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'I've used the word cancer but it's actually good news': discursive performativity of cancer and the identity of urological cancer services

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ABSTRACT:

Drawing on the ethnographic study of urological cancer services, this essay explores how a set of particular discourses, embedded in the everyday clinical work in a large teaching hospital in UK, helps materialise particular configurations of cancer, and the related professional identities. Emerging on the intersection of specific social-material arrangements (cancer survival rates, treatment regimens, cancer staging classifications, metaphors, clinical specialities), and operating across a number of differential relations (curable/incurable, treatable/untreatable, aggressive/nonaggressive), these configurations help constitute the categories of "good" and "bad" cancers as separate and contrasting entities. Involved in materialising particular

distributions of power, these categories are implicated in the making of specific claims about the identity of urological cancer services as unique and privileged. Exploring these issues in view of the feminist and material-semiotic approaches to studying science, technology and medicine, this essay seeks to move away from the understanding of cancer discourses as primarily linguistic performances, proposing to see them instead as arrangements of practices and relations, simultaneously material and semiotic, through which particular categories, entities and phenomena acquire their determinate nature. In doing so, it seeks to contribute to the sociology's broader concern with discursive performativity of cancer. (192 words)

KEYWORDS:

Discourse; performativity; professional identity; urological cancer services; material semiotics

INTRODUCTION

It's trying to reassure them really. Because ... the ones that I'm seeing are superficial and the word "cancer" it's just like everybody panics about it. But superficial bladder cancer ... the likelihood is it's not going to affect their quality of life, it's not going to affect their life expectancy probably and the treatment is very, very easy. It's just a case of surveillance, there's no invasive treatment usually involved. So it's more like reassuring them that actually this is good news... I've used the word "cancer" but it's actually good news ...

In the above quotation Julie, a urology nurse, speaks about her experiences of communicating a diagnosis of superficial bladder cancer.¹ In a matter-of-factly manner she describes patients' emotional difficulties of learning about their cancer and her role in reassuring them that in their case the prognosis is good and treatments easily tolerated. While the topic of these conversations – cancer – is clearly recognised as emotive, Julie's account speaks to the everyday mundane reality of clinical work, underlining the routine and seemingly inconsequential nature of certain procedures, and certain conditions, and the equally routine character of emotion work undertaken by healthcare professionals, particularly nurses (James 1992; James 2004). It is precisely in this gap between the accepted emotiveness of cancer and the apparent ordinariness of related care that Julie performs her caring task of reassurance. It is achieved through a particular reading of a diagnosis of superficial bladder cancer which configures it as an instance of "good news". The effects of this interpretation unfold in the way in which it can be seen to profoundly disrupt the powerful, habitual configuration of cancer as a disease of severe significance. Julie's account thus speaks directly to the discursivity of cancer: to different and sometimes conflicting configurations of this disease, to concrete practices and relations through which these configurations are constituted, and to their powerful effects.

Social theory has long been concerned with the productive nature of discourses. Following from the work of Michel Foucault (1972; 1976), and its reworking in feminist theory and social studies of science, technology and medicine (Barad 2003; Butler 1990; Castañeda 2002; Law 2002; Mol 2002) discourses have come to be seen as "boundary-making" practices (Barad 2003) which enable or constrain particular orderings of reality (Law 2009), and thus bring into being

particular versions of the world (Castañeda 2002). In this understanding,² discourses are not synonymous with rhetorical forms or linguistic performances, and consigned to the sphere of language. Rather, they are particular arrangements of conceptual and material relations and practices, where concepts are always already material as well as semiotic, and materialities bear various meanings. Matter and meaning are here perceived not only as inextricably entangled, but also as mutually constitutive. This has important consequences for the conceptualisation of discourses as performative. Their performativity is no longer thought of in terms of processes “by which human-based linguistic practices (materially supported in some unspecified way) manage to produce substantive bodies/bodily substances” (Barad 2003: 824), but rather as realised in relations, simultaneously material and semiotic, through which particular categories, entities and phenomena acquire their determinate nature. As those relations always involve particular exclusions and distributions of power, discourses are never neutral or innocent, but have real consequences. In Barad’s words, “marks are left on bodies” (2003: 828).

