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The Cancer Hierarchy: Risk, Responsibilization and Morality

by

Lyndsay Gray

Bachelor of Arts- Honours, Trent University, 2008

Master of Sociology, Carleton University, 2010

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Abstract

While biologically all cancers have the same aetiology, cancer is experienced, talked about and appraised very differently depending on its physiological location within the human body. However, socio-cultural interpretations and understandings of cancer tends to approach the study of cancer as ‘cancer writ-large’ or ‘cancer’ as ‘cancer;’ and not ‘breast cancer’, ‘reproductive cancer’ or ‘lung cancer’. The failure to recognize that different physiologically located cancers have different and very unique meanings is a failure to fully understand the highly complex political, cultural, social, and economic relations of power, knowledge and discourse. This thesis examines historical and contemporary discursive constructions of risk, responsibility, lifestyle and morality as they relate to three cancerous bodies. What is revealed from this investigation is a ‘cancer hierarchy,’ where sufferers and potential sufferers’ place on the hierarchy is contingent on their ability to attend to ‘practices of the self’ and normalized conceptions of ‘appropriate neoliberal citizenship’.

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Introduction

While biologically all cancers have the same aetiology (a mutation or abnormal division of a cell), cancer is experienced, talked about and appraised very differently depending on its physiological location within the human body. However, socio-cultural interpretations and understandings of cancer, such as Susan Sontag's infamous, *Illness as metaphor* (1978), James Patterson's *The dread disease: Cancer and modern American culture* (1987) and Jackie Stacey's *Teratologies: A cultural study of cancer* (1997), comprises a body of literature that tends to approach the study of cancer as 'cancer writ-large' or 'cancer' as 'cancer;' and not 'breast cancer', 'cervical cancer' or 'lung cancer'. The failure to recognize that different physiologically located cancers have different and very unique meanings is a failure to fully understand the highly complex political, cultural, social, and economic relations of power, knowledge and discourse. The main implication of this failure is that if we continue to conceive and write about cancer as anything but 'cancer writ-large', we will never be fully able to understand not only the lived reality of sufferers, but also why it is still the case that in the 21st century moral qualities of an individual are based on one's ability and willingness to avoid and prevent cancer.

My inquiry focuses on three different types of cancer: breast cancer, cervical cancer and lung cancer. I specifically investigate these types of cancers because they have acted to shape our primary social, cultural, political and economic understandings of cancer; discursively situating cancer as destructive and epidemic in nature. In the last fifty years these cancers in particular have been a large part of Western popular culture.

Common ideas and images are conjured up when we think about these cancers and the bodies in which these cancers reside. And there seems to be a consensus reached about who gets cancer, why and how. This cacophony of voices resounds: no one is truly safe from the evil that is cancer. However, what Westerners know about cancer, rather, what we think we know about cancer, are the various ways to ‘prevent’ the disease that claims millions of lives globally every year.

In this thesis I break away from the tendency to discuss ‘cancer as cancer’ and work towards an approach that uncovers the complex discursive constructions of three cancerous bodies. The exploration of the historical and contemporary discourses of risk, responsibility, lifestyle and morality as they relate to cancerous and ‘soon-to-be’ cancerous bodies, has revealed the formation of a *cancer hierarchy*; one that evaluates and ranks the moral qualities of an individual based on the cultivation of a ‘cancer-free’ lifestyle. The assessment of bodies in this manner has distressing implications for those who will not, or simply cannot, ameliorate their lifestyles.

To begin, chapter one argues that the contemporary Western world is experiencing a new phenomenon of ‘cancer anxiety,’ which is quite unique. I suggest that ‘cancer anxiety’ manifests itself as a ‘continual, low-grade, diffuse, ever-present sense of anxiety’ and I attribute three reasons for this. The first reason is that cancer is something science just cannot figure out. Second, we experience this anxiety because cancer is so prevalent in contemporary Westerners lives that it is probable that you, someone in your family, or someone you know/knew is/has been affected by cancer. Third, and perhaps the most important reason why we feel this cancer anxiety, are discursive constructions of risks have served to inform, nourish and propel the anxiety we feel about cancer. I use

this discussion of cancer anxiety as a launch-pad to discuss and address the qualities of some of the socio-cultural literature about cancer. Here I argue that although these pieces have merits and most certainly contribute to a unique understanding about cancer in a context other than the bio-medical, they fail to address cancer as anything but ‘cancer writ-large’. By failing to address ‘cancer’ as ‘breast cancer’, ‘cervical cancer’ or ‘lung cancer’, we fail to see and understand the way sufferers not only evoke different metaphors and develop different narratives, but also fail to see how different discursive constructions of different cancerous bodies (and soon-to-be cancerous bodies) have implications on the way these bodies are situated socially, politically and economically.

My theoretical positioning and methodological approach will be discussed in chapter two. First I situate my inquiry through Michel Foucault’s theories of governmentality and biopolitics and discuss how these theories are essential for analysis which takes ‘the body’ as its locus of inquiry. Further, I argue that these theories provide a framework for understanding how and why particular cancerous bodies are subject to self-regulation and moralization based on the physiological location of cancer. The second half of this chapter will explain the methodology of discourse analysis and also address why this methodology best suits the needs of my inquiry.

The first section of chapter three will provide a general discussion of the importance of scientific and medical expertise in neoliberal governmentality. To begin, I briefly discuss two ways science and medical doctors have come to be the foremost experts of the human body and more specifically, I highlight the essential role played by medical expertise in the ‘making-up’ of the self-regulatory subject through the promotion of what Foucault calls ‘practices of the self’ or ‘technologies of the self’ (1984:87). I

argue that practices of the self, which involve a whole host of self-surveillance, self-management and self-regulatory techniques, are chiefly disseminated through public health. Therefore, the second section of this chapter discusses the importance of public health in the promotion and dissemination of practices of the self and the discursive constructions of risk, responsibility, lifestyle and morality as they relate to cancerous and ‘soon-to-be’ cancerous bodies. Utilizing and incorporating Petersen and Lupton’s work on “the new public health” (1996) I argue that the shift in the definition, structure and application of public health since the 1970s has allowed for the increase of practices of the self, which emphasizes self-regulation primarily through risk management and responsabilization. Further, the shift in public health in the contemporary Western world has not only aided in the promotion of practices of the self, but in so doing, has normalized these practices. As a result, anything that lies outside of, or transgresses normalized practices of the self, is subject to moralization. This discussion of the “new public health” is essential for the remainder of this thesis as it provides a framework from which we garner a greater understanding of the ways different bodies are discursively constructed and the implications of these constructions.

According to Powers, “...the goal of discourse analysis is to provide interpretative claims based on a description of power relations in the context of historically specific situations” (2001:53). Chapter four explores the discursive construction of gender, risk, responsibility, lifestyle and morality of the three cancerous bodies. I begin with an examination of discourses associated with cigarette smoking and lung cancer from the late 1800s to the mid-1900s. I have chosen to examine the cigarette smoker, as the discourses that centered on *risk*, *lifestyle* and *morality* historically, are primarily what we

see as the dominant discourses of cigarette smokers today. Further, I have chosen the cigarette smoker because of the causal relationship between cigarette smoking and incidences of lung cancer. The second section of this chapter explores the discursive construction of women with cancer, focusing on women with breast cancer and cervical cancer.

Chapter five will examine the contemporary discursive constructions of risk, responsibility, lifestyle and morality of the three cancerous bodies. The first section is devoted to women and cancer and the second section will explore the discursive construction of the cigarette smoker and the body lung cancer sufferer. This chapter will highlight the role of public health in the creation of the self-regulating, responsabilized subject.

The final chapter begins with a discussion of the importance of the ‘cancer hierarchy’ and the implications of differentiating bodies based on the physiological location of the cancer. I argue that the location of a cancerous body on the cancer hierarchy is contingent upon three factors: first, risk management via practices of the self, affects where one is situated on the hierarchy. Second, I suggest that one finds their place on the cancer hierarchy through the adherence to normalized understandings of the ‘ideal neoliberal citizen’. Finally, one’s place on the hierarchy is also contingent upon gender.

The final section of this chapter will address the implications of placing bodies on a ‘cancer hierarchy’. Here I argue that the first implication, and perhaps the most distressing, is the disparity in research funding for cancer. By examining data from Canada, the United States and the international health body, the World Health

Organization, I argue that the disparity in terms of research funding contributes not only to contemporary discourses of risk, responsibility, lifestyle and morality which are primarily found in public health initiatives, but also contributes to the dominant discourse of the cigarette smoker as the potential lung cancer victim who is unworthy of support. Second, I argue that the cancer hierarchy creates the conditions for disproportionate risk assessment, which sees more women focusing on breast and cervical cancer risk reduction, while simultaneously ignoring more substantial threats posed to women's health, such as heart disease and skin cancer. Finally, I argue that because one's place on the cancer hierarchy is contingent upon the successful management of practices of the self and notions of the ideal neoliberal citizen, the result is an increase of self-regulation and responsabilization which ultimately serves to divert our attention away from the inaction of the state in matters of health and illness.

There could be numerous reasons as to why people write about cancer: they could have experienced it (or still be experiencing it) themselves, they could have had a family member or friend affected by cancer, or they could choose to write, like myself, because cancer is something that causes anxiety inside oneself. Therefore, I have selfishly utilized my own anxiety about cancer as an entry point. The presence of my cancer anxiety serves as a purposeful tool for uncovering why I have this anxiety and why my colleagues, family, and friends, share this anxiety as well. Labeling this anxiety as such has allowed me to pose a number of questions which I will explore throughout this thesis. This anxiety has mobilized me into action—as it has millions of others on a daily basis. However, my action is focused upon investigating why we act, what is compelling us to act, and what are the implications of these actions.

Chapter 1

Cancer Anxiety

Cancer. This word conjures up a multiplicity of images, metaphors and emotions in the minds of those who hear it. It has increasingly become a source of risk and anxiety which we must deal with on a daily basis. The anxiety we feel about potentially getting cancer has put us on guard. We watch what we eat, we exercise daily, we consume less alcohol, we get screened, we get tested, and we most certainly do not smoke cigarettes. We create a 'healthy lifestyle' that is centered on the successful management of the daily cancer risks. A healthy lifestyle and all that it encompasses says much about who we are as individuals and members of a population.

In this chapter I argue that there are three specific reasons why in the Western world today we are experiencing a new phenomenon of 'cancer anxiety'. This discussion will serve as an entry point for addressing some of the socio-cultural literature about cancer. I argue that although the literature has great merits and provides insightful analysis of the socio-cultural 'problem' of cancer, it fails (as much of the literature has done to date) to discuss and analyze cancer as anything but 'cancer writ-large', or 'cancer as cancer'. The trouble with this, as I argue below, is that by only addressing 'cancer' as 'cancer', we fail to see how different cancerous bodies are discursively constructed in the social, cultural, and political realms and the idea that particular cancerous bodies, or 'soon-to-be' cancerous bodies are subsequently *moralized* based on the location of a particular cancer. I suggest that the moralization of particular bodies can be best

understood through an analysis of the discursive constructions of risk, responsibility and lifestyle. Further, and perhaps most importantly, when conceiving of ‘cancer’ as ‘cancer’ and not ‘cancer’ as ‘breast cancer’; ‘lung cancer’; or ‘cervical cancer’, there is a failure to reveal the reality that particular bodies are subject to different forms of regulation (both moral and self-regulation), risk and responsabilization.

In the contemporary Western world, cancer has become a source of anxiety for many. However, I want to specifically suggest and make clear that this cancer anxiety that many of us feel manifests itself as a *continual, low-grade, diffuse, ever-present sense of anxiety*. Unlike the anxiety (sometimes quick bursts or more prolonged manifestations) that accompanies social, political, or economic disruption, cancer anxiety in its current manifestation is a relatively new phenomenon and becomes ever-more diffuse as the neoliberal era progresses.

The *continual, low-grade, diffuse, ever-present sense of anxiety* about cancer is the result of three main factors. First, *cancer is something that science just cannot figure out*. The earliest presence of cancer in humans dates back to approximately 3400 B.C. in which paleopathological (bone evidence) from Egyptian skulls was discovered to have the presence of what we know today to be multiple myeloma (abnormal cell growth occurring in bone marrow) (Ackerknecht, 1958: 114). Recent discoveries of Egyptian artifacts, and more specifically Egyptian papyri dated to approximately 1500 B.C., recorded “‘swelling’ and ‘ulcers’ of the skin, mamma and female genitalia” that can best be described today as the earliest recorded documentation of cancer of the female reproductive system (Ackerknecht, 1958: 114).

As far as historians of medicine can be certain, the etymology of cancer can be traced back to antiquity to the ‘father of modern medicine’, Hippocrates. In his historical account of cancer, Ackerknecht highlights Hippocratic writings which date back to approximately 400 B.C. where “karkinos,” the Greek word for crab, was identified as “non-inflammatory, hard swellings and ulcers of the skin, female breast and genitalia with tendency to generalization, recidive and fatal ending[s]” (1958: 114). Various identifications of cancer were made by Hippocrates and a subsequent theory, “the humoral theory”, emerged and prevailed until the Renaissance period (Braun, 1977 as cited in Olson, 1989: 6). It is apparent that the presence of what we know today to be cancer has existed within the human body for perhaps as long as humans have inhabited earth.

The verity that cancer, established as one of the leading causes of death worldwide, has yet to be tamed by modern science is cause for great anxiety. With rapid technological advancements, billions of dollars invested for research funding annually, and countless discoveries and subsequent eradications of other deadly infections, diseases, and illnesses throughout history, cancer is one of the rare diseases that has evaded the conquest of modern science and medicine. Historically, Western scientific innovations such as the stethoscope, microscope, the germ theory of disease and disease pathology (among other innovations) all played their part in the discovery and subsequent eradication of diseases that were of pandemic proportions; diseases such as Smallpox, Black Death, and Polio. Furthermore, the mapping of the human genome has allowed for the identification, intervention, and treatment of multiple diseases in the modern era. This leads many to speculate that if the entire genomic map of humans has been unfolded,

there *must* be a way to eradicate cancer. Why science has yet to ‘figure out’ cancer is beyond the comprehension of many lay individuals and scientists alike. This sense of evasion that cancer provokes contributes to the anxiety we feel about the impending threat of cancer.

