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Fact in Fiction: Diagnostic Uncertainty and Healthcare in Ali Hazelwood's *Mate*

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Abstract:

Ali Hazelwood is a contemporary author of feminist STEM and paranormal romances. Her 2025 paranormal romance novel Mate follows Serena, who grew up believing she was an orphan human and recently discovered she is a werewolf-human hybrid. This paper offers a close reading of the medical subplot in *Mate* through a medical-humanities. Serena Paris, a hybrid were-human, is misdiagnosed with a "were disorder," given a terminal prognosis, and finally understood only when a midwife recognizes her symptoms as a heat cycle. The paper treats the novel's paranormal setting as an estranged context where the experience of illness under diagnostic uncertainty and the systemic limitations of biomedicine can be examined. Using frameworks from narrative medicine, medical anthropology, and narratology, it analyzes themes such as interactions with the healthcare system, the divergent temporalities of doctors and patients, uncertainty as clinical anathema, the problem patient, and medical pluralism. For each theme, it attends to the literary devices through which Hazelwood renders the experience, including ellipsis, iterative narration, repetition, register shifts, and the staging of recognition and reversal. The paper argues that *Mate* represents illness as a problem of recognition, spanning time, embodiment, diagnostic language, and epistemic authority. It further shows how medical pluralism makes Serena's suffering interpretable. It concludes that speculative fiction is a productive site for examining experiences of diagnostic ambiguity and idiopathic illnesses.

Keywords: Ali Hazelwood, Mate, paranormal romance, medical humanities, close reading, illness experience, narrative medicine, diagnostic uncertainty, medical pluralism.

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Introduction

In Ali Hazelwood's paranormal romance *Mate* (2025), the protagonist Serena Paris, a hybrid were-human, faces two threats at once: a mysterious, debilitating illness, and pursuit by supernatural bounty hunters after she publicly discloses her hybrid status in a media interview. *Mate* is a sequel to Hazelwood's Bride (2024), which introduced Serena in a world where werewolves, vampires, and humans coexist under a fragile framework of treaties. In *Mate*, Serena is being protected from the factions seeking to exploit her by the Alpha of her pack, Koen Alexander, who is also her fated mate.

The novel's medical subplot follows Serena's mysteriously, progressively deteriorating health. Because research into hybrid anatomy is scarce in this world, her doctors diagnose a "were disorder" (223), Cortisol Surge Disorder, and treat her for it. When treatment fails, she receives a terminal prognosis and settles into a near-palliative resignation. Only when a midwife attends closely to her catalogue of symptoms is her condition recognized for what it is: a heat cycle, a biological process rather than a terminal pathology.

The genre of paranormal romance has adopted more feminist themes in recent times, likely driven by reader expectations, as posited by Kollman (3), who observes that in contemporary novels, the widely scrutinized hypnotic thrall is frequently absent, or the vampire is female. A subset of the paranormal genre is the omegaverse novel. Gunderson (36) explains the archetypal version of the omegaverse trope to be comprised of Alphas, Omegas, and Betas. Omegas are both male and female, and experience heat cycles (also called Estrus) that are "periods of increased fertility and urgent sexual desire that coincides with ovulation." Alphas, also "often respond to the proximity of an Omega in heat by going into rut, an intense sexual arousal which in many ways mirror that

of the Omega's heat." The heat cycles, as Gunderson remarks, are one of the defining tropes of the alpha/beta/omega genre.

Heat in the omegaverse therefore provides a speculative vocabulary for discussing reproduction, desire, and bodily interpretation. Using Gunderson's account of omegaverse conventions as a reference point, *Mate* is omegaverse-adjacent rather than an omegaverse text due to the following differences: the Alpha–Omega dynamic is tied to the wolf pack and fated mates rather than operating as a comprehensive social system. One, there are no Betas in this paranormal world. Two, Serena is never referred to as an Omega explicitly, and finally, heats/estrus are described as something that happens to all werewolves (261). Serena is a were-human hybrid who grew up as a human orphan and only recently discovered her hybrid identity. She consequently lacks the knowledge that would allow her to recognize the signs of her own heat. This lack of research and knowledge about hybrid biology is also central to the reading of this medical subplot.

