

Just Cancer

Mckenzie Marciante

Texas Christian University

### Just Cancer

For Gary Lancaster, over twenty-five years of service in the U.S. Navy trumps experiencing cancer—twice. To say something of the everlasting impact of being in the military, it is important to notice the frequency with which Lancaster refers to his time in the Navy, especially in the context of an interview explicitly scheduled for discussing his bout with one of the deadliest cancers in the world. Not only diagnosed with breast cancer at the age of twelve, he also, more recently, conquered the battle of testicular cancer, previously survived a heart attack, and recovered from a broken back some years ago. His sole response to these misfortunes remains, “that’s why you tell people you love them every day” (G. Lancaster, personal communication April 16, 2015). Through the interviewing of Mr. Gary Lancaster, and various research on the topics of post-illness coping, war, and cancer, a conclusion arises: diseases like cancer are often over-stigmatized and over-appreciated in light of other traumatic or otherwise life-changing experiences, especially active war duty, and thus, quite easily, patients of cancer consequently become pressured into one of two extreme avenues of experience and expression after experience—Alan Young, Didier Fassin, and Richard Rechtman (as cited in Bell, 2012) describe these avenues with eloquently simple diction, stating, cancer works either in getting the survivor “‘stuck,’ and unable to progress” in life or, in providing a “kick-start” to positive life transformation (p. 590).

This argument does not serve to belittle Lancaster’s, or anyone else’s for that matter, experience with cancer or other illness, but merely to highlight the greater issue of the expectation and pressure which society places on individuals who receive such diagnoses. Kirsten Bell explains, “a survivor is a triumphant person who lives with, after, or in spite of a diagnosis or traumatic event” (Bell, 2012, p. 584). Because Lancaster has arguably gone beyond

living with, after, and in spite of cancer, twice, he should be acknowledged and honored as such a survivor, as well as an admiration for his tremendous ability to live in almost disregard of having come through one of the most debilitating medical experiences, unfazed. After addressing this due respect for Mr. Lancaster, attention must be moved to the extremely inappropriate “personal link between disease and identity” which society draws (Clarke, 2004, p. 541). American culture places cancer in a divided box of black and white, of progression and digression, of monumental separation—what Barbara Ehrenreich (as cited in Bell, 2012) categorizes, a “makeover opportunity” of remarkable proportions (p. 586). But perhaps, as in the life story of Gary Lancaster, cancer could be a simple point of stagnation. Of non-movement. Of a fleeting memory which pales in comparison to other experiences with less inevitable means, such as war, in Lancaster’s instance. (He touches on his believing that cancer is inevitable when he says everyone has cancer, and his simply “decided to say hello” [personal communication, April 16, 2015.]) Modern society preserves this box, mainly through gender associations and war allusions, forcing cancer survivors to choose a side to fit into, or else risk losing some necessary attention and help in life after cancer.

### **Impacts of War and Cancer**

Unfortunately, scant research exists on the experience of male breast cancer, especially in children—perhaps due the extremely low prevalence of breast cancer in men or, perhaps, due to many men’s attempt to cover up their stigmatized and feminized diagnosis. According to Tom Donovan and Dr. Maria Flynn, some participants in a study of male breast cancer “sought refuge from the struggle by concealing the diagnosis and initiating behavioral changes to limit public knowledge” (2007, p. 468). Gary Lancaster revealed a similar reaction to his being diagnosed with cancer, even as child. He admits to never having told any of his friends or schoolmates and,

to this day, none of them know he ever had it. In fact, very few people in Lancaster's world today know about his experiences in life both with cancer and war; he continues to engage in suppression and creating the impression that no pain exists:

It's sad. It's freakin' sad. [...] So it hardens you sometimes but that's why I'm always smiling because you don't wanna think about all the shit. You know? It masks the pain sometimes...but that was bad. That's a memory I wish I didn't have. Sorry. (personal communication, April 16, 2015)

He said the above regarding a story he told of the "worst thing [he] ever saw in [his] life," which was the corpse of an innocent baby floating down "Shit River" of the Philippines in 1983, having been dumped in by its mother, he assumed (personal communication, April 16, 2015). Even through this emotional suppression, Lancaster's emotional sensitivity to his memories of war remains detectable, a stark contrast to the evident lack of emotion when he discusses cancer.