Second, the increase of cancer anxiety is in part due to the reality that *cancer is so prevalent that it is probable that you, someone in your family, or someone you know/knew is/has* been affected by cancer. In 2009 the Canadian Cancer Society, along with Health Canada, Statistics Canada and Territorial Cancer Registries, released a report estimating that 1 in 4 Canadians will die of cancer and that the lifetime probability ratio of men developing cancer is 1 in 2.2, and for women 1 in 2.5 (Canadian Cancer Society’s Steering Committee, 2009:53). According to the World Health Organization (WHO), cancer is the leading cause of death worldwide and the total number of reported cases of cancer is increasing globally: “the number of global cancer deaths is projected to increase 45% from 2007 to 2030 (from 7.9 million to 11.5 million deaths) and... [n]ew cases of cancer in the same period are estimated to jump from 11.3 million in 2007 to 15.5 million in 2030” (WHO, 2008). In terms of mortality, lung cancer figures as the most deadly cancer in the world and has the highest incidence and mortality rate among men worldwide (Parkin, 2000: 535). Breast cancer is the second most frequent cancer worldwide and is “by far the most common malignant disease in women” (Parkin, 2000: 537). The second most common cancer in women worldwide is cervical cancer, which accounts for approximately 233,000 deaths annually (Parkin, 2000: 539). Therefore, statistically, there is a very high probability that in one’s lifetime, one will develop

cancer, or know of someone who has developed cancer. The closer the proximity to cancer, the greater anxiety one has about potentially developing the disease oneself.

The wide publication and dissemination of statistical data on cancer has a great impact on the degree of anxiety one feels over developing cancer. Statistical data aside, the increased presence of, and the expanding access to individual narrative accounts, literature, socio-cultural research, self-help manuals and online resources and blogs (to name only a few), have all contributed to an ever-expanding ‘cancer culture’ that is intended to quell fear and anxiety and instill a sense of hope and heroism in the sufferer. However, as Jackie Stacey argues, these narratives are worrying “in terms of the cultural ideals they promise” (1997: 21).

The final factor which has the greatest influence (and the one that my inquiry will focus most heavily on) over the anxiety we fear about cancer, is *the risk discourses of cancer which informs, nourishes, and propels anxiety*. The discursive construction of risk as it relates to cancer in the Western world is ubiquitous. It is now the case that the discursive constructions of cancer risks have rapidly begun to shift from being found strictly within the confines of health practitioners, research institutes, and scientific communities; the risk discourses of cancer have trickled their way into the mainstream—invading the social, cultural and political landscapes in such a way that it has become a challenge to avoid the daily reminders of the risks associated with cancer. Pink ribbons (perhaps the most recognizable reminder), countless charity events, cancer runs, TV programs such as “Dr. Oz” and “Oprah”, cookbooks (examples include, “Foods That Fight Cancer: Preventing Cancer Through Diet” and “Cooking Foods That Fight

Cancer”) clothing, kitchen items, key chains, makeup, vehicles, and countless other reminders (far too extensive to chronicle in its entirety) (Appendix A) are indicative by quantity alone, that the discursive construction cancer risks has thrown us into a state of unprecedented, widespread collective ‘cancer anxiety’.

Some may take issue with my argument and assert that these risk discourses are a valuable resource mobilized and disseminated by health care professionals, doctors, research institutes, and public health in order to ‘educate the public’ about the various preventative and self-diagnostic measures an individual can take to reduce the probability of developing or dying of cancer. In response to those who advocate for the promotion of risk logic as an educational and preventative tool, I argue that, yes, these discursive constructions do in fact result in some individuals and populations having greater access to knowledge and education about cancer. However, the implications of such measures for individuals and populations alike ought to be examined; for these discursive constructions of risk are implicitly loaded with self-regulatory and responsabilizing messages which center upon the moral status of an individual.

In “Anxiety and social explanation: Some anxieties about anxiety” (1999) Alan Hunt argues that a wide array of social and historical literature has often employed ‘anxiety’ as an explanatory tool to account for “the occurrence and timing of some social phenomenon [which] is explained by reference to the presence of some elevated state of anxiety which elicits social or political responses by an identifiable group of social agents” (509). Hunt notes that there is an oversight or perhaps failure by many scholars who discuss anxiety, in not recognizing it as such, nor labeling it as ‘anxiety theory’

(1999: 509). Hunt explores some of the problematics associated with this mode of explanation. Further, he makes clear that he does not denounce or commend this style of scholarship but he notes that when employed, anxiety theory “protocols” must be attended to:

A positive contribution can be made by attending to a number of interconnected issues. First, anxieties provide valuable heuristic points of entry for enquiry; they encourage us to ask, ‘What is going on?’. Second, their identification allows inferential connections to be made between elements present within discourses; these may be either external or internal inferences. Third, the concept of displacement provides an important methodological injunction requiring the exploration of the cultural and socio-economic circumstances of the participants, of both agents and targets. Fourth, anxieties can be examined to search out discursive affinities that make it possible to ‘unpack’ the configurations or combinations in which anxieties manifest themselves. Social anxieties whether acute or trivial, stimulate enquiry (1999: 524).

I find it fruitful to situate my inquiry of cancer anxiety by employing Hunt’s anxiety protocols. First: “*What is going on?*” As a response to ever-increasing rates of cancer incidence and mortality, Westerners are becoming increasingly morally and self-regulatory through the discursive constructions of risk, responsibility and what it is to embody a ‘healthy lifestyle’.

Second: “*Inferential connections to be made between elements present within discourse*”. The lifestyle we embody says much about us as individuals and as members which constitute a population. A ‘healthy lifestyle’ has minimal risks attached to it and is increasingly indicative of one of the main characteristics of a responsabilized neoliberal citizen. We make good choices and healthy choices, which are ultimately moral choices

that will work in favour (in theory) of quelling the anxiety we feel about cancer. When one succumbs to cancer because one has not managed their risks properly and is deemed irresponsible in the face of such risks, one is forced to deal with the implications.

Third: *the concept of displacement provides an important methodological injunction requiring the exploration of the cultural and socio-economic circumstances of the participants, of both agents and targets.* Discursive constructions of risk have leaked their way into the social realm and have fed into a “cancer culture” (Ehrenreich, 2001). This ‘cancer culture’ has heightened the sense of anxiety that individuals feel on a daily basis. The consequence of this cancer culture sees the production of a self-regulatory, responsabilized citizen. I believe it safe to stress that we experience a heightened sense of anxiety about our bodies today, so much so that we go to great lengths to ensure risks are mediated and our health, which is paramount, is continuously attended to.

Finally, *anxieties can be examined to search out discursive affinities that make it possible to ‘unpack’ the configurations or combinations in which anxieties manifest themselves.* These “discursive affinities” manifest themselves in the language that is employed and discourses that are utilized in order to talk about cancer in a particular way and thus define the limits of acceptable speech. These discursive affinities of cancer are present within scientific and medical literature, public health, and through narratives and metaphors found within socio-cultural, political and economic milieus. The discourses that define the limits of acceptable speech must be examined more closely in order to reveal how the cancerous body, or soon-to-be cancerous body, is constructed socially, culturally, politically and economically. According to Rose,

It is not so much a question of what a world or a text ‘means’ – of the meanings of terms such as ‘community’, ‘culture’, ‘risk’, ‘social’, ‘civility’, ‘citizen’ and the like – but of analyzing the way a word or a book functions in connection with other things, what it makes possible, the surfaces, networks and circuits around which it flows, the affects and passions that it mobilizes and through which it mobilizes (1999: 29-30).

The task at hand is to reveal the ways that current socio-cultural literature has addressed the ‘problem of cancer’. My analysis reveals that many of the ways we think about cancer today are far too broad, and in order to come to an understanding about the various ways particular cancerous bodies are discursively constructed, what needs to take place is an examination and assessment of some of the socio-cultural literature about cancer.

The publication of Susan Sontag’s *Illness as metaphor* in 1978 paved the way for the materialization of an expanding body of socio-culture literature about cancer. A pleading call to rid illnesses such as tuberculosis and cancer of metaphor, Sontag argued that the way we experience illness has much to do with the metaphors that are associated with illness and disease. Sontag’s historical examination of the metaphors of TB and cancer (and later AIDS in *AIDS and Its Metaphors* (1989)) served to demystify fantasies of illness which had an impact on how people lived with a disease and how suffering patients might not seek medical assistance as a result of the shame and stigma brought on by metaphorical thinking. In the introduction of her text, Sontag writes:

I want to describe, not what it is really like to emigrate to the kingdom of the ill and live there, but the punitive or sentimental fantasies concocted about that situation: not real geography, but stereotypes of national character. My subject is not physical illness itself but the uses of illness as a figure or metaphor. My point is that illness is *not* metaphor, and that the

most truthful way of regarding illness—and the healthiest way of being ill—is one most purified of, most resistant to metaphoric thinking (1978: 3).

Critics such as Clow have contested Sontag's ardent push for illness to be purged of metaphor, arguing that this would be, first and foremost, an impossible task. Furthermore, Clow argues that there are limitations to Sontag's historical interpretation of metaphorical understanding of illness and disease (2001: 310). I agree with the assertions made by Clow, but I want to stress that Sontag's text provided a useful way for us to begin to understand how our modern conceptions of illness and disease today affect the lived reality of sufferers. However, I have one main reservation with Sontag's text, which is the same reservation that I have with the majority of socio-cultural texts about cancer; that is, when one talks about cancer, it is discussed 'writ-large'. If this is the way we continue to conceive and write about cancer we are not fully able to understand the lived reality of certain sufferers: the evocation of metaphors, narratives and discourses are not all the same for all types of cancers. And the failure to recognize this is a failure to fully understand the highly complex political, cultural, social and economic power/knowledge relations, and thus the implications of these relations.

In numerous ways, Jackie Stacey's illuminating text *Teratologies: A cultural study of cancer* (1997) provides valuable insight into to the subject of cultural narratives and metaphors of cancer. Having been diagnosed with a rare cancer herself¹ and developing her own narrative of living in a cancerous body, Stacey was faced with

¹ A teratoma which is, "an endodermal sinus tumor, a malignant growth originating in the yoke sac of an egg cell" (1997:4)

countless cancer narratives from other patients, self-help books, medical doctors, and alternative therapy providers. Stacey's text investigates how cancer is theorized, conceived and experienced in contemporary society through the use of the 'hero' and 'monster' metaphors. She explores the changing beliefs of sufferers and argues that contemporary metaphors of cancer lead to particular ways of individuals constructing narratives about their illnesses and as well as themselves (1997: 201). In chapter three of her text "Monsters," she argues that the insidious nature of cancer creates an enormous sense of revulsion and horror even with the simple utterance of the word.

Stacey's own narrative recounts her reaction to her doctor(s) and several nurses' avoidance of the word cancer, opting instead for metaphors or non-labeling. Drawing from a body of feminist literature (Douglas, 1966, Kristeva 1982, & Butler, 1990) Stacey addresses the socio-cultural and patriarchal history of the female body, more specifically, the abject female body, which once diseased becomes all the more laden with disgust and revulsion. It is in this chapter in particular that I choose to work with the argument laid out by Stacey.

Here, Stacey is 'taking a page' from Sontag, inasmuch as the 'cancerous body' is seen simply as such: a cancerous body. My inquiry, which is focused on particular cancerous bodies suffering from particular physiologically differentiated cancers, reveals a blind-spot in Stacey's analysis, as well as Sontag's. For it is the case in Western society today that different *types* of cancers signal different quantities and qualities of revulsion and disgust and thus experience different moralizations attached to them; socially, politically and culturally. A discursive analysis of particular cancerous bodies reveals a

shift in terms of how *individual* narratives are told and the different metaphors that are evoked by *particular* sufferers. If we treat all cancer narratives, metaphors, and bodies the same (which much of the historical and socio-cultural has done to date) we are unable to inquire as to why some cancer research is funded more liberally than others; why certain collective social mobilizations have experienced an unprecedented upsurge; why we feel compelled to wear pink ribbons; why girls and young women are feeling compelled to regulate their bodies and sexualities to such an enormous degree and; why the cigarette smoker is viewed as the ultimate socially stigmatized health pariah.

Due to the substantial upsurge of empowerment movements centered on specific types of cancer within the last 30 years, namely women's breast cancer, the revulsion and disgust has been substantially minimized in public life and is being replaced with the image of a battling body, a fighting body, a heroic body. Heroes/heroines in pink have made themselves culturally, socially and politically present. Gone are the days when the female sufferer of cancer was to be hidden away with her insidious disease; her body, all the more abject, isolated and confined to private suffering, contemplations of failure, self-revulsion and disgust. I argue that this is now the domain of the lung cancer sufferer. There are no comparable collective movements for the lung cancer sufferer; there is nothing empowering about suffering from a disease that one has brought upon one's self through the sinister act of cigarette smoking. It is almost as if the smoker has 'made their bed and must lie in it'.

One piece of literature that I have found particularly useful to my examination and one that conveys an exceptional analysis of the historical discourses around a

particular type of cancer—that of “carcinoma uteri”—is presented by German scholar, Karen Nolte. In “Carcinoma Uteri and ‘sexual debauchery’—Morality, cancer and gender in the nineteenth century” (2008) Nolte traces the historical, moral and often intensely gendered discourses of *carcinoma uteri* (known today as cervical and/or uterine cancer). Focusing her attention primarily on the first decades of the 19th century, Nolte traces the discourses found within medical and scientific texts and shows the conflation between morality and sexual excess, debauchery, masturbation and feminine weakness. She traces the shift which saw *carcinoma uteri* as an illness that only affected women who were prostitutes or ‘sexually loose’ with their husbands (2008: 34-35); to an illness that was said to have greater occurrence in those who partook in “fantasies, as well as self-polluting lesbian games”(2008: 36).

She argues that near the end of the 19th century, advancements in anti-sepsis, anesthesia, and gynecological professionalization, lead to better surgical procedures (2008: 38), and thus medical and scientific interpretations (and discourses) of *carcinoma uteri* began to change. Further, she notes that with the introduction of cellular pathology and an emphasis on a medical model of health, (which considered social circumstances as a contributing factor to disease and illness) discourses began to shift and it was no longer the sexually excessive woman and her immoral behaviour that suffered with cancer. Rather, it was women of the lower classes who had to struggle with the stress and burden of an impoverished daily life (2008: 41).