Understanding the conventions of omegaverse-adjacent biology is essential because these tropes formalize bodily categories, instincts, and hierarchies that frame how, in *Mate*, Serena's symptoms are interpreted — or misinterpreted — within the narrative's medical system.

This paper reads *Mate* as a fictional context in which the illness experience can be imagined and examined. It does not retrospectively diagnose Serena or equate heat with any human condition. Following Jennifer Anna Gosetti-Ferencei's "mimetic dimension" (427), it treats literature as both referring to and departing from reality. Hazelwood's paranormal setting is a deliberately estranged frame, and the estrangement lets the structures of medical encounter and diagnostic uncertainty stand out. The paper asks how the novel makes diagnostic uncertainty legible, what forms of expertise it imagines as capable of resolving it, and where its medical analogy reaches its limits.

The study is organized around five themes: interactions with the healthcare system, the divergent temporalities of doctors and patients, uncertainty as clinical anathema, the figure of the problem patient, and medical pluralism. These are not arbitrary groupings; they are common concerns in medical humanities scholarship. Each theme is read through frameworks from narrative medicine, medical anthropology, and narratology, and anchored in specific excerpts. Attending to the novel's formal choices (ellipsis, iterative narration, repetition, register shifts, tonal juxtaposition, and the staging of recognition and reversal), the analysis shows how those choices carry the thematic weight of Serena's experience.

Methodology

This study employs a medical-humanities close reading of *Mate*'s medical subplot. It focuses on Serena's first-person, present-tense narration; the sequence in which symptoms, diagnoses, and explanations are disclosed; the language through which clinical uncertainty is articulated; and the contrast between general biomedical care and reproductive expertise. These formal features are read alongside scholarship on illness narratives, diagnostic uncertainty, and medical pluralism, an interpretive act that Sinykin and Winant refer to as "local claiming" (6).

The analysis draws on Jennifer Anna Gosetti-Ferencei's notion of the "mimetic dimension," which allows us to understand literature both in its reference to and its deviation from reality as we ordinarily know it. Although *Mate* is set in a paranormal world, its medical narrative can illuminate real-world experiences of illness and care. The paranormal setting creates a deliberately estranged context through which contemporary medical experience can be reimagined.

The paper does not retrospectively diagnose Serena or equate heat with a human illness. Instead, it asks how the novel makes diagnostic uncertainty legible, what forms of expertise it imagines as capable of addressing that uncertainty, and where the limits of its medical analogy lie.

Theoretical Frameworks

This study draws on frameworks from narrative medicine, medical anthropology, and narratology to examine Serena's illness experience in *Mate*. Rita Charon's concept of narrative competence and her distinction between clinicians' vectored time and patients' enduring time frame the analysis of clinical listening, recognition, and temporal asymmetry. Elliot Mishler's distinction between the voice of the lifeworld and the voice of medicine is used to analyze the discursive conflict between Serena's embodied accounts of illness and her doctors' diagnostic language. Arthur Kleinman's work on the semiotics of diagnosis, explanatory models, and medical pluralism provides a framework for understanding why Serena's symptoms resist biomedical translation and why alternative forms of expertise become narratively necessary.

As a close reading, the analysis also draws on Gérard Genette's concepts of ellipsis and iterative narration to examine the compression and omission of Serena's repeated medical encounters, and on Aristotle's concepts of anagnorisis and peripeteia to analyze the narrative movement from diagnostic misrecognition to recognition and reversal. Together, these frameworks allow the study to read *Mate*'s medical subplot as a representation of how illness is handled within healthcare systems when there's uncertainty and idiopathy attached to it.

Analysis and Discussion

This section offers a close reading of themes that emerge from Serena's illness experience: her encounters with medical institutions, embodied and temporal dimensions of unexplained symptoms, and search for diagnostic recognition. Drawing on medical humanities frameworks, it also attends to the literary devices and stylistic choices through which Hazelwood renders these experiences, such as ellipsis, repetition, register shifts, and tonal juxtaposition, and how they formalize the thematic significance.

Theme 1: Interactions with the Healthcare System

The subplot of Serena's interaction with the healthcare system works in two temporal planes: a couple of months ago, when she first saw a physician, and the present, where she is dealing with extreme, progressively worsening symptoms. Upon reporting her symptoms, she is first diagnosed with Cortisol Surge Disorder (CSD, akin to Cushing Syndrome or hypercortisolism in our world), which is referred to as a 'werewolf (were) illness' in the novel. When the treatments don't work on her, the doctor delivers a terminal prognosis, giving her an estimated three to six months to live.