Reading through this lens of relational performativity, much of the literature exploring discursivity of cancer seems to focus predominantly on linguistic or semiotic practices – “cancer culture” – separating them from, or even contrasting with, its “biological form”, equated with physiological or biochemical processes (Jain 2007). This is particularly visible in the pre-occupation of many authors with metaphors and their role in the shaping of the cultural representation of cancer (Sontag 1979; Stacey 1997; Willig 2011). Certainly, various imageries – of a “war”, a “journey”, or a “gift” – have been employed to represent cancer and its embodied experience in medical practice (Reisfield and Wilson 2004), in the popular scientific discourse (Williams Camus 2009), and in

popular understandings of illness (Clarke 2004; Willig 2011). At the same time, the image of cancer has sometimes been mobilised as a metaphor for moral, psychological or social crises (Stacey 1997), or “a profound disequilibrium between individual and society” (Sontag 1979). Far from being neutral imageries, metaphors figure in these accounts as powerful technologies of signification, which – employed in medical and lay discourses – are productive of particular realities, highlighting certain alternatives and obscuring others (Lakoff and Johnson 1980; Williams Camus 2009). What tends to be overlooked in these interpretations is precisely the way in which these symbolic technologies are inextricably bound with various materialities.

In this essay, we want to move away from such readings of metaphor as a purely rhetorical form, and of cancer as constituted through linguistic performances, and propose an alternative understanding of discursivity of cancer as configured through specific material and semiotic relations and practices. We will attempt to do this while considering a particular set of discourses embedded in the everyday clinical work of urological cancer services in a large UK teaching hospital. These discourses come into being in specific arrangements of concepts, practices and materialities which include, among others, cancer survival rates, clinical procedures, cancer staging, metaphors, and clinical specialities, and which – through their interactions – help constitute the categories of “good” and “bad” cancers as separate and contrasting entities. As we will illustrate, these categories are implicated in the making of specific claims about the identity of urological cancer services and the inter-speciality differences between urologists and oncologists treating patients with urological cancers.

BACKGROUND

Urological cancers

Urological services treat patients with a number of malignancies related to the urinary and male genital system. Those include cancers of bladder, kidney, prostate, testes and penis. For the purpose of service planning and the production of clinical guidelines, these various conditions are sometimes considered as one group (NICE 2002). Viewed in this way, they are relatively common, accounting for 19% of all new cases of cancer diagnosed in the UK every year (34% in men) and 13% of all cancer related deaths (21% in men) (Cancer Research UK 2012). However, as noted in the guidelines of National Institute for Health and Care Excellence: "the patterns of care required for each cancer site vary widely because these cancers are very different in nature and characteristics" (NICE 2002: 8). The prevalence of different urological cancers varies from prostate cancer, the most commonly diagnosed cancer in men, affecting almost 41,000 people every year, to the very rare cancer of penis, presenting with just 500 cases every year (Cancer Research UK 2012). Urological cancers also differ in the populations that they affect with prostate, bladder and kidney cancers found mostly in older people, and testicular cancer affecting mostly young men. Finally, urological cancers vary in the treatments offered for different conditions with a range of treatments available for prostate cancer (e.g. active monitoring, conservative treatment of symptoms, radical surgery and radiotherapy, hormone therapy), and cancers of kidney, bladder, testes and penis treated predominantly with surgery or, in more advanced stages, with chemotherapy (NICE 2002).

Setting of the study

City Royal Infirmary (CRI) is a large teaching hospital in the UK. Within CRI, as in other UK hospitals, services for people with urological cancers are spread over two clinical departments: urology and oncology, with weekly multi-disciplinary team (MDT) meetings helping to coordinate patient care across these departments. Within this system urology healthcare professionals are responsible for many initial diagnostic procedures (e.g. prostate biopsy or bladder endoscopy), the delivery of diagnosis and the treatment and follow up for all patients undergoing surgical intervention, and some patients with non-surgical treatments (e.g. prostate cancer patients on active monitoring). Oncology healthcare professionals, on the other hand, are responsible for the treatment and follow up for all patients undergoing radiotherapy and most patients undergoing medical treatments.

METHODS

The discussion presented in this essay forms part of a study of communication practices and information provision in urological cancer services. This research sought to explore patients and healthcare professionals' experiences of patient information for people with different urological cancers, and to develop recommendations for the design and provision of information for this group of patients. We undertook ethnographic fieldwork in the departments of urology and oncology in CRI. Within a 12 month period (from October 2010 to September 2011) 13 men diagnosed with prostate and bladder cancer were followed through their journey of care: from the referral to the department of urology for diagnostic procedures, through the delivery of diagnosis, pre-

treatment and post-treatment appointments. Formal consultations and informal interactions with urology and oncology doctors and nurses were observed, and interviews were conducted with patients and with 22 professionals (consultants, registrars, nurses and nurse specialists). Fieldwork took place in day and in-patient wards and out-patient clinics, and amounted to approximately 60 hours.

