Cancer and Conjugality in Contemporary Delhi
Medical Anthropology Quarterly
http://doi.org/10.1111/maq.12541
Dwaipayan Banerjee

Cancer and Conjugality in Contemporary Delhi:

Mediating Life Between Violence and Care

A cancer diagnosis does more than just foretell the possibility of death. Rather, it inaugurates a condition that the anthropologist Lochlann Jain has called ‘living in prognosis’ (2013). To live in prognosis is to doubt the integrity of one’s body, to mistrust the social practices through which one relates to others, and to become aware of the precarity of the structures of care and protection that enable life. Yet, for all its unfamiliarity, the new remains embedded within the old. When cancer appears, it makes demands of care, recognition and empathy that are shaped by and within pre-existing social and cultural worlds. In this article, I track these demands of care and recognition, as cancer appears within precarious familial arrangements in middle- and lower-income families in Delhi.

In tracking this relationship between cancer and the kinship worlds within which it appears, I draw upon a year of fieldwork conducted between 2011-2012, during which I accompanied Delhi’s largest cancer-car NGO—Cansupport—to the homes of about 120 cancer patients. During my fieldwork, Cansupport was operating out of 13 centers in and around Delhi. Its staff included 24 teams—each comprising a physician, nurse and counselor, covering a radius of about 15-20 miles. Within this radius, every team was responsible for about 50 families and patients. About half of these patients had heard of the organization from friends or family and called their helpline while another fourth was referred to them by doctors at the AIIMS pain clinic. By the organization’s own estimates, they had provided care to 746 patients over the year before my fieldwork, and roughly equally to men and women (Yeager et al. 2016). According to the same estimates, most of these patients were ‘lower-class’ (54%), while most others were ‘middle-class’ (38%).

It was through following Cansupport that I was drawn to examining the impact of cancer among marital relations, something I had not initially expected to study. When I first started fieldwork, my questions were about state neglect and abandonment. However, I found that any understanding of the afterlife of a cancer diagnosis amongst patients in Delhi also depended vitally on tracking patterns of care, love and violence across kinship networks, and particularly within marriages. This was not accidental: spouses were often the first line of support for many of the cancer patients we visited. The offer of love and support from spouses and the tenor of care they extended depended on long histories of conjugal conflict and domestic violence. In what follows, I track these varied intersections of conjugal histories and presents, demonstrating how vitally they shape the terms and trajectory of care in the aftermath of a cancer diagnosis.

Further, although the patients I visited were equally men and women, I focus on instances where husbands were diagnosed with cancer. As scholars of kinship in India have noted, wives in North Indian family arrangements are often rendered vulnerable because they live in affinal homes, often without recourse to the support of natal kin (Grover 2011, Haider 2000). In the context of this virilocal vulnerability, wives are often subject to abuse from in-laws and husbands. In her ethnography of urban poor women in Delhi, Claire Snell-Rood documents how her interlocutors survived these conditions of structural vulnerability by making distinctions between what they could or could not control (Snell-Rood 2015, 3). These circumscribed possibilities of well-being also means that women often swallowed the knowledge of the harms inflicted on them, continuing to maintain and sustain relations with violent husbands (Das and Das 2005, 36). Thus, acceptance and reconciliation becomes a normative horizon, so strong that even domestic violence counseling interventions and women-led marriage arbitration centers encourage a ‘politics of livability’, teaching women to live within and through kinship norms

(Lemons 2016, Kowalski 2016, Basu 2012).

My aim here is to show how in such situations of structured vulnerability, the texture of care extended by wives to husbands with cancer grew out of these deep-rooted conjugal asymmetries. For the first time, husbands found themselves confined to their homes, in contrast to the relative freedom they enjoyed before. This curtailment was sometimes out of physical debility, but also often because the disease's stigma led men to isolate themselves from networks of kin and neighbors. Cancer concentrated the time and space of the conjugal pair, problematizing the relation in new and sharper ways. If maintaining families and the everyday life and health of households was often normatively understood as the responsibility of women, cancer imposed further responsibilities of care and obligation. At the same time, these deepened responsibilities opened subtle possibilities of inhabiting these norms of care and obligation differently, giving circumspect voice to histories of buried violence—even if for a brief while. Thus, in the dynamics of conjugality after a cancer diagnosis, it often became impossible for me to sift between care and violence: their paths ran through each other, as husbands and wives lived on in sites of prior violence, enacting new kinds of disregard all the while sustaining each other's possibilities of life. In her work on the politics of conjugality, Elizabeth Povinelli asks 'which forms of intimate dependency count as freedom and which count as undue social constraint?' (Povinelli 2006, 6). In what follows, I describe this entanglement of freedom and constraint, of partial speech and secrecy, and of marital disruption and reconciliation in the shadow of cancer.

Such an examination of cancer intimacies—that encourages living on with already difficult relations and reconciling with distress—deepens and shifts how anthropologists have understood the social life of the disease. Specifically, anthropologists writing about cancer have demonstrated the ubiquity of a biotechnical imaginary of hope in the global north (McMullin

2016). Produced by a faith in imminent biotechnological cures and by corporations that commodify survival, this imaginary attracts capital, guides medical encounters and offers patients the possibility of survival and prolonged life (del Vecchio Good et al. 1990, del Vecchio Good 2010). For example, Lochlann Jain examines the pink-ribbonization of cancer in the United States, as public discourses urge patients to take responsibility for their illness and transcend its consequences by the sheer force of hope and personal will (2013). Jain is critical of such discourses that seek to distract patients from the health systems that have failed them and from corporations that proselytize hope while continuing to manufacture carcinogens. In response, Jain asks us instead to understand the many contradictions, betrayals and confusions produced in the space of 'living in prognosis.' In tracking the collective, kin-based conditions of living with cancer here, I join Jain in thinking about the demands of negotiating fraught social worlds demanded of those that live in prognosis.

