Chapter 11
The View from Here and There: Objectivity and the Rhetoric of Breast Cancer

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> *After a tumor, the world looks much more huggable.*
> Nicholas Kristof[1]

This paper is, in part, a metapaper—about two research papers and two researchers. One of the original papers ("Breast Cancer Narratives . . . ") was published in the journal, *Linguistics and the Human Sciences*, in 2007, and the other ("Cancer Experience and Its Narration . . . .") appeared in 2012 in *Literature and Medicine*. Both of the authors/researchers are me. The object of study in each case is the breast-cancer narrative, especially its public function. In 2007, I wrote about publically-rehearsed and widely-circulating cancer narratives of battle, triumph, and survival as instances of an overdetermined genre with a questionable public function. The second paper is more empirical than the first (which was more theoretical); it takes up the written responses of people with cancer, and people close to them, to that same widely-circulating story. Between the writing of the first paper and the writing of the second—in December 2009—I was diagnosed with breast cancer, and my position for any future papers on breast cancer necessarily changed.

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[1] In a personal op-ed in the Sunday *New York Times*, columnist Nicholas Kristof (2010) explained that "the world looks more huggable after you have a tumor"—or, actually, in his case, that it looks more huggable after you think you have cancer (but actually do not have it). Some *New York Times* readers might have objected to Kristof attaching himself to a narrative of survivorship when what he had was a cancer *scare*, and not cancer. That is, perhaps having cancer does change one's outlook on the world—that change is, in part, what my chapter is about—but does significant change come also from spending a month thinking you might have cancer? More likely, the appreciation following that experience is like the appreciation you have of running water after you've been camping for a week: it's real appreciation, but it seldom lasts past your first couple of showers. Kristof's huggability claim exemplifies the tone of public discourse about cancer, and the difficulty, in part because of that tone, of subjecting the personal cancer narrative to any unblinking critique. Kristof: "A brush with mortality turns out to be the best way to appreciate how blue the sky is, how sensuous grass feels underfoot, how melodious kids' voices are" (n.p.).

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What I will explore in this essay is the shift in my authorial position as I went from being one sort of researcher—if not exactly objective, then at least unencumbered by a recognizably contaminating identity—to another. This second position, I wish to argue, is not best called "subjective." In fact, it aspires to a "stronger" objectivity: a nearer view, with standpoint. The title of my essay is a play on Thomas Nagel's (1986) "view from nowhere"; my guide for thinking about objectivity in my own case is standpoint theory, and Sandra Harding's (2002) claim that, "in a certain range of cases, maximizing neutrality is an obstacle to maximizing objectivity" (341).

Before my diagnosis, I observed cancer from a respectable distance. After my diagnosis, my position close to, but outside of, the cancer establishment (a world co-constituted by research scientists, physicians, other health professionals, fundraisers, and the most vocal—and sometimes distressingly univocal—cancer narrators), makes me an epistemic outsider, possibly with (quoting Harding again) "a critical edge for generating theoretically and empirically more accurate and comprehensive accounts" (348): more accurate and more comprehensive than accounts rendered under the objectivity more typically associated with distance and disinterestedness. This is not to suggest a person has to have breast cancer in order to write about it. I do not believe this is the case, although, as I will note, a lot of people who write about cancer have/had it, and cancer cred is not nothing in the literature of cancer scholarship. It is only to suggest that my shift from not having cancer to having it is not, at the same time, a shift from objectivity to subjectivity.[2]

Notwithstanding that my second paper is more data-based and observational than my first—the second one documents the unmediated accounts of people who have dealt with or are dealing with cancer—it is irretrievably rooted in my own experience as a cancer patient, while my first paper was, in a word, academic. My purpose, in contrasting my two ventures as an author about cancer, is not only to indicate some of the problematics of an objective/subjective divide, but also to argue for a Science-and-Technology-Studies (including a Critical-Medicine-Studies [see Chambers 2009; Paul 2009]) approach to patient narratives. An STS approach, for example, would be in contrast to much of the current treatment of patient narratives in bioethics, medical humanities, and, increasingly, medicine. Over the years since cancer experience became a topic of public attention (with the publication of Betty

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[2] In *AIDS and its Metaphors* (1990), Susan Sontag wrote the following about the writing of *Illness as Metaphor* (1978):

> I didn't think it would be useful and I wanted to be useful—to tell yet one more story in the first person of how someone learned that she or he had cancer, wept, struggled, was comforted, suffered, took courage … though mine was also that story. A narrative, it seemed to me, would be less useful than an idea. (101)

My own essay strives to be more idea than narrative, although it will sound like a narrative at times. It is not meant to be about me, except as I now occupy the space vacated by another researcher: the previous me.