Detailed field notes and interview transcripts formed the core of our dataset, and were supplemented by other materials, including patient information leaflets, clinical guidelines, and articles published in medical journals. In analysing these diverse data, we adopted a theoretical-methodological approach developed within feminist science studies (Castañeda 2002; Haraway 1997; Suchman 2007), which focuses on the concept of figuration as a main analytical category. In this approach, figuration describes “the process by which a concept or entity is given particular form” (Castañeda 2002:3), or “figured”, through specific social-material practices that “bring together assemblages of stuff and meaning into more or less stable arrangements” (Suchman 2007: 227). Informed by this analytical framing, our data analysis was guided by a number of broad questions which focused specifically on the issue of different figurations of urological cancers. Particularly, we sought to explore how urological cancers were figured in discursive practices of different constituents (doctors, nurses, patients, medical scientists, clinical guideline panels); how these figurations were embedded in specific diagnostic and therapeutic procedures, and in different measurements associated with them; and how these figurations were also embedded in the specific ways in which urological cancer services were organised.

The research received ethical and management approvals from the relevant NHS Research Ethics Committee and R&D office. All participants gave written consent

before participating in the research. Consent for the participation was also confirmed at the outset of every observation and interview.

FINDINGS

Good news, bad news

We have started this essay with the words of Julie, a urology nurse, speaking of reassuring her patients in the face of a cancer diagnosis. As we have noted, her accomplishment of this task is dependent on a particular interpretation of a diagnosis of superficial bladder cancer which configures it as an instance of "good news". This configuration is not a wilful invention of this particular nurse, neither is it a simple reflection of the "natural history" of this particular disease. Rather, it is an effect of a complex craftwork involving an array of social-material practices. Firstly, the configuration is proposed in the context of a concrete caring task of reassuring patients, and in reference to specific clinical procedures. As such, it is constituted in the particular clinical interactions and care activities, but also through broader material-conceptual arrangements, such as treatment protocols for superficial bladder cancer (Berg 1997), or standards of professional nursing practice (Latimer 2000). Secondly, Julie's articulation of the "good news" of being diagnosed with superficial bladder cancer is made meaningful, and therefore reassuring, through its projected distinction from the instances of "bad news".

In the pragmatic terms rooted in the ethnomethodological tradition, "bad news" events can be defined as those events which disrupt the assumptions of what counts as the normal, predictable and moral order of everyday life (Maynard 1996). More specifically, Julie's reconfiguration intersects with what in the

medical literature is often referred to as the “breaking of bad news”, that is, disclosing information “likely to alter drastically a patient’s view of his or her future (whether at the time of diagnosis or when facing the failure of curative intention)” (Buckman 1984). The “breaking of bad news” is here figured as a particularly challenging instance of clinical interaction, both for patients and for healthcare professionals (Fallowfield and Jenkins 2004; Taylor 1988), and as such has been the subject of a number of clinical guidelines (Baile et al. 2000; Lees 2011). One of the challenges of the “breaking of bad news” is related to the tensions between an imperative of the full disclosure of cancer diagnosis and the practicalities of emotion work undertaken by healthcare professionals while dealing with the emotional reactions and needs of their patients (and their own emotions) (James 1992; James 2004). Julie’s account enacts these tensions, acknowledging the powerful effects of cancer as a classifying category (Bowker and Star 1999) and the need for mitigating its impact on newly diagnosed patients (Flanagan and Holmes 2000). The configuration of a cancer diagnosis as conveying of “good news” is thus crafted in close relation – or intra-action (Barad 2003) – to the notion of the “breaking of bad news” and its tensions. Intersecting with an array of social-material arrangements and practices, at the same time local and specific, and more widely circulating, Julie’s account and the reconfiguration that it proposes attest to the material-semiotic performativity of cancer discourses through which particular categories – such as “good” and “bad” news, or “good” and “bad” cancer – acquire their determinate nature as one, not the other. In the following parts of this essay we will examine other concrete arrangements – of concepts, practices and materialities – which contribute to the discursivity of cancer, by constituting some cancers as curable,

easily treatable and relatively benign, and other cancers as fatal, associated with brutal and ineffective treatments, and aggressive.

(In)curable cancers

We start with an account from a urological surgeon, Mr Mitchell:

I don't think the younger guys, with testicular cancer, a lot of them don't understand that the cure rate is really high, so that for most of them we are going to cure their disease.