While joining Jain's critique, I also draw upon Juliet McMullin's insight that in places where treatments are even more inaccessible than in the United States, hope might not dominate public imaginations about cancer (2016). Indeed, Julie Livingston's ethnography of cancer in Botswana describes how concerns about pain, rather than a discourse of hope, guides the experience of the disease (2012, 142-143). She describes her work as calling into question "some of the prescriptive, heroic narratives and basic assumptions about illness, death, hope, and medicine that many American patients, their clinicians, and family members often take for granted" (Livingston 2012, 21). Here, I join Livingston, McMullin and others in tracking cancer's vastly different public imaginaries in places outside the global north, stepping out of the region through which the disease's social consequences have been understood. [1] Decentering discourses of hope and survivorship, I find and describe an affective horizon of reconciliation and acceptance. Specifically, the ethnographic work presented here unfolds in Delhi, where for most of the urban poor, a cancer diagnosis came too late for curative intervention. That is, long wait times in public health facilities ensured that the disease would have progressed beyond the time of cancer's traditional treatment modalities: chemotherapy, surgery and radiation. To live with cancer in such circumstances often meant to live without the promise of life-prolonging interventions. The horizon of possibility then was not recovery, but the aspiration to reconcile fraught social relations and to die without pain and with dignity. It is no surprise then that NGOs in India like Cansupport orient themselves towards palliative care, taking on the mandate to ease death rather than promote discourses of survival through personal strength. Indeed, Cansupport's ambivalence about a global imaginary of hope was explicit. For example, even as it trafficked in the global tropes of 'walks' and 'runs for life,' at these same events, the NGO was careful to emphasize that its primary mandate was 'adding life to days, *not* days to life.' That is, rather than offer them the false hope of survivorship, they aimed to make the last days of patients meaningful and pain-free. During the time of my fieldwork in 2011, Cansupport's founder Harmala Gupta described this orientation as a realist response to the context of cancer care in India: "Is there any point in investing our limited resources in more and more expensive and futile treatments when the majority of our cancer population is unlikely to benefit from them?"; citing studies by the Lancet and the Economist, she critiqued the blinkered search for an elusive cure as "a path strewn with broken promises, dashed hopes, crushed lives and public health systems that can no longer cope" (Gupta 2011).

By examining how Delhi's cancer care NGOs have oriented their work towards easing pain at the end of life, reacting to a health system struggling to treat the disease, I aim then to develop an anthropology of cancer that takes seriously the experience of palliative care as a set of interventions responsive to consequences of the disease brushed aside by discourses of hope. I focus on the work of reconciliation and acceptance encouraged by palliative care mediations, provincializing the celebrations of survivorship that disguise the dangers of living in prognosis. Focusing on this work helps me reveal with more clarity the problems of healthcare access that are pressing even in most of the global north, but have become harder to discern, shrouded by public incitements to survive against all odds (Jain 2012). More specifically, tracking the entanglement of freedom and constraint in conjugal relationships around the disease in Delhi, I explore the limits of cancer discourses that proselytize its transcendence through hope and individual will, describing instead how the disease sedimented into the give and take of everyday life, demanding reconciliations with difficult pasts in order to sustain life in an uncertain present.

Love Withheld

On a warm afternoon after the monsoons, I accompanied a doctor, nurse, and a counselor from Cansupport to an East Delhi neighborhood. The household we visited comprised a married couple in their forties, Shyamlal and Deepa. They lived in the small home they owned with Shyamlal's parents. Shyamlal had been diagnosed with lung cancer about eight months prior to our visit. As we entered, I noticed the counselor taking in the arrangement of furniture in the room. Through my months of home visits with the team, I had learned to watch for this diagnostic glance. The counselor saw that Shyamlal and Deepa's woven wood beds were both in the same room, but apart and perpendicular to each other. For her, the placement of beds was a reliable clue to the arrangements of intimacy within a home. Shyamlal's bed was pushed up against the side of the room, and he lay with his face pressed up against the wall, unwilling to turn and greet us. This sign of visible annoyance was rare in my visits with the team, and even rarer where the NGO was the only source of licit morphine as an analgesic. Even though India is the world's largest producer of licit opium, narcotics laws restrict it to less than 1 percent of the country's cancer patients. Cansupport was one of the few sources of licit morphine for cancer patients in Delhi. But here, the problem was not of drug access: Shyamlal's pain had resisted high doses of opioid painkillers. Considering this failure, the counselor shifted her attention to matters more social than biological—sensing that perhaps marital conflict had become part of the etiology and intractability of Shyamlal's pain.

Shyamlal had increasingly isolated himself from social contact. As I have discussed elsewhere (AUTHOR), concealment is a widespread practice of coping among cancer patients and families I encountered in Delhi. Upon learning of the diagnosis, neighbors often do more harm than help. Some grieve and lament patients who have not yet died. Others query kin to discover past histories of moral disrepair that might have caused the disease. Still others recount the pain of others they have watched die. Yet Shyamlal was pushing away not only unwelcome neighbors, but even his daughter with whom he had always been close. She called him on the phone every day, but he almost always refused to speak to her. When they had last spoken, he had told her that Deepa — his wife — was trying to kill him by changing the dosages of his medicines. The immediate cause for our visit this day was an escalation in his pain. Deepa complained that he had cried out through the night, waking the family and antagonizing the neighbors with whom they shared a thin wall.