### **Coping**

Though war and cancer had extremely different impacts on Lancaster, and assumedly the difference occurs for others as well, something can be said about their relation. The deaths of some of those whom Lancaster most loved can be attributed to each of the two. His father, an honorable WWII veteran, well-loved by his son, died of a cancerous brain tumor, and it was in Lancaster's own war time that death came to many of his closest friends. Both cancer and war have a wide range of impact on the lives of those who experience each, from life-altering to irrelevant, and traumatic to glorifying. Kirsten Bell (2012) even compares those diagnosed with cancer to soldiers, highlighting how some of the terms used by researchers and writers can "bring radically different groups, such as rape victims, cancer patients, war veterans, survivors of the Holocaust, and major natural disasters, into relation" (p. 592). She also goes further in depth with

the complex discussion on how cancer can have positive impact, as it potentially has “utility in transforming the cancer patient’s lifestyle” for the better (p. 589.) Similarly, war may have impacts of beneficial nature, as it often gets pointed to as the reason behind some personal life-transformations (disciplinary issues resolved, world views broadened, etc.) and increased status and reverence societally. However, both obviously also carry great potential for negative impact as well. The biological harm of cancer needs no explanation, but the social harm often gets overlooked. Male breast cancer, in particular, tends to be one of those most stigmatizing cancers, due to its de-masculinizing nature in society. Tom Donovan and Dr. Maria Flynn (2007) claim, “there is little that men can do [...] to escape the feminine associations that society attaches to a diagnosis of breast cancer” (p. 468). Though men within the classifications of homosexual or, otherwise more feminine, orientations may not find this characterizing to be negative, they most likely still find insult in the questioning of their being authentic and human, and rightly so. Donovan and Flynn quote one of their research participants, a male breast cancer survivor, who says, “some people think that a man with breast cancer cannot be a ‘real’ man. They think ‘he must be gay’ or ‘he is half-woman’” (p. 467). (More on the relationship between cancer and gender later.) War brings stigmatization as well, as many people disagree with war entirely, and greet soldiers with sometimes cold and pitiless, harsh disapproval. Others approve of war but almost to the point of putting it and its participants on pedestals, which motivates them to welcome soldiers home with an expectation that their experience was powerfully traumatic and life-changing. The effects of war and cancer especially share characteristics and intermingle within someone who has experienced *both*. In a study on “Religious Coping and Psychological Distress in Military Veteran Cancer Survivors,” several doctors research one of the great similarities between war and cancer—the necessity, and various methods, of coping. This

research in particular focuses on the dependence of cancer experience on war trauma, as it builds on the assertion that “veteran cancer survivors [are] particularly important and relevant” in examining “psychological well-being following cancer” (Trevino, Archambault, Schuster, Richardson, & Moye, 2011, p.89). They touch on the impact of religion and spirituality in the coping of post-war cancer distress. Religion and spirituality both often get consulted in cancer patient’s struggle to find contentment and hope in their struggle through the disease, as well. Adversely, the experience of cancer may very well depend on war trauma. However, more research currently exists on post-military cancer diagnosis than on post-cancer military enlistment. Avron Spiro III and Richard A. Settersten Jr., in another example, also claim “combat exposure [...] has the potential to impact *coping* [emphasis added] later in life” (2012, p. 186). As aforementioned, other factors impact the coping of cancer as well, both internal and external to the life of the survivor. One such internal factor could be familiarity with the disease, like Lancaster’s previous experience with it through his father’s battle and passing. The spectrum of external factors includes anything outside immediate relationship with the patient—specifically, societal factors prove overwhelming in their measure of (psychosocial) impact on post-cancer recovery.

### **Neutrality**

One thing not often considered, however, is the possibility of either of these—war or cancer—having a neutral impact; so often assumptions place one or the other, or both, on a scale with two sides and no middle ground. In fact, scholars and the like almost always refer to cancer itself as some version of an “implacable enemy” fought only by the weapons in the “arsenal” of medicine; similarly, cancer “treatment is described as aggressive and ‘war-like,’ as ‘smart missiles,’” and “‘ways to disarm the disease’” (Clarke, 2006, 2597). Juaune N. Clarke writes