The disclosure of Serena's symptoms and medical encounters occurs non-linearly: the first documented encounter is an internal analepsis (flashback) from two months ago when she is handed the terminal prognosis, and within which Serena retrospectively narrates her initial visit to Dr. Henshaw a further two months before that. All quotations from *Mate* are cited parenthetically by page number alone.

> When I first came to Dr. Henshaw, my biggest fear was that he would tell me that my odd hybrid biology was too much of a medical head-scratcher to give me a diagnosis. It never occurred to me that my disease might be easy to identify but untreatable. (87)

> We were both here for the last two months, trying pills, injectables, even minor surgery. (88)

Upon close reading, we observe two literary choices. The first is the omission of the individual appointments as scenes, or as accounts of repeated visits and treatments that are so typical of any chronic illness. This is what Genette (106) calls ellipsis, that is, a period of time that exists in the story but is deleted in the narrative or the text. The two months before the prognosis are not, however, wholly absent from the novel. This is where we see the second authorial choice of iterative narration, read through Serena's first-person retrospective account. Iterative narration (Genette 116-117) gathers recurring or cyclical events and posits a compressed account rather than dramatizing each encounter. Valta, drawing on Genette, explains, "In narrative studies, routine is often linked to iterative narration, which designates an action that has happened several times, but has been told only once. Iterative sequences are often used to describe ordinary, repetitive life so as to frame more important narrative events…" This suggests that the compressed version of narrative may also shift emphasis away from the routine sequence of tests and treatments and toward the moment when the provisional search for an explanation becomes a terminal prognosis. An alternative interpretation of this literary treatment of prior medical encounters in the narrative is to see it as more than just the act of compression. This choice formally reproduces the monotony and cyclical temporality of medical encounters in chronic illness: recurring symptoms, tests, and treatments that can make time feel cyclical or episodic, or as Gardner explains of his illness as marked "not by progress but by recurrence, repetition, and ellipses." The appointments may be mundane in their repetition, but their compression also makes that repetition perceptible as a pattern.

Theme 2: How Doctors Versus Patients Experience Time

Charon (44) explains that medical practitioners experience "vectored time, that is, a state of time in which one event leads to another and can even be conceptualized as having caused it." In contrast, a patient "inhabits a timeless enduring." Charon's account of clinical time as oriented toward actionable, causally ordered events offers one way to read Dr. Henshaw's work comprising tests, results, and treatment decisions. Serena's narration instead gathers repeated encounters into an ongoing experience in which much remains unsettled: symptoms persist, explanations are deferred, and the future does not arrive as resolution. In multiple instances in the novel, we read a register shift and a dialogic juxtaposition of Serena's experience of time with her illness versus Dr. Henshaw's. In response to Koen's questioning, Serena shares details of her symptoms, including the timeline:

> "Four months. Twelve years."
>
> His eyes harden. "What a helpfully narrow interval."
>
> "I really don't know. None of this is normal, Koen. None of this is not terrible, and—"
>
> …
>
> "The fevers began four or five months ago. But Dr. Henshaw says that this is a degenerative condition that starts before symptoms manifest… (223)

In another instance, Serena describes her sensory issues with clothing — and fabric against skin in general — as exacerbating. Notice her account of her lived experience of the symptom versus the doctor's handling of the same.

> I agree to whatever he has me trying on, even though my skin has been very sensitive for weeks, and the denim and wool scrape against it like emery boards. The texture of fleece makes me wish there were enough traffic for me to walk into. *A normal evolution of your condition*, said Dr. Henshaw. *Make sure you dress to minimize your sensory issues*. (142)