The team's visits had settled into a predictable pattern over the past month and today was no exception. After the doctor and nurse fussed over details about dosage, symptoms, and schedule, Shyamlal's wife — Deepa — took hold of the conversation. With repetitive compulsion, each week she narrated different threads of a story of three decades of marital abuse. Each time she would say this was the first time she had spoken of this history to strangers. A major element in this narrative was three affairs that Shyamlal had not even really cared to hide. Deepa hinted that partly because of these betrayals, they had stopped sleeping together about fifteen years ago. As she detailed his unfaithfulness, Shyamlal would often draw closer to the wall, sometimes breaking into groans to drown out her voice. At other times, he would speak directly to the team—as if Deepa were not there—and accuse her of lying. And at yet other times, he would address Deepa and demand renewed conjugal intimacy, begging her to consider that he only had a few months left to live. In turn, Deepa would respond to the team and not him: "I can only give him medicine, I cannot even sit on the same bed as him anymore."

Over time, Deepa's narrative further deepened the conjugal conflict. Her natal kin lived in another city, leaving her to the mercy of her affinal family. Early in her marriage she had considered involving her mother to help mitigate the abuse she experienced, but she had kept them in the dark not wanting to "burden" them with the knowledge of her husband's violent behavior. In these vulnerable circumstances, her parents-in-law had tried to force her to accept a bigamous arrangement. They justified it to her as the family's age-old *riwaaz* (tradition). Deepa had refused Shyamlal taking a second wife, recognizing that she might become even further marginalized within an already hostile household. She told us she might have considered it if she could not deliver male progeny. But she had produced both a son and a daughter and stood firm on the grounds of her reproductive success. Yet, her refusal to give in had earned her violent retribution from her affinal household; they had all beaten her in the last decades. She ended one of her visits saying with a couplet: "*apne se bachke raho, paraye se khatra nahin / vishvasghat ussi se ho sakta hain, jispe vishvas ho*." ("Beware of your own, there is no danger from others / you can only lose your faith in those you might have once trusted.") At another meeting, she had told the counselor that Shyamlal had continued hitting her even after receiving his diagnosis. It was only in the last month or two he had become too weak to continue.

Their daughter visited from time to time, but their son was a persona non grata in the family. From the counselor, I gathered he was addicted to inhalants and heroin. The counselor had pieced together that Shyamlal had thrown him out of the house a few years ago. Over the last few years, Shyamlal had turned his attention to his financially unsuccessful younger brother. He had arranged a marriage for him and helped him rent a home in a nearby neighborhood. But after his diagnosis, his brother had stopped visiting or talking to him. The counselor I was visiting with had tried to mend this relational fracture. After much coaxing, Shyamlal agreed to let them call and talk to his brother. Shamed by strangers, we heard later that the brother and his wife paid a visit to Shyamlal and Deepa, but this did not lead to any lasting reconciliation. Partly because Shyamlal was thus estranged from his male kin and progeny—from both brother and son—and partly because he was so dependent on Deepa for care, her position had shifted subtly within their home. Remarkably, he had agreed to sign over the deed to the house they lived in over to her, despite his parents' objections. In a context where property is most often transacted along patrilineal lines, removing property from the domain of his own male kin was a late gesture toward mending at least one of his several broken relations.

Concerned with Shyamlal's recalcitrant pain, the team urged Deepa to swallow some of her anger against him. The Cansupport workers I was with were committed to treating pain as both a physical and social concern. They were sure that if the couple could reconcile their differences, his pain would subside, and he would be able to die a peaceful death. When I later expressed my discomfort about this tack to the counselor, she replied that they had a single mandate: to ease the suffering of the patient's last days. Deepa's reactions to this nudge toward reconciliation was shifting and mixed. She had grown close to the team, and by her own account, treasured their visits. They gave her an opportunity to speak and come to terms with her husband's impending death on her terms. But over time, as Shyamlal's illness progressed, gestures toward intimacy took the place of cathartic accusations. If in the team's first visits she would at most hold her husband's hand while he was in pain, in their later visits they would often find him resting his head on her lap. Yet, she never came around to joining the two beds, nor did she give in to Shyamlal's demands for intimacy; his protestations on this count continued. But the subtle shifts in tone and gesture had an effect on Shyamlal. As the team had predicted, he found real relief from his pain, and they could cut his morphine dose in half.

What might we make of the team's intervention into kinship and conjugality while treating cancer pain? I do not want judge Deepa's experiments with speech and silence as either leading to catharsis or further damage. For decades of her marriage, Deepa had kept silent about Shyamlal's many betrayals and violations. Her silence had been for her a way to cope with her affinal hostility. But ever so slightly, Shyamlal's diagnosis had allowed for the possibility of speech. But to say Shyamlal's cancer had turned the scales and opened new possibilities of recovery for Deepa would be too going too far. Deepa's response had been a careful and dynamic arrangement of circumspect speech and voluble silence. Her strategies of living alongside Shyamlal's death is evocative of descriptions in Clara Han's work in Chile of everyday care and obligations and relations that are lived, embodied and experimented with (Han 2012, 5). Han writes of how even in times of extreme duress, individuals remain caught within webs of social relation. She writes of these times are not normless, but as experiments with life.[2] The analysis of these experiments of care that emerges in Han's work show the deep intertwining of care and violence in the work of living on in the aftermath of medical crisis. Thinking of Deepa's strategies as shifting experiments with norms helps me understand how she both achieved and lost a sense of well-being in proximity to her husband's death.