Rollin's *First You Cry* in 1976, following the public presentation in 1974 of Betty Ford as a person who had undergone a mastectomy—and following Edith Bunker's breast-cancer scare in a 1973 episode of *All in the Family*), patient narratives have become precious objects, on the idea that they are, each of them, subjective ("personal") accounts, worthy of, as narrative-medicine specialist Rita Charon (2006) argues, being "honoured." I will suggest that illness narratives themselves are not simply subjective, just as accounts of apparently disinterested cancer researchers and clinicians are not simply objective. Illness narratives, in fact, are authored in part by scientific and institutional forces that are rendered invisible in narration; personal accounts may include medical ventriloquism. The sort of attention we ought to pay to illness narratives is, in part, for that reason, *critical* attention. Yet stories tend to end conversations rather than continue them: "This happened to me" often signals the beginning of the final turn in a conversation. That personal narratives occupy this privileged conversational space means a lost opportunity for getting things right. A disciplinary corrective may be found in STS.

My first breast-cancer essay began as a paper for a genre-theory conference. When the call for proposals came for that conference, I had been reading Londa Schiebinger and Robert Proctor (2005) on "agnotology": the production and maintenance of ignorance. Schiebinger and Proctor had said that we deploy the resources of research and scholarship to investigate how we know what we know—epistemology—but we do not marshal the same resources to investigate how, and why, we don't know what we don't know: agnotology.[3] The argument of my paper was that genre itself, when we understand it as recurring textual form for routine social action,[4] can be a technology of ignorance; moreover, in the case of the standard breast-cancer narrative, that is what it is. My revised paper appeared in a special issue on genre of *Linguistics and the Human Sciences*.[5] Despite the title of the journal, I make no claims about the paper's scientific nature. It was a humanities essay with a theoretical framework, and more procedural competence (in rhetorical analysis) than structured methodology.[6] However, I had assembled the literature, cited the authorities, made new claims and offered evidence for them, and drew conclusions that followed logically along. The paper was a credible report on research. Where objectivity is a scholarly stance, implying some remove from the object of study, neutral and disinterested except for a stated theoretical perspective, the paper was objective enough.

In fact, a critique levelled at my paper—and not by peer reviewers, in readers' reports, but by two acquaintances with breast cancer, in conversation—was that it was too removed and disinterested; that is, I had written a paper about narrating the

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[3] I have since learned from Ian Hacking (in conversation) that the more common term for the study of ignorance is *agniology*, so named in the nineteenth century. My thanks to Professor Hacking.

[4] The most oft-cited source on this understanding of genre is Carolyn Miller (1984).

[5] The special issue was guest-edited by Débora Figueiredo, Charles Bazerman, and Adair Bonini.

[6] On rhetorical analysis as a methodology, see the Introduction to my *Health and the Rhetoric of Medicine* (Segal 2005).

breast-cancer experience without having had the breast-cancer experience.[7] Indeed, a search of the social-science and humanities scholarship on cancer will reveal that a great deal of it is produced by authors who have had cancer themselves (see, for example, Batt [1994]; Bryson [2010]; Ehrenreich [2001]; Herndl [2006]; Jain [2007]; Orenstein [2013]; Sedgwick [1994]; Sontag [1978]; Stacey [1997]). I was not one of those scholars, and, according to my breast-cancer-experienced critics, that was a liability for me as an author on cancer. In fact, in breast-cancer scholarship, more than in other areas of scholarship, questions of authorial objectivity are subordinated to questions of authorial knowledge, and knowledge is understood as lived knowledge.[8] Objectivity and its correlative distance will offer, the argument seems to go, less than you need to know. I would argue that personal experience does not *de facto* destroy objectivity.

I will say something briefly about the object itself of my inquiry: the breast-cancer narrative. A typical breast-cancer story begins at the moment of the discovery of a lump in the breast or an irregularity on a mammogram; it does not, although it might, begin, for example, at the moment of moving next door to a chemical plant or taking a job at a drycleaner. It proceeds through the anxiety of diagnosis, the challenges of treatment, and the triumph of survival.[9] The narrative, we know, is typically, as Sontag (1978) importantly explained, on the metaphor of battle.[10] The narrator of the story is ennobled by what is often called, though now the metaphors

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[7] While, as I have said, I do not believe that authors must experience what they write about, I did wonder then, faced with this critique, whether, if I were ever diagnosed with breast cancer, I would go to bed as myself and wake up as someone with a sudden taste for pink t-shirts and group runs. That didn't happen. My critics were right that breast cancer would reveal itself to me differently once I became a character in a breast-cancer story. They were wrong, however, about the sorts of things that would change with diagnosis. Both my critics, for example, had said that, as a breast-cancer patient, one is so grateful for breast-cancer fundraising that one is not appalled by pink merchandising. That turned out not to be the case for me.

