months, which I chalked up to the wood chopping—the transformations of bodies are always more dramatic to those who aren't stuck with them.

My changes were clearer to my parents, for instance, and my mom especially. Her brother Rob was a gentle bear of a man, a big guy, deep into Harleys with a beard to match.

He was also a diabetic, from the decades when you could never know your numbers exactly, where the whole game was imprecise³. He died a few years before I became diabetic, his body revolting against itself, one organ after another. And so my mom, seeing me rangy thin, chugging water, disappearing to the bathroom, was attuned. I brushed it off. It was the first time I felt thin, which I liked. But in my hometown, I was driving back from seeing a friend, barely a five-minute drive. It was June and night, warm and lovely in all the ways that Maine is then. I had pissed just before leaving her place, but one minute into the drive, I had to again. Too embarrassed to go back inside, though, to pretend that I left something inside the bathroom, with its thin door. I held it. Sang along with the radio to distract myself. As I turned onto the street where I grew up, a few hundred feet from my house, I knew that all the little tricks and calculations of the body—the prospect of “shame being more potent than pain”—would not cut it. I stopped in the middle of the road, a rolling, shuddering stop, already pissing before the door opened, pissing first myself, then the car, then the street, standing in its middle, jeans soaked in the orange dark. Listening to birds rustle. Not angry, not even confused. Just burning with thirst and the sense that I had become an ajar door through which everything came and went, a gap that I could not shut. I was in the hospital next day, learning to make holes in myself.

THE crux of shame is that we are never *enough* unlike ourselves. We are ashamed because we can never stray far from the self’s terrified inertia. For diabetics, this happens when others see us become partial to ourselves, when a single strand of our life—its pure metabolic need—

3. He didn’t always make things easier for himself. When he’d come up to see us, he’d drive with a box of pastries on the front seat to kill time. To a diabetic, that’s the equivalent of saying *he drove with a screwdriver wedged between the ventricles of his heart*.

swallows the rest of it, yet without a clear demarcation of having happened. Unlike werewolves, diabetics get feral and sugar-berserker without obvious external signs. It creeps up on us, on those around us. And then the world, all tremulous and adrenal, shrinks to its simplest. When we are low (like werewolves, diabetics are always plural, because we cannot separate ourselves from the long paths of scarcity and infrastructure, shame and empire), we come much closer to literally stealing candy from a baby than the expression ever intended. We stare with obscure hunger at apple-cheeked little shits scarfing Smarties in their strollers. We dream of gorging on the donut-rich blood of one type of bro, on the Paleo pancreases of another. Always plural, we nevertheless have absurdly singular senses of time, charted by little metabolic tides that constantly move, setting patterns of affect indifferent to whatever we are doing. We snap out of the blue, flags with their own private wind. We stop fucking to crouch naked in front of the refrigerator, prying honey from the jar with sticky fingers like a porny Winnie the Pooh. We pass out on the floor. We seizure. We get low.

These peculiar shames are dwarfed, though, by the major form of shame that runs through diabetic history, that of blaming of individuals for conditions globally imposed on them. It’s a shame we might simply call class if it wasn’t so shot through with other determinations, especially with the contemporary racial demonization of diabetes. The split structure of the disease has always lent itself to this. Because Type 2—“slow diabetes” (Blackmore), “long diabetes” (Whytt)—has been linked, from the first recorded accounts on, to certain kinds of diet and obesity, it easily opens up charges of fault and blame.

There are, of course, various attempts to lay the blame with less edible forms of morality: Gilbertus Anglicus, in 1320, saw the cause of diabetes in overwork or in “to moche medling [too much meddling] with women.” John Elliotson, a late-eighteenth and early nineteenth century physician, was surprised that a diabetic who died under his care claimed to have never been sex-

ually involved with a women. William Prout, a contemporary of Elliotson, noted with interest that some of his middle-aged patients “confessed they had been addicted to masturbation from early youth.” Pechey—the steel filings doctor—thought it “invades those that are of a lax and crude habit of body.” Grief was a supposed factor, as was anger and other forms of emotional stress. For Robert Saundby, writing in 1897, “the disease is much

Digital sociability is a close fit for the diabetic experience of the body

more common among the educated than the uneducated classes—that is it occurs chiefly among those whose nervous systems undergo more wear and tear.”

Obviously wrong as this is—in which of all possible worlds do the “educated” undergo more wear and tear, nervous or otherwise, than those who the educated employ, colonize, govern, and imprison?—the class-based inflection isn’t. Because for most of its recorded history, Type 2 diabetes was overwhelming the province of those with access to excess calories. They alone had consistent means to consume refined sugars, processed flours, and butter to drench it all in, while those who labored to provide it lived, in the European context from whose medical history I’m drawing, on subsistence diets based on whole grains and

vegetables. Thomas Cocke published *Kitchen-physick or, Advice to the Poor* in 1675, urging prudent diet, but the “poor” had then, as they have now, extremely limited choice about what kind of food to consume. Type 2 diabetes was primarily a toxic luxury that the rich alone could afford and which they might well avoid, if only they took some culinary hints from lower rungs on the social ladder.

In this regard, most of the pre-insulin history of diabetic “advice” centers on urging temperance and permanent fasting, as in the counsel of John Wesley, the founder of Methodism and a diabetic: “Abstain from all mixed, high-seasoned food. Use plain diet, easy of digestions, and this as sparingly as you can, consistent with ease and strength.” Other advice was even plainer: having witnessed that during the 1870 siege of Paris, glucose disappeared from the urine of some patients because they were starving, Apollinaire Bouchardat urged diabetics to simply “eat the least that is possible.” (In other words, diabetic life does best in a permanent state of siege.) For those with rich patients, attempts to reform consumption often took the form of chiding a bit of good-natured over-indulgence, the blame laid especially at the feet of the epoch—“our age given to good fellowship and guzzling down of unallayed wine” (Willis)—rather than on the decisions of those with the time and cash to *actually* choose what they ate⁴. The course of treatment, in sum, for the rich: house visits and some chummy reminders, even if neither had much effect.

For the poor: shaming and attempted confinement. In the *British Medical Journal* of 1865, one reads that enforcement of diet “may be comparatively easy to effect in private practice [i.e. with those who can afford it]; but in the case of the poor, especially the outpatient poor, who cannot be made to understand the necessity of abstaining from bread,

4. This fact is responsible for one of the best diabetic moments in literature, that of the “suicide by cake” in Thomas Mann’s *Buddenbrooks*: “And there they found his lifeless body, the mouth still full of half-masticated cake, the crumbs upon his coat and upon the wretched table.”

potatoes, apples etc., it becomes a very difficult task to teach them what to eat, drink and avoid.” The only thing one could do, some doctors suggested, was to lock them up: “The gentlest exercise only to be permitted: but confinement to be preferred” (Rollo). Otherwise, they would “commonly trespass, concealing what they feel as a transgression on themselves” (Rollo) or indulge “clandestinely in the most injurious of the prohibited articles of food” (Donkin).

THE situation is manifestly different now. Diabetes is a slow-motion pandemic, one of global modernity’s signature ills that has moved relative infrequency to a permanent fixture. In 1897, Saundby called it “one of the penalties of advanced civilisation.” Saundby wrote this at the exact mid-point of W.P.D. Logan’s study of English and Welsh deaths over a century (1848 to 1947). The study showed that general mortality from diabetes rose and rose, *even after the introduction of insulin* (in 1922), only declining during wartime deprivations when there simply weren’t enough carbohydrates available to spike the blood. In the second half of the twentieth century and into the twenty-first, the disease grew unchecked. In the U.S., the national rate of diabetes grew 49 percent in a 10-year span alone, from 2003 to 2013. Among American children, Type 2 diabetes—previously associated almost exclusively with much older populations—rose 30.5 percent in just eight years (2001–2009). It is hardly limited to the U.S.: In China, it has risen from 7 million in 1994 to 114 million as of 2013, wildly eclipsing previous estimates of 45 million by 2020. Globally, the total number of diabetics will double by 2030, leading to an estimated 10 percent of the world’s population diagnosed as diabetic. *Diagnosed*, we should stress, because for major portions of the world, the bloom of Type 1 and especially Type 2 diabetes is itself a silent creep: it’s estimated, for instance, that 78 percent of diabetics in African nations are undiagnosed.

Just as dramatic as this still accelerating prolifera-

tion of diabetes is the total inversion of its class dynamics. Type 1 remains nominally random, although clearly bound to family lines (and itself increasing, indicating long-term environmental and dietary effects). Type 2, however, has entirely shifted from a deadly affliction of the mostly rich to a devastating and diffuse biopolitical violence against the entirety of the global poor, especially the non-white. In the U.S. alone, for instance, incidence of diabetes sketches an extremely literal map of colonial expropriation and domination: indigenous populations have fully twice the rate of diabetes (15.9 percent) as whites (7.6 percent), with “non-Hispanic blacks” and “Hispanics” closely behind (13.2 percent and 12.8 percent respectively).

Why this proliferation and this demographic specificity? Across the twentieth century, capitalism nominally conquered scarcity, reducing famine to something its champions could claim as isolated aberrance in zones of the world deemed “unstable.” Yet it conquered that scarcity through monocropping, adulteration, and padding out its food, flooding markets with variations on extremely cheap, easily available, near unspoilable, and heavily processed food that technically answers caloric need but, in the long run, wreaks sheer havoc on the body. The proper name of that havoc is diabetes. And in this way, diabetes is, more broadly, itself just the name for one particularly common variety of the brutal and repetitive intersections of individual bodies with a global circulation of commodities, energy, and pollution. This circulation results, and only can result, in the ruination of those bodies because its infrastructure and wealth was and is built with their stolen labor, because it exists for the purpose of reproducing a social order that would sooner kill its humans than rearrange itself.

What haven’t changed, despite this social inversion of Type 2 cases, are the forms of shame—both shaming and feeling ashamed—that accompany dealing with your own body as the fallible, wretched, and painful site where this degradation and contradiction gets worked out, all the way to infection and beyond. Online diabetes forums are

particularly striking spaces to witness this.⁵ Their popularity makes a lot of sense. In part, it's because anonymous diabetics can help each other feel less lonely in ways that physically proximate friends, lovers, and family often can't. But there's also the sense of being estranged from oneself, a self that has to be attended to and monitored. Because diabetes doesn't mark itself as an event (other than the first diagnosis, or "Dx"), nor even as something partially dormant yet capable of flaring up, its timescale is that of the relentlessly same. Damage is felt and seen slowly, marked above all by *not* feeling, the nerves going dead, and by *not* seeing, the eyes blurred to blindness with burst blood. For this reason, digital sociability is a close fit. We check in on ourselves on Twitter with the affective hook and frequency of caring for a Tamagotchi, which is essentially the diabetic experience of our own bodies and how we measure them.

Like most medical (and weightlifting and RPG) forums, the signature for each post tends to be an arcane list of personal statistics ("DxT2: 1/26/2010: 6'2" 268lbs. A1C 7.8, FBG 266 A1C: 1/2010: 7.8 ; 6/2010: 4.7 ; 9/2010: 5.1 ; 12/2010: 5.2 ; 4/2011: 5.3 ; 9/2011: 5.3"), linked to the desire to make it to the unofficial "5 percent club" (a hemoglobin A1C long-term blood sugar reading under 6 percent), and lists of medications ("Metformin ER, Lantus, Novolog, Zofran for Gastroparesis, Gabapentin-Neuropathy, Zocor 40MG, Fish Oil 4000MG"). Amongst the impressive display of affective mutual aid, though, are extensive representations of shame. In one thread titled, "Anyone ever been ashamed when buying your meds etc...", the poster writes,

Just curious if this is just me...but I am so ashamed that I am a Type 2 diabetic. Whenever I go pick up my meds or buy strips, I am thinking that everyone is thinking... "What a slob, she is costing everyone so much money, etc. Of course this motivates me to stay with my lifestyle changes...my goal is to be a skinny diabetic ...LOL! I know I don't like telling anyone I am diabetic...unless they are close friends.

5. I am writing a longer study of these and other medical forums. What appears here is a very quick look at some of their recurring patterns.

If you read across the threads, the same situation recurs over and over again, especially with Type 2s. For the Type 1s, whose illness is more cleanly (and socially) decoupled from individual histories of consumption, the primary moments of shame center around discomfort about injecting or bleeding oneself in public, being a general emotional nightmare, the consequences it could have for employment, or blacking out from hypoglycemia, which one woman frames in terms of "the walk of shame": "the feelings of embarrassment and shame; the feeling that everyone is watching me to see if I will pull a repeat performance and pass out again." Diabetic solidarity appears to founder on the rocks of blame, though, because while the forums are largely supportive, one sees hints of the kind of prejudice against Type 2s that extends far beyond the forums. One forum member, who has since been banned, writes that, "The motto for Type 2's should be 'Ask your doctor about how long you can expect to live if you don't accept personal responsibility.'" That move is, at best, mean-spirited and wrong, and, at worst, classist, white supremacist, mean-spirited, and wrong. But even without such sniping, the barbs of shame are sunk deep, twisted by the posters themselves. "sometimes I'm bad in secret—I almost feel like an alcoholic must feel," one writes. Another, at length:

I look in a mirror and see me looking back and think, "I can't believe you did this to yourself!" Be it the four slices of pizza, the two heaping plates of pasta, or a bowl of M&M's at my desk providing a steady carbohydrate drip. *I* did this [to] me. I was warned, but did nothing. To me, that clearly shows a lack of my self control and discipline. For that, I am indeed embarrassed.

None of this is helped by the fact that as far as recent research shows, one could in fact largely, if not entirely, reverse Type 2 with "dietary energy restriction" alone. Such research leads to the further excoriation of diabetics by celebrity doctors, like Dr. Mark Hyman, who writes of Type 2's "bingeing on donuts and soda."

But to even frame it in these terms, of what could be achieved with an "ideal" diet, entirely misses two points.

First, and most obviously, the cost—monetary and time—of that ideal “restricted” diet de facto excludes the majority of those who have to deal with diabetes. Try and find diabetic-tolerable food, enough for a meal, for under \$5 anywhere in Manhattan, that isn’t just a handful of protein powder and doesn’t require going 30 minutes (and \$2.50 of transport fare) out of your way. It will become crystal clear that the entire discourse about “doing it to yourself” must be inseparable from much harder conversations about what is done *to* and *through* us by an indifferent, material, and very police-backed organization of space, race, gender, and wealth. Of course, if we all “cook our own meals,” a general management and deceleration of diabetes would be achievable. But the changes this would require, in terms of access to time, resources, and money for the populations most struck by diabetes, would be so thorough-going that they literally cannot be answered outside a situation of total social upheaval.