Words in the Wind

At the beginning of a visit to a home in West Delhi, the team parked our car near a large open sewer, so we could make the rest of the journey on foot. After a short walk, we arrived at the storefront of a small convenience store. Suresh, the owner of the store, had been diagnosed with laryngeal cancer about two years ago. As far as the doctor on our team could tell from his reports, after six months of chemotherapy the cancer was in remission. Suresh motioned to us to go to his house above the store — laryngeal cancer had robbed him of speech. He gestured that he would close and join us soon. Upstairs, Suresh's wife broke down in tears before he arrived. "He beats us all, he isn't himself after he's finished his bottle at night." While she spoke, one of her two sons walked in; he looked to be in his mid-twenties. They took turns telling us that two nights ago, Suresh had picked up a metal pipe and threatened to beat them all with it. The two sons had managed to restrain Suresh and tie him down to the bed. The son looked upset as he said that he never imagined he would raise his arms against his own father. The counselor intervened, aiming to tackle Suresh's alcohol addiction. "What do you think is leading him to drink, what is it that seems to be making him angry? Do you think it might be the stress of the illness?" Mother and son replied almost in unison: no, it is not the illness, he has always been like this, it is just habit (*aadat*), there is no cause. The counselor asked. "Why not talk to the treating oncologist at Guru Tegh Bahadur [the public hospital where he was getting treatment] and get him admitted for de-addiction during his next visit?" Mother and son were incredulous at this suggestion. "The doctor is moody, if he finds out about the addiction, he'll stop treating him.

He'll cut the phone if we even say the word — addiction." For most families, effective cancer treatment is scarce. To negotiate the many forms of triage in public oncology facilities, patients must make themselves out to be perfect candidates. This involves hiding anything—including alcoholism—that might signal future non-compliance.

After spending two hours talking to Sunita and their son, we walked down again through the store, making our way out onto the street. Suresh had come upstairs during that time, but seeing the tone of the conversation, had made a sound of disapproval and returned to the store. When we finally left the house, Suresh waved to us that he would follow us to the car. We waited for him to join us, and in a few minutes, he arrived. Seeing my fieldwork notebook in my hand, he gestured to ask if he could borrow it. He turned the pages to the end and started writing. After every few sentences, he tore the page, handed it to us, took it back after we read it, crumpled it up in a ball, and threw it into the wind in the sewer's direction.

Suresh's story contradicted his wife's version of events. He wanted to convince us he had been sober for years before his daughter's death a few months ago forced him back to drink. The counselor told me later that Suresh's daughter had been married about a year ago and had died a few months later in her affinal home. The family suspected dowry murder but were hesitant to start the tiring and long police and judicial process. Suresh then wrote that his daughter's death had opened his eyes to the plight of his new daughter-in-law. He explained that his wife had found their son his new bride, and that she was both five years older and five inches taller than their son. Their son had agreed to this marriage, but begrudged his bride both her years and inches, and hardly ever allowed her out of the home. Then, Suresh wrote that Sunita and their sons resented him not because he drank, but because he advocated for his daughter-in-law. He rejected his wife and son's story that he assaulted them; in fact, he said, it was the other way around. The violence the neighbors heard was from when he tried to protect his daughter-in-law when Sunita and their son attacked her. Later, the counselor and nurse would talk about how they had seen the daughter-in-law looking distressed in previous visits. Suresh then gathered the crumpled words that the wind had not carried into the sewer and stuffed them in his pockets.

It is not for me to adjudicate the truth of either Suresh or Sunita's narrative. Rather, I want to locate this speech and silence folded within broken kinship worlds. When asked whether cancer had contributed to Suresh's addiction and violence, Sunita had contested that framing, suggesting instead that it was *aadat*. The word *aadat* translates to both habit and addiction, and its double valence is telling. When asked by the counselor, Sunita refused to carve out a specific space for cancer as a necessary or complete rationale for his addiction and violence. At another visit, she confirmed Suresh's claim that he had been sober for about two years before his diagnosis. Importantly then, while Suresh and Sunita disagreed on the what and why of the violence between them, neither placed its weight on cancer. Recall that Suresh had offered his daughter's death as the proximate cause for his return to addiction, not his disease. Both Suresh and Sunita folded the disease within the everyday give and take of violence and addiction.

In thinking about the unstable relation between disease and habit (*aadat)* I am reminded of anthropologists Veena Das and Zoe Wool's delineation of the critical and the normal (Wool 2015, 22, Das 2015, 26). Both warn against drawing clean, self-evident lines between the ordinary and the catastrophic in times of illness, focusing our attention instead on their dynamic entanglement. The diagnosis of cancer did not wrench Suresh out of the everyday. Instead, prior and new failures of social relations — between son and father, wife and husband, affinal and natal kin — haunted his life with the disease. The form of this haunting was not that of an inversion of the ordinary. It was not as if the patriarch's cancer overturned ordinary arrangements of silence, speech, and gendered violence. If Deepa's experimentations with life blurred the lines between harm and well-being, a similar incoherence was at stake here. Threatened with cancer, Suresh had been brought close to death, and it had rendered him mute. But while norms and ordinary arrangements of violence and speech bent under the pressure of disease, they did not break. As much as Suresh and Sunita disagreed on its form, they agreed on the fact of the enduring vulnerability of women to affinal violence. As for who occupied the position of the witness, that too was not a settled question. Neither was it self-evident whom the intersection of violence and disease had silenced, and whom it had rendered voluble. We saw how as Suresh threw his words to the wind; the wind carried some to the water but returned others to his feet. I can find no better way to describe the weaving together of critical illness and the fragile norms within which they appear and retreat.