[8] Moreover, books about cancer are frequently reviewed by reviewers who have/had cancer, and who foreground their own experience in the review. See, for example, Sarah Harvey's (2006) review of Marisa Acocella Marchetto's *Cancer Vixen*—or Adam Baer's (2011) hybrid personal narrative/book review of Siddhartha Mukherjee's *Emperor of all Maladies*. Even cancer television is reviewed by reviewers who have/had cancer. See, for example, reviews of Showtime's *The Big C* by Jenni Murray (2010) and Deborah Orr (2010), each review referencing the author's personal cancer experience. (Murray's byline includes, "Journalist and broadcaster who was diagnosed with breast cancer in 2006.")

[9] "Survival" itself is a contested term—not only ideologically (what does the term connote?) but also empirically (when does survivorship begin?). While, in some accounts, survivorship begins when a person, having been diagnosed, is 5-years cancer-free, in others, it begins with completion of treatment; in still others, survivorship begins from the moment of diagnosis. For discussions of survival, see Mullen (1985) and Rowland (2008).

[10] Despite critiques of the battle metaphor for cancer—and for medicine more generally (see, e.g. Fuks [2011])—the metaphor persists, and seems even to have become more aggressive. In a recent advertisement in the *New York Times Magazine*, North Shore-LIJ [Long Island Jewish] Hospital Cancer Institute promises to marshal "a relentless army of doctors": "Isolate. Attack. Overwhelm. Together, it's what we do to cancer" (North Shore-LIJ 2013).

are a bit mixed, her "journey" (see Silcoff [2011]). She has, in the end, a deeper understanding of all things, especially herself—and she has, reportedly, a better life than she had before. The standard story includes the sentiment and, more often than one might expect, the actual sentence, "Cancer is best thing that ever happened to me."[11] In my genre essay, I argued that features of the standard breast-cancer narrative are so conventionalized, the stories so pre-scribed, that the genre writes the story. Then, every person diagnosed with breast cancer has to contend with this narrated set of values in the performance of her own illness, one way or another. The agnotology thesis is that the generic story suppresses not only other cancer stories (like environmental or population-health stories) but also other genres (like genres of protest) in which cancer might be told.

My later breast-cancer-narratives paper (2012) began as a talk for an interdisciplinary social-science and humanities workshop on "critically interrogating cancer survivorship."[12] The paper is, for the most part, a report on how people with cancer, and people who care(d) for and about people with cancer, respond to the conventionalized story of battle, triumph, and survivorship I had written about before. The paper is an "accidental" study, as I will explain. It is, more to the point, inescapably written by a person who has/had cancer. For the same reasons that some readers may find my second paper less persuasive than my first (any distance I had in relation to breast cancer is gone), some may find it more persuasive (I have knowledge that was not available to me before).

Here is how the second paper came to be. Early in 2010, shortly after my lumpectomy and before the start of my radiation treatments, I set out to meet a commitment I had made, some months before, to write a topical op-ed for the *Vancouver Sun*, one of the two mainstream daily newspapers in the city where I live. I did not plan to write about cancer; in fact, my proposal and initial drafts

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[11] For example, a set of personal narratives appears in the breast-cancer-survivor magazine, *Beyond*, under the heading, "Cancer is one of the best things that ever happened to me" (2007). This excerpt is from a story called, "Curly Hair and Other Gifts Cancer Gave Me":

> Just before my diagnosis, my husband and I decided to try for a third child. Instead of getting pregnant, I got cancer. A cruel trade, I thought at the time, but now ... I think perhaps I was not meant to conceive a child at that moment .... Another baby might have sent me over the edge. Cancer was a blessing in disguise. ... Also, I have always wanted curly hair. ... Cancer inspires me. I've been given a wake-up call that many people will never receive [and] I am happy to simply be alive. (Donaldson 2007, 26)

For a recent illustration of cancer-discourse tone, see Silcoff (2011). The subject of her "Every Cancer Has a Silver Lining" is "wellness warrior" and "cancer entrepreneur," Kris Carr, maker of the film, *Crazy Sexy Cancer*, and author of its associated books.

[12] The workshop, "Critically Interrogating Cancer Survivorship: Social Science and Humanities Perspectives," was held in Vancouver, British Columbia, July 21–22, 2011. The workshop was organized by Kirstin Bell and Svetlana Ristovski-Slijepcevic, with funding by the Canadian Institutes of Health Research, the Social Sciences and Humanities Research Council, and the University of British Columbia. Bell has recently (2014) published an illuminating essay on the "breast-cancerization of cancer survivorship."

were for a short piece on swine flu, much in the news at the time, and health inequities. In the end, however, I did write about cancer, almost as if I couldn't stop myself. I submitted a 700-word essay on the tyrannical nature of the triumphal cancer narrative I had already been thinking a lot about and was now contending with myself as a cancer patient. I called my essay, "Cancer isn't the best thing that ever happened to me" (2010). The *Sun* liked my cancer essay (arguably, for all the wrong reasons; more on that in a moment) and published it on April 1, 2010, to mark the beginning of Cancer Awareness Month. April 1, 2010 happened also to be the first day of my radiation treatments, and so the reader email the op-ed generated arrived at an interesting time for me. My workshop paper, later published in *Literature and Medicine*, took those emails as its data.