Second, to even enter the terrain of the counterfactual—*what if “they” didn’t eat this way? what if we didn’t wreck ourselves upon ourselves?*—is to fall into a trap of seeing sickness as natural, a direct line between a body and its subject. But sickness is not natural. It is always social and always historical, necessarily inseparable from forms of rule. The siphon through which the world streams is always bent by that world, long before we puke and piss, metastasize and rot, strike and coma. And diabetes—the condition of being a metric, extensive subject dependent upon the same circuits of production that make you sick to start—shows just how extensive that bending has become, reaching far beyond those who are technically diabetic. What else, after all, is the recent fetish for unnecessary biometrics—those Nike and Fitbit and whatever bracelets that sync to your phone and tell you how many calories you have burned—than a sort of generalized becoming-diabetic? For us whose days are numbered, in all senses of the word, this urge toward the quantitative is as familiar as it is horrifying. I have, for 14 years now, lived a hamfistedly biopolitical life, in

which all food is quanta and my blood talks in numbers. Yuppies, it seems, just can’t wait to do the same.

I don’t doubt that sometime before Manhattan has gone and become New Atlantis, there will be a genetic advance that stimulates the reproduction of beta cells in the pancreas and “cures” diabetes. Or at least an artificial pancreas that doesn’t require a life of immunosuppressants. Diabetes, the world’s eighth largest cause of death, will technically be a thing of the past. And yet, it won’t. It won’t because the sickness is just one small stop in a situation that allows no such partial fix. Diabetes will exist, even after it is cured, because capital cannot both accumulate and overcome its necessary neglect for the majority of those who make it turn. The disease flourished so widely because the growth of capital requires and enforces a strict indifference to lives in particular. In an era where openly declared war has been exchanged for permanent crisis operations, it would be sheer gall to expect that a century and a half of industrial food production and distribution—the system that allowed capitalism to technically feed all while poisoning the many—will be overturned because of lives lost and costs to a medical system.

In many ways, diabetes is to the body as debt is to time. Neither was invented by capital but both expand within it, bloating tremendously in the most recent decades. Both turn around the mobilization of shame and the daily violence of living with what we are told are the fault of individual decisions. Both write themselves on and in the body: the frayed nerves of debt, the missing limbs of diabetes. Both are a quantification of the undecided and a winnowing of possibility, the constriction of the future by means of what has been consumed in the past. Above all, both will be permanent features of capital, slowly accumulating consequences of quick fixes made long-term plan, until the structure that demands them will be undone, by bodies and in time. As that happens, we’ll have to figure out anew what we even mean by *body* and *time*: how they work for us, and how to endure, together and without shame, when they refuse to, when sugar gathers around us like snow in summer. **TNI**

Of Suicide

By NATASHA LENNARD

Questions of intent can't get to the real roots of suicidal experience



SOME suicides are akin to manslaughter. I don't mean that they are criminal. I mean simply that some suicide belongs in that liminal category between the acci-

dental and the intentional. An attempt is made on a life without premeditation, messy and unmeticulous. It is impossible to answer definitively, "did they mean to do it?"

These are those anguished leaps for oblivion, which—not for want of medical and psychiatric pathology—remain mysterious. These acts stand in stark contrast to the deliberated acts of suicide, either assisted or solo, in which an individual determines that their life is better ended. When 29-year-old Brittany Maynard moved to Oregon—where it is legal to die with a physician-prescribed lethal dose of barbiturates—she asserted sovereignty over her own life. Facing swift and terminal brain degeneration from cancer, the young woman took to YouTube before her scheduled November death to publicize her case and argue that others, like her, should be permitted to Die With Dignity. Cases need not be as clean cut or imminently terminal as Maynard's to be defensible. I see no moral ill in deciding to die; players should be able to fairly choose how many hours to strut and fret upon this stage.

Had any of my attempted suicides been successful, I believe they would have been equally morally defensible. But it would not have been death with dignity, nor deliberation. "Crime of Passion, Your Honor," I'd tell the judge, "it was manslaughter."

I've tried to kill myself twice. I feel a twinge of disingenuousness even writing that, because those are uncompromising words, "I tried to kill myself." The sentence sits ill with me, though it is straightforwardly verifiable: Twice I have landed in a Brooklyn emergency room because I overdosed. Most recently it was fistfuls of Ibuprofen and Seroquel—an anti-psychotic medication, prescribed for bipolar disorder. (This gives some context, I suppose.) Just over a year before that, it was anything I could find in the disheveled bedroom I shared with the violent and broken man with whom I had planned to spend my life (there's some more context for you)—painkillers, anti-depressants, Klonopin, some methadone a passing junkie had left behind.

All of which is to say, these were the sorts of concerted efforts which left me hooked up to IV fluids, Under Observation and shitting black activated charcoal for a week.

And that gets called attempted suicide. In both instances, though, intent was a grey area. Distressed, unplanned, and, thankfully, unsuccessful, these were attempts at self-annihilation rooted in a transient despair. My overdoses are memory black spots. I don't remember the ambulance or how my best friend knew to get there or when they swapped my clothes for the green gown that would make even a paragon of wellness appear sickly. I don't remember deciding to take the pills or deciding that I wish I hadn't. I do remember the way a handful of Ibuprofen felt in my palms, sweaty and melting red dye, though not in my mouth nor going down my throat. I do remember that I couldn't form words when asked, "Did you intend to kill yourself?" or "What happened?" I was too out of it to speak and, in truth, I didn't know. I still don't.

I both did and did not intend to die. EMTs and ER staff, however, don't barter in such equivocations. Risk assessments have to be made and patients must be sorted into the suicidal and the accidental. Psychiatry distinguishes between suicidal ideation, intent and risk. Ideation is common and, while a mark of certain depressions, is no consistent indication of intent or risk to self-harm or death. I've thought about the fact of suicide for as long as I can remember—but those familiar vertiginous fancies, arising, say, at the edge of a subway platform ("how strange, just one more step, such a small and common act, most simple, most difficult")—are a world away from the implacable terror or dread-like sensation that preceded my suicidal acts. Though still overly simplistic, the differentiation between suicidal ideation, intent and material risk goes some way to acknowledge that our sovereign relations with our own mortality, our control over it, are fraught and complicated.

It is correct and unavoidable to point in cases like mine to mental illness and substance abuse, and wherein the two meet. It is also irredeemably circular. Un-premeditated suicide, manslaughter suicide, is understood as the act of an unsound mind. Pathology, bartering as it does in

cause and effect, posits such suicide as an effect of mental illness and seeks causal explanation in the realm of mental illness. In his book *Suicide: Foucault, History and Truth*, Ian Marsh notes that “unequivocally” suicide is treated as “an issue to be categorized, managed, controlled and prevented, and solutions to the problem are pharmacological and psychotherapeutic.” As Marsh argues, psychiatry has constructed a “regime of truth” that produces a “compulsory ontology of pathology in relation to suicide.” We can’t even think about impulsive suicidal acts without reference to mental illness. Like any regime of truth, suicide-as-pathology posits a particular world of subjects, objects and relations to make sense of suicide. Above all, it assumes that sense can be made.

But the pathologized suicidal subject is ontologically weird. “She killed herself”—the sentence’s subject and object are the same individual. It is no stranger than any other instance of apparent subject-object collapse—a perennial problem philosophy finds for itself. In David Hume’s troubled appendix to his *Treatise on Human Nature*, he expresses some despair that the self presents as no more than a contiguous series of mental states, but, this being so, the pesky “I” that experiences these states persists, evading reduction to empirical explanation. “When I turn my reflection on myself,” wrote Hume, “I never can perceive this self without some one or more perceptions; nor can I ever perceive any thing but the perceptions.” The self as object, this set of perceptions, cannot account for the phenomenon of the self as subject. Of this quandary, the Scottish philosopher wrote, “I find myself involved in such a labyrinth, that, I must confess, I neither know how to correct my former opinions, nor how to render them consistent.”

I find myself, the suicidal subject, irretrievably tangled in this dualism of self: both attempted killer and her would-be victim. I designate the former as unwell and monstrous, an Edward Hyde of my own making, my own being. Petrified that she might strike again, I try to oblit-

erate her, first with medication, more sleep, and appointments in a psychiatrist’s office twelve floors above Union Square. The view from the window captures every Manhattan skyline landmark, like a snow globe. Philosophically, my split suicidal self is incoherent; therapeutically, the split provides some relief and refuge from the nagging question of whether I did or did not really mean to die. Placing the suicidal subject within the realm of the clinically pathological provides a story that makes sense of my attempted self-manslaughter. Yet, for reasons unclear and probably historical, the problem of intent lingers. It’s not a question I seek out, but one that haunts me: Did I mean to do it?

The need (or the feeling of need) for answers about intent emerges in part from the gravity of the matter at hand. When Hume, one of the key defenders of suicide in the Western philosophical canon, wrote in 1750, “I believe that no man ever threw away life while it was worth keeping. For such is our natural horror of death that small motives will never be able to reconcile us to it,” he gestured to the weightiness normally, or normatively, applied to considerations of mortality. If all suicides were of the deliberate and considered variety, like Brittany Maynard’s, Hume would have been quite right. His proposition that an individual is a correct judge of when to end her own life posits the suicidal subject as an ultimately rational actor.

Hume’s tract, “Of Suicide,” is an attempt to salvage suicide as defensible within a moral context that demanded an act neither abrogate duty to God nor the Laws of Nature to be considered justifiable. I am unburdened by religiosity and without a metaphysical commitment to life’s inherent value I’m not interested in a moral argument in defense of suicide. I simply suggest, contra Hume, that not all suicides or attempted suicides involve a suicidal subject reconciling herself with the “natural horror of death.” In my case, at least, the brute fact of having tried to die, and there is horror in that, only hit post hoc and remains unreconciled.

Any survey of suicidal intent is stymied by survivor bias; even the most diligent research can't reach beyond the grave and ask those who take their own lives whether they had really "meant" to. Some leave notes, some don't.

Despite all the answers psychiatry and pharmacology have to offer, none of them can resolve the haunting self-knowledge that in some sense, I tried to die, both meaningfully and without really meaning it

But we must avoid the sort of tautological thinking that asserts that if a suicide attempt was successful, the actor had really intended to succeed in ending their lives. Even with a complete and coherent pathological explanation of

a suicide attempt, intent can remain a gray area.

Attempts to attribute intent or complete lack thereof in suicide cases is understandable. Intent is dramatized in suicide narratives because the stakes are so very high. Grasping for understanding, we run the risk of ascribing complete and reasonable deliberation (such as in Maynard's case) or a psychopathology in which any sort of intention is impossible. Suicide becomes the purview of the mad or the meaningful, and nothing in between. Speaking from little more than personal experience, I suggest that it might not be so. Despite all the answers psychiatry and pharmacology have to offer, none of them can resolve the haunting self-knowledge that in some sense, I tried to die, both meaningfully and without really meaning it. An explanation from mental illness feels necessary, but not sufficient. And I tentatively conclude that this is okay. While impulsive self-manslaughter attempts can be explained, the feeling of having committed the act will persist like a haunting and threat, unsettling and unsettled. Maybe I just haven't come to terms with it yet, but something tells me the terms might just not be there. Like Hume, I find myself involved in the labyrinth trying to locate an "I," which maybe I cannot.

Meanwhile, life continues. In the weeks—and it has only been some weeks—since my most recent overdose, my days have been surprisingly normal. I scared myself and have renewed commitments to better self care; I did that last time, too. Surviving my own attempted manslaughter brought no revelation. On a few fleeting instances I have paused for something like sentimentality, or appreciation. My best friend was sick one night, I sat with her, stroked her hair and watched her fall asleep; I was pleased to watch her feel better, and was pleased to be alive to watch her feel better. My lover's body is always warm, remarkably warm. He feels like energy and I have, once or twice in the weeks since I didn't die, pressed my face against his chest to appreciate heat and heartbeat. After writing that sentence, I rested two fingers against my throat to feel my own pulse. **TNI**

Weight Gains

By WILLIE OSTERWEIL

Capitalist agriculture has found the best spot to store its surplus: in the bodies of workers



IT happened last summer without much media fanfare: Mexico surpassed the United States as the fattest country on earth. Though seemingly cause for American joy, these days even the loss of negative American exceptionalism is too demoralizing to celebrate. Or maybe it wasn't widely discussed because it wasn't achieved by some massive weight loss in the U.S., but a shockingly fast

growth in the overweight population of Mexico.

Whatever the reason for the lack of coverage, the fact puts some claims about the U.S.-American "obesity epidemic" permanently to rest. It is not rooted in some shift to sedentary middle-class labor, excessive driving, and too much sitting: A much higher percentage of Mexican workers still work in primary production or agriculture, while

many fewer own cars. Obesity there can't be blamed on a so-called culture of laziness and excess à la *Wall-E's* floating invalids: claims centered on specifically U.S.-American attitudes to work or disposable income level must be chucked. So what has caused this massive rise in Mexican BMI?

The most scientific answer: no one knows for sure. As public health methodologies, data collection, and scrutinizing organizations proliferate, it becomes clear that when it comes to tracing an illness there are almost always too many factors—environmental, genetic, cultural, political, and psychological—to ever locate simple cause and effect. That is particularly true when tracing phenomena across long periods of time through large populations (in this case, a decades-long process across a nation of 120 million people). If this is true for even more directly diagnosed diseases, the complications practically become fractal when addressing “overweight/obese” populations, as body weight is an almost sublimely arbitrary, politicized, and medically indeterminate measure of health.

The simplest answer, however, is NAFTA. One of bipartisanship's great achievements, negotiated by George H.W. Bush but signed by Bill Clinton, the North American Free Trade Agreement went into effect in 1994. Ending all tariffs between Mexico and the U.S., within a decade NAFTA both increased the flow and reversed the balance of trade between them. Mexico had a long-standing trade deficit with the U.S., mostly importing consumer goods. But after NAFTA's passage, Mexican industrial production for U.S. markets exploded and a trade deficit became a moderate trade surplus. Of course, this manufacturing appeared because factories were ripped out of the unionized American heartland and transformed into sweatshops across the border (one reason why conservatives blaming Mexican migrants for white working-class joblessness is comically backward).