multiple articles on the current image of cancer in society, but seems never to present anything but comparisons to war. These innumerable allusions continue to build on this idea that both war and cancer are terrible and traumatic, or else *temporarily* bad and eventually resulting in the other extreme of life improvement and benefit. Yet, the middle ground still remains almost entirely unspoken of. Though Gary Lancaster's experience with war does in fact prove to be on the negative side, his cancer experience(s) quite prove the existence of this unspoken neutral-impact-zone of experience. In a portion of an article later referenced for its discussion on gender issues with cancer, Juanne Clarke also talks about this comparison of cancer to war, and, again, noticeably gives no lead to an idea of its non-impact. She speaks of the metaphors other authors and researchers use to masculinize cancer, especially its similarity to war. Clarke cites articles by Armstrong and Jenkins, for example, when she highlights the "the war against cancer," in which patients must supposedly brave "the relentless attack" to "beat a deadly" disease (2012, p. 547). She even mentions, in an article by Armstrong and Sager, how Lance Armstrong referred to his own bout with cancer as "the toughest battle of [his] life" (p. 547). Gary Lancaster, at one point in his interview, does mention this war-like effect of cancer on life and its ability to eternally alter life. But, in his own experience, all he has to say looking back on his cancer is "that sucks, you know I could think of better things to have" (personal communication, April 16, 2015). He further explains his difficult struggle with cancer—undergoing chemotherapy for a year in which he was constantly sick and even thought he was going to die at one point because of the torture—and later with war, yet the only time in the entire interview he relates the severity of cancer to war is when he compares his Naval experience in Bay Route with the time of cancer. This comparison occurs when he inserts a comment, amidst the cancer talk, about how Bay Route was the worst day of his life (or, one of several mentioned—all war-related). He says of his thoughts

as a child, “cancer kills, right? I mean that’s the thing I thought” (personal communication, April 16, 2015). The questioning he did as a child perfectly portrays the result of what this comparison to war can do in patients who have cancer. It also instills beliefs and passions which become expected of a survivor, which motivate that survivor to participate in and contribute to organizations such as the “Susan G. Coleman crap” Lancaster bluntly refers to (personal communication, April 16, 2015). His final comment on his experience with cancer was the most revolutionary in its revealing of his truly unaffected, almost lackadaisical, attitude toward the cancer experience: “I mean I don’t know, it’s like life-changing, it’s for the rest of your life you know you’re different. Something’s different. You get to wear pink, a ribbon...[chuckles] wow” (personal communication, April 16, 2015). Though initially masked by a typical and socially-acceptable survivor’s response, employing diction which makes the cancer impact appear significant, his almost satirical tone when talking about wearing survivor-pride ribbons exposes the truth: that cancer isn’t always like war, this life-altering event which inevitably affects the identity of the survivor for the rest of their life. That sometimes, cancer is just cancer, just a sickness.

### **Gender and Cancer**

Society also asserts specific associations between certain diseases and a corresponding gender (correspondence being subject to cultural context). These associations often tend to “[permeate] and [shape] the relationship between diagnosis, treatment, and the experience of MBC [male breast cancer],” proving problematic in their work as “defining feature[s]” of the life of men diagnosed with it (Donovan & Flynn, 2007, p. 466) Most prominently, this relationship between gender and cancer stands as an issue effecting the reputation and mentality of patients coming out of a bout with the disease. The correlation stands out very clearly in Juanne Clarke’s



writing on cancer coverage in the media; she both directly addresses the issue itself, and implicitly gives example to it. Clarke explains the classifications most commonly associated with cancer and gender, claiming, “to be a ‘feminine’ women is to be vulnerable to breast cancer and to be a ‘masculine’ man is to be vulnerable to testicular cancer when young and prostate cancer when older” (2004, p. 541). When trying to apply that rationale to someone like Gary Lancaster, it seems completely irrational or otherwise impossible for him to beat such odds—being a male with breast cancer, and an *older* man with testicular cancer, *and* still having no appearance of consciously questioned masculinity. However, among the flaws of current American culture, lies this powerful social connection between being a man or woman and having these diagnoses. Clarke’s article continues to exemplify this relation as it lists some of the most common negative impacts of breast cancer treatment, these include: “menstruation disruption,” “vaginal dryness,” “vaginal bleeding,” “uterine cancer,” and “premature menopause” (p. 545). These were just five of the symptoms mentioned, but they easily show the overwhelmingly feminine focus of breast cancer, even in talk of its treatment and its side effects. The gender-cancer connection not only brings further stigma to an already extremely stigmatized disease but it also forces cancer patients to make associations in their own mind. (An instability from lacking knowledge accompanies the stigma as well, in the case of breast cancer, as so much focus on women’s struggle with the disease leaves men *wondering* with important questions about their future well-being such as “how breast loss might affect a man” [Clarke, 2004, p. 545].) Lancaster, for example, seems almost to use his cancer (internally) to foster a bond between himself and women both who have and haven’t had breast cancer. This type of artificial (not artificial as in fake, but as in existent only because of its *creation* by specific circumstance) relationship not only intrudes on the social life of cancer survivors, but also their mentality concerning self-