Reader email in response to my op-ed was surprising, both in its quantity—I received about 50 direct replies, separate from Letters to the Editor, despite the fact that the article did not include my email address or solicit response—and in its substance: every email, bar none, expressed gratitude and support. Not a single response was the disapproving pink-inflected mail I had convinced myself I should expect.[13] The emails were versions of (I paraphrase), "Thank you for that. I have cancer; I feel nauseated, sad, and terrified, and I'm incredibly sick of pretending this has all been a fabulous, if difficult, experience in personal growth." Following is the text of one email. I include it to illustrate the point I am about to make: that my correspondents were not writing to me as a researcher; they were writing to me as a cancer patient. This email is from Kathleen Beaumont, who has given me permission to use her name:

> I read your article in the Vancouver Sun which resonated with me to the point that I was motivated to write and thank you.
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> Many of the thoughts that you identified have crossed my mind and I have dismissed them because of the disconnect that I have experienced between my personal attitudes towards having had breast cancer and the conventional attitudes that are projected in the media. … I sometimes feel guilty that I'm not out there with the other "survivors" running, walking and singing the praises of the sisterhood. I'm in great physical shape and I could do it, but its not my style and it never will be, yet I'm still left with the feeling that I let someone down or I didn't pay back my debt to society. … I see myself as a person who got sick, very sick, then fought my way through it, then got on with my life. …. Sure there were changes and like you I felt I had been tossed around vigorously. … I can recall the strength that I received from individuals who supported me and I am happy to offer the same back, but the pink club, that bothers me. … Your article gave me affirmation that it was OK to think about my experience in any way I like. Not conforming to the pink code is OK too. Thank you for so eloquently putting some of my deepest thoughts into words. (Personal correspondence, 2010)

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[13] While not comparing myself to Ehrenreich, I could not stop thinking about her. Her well-known *Harper's* essay, "Welcome to Cancerland" (2001), documents the reception of her negative postings about her cancer experience to the Susan G. Komen message board: her postings were met, she said, with "a chorus of rebukes" (50). Letters to the editor of *Harper's* in response to "Cancerland" were no more sympathetic. Even cancer researcher Barron H. Lerner (2002) chastised Ehrenreich: "Although pink ribbons and teddy bears may be infantilizing," he wrote, "many survivors appreciate these touches or at least tolerate them as furthering a worthwhile cause" (4).

I answered each email as it arrived; in some cases, my answers elicited further responses and more narratives that were, in relation to the dominant narrative I had described, counternarratives. (One of my correspondents, a physician with breast cancer, was undergoing radiation treatments exactly when I was, and I wondered if we passed each other anonymously in the radiation waiting rooms of the Cancer Agency before we each went home and wrote to each other.) When, nearly a year later, I was invited to contribute a paper to the "survivorship" workshop, I thought back to the op-ed and the reader response, and I wrote again to my correspondents and requested permission to reproduce their messages for presentation and possible publication. Everyone who received the request consented enthusiastically, and I began to draft the second breast-cancer-narratives paper.

The first thing that my shift in authorial position gave me, then, was access to speakers who might not, in other conditions, have spoken at all. If I had the perceived objectivity of an academic researcher, I would not have this data for the second essay. I am not saying that I could not have written an op-ed about cancer narratives without having cancer; of course, I could have, and readers may have responded to it. However, my self-presentation in the op-ed as a person with cancer was, at least in part, what elicited the particular reader response that I got. My correspondents did not write about their cancer experience simply in reply to my commentary on cancer narratives; they wrote about their experience in reply to my account of my own experience *as a cancer patient*. I did not write the op-ed to collect data—I did not recognize the responses *as* data until long after I had collected them—but I know, from their messages, that the person my correspondents were writing to was, in the first instance, a cancer patient.

Insider credibility is only one, obvious, researcher advantage of surrendering the (putative?) objectivity of the uninvolved. Another advantage of experiential knowledge is the ability to pose new research questions: before I had cancer, I more clearly didn't know what I didn't know. Most importantly, however, as a researcher with cancer, I could discover the *mechanisms* of certain social processes whose existence I had only previously noted or deduced.[14]

For example, there has been, for decades, a field of research, populated mostly by nurses, counsellors, and social workers, aimed at understanding and improving what is called, "the cancer experience." Nevertheless, this is a fact about cancer in public institutions: despite this expert focus, there remains a relatively poor understanding of the experience of cancer patients. In Spring 2010, the cover story of the official magazine of the B(ritish)C(olumbia) Cancer Foundation, *Vim and Vigour*,[15] was,

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[14] For some of the same reasons that we sometimes pluralize "knowledge," we take a special interest in health professionals who have become patients (see, for example, Glouberman [2011] and Klitzman [2008]), and patients who, on particular topics, have become medically expert (see, for example, Montgomery [2006], on breast cancer). In certain situations, it is possible to think about empathy and epistemology together.