But in exchange for increased exports and the resultant GDP bump, Mexico essentially renounced its food sovereignty. Mexico is the homeland of corn. It's where

maize was first domesticated, and for millennia corn has been the backbone of Mexican food culture. Until NAFTA, a non-industrialized agrarian hinterland was supported by strong protectionist food policy, which had meant that Mexico maintained the bounty of maize's evolution, with 59 distinct local breeds. Maize biodiversity had flourished in Mexico in the face of genetically modified corn monocultures to the north, and small subsistence farmers, many of them indigenous, made up much of the Mexican population outside the cities.

NAFTA spelled the end for all those protections, and U.S. corn and soy products flooded Mexican markets. The resultant drop in Mexican crop prices has dramatically accelerated the ongoing collapse of small Mexican farms, increasing rural proletarianization and urban migration. But these cheap products didn't just shut down farms and swell Mexico City's slums. Studies by the liberal Institute for Agriculture and Trade Policy (IATP) show that the rise in obesity correlates exactly with NAFTA, that NAFTA's trade liberalization led to a proliferation of cheap processed meat, soda, sugary drinks, animal products, fats, and sweeteners in Mexican stores and homes. As the IATP's Dr. David Wallinga argues, “What people eat depends heavily on what food products in their immediate environment are easiest and most accessible.” The availability of cheap food led to more Mexicans adopting unhealthy diets, and, eventually, a public health crisis.

At first, this argument about the “foodscape” seems like a welcome relief from the moralistic diatribes focused on personal choice, self-discipline, and exercise that make up the general cultural conversation on food and obesity. Such individualist snake oil is perfectly embodied in government programs like Michelle Obama's “Let's Move!” campaign, which aims to end childhood obesity by encouraging more physical activity in children and teenagers. From “Let's Move!” to consumer devices like the Wii Fit to the massive success of questionably effective programs like Weight Watchers, fatness is seen as an individ-

ual failing that can only be solved by personal discipline and sacrifice.

But all of these state initiatives and lucrative businesses are built on the presumption that being fat is bad, both morally and medically: a presumption with shaky scientific ground and a relatively short history. For most of 19th century America, plumpness not only indicated health, wealth and leisure, it was the definition of attractiveness. But the rise of railroads, refrigeration, and techniques increasing farmland productivity in the 1880s-90s meant more people had access to more food. Thickness began to lose its power as a sign of wealth with the widening girth of the working-class. Predictably, fatness also lost its place at the top of the beauty hierarchy. By the 1920s, the rail-thin flapper was the definition of modernity and sexiness.

Concurrent with its desexualization, fatness was pathologized as a health concern

Concurrent with its desexualization, fatness was pathologized as a health concern. Important activist and academic work has been done demonstrating that “obe-

sity” is not a medical category at all, but rather a device for shaming and domination. As Pat Lyons argues in “Prescription for Harm,” the scientific evidence on “obesity” being a medical problem is at best dubious and at worst bunk. The supposed deadliness of obesity—you still occasionally hear the statistic that it kills 300,000 people a year in the U.S.—was constructed when the dieting industry purposely misconstrued a single study from 1993 whose authors have since consistently and publicly objected to its misuse, to no avail. Studies directly linking being overweight to negative health outcomes are significantly less consistent than those connecting negative health outcomes to smoking, psychological stress, racial discrimination, or poverty. The evidence that losing weight in and of itself has good health outcomes, meanwhile, is so contradictory as to be non-existent, while weight-cycling and constant dieting in an attempt to lose weight have been rather definitively connected to increased blood pressure, depression, and eating disorders. But, due to the incredibly lucrative dieting industry (in 2013, it was estimated at \$61 billion, or twice the size of the U.S. film industry) embedding itself through lobbying, placement in public health agencies, and extensive marketing both to consumers and doctors, there has been a generalized cultural pattern toward “exaggerating the health consequences of higher weight while downplaying treatment failure.” Thus we are left with warnings of an “obesity epidemic” that afflicts over 70 percent of the population.

Even if the stigma connected to fatness is totally politicized, even if most of these overweight people’s health outlook actually has little to do with their body size, something needs to explain the (undeniable) rise in BMI. And so, as in the IATP study, over-production and general availability of cheap calories becomes the liberal consensus explanation for the “obesity” epidemic in both the U.S. and Mexico. Supported by wildly protectionist subsidies from the federal government that mean agribusiness will always make more money if it grows more food, buoyed by

marketing (which has been shown repeatedly to directly affect the amount people eat) and lax regulation, the argument goes, cheap food is just too readily available.

An entire market is built like an eating disorder. Consumers ping-pong back and forth between food and diet, giving both industries yet more money and yet more power

The argument isn't entirely wrong. But if this flood of cheap food was always available as a strategy to agribusiness—subsidies go back to the New Deal, after all—why has it only emerged in the last 40 or so years? And why has the market in cheap food also meant a general fattening of the population? Fatness, as it is currently constituted, has to be understood not purely as a question of overproduction, but as one of the “spatial fixes”—the process of opening up new markets to capital in new territories—to

the general crisis of underconsumption and falling profits that capital has faced since 1973.

There are, in theory, limits to how much food you can sell to a population. Any food market will hit the ceiling of “inelastic demand.” With the technological intensification of farmland productivity—through labor-cutting industrialization, GMOs, pesticides, fungicides, and food substitution (like corn syrup for sugar)—businesses can produce almost limitless varieties and amounts of food as long as they have somewhere to sell it and someone to sell it to. Throughout the 20th century, U.S. imperialist strategies in Central America (like United Fruit), its wartime agricultural support for allies, and even its humanitarian food aid were all designed to open up new food markets. NAFTA is another perfect example of such a spatial fix: It both reduces the cost of labor and creates new customers for their product. But there is another spatial fix that agribusiness has stumbled upon, one that has little to do with borders. Space has been opened up in the actual bodies of workers.

As Julie Guthman argues in “Neoliberalism and the Constitution of Contemporary Bodies” (from *The Fat Studies Reader*), cheap food and fat people perfectly solve the problem of agricultural production outpacing demand. Guthman explains: “Not only does [fast food] involve the super-exploitation of the labor force, but it also provides an outlet for surplus food. Insofar as this surplus manifests in more body mass, the contradiction is (temporarily) resolved in the body.” As long as people get fatter, they can continue to eat more food, incubating the market in their bellies. What about when people reach a material limit of their fatness, deciding they want to lose weight or eat more moderately? Agribusiness has got that market covered too, selling faux foods like Diet Coke and Splenda. “This double fix of eating and dieting, in other words, is not epiphenomenal; it has become a central piece of the U.S. economy,” according to Guthman. The market literally expands with waistlines, but when the waistlines contract, a market grows there too.

Of course, certain bodies are more prone to these techniques than others. Fattening-as-market-expansion happens disproportionately to the poor, women, and people of color. The rich are afforded the right to buy both food and thinness, while the poor afford only calories. But calories are not food, and food is not reducible to calories, unless you're selling it. Cheap corn, soy, and animal product-intensive foods have very low nutritive value, so a person has to eat way more of them to get the same nutrition. Cheaper calories mean fatter bodies, not wallets.

Thanks to the massive social stigma produced by a century of public health misinformation, a shame-based culture industry, and health care professionals (mis-) trained to recognize body size as a health indicator *sui generis*, over 70 percent of the U.S. and Mexican populations are made to feel intense body hatred (though it's plausible that the other 30 percent feel some too). This drives them further into the beauty and diet industries, which provide the same "weight loss" solutions they've pushed for 40 years, despite those "solutions" having upwards of a 95 percent fail rate. Guthman describes this as structurally bulimic: an entire market built like an eating disorder. Consumers ping-pong back and forth between food and diet, giving both industries yet more money and yet more power to place their scientists at the head of public health institutes and continue to push their conceptions of obesity and health on an increasingly overweight and self-loathing public.

NAFTA didn't merely open Mexican markets to cheap calories, but to an entire nexus of products. The pharmaceutical, fitness, and "health and wellness" (e.g. low fat) food industries are growing dramatically in Mexico. The markets opened up by these industries in turn benefit off of the dysphoria produced by a cultural aversion to fatness, an aversion that the U.S. also exports. One 2012 study found that, controlling for all other factors, there was a direct correlation between weight gain and time spent in front of English-language U.S. television

among children in Baja, Mexico. The U.S. exports both fatness and anti-fatness, and does so both materially and ideologically. Neoliberal ideologies of personal responsibility and market solutions seal the deal, leaving fat people blaming themselves for their structurally-produced fatness while throwing money away at both shitty food and shitty "health" solutions.

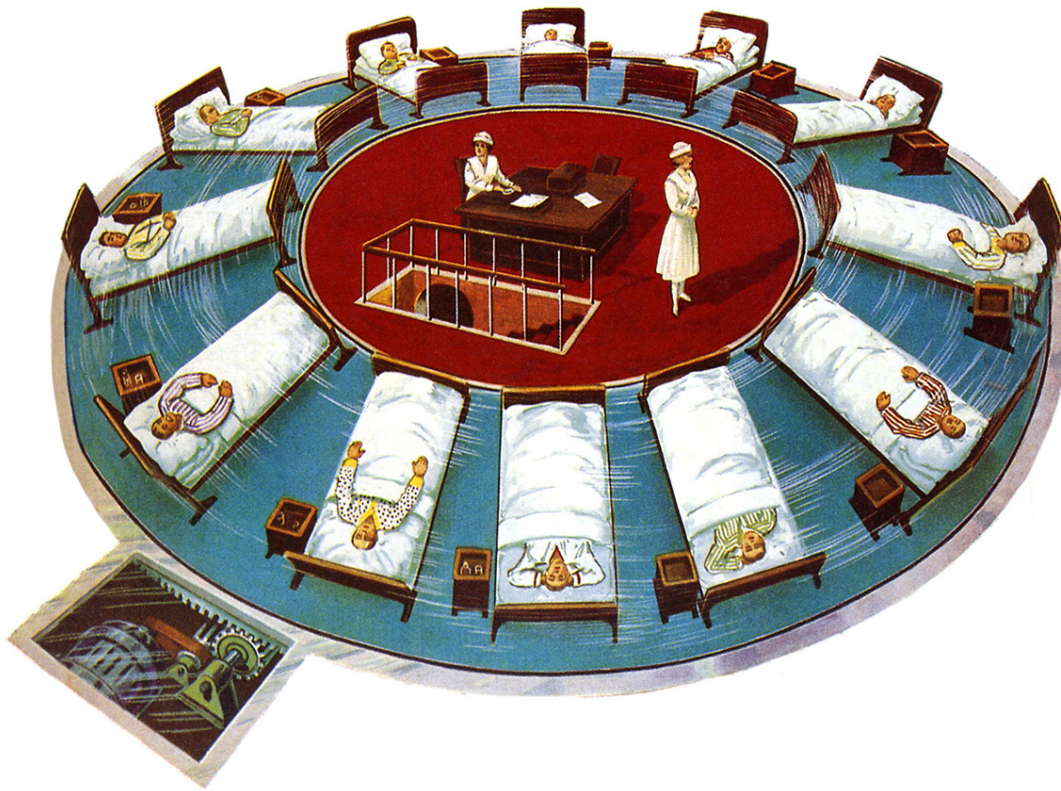
What would a collective response look like? On the production side, Mexican farmers have organized against GMO foods, though these struggles have often focused on petitioning the government for a return to historical protections. While CSAs, "locavorism," and farm-to-table food are more often than not a part of gentrifying projects, community gardens and urban farms can become nodes of resistance where the fight for food autonomy and struggles against urban development meet. Meanwhile, many fat activists have worked to destigmatize fatness, though their work is often stymied by recuperation on the one hand and the knee-jerk (diet-industry produced) assumption that being overweight actually *is* bad for you on the other. Queer and anti-racist practices that celebrate otherwise marginalized bodies (as opposed to the mass-culture fetishization of "bears" or big asses on otherwise skinny women) also offer potential first steps.

Food autonomy, a total reevaluation of health and beauty standards, and a non-disordered cultural relationship to food, however, will require more than just the sum of such (important) struggles and interventions. The "lank, narrow-chested, hollow-eyed ghosts" that Engels observed in working-class London still haunt the salvage-heaps, slums, and sweatshops of the world. But increasingly, much of the global proletariat is fat. Not merely working at the behest of the market, their bodies have become literal geographical expansions of it. That a particular way of eating is now a part of their labor makes them no less well-positioned to destroy capital through their organized refusal to work. The workers have nothing to lose but their pounds. **TNI**

Who Cares

By LAURA ANNE ROBERTSON

The supposedly natural emotions of love and compassion are used to compel many people, especially women, to work for free



AT an interview for a mental health nursing program, I was asked what I would do if a patient wet themselves at the end of my shift. In terms of my experiences

of nursing, the question made no sense: In reality, the last half hour of a shift is spent handing over patients to new staff coming on duty. It would be their responsibility to

clean my patient. But at interview, I said what I knew I was supposed to say: that I would clean the patient myself, regardless of when my shift ended. Wannabe nurses must demonstrate their compassion. And compassion, we are taught, means cleaning shit for free.

I work in the U.K., but my experiences as a trainee nurse will be familiar to other nurses in the U.S. and worldwide. In many caring institutions, stretched resources mean high ratios of patients to staff. Nurses must meet the complex and diverse needs of the people they care for—washing, dressing, meal times, medication, counseling, liaising with social services—at the expense of lunch breaks and evenings. Feelings of guilt and panic pervade the working day. If you leave exactly when your shift ends, you feel you are failing your patients. If you stay late, you are effectively working for free and affirming the expectation that you *should* work for free, making it harder for your colleagues to leave on time. You are trapped between two kinds of compassion: your compassion for your patients, and your compassion for your co-workers.

Reports of neglect and abuse in hospitals and care homes appear with alarming regularity. Received narratives blame “burn-out”: understaffing, low wages and squeezed margins transform overworked and overstressed carers into monsters. The proposed solution is extra vigilance and “Compassion Training.” Shifting the question of working practices and worker wellbeing onto the terrain of compassion is a sleight of hand. It implies that care workers should police themselves and their colleagues rather than fight collectively for better pay and conditions. By this account, compassion flows in one direction only, from nurse to patient, and never between nurses, or from the nurse to her or his own family and friends.

Nurse-lecturers, who have swapped bedpans for classrooms and higher salaries, use some startling methods to help student nurses adopt a compassionate approach. We are encouraged, for example, to imagine that a patient is our mother, to help sweeten the bitter

pill of unpaid overtime. This assumes that the mother-child relationship invariably provides a robust and appropriate model for compassion. In reality, many people have messy or even abusive relationships with their mothers. Our work as nurses brings us into contact with the complexity of actually existing family relationships. We treat patients who no one visits, or who are aggressive and challenging. The training we are given in compassion asks us to ignore compassion’s basis—attention to lived experience—in favor of a platitude about the mother-child bond, half fairytale and half emotional blackmail.