This text is valuable for my inquiry as it focuses specifically upon the discourses of a particular type of cancer. However, the one failing of this article lies in the abrupt

mention of the '*new moralization*' of this cancer born out of the aetiological link of the Human Papillomavirus and its subsequent vaccine. At the end of her text, Nolte notes that, "a comparison of medical writings on cervical cancer in the United States and German-speaking countries, and of respective notions of sexuality and morality, would certainly be worthwhile" (2008: 42), and arguably so. For it is inquiries such as those presented by Nolte that provide a foundation for an investigation of the historical and contemporary discourses that surround particular types of cancer and the repercussions therein, for potential sufferers (or those 'at risk') and sufferers alike.

Although these socio-cultural accounts of cancer provide readers with a unique way to think about cancer (beyond the bio-medical) they fail to *compare* different cancers, or simply put, to address cancerous bodies, and soon-to-be cancerous bodies, *in relation to one another*. This oversight, or perhaps failing, results in a lack of critical engagement and observation which could otherwise result in a new way to conceive of the cancerous body in our social world. Therefore, I propose that by moving beyond such a broad analysis of cancer, we come to better understand whose bodies are more regulated, how, and why, and what the implications are for not only the diagnosed cancer sufferer, but for those of us, all of us, who could one day develop cancer.

In *Liquid Times: Living in an Age of Uncertainty* (2007) Zygmunt Bauman argues that globalization has prompted a shift in modern society: the shift from a solid state to that of a liquid state. He notes that the absence of boundaries (once solid, now liquid) in our contemporary world has created an unprecedented state of injustice, which has ultimately created an existential fear in individuals and the population at large (8-12).

This fear, he contends, manifests itself as a “new individualism” which is accompanied by the rapid replacing of “human bonds” and “social solidarity” (24). I find it useful to quote (at great length) a passage by Bauman, as his conception of modern fear underpins the logic of my inquiry throughout this thesis. Further, this quotation will provide a suitable lead-in for a discussion in chapter two about my theoretical positioning and methodological approach. Bauman’s text, in its entirety, is useful for this present undertaking, as well as for a general understanding about the rapid shifts that are underway in our modern world. The significance of highlighting these global shifts allows for an understanding, or at least a starting-point of inquiry, for inferential connections to be made between the discursive construction of particular cancerous bodies and the governance of contemporary life.

Unable to slow the mind-boggling pace of change, let alone to predict and control its direction, we focus on things we can, or believe we can, or assured that we can influence: we try to calculate and minimize the risk that we personally, or those nearest and dearest to us at that moment, might fall victim to the uncounted and uncountable dangers which the opaque world and its uncertain future are suspected to hold in store for us. We are engrossed in spying out ‘the seven signs of cancer’ or ‘the five symptoms of depression’, or in exorcising the specter of high blood pressure, a high cholesterol level, stress or obesity. In other words, we seek *substitute* targets on which to unload the surplus of existential fear that has been barred from its natural outlets, and we find such makeshift targets in taking elaborate precautions against inhaling someone else’s cigarette smoke, ingesting fatty foods or ‘bad’ bacteria (while avidly swilling the liquids which promise to contain the ‘good’ ones), exposure to sun, or unprotected sex...No amount of effort invested in those areas is likely to neutralize or block the source, and so it proves impotent to placate the anxiety, however earnest and ingenious that effort might be. It is for this reason that the vicious circle of fear and fear-inspired actions rolls on, losing none of its impetus—yet coming no nearer to its ostensible objective (2007: 12-13, *emphasis in original*).

Chapter 2

Governmentality, Biopolitics and Discourse Analysis

For the first time in history, no doubt, biological existence was reflected in political existence; the fact of living was no longer an inaccessible substrate that only emerged from time to time, amid the randomness of death and its fatality; part of it passes into knowledge's field of control and power's sphere of intervention. Power would no longer be dealing simply with legal subjects over whom the ultimate domination was death, but with living beings, and the mastery it would be able to exercise over them would have to be applied at the level of life itself; it was the taking charge of life, more than a threat of death, that gave power its access even to the body (Foucault, 1984: 264-265).

At the end of chapter one I presented a lengthy quotation by Zigmunt Bauman which discussed the implications of the global shift in modern society from a solid state (characterized by solid geographical, political, and economic boundaries) to a liquid state (characterized by free-flowing capital, culture and political ideologies across geographical boundaries). This shift, Bauman asserts, has manifested itself into a feeling of insecurity and injustice. To neutralize this fear we face on a daily basis we seek out a variety of ways to placate and control this fear—namely through vigilance to bodily practices and the cultivation of a healthy ‘lifestyle’. The use of language, concepts and examples employed by Bauman appears to suggest (and although not explicitly stated within the text itself) that the occurrence of this shift has much to do with a mentality of modern rule—a mentality which chiefly focuses on the body and is very much akin, if not to say is in actuality, situated through Foucault’s theories of biopolitics and governmentality.

Governmentality and biopolitics provide a foundation and framework for understanding the ways in which particular bodies are subject to different regulatory practices and allows for a discussion of the implications of these practices on the bodies of subjects. This chapter will outline the theoretical perspectives I have chosen and why. The second half of this chapter is devoted to an introduction of, and justification for the use of the methodological approach of discourse analysis.

It is important to begin this chapter by addressing one of the main issues which emerged from the recently published, *The birth of biopolitics: Lectures at the Collège de France 1978-1979* (2008) by Michel Foucault. This long-awaited English translation has provided many new insights into Foucault's later work and his development of the theory of biopolitics. One of the most significant insights gleaned from these lectures is the idea that biopolitics, or the regulatory controls and interventions required to manage a population, would not be understandable and/or operable without liberalism as a mode of governance (Foucault, 2008: 22). Foucault argues that in the liberal art of government, 'freedom' of behavior is,

entailed, called for, needed, and serves as a regulator, but also has to be protected and organized...freedom is something that is constantly produced. Liberalism is not acceptance of freedom; it proposes to manufacture it constantly, to arouse it and produce it, with, of course, [the system] of constraints and the problems of cost raised by this production (Foucault, 2008: 65).

According to Dean, the power and the forms of power which constitute liberal practices of government operate on the conduct of the governed (1994: 177). As 'free individuals' in a liberal society we are imbued with the ability to make various choices

over our lifetimes. However, the choices we make are to be the right choices, the good choices, and the healthy choices: the choices that are 'less risky'. Because liberal rule is made operable, and most successful through the 'free individual' who is rarely subject to coercive authoritative intervention by the state, what are required are regulatory mechanisms whereby a system of non-coercive rule allows the state to monitor and intervene upon individual behaviours, actions, and practices. This regulatory mechanism, or mechanisms, is made possible through the authority that is afforded to experts. According to Rose (1993),

Liberal forms of government...have depended for their possibility upon the power of experts and the authority of truth. The relations between expert authority and the political apparatus have varied in different formulae of rule. But the authority of expertise has played a crucial role in making liberal rule operable, in implanting forms of sociality and norms of responsible autonomy with subjects of rule, and in connecting up key locales to the ambitions of government in ways to both preserve and shape their internal systematic (297).

The state ensures the health of the population through its reliance upon medical and scientific expertise. In liberal governance medical and scientific experts become experts of the human body. Because these experts are the foremost leading authorities of the human body, they make special claims to esoteric knowledge and this knowledge becomes the way in which bio-medical intervention onto the bodies of individuals is not only accepted by the state and individuals themselves, but this knowledge establishes and furthers a trust between the medical and scientific experts, the individual and the state.

[I]n the name of social and personal well-being, a complex apparatus of health and therapeutics has been assembled, concerned with the management of the individual and social body as a vital national resource, and the management of 'problems of living', made up of techniques of

advice and guidance, medics, clinics, guides and counselors (Miller & Rose, 2008: 199).

For the purposes of my inquiry, this elucidation by Miller and Rose proves fruitful, as the management of the health and well-being of individuals and populations comes to be the imperative for the successful operation and maintenance of the neoliberal state. However, this is a very complex set of operations and practices and requires internal and external vigilance and maintenance on the part of the individuals who constitute a population, the government and the state. The main goal of liberal governance and the biopolitical operations therein, is to ensure stability, security and permanence. According to Foucault,

[w]hat government has to do must be identified with what the state should be. Governmental *ratio* is what will enable a given state to arrive at its maximum being in a considered, reasoned, and calculated way. What is it to govern? To govern according to the principle of *raison d'État* is to arrange things so that the state becomes sturdy and permanent, so that it becomes wealthy, and so that it becomes strong in the face of everything that may destroy it (Foucault, 2008: 4, *emphasis in original*).

Experts and their claims to a particular kind of knowledge in liberal rule allows for the surveillance, management and intervention into the daily lives of individuals and populations, however, not in a coercive corporally interventionist manner. It is through highlighting the role of medical and scientific expertise and their knowledge that we come to an understanding about how the operation of liberal rule not only allows for, but encourages individuals to police, survey and regulate themselves—becoming responsible for their own health and the health of their fellow citizens. The authority which is

afforded to medical expertise in liberal governance plays such a large part in our everyday lives, and the successful operation of liberal governance is largely dependent on the invocation of claims to special knowledge(s). It is through these claims to special (esoteric) knowledge(s) that we inevitably find claims to truth. This significance of this insight will be explored in the following chapter.

Governmentality

Foucault's theory of governmentality emerged from his genealogical exploration of population and the emergence of liberal governments in the 18th century. Defined as a mentality of rule or the "conduct of conduct" (Gordon, 1991: 2) governmentality implies the ethical relation of self to self, and concerns strategies for the direction of conduct of free individuals (Foucault, 1974: 19-20). Governmentality provides an understanding of the organization of governance and the mechanisms, practices and rationalities that are required in the governance of the conduct of subjects. Since the 18th century, individuals have been charged with the task of "knowing oneself"; establishing a relation of self to self, self to state, and self to the population. Rose argues that, "governmentality is a way of problematizing and intervening upon conduct that is intrinsically dependent upon knowledge and knowledgeable persons" (1994: 363). How this knowledge comes to bear on the daily lives of individuals and populations is not achieved through measures of corporeal domination or coercion, rather it is dependent upon the internalization and normalization of acts of choice (Dean, 1994: 177).

Clarifications and minor adaptations of Foucault's theory of governmentality have been taken up by several "neo-Foucauldian's" such as Rose (1994), Dean (1994 & 1999) and Miller (1991). For explanatory and definitional purposes, I have chosen to focus on the work of Rose, who states,

[...] 'governmentality' refers to the emergence, since perhaps the eighteenth century, of a *mentality* of rule, a way in which political rule understands itself, conceptualizes the necessary and legitimate obligations of the rulers, and seeks to enact these, putting together a multitude of strategies for the exercise of rule. The term governmentality sought to draw attention to the way in which the exercise of rule, since that time, had become linked to attempts to know and regulate the wealth, health, happiness of populations through an ensemble of institutions, procedures, analyses, reflection, calculations and tactics (1994: 363, *emphasis in original*).

Governmentality highlights the significant role played by, and the making up of the active subject: a subject that is imbued with the power to be a responsible and self-regulatory citizen, via "practices of the self" or "techniques of the self" (Foucault, 1984: 87). According to Foucault,

techniques of the self involves the procedures, which no doubt exist in every civilization, suggested or prescribed to individuals in order to determine their identity, maintain it, or transform it in terms of a certain number of ends, through relations of self-mastery or self-knowledge. In short, it is a matter of placing the *imperative* to 'know oneself' (Foucault, 1984: 87, *my emphasis added*).

If individuals are charged to take on the role of self-mastery and self-regulation, the *responsibility* for oneself is inevitably the ideological driving force behind this mentality of rule. Governmentality therefore provides us with a coherent way to

conceptualize not only the various forms of power relations and knowledge but also the rationality of governance (Dean, 1994: 176). Furthermore, it serves to establish an intersection between technologies of the self/practices of the self (self-regulation) and technologies of government (social and moral regulation). According to Dean, “if one likes, the ethos or mode of being of political rationality is the correlation between two diverse forms of political individualisation and political totalisation in which human beings are regarded as both self-governing citizens *and* members of the flock who are governed, members of a self-governing political community *and* members of the governed population” (1994: 1985, *emphasis in original*).

Biopolitics

Biopolitics (1980a & 2008), is a theory which allows us understand the various ways and measures by which individual bodies constituted as a population, are subject to particular forms of management, surveillance and regulation. Foucault argues that in the 18th century, biopolitics was presented as a way to, “rationalise the problems presented to governmental practice by the phenomena characteristic of a group of living human beings constituted as a *population*: health, sanitation, birthrate, longevity [and] race” (1978: 74, *my emphasis added*). Liberal governance of the 18th century took as its main resource, and concern, population, and had to devise a way to govern and manage populations, while espousing the liberal organizing principle of the “free subject” (Foucault, 1978: 74). Governments began to slowly move away from the direct corporeal control or management of individuals, and instead moved toward the creation of a wide variety of institutions (such as public health, medicine, and education, to name only a few) that

would be charged with the implementation of measures that assisted in the production of self-examining and self-managing individuals (Dean, 1994: 176-7).

For the purposes of this thesis, Foucault's theory of biopolitics allows for a discussion of the vital dependency that the state has on a 'healthy,' happy and productive population. From the 18th century onward, institutions such as medicine and public health emerged as a way to police the individual and social body through regulatory mechanisms such as self-regulation, self-management and self-surveillance. This rationality of governmental rule ensures the health and well being of entire populations, not just for the capitalist economy, but also for the disciplining of populations en masse for political objectives:

demographic estimates, the calculation of the pyramid of ages, different life expectations and levels of mortality, studies of the reciprocal relations of wealth and growth of the population, various measures of incitement to marriage and procreation, the development of forms of education and professional training. Within this set of problems, the 'body'—the body of individuals and the body of populations—appears as the bearer of new variables, not merely between the scarce and the numerous, the submissive and the restive, rich and poor, healthy and sick, strong and weak, but also between the more or less utilizable, more or less amenable to profitable investment, those with greater or lesser prospects of survival, death, and illness, and with more or less capacity for being usefully trained (Foucault, 1984: 278-279).

Monitoring, counting, measuring, and surveying populations based on biological traits allows for the assessment of markers of ill-health, abnormality and pathology in relation to an established standard of normality, continuity, and stability. Foucault notes that, "the biological traits of a population become relevant factors for economic management, and it becomes necessary to organize around them an apparatus which will

ensure not only their subjection but the constant increase of their utility” (Foucault, 1984: 279). In essence, this apparatus relies on technologies of the self, “which permit individuals to effect by their own means or with the help of others a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality” (Foucault, 1988: 18).