[15] The BC Cancer Foundation "raises funds to support research and enhancements to patient care at the BC Cancer Agency." The mandate of the BC Cancer Agency "covers the spectrum of cancer care and research, from prevention and screening to diagnosis, treatment, supportive care,

"High Notes: Singer Diana Krall stays healthy by looking on the bright side." Inside the magazine, the story began, "Even as she faced a terminal illness, Adella Krall [Diana's mother] always saw the good in life. She liked to say that, if her barn ever burned down, it would make it easier to see the beauty of the moon at night" (McCafferty 2010, 28).[16]

I have nothing but respect for Diana Krall's late mother, and others who find strength where she did. I am, however, concerned about others who are ill, who experience a wider range of affective response. When I left the Cancer Agency after my tenth radiation treatment and leafed through the free copy of *Vim and Vigour* I had picked up in the lobby, I was most offended not by the (s)mug shot of Diana Krall (30), but by the advice across the page on how to turn my negative thoughts into positive ones: how to replace, "I never have enough time" with "I can prioritize my commitments"; how to trade in "I look old" for "I look and feel good for my age" (31)—and, implicitly, how to replace, "I feel like total crap and I cry all the time" with "cancer is a wonderful learning experience." I had just lain supine and motionless on a table while a man in his twenties—who thought to tell me, after he'd asked what sort of work I did ("English Professor"), that he had always hated English and done poorly in it—directed a radiation machine at my fully exposed breast. The official Cancer Foundation magazine lacks the understanding that saying "improve your attitude" to cancer patients is not necessarily helpful.[17]

One reason that cancer outreach fails so many cancer patients is that institutional research on the cancer experience is not itself objective—although, claiming a scientific character, it appears at first to be. It is hardly neutral or disinterested. Research and clinical practice at the BC Cancer Agency are informed by the ideology of, for example, the American and Canadian Cancer Societies and the massively-successful fundraiser Susan G. Komen for the Cure. (That foundation claims its position as pro-woman, but not pro-feminist[18]). The ideology of the breast-cancer establishment, as we know from Ehrenreich (2009), Samantha King (2006), and other authors, as well as from the documentary film, *Pink Ribbons Inc.*

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rehabilitation and palliative care" (*Vim and Vigour* masthead). In other words, *Vim and Vigour* is the institutional voice of cancer in British Columbia.

[16] I could cite countless such breezy articles from *Vim and Vigour*. More recent cover stories are headlined, "Breath of Fresh Air: The always perky—and quirky—DIANE KEATON doesn't let asthma slow her down" (Paterik 2013) and "New Hope for Brain Cancer Patients" (Anonymous 2013). (Really? The "new hope" trope—here? The phrase "new hope for" today gets over 80 million hits on Google [July 14, 2014], most pertaining to illness or disease.)

[17] The lack of fit between institutional messages and the needs of cancer patients is well documented (see, for example, Lorde [1980]; Batt [1994]; Ehrenreich [2001; 2009]; Sinding and Gray [2005]). It is also well described by the respondents to my op-ed (Segal [2012]).

[18] In 2012, Nancy Brinker, CEO of Susan G. Komen for the Cure proved this by moving to defund Planned Parenthood, despite the work Planned Parenthood does in making screening mammography available to women who could not otherwise afford it. (The benefits of screening mammography are another topic, and controversial; the point here is that Komen is not pro-feminist and, it seems, not completely pro-woman.) Brinker reversed her position under public pressure.

(Pool and Din 2011), is characterized by positive thinking, free-market fund-raising, and individualism. Breast cancer is constructed as occupying one hapless body at a time, producing one “survivor” at a time. The focus on the individual body prevails even though the story of diagnosis is told about 270,000 times every year in North America. The dominant breast-cancer ideology is also an anti-disabilities ideology: the ideal breast cancer patient does not seek to find common ground with other people who may be ill or weak; rather she seeks to claim the space of a new normal (see also Herndl [2006]). In the standard cancer story, illness and disability are implicitly shameful, while *normal* has been expanded to include women who may be amputated, vomiting, and burned, but are still keen to walk and run and climb for the cure, and, until they can do that, to shop for it. As King (2006) has noted, in the public presentation of cancer, activity replaces activism.