Like everyone, nurses all have different personal experiences of being mothered or being mothers. In drawing on naturalized ideals of tenderness and care, the teaching of compassion makes heavy presumptions about nurses’ own families, or disregards them entirely. In the essay “Caring: A Labor of Stolen Time: Pages from a CNA’s Notebook,” first published in *Lies* journal, the writer points out that many care workers are forced to neglect their own families, sometimes overseas, whilst engaging in long hours of low waged caring labor: “As if eight hours and the emotional shrapnel that spill over into our non-work time is insufficient mental colonization. Now, they even try to get family involved... We are torn from our family, and yet our shameless bosses try to milk our love for family.”

Of course, the majority of care workers—parents but mostly mothers, children but mostly daughters, spouses but mostly wives—never receive any wages at all. Within families, and other close interpersonal relationships, love and guilt are the mechanisms by which caring labor (cleaning, wiping, feeding and so on) is extorted from a largely female workforce. Perhaps this is what nurse-lecturers are really alluding to when they ask students to imagine their patients as their mothers. When women, who dominate caring professions, take their capacity to care away from the private sphere and sell it on the labor market instead, the same mechanisms—love and guilt—are called upon

to bridge the shortfall in staff, resources and wages that characterize many caring institutions, whether they are run for profit or by the state.

The pact of caring labor is double-edged. Caring means giving more than you get, or giving without hope of receiving. But in order to receive this supposedly immeasurable care, you must first make yourself sufficiently loveable. There is a reason mothers implore their children to settle down and start a family. You must make friends or have children or find a life partner. You must ensure those people stick around long enough to care for you when you get sick or grow old. You should try to avoid falling ill in prison. Inevitably, not everyone is willing or able to meet these demands. Those who are challenging or aggressive can struggle to find people to meet their care needs. They might be left in pain, or go hungry, because they cannot make themselves sufficiently likable. Because they cannot form the kinds of relationships within which caring labor is dispensed (e.g. marriages, friendships, families). Whilst nurses are paid to form these relationships with everyone and anyone, in the context of over-stretched health care systems, it is inevitable that the most challenging, least likeable patients will lose out. This is one of the unintended implications of advising nurses to pretend that patients are people they love. It is hard to love people that are abusive or ungrateful or racist. Compassion is in permanent crisis: love and guilt cannot ensure that everyone in society is adequately cared for.

Feminists differ in their attitudes towards caring labor. Valerie Solanas, in the *SCUM Manifesto* argues that care work is a demeaning artifact of a society controlled by men:

The reduction to animals of the women of the most backward segment of the society—the “privileged, educated” middle-class, the backwash of humanity—where Daddy reigns supreme, has been so thorough that they try to groove on labor pains and lie around in the most advanced nation in the world in the middle of the twentieth century with babies chomping away on their tits.

In the *SCUM Manifesto*, Valerie Solanas proposes that “thrill-seeking females overthrow the government, eliminate the money system, institute complete automation and destroy the male sex.” In her vision of post-revolution society, all work will be performed by machines. Caring labor will be eliminated and will no longer be constitutive of expressions of love between individuals. Instead, women will spend their newfound leisure time expressing love for each other through intellectual discourse and great projects (e.g. curing death).

While increased leisure time and revolutionized interpersonal relationships have not yet been forthcoming, technology has already been employed in a range of caring tasks from baby formula milk or TV as babysitter to animal robots. However, we remain a long way from machines raising the next generation of workers and carers. As demonstrated by Harry Harlow’s heartbreaking experiments raising baby monkeys in isolation chambers with inanimate robot mothers, the task of reproducing socialized primates is complex and nuanced. So far, despite the deficiencies of some human carers, we do not have a machine that can care for the sick or bring up a child.

Many feminist theorists disagree with Solanas’s analysis. They argue that while in patriarchal capitalist societies women are overburdened with the tasks of love and care, these tasks are an inherent part of what it means to be human. For example, Selma James, co-founder of the International Wages for Housework Campaign, defends care work like this: “Mothers feeding infants, in fact all caring work outside any money exchange, is basic to human survival—not exactly a marginal achievement. What, we must ask in our own defense and in society’s, is more important than this?”

Thus the International Wages for Housework Campaign demands a substantially reduced working week, a guaranteed income for all (women and men) and free community-controlled childcare. In her essay, “Wages

Against Housework” Silvia Federici argues that these demands are revolutionary—they have the power to undermine capitalism and to radically transform society: “Wages for housework, then is a revolutionary demand ... because it forces capital to restructure society in terms more favorable to us and consequently more favorable to the unity of the class.”

In advocating for the defense of, and investment in, caring labor as a central revolutionary demand, the International Wages for Housework Campaign presents caring work as an essential and redeeming feature of humanity. Unlike Solanas’s vision of mechanized care, in this version of feminism, caring labor is not eliminated—it remains an important aspect of human relationships and expressions of love within those relationships. Care for the sick would still depend on love, whether within close interpersonal relationships or as part of a more generalized, universal love for all people.

Of course, in this post-revolutionary, transformed society, caring labor would no longer be primarily the domain of women. Freed from wage slavery, men and women would both have time to care for the young, old and sick. The collapse of the patriarchal family, a cornerstone of capitalist society, would engender the development of communized care institutions: People would continue to express their love for each other through caring work but this love would no longer be confined within exploitative interpersonal relationships or waged employment (i.e. families or existing social service and health care structures).

Silvia Federici, and others in the Wages for Housework movement, are skeptical about the role of technology in revolutionizing care work. They do not share Solanas’ optimism about machines. They point out that the production and consumption of technology is characterized by the exploitation and domination of workers, for example in factories like Apple-Foxconn. Machines are creat-

ed by capitalism and therefore should not be trusted. But capitalism also requires workers who are able to work. If workers get sick, someone must take care of them, whether within families or healthcare institutions. As we have seen, love and guilt are the key emotional mechanisms by which capitalism appropriates (mostly female) unwaged caring labor to these ends. Perhaps then, we should also be skeptical of models of utopia that revolutionize the organization of society but leave care work, and its associated emotions, intact.

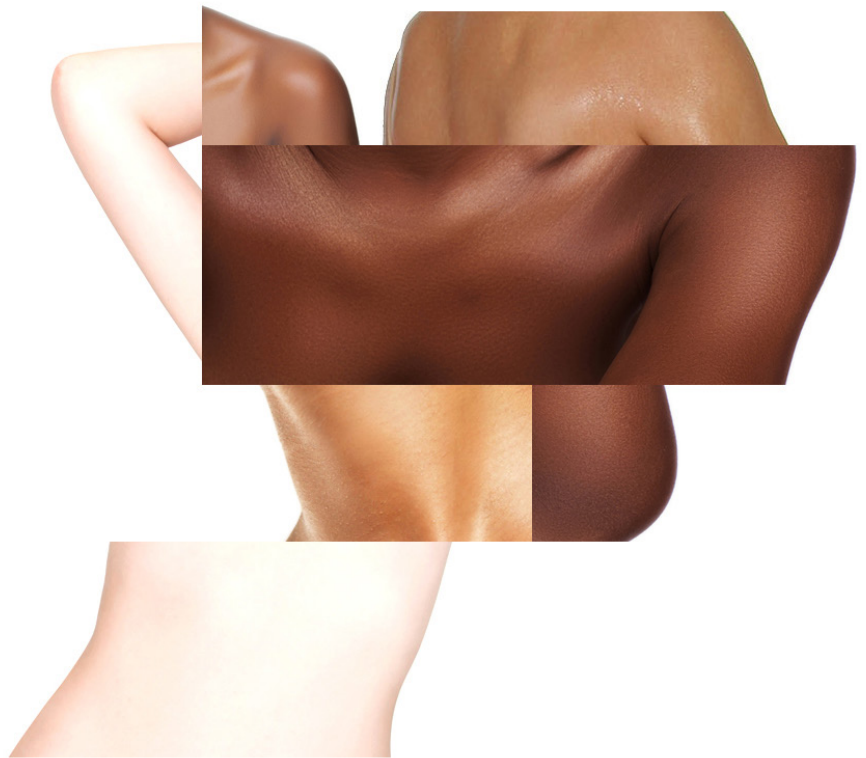
Is it possible to imagine a restructured society in which love remains the primary motivation for engaging in care work but where this labor is provided freely, without exploitation? We might assume that rich women love their families, but just as they don’t work in the factories where their iPhones are made, they rarely perform the hard graft of caring labor themselves. Instead they employ nurses and nannies. The reason that some working class women perform care work for rich people as well as for their own families and communities is not that they experience love more intensely. Or if they do, perhaps they experience it more intensely because they are required by capitalism to perform this labor. Ultimately they do it because they do not have a choice.

There are potentially a million different possible ways to treat the sick, raise children or organize intimacy. It’s at least imaginable that in a different social form we could cure ourselves with shared knowledge of pharmacologically active substances, or that sick people might choose to meditate on their pain alone, or countless other examples. In a fully communized society, it might be possible to retain both love and iPhones, but the conditions of their production and consumption would need to be radically transformed. It might be necessary, as Solanas suggests, to de-couple love from care work. Whatever happens, we must stop taking it for granted that women care and want to care. And we must begin to investigate the meaning of that caring. **TNI**

Circle Circle Dot Dot

By YAHDON ISRAEL

Cooties, like racial identity, pass from body to body. But how can you protect yourself from a danger that looks like yourself?



WE often work to convince ourselves that the individual is the most important thing in our society; that is, until they get sick. And while the death of a single body is tragic, the true tragedy is that we don't value the afflictions of the single body until multiple bodies become the casualty of our disgust and contempt. The cooties did do its number on adults, but the numbers were far worse amongst those who had not yet learned how to count.

If war gives us the language of attacking others, then disease gives us the language of defending ourselves. The U.S. military came into direct contact with cooties when they joined the British Allies to fight in the South Pacific during World War II. "Cooties" was a slang word developed by the British soldiers to describe *kutu*, the Austro-nesian word for "body lice." Fighting closely in the same

trenches not only led to the American soldier's contraction of body lice, it also led to the contraction of the world's maladies. While it can be said that World War II ended with the Allied Powers' effective healing of bodies contaminated by the Axis of Evil, it can also be said that the healing of one body does not guarantee the immunity of others. These bodies, thought to be immune, returned to America after the war bringing what they were exposed to with them.

During the U.S. polio epidemic of the 1950s, parents' fears about their inability to protect their children from foreign invasion provided the pretext for setting up lines of defense. In the previous war, bombs, guns, missiles and grenades were used to cure foreign bodies in foreign lands, but conventional weapons and strategy could not be used here.

The bodies involved were no longer foreign, but familiar. Many parents became anxious that they could not control their child's health once the child left the house to do God knows what with God knows who. Danger, supposedly clear and present for men going to war, became insidious and invisible in the case of children going to school. The fear of invisible dangers informed ideas about healthy bodies: What they were supposed to do and look like, and what they did not do and could not look like when unhealthy. Fear also informed ideas about how unhealthy bodies had to be quarantined to protect healthy ones. Long after the vaccine for polio was first developed and administered to American children in 1955, the fear of invisible dangers remained. There is no panacea for fear. And "cooties" became one of the weapons of choice for people living with the fear that other people's bodies were a threat to their own.

I'm not sure how I caught the cooties but I do remember when. I was in my kindergarten classroom, playing by myself. Looking around for others to play with, I spotted a small group of kids playing with blocks. Their smiles were infectious, their laughter was contagious, and I wanted them to give me what they had, so I walked over.

"Hi, my name is Yahdon."

And when I went to extend my hand for a shake, this one girl's whole body recoiled in repugnance.

"Eww, don't try to touch me, you have the *cooties*."

Cooties? What the hell? I thought to myself. I tried to laugh it off and went over to another kid. And before I could extend my hand, the same girl interjected—

"Don't touch him! He has the *cooties*!"

He looked at my hand for a second, "Touch me and I'll punch you." I was confused. I went back over to where I was and examined the hot wheels car and track I played with. *I don't see anything on here.* I smelled the car, the track, and the area of the play-mat. *It doesn't smell bad.* I looked back over at the group of kids. *Maybe I should try sharing with them ... that usually works.* I went back over to the group and offered the hot wheels car. "Do you want to play

with it?" One of other kids seemed eager to take the car. But before he could take it—

"Don't touch that! It has *cooties* on it! If you touch it, you'll have it too!"

The boy didn't seem to care, and reached for it anyway. When the girl saw this, she smacked the car out of my hand and, before it could hit the floor, she roundhoused it. *This little bitch just Chun-Li kicked my car.* I started crying. Tears first ran because I was caught off guard by how impressive the kick was; they continued to flow, however, because I couldn't understand what I did to deserve this.

When I got home, I rushed to the mirror to look at my face to see what had changed between now and this morning. With my thumb and index fingers, I drew back my eyelids to see if the cooties were there. *They don't look different.* I opened my mouth and stuck my tongue out so that I would be able to see the back of my throat. *What do doctors look for back here anyway? I don't see anything.* I then began examining every gap where teeth had been, or were returning: *nothing.* I looked at my hands and smelled them. Whether or not my hands smelled didn't matter. I washed them over and over again.

I turned the water off, dried my hands, which, by this time, felt like I would qualify for Social Security, and went to the kitchen table. Fried chicken, mac and cheese, and cauliflower greeted me when I sat down but I couldn't eat; I could only look at my hands.

"What are you doing *now*?"

"Looking at my hands, Ms. Palmer."

"Why? You were in that bathroom washing your hands for almost an hour ... unless you were doing something else."

"What?"

"Don't act like you don't know what I'm talking about."

I didn't know what she was talking about—at least not then. Ms. Palmer was my foster mother at this time. She was a sweet woman but always thought I was doing something I wasn't supposed to—mainly because I was, but not this time. I was too busy staring at my hands. I didn't want to ask

Ms. Palmer what the cooties were because I didn't want her to think I had them. If she found out I did, she would have probably roundhoused my fork like that girl roundhoused my car so I didn't say anything. Instead I decided that whatever happened today would be over if I just went to sleep.

I woke up the next morning feeling great. My hands had sprung back to their youthful vigor. But I still wasn't convinced. I went downstairs to find Ms. Palmer in the kitchen making breakfast. I asked her for a cup of orange juice, drank it, and gave her the cup to see if she'd take it. And she did! *Welp, guess I don't have the cooties anymore!* Feeling confident, I got ready for school.