Mr Mitchell's words resonate with those of the authors of the NICE guideline, which describe the effectiveness of treatments for testicular cancer in the following manner:

... success rates are high – fewer than 10% of patients die from testicular cancer – but the problem may recur: up to 5% of men develop cancer in the remaining testis within 25 years of the initial diagnosis. (NICE 2002: 17)

These two passages speak of the chances of cure for people diagnosed with testicular cancer. A number of issues are being conflated in them: firstly, there are bodies to be treated and cured; secondly, there are procedures to affect the cure; finally, there are tools to measure it. The bodies to be treated and cured are those of men – younger men – with tumour in at least one of the testes. Most of these men will be cured, although some of them might die, and for some the cancer might reappear. The procedures to bring on the cure, not described but implied in these particular quotes, involve a surgical removal of the affected testis. This carries with it the usual attributes of a major surgery – hospitalisation, anaesthesia, wound – as well as the specific changes in bodies,

and in embodied gender identities (Chapple and McPherson 2004; Chapple and Ziebland 2004). Finally, the tools to measure the cure are those of statistical frequencies, cancer survival rates, which associate bodies – living or dead, free of cancer or not – and procedures performed on these bodies with population-based calculations of probabilities (Hacking 1990). One in ten patients will die from testicular cancer; one in twenty will develop a new cancer. Bodies, procedures and measurements are thus mutually entangled in the notion of cure rate, and implicated in the configuring of two other notions: of the cure, and of a curable cancer.

The Oxford English Dictionary presents the definition of cure as a “successful medical treatment; the action or process of healing a wound, a disease, or a sick person; restoration to health” (Definition II 6a). This definition associates the cure with restored health, the action of achieving it, and the method by which this is being accomplished. In simple terms, it relates the cure to a situation when a disease has been successfully treated and does not return. In cancer care the notion of cure is configured in more modest terms as a specific period of time over which the recurrence of cancer cannot be detected. This constitutes two important breaks from the OED definition. Firstly, it treats the restoration of health as conditional and time specific. Secondly, it predicates the presence/absence of a disease upon the method of its detection rather than the method of its eradication. Cancer survival rates are crucial in crafting this qualified notion of the cure,³ although – as evidenced by the above quotation from the NICE guideline – they do not do so in a simple or coherent way. With different statistical measures used to calculate a cancer prognosis – overall survival, cancer-specific survival, disease-free survival – the chance of curing a cancer might be constituted in relation to a number of people who were alive ten

years (or one, or two or five) after their diagnosis; or, who have not died from cancer within this particular period of time; or, who were alive and free from cancer, again in a given period of time since diagnosis.⁴ With all those contingencies, the measures are implicated in the configuring of some cancers as curable cancers.

A recent publication in Health Statistics Quarterly (Woods et al. 2010) presents the following estimates of the relative 5-year survival for different urological malignancies: for prostate cancer 74%; for testicular cancer 97%; for bladder cancer 69% for men, and 57% for women; for kidney cancer 49% for men, and 47% for women. From a brief glance some of these figures appear quite high: 97% seem like very good odds, and so do 74%. It is perhaps more difficult to judge with 57% or 49% chance of survival, unless it is compared with even less favourable odds: 9% survival rate for oesophageal cancer, 7% for lung cancer, or 3% for pancreatic cancer. As the statistics which help constitute it, the configuration of what can be considered a curable cancer seems contingent too. Testicular cancer, and other urological malignancies, are constituted as curable in a differential relation to other cancers – classified as incurable – for which survival rates are much lower. In the words of Lorna, another urology nurse:

I think it's important for a patient to know the difference between a potentially curable cancer, to inform them that not all cancers, [that] cancer is not just one condition and the outcome is completely different from a cancer cell that creates lung cancer to a cancer cell that finishes up as a prostate cancer.

As illustrated above the distinction between prostate and lung cancer is constituted through a material-semiotic arrangement of particular statistical

measures: cancer survival rates. But other social-material arrangements intersect in Lorna's account too. These include among other the globally circulating popular configurations of lung cancer as an epitome of cancer, as a disease of severe consequence, while taking into account its high mortality rates, painful symptoms, and difficult to bear treatments.⁵ It is to this last issue – of cancer treatments – that we now turn in our attempt to further elucidate the discursivity of cancer and the distributions and exclusions that it brings forth.

(Un)treatable cancers

Let us return briefly to Julie's words proposing a reconfiguration of a diagnosis of superficial bladder cancer as an instance of "good news". One of the constituting elements of this reconfiguration was the categorisation of treatments for this particular disease as non-invasive and easily tolerated, as cases of "surveillance" rather than actual treatments. Or, in the words of Mr Duncan, another urological surgeon:

[superficial bladder cancer patients] will be coming back for regular [check up] and their follow up is ... usually a cystoscopy ... the treatment is relatively mild endoscopic treatment as and when they need it ...