awareness. Donovan and Flynn remark, “for men with cancer in particular, there may be an adverse impact upon somatization and activities of daily living if the issue of gender is not considered” (2007, p. 466). Perhaps this “adverse impact” explains a certain hesitation for openly expressing emotion Gary Lancaster had in his interview. When referencing the loss of his best friend—lost during duty but, unluckily, in a car wreck rather than in battle—he hesitated to say the word “love.” He cut himself off from using it, instead saying, “when you lose someone you lo— care about” (personal communication, April 16, 2015). He did say “love” when speaking generally about loving everyone, people as a whole, but noticeably avoided the emotionally heavy diction in discussion of this more personal memory...perhaps because of some underlying emotional expression issue of being weak or womanly, caused by the shame of having such a disease generally characterized as for women. Of course, Lancaster’s hesitation at the concept of love could possibly have more to do with his childhood, outside of the year with breast cancer. He mentioned his parents’ way of expressing their love for him “without saying the words” (personal communication, April 16, 2015). For example, his father would always respond to Lancaster’s saying he loved him with an “I love me too” (personal communication, April 16, 2015). Yet, he then continues with clarifying how he *knew* his father loved him. So, the *socially produced context of cancer* remains the most probable reason for Lancaster’s avoidance. Nancy Waxler brings another painful example of a “Social Construction of Illness” in her piece on the quite unnecessary stigmatization of leprosy. She words the issue perfectly:

People diagnosed as having a particular disease learn ‘how’ to have it by negotiating with friends and relations as well as with people in the treatment system; this process is affected by society’s beliefs and expectations for that disease. Finally, society’s definition of and expectations for a particular disease are sustained by social and organizational

forces that may have little to do with the disease itself as a biological process. (Waxler, 2010, p. 151)

She discusses the impact of social stigma on leprosy patients, and its irrelevance with a disease not actually contagious. Cancer also gets stigmatized to the point of completely reconstructing the illness experience. But disease is not the only culturally-weighted aspect of health, as defining the body itself comes even before defining disease. Clarke, still referencing gender-related cancers, explains how “the testicles are in some ways equated with manhood and masculinity,” one man even described his own testicles as the ““most sacred part of [his] anatomy, the core of masculinity that provides backbone and character, drive and passion”” (2004, p. 547) Without the “Social Construction” of the body and diseases, conditions such as cancer would cause minimal damage in the lives of patients. Impact would be limited to physical accompaniments of the disease and treatment, even death in extreme cases, but would be nothing more than a sickness.

## **Conclusion**

That is the point with cancer, at least in Gary Lancaster’s case. Cancer is *just cancer*. Not only does society *push* cancer patients and survivors towards the two widely-accepted poles of experience, but it even goes so far as to forcefully *create* these polarized circumstances of experience. Lawson and Flocke (as cited in Bell, 2012) describe the unjustifiable actions of this force, saying it imposes so-called “teachable moments”—either having upliftingly high (even if after initial trauma), or destructively low moments—into the cancer experience by “actively *creat[ing]* and *exploit[ing]* them rather than simply wait[ing] for” them (p. 588). Lancaster said of his career experience, “work sucks, work is work,” and, based on his nonchalant attitude about cancer and his focus on his service in the military, the same could be said of his cancer