I came to class with a reinvigorated attitude. I had broken the spell of the cooties and everything was back to normal. But sitting down, I noticed that all of the kids were whispering to each other. While mouths moved toward ears, all eyes were on me. I already knew what it was: *I still have these damned cooties.* I had seen enough of what these kids were capable of and decided that it made no sense to act as if what I had didn't exist. I decided that, if I had the cooties, the whole class was going to have them too.

Whenever I was bored, I would get up, walk around the classroom and sit back down. This time when I got up, I started touching everything: the books, the crayons, the doll house, the cubby-closet, the chalk, everything. I even went as far as licking one kid's pencil. I took pleasure in watching these kids cringe as I touched their favorite things. *I'd like to see who'll have the cooties now.*

Lunchtime came and instead of rushing to the playmat like I usually would, I sat back and watched to see what these kids were going to do. I figured since they ruined my fun, I'd ruin theirs. I figured wrong. "Circle, circle, dot, dot, I got my cootie shot." All of these kids began saying this while injecting their crossed index and middle fingers into their arms. *Oh, come on! There was a cure for this the whole time?!* I was initially disheartened that this ritual undid what I had done but then I thought *well if that worked for them, maybe it'll work for me.*

"Circle, circle, dot, dot, I got my—"

"What are you doing?"

"Giving myself the cootie shot."

"You can't get rid of the cooties, only I can."

"Why?"

"Because that's the rule."

"Well everyone else didn't have to do that."

"That's because *they* didn't have the cooties. *You* do."

"How did I get them in the first place?"

"Because I gave them to you."

"So give me the shot."

"No!"

"Why?!"

Because she was a bitch, that's why. But she was so pretty. She had long soft black hair, and really nice skin. She had the eyes of a Disney princess and although she was five, she had all of her permanent teeth—and they were straight without braces. We all wanted something from her: Boys in the class wanted her to be their "for real for real" girlfriend; girls wanted her to be their "BFF"; I just wanted her to get rid of my cooties. What strikes me now, which never did then, was how I got something from someone I never touched, talked to and until then, never even knew existed. But just like my hands being clean had done nothing to prevent me from washing them for an hour, me not touching, talking, or knowing this girl did not stop me from trying to get her to get rid of my cooties. For a while, there was nothing I wouldn't do for that girl. I did her homework, I let her use my 64 box of crayons, I gave her my snacks for lunch and yet, I still had the cooties.

During snack time, the girl came over and asked for my brownie. I told her no. When she threatened that she wouldn't give me the cootie shot, I thought about it. I thought about how long I'd been living in denial, never accepting that regardless of what I did, she was never going to rid me of these cooties. But then I began thinking about how I got them in the first place. If she gave them to me, how was it that only I had them? I looked at her skin then

looked at mine; looked back at her skin then looked back at mine. I noticed how light her skin was and how much darker mine was in comparison. I started looking at her hair: permed and pressed—silky straight. I touched mine: knotted and nappy, dreaded and locked. I stared into her eyes thinking about mine. Hers were a light brown or hazel, mine were black. I started to really think about why so many boys wanted her to be their “for real, for real” girlfriend, and why the girls all wanted *her* for a friend in particular. There were other girls in the class who were pretty; instead of fighting over who got to be *this* girl’s friend, they could have been each other’s. Then it hit me: *She doesn’t have the cooties because she’s light-skinned.* How that girl passed something onto me without having it herself was beyond me. But I’ve come to find out that “passing” has been in our blood for generations.

Whenever a black person is sure that another person is black, but isn’t sure what else, they always ask, “What are you mixed with?” They never ask if you’re mixed with black; the black is already acknowledged in the way the question is asked. If they were unsure altogether, they’d ask, “What are you?” Only uncertainties are questioned. But when you’re sure of something, there is no need to inquire. There was a time, however, when even the most certain of rules still allowed for the most uncertain of circumstances.

“Passing” was a term used by black Americans to describe black people who looked “white enough” to pass for white, and decided to. People who “passed” didn’t look like Barack Obama, Jasmin Guy, Blake Griffin, or even Mariah Carey; they looked exactly like the sheriffs who arrested you, the waitress who refused to serve you, the teacher who told you that you couldn’t be a lawyer, or the boss who wouldn’t pay you what you were worth. The people “passing” looked exactly like the people who didn’t have to. But imagine looking exactly *like* the sheriff, and yet only one of you has the power to arrest the other. Or having the same features as the waitress at a restaurant where you can’t eat.

Lawrence Otis Graham’s *Our Kind of People: Inside America’s Black Upper Class* includes the story of a woman who’d been trying on hats at a high-end department store in Memphis. When her friend Erma spots her, Erma walks over to hug her. “No,” the woman whispers, “Erma, please don’t hug me. Don’t touch me.” When the woman sees the hurt in her friend’s face, she apologizes. “I’m sorry, Erma. I’ll grab your hands and shake them. It’s very nice to see you, but not *here.*” At first Erma couldn’t understand what was happening. Then, in looking at the price tag that hung from the hat of her friend, Erma realized why she couldn’t hug her. At the time of this incident, black people were not allowed to try on hats in the store. They had to either buy it or look at it without touching it. “I realized she was passing,” Erma concludes, “and if she’d hugged me, I would have blown her cover.”

In thinking about how contact between black and white bodies only exposed bodies discovered to be black rather than bodies incapable of becoming white, I wonder what this meant for the people fighting behind enemy lines. “Passing” must have entailed a perpetual fear and paranoia that any and every black body was a threat to your white-appearing one; but it must have also meant living in fear of white bodies too. After all, what *is* a white body if a black body was capable of passing as one?

This must explain why so many white people I know act weird about me touching them. It also explains why the light-skinned girl in my kindergarten class was more worried about me touching her than I was worried about her touching me. And it explains why, throughout the time that I had the cooties, it never occurred to me to touch her. While it could be said that, in my refusal to touch that light-skinned girl, I showed how mortified I was by her body’s power over mine, it could also be said that my body’s mortification had more to do with the fact that it wasn’t me who had the cooties in the first place. And if I still do have them, I’m not the only one. **TNI**

The Sororal Death

By ANNE BOYER

Writing about a disease suffered almost exclusively by women presents the disordering question of form

IN 1972, Susan Sontag made notes in her journal for a work to be called “On Woman Dying” or “Deaths of Women” or “How Women Die.” Under the word “material” she listed 11 deaths, including the death of Virginia Woolf, the death of Marie Curie, the death of Jeanne d’Arc, the death of Rosa Luxemburg, and the death of Alice James. Alice James died of breast cancer in 1892, at the age of 42. In her own journals, James describes her breast tumor as “this unholy granite substance in my breast.” Sontag quotes this description in *Illness as Metaphor*, the work she wrote after undergoing treatment for breast cancer.

Sontag is diagnosed with breast cancer in 1974, at the age of 41, but *Illness as Metaphor* is cancer as nothing personal. Sontag rarely writes “I” and “cancer” in the same sentence. As she explained in *Aids and Its Metaphors*, “I didn’t think it would be useful—and I wanted to be useful—to tell yet one more story in the first person of how someone learned that she or he had cancer, wept, struggled, was comforted, suffered, took courage ... though mine was also that story.” Rachel Carson was at work on



Jo Spence, *A Picture of Health: Property of Jo Spence?*, 1982

Silent Spring when she was diagnosed with breast cancer in 1960, at the age of 53. Like Sontag, Carson wrote one of the most significant books in the cultural history of cancer, but Carson won't admit the link between herself and the disease she dies of in 1964.

Sontag's journal entries during cancer treatment are notable for how few there are that mention her cancer and how little they say. The little they do say illustrates breast cancer's cost to thinking, a price paid most dramatically during chemotherapy—Sontag was in chemo for two and a half years—which can have severe and long-lasting cognitive effects. In February 1976, while undergoing treatment, Sontag writes “I need a mental gym.” The next entry is months later, in June 1976: “when I can write letters, then ...”

In Jacqueline Susann's novel *Valley of the Dolls*, one character, Jennifer, suicides by overdose after a breast cancer diagnosis. “All my life,” Jennifer says, “the word *cancer* meant death, terror, something so horrible I'd cringe. And now I have it. And the funny part is, I'm not the least bit frightened of the cancer itself—even if it turns out to be a death sentence. It's just what it'll do to my life.” The feminist writer Charlotte Perkins Gilman, diagnosed with breast cancer in 1932, kills herself too: “I have preferred chloroform to cancer.” Susann, diagnosed at 44, dies of breast cancer in 1974, the year Sontag is diagnosed.

The poet Audre Lorde is also diagnosed at the age of 44, in 1978. Unlike Sontag, Lorde uses the words “I” and “cancer” together, and does so famously in *The Cancer Journals*, which includes both an account of her diagnosis and treatment and a feminist call to arms: “I don't want this to be a record of grieving only. I don't want this to be a record of tears.” For Lorde, the crisis of breast cancer meant “the warrior's painstaking examination of yet another weapon.” She dies of breast cancer in 1992.

Like Lorde, the novelist Fanny Burney, who discovers her breast cancer in 1810, writes a first-person account of her own mastectomy. Her surgery, though—rare at the

time—is done without anesthetic, and she is conscious for its duration: “...not for days, not for Weeks, but for Months I could not speak of this terrible business without nearly again going through it! I could not think of it with impunity! I was sick, I was disordered by a single question—even now, nine months after it is over, I have a headache from going on with the account! and this miserable account which I began 3 Months ago, at least, I dare not revise, nor read, the recollection is still so painful.”

“Write aphoristically” Sontag notes in her journal when considering how to write about cancer in *Illness as Metaphor*. Breast cancer exists uneasily with the “I” (almost always a woman's) that might “speak of this terrible business”—the “I” often appearing in excess, or not at all. It is an “I” sometimes annihilated by cancer, but sometimes pre-emptively annihilated by who it represents, either by suicide or by an authorial stubbornness that does not permit “I” and “cancer” to be joined in one unit of thought:

“[Redacted] is diagnosed with breast cancer in 2014, at the age of 41.”

or

“I am diagnosed with [redacted] in 2014, at the age of 41.”

The novelist Kathy Acker is diagnosed with breast cancer in 1996, at the age of 49. “I am going to tell this story as I know it,” begins the uncharacteristically straightforward piece she wrote for the *Guardian* titled “The Gift of Disease”: “Even now, it is strange to me. I have no idea why I am telling it. I have never been sentimental. Perhaps just to say that it happened.” Acker doesn't know why she would link herself to her cancer and yet she still does: “In April of last year, I was diagnosed as having breast cancer.” Acker dies of it in 1997.

There is no disease more calamitous to women's intellectual history than breast cancer: this is because there is no disease more distinctly calamitous to women. There is also no disease more voluminous in its agonies, agonies not only about the disease itself, but also about what is not writ-

ten about it, or whether to write about it, or how. A disease suffered almost entirely by women presents the disordering question of form. The answer is competing redactions, and these redactions' interpretations and corrections. For Lorde, the redaction is cancer's and the silence around it is an opportunity: "My work is to inhabit the silences with which I have lived and fill them with myself until they have the sounds of brightest day and loudest thunder." For Sontag the redaction is the personal. As she wrote in a note under prospective titles for what will become *Illness as Metaphor*: "To write only of oneself is to write of death."

A fourth title Sontag proposed for her never-to-be-written piece was "Woman and Death." She notes that "Women don't die for each other. There is no 'sororal' death." But Sontag was wrong: The sororal death is not women dying for each other, but women dying of being women. Queer theorist Eve Kosofsky Sedgwick, diagnosed with breast cancer in 1991, at the age of 41, wrote that at her diagnosis she thought "Shit, now I guess I really must be a woman." Sedgwick dies of breast cancer in 2009.

The sororal death is not without some sacrifice. At least in the age of "awareness," that lucrative, pink-ribbon wrapped alternative to "cure," women might not give up their lives for each other, but they do give up our breast cancer stories for the perceived common good. Reluctance to link one's self to the disease, once typical of the silence around breast cancer, has been replaced with an obligation to always do so.

Though I might claim, like Acker, not to be sentimental, this sentence joins myself and my breast cancer in—if not a sentimental story—at least an ideological one:

"I was diagnosed with breast cancer in 2014, at the age of 41."

Breast cancer's formal problem, then, is also political. An ideological story is always the story which, like Acker, I don't know why I would tell but would tell regardless. And the sentence that begins the story—with its "I" and its "breast cancer"—joins "awareness" turned into perilous

ubiquity. As S. Lochlann Jain writes in *Malignant*, ubiquity, not silence is now the greatest obstacle to finding a cure for breast cancer: "Cancer everywhere now drops into a sludge of nowhere."

Most often only one class of people who have had breast cancer are regularly admitted to the pinkwashed landscape of awareness: those who have survived it. And to the victors go the narrative spoils. To tell the story of one's own breast cancer is to tell a story of becoming a "survivor" via neoliberal self-management—the narrative is of the atomized individual done right, early-detected and mammogrammed, of disease cured with compliance, SKs, organic green smoothies, and positive thought. As Ellen Leopold points out in *A Darker Ribbon*: "The external world is taken as a given, a backdrop against which the personal drama is played out."

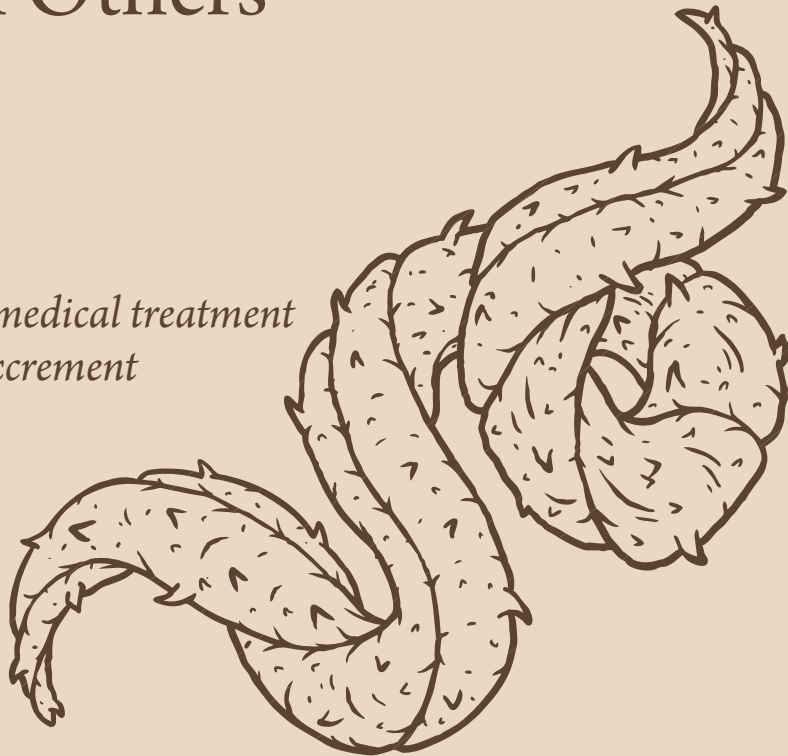
To write only of oneself, then, as Sontag suggested, might be to write not of death, but a type of death—or of a kind of death-like state to which no politics, no action, no larger history might be admitted. Breast cancer's industrial etiology, its misogynist and racist medical history, capitalist medicine's incredible machine of profit, and the unequal distribution by class of suffering and death are omitted from breast cancer's now common narrative form. But to write of death is to write of everyone, or as Lorde wrote, "I carry tattooed upon my heart a list of names of women who did not survive, and there is a space left for one more, my own."