The Promise of Self-Harm

The Cansupport team and I were struggling to find a house we were visiting for the first time. Walking through its lanes, we asked for directions and were guided toward a plot of land littered with construction materials and equipment. When construction is being carried out is often a time of precariousness in Delhi where the possibility of the theft of material and illegal land takeovers are always imminent before built structures are occupied. Charandas, the sixty-year-old patient we were visiting, had come into some money through the sale of his agricultural land in a nearby newly developing area, Kishangarh. He bought this plot with that new income and moved into a room part of the ongoing construction of his house with his wife Lalita. Together, they kept vigil over the construction site. However, right from the beginning of our conversation, I saw how this promise of a stable future in brick and mortar was haunted by the instability of an embittered marital past. Charandas had been diagnosed with pharyngeal cancer about three years ago. He had stopped visiting his oncologist after a year of treatment. He had not kept his medical records, and his prognosis remained unclear to us. His first words of greeting to our team were: "I stay awake from one to four o'clock at night, every night. All I think of is suicide, the only thing that is left is the *action* [in English] itself." The table in front of him was littered with *beedis* (local cigarettes), but this was not his only addiction. He was a heavy drinker, and after his diagnosis, developed a dependence on narcotics and most recently, a generic form of Spasmolin—a drug that slows the activities of the brain and nervous system. Charandas and his wife Lalita sat in two different beds, at perpendicular angles as far from each other as possible within the space of the room.

In her conversation with the Cansupport counselor with whom I was visiting, Lalita confessed a narrative of thirty-five years of marital conflict. Willing at first to only to talk to the counselor, Lalita called her aside. They then talked for an hour in whispers on Lalita's bed. The doctor and I continued to talk to Charandas. Later, the counselor told me in broad strokes the themes that recurred in many of the families I visited: addiction, domestic violence, and hints of long histories of the husbands' extra-marital affairs. Later visits would reveal that this couple's long history of marital discord had been exacerbated by a string of recent familial events. Their young, unmarried daughter had worked part-time at a Hindi language call center in the nearby township of Gurgaon. A few months ago, she had not returned from work. After much worry, they found out she had eloped with a Muslim man from her workplace. This contravention of intra-religious kinship norms had brought shame to their Hindu family. Charandas complained, "This happens in upper and lower-class families. For a middle-class family like ours, this means ruin." Lalita elaborated further, "She has more or less killed us. But how could she have done otherwise? All she saw between me and my husband [was] his mistreatment of me. We failed to raise her the right way." After a prolonged period of silence, two days before our visit, the daughter had called and informed them that she and her lover had run away to Pune. Her two brothers had sworn violent revenge on both sister and brother-in-law if they ever returned to Delhi. Lalita said, "They hate her for what she has done to us and want nothing to do with her ever again." Lalita wanted nothing to do with her husband, blaming him for their present troubles. She blamed him for losing a daughter and losing their ability to give her away in a marriage of their choosing. The counselor tried to reiterate a familiar theme in the affinal politics of Indian kinship, "Girl children are anyway never your own, they always belong to someone else [affinal kin]." Lalita countered, "But not in this way, we were never able to give her away." Charandas' response was equally accusatory: "Why do you only think of the past? You're killing me now and our future. Let this cancer take me, I don't care about living, if living is like this, with her." The doctor continued to speak to Charandas, "Do you get out and get fresh air in the day?" Charandas countered, "How can I show my face in this neighborhood? I used to pass the time by standing out in the street, now I cannot look at how the neighbors look at me." The anxiety about respect and shame in the neighborhood continued to poison the marriage in the present, resurfacing the ongoing difficulties of a thirty-five-year marital history. Yet, unable to share a world, they continued to build a dwelling.

The course of the disease and the course of the decaying kinship biography ran together. The breaks in kinship ties had slowly chipped away at Charandas's will to live. He had stopped treatment, and developed and exacerbated his addictions to nicotine, narcotics, and painkillers. The team would say later that it was miraculous that while so many others fought desperately for the last months of their lives, Charandas's willful acts of self-harm had not visibly debilitated him. As Lalita would tell the counselor, the illness had placed a burden of care and responsibility upon her. Her response took the form of a constant vigil; she had nursed him through the most difficult periods of his illness. Yet, like Deepa, she had found herself unable to mingle care with love. Charandas's will to live depended on the mingling of the two. He said simply in response: "I can't live without you." His cancer certainly lent weight to his utterance. Yet, a history of domestic violence, addiction and extra-marital affairs haunted his words, undermining this late gesture toward reconciliation. In this case too, the experience of critical illness disturbed social mechanisms through which gender and intimate power hierarchies were muted, allowing histories of violence to rise to the surface. But it was not just cancer that had disrupted their everyday negotiations of living together, it was also their daughter's elopement. The co-incidence of both kinship and disease opened the possibility of public expressions of the past to cancer care workers. The possibility of Charandas and Lalita's future was staked in this house, but the past made living on difficult.