Institutional cancer research is aimed at producing a particular kind of patient: docile, civil, unthreatening, and as easy as possible to live with. As I have been swept up in the social effort to produce that patient, I have learned more about its routines. Moreover, I can see the discursive interplay between the cancer-care establishment and the oft-published stories that so persistently attracted my attention before.

If narrative is a technology of ignorance, it works on the order of a drama. The personal breast-cancer story can be described using the terms of rhetorical theorist Kenneth Burke’s ([1945]1969) *dramatism*, where dramatism suggests a symbolic order and a procedure of analysis in contrast, Burke says, to *scientism*. In dramatism, the resources of ambiguity, resulting from shifts of focus, are exploited, contra objectivity. The key terms of Burke’s dramatism are *act*, *agent*, *agency*, *scene*, and *purpose*. On a dramatistic model, we might say the telling of the breast-cancer story is an act; the story-teller is an agent, but not a free agent. The story itself is an agency or an instrument—of a larger, unarticulated, policy for regulating illness behavior. The story has many purposes: its personal purpose is a proxy for its cultural purpose. Its social purpose is to smooth over difficult things. The act of story-telling takes place on the scene of medicine, the scene of competitive fundraising, and the scene of the self. Burke would have us go on, with new ways to fill the slots created by his pentad.

My cancer places me in the drama and I come to see the means by which the standard story asserts itself. I do not do this on purpose. I learn about the requirements of breast-cancer story-telling the way a child learns language in social interaction: mostly inadvertently. I’m at dinner with a friend, across a table at a restaurant. It’s a month after my surgery and she asks how I am. I begin to complain, but not about the cancer; I complain about all the things I don’t like about being a cancer patient. I say, anyway, I feel neither positive nor embattled; I say it in a way that’s not funny. I see my friend sit back in her chair, just a little. She folds her arms; I change the subject. Next week, different restaurant, different friend; I know what I have to do. In any case, I am a participant in my own research.

In the months between surgery and radiation, my research continues. I am getting cards and emails from old friends, former students, distant family members. I am touched to receive their good wishes (although, frankly, some people say some really scary things to me). In fact, I’m impressed that anyone is speaking to me at all;

I know it’s hard to know what to say. Here is something I start to notice: many of the messages I’m getting are congratulating me for being strong and positive and brave. “I know you are a fighter,” they say. “You can beat this thing.” I begin to find these messages disconcerting—because I am certain I’ve provided no evidence at all of possessing the virtues for which I am being praised.

I begin to think of Aristotle’s classification of rhetorical occasions (as one does). I think especially of epideictic rhetoric. Epideictic rhetoric is, in its prime example, the rhetoric of the funeral oration, or, perhaps, the rhetoric of the Academy Awards. Epideictic speeches are not aimed at a particular course of action; their *raison d’être* is not exhortation and dissuasion but rather praise and blame.

In eulogies, people are praised for embodying community values: they are praised for being generous, for example, and when they are so praised, the value of generosity in the community is not only invoked but also reinscribed. People are seldom *blamed* in eulogies, but blame is established implicitly in respect to values opposite to the ones admired: if it is good to be generous, then it is bad to be miserly. At the Oscars, people are praised for their humility, their pleasure in their work, their ability to be good friends. Speakers typically exhibit the very qualities for which they praise others, making the speech reflexively epideictic.

I stare at my cancer messages. People are not telling me I *should be* strong and positive and brave; they are (ingeniously, really) instead praising me for already being that way. At the same time, they are, implicitly, advising me that it would be disappointing if I were otherwise. If what I was about to say in reply to these messages was that I was exhausted and afraid, I think again; I really should stifle that. I write back and say, “I’m fine. … The pathology report was great. I’m not teaching, but I’m still advising graduate students. I’m looking forward to the radiation starting so that it can finish.” I write many of these messages. I’m not lying, but I’m not telling the truth either. The possibilities for the exhibition of me were narrowed with every message that praised me already for being brave and positive. These are the mechanisms by which the standard story comes to dominance: a conversational partner folds her arms; a well-wisher confers approval pre-emptively.

In my first breast-cancer-narratives essay, I had written that the generic cancer narrative, with its gospel of positivity, was coercive, that it made it harder for people with cancer to report honestly on their experience. My research had been both theoretical and observational and my essay included a discussion of the public reception of unconventional narrators.