experience: cancer sucks, cancer is cancer; he also quotes a well-known phrase commonly enforced by his grandmother, one which accurately describes (at least the apparent) attitude he carries throughout life: “grin and bare it” (personal communication, April 16, 2015). Perhaps this outlook Lancaster has about cancer (and life) is not revolutionary at all. Perhaps other cancer patients and survivors, victims of culturally-stimulated dramatization, feel the same way. Arthur Frank argues a similar point, in his writing on culturally-induced facades during or after a medical condition; he says, “society praises ill persons,” but only when they migrate to one of the poles of extremity (2005, 26). Either the ill have to do “work [...] to keep up an appearance,” with positive expressions or they have to express some sort of negativity in order to elicit a response—sick patients “have to decide what support [they] need and what [they] must give others to get that support. Then [they] make [their] ‘best deal’ of behavior to get what [they] need (Frank, 2005, p. 26, 28). However, choosing to display a positive experience with illness becomes even more complicated by the risk of accusation of denial, as according to Frank, medical personnel define a patient “who is cheerful, makes few demands, and asks fewer questions” as being in denial (2005, p. 28). Of course, patients who express extreme negative emotions receive attention too, as the structure of American culture focuses on the importance of community and support systems, especially in the midst of struggle (hence the innumerable programs, funds and centers for major illnesses). The goldilocks requirement for positivity restrains patients from raw positive experience, and this idea of patients’ having to pay for attention with some perfect balance of either positive *or negative* experience expression completely turns the diagnosis of a serious illness such as cancer into some sort of twisted societal game. In one interview, Gary Lancaster seems to successfully represent patients who lack the key attributions which classify their experience as belonging to one pole or another,

whose ideas of and experiences with cancer do not depict it as the entirety of life, but rather as *single event* within the span of their whole life. Through Lancaster's interview, and a study on the comparison of cancer to war as well as on its association to gender, the overly dramatizing influences of culture surface, and even prove insignificant to the actual lived experiences of cancer patients and survivors who get a diagnosis, receive treatment, and eventually move on to live the rest of their life mostly unaffected by the memory of the disease. In cases such as Lancaster's, the cancer is nothing more than just cancer.

## References

- Bell, K. (2012). Remaking the self: trauma, teachable moments, and the biopolitics of cancer survivorship. *Culture, Medicine & Psychiatry*, 36(4), 584-600. doi:10.1007/s11013-012-9276-9
- Clarke, J. N. (2004). A comparison of breast, testicular and prostate cancer in mass print media. *Social Science & Medicine*, 59(3), 541-551. Retrieved from [www.sciencedirect.com](http://www.sciencedirect.com).
- Clarke, J. N. (2006). Cancer in the mass print media: Fear, uncertainty and the medical model. *Social Science & Medicine*, 62(10), 2591-2600. Retrieved from [www.sciencedirect.com](http://www.sciencedirect.com).
- Donovan, T., & Flynn, M. (2007). What makes a man a man? *Cancer Nursing*, 30(6), 464-470. Retrieved from <http://www.ovid.com/site/index.jsp>.
- Frank, Arthur (2005) The cost of appearances. In *The Social Medicine Reader: Patients, Doctors, and Illness*, Nancy M.P. King, et al. Durham: Duke University Press. (Dr. V.'s packet)
- Spiro, A., III., & Settersten, R.A., Jr. (2012). Long-term implications of military service for later-life health and well-being. *Research in Human Development*. 9(3), 183-190. Retrieved from <http://www.tandfonline.com/>.
- Trevino, K., Archambault, E., Schuster, J., Richardson, P., & Moye, J. (2011). Religious coping and psychological distress. *Journal of Religion and Health*, 51(1), 87-98. Retrieved from <http://link.springer.com/>.
- Waxler, Nancy (2010) Learning to be a leper: a case study in the social construction of illness. *Understanding and Applying Medical Anthropology*, Peter Brown and Ron Barrett, eds. Pp. 150-161.

## Interview

Interviewers: Gabby Maenner and McKenzie Marciante

Interviewee: Gary Lancaster

## Questions:

1. What is your occupation? What were your past occupations? If you could classify yourself as one type of person, what would it be?
2. What sort of education have you received?
3. Where were you born/raised?
4. What is your religion background like? What role did religion play in your life or did it exist?
5. What is your family structure like?
6. What were your parents' occupations?
7. How would you describe your personality?
8. What are your favorite hobbies?
9. Tell me what it was like for you growing up? Who raised you? Do you have any siblings and what role/how big of a role did they play in your life?
10. What was your disease onset?
11. When did symptoms start? Describe them.
12. How was your diagnostic process?
13. Explain the condition in your own words.
14. What were your choices about disease resolution?
15. Explain your experience of therapies.
16. How did you feel when you first heard about/noticed your health problem?
17. What did you do right after you got your diagnosis? Describe the day you were diagnosed. What do you remember and how did you feel?