It was in this context that Charandas both showed and threatened self-harm. The way he told it, his increasing dependency on substances resulted from the betrayals *he* had suffered: first by his daughter's elopement, and second by his wife's inability to reconcile with their past for the sake of their present and future. By his account, he had lost his will to live because of them, and not because of the onslaught of cancer. Because we did not know his prognosis, it was difficult for us to sift through his narrative claims. The team remarked on his apparent good health, comparing him to other patients under their care. Yet, they also knew the appearance of health could be deceptive. If I move past the desire for certainty about his etiology, something other than the relation between cause and effect becomes clearer. As a performative gesture of self-sacrifice, Charandas was trying to recover a position of authority within the household, a position that had come into question after his diagnosis. In the presence of strangers, Lalita had laid bare his failings as a husband and father. Bearing Deepa and Shyamlal's story earlier in this chapter in mind, I understand Charandas's suicidal discourse as having more to do with the gendered asymmetries of power, than as revealing of how the disease had exhausted his will to live. Bearing witness near death is not an ethical act of achieving narrative closure to a life, but a battle for recognition. These testimonies to strangers reveal much about the shifting dynamics of who can bear witness, how (through speech or silence), and to what (past or present betrayals). Thus, bearing witness to death is not only a gendered act but also revelatory of the shifting grounds of gender asymmetries in the shadow of disease.

Failures of Recognition

Several scholars of Indian medicine and social life have borrowed an emic category—*sevā*—finding in it conceptual tools to parse the violence and care that runs through Indian familial life. For example, Sarah Lamb and Lawrence Cohen uses the term to understand the work of intergenerational care (Cohen 1998, 57-61, Lamb 2000). When focusing on the care from sons to parents, both describe sevā as a marker of power, overtly of the elder being served, but covertly of the increasing power of sons as their fathers' strength declined. Yet, both describe how the promise of *sevā* as a transfer point of power remains provisional; old age continues to have a voice and demand authority while children's sevā is always partial and falls short of its ideal. In this subtle balancing act of familial authority, excessive demands of recognition risk being labeled as deviance. Particularly clear in Cohen's description, an excess of voice sometimes masquerades as psychiatric madness, a failure of "adjustment" in old age that threatens the stability of intergenerational power.

I think with sevā here not in relation to inter-generational care, but as a transfer point of power through which *conjugality* is negotiated in times of illness. As a relational action enacting a shift of authority from the receiver to the giver, sevā helps parse some scenes I have described. To understand sevā requires sensitivity to the complex and shifting conjugation of speech and silence in marriages. In conjugal care as it appears here, the wife's sevā is both a form of intimate care, and a subtle enactment of partial critique. To withhold love from care—to make certain to distinguish the two—undergirded the narratives of several of my informants, including Deepa. Yet, the insistence of Cansupport workers to mingle care with love, especially at the end of a patriarch's life, entailed a new form of adjustment, reconciliation, and acceptance. Thus, this dynamic of sevā, as it inflected possibilities of speech and silence and modes of bearing witness, helps thicken my understanding of the shifting dynamic, but also hardening of gender asymmetries in the shadow of cancer.

In her work on domestic violence interventions, Julia Kowalski writes of how counselors operationalized sevā as a framework and context within which they offered women advice (2016). Kowalski argues that instead of emphasizing a liberal conception of independence as a solution, they emphasized inter-dependent relations of sevā, working within ideologies of patriarchal kinship to offer a subtle reordering, rather than escape, from household violence. In the absence of robust frameworks for the assertion of legal rights, this compromise—where they substituted 'women's rights' for more secure kin-based dependence—was the most plausible solution at hand. Much in the way Kowalski describes, the counselors I worked with also encouraged conciliation over rupture. For example, in emphasizing the reintroduction of love in the work of sevā, they too sought to work within and through kinships norms. But, the crisis of cancer focused the time and space of the conjugal pair in ways that are subtly different from other contexts of conciliatory interventions. Kowalski describes how counselors intervened in kinship by shifting the focus of disagreements away from the conjugal pair, to disorder in other kin relationships, such as those between the wives of elder and younger brothers, that were more amenable to change. But in the shadow of cancer, kin both within and outside the household sometimes became distant and reluctant to take part in the daily work of care. In others, even when wider kin networks were available as a source of support, wives were expected to take on the daily and demanding work of caring for weakened husbands. This, while prior asymmetries in mobility came to be limited with the debility brought on by disease. Condensing past violence, present disagreements and impossible futures, the time of cancer focused attention on conjugality in ways from which there was no escape.

This is not to say that conjugality came to stand apart from and outside wider kin relations. While conducting fieldwork, I chanced upon a Hindi play about cancer—*behatar hain maut* (“a desire for death”)—that dramatizes this potential juxtaposition of intra- and inter-generational sevā in the time of disease. The play takes place in the aftermath of the cancer diagnosis of Narendra Mohan—a sixty-five-year-old man who lives with his wife Ramadevi, his unmarried daughter Neelima, and his two sons. Narendra is beset with unbearable cancer pain, which breaks into the plays script as half-blank pages, incomplete words, and onomatopoeic syllables. As Narendra’s pain heightens, he describes his pain as his closest kin. Yet, in the play's action, Narendra’s pain takes backstage to an unfolding family drama. The characters of the play are taken from a stock of kinship tropes that are the staple of Indian family dramas: two sons (one dutiful and the other profligate), devoted daughter, and mistreated elders in a time of social change. In the second half of the play, the profligate son marries a wife equally uncaring toward his father and they together lay claim to parts of the house their father occupied. In this new arrangement, he is relegated to a corner of the house where Narendra no longer feels able to entertain guests and becomes increasingly isolated. While Narendra has few expectations of his profligate son, he is disappointed by how his devoted son also feels exhausted from care. Tired of suspending his own life for the sake of his father, the once devoted son marries and moves away to a different house. With both sons absconding from their responsibilities, Neelima is left alone to care for her father. In contravention of the ideal of sevā, but close to its practice, women are left to bear the burden of care without the privilege of a transference of inter-generational authority. Neelima gives up hope of marrying, as her own romantic interest tires of waiting for her and moves to another city.