In 1974, the year she was diagnosed with breast cancer, Sontag writes in her journal about a discovery made when thinking about her own death: "My way of thinking has up to now been both too abstract and too concrete. Too abstract: death. Too concrete: me." She admits, then, what she calls a middle term: "both abstract and concrete" The term—positioned between oneself and one's death, the abstract and concrete—is "women." "And thereby," added Sontag, "a whole new universe of death rose before my eyes." **TNI**

Taking Shit From Others

By JANANI BALASUBRAMANIAN

Recent FDA regulation of shit as a medical treatment brings to light the ambivalence of excrement



SHIT, that most abject of materials, can save lives. Fecal transfer has been known and practiced for millennia, most notably in Chinese medicine. It has been officially practiced in the U.S. since 1958, although marginalized and under-researched. Recent attempts at U.S. regulation have focused new attention on this little-known treatment, which can cure chronic diseases and challenges the assumptions of filth and shame, the shit that adheres to shit.

Last year, the United States FDA declared shit an Investigational New Drug, restricting its use for medicinal purposes. Patient advocacy groups have rallied to protest the decision, which threatens the existing infrastructure of stool banks. These banks are exactly what they sound like: schemes where donors offer their shit to strangers suffering from serious intestinal conditions. The only

other resource for chronically ill people is to approach relatives and friends for donations, which can be embarrassing, time-consuming, and difficult for people whose symptoms have left them isolated. For many, fecal transfer is still worth it despite these barriers, as for some patients it can effect dramatic improvements.

Donor shit displaces bad bacteria and fosters the development of more robust microbiota that are able to fight infection. Fecal transplants are used for treating the bacterial infection *C. difficile*, as well as a number of other internal conditions like IBS, Crohn's disease, colitis, and constipation. Some trials show it's even effective as therapy for Parkinson's disease. Enemas are the most common exchange method, but one of the motives behind FDA regulation is to facilitate the development of shit pills for less invasive transfer.

In 2012, a team of MIT affiliates launched the first official, FDA-approved U.S. stool bank, OpenBiome. Registered donors can make \$40 per day. If the compensation seems generous (though it's comparable to sperm donation), it's because OpenBiome is able to profit from the sale of small samples, literalizing the psychoanalytic link between shit and money. Despite the amazing healing properties of shit and the FDA's support, OpenBiome was initially greeted with suspicion. One MIT colleague was convinced that the project was a joke.

Report after report on fecal matter transfer refers to the practice as a miracle cure. Despite this, the U.S. medical establishment has taken a long time to accept the benefits of shit, partly because it's hard to monetize, and partly because of cultural perceptions that shit is self-evidently just gross. Collective shame around shit looms so large as to seem like an unchangeable fact, even as fecal transfers offer significant curative properties. How many of us shit as discreetly as possible to avoid being heard? How many avoid shitting in front of intimate partners? Against all this erasure, the image of the stool bank conjures the earliest gesture of babyhood: shit as gift, one of the first things we are able to give to the people around us.

The shame of shit is a shame, not least because two-thirds of the immune system is found in our gut. There are 10 times as many microflora living in our digestive tract than there are cells in the entire body. Over the course of our lifetimes, our floral microbiota bloom and react to the composite of factors in our physical and emotional lives. Geography is a huge initial determinant; our microbiota bear the signature of the literal places of our birth. They are also passed on generationally. Over time, our flora respond to everything we experience: stress, joy, trauma, rage, and so on. Recent studies shows that shifting the balance of our gut bacteria can positively affect anxiety and depression. That "feeling in your gut" is more than a metaphor for something deeply felt—it marks the relation between our intestinal residents and our emotion.

High-stress, high-anxiety environments disrupt microbiota and, inversely, microfloral imbalances can produce depressive and neurological symptoms. To put it simply: 100 trillion tiny creatures inside us carry the extent and impact of our external lives. They are living their life, we are living ours, and those life acts are nonlinearly inter-linked. Their collective existences are contained within ours, and vice versa.

How does the medicalization of shit impact our understanding of the microbiome and its intimacies? If the sharing of shit becomes more generally normalized, as it already is among those engaging in fecal matter transfer, will this shift our understanding of shit? The fecal transplant constitutes a transfer of the accumulation of other people's sensations and emotions from one gut to another. Unlike genes, flora don't code our initial formation—they code the ways in which our environments and histories have impacted our insides. You can test a stool sample for hepatitis, but not for heartbreak.

Like most physical acts, shitting is imbued with gendered meanings. A company that marketed post-shit perfume spray to women managed to sell nearly 4 million bottles in just a few years. The specter of a special taboo on women shitting echoes psychoanalytic theories that link the stool and the phallus: Femme people aren't supposed to shit because shit has phallic connotations. Alternatively, perhaps the taboo springs exactly from the gender-indeterminacy of the anus. The perception of shitting as unfeminine reinscribes gender in a place where it threatens to disappear: the asshole. Other things can also disappear there; thousands of ER visits are made in the U.S. every year by people who inserted objects without flared bases—vibrators, pencils, remote controls, and so on—into their anuses and couldn't get them out. Unlike the vagina, to which the cervix and uterus serve in the heterosexual imaginary as a properly reproductive stopping point, the anus opens out onto the endless coiling vista of the intestine, passing all the way through the body to

the mouth. This infinity evokes the possibility of castration and phallic disappearance. What goes in might never return. But the social signification of the cis man's body is a huge flared base that lets him withdraw even from the asshole with his privilege intact.

Mary Douglas's book *Purity and Danger* explores the construction of dirt and impurity across different cultures. Dirt is matter out of place (on our clothes, under our fingernails, in corporate tax records, etc). Perception of this dirt as ungraceful and even dangerous requires the fantasy of otherwise good order. Douglas writes of dirt, "It implies two conditions: a set of ordered relations and a contravention of that order. Dirt then, is never a unique, isolated event. Where there is dirt there is system... uncleanliness or dirt is that which must not be included if a pattern is to be maintained." In a system that tries to flush away and hide shit's existence, shit is problematic evidence that the products of the body, and bodies themselves, can disperse and be out of place. It is this that gives shit the power of taboo, the power to disgust or arouse.

From this perspective, the dispersed bodies of colonialism are also impure. White-supremacist metaphors of excrement and dirtiness stick to people and cultural practices. For example, colonial narratives have depicted brown peoples as dirty and smelly, and non-western toilet practices as primitive. In the colonial system, the existence/resistance of colonized people is the grit in the machine, the dirt antithetical to the clean and ordered relations of the colonizer. Western-style toilets are designed to put as much distance as possible between the body and its waste. You can be *filthy rich*, but the white rich are not filthy. The function of patriarchy, professionalism, and plumbing here has been to separate the human/proper/white body from dirt and ascribe that dirt to others. Whether what's pushed away is shit, people, or disturbing ideas, the agent of this rejection is always an asshole.

But shit can be shared, and shit can heal, because it

is the mark of our contiguity with our environments. No one lives autonomously, even within a single body. The microflora that inhabit our guts have their own response to our existences. The digestive system, a body within a body, terminates at either end in the emotionally charged orifices of mouth and anus that mark the boundary of inside and outside. The lives of our digestive microbiomes reflect and refract back onto the conscious life of that other body of head and limbs. The surface of the body can appear in the world, but the bag of the stomach and the lossy whorls of the intestine are internal, secret, fleshy and mysterious. Respectability relies on denying them social meaning, while this same denial produces undercurrents of desire and curiosity. Alien life populates our innermost parts. Our microbiota hold deep levels of possibility and feeling, but they die under conditions of duress. They are who they are, and they are us too. They hold both life and life's consistent death.

In Roald Dahl's *Big Friendly Giant*, the title character and his giant colleagues move through the world collecting dreams from sleeping humans and storing them in great warehouses. They then redistribute those dreams to other sleeping humans by blowing them into their ears. The BFG is the only giant who happens to exclusively collect and distribute good dreams (which can still be full of various sadnesses) and refuses to eat humans. Despite the consent forms and now FDA regulation, a stool bank feels more similar to a warehouse full of dreams than a blood repository: the freezers are full of subconscious matter. In the stool bank, the fecal transplant is sanitized and rendered anonymous, as are the moments of giving/shitting and taking/insertion. But at the moment that the anonymous donor's shit is sent into the vast possibility of the recipient gut, creatures who have lived by the trillion in another microbiome interact for the first time with their counterparts in an unfamiliar body. Microbiotic dreams, stored joys and trauma, move between individual bodies and transform them. **TNI**

Sickness Unto Death

BY DEREK AYEH

Atul Gawande's newest book wagers that a new attitude toward mortality can help save American medicine

Atul Gawande, *Being Mortal: Medicine and What Matters in the End*. Metropolitan Books. 2014. 304 pages.

ON November 1, Brittany Maynard ended her life as she had planned. Ten months earlier, the 29-year-old had been diagnosed with terminal cancer. After undergoing unsuccessful brain surgery, her physicians told her she had stage 4 glioblastoma, a brain cancer that today's medicine is still incapable of effectively treating. In April her life expectancy was six months. Instead of accepting the chemotherapy and radiation options offered by her physicians, Maynard decided to move to Oregon to take advantage of the state's Death With Dignity Act that would allow a physician to prescribe her a lethal dosage of sedatives. In October, Maynard partnered with the right-to-die advocacy organization Compassion and Choices to launch a video campaign. In it, she expressed her hope that one day all Americans would have the ability to make

the choice she was able to, and die on their own terms. Her video quickly went viral, reaching several million viewers and reinvigorating "death with dignity" conversations across the country.

Thinking about her story, I can't help but find it sad—not because she chose to die, but because medicine only provided Brittany Maynard with two choices: suffer from extreme, intensive treatments or beat her cancer to the punch. This is the norm for most people with fatal illnesses across the country. The portrait of the dying patient robbed of independence by aggressive medical treatments and unable to enjoy life or see the world outside of the hospital is found everywhere in medicine. Bioethicists constantly point to it in their articles, books, and clinical cases, and I'm sure like me they've grown weary

of it. Physicians who find themselves terminally ill refuse to set foot in the hospital. A recent study found that 64 percent of physicians surveyed had advanced directives, or instructions for how they wanted to be treated in the event of their incapacitation, as compared with 20 percent of the general population. These directives frequently ruled out the kind of care they provide to their patients. Today's health care workers are preparing for their own mortality by assuring they will avoid the medicalized deaths that they administer. Yet while health care professionals see medicalized death as the physician's great crime to the patient, they seem despairing, resigning all attempts to fix it.

Atul Gawande's newest book, *Being Mortal*, provides a foundation for solving our current predicament. As I read the early chapters, I recognized Maynard's story in a different character. An elderly man named Harry R. Truman who lived near Olympia, Washington appears as a figure of the gravity of death at the hands of medicine. In March 1980, he refused to leave his home at the base of Mount St. Helens, despite the threat of a volcanic eruption. The local authorities tried to convince him to leave, but time and time again Truman refused. When the volcano finally erupted Harry Truman and his home were buried underneath the lava.

What did Truman fear? According to Gawande, he was unwilling to give up control of his life. At his age, doctors wanted to put him in a nursing home and with that his freedom would be gone. Schedules would control when he slept, woke up, ate, changed, and bathed. Nursing staff would force him to take medications for whatever frailties it turned out that he had been living with, a list that would surely increase the longer he stayed. He would be a patient for the remainder of his life, trapped in the equivalent of a hospital reserved for the elderly. For Truman, this fate was worse than being buried in lava or volcanic ash.

At the end of Truman's life, he became a town hero. He "lived life on his own terms in an era when that possibility seemed to have all but disappeared," Gawande

writes. Truman's community respected his choice to retain his independence, even at the expense of his own safety and security. But Gawande complicates his heroism, posing the question which is the driving force behind his book. Why was the only alternative to Truman's choice to lose all freedom? Our medical system forces the elderly and the terminally ill to become completely dependent on profit-seeking caregivers and sacrifice most or all claims to quality of life. But surely this cannot be the only other option.

Being Mortal is a book of narratives. At every turn of the page, Gawande is telling the story of another person's life. Here is Felix Silverstone's struggle to preserve his disabled wife's happiness and their life together while doctors tried to push her into a nursing home. There is Alice Hobson, the grandmother of Gawande's wife, who sinks into depression and loneliness after losing her car, her home, and moving to a retirement facility at the request of her family. Gawande speaks to the experiences of healthcare workers, nursing home staff, his patients, and even shares the story of his father's battle with cancer and eventual passing. Alice Hobson's story ends on a particularly disheartening note: After succumbing to the hopelessness of her predicament, after coming to hate the nursing home and the state of her life, she chose to die alone. She vomited blood in her room, but told no one and made no calls. When the aides came to check in on her she had already passed.

Gawande's book centers human frailty and the disasters like these that leave people helpless. There is no shortage of desperation to be found in medical practice, but Gawande makes us confront the sad truth: we fail the dying. Many of them pass away isolated and filled with regret. I think Gawande is correct to assign fault not only to medicine, but American society at large. Ours is a culture that pushes to see the eldest members of our families safe and secure above all else. We don't see that the institutions entrusted with protecting them often rob the infirm of a

sense of self-directedness. We fail to realize that the elderly value their independence just as highly as we do. We refuse to acknowledge when a family member is near the end of life due to age or disease, focusing only on more treatment. We ask the doctors to give our loved ones more time, as if time was intrinsically valuable, and we never ask ourselves whether the time we secure is meaningful until it's too late.