18. What changes did you experience in daily life?
19. Were your relationships (romantic and not) with people affected?
20. Did people treat you differently after your diagnosis?
21. Are your family/friends supportive of your health problem?
22. What do you call the problem you suffer(ed) from? What do you think caused the problem? Why do you think it started when it did?
23. Do you have any prior experience with the condition? Did a family member have it? Did you know anything about it before you were diagnosed with it?
24. What had you heard about/been exposed to concerning your health problem as far as stigmatization?
25. What is the most memorable medical experience you have had and why was it memorable (biomedical or otherwise)?
26. How does the condition change your views about yourself?
27. Describe your new “normal” if it is different than before.
28. Do you consider this condition to be life altering?
29. How have reactions about your health problem differ between people you know versus people you don’t?
30. How does this condition shape your ideas of the future and your future?
31. How do you look forward? What does your hope look like?
32. Did you fear death? Do you still fear death? Did the experience change your views about death?
33. Is there anything else you would like to add?

Notes:

- Navy at 17
- “get the hell out” of OK
- Emancipated to join
- 1<sup>st</sup> time from home
- Gained weight at boot camp, enjoyed it
- Cab driver-drug dealer



- Cuba→Jamaica
- 1980 Europe deployment
- Turkey executions
- 6 months home, 6 months out, then two years out
- Europe→Latin America
- Married 3 different women from OK, GA, TX
- First wife got pregnant, had two kids by time he was 27
- Drill instructor at 23
- Gulf War-1 year-payoffs
- 1983 October-Lebanon embassy-256 Americans, “worst day in my life”
- 6 ships, 13 years at sea
- Naval Air Station
- October 19, 2003
- “travel bug”
- “traveler,” outgoing, Navy “magnified who I was”
- 19 ½ years + 3 kids= divorce
- Injury→Europe
- Not accepted to Harvard, accepted to Cornell (did all online, Art History)
- From Bixpie, OK
- Dad was best friend, passed away
- Was shy and quiet, “just a little guy”
- Never regretted Navy-friendships, every man (not women unless they want to) should go, respect issue, “don’t wear a hat”
- Hasn’t been to Africa besides Morocco, Egypt
- Father-horticulture, grass on football fields, \*Cowboys and pro-wrestling
- Mother-crazy, “pro-lazy,” lunch lady, over-protective, story of championships at 17, most important lesson from mom is what not to do with kids, still her little boy
- Always around women
- Sister-teacher, beat up in interracial
- “travel’s my thing”
- Kids>everything
- “I like giving,” not getting gifts, “if I need it I’ll buy it”
- Grandma-Pentecostal “freaked me the hell out”
- 2 commandments
- “grin and bare it”
- Lost best friend in Bahamas in car wreck-hesitated to say “love,” “when you lose someone you lo— care about”
- “one thing I wish” relationship with son, “my daughter is my life” (youngest daughter)
- Hobbies: travel, sports, “Mountain Monsters” show “because it’s funny”
- “a lie takes longer to explain than the truth”
- “people say shit they don’t do shit”
- Hate only Andrew Jackson and Hitler, no time for hate
- Earth is Hell
- Family first

- “poor white trash kinda guys”
- Hometown doctor that “brought you into the world and helped you out”
- Mentioned multiple concussions many times-fuzzy
- Summer of ‘73
- Describes exact moment
- 12 years old
- Chemo for 1 year-like torture, he thought he was gonna die-bad year, sick all the time, saw psychologist
- Bay Route>cancer
- Didn’t tell his friends-they never asked!
- “freakin’ check”
- “hard-ass lump”
- Current sagging
- Parents encouraged but love “without saying the words”
- 1 time in life dad said “I love you”
- WWII dad, “I love me too,” brain tumor cancer, “I knew he loved me”
- Everyone has cancer, “mine decided to say hello,” “I’m lucky I guess”
- Relation to women because of cancer
- Sober since June 6, 1984
- Navy-tattoos (4), alcohol (rehab in Philippines in ’83), women
- Addictive personality
- Heart attack, broken back, cancer twice (all left side?), “that’s why you tell people you love them every day”
- “what if” people vs. “why not”
- Don’t have a bad day
- 10 important things→3 (family, kids)
- High BP meds for heart
- Bucket list
- “people don’t know the world’s out there,” “it’s cool it’s beautiful it’s amazing”
- Navy life-changing
- “work sucks. Work is work”
- “worst thing in my life”: “Shit River” in 1983, dead baby floating in the Philippines
- Hardens-“that’s why I’m always smiling”