Biopolitics therefore is an instrument of self-regulation, moral regulation and normalization and according to Foucault, “a normalizing society is the historical outcome of a technology of power centered on life” (1984: 266). The process of normalization enables practices of self-regulation to become accepted and unquestioned. What becomes inscribed in normalization practices are discursive constructions of what is normal (healthy, responsible, moral) and anything that lies outside the established ‘norm’ is deemed to be unhealthy, irresponsible and immoral and therefore subject to various forms of intervention and regulation. In this thesis I argue that scientific and medical expertise and public health figure as institutions of normative control, and are called upon to take charge of bodies to ensure individuals and populations at large are in ‘good health’ through the promotion of practices of the self.

Methodology

One central purpose of this thesis is to explore the discursive constructions of risk, responsibility, lifestyle, and morality as they relate to three cancerous bodies. From the outset, it is imperative to provide a definition of what discourse is and how it works. According to Deborah Lupton discourse is,

the ways that meaning is established with an understanding that language does not exist in a social vacuum but is embedded in the social and political settings and used for certain purposes. Discourse, in this usage, can be described as a pattern of words, figures of speech, concepts, values and symbols. A discourse is a coherent way of describing and categorizing the social and physical world (1992: 18).

If, according to Lupton, discourse is “a coherent way of describing and categorizing the social and physical world”, it thus becomes my task to inquire into the existence, operationality and meaning of various discourses of cancerous bodies found within public health. Because public health is the primary vehicle for the dissemination of expert knowledge about cancer (as I will argue in the next chapter), it serves its purpose as the principal site from which to conduct my investigation.

The discursive constructions found within public health reveals the way power, knowledge, and truth operate and subsequently bear great weight upon the conduct of individual's daily lives: for it is not just the cancer sufferer that is a target of these discourses, but rather, all members of the population that could be affected by cancer. The application of discourse analysis then, serves to uncover the power, knowledge, meaning and ‘truth(s)’ about particular cancerous, and ‘soon-to-be’ cancerous bodies.

According to Powers,

Social agents have become responsible for dissemination of the results of truth-producing discourses in a manner that ensures understanding and compliance. Social agents include bureaucrats, police, teachers, nurses, doctors, lawyers, and other members of disciplines that employ a body of knowledge, or a discourse. Since the results are considered to be ‘true’ because they were generated by the scientific methodology, then the news

must be spread far and wide so that people have choices in a democratic society and are not prevented from knowing the 'truth' (2001: 23).

In chapters four and five I will utilize discourse analysis in order to explore the historical and contemporary discursive constructions of gender, sexuality, risk, responsibility, lifestyle and morality of three cancerous bodies. Further, analysis of the temporal, cultural, social, political, and economic milieu in which these discourses are found reveals the ways in which different cancerous bodies are subject to different forms of regulation. Because discourse defines the acceptable limits of speech, it authorizes and legitimates particular claims to knowledge and truth. Here Foucault is critically important:

...in a society such as ours, but basically in any society, there are manifold relations of power which permeate, characterize and constitute the social body, and these relations of power cannot themselves be established, consolidated nor implemented without the production, accumulation, circulation and functioning of a discourse. There can be no possible exercise of power without a certain economy of discourses of truth which operates through and on the basis of this association (1980b: 93).

My investigation will reveal the various ways in which the discursive constructions of cancerous bodies establishes an impetus for different forms of regulation (moral and self) to be enacted, practiced, and thus normalized. How and from where these discursive constructions appear and become widely circulated, embedded and dominate in contemporary Western life, will be discussed in the next chapter. Therefore, it is significant to address the role of expertise and public health in the dissemination of

these discourses, as it not only illuminates the intricate power/knowledge structures entrenched in particular discourses, but also provides insights into why some discourses are more 'dominant' than others.

Chapter 3

Expertise and Public Health

Expertise

Claims to normalcy, as they relate to a healthy body, are intricately linked to medical experts claims to knowledge and truth. Ontologically, to be healthy is to be just that: to embody certain notions, feelings, ways of being and practices and to be unhealthy is to embody nothing of what it means to be healthy. What is crucial to address is not only the ontological categorization of 'healthy' and 'unhealthy' but to question how 'healthy' and 'unhealthy' has come to be conceived of today and where these notions come from and why. The conflation of a *healthy body* as a *normal body* is all too encouraged and accepted by way of medical expertise. Historically, there has long been a relationship between expertise and normality. According to Rose,

The social citizen was the normal citizen, and normality itself became the object and target of the pedagogies of expertise. Experts elaborated the lineaments of what they took to be the normal family, the normal mother, the normal child, the normal worker. Normality here was that which was desirable, that which was healthy, that which was natural, yet simultaneously normality was difficult to achieve, constantly under threat, and needed to be safe guarded by acting in ways educated by expertise, and by constant monitoring by doctors, health visitors and other experts of the normal self (1994:380).

This quotation by Rose gives us a sense of the role played by expertise in the creation and continual perfection of the 'normal' citizen. In a similar vein, Thomas points to the implications of normalization by arguing that, "to ignore the advice tendered by doctors and health counselors is, in the eyes of many, not just imprudent but morally culpable

and health counselors is, in the eyes of many, not just imprudent but morally culpable” (1997: 15).

It is at this point that a discussion of the role and significance of expertise in neoliberal governance and public health must be elucidated. The first section of this chapter will explore the vital role played by expertise in the ‘making-up’ of the self-regulating subject in contemporary neoliberalism and the mechanisms by which this is accomplished. This brief discussion will serve as an introduction to the role of contemporary public health, or “the new public health” and its emphasis on ‘practices of the self’. Taken in its entirety, this chapter provides a framework for a broader understanding of the recent proliferation of discourses of risk, responsibility, lifestyle, and morality as they relate to particular cancerous bodies, and will also serve as a basis for the final chapter which will explore the social, cultural, economic and political implications these discourses and conceptions of health and lifestyle have on particular cancerous and ‘soon-to-be’ cancerous bodies.

One way we can attempt to answer the question of how and why medical expertise is the foremost authority on the human body, and has been granted virtually unmediated access to the surveillance, diagnosis, and curing of individual bodies and populations, is to highlight the role that *expert knowledge* (or claims to a special type of knowledge) plays in defining the ‘normal’ body. The knowledge that is accumulated and circulated by medical experts of the body is legitimated by the state, individual bodies and populations at large, through a process whereby special types of knowledge function as ‘claims of truth’. As a starting point, it is necessary to stress that medical knowledge and medical expertise did not always exist as such. The truth claims made by medicine

were not taken-up and advanced until, first, medicine aligned itself with biological and chemical science, and second, medicine formed a profession and functioned as an institutional body under and through the auspices of the state.

Interestingly, the presence of medical expertise and the power over the body that is afforded to them today is a relatively recent occurrence. The idea of a doctor possessing some sort of special skill(s) and knowledge can be traced back to the late 19th century when medicine became allied with important breakthroughs in anesthesia and antisepsis and the creation of the germ theory of disease (Conrad & Schneider, 1992: 13-14). The acceptance by the state and the population of new knowledge claims made by medicine that was born from this alliance and was in large part due to the widely held notion that science as a discipline embodied and upheld the principles of objective, rational and calculable ‘truths’ via, “the scientific method” (Larson, 1984: 53-55). Conrad and Schneider assert,

The rise of scientific medicine marked a death knell for medical secretarianism (e.g., the homeopathic physicians eventually joined the regulars). The new laboratory sciences provided a way of testing the theories and practices of various sects, which ultimately led to a single model of medical practice. The well-organized regulars were able to legitimate their form of medical practice and support it with scientific evidence (1992: 14).

It can rarely be contested that in today’s society, medical experts are afforded the highest levels of power, prestige and prominence by not only the state, but the population at large. Medical experts have the power, granted through medicine’s link to biological science, to observe, describe, define and dictate what a healthy body is and what a normal

body is. It is because of medicine's link to science that we rely upon, and in fact, encourage medical experts' intervention into individual bodily health. Science, we are told, is rational, objective, calculable and based on fact. Based upon these four principles alone (obviously more principles are said to embody good scientific research) and medical and scientific claims to special knowledge and truths, we as a society are constantly reminded of the truth and knowledge capacities that science and medicine has offered us in the past, and still offers us today. According to Ehrenreich and English,

Science...is the embodiment of disinterestedness. It is rational and calculative, but only in the interests of *truth*. Ideally, neither whimsy nor wishful thinking nor the desire for fame can becloud the scientist's deliberations: The judgment of the 'results'—the graphs, columns of figures, comparative measurements—is final. It is this image of uncompromising disinterestedness and objectivity which gives science its great moral force in the mind of the public. Science is supposed to serve no special interests, no class or privileged group (emphasis in original, 1978:69).

As of the 19th century¹, the intimate link between medicine and science, allowed for medicine to become a teller of a particular kind of truth—in the scientific truths—and thus, also moral truths. Conrad and Schneider vehemently note,

¹ According to Brandt, "The rise in life expectancy, the end of infectious epidemics, and the growth of effective and dramatic medical interventions all lead to an era of rising status and authority of the medical profession. Medicine was the undifferentiated past, where doctors could offer patients little beyond support and theory; biomedicine was the result of a 'revolution' in bacteriologic and immunologic science. The 'miracles' of modern science, dispensed in doctors' offices as well as technologically sophisticated hospitals, had brought new respect and acclaim to a profession that only a generation earlier had been little more than a competitive trade. In the nineteenth century, as all forms of regulation had eroded, it had become increasingly difficult to distinguish among a wide variety of medical sects, local healers, quacks, and so-called regular physicians who possessed a specialized education. But by the early twentieth century the profession was able to consolidate its authority and power, in large measure as a result of the germ theory and the increasingly esoteric, 'privileged' knowledge of science" (1997: 58).

Cloaked in the mantle of science, medicine and medical practice are assumed to be objective and value free. But this profoundly misrepresents reality. The very nature of medical practice involves value judgment. To call something a disease is to deem it undesirable. Medicine is influenced by the moral order of society...yet medical language of disease and treatment is assumed to be morally neutral. It is not, and the very technological-scientific vocabulary of medicine that defines disease obfuscates this fact (1992: 249).

Before medicine could gain true prominence, and legitimation by and through the state and the public, medicine was a loose amalgamation of pseudo-doctors, many of whom did not have proper training and certification, and operated under the auspices of no formal institutional body or state apparatus. A key juncture in the revolution of government in the 19th century was the authorization of medical expertise by the state, through the formal process of professionalization. Larson argues that, “the ideological destruction of the political effected by liberal philosophy provided the necessary background for an ideology of professionalism which based legitimate social power on the foundations of private monopolies of expert knowledge” (1984: 32). The alignment of the state and medicine would result in a newly fashioned apparatus of power where, “the ideology of expertise conceals both the political nature of science and scientific practice, and their close relationship with an apparatus of domination” (Larson, 1984: 67). Further, when we conceive of the power relations that are produced by way of the state and medicine’s courtship, it becomes apparent that,

the modern state is involved at least as sponsor and guarantor, if not also the chief employer of qualified personnel, or as chief provider of services. The ‘background’ role of the state is a constant reminder of the double process of dispossession that average citizens suffer as a result of the

multiple associations of maldistributed power with unequally distributed knowledge (Larson, 1984: 48).

In referring specifically to the power accorded to the medical profession and the political ties which result from this alliance, Friedson writes,

The foundation of medicine's control over its work is clearly political in character, involving the aid of the state in establishing and maintaining the profession's prominence. The occupation itself has formal representatives, organizational and individual, which attempt to direct the efforts of the state toward policies desired by the occupational group. Thus, it is by the interaction between formal agents or agencies of the occupation and officials of the state that the occupation's control over its work is established and shaped (1970: 23).

The American Medical Association (AMA) serves as an example of Friedson's claim. The AMA is an institution which not only functions at an autonomous level—i.e. more or less autonomous from state intervention—it also works with the state (and some may say for the state directly) in the analysis of various forms of health data and proposing, recommending, and overseeing of health policy (Friedson, 1970: 28-9). The AMA is a monolithic power-house which is imbued with the authority to seek out methods of intervention onto individual bodies and populations by way of its designation as a professional institution. The AMA and the medical professionals which constitute it, come to be protected by virtue of its prestige and organized autonomy, and are almost virtually impervious to political and economic intervention. If we take the example of the AMA and apply it to the quotation by Friedson below, it becomes comprehensible how and why medical expertise, such as that which emerges from bodies such as the AMA

and Health Canada, plays such a large role in the construction of a particular kind of self-regulatory subject:

...what has happened over the past century is that [medicine] has not merely devoted itself to serving the needs which the public has brought to it. Quite understandably, it has also devoted itself to discovering and delineating new needs by developing its own moral conceptions of what men [sic] can or should ideally be. Protected by its prestige and its organized autonomy, it has also come to develop its own institutions for serving public needs, institutions increasingly independent of the public and organized by the professional rather than by lay standards. This is to say, after becoming autonomous the profession has less and less come to reflect what the public asks of it and more and more come to assert that the public should get from it. Consulting the profession, the state obtains not only expert opinion on how to serve the needs the public perceives but also partisan opinion about the public's need actually are irrespective of lay opinion. Social policy is coming to be formulated on the basis of the profession's conception of need and to be embodied in support of the profession's institution (Freidson, 1970: 350).

New knowledge and truth which emerged as a result of the professionalization of medicine, established a different way to talk about, treat, and regulate bodies. Larson remarks, "by their actions—if not always by what they said—professional and intellectual leaders revealed a keen sense of the impersonal potency of discourse as a non-coercive form of power. Although the discourses over which they claimed rights were increasingly specialized, they also produced a general legitimation for their special projects" (1984: 36).

Claims to esoteric knowledges and scientific truths allowed the state and individuals to view medicine as worthy of the designation of 'expert' which thus

advanced the pace of biopolitical and biomedical intervention. As of the early 20th century, "...expert information [became] indispensable to the conduct of government, casting a web of politically salient numbers over the lives of individuals, populations and territories" (Rose: 1994: 367). Moreover, Rose notes that "government is dependent on knowledge...[it] depends upon the production, circulation, organization, and the authorization of truths that incarnate what is to be governed, which make it thinkable, calculable, and practicable" (1990: 31).