Toward the end of the play, the mise-en-scène shifts—away from the intimate space of the home to a courtroom. There, we find Neelima and Narendra begging the judge to allow his assisted suicide and his release from the unbearable pain of his cancer. Neelima has heard that the rich have access to "clinical death," and she demands that the poor also be given this right to *iccha-mrityu* (self-willed death). But Neelima's eruption into public speech is short-lived. After only two pages, she is returned to silence. From then on, she appears only in relief to the volubility of reporters, kin, lawyers, religious leaders, and doctors that decry her plea, ask for her arrest, and point to her as the perfect manifestation of *kalyug* — the mythic time of social decay. Finally, only in the last page of the script, Neelima breaks both her silence and the fourth wall. She does this to declare that she spoke not with the expectation of relief, but in the certainty of the failure of her speech to be heard. This draws fresh ridicule from the chorus who see her now as a hysteric, as having lost her sanity. The play ends with her plaintive lamentation to her dead mother: "I cannot bear this responsibility over life and death any longer, mother—please come, please come and take this responsibility back. Please take it back."

What I find remarkable about this play is its return to the theme of women bearing the responsibility of witnessing and lamenting. Neelima laments the pain of her yet alive father, abandoned in a zone between life and death. But, in her lament, she only briefly faces the judge or the journalist—as they stand in for public order. In the closing scene of the play, she directs her lamentation instead to her dead mother. Her death, which happens halfway through the play, happens off-stage, and is only evoked by Narendra's monologue in the middle of the play. His wife's death occasions his thoughts on the intimacy between life and death, and how death carries life around like a cat carries its young, with her teeth grasping the nape of its neck. We are never told the circumstances of her death. Rather, the reader is left to surmise that her death had something to do with the exhaustion of care.

I understand Neelima's lament then not just as a critique of an unjust social order—personified by the chorus—but also as an invocation of female kinship in shared suffering. In her final scene, she reaches out across the threshold of life to her mother, whose presence and silence haunts the play. She testifies to this silence that she is bound to inherit. But rather than giving speech to the failure of the social order, she testifies to its arrangement of recognition and misrecognition, within which she knows in advance she will never be heard. She does not ascend to the status of a fully formed subject through this act of transgressive speech. Instead, she descends back to silence and joins her mother in the shadows of the play, a double structure to her witnessing: she testifies not only to her father's cancer, but to her inability to fulfill her role as a witness through which his death can be rendered good, as she is thwarted by a public that refuses to recognize her. As in the stories of the women that have appeared in this article, Neelima's activity lies somewhere between silence and speech, between representation and expression. In her inability to shift legal and familial norms, she captures how these norms structure the force of recognition, within which the pain of her father, the silence of her mother, and her own disempowerment are fated for the shadows.

Conclusion

As disease enters kinship worlds, it articulates with the past, present, and future in unpredictable ways, folding into pre-existing arrangements of betrayal and reconciliation. It does not overturn and rupture social worlds, as much as it comes to be diffused throughout an existing social field, all the while absorbing, augmenting or hardening prior vulnerabilities. In these instances of North Indian kinship, the disease shifted the capacity of husbands and wives to inflict and absorb violence. The debilitating experience of cancer often confined husbands within their homes and, for the first time, made explicit their dependence on the gendered work of everyday care. And consequently, these subtle shifts opened cracks in the domestic world that allowed for long histories of violence and betrayal to seep through and become speech. But at the same time, cancer did not invert existing norms of speech and silence around gender, allowing women the possibility of free expression they did not previously enjoy. They continued to inhabit the vulnerable space of affinal homes where speech always carried with it the possibility of future harm. In such a world, speech and silence often followed the other's tracks, taking the place of the other, as time and necessities shaped their possibilities.

In examining the social life of cancer in the United States, Lochlann Jain reveals the dangers of imaginaries of hope, as they hide the violence of a system that pushes responsibility on to patients, while absolving corporations, medical systems and governments. In response, Jain offers an engagement with the experience of living in prognosis: 'If the term survivor offers a false identity formed around cancer, living in prognosis offers an uneasy alternative, one that inhabits contradiction, confusion, and betrayal' (2013, 223). My work here explores precisely such a space of contradictions, confusions and betrayals of lives in prognosis, joining Jain and others in questioning the promises of escape offered by discourses of survivorship that dominate cancer's public imaginaries. My effort here has been to provincialize these discourses by describing the inescapable centrality of pain and death in public configurations of the disease in Delhi.

Further, thinking through cancer pain offers an opportunity to clarify the *collective* stakes of this condition not only in Delhi, but also in other parts of the world where its realities have been obscured by tendencies to proselytize its eclipse through hope and individual willpower. That is, even as some public health experts foreground an "epidemic" of late-stage cancer pain in lower- and middle-income countries due to the lack of timely treatment, others point to a simultaneous under-treatment of cancer pain in the United States and Europe (Goudas et al. 2009). Following the work of Jain suggests that this under-treatment might be a consequence of the overwhelming discourse of transcendence, hope and survivorship. Thus, centering pain and kinship in a discussion of cancer, as I have done here, forces an acknowledgement of messy realities otherwise obscured by campaigns that "pink-wash" the many inequalities that contribute to the disease's etiologies, social distributions and consequences.