In both examples, the register shift is noticeable: the patient speaks in embodied, experiential, biographical language; the doctor shifts to clinical, categorical, managerial language. The juxtaposition is not merely one of tone but of temporal orientation. Serena describes her symptoms through lived duration: they have persisted, accumulated, and become part of her embodied experience over time. The doctor responds by converting that duration into clinical trajectory. "Normal evolution" does not explain the sensory experience; it places it within an expected disease course. The patient's time is time endured; the doctor's time is time anticipated and managed. Mishler's distinction between the "voice of the lifeworld" and the "voice of medicine" clarifies this asymmetry (104, 108). Mishler states that the doctor may either open space for the patient's lifeworld account or close it down by reasserting the authority of medical reasoning. In *Mate*, the doctor's reply seems to have accomplished the latter. By naming the experience "normal," the clinician removes its claim to singularity and urgency. By advising Serena to minimize her sensory issues, the response shifts attention from explanation to adaptation. Uncertainty is not resolved; it is made administratively manageable. This management of uncertainty prepares the ground for the following theme, which examines the clinician's discomfort with diagnostic ambiguity.

Theme 3: Uncertainty as Clinical Anathema

In her first-person iterative narration, Serena recounts Dr. Henshaw's progression from curiosity in her as a patient, to increasing bewilderment at her body's failure to respond, and later,

detachment as the suggested treatment options, one by one, were crossed off as ineffective in addressing her pain.

> But I steadily got worse, and Dr. Henshaw's even-keeled *We just haven't found the right treatment yet* became a frustrated *You're not responding as well as I'd hoped*, then unspooled into frowns that I interpreted as *What…is wrong with your body?* (88)

The physician is portrayed as distressed as he explained that while CSD is a very common illness for Weres, even a leading cause of death, and it was highly unusual for someone as young as Serena to have that disorder. We later learn this was a misdiagnosis, since her symptoms were of her upcoming heat cycle. This experience resonates with scholarship of chronic illness care: misdiagnosis is common (Sloan et al.), and even when diagnosis occurs, it often requires years of persistence (Merone et al.). Serena wasn't responding to treatment, and her condition was deteriorating faster than the physician had ever seen before. His delivery of the terminal prognosis also aligns with the previous reading of management of uncertainty and lack of answers with the voice of medicine. (We will discuss the choice of his words in "not compatible with life" in a later section.)

> My colleagues and I are in agreement that your body cannot sustain this level of adrenal imbalance for much longer. It's simply not compatible with life, both from a Were and a Human physiology standpoint. And the rate of your decline…(88)

The novel does not explicitly state that Dr. Henshaw is anxious because he lacks answers, but the medical humanities lens can be useful to interpret this nervousness.

Kleinman's account of the semiotics of diagnosis explains why Serena's doctor responds to her ambiguous symptoms with hesitation rather than sustained inquiry. For the clinician, diagnosis

involves translating the patient's complaints into biomedical signs; they "sleuth for pathognomonic signs — the observable, telltale clues to secret pathology — that establish a specific disease." Serena's hybrid body disrupts this translational process. Her symptoms cannot be neatly mapped onto a known disease category, and therefore cannot be converted into the kind of diagnostic sign that would allow the clinician to proceed with confidence. This produces the intolerance of ambiguity at work in the encounter.

In her investigative memoir, The Invisible Kingdom: Reimagining Chronic Illness, Meghan O'Rourke (70) examines what happens when doctors aren't able to hand over a straightforward diagnosis, and how doctors' intolerance to uncertainty dictates their behaviour towards such patients. She cites a palliative care pioneer explaining why this feels like an affront to their expertise: "The nagging worry is that if you can't see it objectively, you are missing something medically or being bamboozled somehow—fooled by the patient. That is scary to doctors."

This intolerance to uncertainty among practitioners is well-documented (Begin et al.), even more so in the post-COVID illness landscape (Varghese et al.), and there has been increasing recognition of the need for doctors' acceptance of uncertainty that a culture of medicine is unwilling to acknowledge and embrace (Simpkin and Schwartzstein).

Serena's symptoms cannot be readily translated into a known diagnostic category, and the doctor's response converts that epistemic gap into normalization, deferral, or behavioral instruction. Rather than tolerating uncertainty as a condition of care, the clinician seeks to contain it. The physician's helplessness in this scene can be read alongside scholarship on clinicians' discomfort with uncertainty, which Simpkin and Schwartzstein implore doctors to rectify: "Our value as physicians

will lie in the gray-scale space, where we will have to support patients who are living with uncertainty—work that is essential to strong and meaningful doctor—patient relationships."

The following theme examines another consequence of this tension surrounding uncertainty.