What are these mild, easy and non-invasive procedures, which seem hardly to qualify as treatments? According to an article published in a urology journal:

Currently transurethral resection of bladder tumours (TURBT) represents the treatment of choice for low-grade, low-stage tumours. TURBT is not only a treatment for superficial bladder tumours but is also used for the diagnostic evaluation of most bladder tumours (all stages and grades) ... (Traxer et al. 2004)

As illustrated by this passage (and the accounts of Julie and Mr Duncan), in the case of some forms of bladder cancer a diagnostic evaluation, treatment and follow up care are all effected by the same procedure: transurethral resection of bladder tumour (TURBT). The procedure is usually undertaken with the use of an endoscope, in this case a resectoscope, fitted with different electrodes: a looped cutting electrode for dissecting the tumour, and a ball or bar coagulating electrode ensuring haemostasis. The resectoscope is inserted into a patient's body through the urethra, thus eliminating the need for an external incision. As with many other surgical procedures, it requires anaesthesia, general or spinal, and is associated with a period of hospitalisation, usually no longer than 48 hours. It is also associated with a risk of complications, such as bleeding, infection, and the damage to the bladder (Traxer et al. 2004). In many cases TURBT is followed by a course of chemotherapy administered directly to the bladder (NICE 2002). In many cases it is repeated to treat the recurring tumours, often on a regular basis for a prolonged period of time (Avritscher et al. 2006).

As made obvious by this short description, the seemingly mild character of the treatment for superficial bladder tumours is constituted not only through the particularities of its procedure, but also, and perhaps more importantly, in a relation to other, more invasive, regimens routinely used to treat other types of cancer (including advanced stages of bladder cancer): open radical surgery, radiotherapy or chemotherapy. This is a relation both of contrast, and of gradation. As a series of endoscopic treatments is figured as less invasive than one major surgery, a radical surgical treatment is in turn figured as easier to tolerate than a course of radiotherapy or chemotherapy. To quote Andrew, as he

reflects on his two cancer treatments: a recent one, for localised prostate cancer, and an earlier one, for colorectal cancer:

... it's the second time in six years, I've been lucky on both occasions, I mean I've had two cancer operations, I've never had a bit of radiotherapy, chemotherapy, it's just been a case of cut the cancer out but that's because it's been caught early, so I've been fortunate twice.

And later on:

But radiotherapy is something, having seen my mother go through it, so it's not something I would have been looking forward to in any shape or form.

Andrew considers himself as fortunate; he might have been diagnosed with cancer twice in the past six years, but on both occasions his cancer had been caught early: early enough to be treated with surgery, and also, implicitly, early enough to be considered curable. Andrew's good fortune of having his cancer treated with surgery, and the related interpretation of surgery as a more effective and less gruelling treatment, is once again constituted in relation to particular arrangements, both local and specific, and global-general. Firstly, they are bound to a particular understanding of surgery as a treatment able to "cut the cancer out" and therefore to truly eradicate it. Secondly, they are grounded in Andrew's memories of a radiological treatment received by his mother for breast cancer several years earlier, a treatment that was both difficult to tolerate and unsuccessful. Finally, they intersect with certain globally circulating notions of cancer treatments – particularly radiotherapy and chemotherapy – as brutal, counter-intuitive, often "worse than the disease" (Sontag 1979:64). In these global configurations the severe side effects of these treatments (nausea, hair

loss, scarring), and their sometimes uncertain results, are connected with some broader concerns, such as the threat of nuclear energy.

Chemotherapy and radiotherapy evoke a further sense of dread. The vomiting, the hair loss, the burns. ... Why submit yourself to radiation, which our collective memories associate with destruction – or even with more cancer? The stories of radiation in the postwar period involve the production of cancer, not its extinction. (Stacey 1997: 73)

It is in relation to these and similar configurations that some urological malignancies, by the virtue of their seemingly mild, non-invasive treatments, are figured as easily treatable but also, at the same time, as relatively benign. In the next section we turn our attention to the issue of the apparent non-aggressiveness of certain cancers, and to these social-material arrangements through which some cancers are configured as indolent and slow growing, and other cancers as high-risk or aggressive.

(Non)aggressive cancers

Let us return to Mr Mitchell, as he speaks about the specificity of prostate cancer as a potentially nonfatal disease:

I don't think people understand, for example, that prostate cancer, for a lot of them, it is a slow growing disease and they may not die of it, that they may die of something else...

Mr Mitchell's words intersect with the current medical understanding of what constitutes the "natural history" of prostate cancer, particularly at its early, localised stage:

In most patients, early stage PCa [prostate cancer] exhibits a relatively nonaggressive course during the first 15 years of diagnosis. (Crawford 2009: 9)

This widespread understanding figures prostate cancer as a largely nonaggressive, indolent disease which often remains asymptomatic over an extended period of years (Crawford 2009; Johansson et al. 2004). It also figures prostate cancer as a disease of older men, with over 75% of new cases diagnosed in men over the age of 65, and the highest incidence noted in men between the age of 75 and 79.⁶ In these older men prostate cancer may well be a disease one dies with rather than of. This expectation that the cancer will remain indolent and nonfatal is premised largely on the assessment of a patient's life expectancy.