Medicine's claims to specialized knowledges and truths usurped the once traditional faith-based authority of religious orders. The idea that science and medicine can provide 'answers' to almost any question: from the origins of human species, to finding a cure for pandemic disease, to mapping the entire human genome, serves to solidify medicine as the highest, most trustworthy form of expertise. How it comes to be that the state is so successful at governing bodies through managing the health of the population occurs through the normalization of individual self-regulation and responsabilization. What is of vital importance about medical expertise is that it provides the knowledge and techniques of intervention so the state does not have to. Miller and Rose assert that, "expertise requires powerful capacities, not only in linking deliberations in one place with actions in another, but also in promising to align the self-governing capacities of subjects with the objectives of political authorities by means of persuasion, education and seduction, rather than coercion" (2008: 208-9). Therefore, the ambitions of government, as well as the citizen, are grounded in an individual's 'choice' and 'free will'. According to Greco,

A health that can be chosen...represents a somewhat different value than a health one simply enjoys or misses. It testifies to more than just a physical capacity; it is the visible sign of initiative, adaptability, balance and strength of will. In this sense, physical health has come to represent, for the neo-liberal individual who has 'chosen' it, an 'objective' witness to his or her suitability to function as a free and rational agent (1993: 370).

There appears to be something 'new' happening with expertise in neoliberal governance. Although I will only briefly mention this here (for sake of space and the trajectory of my inquiry) it must be recognized that there no longer appears to be a unitary medical expertise model, in which medicine holds all of the rights over claims to privileged knowledge and truth. Since perhaps the 1970s, where we see the expansion of public health, we also see a fragmentation of scientific and medical expertise. Increasingly, there are more contestations in regards to medical expertise from the state, individuals, and within medicine itself. Further, it must be recognized that due to this fragmentation of medical expertise, patients are not as willing as they may have been in the past to simply accept without question the expert advice offered by medicine. The rise of the self-help movement and the internet could in large part account for the fragmentation we see today; coupled with the notion that it is increasingly important for individuals to attend to practices of the self (and inherent in these practices of the self is the accumulation of knowledge of one's self). Therefore, patients are increasingly becoming experts for and of themselves. However, it must be noted that now perhaps more than ever before, people rely on scientific and medical expertise—in all its competing forms. The objective, rational and calculable nature of scientific and medical expertise still provides a sense of security and reassurance in times of uncertainty (and we have plenty of uncertainty these days according to Zigmunt Bauman). Whether we get the

expertise from our doctors, journals, magazines, or internet medical blogs, forums and/or med-help websites, we are constantly looking for the expertise that will quell the risk, fear and anxiety that constitutes our contemporary lives.

The purpose of highlighting the role of scientific and medical expertise in contemporary neoliberal governance is to show how practices of the self are informed by medical expertise and that public health is the main vehicle through which discourses of risk, responsibility, lifestyle and morality are promoted and normalized. The next section of this chapter will examine the role of contemporary public health in the creation of the self-regulating subject.

Public Health

In *The new public health: Health and self in the age of risk* (1996) Petersen and Lupton assert that for as long as the term 'public health' has existed, there has been a continual struggle between scholars and legislators alike, to come to a consensus on what 'public health' actually encompasses. They note that its most basic (and widely consensual) definition refers to public health as forms of health care delivery not provided by the 'private' sector (3). Definitional and conceptual struggles aside; they suggest that the state of public health has been substantially altered in its constitution and application since the 1970s. Petersen and Lupton highlight that this significant modification to public health has, like liberalism's progression to neoliberalism, transfigured into something 'new': a 'new public health'. They attribute this shift to a series of rapid (and some argue global) governmental, legislative, environmental, and economic transformations which began in the mid-1970s and early 1980s. They argue

that as a result, these transformations reworked the old definition(s) and conceptualizations of public health (1996: 5).

The expansion of public health post-welfare state, would see the incorporation of private business into public health, as well as the incursion of this new model into the private lives of citizens in very unique and often-times complex ways. Perhaps one of the most significant aspects of the new public health is that today it is highly dependent on the notion of ‘volunteerism’, which is a driving principle behind neoliberal governmentality.² Moreover, the paradigmatic shift experienced in the 1970s saw a reconfiguration of discourse within public health. Brandt argues, “by the mid-1970s, discussions of the ‘right’ to health care had been transformed to the ‘duty’ to be healthy” (1997: 70). The results of this shift according to Petersen and Lupton, saw “the development of a ‘duties discourse’ in parallel with the ‘rights discourse’ [which] brought a stronger *emphasis on social obligations and personal responsibilities* that are restricted neither to national boundaries nor to a single generation” (1996: 12-13, *my emphasis added*).

For clarification, if not definitional purposes, it is worth citing Petersen and Lupton at length:

The new public health encompasses such concepts and strategies as health promotion and health education, social marketing, epidemiology, biostatistics, diagnostic screening, immunization, community participation, health public policy, intersectional collaboration, ecology, health advocacy and health economics. All of these are relatively ‘new’ approaches, which are used in conjunction with, or have supplanted, older methods of preventing diseases such as quarantine, isolation and sanitary inspection. The new public health mainly incorporates voluntary actions on the part of citizens but also uses legislation...Emphasis is placed on

² This aspect of the new public health will be explored further in the final chapter of this thesis.

cooperative relationships between state institutions and agencies, agencies and organizations in the private sector, and voluntary organizations; this is typically described as 'intersectional' cooperation (1996: 5).

For the purposes of this chapter, and the thesis as a whole, I situate my analysis of the discursive constructions of risk, responsibility, lifestyle, and morality through Petersen and Lupton's conceptual and theoretical framework of 'the new public health'. Exploring the operations and implications that the new public health has on populations and the bodies therein, allows for a connection to be established between the theoretical and the practical: of the making-up of the everyday normalized, responsible self-regulating subject. Therefore, this section of the chapter will provide a theoretical framework and foundation for exploring the discourses surrounding different cancerous bodies and the social, cultural, political and economic milieu in which they reside.

Public health is the site through which individual bodies become the target of projects of moral and self regulation. Socio-cultural and political discourses which centre on notions of what a normal body is and what a normal is not, is made possible, visible, operable, practiced and perfected through discursive constructions found within public health. Public health today has prompted a shift in the way we conceive of our bodies. Particularly in the West, we have formed a 'hyper-awareness' of our bodily actions on a daily basis. I suggest that this hyper-awareness differs drastically from a historical conception of the body in which people only accounted for and attended to their bodies after disease or illness had set in. It is now the case that from a very early age, and through the entirety of our lives, we are constantly and acutely aware of our disease/illness potentiality and mortality. What is disconcerting about this new

conception of the body is that this hyper awareness and corresponding bodily vigilance has become all too common, if not to say, normalized.

As many Foucauldian scholars who take ‘the body’ as an object of exploration and analysis have noted (see, Petersen & Lupton 1996; Lupton, 1995; Rose, 2006; Turner, 1992) the implications of normalizing conceptions of ‘health’, ‘lifestyle’ and ‘the body’ not only create the conditions for dichotomies to emerge around the body: health/illness, right/wrong, good/bad, normal/abnormal, success/failure, but also situates acts that *transgress* normalized bodily practices as immoral.³ Further, and as a result of the processes of normalization, the associations between health, the body and morality are conflated to such an extent that it becomes increasingly difficult to conceive of one without the other (or ‘others’ as the case may be). Petersen and Lupton note,

The ‘healthy’ body has become an increasingly important signifier of moral worth, a mark of distinction that serves to delineate those who deserve to succeed from those who will fail. The pursuit of health through work on the body has become a crucial means by which the individual can express publically such virtues as self-control, self-discipline, self-denial and will power—in short, those qualifications considered important to being a ‘normal’, ‘healthy’ human being (1996: 25).

In essence, this normalization process provides the general praxis for how individuals are to be measured in relation to themselves, to one another, and to the state. The normalization of public health surveillance and intervention in general, and medical surveillance and intervention in particular, serves its grand purpose in neoliberal

³ These ‘transgressions’ could range from improper eating habits, to insufficient amount of exercise, over-consumption of alcohol, cigarettes and drugs, unsafe sexual practices or anything that could be constituted as ‘risky’ lifestyle practices.

governmentality, where the *regulation of the self* is the definitive act of a normal and moral citizen. According to Lupton,

Through normalization, the late modern individual is fabricated within a network of instruments and techniques of power. The technologies of mass surveillance, monitoring, observation and measurement are central to this disciplinary power, helping to construct understandings of bodies in space and time and to use these understandings to regulate them (1999: 87).

Public health is an expansive entity that not only promotes and circulates notions of self-regulatory health and lifestyle practices, but through its very composition, entrenches highly complex relations of knowledge, truth, and power. Today in the Western world, every citizen to some extent has been, “caught up within what has become an expanding web of power and knowledge around the problematic of ‘public health’” (Petersen & Lupton, 1996: 5-6).

In “Risk and the regulated self: The discourse of health promotion as politics of uncertainty” (1996), Petersen argues that the new public health moves away from an older model of public health which centered on practices of ‘victim blaming’ (44). Various critiques of the old model of public health argued that it was insufficient because it blamed the victim based on factors that lay beyond the control of the individual, namely, socio-economic status, geography, race, gender, age.

Petersen argues that because many of the individual lifestyle choices are very much shaped by social, cultural, political and economic factors, “attempts to force lifestyle changes on individuals [is] not only counterproductive but [is] repressive” (1996: 44). He notes that the new public health sees a broader and more inclusive conception of

health promotion which situates health as being a product of a multiplicity of influences and forces of the social and physical environment and is premised on the involvement of all citizens in defining health and influencing the circumstances affecting health (Petersen, 1996: 45). To an extent, I agree with Petersen's assertion that the new public health is far more inclusive, and most certainly attends more closely to 'non-modifiable' factors such as those listed above. For it was the case that in the previous model of public health, some would be highly regulated, monitored and contained (infectious bodies being quarantined) and some would be greater targets for sanitation reform than others (lower classes in newly industrialized cities). What Petersen fails to address however, and what concerns me most here, is that the byproduct of this more inclusive public health model sees the casting of a wider umbrella under which *all* individuals are made responsible for lifestyle choices; and these choices are more so now than ever before, subject to moral scrutiny. One's failure, or even inability, to attend to (normalized conceptions of) practices of the self, places an individual on a vertical moral continuum, a hierarchy, that takes as one of its point of reference, the discursive constructions of 'duty,' 'wellness' and 'citizenship'.

In the same article by Petersen, he makes the assertion that, "under the health promotion banner, the distinction between healthy and unhealthy populations *totally dissolves since everyone is 'at risk'*" (Petersen, 1996: 49, *my emphasis added*). I do not dispute his claim that everyone is now 'at risk', however, I believe that to allege that the distinction between 'healthy' and 'unhealthy' dissolves as a result of everyone being 'at risk,' is a far too simplistic claim which ignores the *conflation* between risk and health, particularly within contemporary Western neoliberal governmentality. The word 'health'

instantaneously conjures positive associations—associations that are linked to a conception of a contained, virtuous, regimented whole. Alternatively, the contemporary notions of ‘risk’ are almost exclusively conceived of as negative and dangerous—as potentially threatening to disrupt the contained wholeness of ‘health’ or a ‘healthy body’. The classification of someone as ‘healthy’ or ‘unhealthy’ is contingent upon the multifarious interactions that an individual or population has with risks. Moreover, Petersen’s argument misses the mark once again, as not all health promotion strategies are distributed evenly or with the same vigor.

Take for example health promotion strategies around cigarette smoking and excessive exposure to ultraviolet light. Both are ‘risky’ because they can cause cancer, and that over-indulgence in either can result in disease and/or death. But health promotion strategies do not necessarily conflate the notions of risk and health as strongly with ultraviolet exposure as they do with cigarette smoking. Because the resultant diseases from over-exposure to cigarette smoke and ultraviolet light are almost avoidable if behavior is modified, coupled with the notion that the incidence of people diagnosed with skin cancer far outweighs the incidence of lung cancer worldwide, one would assume there would be greater strategies on the part of public health to ‘spread the word’ about the dangers of ultraviolet light.⁴ Although the scope of this chapter prevents me from expanding on this insight, this small example serves to highlight the propensity on

⁴ This is just one example that can be highlighted—another example might include heart disease. Heart disease kills more people a year worldwide than lung cancer. Further, (limited incidence of hereditary and genetic causation aside) eating ‘well’ and getting more exercise would reduce heart disease incidence and mortality rates significantly. Public health tends to take as its dominant discourse, eating right and daily exercise as ‘fitness’, ‘well-being’ and ‘looking and feeling healthy’(read: slim) as opposed to eating right and daily exercise can help one avoid heart disease.

the part of public health towards an uneven distribution of risk discourses around particular acts.

Since the 1970s there has been a distinct ideological shift wherein the state was to *protect the health of individuals and populations*, to a situation today where *individuals are responsible to protect themselves from risk* (Petersen, 1996: 49, *my emphasis added*). Petersen argues that, “a close examination of the goals of health promotion and of its related strategies shows how the processes of risk management have, in effect, served the objective of privatizing health by distributing responsibility for managing risk throughout the social body while at the same time creating new possibilities for intervention into private life” (1996: 49). The principal consequence of this shift is that the state becomes less responsible to the populations it is supposed to be responsible for. ‘The health of one is the health of all’ neoliberal ideology, serves as a guise which deresponsibilizes the state. In place of state action and accountability, we see the emergence and expansion of acts of health empowerment through self-regulation, various lifestyle management techniques, countless fundraisers for the fighting of a host of diseases, and more generally, practices of the self which increasingly serve to divert *our* attention away from the inaction of the state.

At the beginning of this section I presented Petersen and Lupton’s definition of the ‘new public health’. The “intersectional cooperation” of the new public health can best be understood as an amplification of health promotion strategies which blurs the lines between public and private, local and global, freedom and submission. Under the guise of these more diffuse and inclusive health promotion strategies, the new public health ‘un-blurs’ the once blurred lines of risk and certainty, healthy and unhealthy,

responsible and irresponsible, moral and immoral, citizen and alien, and individual and community. The compulsion 'to be' and remain on the right side of the dividing line is stronger today than ever before. The failure to embody the associated processes and practices through excessive vigilance to practices of the self can have detrimental repercussions. The new public health that is said to be more inclusive and less blameworthy is most certainly creating the conditions for hyper- individualization and responsabilization through self-regulatory mechanisms.