Theme 4: Serena as a Problem Patient

Serena risks becoming what clinical discourse calls a problem patient because her illness resists the diagnostic and temporal expectations of her doctors. Kleinman writes that a practitioner trained to think in terms of precise outcomes might find chronic illnesses and diagnostic uncertainty messy. As a corollary, he adds:

> Predictably, the chronically ill become problem patients in care, and they reciprocally experience their care as a problem in the health care system.

The label "problem patient" is significant because it shifts attention from the limits of medical knowledge to the patient's perceived difficulty, transforming unexplained illness into a problem of compliance, communication, or emotional manageability. Serena's self-presentation suggests that she may be subscribing to this stance toward her care. Serena feels considerable guilt over the resources being expended to keep her safe, and she was hesitant to share the details of her poor health with others throughout the story. When Koen inquires about her dwindling health, she downplays the cluster of symptoms ("nothing bad") and the pain as discomfort.

> "Nothing bad. You're right, my appetite has been low. Nausea. Issues sleeping. One of the Southwest physicians, Dr. Henshaw, said it's stress from…Take your pick. Basically, I just need to wait it out and chill. Hence the cabin."
>
> "Are you in pain?"

> I shake my head, instinctively.
>
> His expression looks so dubious, I wince. “It’s more like discomfort.” (78)

Dr. Henshaw’s attribution of Serena’s symptoms to CSD and stress can be read as a form of diagnostic overshadowing (Hallyburton), the misattribution of symptoms to an existing diagnostic frame, and as disenfranchising talk (Hintz) that distances Serena from appropriate care.

> The fevers are caused by…Basically, chronic stress fucked up my inflammatory and anti-inflammatory signals. Again, not uncommon.”
>
> “CSD can be treated.”
>
> “Yeah. In Weres, it can. Sometimes. But my hybrid biology hasn’t been responding to meds. My hormonal levels are getting worse, and Dr. Henshaw said…” I suck my teeth. “Not compatible with life. That’s how he put it.” (223)

Studies on shame in chronic illness note that participants frequently worried they would be perceived as “complainers” or “whiners” if they discussed their symptoms. (Werner et al.) Her reluctance to foreground her illness can also be read as a product of the physician’s lack of answers, an experience often seen across chronically ill patients facing “the repeated refusal of care and services, the constant denial of one’s experiences, the slow exacerbation of one’s symptoms, the years without recognition or diagnosis, the waiting” (Kafer 37).

Serena defends the physician, downplays her symptoms, and appears to accept the prognosis fatalistically. The following statements are not merely signs of her inner state, but can also be read as choices in a clinical relationship where she may fear being seen as difficult or burdensome.

> He involved his colleagues, and…believe me when I say, no stone was left unturned. But the side effects were bad, and my deterioration was steady. Linear, originally, then exponential. (224)

> To his credit, Dr. Henshaw did everything he could. He consulted several of his colleagues. He shared my anonymized labs with specialists. He compared notes, asked for advice, and ordered additional tests on their behalf. (87)

Serena's reluctance to impose on Dr. Henshaw, even as she receives life-altering news, finds parallels in O'Rourke's account (62-63) about how she hesitated to ask all her questions to her doctor because she felt she had "already imposed and exhausted the physician's generosity" even as her ailing body was in the middle of a hectic, distressing period of specialist-hopping, blood tests in succession, doctor's appointments where she felt the pressure to find the right words to get them "on my side." In a reversal of roles, we also see Serena reassuring and comforting Dr. Henshaw instead, when he comes empty-handed.

> He is a kindly older man, good at his job. My issues stump him and challenge his self-perception, which accounts for half of the urgency in his tone. The other half…It cannot be easy, delivering the kind of information he just did. 'Don't worry about it. It's not your fault,' I say, hopping off the exam table with a smile. (86)

Serena's first-person account of Dr. Henshaw is marked by repetition and rhetorical overcompensation. The insistence (shown through repetition) that "no stone was left unturned," that he "did everything he could," and that he consulted colleagues and specialists, reflects Serena's need to believe it. Serena's narration exhibits what might be internalized medical deference, that is, she adopts medicine's own criteria of good care comprising consultation,

referral, testing, and procedural diligence as sufficient evidence that she has been properly cared for. She does not evaluate Dr. Henshaw by whether he has understood or relieved her suffering, but by whether he has performed the recognized exercises of clinical diligence: consulting colleagues, sharing labs, seeking specialist advice, and ordering further tests. This framework preserves the doctor's moral authority within the medical model, even as her condition worsens.