...our data indicate that the probability of progression to a more aggressive and lethal phenotype may increase after long-term follow-up [over 15 years post diagnosis] of prostate cancers that are diagnosed at an early stage and initially left without treatment. These findings argue for early radical treatment of patients with long life expectancy. (Johansson et al. 2004: 2718)

For patients with life expectancy estimated as higher than 15 years, that is, for younger and healthier men, prostate cancer may not remain benign and slow growing, but, instead, it may turn into an aggressive and potentially fatal condition. The configuration of prostate cancer as a relatively nonaggressive disease is thus achieved through the differentiation between, on the one hand, its apparent indolence in older men and, on the other, its much greater threat to

younger men. The notion of cancer risk groups and the related concepts of the staging of disease are also implicated in this process.

The NICE guideline presents the following stratification of risk groups in localised prostate cancer:

Several factors have been shown to predict the risk of recurrence after treatment of localised prostate cancer. These include the Gleason score, the serum PSA level, and the T-stage. These predictive factors have been used to classify localised prostate cancer into risk groups, specifically:

- *Low-risk - PSA < 10 ng/ml and Gleason score \leq 6, and clinical stage T1-T2a*
- *Intermediate-risk - PSA 10-20 ng/ml, or Gleason score 7, or clinical stage T2b or T2c*
- *High-risk - PSA > 20 ng/ml, or Gleason score 8-10, or clinical stage T3-T4 (NICE 2008: 23)*

Several things are being coordinated to configure the different risk categories for cancer. Firstly, there are the results of biochemical tests measuring the level of prostate specific antigen (PSA) in the blood. Secondly, there are the results of histologic analyses assessing the level of cell differentiation on the Gleason scale (which constitute the pathologic staging of cancer). Finally, there are the results of clinical examination establishing the size and possible spread of cancer beyond the prostate gland (which constitute the clinical staging of cancer).

These different results are configured through different practices in the clinic (taking blood or tissue samples, performing a digital rectal examination), and in the laboratory (performing biochemical or microscopic analysis), and in relation to different objects or apparatuses (an ultrasound probe and a biopsy needle, a

doctor's finger, a microscope, an immunometric assay kit). And they are instrumental in the crafting of different concepts of cancer: as presence of particular serum biomarkers detected through biochemical tests; as particular patterns of cell differentiation visible under the microscope; as presence of a mass noticeable to the touch.⁷ The different arrangements of clinical and scientific practices and apparatuses, and the different concepts of disease they help constitute, become coordinated in the stratification of cancer patients into low-, intermediate-, and high-risk categories.

The staging of cancer and the allocation of patients into different risk categories are thus mutually entangled and implicated in the configuring of some cancers as low-risk and therefore relatively benign and other cancers as high-risk or aggressive, or – to use a metaphor popular among urologists and prostate cancer patients⁸ – as “pussycats” or “tigers”.

Mr Swift [urological surgeon] explains again [that] surgery and radiotherapy options are meant to cure the cancer if they believe that it is aggressive. But not all cancers are aggressive, some of them just linger. The first option – to watch it – would help to determine what type of cancer it is. Frank [who had just been given the diagnosis of prostate cancer] exclaims that Mr Swift is the expert and asks him what to do. Mr Swift replies that they can watch it for a while and make PSA tests. If there is any sign of PSA going up they can go for an active treatment. But at least it will let them know if it is a tiger or a pussycat.

In this metaphor, low- and high-risk categories of prostate cancer are figured respectively as a harmless pet and as a dangerous beast, but also as two of a kind, two contrasting specimens of the same animal: one tame and easily

managed, the other wild and uncontrollable. The framing of the metaphor within the consultation between Mr Swift and Frank indicates, however, that the nature of the beast, the aggressiveness of cancer, is far from certain, but is in the process of being determined in relation to particular tests, procedures and protocols. The differentiation between the apparent majority of indolent and nonaggressive cancers and the seemingly less common cases of high-risk and aggressive cancers seems therefore contingent: in the uncertainty of its prognostic potential, and in its reliance on particular social-material arrangements which link metaphors, prognostic models and treatment regimens with the broader "natural history" of prostate cancer. In the final part of this essay we turn our attention to the consequences of this and other earlier discussed configurations of cancer, to the particular distributions and exclusions they help materialise, and to the specific claims about the professional and institutional identity of urological cancer services they make possible.