Both Ehrenreich (2001, 2009) and King (2008) had noted that breast-cancer discussion groups and internet message boards exert a conservative influence on breast-cancer discourse, with many web sites discouraging contributors from raising questions about environmental carcinogens and pharmaceutical-company profits. That conservative force, I discovered, was evident elsewhere as well. In 2006, Canadian broadcast journalist Wendy Mesley went public with a cancer story that was jarring to an audience primed for a pinker story. Mesley’s television documentary, *Chasing the Cancer Answer*, was rooted in her own breast-cancer experience, but it was not a survivor’s inspirational tale; it was an account of what we know and do not know about the causes of cancer in populations. The day after the documentary ran, *Globe and Mail* columnist Margaret Wente (2006) accused Mesley of "drive-by" journalism, calling the documentary, "stunningly simplistic," "full of misleading information and fear mongering" (A17). Physicians for a Smoke-Free Canada (Collishaw 2006) was quick to publish an open letter to Mesley, accusing her of telling only part of the cancer story.[19]

My essay documented a further example of narrative regulation in the public realm, this one from personal experience: One afternoon in 2007, I was listening to and recording a radio phone-in show (CFUN Vancouver) on the topic of breast cancer. I heard a caller, who self-identified as a "survivor," say this to a fawning host: "I just kept the image of my kids in front of me and refused to die." The host praised her lavishly for her personal triumph over cancer, and I found myself moved to contribute to the conversation. I did not phone the program, but I sent an email to the host, still on air, to say that I was concerned about the implication that women who had died of breast cancer had just not tried hard enough, had not loved their children enough to save their own lives. The host emailed me back in a commercial break. "I wish you had phoned the show," she wrote. "Then we might have helped you have a better attitude."

In my first essay, I displayed examples of the public reception of the renegade cancer story and leavened these with various things I had learned about narrative regulation. More of a sense of how things worked was obscured, however, until I was diagnosed, and those cards and emails came, and I saw that I was being formed in the image of one of those "survivors" who believes we can put the picture of our children in front of us, and refuse to die; I was being formed in the image of someone I hated.

In March of 2010, when I wrote to the *Vancouver Sun* Arts editor to describe the cancer op-ed I wanted to write (in lieu of the swine-flu one), she wrote back immediately to say that the newspaper would publish it. In in-house correspondence forwarded to me later, she had said to another editor, "Judy's story is beautiful and amazing." Of course, my story was exactly neither of those things: it was a complaint against the very idea that cancer stories should *be* beautiful and amazing—but the liaison in people's minds between breast cancer and a particular narrative aesthetic is strong. The connection is nearly impossible to loosen, and difficult, really, even to see: A 26-year-old woman (Elizabeth Sarah Barry) dies of lymphoma; her father (Barry [2010]) writes a "Lives Lived" column (an extended obituary/eulogy) in Canada's national newspaper, the *Globe and Mail*. He says his daughter wanted her cancer journals to be published, and that publication had begun at *blogspot.com*: "Elizabeth's thoughts," he wrote, "were that we as a society read

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[19] The response might seem a curious one to what was really just investigative journalism. I believe Mesley inspired such ire for two reasons: first, she did, in the documentary, directly challenge the Canadian Cancer Society, an agency that is seen by many to be sacrosanct; second, she jumped genres. Here was a national celebrity (Mesley) who was known to have had breast cancer. Members of the viewing audience expecting to be treated to a personal narrative were jolted by a different sort of report—not about Mesley's own cancer experience but about carcinogens and the public policies that keep them in our midst.

and hear of so many ‘feel good’ stories about cancer survivors, but we need to realize there are many more stories that do not have positive endings. She believed that we can lose sensitivity to the fact that cancer is so personal, and so very devastating.” But Elizabeth’s father is clearly unaware of the contradiction of that sentiment with this one in his own eulogy: “When [Elizabeth] was diagnosed with lymphoma in January, 2009, she remained positive. She would always respond to the question, “How are you doing?” by saying, “I’m doing great.” This when she had spent days vomiting, or was struggling to breathe.” (L6) Why in the world did Elizabeth respond that way? Why, *given the terms of her own journals*, was it praiseworthy that she did?

My cancer experience was not immune to this cancer aesthetic either; it included a set of virtues I had internalized against my will. I had written critical papers; I had pilloried the standard story; I had called it “the standard story”! Yet, one night in the course of my treatment, I said to my partner, “I think I would be prouder of myself if I didn’t still go to sleep crying sometimes—if I muscled through, if I never missed a deadline because I was tired.” That is, in spite of everything I knew and had said and had written, I had expectations of myself—preferences, certainly: in the face of illness, it is better to be strong than weak; coherent than chaotic; hopeful than despairing; angry than sad. It is better to resist than to rest. When the graphic novel *Cancer Vixen* appeared in 2006—an attractive and successful book about an attractive and successful woman with breast cancer—the Breast Cancer Research Foundation reviewed it, saying, “We salute women like [Marisa Marchetto, the author], who not only have the courage to battle breast cancer, but are able to do it with … unflagging optimism, creativity, and humour.” The moral and aesthetic values of the review (let alone of the book) are almost impossible not to absorb.

How does all this add up for Objectivity?