Serena's fatalistic acceptance highlights the gulf in the doctors' understanding of the kind of support chronically ill patients, or those with ambiguous symptoms, want from them. A chronic illness diagnosis prompts the patient to invest time and effort in figuring out a new story of their life. As such, "in a treatment setting, then, patients want to be listened to, not least because they view doctors as authorities conferring further meaning and recognition, which doctors may not realize" (O'Rourke 67).

In the medical advice Serena was offered alongside a conclusive prescription for palliative care (cited earlier), we see how Dr. Henshaw ultimately pronounces her symptoms and physiology as "not compatible with life," a phrase that Serena later dwells on, multiple times, including when she later shares her prognosis with Koen. The repetition emphasizes that Serena has internalized the phrase. It also invites the reader to infer that Dr. Henshaw's response may be shaped by frustration, defeat, or overwhelm, emotions associated with "heartsink" patients (O'Dowd).

The phrase "not compatible with life" invites inquiry, for it exemplifies the clinical detachment of the voice of medicine. It translates the upheaval of Serena's body into a detached diagnostic formulation, naming biological impossibility while leaving unspoken the fear and vulnerability it produces. Kleinman argues that corporeal betrayal can take a toll on the ill beyond physical symptoms. It can lead to loss of confidence, or even the grim expectation of the worst,

demoralization, and hopelessness (as we observe in Serena's case), and it implores clinicians to acknowledge and respond to patients' feelings as well, pointing towards the practice of narrative competence. Narrative competence, as Charon defines it, involves the capacity to recognize, absorb, interpret, and be moved by stories of illness. O'Rourke's account similarly emphasizes the importance of finding "caring physicians who would eventually become partners in (my) quest for health" (61).

Theme 5: Medical Pluralism & Subversion of Serena's Symptoms

Once Serena explains her worsening symptoms and terminal diagnosis to Koen, they decide to visit Dr. Sem Caine, where we see Koen advocating for her, with misplaced anger, telling the doctor, *"Don't be sorry—that's not your job. Your…job is to cure ill people. Why do you have no idea how to do that?"* (229) Dr. Sem's initial confirmation of Dr. Henshaw's diagnosis produces a false resolution. Serena and Koen are asked to accept a prognosis that explains neither the fullness of Serena's suffering nor its continuing deterioration; their resignation appears to close the narrative of medical uncertainty. The following day, however, intervention from Layla (Dr. Sem's wife and a midwife by profession) transforms that closure into recognition. Her midwifery knowledge enables an anagnorisis: the symptom catalogue that biomedical expertise could not interpret becomes legible within a different explanatory model. This recognition then effects a peripeteia, reversing Serena and Koen's situation from inevitable decline toward possible intervention.

This narrative structure thus prepares the ground for reading Layla as an allegorical figure for alternative epistemic authority within medical pluralism. The novel thus draws on Kleinman's concept of explanatory model: that in cases of idiopathic or diagnostically uncertain illness,

pluralism can correct the blind spots of a single dominant system, and answers for embodiment, lived context and symptom management of an illness can come from a different explanatory model. Notably, the eventual explanation—Serena's heat cycle—is a biological phenomenon rather than necessarily a pathological one.

This pluralist resolution also changes how the novel's earlier symptom descriptions should be read. Gunderson (39) explains that the experience of heat is "*often described in terms connoting distress, helpless urgency, and overwhelming need, with symptoms resembling physical illness.*"

This corroborates the symptoms that were intensifying for Serena:

> ...temperature would spike even higher, and the heat would probably kill me…I'm a heap of perspiration and tears and shivers…Some nights, I only deal with the fever…For now, though, my heart hammers against my rib cage, my body arches and contracts, and I swallow the pain of a hundred bones crumbling. And since it's all I can do, I sit, bury my face in my knees, and wait. (84)

> The night brings spanking new levels of pain and mortification. The recollections do not abound, but as far as I can tell: I wake up a few hours after going to bed, gasping like a rhino with sleep apnea, and make my way to the bathroom as my body works through spasms, cramps, and the fire taking over every layer of my epidermis. I sit in the shower as cold water flows over my head and beg my soon-to-be corpse to pipe…down. (170)

Hazelwood's meticulous cataloguing of Serena's symptoms also exposes a deeper structural issue: these manifestations were never medically obscure. When read alongside the novel's account of were physiology and heat cycles, Serena's symptoms appear legible to a clinician with relevant

specialized knowledge. What appears, within the diegesis, is a failure of access: access to the right specialist, to the right diagnostic framework, to someone who knew what to look for.