In this chapter I have outlined the role of expertise in the promotion of the self-regulating citizen, via practices of the self. The importance of highlighting the role played by expertise (medical expertise in particular) allows us to understand not only the power that is afforded to them and their associated techniques of surveillance and intervention onto the body, but also serves to make us aware of the importance of medical and scientific expertise's presence in public health. Further, I argued that public health is the site through which expertise's claims to knowledge are disseminated and enacted. As discussed in the first section of this chapter, to ignore the knowledge (of risks) presented by experts, is not just imprudent, but morally culpable. In essence, neoliberal governmentality since the 1970s has transformed not only the structure and scope of public health, but also resulted in greater power afforded to scientific and medical expertise. A primary result of these shifts is the emergence of new discursive formations and discursive limits being defined that are very much in accordance with neoliberal governance. The next two chapters of this thesis will be devoted to an exploration of historical (pre-1960s) and contemporary (1960s to the present day) discourses of risk, responsibility, lifestyle and morality as they relate to particular cancerous bodies.

Chapter 4

Historical Explorations of Cancerous Bodies

This chapter explores the discursive construction of cigarettes smokers, women with breast cancer and women with cervical cancers (and those bodies *at risk* of these cancers) from the 18th century to the early 20th century. This chapter also provides a foundation for an analysis of the contemporary discourses around particular cancerous bodies, which will take place in the following chapter. For ease of readability, I have divided this chapter into two sections. The first section is devoted to an examination of cigarette smoking and the lung cancerous body and the second section will examine the historical discursive constructions of women and cancer.

Historical discourses of smoking and lung cancer

It is fruitful to open this chapter with a quotation from Richard Klein's *Cigarettes are sublime* (1993). According to Klein,

Smoking cigarettes is not only a physical act but a discursive one—a wordless but eloquent form of expression. It is a fully coded, rhetorically complex, narratively articulated discourse with a vast repertoire of well-understood conventions that are implicated, intertextually, in the whole literary, philosophical, cultural history of smoking (182).

Since approximately the mid-1900s lung cancer has become widely accepted as the 'cigarette smoker's disease'. Although a large majority of lung cancer incidences have been causally linked to the consumption of cigarettes, not *all* cases of lung cancer,

historically or today, have be attributed to the act of cigarette smoking.¹ Moreover, many cigarette smokers who have smoked their entire lives will never be diagnosed with lung cancer.

Although the slightly-modified version of the cigarette that we see today circled its way around the globe in the early 19th century, it was not until 1869 in the United States that the cigarette took on its modern form through the refinement of manufacturing technologies, and the mass marketing and consumption of the product (Brant, 2007: 25-27). Before the emergence of a large body of scientific and medical literature in the mid-1900s established a causal connection between cigarette smoke and various diseases such as cancer, stroke and heart disease, the historical socio-cultural discourses around cigarettes were anything but clear cut.

When cigarettes began being widely manufactured and distributed in the United States and Canada, many smokers and non-smokers alike saw cigarettes as an emblem of modernity and sophistication (Tate, 1999: 4). Further, many saw smoking as an instrument of self-control and a tool to relieve the everyday stresses of industrial life (Hughes, 2003: 91). Hughes (2003), Klein (1993) and Brandt (2007) all argue that one of the main reasons why cigarette smoking was so popular (and received far less ‘negative attention’) in the late 1800s and the early 1900s, was in large part due to the association between smoking and masculinity. Klein in particular argues that the phallic symbolism of the cigarette was deeply linked to masculine qualities (1993: 62). And according to Rudy, the late 19th century witnessed “the height of the relationship between respectable

¹ Other incidences of lung cancer have been attributed long-term exposure to second hand smoke and also practices associated with labour. The inhalation of toxic substances over a prolonged period, such as the ingestion of sediments, gases, vapors and asbestos is also attributed to the rise in the world-wide increase of lung cancer incidence and mortality.

masculinities and smoking. Male smokers saw themselves as having self-control and as being connoisseurs. Smoking brought men from different backgrounds together. It gave odour and visible shape to spaces socially constructed as male” (2005: 6).

Another reason why cigarettes were so popular at this time is that they were also a socio-cultural symbol for intellectuals, philosophers and artists. Kant, Sartre, Picasso, and Coco Chanel were but a few of the intellectuals, philosophers and artists which sought intellectual, emotional and artistic inspiration through cigarettes; thus adding to the allure, seduction and sexuality of not only themselves but also their work (Klein, 1993: 30 & 43). Many writers would employ the cigarette as a metaphor for a variety of daily pleasantries and would express the physical, mental, and symbolic power of the cigarette through their work (Klein, 1993: 33).

Almost every social historian who has written texts devoted to the topic of cigarettes has placed great emphasis on the role of cigarettes in both World Wars. During both World Wars many anti-tobacconists in the West, including the Women’s Christian Temperance Union, and various governmental lobbyists, argued against the military’s reliance on tobacco, citing the physical and moral implications that it had on soldiers. However, both soldiers abroad, and patriots for the cause at home, argued that first and foremost, cigarettes served as a distraction to the grave tragedy of war; and second, cigarettes became a symbol of bravery and masculinity in the face of the enemy (Klein, 1993: 139-140). Cigarettes, like food, would be sent to the troops and rationed. They were an essential part of military life and embodied ideals of citizenship and patriotism (as the manufacturers were seen as performing a very patriotic act by way of producing the cigarettes) (Rudy, 2005: 132). Brandt argues, “in the face of war’s bloodshed, the

traditional notions that a prohibition on tobacco protected the troops from moral harm and health risks seemed frivolous...the moral threat of the cigarette suddenly seemed tame and anachronistic, and smoking seemed positively safe compared to the profound violence confronting the men overseas” (2007: 51).

Before the end of World War One smoking was a highly gendered activity. Women were not only discouraged from taking part in smoking, but were often said to be of loose moral character if they dared to try a puff. The idea that a woman should not smoke stemmed from the notion that first, smoking was associated with masculinity and industrial labour, and second, that women as the bearers of the future generation must be healthy and not partake in an act that could endanger the physical and moral health of her children (for a compelling example of this, see Appendix B). It was not until the inter-war years that smoking became increasingly acceptable for women. Realizing the extreme profitability of cigarettes, manufactures intensified advertising, and endeavored into the relatively untapped market of women. Advertisers and tobacco companies made cigarettes ‘sexy’ for women and for men (Hughes, 2003: 88). For women, the image of the slender, self-confident and ‘independent’ woman was ubiquitous. As for men, masculine, rugged and stoic images clouded the North American cultural landscape.

Although the body of the cigarette smoker has been discursively constructed in various ways throughout history, I have chosen to focus specifically on the discourses that centre on risk, and most importantly, morality. Further, I have chosen to pursue the task in this manner, because by and large the temporally prevalent discourses of cigarette smokers as sexy, stoic, heroic and the vice of intellectuals and artists, has been virtually cast aside. The prevalence of dominant discourses which situate the smoker as immoral,

dangerous, risky and irresponsible has remained and been exacerbated due to the scientific link which established smoking as the leading cause of lung cancer. The discourses that have been revealed as a result of my inquiry fall into four 'categories'. However, it must be noted that these are not mutually exclusive, and do in fact overlap. First I will examine the 'bodily harm discourses'; second I will examine the 'contamination discourse'; then I will look at the 'religious discourse'; and finally I will examine the 'self-control discourse'.

Many of the discourses that have emerged from a historical examination of the cigarette smoker situate cigarette smoking as an offence to the mind and the body of the smoker (and also the non-smoker who was affected by the rancid smell). Cigarettes were said to attack the smoker's emotional and intellectual health. In *The household guide, or domestic cyclopedia* (1894), Jefferis and Nichols argued that, "[cigarettes smoking] burns up good health, good resolutions, good manners, good memories, good facilities, and often honesty and truthfulness as well" (190). Moreover, the act of smoking was often said to cause mental disturbances and neurotic behaviours. Hughes presents an account given by a doctor of medicine in the early 1900s, where the doctor noted that all of the mentally-ill patients that sought his assistance were smokers, and he vehemently advised all of his patients that if they smoked, or dared to smoke, were to surely suffer from mental distress and perhaps even insanity (2003: 100). The link between insanity, mental illness and emotional distress has long been viewed as an individual weakness in which one's capacities to make proper judgments and rational decisions are compromised. The irrational character of the smoker signaled a link to immorality: uncontrolled emotions

were a sure sign that there was something lacking in an individual's character and psyche.

The effects of cigarette smoking did not just wreak havoc on one's psychological, emotional and intellectual capacities, it also had substantial implications on one's physical capacities. Sullum notes, "among other things, [cigarettes] were said to cause stunted growth, weakened immunity, insomnia, shattered nerves, shaky hands, poor motor coordination, heart palpitations, cardiovascular disease, high blood pressure, lowered vitality, restlessness, drunkenness, and impaired mental ability" (1998: 31). The harm that cigarette smoking caused to one's body appeared to be endless. Jeffers and Nichols mince no words when they explain the deadly repercussions of smoking (especially upon young boys):

...cases of epilepsy, insanity and death are frequently reported as the result of smoking cigarettes, while such physicians as Dr. Lewis Sayre, Dr. Hammond, and Sir Morell Mackenzie of England, name heart trouble, blindness, cancer and other diseases occasioned by it...[l]ook at the pale, wilted complexion of a boy who indulges in excessive cigarette smoking. It takes no physician to diagnose his case, and death will surely mark for his own every boy and young man who will follow up the habit. It is no longer a matter of guess (1894: 190-191).

The notion that one's physical, emotional, and intellectual capacities could be at risk as a result of cigarette smoking was increasingly abundant in latter part of the 1800s and worked to counteract the rhetoric evoked by masses of people who saw cigarettes as a symbol of modernity and progress. Anti-smoking/anti-tobacco advocates combined the

physical, emotional and intellectual risks of smoking, with the risk that one's social location might falter.

Another discourse that emerged around cigarettes in the late 1800s, was one that saw cigarettes as a contaminant; not only a contaminant that clung to the clothes, teeth, hair and breath of the smoker, but one that contaminated non-smokers: the ones who sought and fought for 'the right to breath clean air'. Because anti-tobacconists and many upper class women viewed smoking as a dirty and vile habit, many male smokers were prompted to take precautions, so as not to offend the lungs, clothes and sensibilities of non-smokers (specifically women and children). In 1852 Charles Day expressed his concern over cigarette smoking in his text, *Hints on etiquette and the usages of society: with a glance at bad habits*. He writes,

If you are so unfortunate as to have contracted the low habit of smoking, be careful to [practice] it under certain restrictions; at least, so long as you are desirous of being considered fit for civilized society. The mark of a gentleman is a sensitive regard for the feelings of others; therefore, smoke where it is least likely to prove personally offensive by making your clothes smell; then wash your mouth and brush your teeth. What man of delicacy could presume to address a lady with his breath smelling of onions? Yet tobacco is equally odious. The tobacco smoker, in *public*, is the most selfish animal imaginable, he perseveres in contaminating the pure and fragrant air, careless to whom he annoys, and is but the fitting inmate of a tavern (1852: 53-54, *emphasis in original*).

Although the visibility, and thus acceptability of smokers has experienced an ebb and flow over the last two hundred years (the war periods helped to push cigarette consumption into a more public spaces) non-smokers have almost always taken great offence to the habit. In the next chapter I will examine the

contemporary contamination discourse and attempt to highlight how this notion of contamination has resulted in the re-confinement of smokers spatially (through legislation), as well as confined them to a non-material space in which their actions, behaviours, and habit is considered to be socio-cultural segregation.

Another way in which cigarette smoking became discursively linked with risk and morality was through the use of metaphors which declared the cigarette and the smoker as evil: as partaking in an ungodly act. Jeffers and Nichols note, “leading physicians of America unanimously condemn cigarette smoking as one of the vilest and most destructive evils that ever befell the youth of any country...its direct tendency is a deterioration of the race” (1894: 191).

During the early 20th century, when the medicalization of cigarette smoking was on the rise, many doctors held that the “evils of tobacco” were leading to the deterioration of the moral and physical capacities of many men, women, and especially ‘youth’ (Hughes, 2003: 98-99). The conflation between ‘evil’ and cigarette smoking was advanced through various attempts at prohibition; chiefly from the Women’s Christian Temperance Union (WCTU). Miss Mills of the WCTU, a strong advocate for alcohol prohibition, switched gears in 1929 and became one of the leading advocates for the prohibition of smoking which primarily targeted ‘youth’. In an article which appeared in a 1929 edition of *The New York Times*, Miss Mills was quoted as saying, “[tobacco is] a great menace to our young people as alcohol—probably more so” and that, “never was there a time when it was so necessary to warn young people against the dangers that beset their paths. No child who is going to school is safe today from the insidious influence of drugs and tobacco” (New York Times, 1929). The early 20th century also saw a

proliferation of a host of cigarette epithets and religious connotations: “coffin nails, little white slavers, dope sticks, paper pills, brain capsules, coffin pills, Devil’s kindling wood” (Sullum, 1998: 31). The discursive construction of the cigarette smoker as a soon-to-be suicide victim also pervaded the discursive landscape of the cigarette smoker (Klein, 1993, Sullum, 1998, & Brant, 2007)

To a great extent, much of the religious discourse centered on the inability of smokers to control their urges; as if they had been taken over by an ungodly force which further propelled them into a darker place where self-control was completely absent. The labeling of smokers as ‘cigarette fiends’ signaled an inability for self-control and self-regulation (Sullum, 1998: 28). This lack of self-control through the consumption of cigarettes was often discursively linked to other addictive, excessive, and delinquent behaviours such as alcohol consumption, family/relationship violence and divorce (Troyer and Markle, 1983: 38). In an opinion column from *The Washington Post* in 1924, Antionette Donnelly reflected on the recent suicide of a 23 year old girl. She asserted that more than likely the girl’s suicide was induced by the destructive, evil and unforgiving act of cigarette smoking. Donnelly attributed the untimely death of the girl to the lack of self-control—and much like alcohol, coffee and other “stimulating habits”, the longer the use, the harder it became to rid one’s self of the habit and greater destruction would surely ensue (Donnelly, 1924: SM10). In an attempt to warn parents (specifically fathers) of cigarette-consuming “flapper girls” across the nation, Donnelly writes,

We hope daughter has not become one of a growing army of cigarette users who cry aloud for their weed the moment their eyes are open to the light of day; who cannot [sic] sit down to a meal without danger of letting the ashes fall into the soup, the gravy and the ice cream. Because, when

you have the habit to that extent, you are in danger. The thing has gone far beyond a mere problem of esthetics (Donnelly, 1924: SM10).