Privileged identity of urological cancer services

Cancer survival rates, treatment regimens, staging classifications and metaphors are just a few of the many material-conceptual arrangements contributing to the different configurations of urological cancers. These configurations operate and are materialised across a set of differential relationships: between cancers that are curable or those that are deemed incurable, between cancers that are easily treatable and those associated with difficult treatments of uncertain success, between cancers that are relatively benign or those that are considered aggressive. In the everyday work of urological cancer services in CRI these different configurations are mobilised in making certain claims about the distinct identity of these services as treating predominantly the more curable, treatable

or benign cases of cancer, in other words, “good” cancers. To quote Peter, a urology nurse:

...a lot of patients when they hear the word “cancer” probably think they’re going to be dead within either a few months or a year or two, and a lot of the cancers that we deal with in this department that is not the case. Unfortunately it is for some but [for] a lot that’s not the case...

In this account, no longer referencing particular types of cancer (prostate, testes, or bladder) but rather an unspecified group of cancers dealt with in the department of urology, urological cancers are figured as one category, seemingly distinctive from any other malignancies. In this interpretive move the conditions which often differ in their aetiology and treatments, and in the way they affect people’s embodied experience, are rendered singular, their multiplicity effaced (Law 2002; Mol 2002). This reconfiguration is made even more evident in Lorna’s account, which makes an explicit use of an overarching category of “urological cancers” and mobilises it to emphasise a “privileged position” of urological cancer services:

...part of our job is the reassurance that they’re not going to die. Now we obviously can’t a hundred percent give them that and we’re in a very privileged position in urological cancers because eighty percent of our cases are probably curative intent so I think to me that’s a reassurance.

Certainly, Lorna and Peter’s configuration of urological cancers, and urological cancer services, intersects with the everyday practicalities of clinical work in the department of urology, where the early, curable stages of prostate cancer and bladder cancer form a major part of the cancer-related clinical workload.

Localised prostate cancer and superficial bladder cancer may well account for

many of the “eighty percent of cases with curative intent” that urology professionals encounter in their daily work. However, by figuring urological cancers as largely “good” cancers, and urological cancer services as “privileged” and unique in treating them, this configuration helps effect a particular exclusion. In this process, the cases of “bad” cancer (those deemed as aggressive, or incurable, or associated with difficult treatments) are marginalised, their presence – as an antithesis to “good” cancers – both materialised and rendered invisible. In clinical practice there are no certainties, no “hundred percent” guarantees, and in some cases the diagnosis of a urological cancer is still linked to a limited life expectancy, and to unpleasant, invasive treatments. But, in the discourses which configure urological cancers as curable, easily treatable and benign, and their diagnosis as an instance of “good news”, patients with rare, incurable and difficult to manage illness seem to be granted little space. The distinctive identity of urological cancer services is thus constituted through the omission or silencing of those cancers which do not fit with the image of “good” cancer. It is also configured through the specific organisation of those services on the intersection between different clinical departments and specialities, particularly urology and oncology.

All patients with urological cancer – both new and existing – should be managed by appropriate MDTs [multi-disciplinary teams]. Documented clinical policies for referral and treatment should be agreed between cancer leads in primary care and lead clinicians representing urological, oncology and palliative care services. (NICE 2002: 25)

As illustrated by the above passage, the care for patients with urological cancers is coordinated across different clinical teams, and this process requires specific policies, written down (documented) and agreed on by their representatives. In

this emphasis on the procedures of coordination, the authors of the guideline seem to be highlighting the inter-speciality differences between urologists and oncologists, and between primary care and palliative care professionals. These differences are constituted, among other things, through the commitment of different specialists to particular treatment regimens.⁹ In the words of Mr Swift:

...being a surgeon it may be that my bias may be towards surgery, allocating surgery as opposed to radiotherapy, for example; as opposed to the same patient going to an oncologist, a radiation oncologist, their bias might well be towards radiotherapy...

The clinical collaboration and coordination across different departments and specialities, epitomised in the weekly MDT meetings, is thus enacted in close relation to intra-professional boundaries (Martin et al. 2009; Powell and Davies 2012; Serra 2010). The configuration of urological cancers as largely “good” cancers is implicated in this process. To quote Dr Adams, a radiation oncologist:

... with urological cancers there are far fewer problems that there are with some of the other malignancies that I deal with. Patients ... tend to be relatively informed ... and also to have expectations that tend to be very realistic. ... [I]f you contrast it with the other major workload that I have which is with lung cancer patients: most lung cancer patients will only have known their diagnosis for sometimes a few hours or maybe a few days before they meet with an oncologist and many times the news that they're going to get is not good news. ... [This] makes it [treating patients with prostate cancer] in many ways a more rewarding, pleasurable area than some of the more difficult bits of oncology that I do.