Gawande makes us confront the sad truth: We fail the dying

Though Gawande brings many issues with our treatment of the end of life to light he also shows that all is not lost. There are innovators attempting to change the field. Bill Thomas enters the book as an emergency physician from upstate New York who becomes the medical director of Chase Memorial Nursing Home and is immediately confronted by the despair of the home's residents. The elderly at Chase Memorial were heavily medicated and lifeless, and Thomas wanted nothing more than to ensure that up to their final moments his residents had lives they enjoyed, lives worth living. His proposal? Bring in two dogs, four cats, and one hundred parakeets, enough for every room to have a pet.

Bill Thomas's story was one of many in *Being Mortal* where someone with fresh ideas came around to break the rules of medicine, hoping to bring life back to the end of life. Each experiment Gawande chooses to tell was different, but the results were always the same: People came alive. In Thomas's case, residents who the nursing staff believed couldn't speak started speaking. They began leaving their rooms and interacting with the staff and one another. The animals became a central part of their lives and watching and caring for these pets gave them a purpose. Walking the dog or feeding the birds in the morning was a reason to wake up. Gawande notes that we might consider these small joys but at the end of life it is often the small things that we desire most.

But not all innovation stories end happily. Gawande tells us the story of Keren Brown Wilson, one of the original creators of assisted living facilities. Her first was built in Oregon during the 1980s as an alternative to the nursing home. The core of her idea was similar to Bill Thomas's: Give back a sense of autonomy and self-directedness to the elderly. These projects were wildly successful, allowing elderly residents to sleep when they wanted, eat what they wanted, refuse to take medications, and even lock their front doors. In the 1990's Wilson sought investors to help her build more houses and expand her project. However, when business, profit, and the fear of liability gained a heavier presence in the product, Wilson's vision was altered and her philosophy abandoned. The new assisted living facilities were nursing homes in all but name, and the elderly who entered them suffered the same loss of autonomy. Eventually Wilson stepped down as CEO and the ideas behind assisted living were altogether dropped on the path to bigger profit.

The constraints of giving care under capital notwithstanding, Gawande's purpose in writing *Being Mortal* is to point us to crucial and easily missed fact: American medicine is about to be transformed, for better or worse. The country currently has a patchwork quilt of standards of

care for the dying. Many of us have only seen one side of the story: patients who are forced to undergo treatment until every bit of quality in their lives have slipped away. This is why we applaud a man like Harry Truman and his decision to die on his own terms: We no longer know another way to die. But Gawande shows us that there now exist a growing number of possible futures for end-of-life and health care. Palliative and hospice care are powerful tools that can improve the lives of the ill and infirm if given the chance. Thomas and Wilson's visions exist in many forms, and while it is no easy task to find the right home for a loved one, it's becoming increasingly more possible that the right home exists.

Gawande argues for modern medicine to adopt the well-being-centric approach of palliative and hospice care. A narrative approach asks what can medicine do to aid in achieving other goals, rather than making treatment and survival the sole goal. As Gawande describes it, the point is to find what a patient wants from life, what is important, and what sacrifices are acceptable in pursuit of joy. Having a "hard conversation," as he calls it, enables a physician to consider the desires of a patient as well as the sacrifices that they will be willing to make. Most importantly, in practice physicians will have a guide to base their actions on when tough choices are called for.

These are not novel thoughts. Bioethicists have copiously discussed the different kinds of doctor-patient relationships, creating a number of different models that more or less stand on a spectrum with total physician paternalism on one side and complete patient autonomy on the other. In the narrative or "interpretive" approach, the goal of any physician is to understand the longer arc of a patient's story and find the way that medicine best helps that story continue or find closure. The function of medicine should always be to increase the quality of life and promote well-being, without making sacrifices that the patient might find unnecessary or detrimental to the overall narrative arc of life.

Gawande's book serves as a roadmap for physicians trying to adopt a narrative model of practice. *Being Mortal* spends a great deal of time recounting the stories of patients' experiences, and readers will find a great deal of dialogue and conversation throughout the book. But the dialogue has a function other than enlivening his accounts; it provides a script for patients and physicians who are facing the complexities of mortality. Gawande admits that for a long time he didn't know how to speak to his dying patients. Instead of addressing the possibility of death or trying to start a discussion about what his patients thought was most important, he would turn into "Dr. Informative" and spew medical knowledge. Different treatment options, even experimental ones with no chance of success, had more of a chance of being discussed seriously then preparations for dying.

Being Mortal is the result of time spent working past that blocked conversation. It provides a litany of important questions that Gawande has learned from speaking to and observing palliative care and hospice workers. *What is your understanding of your condition? Do you know that you are going to die? With limited time, what's important to you? What does your best possible day look like?* These are questions most doctors and families don't ask, or perhaps don't know how to ask. *Being Mortal's* biggest accomplishment is that it gives us the words and prompts to help decide what's important when life is imminently threatened by mortality. Sometimes the patients in Gawande's book don't have answers, or family members who don't want to give up respond with hostility. But once a physician and family understands a patient's answers to these questions it's easier to move forward and understand how to best end the narrative of life together.

Because we are in the middle of a fundamental shift it's hard to tell what the dominant mode of treating the dying will be next. If medicalized death as we know it ends, what will come to replace it? The models presented by hospice care present one possibility, but right-to-

die is clearly another. In countries like the Netherlands, physician-assisted suicide has already become a major portion of the end-of-life response. And in the U.S. with each case like Brittany Maynard's that takes the spotlight, the right-to-die movement grows stronger. America could be on its way to one day fulfilling Maynard's goal, assuring that anyone who fulfills the medical criteria can choose when and where they meet their end.

Gawande's book serves as a road map for physicians trying to adopt a narrative model of practice

Gawande spends only a small amount of time addressing the Death With Dignity movement. He makes it clear that he is not an avid supporter, though he acknowledges that there are times when a patient ending their own life might be necessary. His response is not to critique it. He takes it as a chance to again point to the shortcomings of the medical field. It is medicine's own failing that causes patients to look to it for a good death rather than a good life. Gawande's point here is key—the Death With Dignity movement is in many ways a product of medical-

ized death, and the movement owes its strength to modern hospitals' failure to reform. But there is still time for that reformation to happen, for physicians to start considering the narrative of their patient's lives and use medicine to help those patients find a fitting ending. It's not too late to create a health care system that actually helps people more than it hurts when mortality is involved.

On finishing *Being Mortal* I thought again about Brittany Maynard and the options she said her physicians presented—radiation, chemotherapy, or hospice care. Even hospice care sounded like a bleak option: She could have developed morphine-resistant pain while her tumor took away her cognitive abilities and motor functions. As Gawande said, there are cases where ending life is a reasonable decision, and it appears Brittany Maynard's case is one of them. I'm glad that Maynard did her own research, thought about her options, and made a decision on how she wanted her story to end. But hers is an atypical story. *Being Mortal* presents the distressingly typical cases where lives end in misery and pain, all because physicians and families are unwilling to have those hard conversations. Maynard's physicians didn't ask her what was important or what her goals were, knowing she had limited time. They acted only as Dr. Informative, presented her with some options, and left her alone to choose.

We need physicians who are willing and know how to have hard conversations. *What does your best possible day look like? What are you unwilling to sacrifice?* The key to dying well for each individual may be in the answers to these questions. When Bill Thomas and Keren Wilson answered those questions, they revolutionized care for the elderly with the homes they built. I believe we'll find those questions behind Maynard's decision to die. At its best, the medical world is capable of helping each of us find the unique ending, one that fits our personal narratives. The use of a book like *Being Mortal* is that it gives medicine the words to use and the questions to ask in pursuit of that ending. **TNI**

The Host in the Machine

BY SARA BLACK MCCULLOCH

Immune systems don't make for clean narratives, even as we expect them to keep us pure

Eula Biss, *On Immunity: An Inoculation*. Graywolf Press. 2014. 216 pages.

Spinoza said: we don't know what a body can do. The question of a body's power [pouvoir] pushes aside another question that we tend to ask right away: the question about what it is, its nature, its identity. We need to know what it can do, before we can worry about what it is.

—François Guéry and Didier Deleule,
Le corps productif (translated by
Philip Barnard and Stephen Shapiro)

How much can a body endure? Almost everything.

—Chelsea Hodson, *Pity the Animal*

THE first time I learned about the immune system, I was in university, and my professor introduced the subject by saying that you don't appreciate how something works for you until you lose it. To ensure the cliché would not likewise be lost on us before it had a minute to work, he blasted Joni Mitchell's "Big Yellow Taxi," projecting the chorus onto a screen from his PowerPoint: "You don't know what you've got / 'til it's gone." We were over 600 students crammed into an auditorium. Most of the people wanted to become doctors. Most of these people were laughing, but he wasn't joking. How could he convey to over a half thousand kids—who, I can assume, were all in

good health—the horror that is your body not doing what it was meant to do?

We have immune systems for the same reasons we are told we have homeland security: Our bodies are always under attack by foreign invaders, especially the invaders we can't see. The only way an immune system can identify these dangerous microorganisms is by comparison to the familiar, and so immune cells need not only to identify danger, but also to recognize the self. An immune response is a split decision, between those cells which are "us" and those cells which are "not us." If "not us," get out.

To this end, cells interpret signals from pathogens (these signals could be the proteins and toxins produced by bacteria, for example). Some immune cells have memories, so that, if exposed to the same pathogen (of disease) after the initial, intentional exposure (of the vaccine), the response will be faster and stronger. No one seems to know exactly how these cells remember. We wonder that they do. Like the stories passed down along genetic lines, the received ideas about immune systems make for a clean, easy narrative that you'll read in textbooks and memorize for multiple-choice exams, or skim on news sites as you prepare to get inoculated. I did, and it's so simple it sounds like the truth.

I remember most of what was taught in the lecture, mostly because of what wasn't. Every year, the professor said, he wrestled with whether to tell us everything about the immune system. Do I tell you the truth? If I told you everything, it wouldn't even be the truth because we still don't know it all yet.

The truth is notoriously hard to pin down, and context only makes it harder. Here, the context is the body, where sometimes it feels like truth goes to die. Bodies are marvels. Bodies are weird, and do what they want. Bodies don't always follow a script. What makes the body and its systems so difficult to understand is that we can't see what's going on just by looking at each other. We sometimes feel when our body is fending off disease—we feel fatigue, nausea, fever—but we are almost never sure whether the symptoms mean we're healing or getting sicker. The immune system, when it does work properly, is supposed to keep us safe inside our skin. But this view is simplistic; it implies that our bodies are separate from our world, that the medical decisions we make affect just one body.

'You've had a lot of people's hands in you,' she said frankly. Some of the hands were hers, in me to help deliver the baby and the placenta, but then there was also my surgery, which was performed exclusively with human hands, leaving no incisions. When I learned this, it struck me as both magical and mundane that the technology that had saved me was simply hands. Of course, our technology is us.

—Eula Biss, *On Immunity*

AROUND the time Eula Biss' *On Immunity: An Inoculation* came out, newsstands were covered in pictures of long, worm-like particles budding from infected cells. People were Googling Ebola symptoms. People were asking about a vaccine. People were inquiring about treatment options. Many people were especially preoccupied with tracing it back to the person who brought it to America. Thomas Eric Duncan, the first patient diagnosed with Ebola in the U.S., was instantly dehumanized because

the public made him the disease. He was the foreign invader, embodied. He became what ultimately killed him.

It's a cell that starts an epidemic. Biss, an American writer who investigates the anxieties that sear our language, explains that "there will always be diseases against which we cannot protect ourselves, and those diseases will always tempt us to project our fears onto other people." For Biss, vaccination transcends medicine, for it "allows us to extend some of the power and privilege of our good health to others." Psychologist Mark Schaller called the practical manifestations of this privilege, or of the way it's transmuted into custom, "behavioral immunity:" after using the five senses to detect a proximate infection (or the fifth estate to learn of it), we use not the sixth but the seventh sense, the "common sense," to avoid being infected. Disgust and hygiene are self-protective, even net-positive products of behavioral immunity; so too, however, are "social outcomes such as xenophobia and the moral condemnation of norm violators." Behavioral immunity is your reaction to someone coughing in a crowded elevator during flu season. It can be the way someone reacts when you tell them you have cancer. It's especially the stream of racist Ebola tweets. Behavioral immunity is an unrealistic sense of superiority.

Viruses and bugs get inside us by breaking the skin, or entering through mucous membranes. Vaccines are preventative, but they too pierce the skin, putting us in direct contact with the very thing we fear. Yet we are often already waiting for our cells to do what they've been trained to do, exercising a blind kind of trust. If we trust so, why do we still fear the vaccine? In a recent interview with NPR, Biss explained that while the medical community is currently trying to better educate the public, what they are doing "is still too limited" because primarily concerned with the medical. "I think it's a social debate," she explained, then cited some examples of social concerns: political unrest, widespread mistrust of the government, corrupt pharmaceutical and medical systems, and, of course, capitalism.

Some of these concerns belong to the post-Occupy era, which holds that the cancer is coming from inside the house, which is to say, metonymically, the White House. The concerns of the majority, however, belong to the post-9/11 era, which reacted to a foreign invasion by reasserting whiteness without irony.

Corollary to this, and well in evidence throughout *On Immunity*, is our preoccupation with bodily purity and the rise of all things “natural” and “local” or “grown at home.” These obviously protectionist “concerns for bodily purity” have long been responsible for brazen eugenics, miscegenation laws, and forced sterilization of genetically “undesirable” mothers. Now the same concerns are responsible for subtler versions of the same, like immigration laws and labels on products that swear to purity. Yet we’re not even born pure. “We are already polluted,” Biss writes, adding that chemicals and bacteria come in through the umbilical cord, inhabit the membranes surrounding the fetus, swim in the amniotic fluid and the fetal urine. Our bodies from the beginning are open systems.

Biss says we are doubly bound: to nature and to technology, neither system we can either comprehend or reject completely. The cyborg scholar Chris Hables has written that many of us are “literally cyborgs, single creatures that include organic and inorganic subsystems.” The inorganic subsystem, Hables explains, is the “programming of the immune system that we call vaccination.” The vaccines are made by corporations, but corporations are made by people, and both the im-

mune response and the antibodies it produces—to wit, the organic subsystems—are made by cells. Yet cells are so numerous, so automated that they resemble, in a way, corporate drones. Very little about the subsystemic is unique, and yet our refusal of the inorganic, enforced by our incomplete trust in the organic, is predicated on a belief that goes like this: “My body knows best.” Hundreds of variations of this phrase appear across web searches, reiterating a stance against vaccines or diets or Western medicine: “I trust that my body knows best.” “I am hoping my body knows best.” “If I believe my body knows best yet I turn it over to the whims of modern medicine, I’m rolling the dice.” “I find that often my body knows best what it needs.” “Your body knows best what it has been through.”