As Miriam Solomon (2008) has argued, medical knowledge does not divide neatly or hierarchically into science/evidence-based medicine on the one hand and narrative/experiential knowledge on the other. The problem of epistemic authority is not solved, in any case, if we say that there are complementary knowledges: doctors know about disease, and patients know about illness; doctors are expert in diagnosis and treatment and patients are experts in their own experience. (That is the principle on which much of narrative medicine is based: patients have a special sort of knowledge and good doctors know how to listen to what patients have to say.) Solomon queries and complicates the science/art binary in medicine, saying, among other things, that proponents of narrative medicine ought not claim for narrative a special epistemic status and moral authority over science. I have Solomon in mind when I say that I did not, with my cancer diagnosis, slide from having one sort of knowledge to having another, along an objective/subjective axis. Such an axis is too complicated to exist anyway.

In much of current bioethics, medical humanities, and medicine (see, for example, Nelson 2001; Montgomery 2006, and Charon 2006, respectively), discussion about patients’ knowledge of their own experience, and what that knowledge may bring to bear on patient care, takes for granted certain oppositions: for example, expert/layperson; scientific knowledge/personal knowledge; evidence-based medicine/narrative medicine; fact/value. All these may be understood in terms of the opposition, objective/subjective. A claim frequently made of late in doctor-patient literature is that all the bottom terms (layperson, personal, narrative, value, subjective) have special worth and deserve a place in medical decision-making.[20] That liberalism, however, often does not go far enough, as it does not capture the presumptions and ideologies that characterize scientific (and social-scientific) investigations, and it does not recognize the medical values that are *already* in place in patients' stories.

When I wrote my first breast-cancer-narratives essay, I believed that generic narratives were produced by irresistibly-constituted generic narrators, and that these narrators, so fully instructed in the values of a bright-sided culture, might, for that reason, narrate a somewhat false experience. I now believe things are more complicated than that. Patient narratives are composed with the material of medical culture. They are not simply subjective, and science and medicine are, likewise, not simply objective (along Mertonian [1973] lines: neutral, disinterested, and so on).[21] Cancer stories are not simply produced, governed, and policed by cultural habit and genre; rather they are engineered—not necessarily on purpose—by the American and Canadian Cancer Societies, Susan G. Komen for the Cure, and other institutional actors (pharmaceutical manufacturers, diagnostic-technology marketers, and so on) with an interest in cancer. Among the people who produce the stories that patients tell, are scientists and physicians who deposit their values and expectations in these stories and then disappear from view as authors. Genres may write stories, but institutional medicine writes them too.

This shift in my view returns me to my original question about the shift in my own authorial position: like the patient narrators and stealth institutional authors I have been describing, I exist in an ambiguous space as regards objectivity. In the shadow of prior questions in this volume about what we mean when we talk about objectivity—and, indeed, whether we should talk about Objectivity at all (see Chap. 2 by Hacking, this volume)—it is difficult to assert with confidence claims about more objectivity and less of it. Still, I would say that my ability to see the breast-cancer narrative, the object of my study, was enhanced, rather than vitiated, by my diagnosis; what I took on with my cancer was not subjectivity but standpoint. In Harding's (1993) strong objectivity, quality of observation does not depend on distance from the thing observed or denial of perspective, but rather on a view from outside the usual positions. For Harding, those positions are male, white, European (among others). For me, they are positions, in the first instance, medical-institutional. I have also, as much as possible, stood outside the patient

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[20] But also see Ho (2009) on "epistemic humility."

[21] In a landmark essay in rhetoric of science, Paul Newell Campbell (1975) takes up questions of objectivity through the trope of *persona*, the implied character of the speaker in any work. *Persona* itself, he says, which is unavoidable, is also at odds with claims of objectivity, because it necessarily calls for ethical judgment: there is no character without values. In this view, objectivity itself is a stance (and therefore not objective [in the sense of aperspectival]): to view something dispassionately *is* to stand in relation to it—to attribute a value to it, only not a very high one.

positions that, notwithstanding their place in the category of the personal, the medical-institutional has already wrought.

An exchange economy, in which the objective has elements of the subjective and vice-versa, raises questions for any scientific/narrative divide that persists as a concept in medical epistemology. If a patient's story is not simply an innocent account of personal experience, then the weight of research on patient narratives should move away from disciplines in which these stories are treated as sacred objects: personal, precious, and protected. Research on patient narrative should shift to STS and Critical Medicine Studies. Charon (2006) has said, as I have noted, that patients' stories are an important source of medical knowledge, and should be honored. Patients' stories are also a source of cultural knowledge, including knowledge of institutions of health and medicine, and should be studied. It might even be good to *argue with* them, from time to time, to plumb their values. (As things stand, that constitutes a pragmatic violation: an argument is not a response to a story.) I am not saying that we should not honor patients' stories, that medicine should return to a time when patients' stories were silenced or interrupted, ignored or appropriated, corrected or reconstituted. To argue with—at least, to answer—stories, however, would be a form of respectful engagement, epistemic in itself.

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