In this account cancer is once again configured across a number of differential relations. In intra-action with lung cancer as an ultimate instance of “bad news”, urological cancers – in the singularity of their unified category and in the particularity of the prostate cancer exemplar – are figured as treatable and nonfatal. Those affected by these cancers are, in turn, characterised as resilient patients whose emotions and expectations can be successfully managed, thus leading to a more “rewarding” clinical interaction.¹⁰ Figuring the care of urological cancer patients as less challenging than other “more difficult bits of oncology”, the remarks of Dr Adams help materialise another type of exclusion, this time in relation to intra-professional differences. As oncology emerges as a clinical discipline dealing primarily with problematic and unpleasant cases, with “bad” cancers, urological cancer services are cast again as distinct from other cancer services.

CONCLUSION

In this essay we have explored the way in which a set of particular discourses, embedded in the everyday clinical work of urological cancer services in a large teaching hospital in UK, helps materialise particular configurations of cancer, and the related professional and institutional identities. Emerging on the intersection of specific social-material arrangements (cancer survival rates, treatment regimens, cancer staging classifications, metaphors, clinical specialities), and operating across a number of differential relations (curable/incurable, treatable/untreatable, aggressive/nonaggressive), these configurations help constitute the categories of “good” and “bad” cancers as separate and contrasting entities. Involved in materialising particular distributions of power (between the majority of “good” urological cancer and the minority of “bad”

cases; between urological cancer services and the “more difficult bits of oncology”), these categories are implicated in the making of specific claims about the identity of urological cancer services as unique and privileged in treating predominantly the cases of curable, easily treatable and relatively benign cancers.

These specific configurations of cancer emerge from and are materially and semiotically constituted through a specific and located set of practices and arrangements (such as concrete clinical interactions or distinctive organisations of services). As such they can be considered “local” and “particular”. However, as we have demonstrated, these specific configurations are also inextricably entangled with broader, widely circulating arrangements (such as clinical protocols or statistical measures), and can therefore – to a certain extent – also be considered “global”.¹¹

Exploring these global-local configurations of cancer, and the concrete practices and apparatuses through which they are constituted, this essay contributes to the broader sociological debate concerning the discursive performativity of cancer. Drawing on the feminist and material-semiotic approaches to studying science, technology and medicine, it seeks to move away from the understanding of cancer discourses as primarily linguistic performances seemingly separated from the “biological” forms of the disease. Instead, it proposes more relational readings of the discursivity of cancer which – in Barad’s words (2003) – interpret “discursive practices ... not [as] human-based activities but rather specific material (re)configurings of the world through which local determinations of boundaries, properties, and meanings are differentially enacted” (828). As we have demonstrated, the categories of “good” and “bad” cancers, and distinct professional and institutional identities they help to

materialise, are not wilful inventions of urology doctors and nurses working in CRI, neither are they simple reflections of the “biological form”, or “natural history” of different urological cancers. Instead, they emerge from and are constituted through an array of social-material arrangements and practices which involve both human and non-human participants.

NOTES

- (1) We have replaced the names of all persons and places with pseudonyms.
- (2) The reading of the concept of “discourse” that we propose here draws on writings of different authors subscribing to the broad tradition of material semiotics (Barad 2003, Bowker and Star 1999, Castañeda 2002, Latour and Woolgar 1979, Law 2002, Mol 2002, Suchman 2007).
- (3) As we will illustrate below, diagnostic tools are also essential in this process. See also: Bell (2013), Bell and Kazanjian (2011).
- (4) In addition, as noted by Jain (2007), these population-based prognostic measures are highly problematic when looked at from the perspective of individual patients: “...the statistical prognosis poses both a stunningly specific (one has x percent chance of being alive in five years) and bloodlessly vague (you, yourself, will either be dead or alive) fact about the future” (78).
- (5) Chapple et al. (2004) discuss this configuration of lung cancer drawing particular attention to the stigma of this disease as a “self-inflicted injury” constituted through its association with smoking.
- (6) <http://www.cancerresearchuk.org/cancer-info/cancerstats/types/prostate/incidence/#age>

- (7) Bowker and Star (1999) make similar observation in the context of different classifications of cancer in ICD.
- (8) For other examples of the use of these metaphors see: Evans et al. (2007).
- (9) For instance, Broom (2005) speaks about the competition and conflict between urologists and oncologists in the context of prostate cancer treatments.
- (10) Willing (2011) talks about the figure of "resilient patient" as linked to another globally circulating configuration of cancer, the one she describes as "the imperative to 'think positively'".
- (11) Where – as indicated by Castañeda (2002) – global is always already located and particular.

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