At the same time, I have described the challenges NGO interventions face, and the difficult ethical dilemmas inherent in working to mend frayed social relations. Acknowledging cancer pain demands the work of intervening into social relations. In conditions of vulnerability, some of these relations had been brittle long before diagnosis; living with cancer entailed living with a pervasive doubt about the present and future viability of such relations. In this space, my interlocutors—NGO workers, families and patients—experimented with strategies to negotiate this doubt, never entirely dispelling it, but keeping its capacity to overwhelm at bay.[3] This was not only because treatments were often scarce and or because remission was always a risk, but also because efforts to maintain brittle social ties around a patient required continuous work. Examining this work of intervening into social relations, as I have described here, exposes the hollowness of cancer's public imaginaries that proselytize hope and survival, transcending the social through a sheer force of individual will. Mending relations required a descent into durably uncertain socialities around critical illness, accepting reconciliation as a horizon, while making an uneasy peace with difficult pasts.

Basu, Srimati. 2012. "Judges of normality: mediating marriage in the family courts of Kolkata, India." *Signs: Journal of Women in Culture and Society* 37 (2):469-492.

Cohen, Lawrence. 1998. *No aging in India : Alzheimer's, the bad family, and other modern things*. Berkeley: University of California Press.

Das, Veena. 2015. *Affliction : health, disease, poverty*. First edition. ed, *Forms of living*. New York: Fordham University Press.

Das, Veena, and Ranendra Kumar Das. 2005. *The Interface Between Mental Health and Reproductive Health of Women Among the Urban Poor in Delhi*, *Gender and Social Issues in Reproductive Health Research*. Thiruvananthapuram: Achutha Menon Centre for Health Science Studies, Sree Chitra Tirunal Institute for Medical Sciences and Technology.

Das, Veena, and Clara Han. 2015. *Living and dying in the contemporary world: A compendium*: Univ of California Press.

del Vecchio Good, Mary-Jo. 2010. "The medical imaginary and the biotechnical embrace." *A reader in medical anthropology: Theoretical trajectories, emergent realities* 272.

del Vecchio Good, Mary-Jo, Byron J. Good, Cynthia Schaffer, and Stuart E. Lind. 1990. "American oncology and the discourse on hope." *Culture, Medicine and Psychiatry* 14 (1):59-79.

Goudas, Leonidas C., Rina Bloch, Maria Gialeli-Goudas, Joseph Lau, and Daniel B. Carr. 2009. "The Epidemiology of Cancer Pain." *Cancer Investigation* 23 (2):182-190. doi: 10.1081/cnv-50482.

Grover, Shalini. 2011. *Marriage, love, caste, and kinship support : lived experiences of the urban poor in India*. New Delhi: Social Science Press.

Gupta, Harmala. 2011. "Easing The Burden." *Times of India*, October 17, 2011.

Haider, Saraswati. 2000. "Migrant women and urban experience in a squatter settlement." *Delhi: Urban Space and Human Destinies*:29-50.

Han, Clara. 2012. *Life in Debt: Times of Care and Violence in Neoliberal Chile*. Oakland: University of California Press.

Jain, Lochlann. 2013. *Malignant : how cancer becomes us*. Berkeley: University of California Press.

Kowalski, Julia. 2016. "Ordering dependence: Care, disorder, and kinship ideology in North Indian antiviolence counseling." *American Ethnologist* 43 (1):63-75.

Lamb, Sarah. 2000. *White saris and sweet mangoes: Aging, gender, and body in North India*: Univ of California Press.

Lemons, Katherine. 2016. "The Politics of Livability: Tutoring “Kinwork” in a New Delhi Women's Arbitration Center." *PoLAR: Political and Legal Anthropology Review* 39 (2):244-260.

Livingston, Julie. 2012. *Improvising medicine : an African oncology ward in an emerging cancer epidemic*. Durham: Duke University Press.

McMullin, Juliet. 2016. "Cancer." *Annual Review of Anthropology* 45 (1):251-266.

Povinelli, Elizabeth A. 2006. *The empire of love: Toward a theory of intimacy, genealogy, and carnality*: Duke University Press.

Snell-Rood, Claire Natalie. 2015. *No one will let her live : women's struggle for well-being in a Delhi slum*. Oakland, California: University of California Press.

Wool, Zoë H. 2015. *After War: The Weight of Life at Walter Reed*. Durham: Duke University Press.

Yeager, Alyssa, Anna W. LaVigne, Ambika Rajvanshi, Birbal Mahato, Ravinder Mohan, Reena Sharma, and Surbhi Grover. 2016. "CanSupport: a model for home-based palliative care delivery in India." *Annals of Palliative Medicine* 5 (3):166-171.

---

[1] Livingston describes her work as calling into question "some of the prescriptive, heroic narratives and basic assumptions about illness, death, hope, and medicine that many American patients, their clinicians, and family members often take for granted" (Livingston 2012, 21).

[2] For a longer genealogy of the phrase 'experiments with life', going back to Canguilhem, see (Das and Han 2015).

[3] In her work, Jain calls for an 'elegiac politics of mourning' as a response to the dissonance of living in prognosis. Such a politics resuscitates HIV-AIDS activism in the 1990s, where activist spectacles of death demanded a recognition of the political neglect. The politics of quiescence I have described contrasts with Jain's call, driven as it is by a different set of aims.