Cigarettes were not only risky to one's 'esthetics', as Donnelly states, but the smoker was put at risk for becoming an addict: physically and mentally dependent on a 'drug' which weakened one's sensibilities, reason and jeopardized one's social reputation.

It is worth presenting a long quotation by Brant, which addresses many of the moral complexities that surrounded early cigarette smokers. Also, I must note that although the worries of anti-tobacconists might not appear the same today (for example the notion that one would commit suicide because she/he was a smoker) the moral complexity still endures and, I argue, is quickly approaching its apex. For it is the case today that the cigarette smoker has much more to worry about than disgruntled stares and looks of disgust. When the smoker has been diagnosed with lung cancer, there is no escaping the moral complexities which accompany the onset of such a disease.

Moral considerations were practically indistinguishable from concerns about the health effects of smoking. Did smoking cause degeneracy? Or was it simply that degenerates liked to smoke? This question, posed in a wide variety of forms for a breathtaking range of negative effects, succumbed to no easy answers. Was the cigarette but a signal of 'relaxation of self control,' poor scholarship, and other signs of moral laxity, or could the problems of youth be attributed to smoking itself? In the face of such unanswerable conundrums, moral presumptions about smoking frequently surfaced to dominate the debate (Brant, 2007: 108).

Dependent upon the era of particular consumption habits and socio-cultural acceptability, cigarettes have been demonized as immoral and dangerous; praised as fashionable, sexy

and a large part of the cultural norm; implicated as a social ill that must be cured/made absent, and in the contemporary era, deemed to be one of the most deadly acts resulting in ill-health and indicative of the need for regulation at the level of the individual and the state.

There were two main events that emerged out of ‘scientific and medical discovery’ which threw cigarette smoking further into the depths of moral laxity: the first was the release of the Surgeon General’s Report on Smoking and Health in 1964. This report, released in the United States, drew upon ‘scientific’ and ‘medical’ experts who showed a positive correlation between individuals who smoked cigarettes and the prevalence of lung cancer. Although the findings of the report had little effect on individual cigarette consumption through the mid-to-late 1960s (Brecher, 1972) a growing number of public health initiatives and scientific research based groups and committees emerged with full force. At this time, the medical and public health initiatives were focused on the risk individual cigarette smokers posed only to themselves. It was not until 1986, with the discovery of second hand smoke (known then as Environmental Tobacco Smoke [ETS]) that the immorality of harming others with one’s own tobacco smoke was made explicit—not only in scientific and medical literature, but also within the social, legal, and public health realms (Sullum, 1998: 140). In the next chapter I will examine the contemporary discourses of smoking and lung cancer by highlighting the significance of these two ‘discoveries’ outlined above.

Historical discourses of women and cancer

This section of the chapter reveals the discourses of women with breast cancer and cervical cancer, as well as women in general who could *potentially* suffer from these cancers, from the mid 18th century to the early 20th century. I must note from the outset of this section that due to the nature of this inquiry, namely its focus on the discourses that surrounded women and cancer, there is a paucity of historical accounts from which to glean a comprehensive understanding of the way these bodies were discursively situated. The limited amount of contemporary socio-cultural texts about the historical situation of women and cancer in the 18th and 19th centuries speaks to the limited existence of historical documentation about women's experiences with cancer. Almost all of the authors who have sought to explore the history of women and cancer attribute reasons for this void (Yalom, 1997, Leopold, 1999, Jasen, 2002 & Stacey, 1997).

The first being, historically men's bodies have largely been taken as a point of reference for anatomical and physiological investigations. The notion that the male body is superior, made it easy for women to be absent from almost all scientific and medical literature which discussed the functions and operations of the human body. As a consequence of this, the second attribution follows. The veiled position of women in almost all spheres of public and scientific life, and the notion that women's bodies and sexuality were taboo, accounts for the limited historical sources we can draw from today.

Women's bodies have long been discursively ambiguous bodies. At times they have been conceived as evil, vile, leaky and in need of strict containment and control. At other times they have been seen as liberatory, natural, powerful and essentially perfect. From the time of antiquity through the early Renaissance, a woman's body was thought to be the inversion of the male body. Where males were to be considered warm, women

were cold; male genitalia was exposed, women's was hidden; the male body was perfect, while the woman's body was the imperfect inversion of the male form (Laquer, 1990). Several historical analyses of the scientific, anatomical, and physiological accounts of bodies from antiquity onwards, suggests that women's bodies in particular have long personified ideological, discursive, and material spaces of ambiguity. Laquer argues that it was not until the female body was seen as inherently (physically, emotionally, and intellectually) distinct from the male body, that women's bodies were marked as defective, powerful, emotional, innocent, hysterical, etc. The fact that women's reproductive organs were hidden signaled not only mystery, but the potential for powerful intervention into the public lives of men (Laquer, 1987: 24-27). According to Laquer, it was the distinction of organs through new language (labeling) that initiated the construction of two very distinct sexes and genders. Laquer employs the example of female menstruation and asserts that the impact of naming organs, such as the ovary (which was long referred to only as the female version of the male testies) revealed not only the different functions of these organs, but the idea that these functions were distinctly female and thus a symbol of women's inherent power: "the ovary, whose distinction from the male testies had only been recognized a century earlier, became the driving force of the whole female economy, with menstruation the outward sign of its awesome power" (Laquer, 1987: 27-28)

Biological discourses of women had great influence on the social and the political discourses of women. Schiebinger argues that in the sixteenth century (with all of its advancements in anatomy and physiology) there emerged a discourse of inferiority of women based on the female skeleton (1987: 43). She argues that the images of the first

female skeletons, depicted with smaller skulls, did not represent the growth of realism in anatomy, rather it represented women's intellectual inferiority to men (Schiebinger, 1987: 43). Further she asserts that,

This scientific measure of women's lesser 'natural reason' [through skull measurement] was used to buttress arguments against women's participation in the public spheres of government and commerce, science and scholarship. The larger female pelvis was used in parallel fashion to prove that women were naturally destined for motherhood, the confined sphere of hearth and home (1987: 43).

The ambiguity of the female body, many argue, was most visible in the Victorian era. For example, feminist scholar Smith-Rosenberg argues,

Women, Victorian society dictated, were to be chaste, delicate, and loving. Yet her Victorian contemporaries assumed that behind this modest exterior lay a complex network of reproductive organs that controlled her physiology, determined her emotions, and dictated her social role. She was seen, that is, as being both higher and lower, both innocent and animal, pure yet quintessentially sexual (1985: 183).

The long-held notion that women are inferior to men (biologically, socially, politically and economically) had substantial impacts on the way women were treated within medicine (or not treated, as the case may be). This historical hegemonic ideology of the insufficiency of a woman's body and mind negated her visibility and thus participation in everyday life, which included scientific and medical life.

The 'nature' and capacities of women (and the feminine) were almost entirely absent. As a consequence, women had little opportunity to employ the methods of science in order to revise or refute the emerging claims about the nature of women. As science gained social prestige in the course

of the nineteenth century, those who could not base their arguments on scientific evidence were put at a severe disadvantage in social debate. Thus emerged a paradox central to the history of modern science: women (and what women value) have been largely excluded from science, and the results of science have often been used to justify their continued exclusion (Schiebinger, 1987: 43).

Jasen argues that during the Victorian era, public silence around breast cancer and cervical cancer was heightened, as many in middle and upper-class society considered the disease or illness to be a disgrace and something that must remain hidden (2002: 28). Moreover, Taylor (1998) notes that females suffering illnesses were confined to the private sphere and rarely made their illness known to the rest of the family. Women of all social classes were expected to go about their daily routines as best they could and keep their dreadful secret concealed. Often times when a woman was found to be suffering from cancer, the shame and stigma of having the illness would remain hidden and the woman would suffer in silence. The shame and stigma that illness brought upon middle and upper-class households often times proved fatal for many women; as seeking help outside of the immediate family was rarely undertaken.

As a result of the androcentric nature of science and medicine, many sufferers of breast cancer had very little (if any) physical contact with their doctors. Yalom discusses the doctor-patient relationship in the 18th and 19th centuries and argues that there existed an extreme taboo around doctors touching and looking, specifically at women's breasts and chest area. If doctors were unwilling to touch a woman's breast, they were unsure of the progression of the lump, and thus unable to intervene and provide solutions to a growing tumor; which was often accompanied by severe and prolonged pain and

suffering (1997: 219). Renowned physicians such as Matthew Baillie, who published one of the most important and influential medical works of its time, *The morbid anatomy of some of the most important parts of the human body* (1797) devoted a substantial portion of the text to what would have been broadly defined at that time as ‘the diseases of women’. The ‘diseases of women’ (as it was referred to by other authors of influential anatomical texts) often times only included diseases which resided in a woman’s reproductive system. Baillie never once mentioned the word ‘breast’ throughout the entire 200 plus pages of the text. The cultural taboo over women’s breasts was so strong at that time, that investigating the breast would result in the transgression of strictly defined physical and moral boundaries. Prior to the introduction of the ‘medical gaze’, the idea of touching a woman, let alone her breasts, was almost always out of the question, as doctor’s “delicate morals” prevented them from performing such an examination (Foucault, 1973: 201).

Although there may be more complex reasons as to why there have been limited amounts of historical evidence of women and cancer, I feel that I have addressed the substantive ones. What was uncovered in the small amount of literature available on women and cancer will be addressed below.

Quite similar to the cigarette smoker in the late 19th century, the state of the mind and the body garnered special attention for women who suffered from breast cancer and cervical cancer. Although early scientific and medical theories could not pinpoint the exact cause of cancer in women, many theories speculated a number of causes and many of those speculations targeted a woman’s ‘natural/essential’ emotional and physical capacities as one of the main causal factors in the development of cancer. Jasen’s

historical tracing of breast cancer notes that in the late 18th century, there were numerous theories as to why women developed breast cancer:

problems with lactation, a stoppage of menstruation and the onset of menopause, an exposure to cold, the experience of unhappy emotions, and the damage done to the breast by a blow. None pointed with certainty to the origin of the disease, but all were circumstances long associated with women who developed breast cancer (2002: 22).

Women's 'excessive' emotions and sensibilities were often cited as the cause of breast cancer. Further, "wrath, fear and grief" weakened women's constitutions and allowed women to become exposed to outside stimuli (Jasen, 2002: 21 & 24). For those who failed to regulate their passions, emotions and sensibilities, breast cancer would surely be the outcome (Jasen, 2002: 25). Jasen argues that the association between breast cancer, hysteria and neurosis was commonplace in late 19th century medical literature (2002: 34). Similar to this early discursive construction of the breast cancer sufferer, women's 'essential nature' was often cited as the cause of cervical cancer. Overstimulation that occurred through dancing and reading as well as physical and intellectual strain was speculated as of the main risk factors of cervical cancer (Nolte, 2008: 35). In reflecting on the epidemiological investigations undertaken by Domenico Rigoni-Stern, Scotto and Bailar list the various contributions made by Rigoni-Stern to the field of cancer epidemiology. They bring to light his theory that many of the women who were at a greater risk of uterine cancer were said to be "excessively sensitive morally and nervously irritable" (1969: 69).

As early as the beginning of the 18th century, the ‘father of occupational medicine’ Bernardino Ramazzini, observed an abnormally high incidence of breast cancer among nuns and cervical cancer among prostitutes. Ramazzini’s occupational epidemiological investigations established many causal links between different types of cancer and the environment within which the person with cancer worked and lived. What was most significantly highlighted by Ramazzini was the appearance of an inverse relationship of those who suffered with breast cancer and those who suffered from cervical cancers. He surmised that if nuns were a greater risk for breast cancer, they were at far less risk of getting cervical cancer (Patterson, 1987: 13 & Proctor, 2001: 83).

Women’s sexual lifestyle was said to be one of the main risk factors for the occurrence of cancer; “excessive sexual activity” and taking part in the “debauchery in the pleasures of love” was often cited as the main cause of cervical cancer (Nolte, 2008: 35). Reports of the “nervous over-stimulation of the female lower abdomen caused by passionate fantasizing” lead many to conclude that women who were not married and engaged in ‘excessive’ sexual practices (prostitutes) were “slandered and unchaste and therefore deviant” (Nolte, 2008: 33 & 36). Nolte cites the work of Caspar Mende (1810) who wrote, “‘excessive sexual relations’, ‘intercourse during the monthly flow’, and the ‘unnatural satisfying of sexual instincts through rubbing and pressing of the birthing parts’...as well as masturbation” could also lead to cervical cancer (Nolte, 2008: 34). Ramazzini believed that breast cancer hid its origins in uterine abnormalities, and that because of their commitment to celibacy, nuns imposed abnormal stress on the uterus, which eventually led to breast cancer. These observations made by Ramazzini were

confirmed in 1844 by one of the most prominent epidemiologists of the 19th century, Domenico Rigoni-Stern (Wright, 1940 as cited in Olson, 1989: 69 & 135).

In the early 19th century, Domenico Antonio Rigoni-Stern not only confirmed the epidemiological insights garnered by Ramazzini, but extended Ramazzini's ideas in order to investigate the incidence of uterine cancer in nuns, prostitutes *and* married women. Rigoni-Stern's epidemiological investigations of the causes of various types of cancers resulted in epidemiological theories which concluded that women's sexual activity was *the largest risk factor* associated with both reproductive and breast cancers. Echoing his predecessor Ramazzini, he surmised that the frequency of breast cancer was inversely related to the incidence of uterine cancer for different age groups; that married women experienced a greater incidence of cervical cancer than unmarried women; and that Catholic nuns and Jewish women rarely, if ever, suffered from uterine cancer (Scotto & Bailar, 1969: 68). It seems clear that there was a very moral line (based on statistics) that was drawn by Rigoni-Stern in regards to cervical cancer, breast cancer and sexual activity.

Due in part to Ramazzini and Rigoni-Stern's investigations, there became a growing condemnation over the use of wet-nurses. Jasen notes that this growing condemnation was also due to some scientific, medical and epidemiological research which argued that breastfeeding acted as direct protection against breast cancer (2002: 27). Both Wynder (1969) and Jasen (2002) point out that in the early epidemiological literature it was suggested that pregnancy in early life would reduce a women's risk of getting breast cancer. Further, if she were to have children, she should do her best to ensure that she breastfed them herself, and did not rely on a wet nurse (Jasen, 2002: 27).