Hazelwood reinforces this point through the narrative's early allusions to symptom fluctuations: moments where Serena experiences temporary relief that the reader cannot yet interpret. For instance, we are told that she begins to feel calmer, more grounded, or marginally less feverish in Koen's presence or surrounded by objects carrying his scent:

> This is nice. I am, for once, not cold. My bed smells pleasant and woodsy, not at all like rancid nightmare sweat. The pillow is the perfect consistency. Everything about the situation is cozy and restful, and I see no reason to interrupt it—until a worried voice pierces through my cocoon of joy. (56)

> Could be a Were evolutionary trait: in the face of probable death, seek refuge close to Alpha. I might be onto something. (170)

These subtle indications of "nesting" behaviour, characteristic of were females entering heat, are structurally embedded clues that Serena herself cannot decipher. What reads, at first, as a mysterious reprieve is later revealed to be physiologically consistent with her actual condition.

This pattern of symptoms fluctuating in response to environmental or relational triggers echoes contemporary experiences of patients with chronic or invisible illnesses, who are routinely encouraged to track their symptoms in order to identify exacerbating factors or sources of relief. These take the form of symptom diaries or trigger logs (Hodge), or even m-health wearables (Hayes et al.). Serena's body offers data; what she lacks is a clinician able to interpret that data within an appropriate diagnostic schema. The novel thus stages a pointed contrast between perfunctory medical encounters that overlook the value of patient-generated information and the

attentive, interpretive labour undertaken by Layla. Viewed through this lens, Serena's subverted symptoms are less a narrative misdirection and more a commentary on how diagnostic clarity depends on the alignment of embodied knowledge, specialist expertise, and the structural conditions that allow both to meet.

Conclusion

This paper has argued that *Mate* represents illness under diagnostic uncertainty as a problem of recognition — of time, embodiment, diagnostic language, and epistemic authority — and medical pluralism becomes the narrative means by which Serena's suffering finally becomes interpretable.

Across five themes, Serena's medical narrative stages the structures that make idiopathic illness difficult to navigate: encounters compressed into routine, a clinical time of anticipation set against a patient's time of endurance, a medicine that contains uncertainty rather than tolerating it, a patient who learns to perform undemanding compliance, and a resolution that arrives only when a different explanatory model is admitted. Hazelwood's formal choices, including ellipsis, iterative narration, repetition, register shifts, and false resolution, make them perceptible as patterns. The novel's resolution offers a site of study for critical medical humanities. Serena's symptoms were not medically obscure, but were illegible within the framework her doctors held, and became legible when a practitioner with different expertise listened to them. In this way, *Mate* locates medical pluralism as the condition under which Serena's suffering can be interpreted or managed at all.

More broadly, the study suggests that speculative fiction is a productive site for examining illness without strict referentiality. Because the paranormal setting estranges the medical encounter, readers can see its structures anew while the experiences they recognize remain real. A genre so

preoccupied with bodies, reproduction, and care is fertile ground for questions of diagnostic ambiguity, reproductive knowledge, and care ethics.

The study has limits. It examines a single novel, and heat is a biological phenomenon rather than a pathology, so the analogy to real-world illness holds only partially. Its resolution is also tidier than the experience of most patients with idiopathic conditions, who may never receive a satisfying explanation. Future research could compare how other speculative and romance texts, including omegaverse works, handle illness, reproduction, and pain, and whether similar narrative patterns recur. It could also ask how fiction narrates illness for which no settled terminology yet exists, and how it fills the gaps in vocabulary and recognition that medicine leaves open.

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AI Use Declaration

The paper was proofread using Grammarly, which often employs AI in its suggestions, substitutions, and rewrites.