In Mamoru Oshii’s adaptation of *Ghost in the Shell* (based on Masamune Shirow’s manga franchise) the Puppet-Master—an artificial intelligence program in a world of post-humans, no longer obligated to reproduce—explains to the other Ghosts that man, in the universal sense of man, “is an individual only because of his intangible memory. Memory cannot be defined, yet it defines mankind.” What makes the ghosts human is their consciousness, not their bodies; metal, armor, circuits, and microchips are now substitutes for biological material. Shirow’s imaginary world is one in which regular corporeal threats have been phased out because bodies are shells. Cyberbrains can move between bodies. Bodies are only useful to house a ghost. Like some kind of cybernetic Holy

Our bodies from the beginning are open systems. We are not even born pure

Ghost, an individual packs up and moves.

So many times in *Ghost*, the body disappears—yes, because of thermo-optical camouflage, but also because the body's importance is played down. So many times bodies are destroyed only to be completely rebuilt. The film opens in a body-making factory—synthetic skin is layered over muscle and bone and then cooled. Go in as parts. Come out being a body. And because this is easy, the ghosts begin wondering what it is that makes them human, for whatever it is must be difficult, complicated, hard. *Ghost in the Shell* is filled with revenant questions of the mind versus the body, the old Cartesian dualism, but it gets stuck trying to answer more important ones: How is it that we feel, and can a program feel too?

In *Ghost*, the main fear is getting hacked and having someone else rewrite your memories; there is a parallel fear of being contaminated, a fear that seems to rest on some a priori knowledge of being clean. Health, in *Ghost* as in life, isn't perceived as a range of possibilities, but as a switch: well or sick, living or dying. To many, healthy means not just untouched by illness, but also untouched by medical intervention. As if our bodies are pure until proven ill. As if we were not born tainted. Or if we are, we are far less stigmatized than those who become tainted.

Consider HIV/AIDS. Viral immunity kills the majority of viruses, but there are some, like HIV, which actually destroy the crucial parts of the immune system that usually fight infection and disease—much as the most effective terrorism sets out to destroy not the greatest numbers of people, but the greatest symbols of value (Twin Towers, Olympics), the parts of our externalized selves built to ward off despair and unpatriotism and to sustain our aggregate memory. When HIV/AIDS and hepatitis C are stigmatized in adults, it's because of the way we assume adults get infected: sharing needles, screwing without protecting, engaging in anything we might deride as a lifestyle choice. We suspect that the sufferers chose lifestyle over the value of life, and therefore deserve to lose out. We sus-

pect this even as we know that humans may contract HIV/AIDS or hepatitis C via breast milk or blood transfusions, in hospitals and on vacation in America. We are still reluctant to believe that our bodies are more intertwined with the environment and with each other than they are individual agents, and this affects our understanding of disease or infection; the way the media covers it; the way politicians, and even some doctors, discuss it. Our bodies are capable of fending off disease, but sometimes they're primed to incubating it too.

The pathogen threat theory doesn't integrate with the profundity we feel when we talk about values. When we think about our religious or political beliefs, we feel like we've decided on them. They don't feel like a defense against disease. ... They feel like the truth.

—Randy Thornhill to Ethan Watters,
Pacific Standard magazine

WE “contract” disease, as if it were something we could sign for, sign up for. We “fight” disease, as if we were drafted in service of our country. We “fall sick,” as if in battle. Cancer patients who do not fall permanently are “survivors.” The sick can be ostracized, and the sick can be glorified, but in almost all cases, the sick cease to be civilians and become fighters either for or against us. In a climate of perpetual war, Eula Biss resists the metaphors, giving us instead a different way of looking at illness and disease. She speaks of “herd immunity,” i.e. the idea that if whoever can get vaccinated does get vaccinated, we can protect those most prone to disease (and those who can't get vaccinated), like cancer patients and pregnant. She rephrases, saying it's a “banking of immunity,” a trust fund: We know that immune individuals won't carry infectious diseases, won't diminish our value.

Language is said to be a virus, but anxiety is the virus that language only carries. “Only,” and yet a virus is noth-

ing without a carrier. Old misconceptions thrive on an on in our words. “We are not being invaded,” Susan Sontag wrote in *Illness as Metaphor*, decades ago. “The body is not a battlefield. The ill are neither unavoidable casualties nor the enemy... About that metaphor, the military one, I would say, if I may paraphrase Lucretius: Give it back to the war-makers.” Yet in our words we are still more often war-makers than nurses, far from immune or safe, terrified often that our bodies won’t heal without a fight.

Sometimes our immune systems lie to us. Autoimmune disorders attack the nonthreatening self, destroying vital body tissue, as with rheumatoid arthritis, multiple sclerosis, and Graves’ disease. Like even the best intelligence agencies, our immune systems sometimes fail to recognize when the self becomes a threat, the body a double agent: the cancer is coming from inside the house, at least where the house is flesh, and the immune system doesn’t see its cells as foreign. Some of us get chicken pox again, and shingles. Many of us still have allergies. A simple answer is that the immune system isn’t a perfect system. Another answer is that the immune system is perfect, and we just don’t know it well enough yet.

In Halifax, a clinical trial is being held for an Ebola vaccine. Forty people between the ages of 18 and 63, “in generally good health,” will take part in an early phase study. This particular vaccine doesn’t contain the Ebola virus, but a VSV virus, a vector that will express one of the proteins of Ebola. No one can get Ebola from the vaccine, but the study is seeking what some known side effects can be. “Part of the study,” one of the overseeing doctors has explained, “is that we’re trying to measure these side effects and find out what they are, so the risk is doing something with a new vaccine.” No one can say with certainty what contributes to a recovery from Ebola. Some reports have credited health care; others, stronger immune systems. The one thing these reports do not mention is that the patients are now immune to the virus, having developed antibodies that could last for 10 years, and maybe longer. A threat em-

bodied, a hostage taken, survives to become paradoxically the safest American.

The last thing I remember from that lecture in university was my professor saying that three things control your life: your genes, your environment, and luck. “And if you have the choice, take luck,” he said. This I found telling, because luck is the thing you can’t choose, a gift of tautology: Being born lucky “is the biggest piece of luck in this life,” Fran Lebowitz said. “No one wants to admit that, in this country especially because it agitates against the very notion of America.” We prefer the predestination of genetics, and lie of an individual body, an individual fate, a will sui generis and secret. At the time I was sitting in this lecture, I had been diagnosed with cancer.

Was it something I did? I asked the doctor, stupidly. He told me no. He told me it could have been a number of things: a mutated cell my body didn’t find; a statistical anomaly. Bad luck, yes, but it was good luck, too, because it was caught early; was treatable; hadn’t metastasized. That year I learned about most types of immune responses, but we didn’t cover cancer immunology, and I wonder if it’s because we weren’t specialized enough yet, or because of how little was known or understood about it—imagine the exam questions, full of maybes, not a clean narrative at all. I still wonder if, had I known more, I would also have known sooner about the cancer. If I could have been more in touch with the body, could have sensed that something was off. What concerns me more, however, is the battalion of blood tests, the scans, the ultrasounds. The fact that I’ll never again be a civilian, in the common parlance. One misstep and the cancer could begin again; I could move from “on alert” to “on duty.” I would have need then of what Biss, and Sontag, and many of us have already wished for: a language of rapprochement, a softening of the borders between well and sick, between one body and another, so that we understand that the cancer comes from inside a house we all share. **TNI**

DEAR MAROONED ALIEN PRINCESS

BY ZAHIRA KELLY



Exposed

NO MEETINGS
TO-NIGHT

All engagements are cancelled owing

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AN obvious but often overlooked fact about maps of the world is that they are not exact copies of reality but rather representations created with the purpose of helping us navigate. Nevertheless people often freak out the first time they see unconventional maps that more accurately redistribute the globe on a flat surface to de-center the tiny cluster of countries making up western Europe, or even inverted world maps that place the global south at the north and vice versa. Whether or not you believe that, for example, minimizing the whole of Africa and making the U.K. look ridiculously big was accident or ideology, you have to admit that all those landmasses, as familiar as well-known logos, suddenly look totally different upside down.

Our advice columnist Zahira Kelly's work performs a similar move, rearranging or inverting mainstream hierarchies. Thus the radical academic who makes a career out of treating working class or racialized lives as raw material for theoretical texts suddenly looks less like a genius and more like a well-fed vampire. And a black woman despairing of the men she dates might reflect that from this new perspective they look less like unattainable Romeos and more like the threadbare best of a bunch of bad options. When the margins are flipped to the center, the center might finally understand that everything worth knowing comes from the margins. Kelly tirelessly reflects on how this world both abuses and relies on women of color's powers of endurance.

This month is the Sick issue, so let's not forget that everyday life can be pretty much as sickening as conditions recognized by medical science. In the third of her New Inquiry columns, here's Zahira Kelly helping out on questions of dating and academic research.

****Questions have been edited****

Dear Zahira,

I have been trying to date and find that pretty much all the men I meet have sexist and patriarchal and often racialized ideas too about who I am as a black woman. I'm talking about even the ones who seem okay at first. I try to overlook it for the sake of giving people a chance but sometimes it gets too much. I feel kind of ashamed that I give these men my time at all, but the fact is that I do want a male partner so I feel stuck with this. How do I reconcile being a feminist and wanting to date these people?

This is what happens when everybody's colonial conception of the universe either outright excludes you from humanity or posits you as subhuman and at everyone else's service. Society is structured so that we are seen to be not as valuable as other non-black and/or male people. These dudes' mamas (not just their daddies) often taught them to feel superior to women. All of their surroundings join them in consensus.

Supposedly "progressive" patriarchal assholes are a dime a dozen too. Their fancy male-centered books,

leaders and theories conveniently also tell them that the voices of women like us are irrelevant to liberation. The books and theories don't always say that straight out, but they always imply it.

●

***It's not your fault
if you can't find
some magical pool
of men who missed
the last 500-plus
years of anti-
black misogynist
socialization***

●

We outchea forced just to try to find the lesser evil because they all have yet to unlearn their views of us. I've had men who were raised by white feminists pull all kinds of possessive shit and cater to racist white damsels in distress even as they insist that I as a black woman do not feel pain.

The problem spans the "enlightened" crowd all the

way to the "ignorant." I used to tell myself maybe American men were better to date than Dominicans on the island. All I ended up learning is that Americanized men will play egalitarian but hit you with men's rights activist logic that was created to counter equality of women and posit men as victims of women with no institutional power. Machistas back home won't beat around the bush. They will just tell you they're raised to feel superior to you – but at least they don't have the faux-aggressive bro arguments ready when you explain your situation as a woman. They are actually more likely to listen, ironically.

It's not your fault if you can't find some magical pool of men who missed the last 500-plus years of anti-black misogynist socialization. We didn't create this mess. This is what they've left for us. All we can do is try our best to navigate these conditions and try to work out who might hurt us a little less. This is definitely a sad reality. It can be fucking depressing. But rest assured, it is not you. It's them.

It doesn't make you less of a feminist to have to navigate whatever it is you are dealt however you can. Feminists aren't defined by how little oppression they have to endure (contrary to mainstream white feminism's out-of-touch yammering). This is just another way to lay the planet's burden on black women's shoulders. If that was the case, only the very richest, whitest, most coddled women would be "real" feminists--in other words, only the women who need it least. And that ain't feminism at all. It's status quo and gatekeeping. The whole point of feminism is aiming for a world where we won't be forced to choose between bad and worse anymore. So please don't ever feel it's you who has failed when inequality hinders you after hundreds of years of globalized dehumanization at everyone else's hands. We can't fix everyone or materialize mythical untouched partners for ourselves. If we had that power, we'd already have world peace.

●

Dear Zahira,

I studied at postgraduate level but I also relate to a lot of what you say about academia's elitism. I am trying to change and re-examine what I was taught in school, while keeping the insights I learned there. What role, if any, do you think academic thought could play in a fair system?

My experience with academia began in the Dominican Republic when an American academic approached me about doing some research, and I almost let her into my community. When she decided to start dictating our own life to us and drawing uninformed conclusions with no regard to our own views, I had to tell her to go home. Later I got on Tumblr, where academics seemed fascinated by me. But some also began sending me hate mail criticizing my grammar and demanding sources, so they could claim my ideas as their own. Eventually I had academics presenting my work in conferences, thanking me for helping them get chosen to speak, when I never consented to it. They published articles paraphrasing me for "cred" while I remain without any. They continue to plagiarize me like I am a free-for-all but keep their own work under lock and key, and cry into the night if anyone misuses or steals their work. Their words matter but other people's are somehow trash unless they can be exploited.

Academics all work in opposition to fairness. Your educational institutions teach you it's OK to speak over and for marginal communities and treat them like non-sentient pet projects, info mines, excuses for grants, and notches on your belt rather than human

beings with their own voices and context. Academics come in and decide what we need without ever asking us and interpret us from an outsider's viewpoint that you call objective but is actually woefully out of touch and often harmful to us. There's an academic tourism circuit where people put in for grants to be able to travel and plop down in our communities uninvited, exploit us for their fuckshit papers and dissertations, and then leave us in the same state (or worse) like nothing happened.

In a functional version of academia, you would not go anywhere uninvited, you would not play savior, and you would be the footnote and tool for marginal people's liberation rather than use marginal voices as footnotes to your bullshit decontextualized theory. Academia would be the community's research team and the objects of research would no longer be objects but rather the ones leading, theorizing, and drawing conclusions with the data and labor academics provide. The community would decide what they lack and what would be beneficial for academia to do for them.

This flips the current elitist dynamics that hold academics as authorities over experiences they never lived, as the voices of people who do live those experiences are erased and devalued. It would let communities in need decide where the grants and funding should go instead of having outsiders dictate, pocket the money, and leave them high and dry after the fact. It would acknowledge that we are the only experts on ourselves and should be centered as such. This kind of research would add to a community's survival tools and records, not just make your own shoddy offshoot that you'll drop in a few months and leave for dead when you move on to the next novel group or issue.

Essentially, no one from outside marginal communities should be theorizing for them or deciding what they need. That is all for them to determine and guide you on. That is fair. **TNI**



Erin O'Connor, Jean Paul Gaultier, Fall 2003 Couture