In terms of the discursive construction of the risks of cervical cancer, Nolte remarks that marital relations were obviously seen as less risky, and therefore more healthy than non-marital sexual activity. What she discovered in much of the literature was that married women were cautioned to partake in limited amounts of sexual activity (no more than one would require for reproduction) and that sexual excess within marriage could also put women at a higher risk of cervical cancer (Nolte, 2008: 35). The notion that cervical cancer existed primarily in 'sexually loose' women, namely prostitutes established a connection between sexuality, morality, risk and cancer. Whether she had children, how many she had, and whether she breastfed them or not, provided the basis for the earliest forms of breast and cervical cancer risk assessment. By all accounts it appeared that in order to avoid the risk posed by these cancers, women had to ensure that very specific lifestyle conditions were attended to. In the case of breast cancer, it was said that a woman's risk substantially increased when, "'unsafe sensibilities' were combined with poor physical habits, such as the wearing of clothing which exposed the breasts to cold and injurious pressure, and a poor diet which caused indigestion and the contamination of 'weakly' constitutions"(Jasen, 2002: 25).

Rigoni-Stern's theories about cervical cancers had prevailed and been accepted as truth for many years. It was not until the early 20th century that epidemiological inquiry, coupled with the professionalization and immense expansion of oncology and gynecology, that better and more refined statistical records were produced which revealed that Rigoni-Stern's and Ramazzini's epidemiological theories were false. The rapid expansion and diffusion of biomedicine beginning in the early 20th century sought to find the 'truth' about the aetiology of breast and cervical cancers. Two very influential

publications pleading for the erasure of the previously prevailing theories about women's cancers appeared in the late 20th century. Their case was simple: the previous statistics were flawed and this led to large groups of women being overlooked for cancer screening and as a result, many women died.

In his brief article, "Cervical cancer in nuns and prostitutes: A plea for scientific continence" (1988) Skrabanek attempts to debunk the long-held assumption that cervical cancer is a disease that mainly resides in the bodies of prostitutes, and alternatively that nuns rarely, if ever, experience the disease. He outlines several studies and suggests that the epidemiological 'evidence' offered by the researchers is invalid and the product of poor statistical evaluation and scientific exploration. He further suggests that none of the studies he outlined in the article could show causation and argued that if these erroneous statistics remain as truth, there would be little chance of discovering the true aetiology of cervical cancer (Skrabanek, 1988). Much like Skrabanek, Griffiths attempts to debunk the long-standing myth that nuns, virgins and spinsters were unlikely to develop cervical cancer. Griffiths' study argued that women such as nuns should not be overlooked for screening practices and technologies. He argued, "none of the studies referred to has actually shown cancer among nuns to be the rarity that has been claimed" (1991: 801).

My inquiry of the historical discourses of breast cancer and cervical cancer reveals that the concept of risk is not a new concept by any means. Historically, women's bodies have been 'at risk' for any number of ailments and the responsibility that women bore for these risks has always been exceedingly more burdensome when compared with men's. Jasen argues that the concept of risk was, "historically seldom separated from ideas about women's essential nature...as the nineteenth century progressed, women's

biological destiny, from child-bearing to breastfeeding to menopause, was increasingly linked with their ‘cancerous tendency’”(2002: 20). The discourses of women and cancer in the 18th and 19th centuries, reveal the conflation between women’s sexuality, intellectual and emotional statuses and morality.

As I stated above, and will state again, due to the paucity of sources of women and cancer, it is difficult to glean a comprehensive overview of the discursive constructions of risk, responsibility and morality as they relate to women and cancer. However, what was exposed through the sources examined, reveals that many of the discourses of risk, responsibility and morality centered on women’s sexuality and ‘essential nature’. The examination of these limited sources prove valuable, however, when I examine the contemporary discursive constructions of risk, responsibility and morality of women and cancer in the following chapter.

Chapter 5

Contemporary Explorations of Cancerous Bodies

This chapter is devoted to the exploration of contemporary risk, responsibility, lifestyle and moral discourses of breast cancer, cervical cancer, and lung cancer. I have divided the chapter into two sections; the first will focus on breast cancer and cervical cancer, and the second will focus on lung cancer. The exploration of these discourses in the contemporary era is vital, as it situates the discursive construction of these bodies temporally, socio-culturally, politically and economically. The examination of the historical discourses, read alongside the contemporary discourses allows for connections and divergences to be accounted for. It allows us to consider the milieu in which these discourses emerged and why at particular times, some discourses are more dominant than others.

Contemporary discourses of women and cancer

In this section I explore the contemporary discourses of breast cancer and cervical cancer. The exploration of these discourses allows for a connection to be made between ‘healthy’ lifestyle practices and the normalization of these practices in everyday life. The normalization of these practices serves to open up a discussion to address the implications that women face when they do not, or cannot, embody the prescribed *norms* associated with the self regulatory practices of a healthy, cancer-free lifestyle. The exploration of these discourses will take place through the analysis of visual and textual sources found within public health literature (in the form of pamphlets and information

found on the Health Canada website), from the Gardasil website, The Canadian Breast Cancer Foundation website, and other online health information sources.

As addressed in the previous chapter, cervical cancer incidence rates have long been associated with women's sexual practices. Although there existed much debate historically as to the validity of the claim that more sexually active women experienced a higher incidence of cervical and uterine cancer, it was not until the 1980s that there was 'scientific proof' that the incidence of cervical cancer in women was caused by a sexually transmitted infection, the Human Papillomavirus. In the late 1990s Merck Frosst, one of the most highly successful pharmaceutical companies in North America, recognized that developing a vaccine against HPV could be a profitable endeavor, and to this end, began a process of research and clinical trials that spanned more than a decade. The ultimate result of this process was the creation of a vaccine that would come to be marketed under the trade name Gardasil. On June 8, 2006, the FDA approved Gardasil for sale in the United States. Following suit, Health Canada approved Gardasil on July 18, 2006 (CBC News, 2007). The vaccine is said to target four of the more than 100 types of HPV that are contracted through sexual contact: types 16 and 18 which cause approximately 70% of cervical cancers, and types 6 and 11 which cause approximately 90% of genital warts (Gardasil, 2010). The establishment of a causal link between HPV infection and cervical cancer highlights the reemergence of many of the discourses that surrounded women and cervical cancer historically. However, due to the establishment and solidification of this scientific truth about HPV and cervical cancer (and the vaccines that are now available to protect women from the virus), the discourses of risk, responsibility, sexuality, lifestyle and morality have become heightened and more diffuse.

The ‘contemporary’ discourses of women and breast cancer that I will examine begin from the early 1980s. Before this time, breast cancer was still a disease that was largely private and hidden (Leopold, 1999: 153). According to Leopold the main reason for the extremely late emergence of breast cancer awareness in the public realm was due to the Women’s Health Movement in the late 60s and early 70s. Led by young feminist activists, their primary concerns were for their own bodies and focused on reproductive and contraceptive rights (Leopold, 1999: 230-233)¹. However, the Women’s Health Movement was the precursor to today’s breast cancer movement. Leopold argues that in the late 1970s, the Women’s Health Movement promoted “the freedom to choose” and this notion served as the basis for many women to consult with their doctors (post-diagnosis) as to the treatment options available for breast cancer. Before this time, it was the standard procedure for women to be anesthetized for a biopsy, and if the tumor was found to be malignant while she was still ‘under’, the woman would not be able to consent when her doctor took the opportunity to remove her breast by a procedure called the radical mastectomy.²

The ‘freedom to choose’ movement opened-up a dialogue about alternative treatment options between female patients and their doctors. The significance of this movement was the stepping stone for the emergence of breast cancer as a ‘public disease’. The mid-1980s saw women’s narratives about their experiences with breast cancer emerge through women’s magazines, television soap operas and celebrity ‘cancer confessions’. Furthermore, the Women’s Health Movement of the 80s experienced a shift

¹ Leopold argues that during the infancy of the Women’s Health Movement, breast cancer was glossed over, as it was recognized as a health issue for older women.

² Also known as the Halsted method, the radical mastectomy was first performed in the late 1880 by William Stewart Halsted and was the primary and most widely adopted surgical procedure (and basically one of the only options for women) used to treat breast cancer until the 1970s.

in where their activist priorities were directed, as many of the early activists were aging and facing the risks that breast cancer posed to women in later life (Leopold, 1999: 240-245). Yalom notes that the mid-to-late 1980s marked a worldwide feminist driven celebration of the female breast which attempted to remove the long-standing association of the female breast as the *defining* maker of female sexuality and vehemently targeted the exploitation of the breast by patriarchal advertisers, medicine, and science (1997: 241-247).

The role of expert knowledge in the construction of risk says much about the constitution of late modern subjectivity (Lupton, 1999: 86). Risk discourses, as they relate to health and illness, have become abundant in the late modern era, and have transformed the way in which people conceive of their bodies not only in relation to other bodies, but also the medical, social and political milieus in which these bodies reside. The plethora of risks associated with our daily lifestyles serves to function as a mechanism of daily self-monitoring, self-surveillance and self-regulation. According to Lupton,

Risk-avoiding behavior...becomes viewed as a moral enterprise relating to issues of self-control, self-knowledge, and self-improvement. It is a form of self-government, involving the acceptance and internalization of the objectives of institutional government. Because the project of selfhood is never complete, but rather is continuing throughout the lifespan, so too the project of risk avoidance as a technology of the self is never-ending, requiring eternal vigilance (1999: 91).

Women, cancer and risk

All women are 'at risk' of cervical cancer and breast cancer simply because of our biology. When exploring the risk discourses of women and cancer, almost all of our daily

practices and behaviours place us in a 'risk' category, however, some women are at a 'higher risk' than others. Lupton argues that, "...particular social groups or populations who are identified as 'at risk' or 'high risk', [require] particular forms of knowledge and interventions" (1999: 87).

There are two different types of risks associated with cervical cancer and breast cancer: "non-modifiable" risks and "modifiable" risks. According to Health Canada, there are some 'non-modifiable' risks that are associated with both cancers: gender, ethnicity, age, time of first menses and the time of the onset of menopause (Health Canada, 2010a). In terms of "modifiable risks" associated with cervical cancer, almost all of the risks are associated with the sexual lifestyle of the woman. Again, according to Health Canada, modifiable risks associated with cervical cancer are: the age of first sexual contact, the number of sexual partners, being with a male who has had multiple sexual partners, exposure to the Human Papillomavirus, and use of oral contraceptives (Health Canada, 2010a). According to this same publication, women who want to minimize their risk of getting cervical cancer should have a Pap smear at the age of 18 (or earlier if sexually active before that age) and make it a part of their health routine and get screened more often if there was a presence of HPV. Further, women are told explicitly to limit their sexual partners (Health Canada, 2010a).

The risks associated with breast cancer, much like cervical cancers, are also based on 'modifiable' and 'non-modifiable' risk factors. On The National Cancer Institute's website there is an online "breast cancer risk assessment tool" (designed by "scientists") that poses seven questions in order to assess a woman's risk of developing invasive breast cancer. The questions that appear in this assessment tool are primarily based on 'non-

modifiable' risks, such as age, age of first menses, race/ethnicity, and familial history and heredity factors (National Cancer Institute, 2010). However, many of the dominant discourses that we find within public health in Canada assess a woman's risk of developing breast cancer largely on 'modifiable' risks: her daily consumption of alcohol, whether she smokes cigarettes, her diet, the amount of exercise she gets, her exposure to carcinogens, her use of contraceptives, and her reproductive status (Canadian Breast Cancer Foundation, 2010).

Similarly, Merck Frosst, the manufacturers of the HPV vaccine Gardasil, provide a link to a risk assessment tool designed to assess women's risk of getting cervical cancer. The risk assessment tool is based on 13 questions which range from age, to the number of sexual partners, to family history, to the daily consumption of "yellow fruits and vegetables", cigarette smoking habits, and ethnicity. Out of curiosity I decided to take the quick test to see how the tool would assess my risk of getting cervical cancer. Being a queer woman, who has only had two life-time same-sex partners, and consumes plenty of "yellow fruits and vegetables daily", I found it astonishing that my risk for cervical cancer was assessed as being "high". According to the online assessment,

At your age, 25, the risk for cervical cancer is usually relatively low. You appear to be at an above average risk for women in your age group, however. There are behaviours and other factors at this age that can decrease or increase the likelihood of developing cervical cancer in later life (Health Ink & Vitality Communications and Atmedica USA, 2010).

Unlike the breast cancer risk assessment tool discussed above, few 'non-modifiable' risks determine the outcome of the risks associated with cervical cancer (these included age,

ethnicity, and family and personal history with cervical cancer). The focus of this risk assessment tool for cervical cancer is primarily derived from ‘modifiable risks’ that take women’s sexuality and sexual practices to be the primary measurement for women’s risk of developing cervical cancer. Due to the causal link established between sexual practices and the incidence of cervical cancer, many of the questions center upon women’s sexual lifestyles: age of first intercourse, number of sexual partners within the last five years, use of contraceptives (oral and condoms), current marital status and current sexual status (Health Ink & Vitality Communications and Atmedica USA).

Whether risk discourses associated with cervical cancer and breast cancer are “non modifiable” or “modifiable” the picture is clear: everything that a woman is and everything that a woman does puts her at risk of getting cancer. The exploration of risk discourses in public health around cervical cancer and breast cancer conflate the notions of sexuality, disease and lifestyle. Genetics, age, and race aside, these risk discourses serve to reify the idea that risky sexual and lifestyle practices inevitably move a woman up a risk ladder; placing her at ‘high risk’, which makes her body and lifestyle more *dangerous* and *threatening* to not only herself, but also her fellow citizens.

Women, cancer and responsibility

With the designation of someone being ‘at risk’ results in an inherent correlative: responsibility. Risks serve a very important function within contemporary neoliberal governmentality. One such function is when something or someone is deemed to be ‘risky’ or ‘at risk’ individuals feel compelled to take *responsibility* to manage these risks. Many of the discourses of risk that surround women’s health and lifestyle suggest that it

is the responsibility of the woman to know, monitor, and manage the various risks that she faces on a daily basis. The failure to adequately manage risks signals a failure, or inability, to master the self. According to Lupton, “[d]iscourses on risk are directed at the regulation of the body: how it moves in space, how it interacts with other bodies and things. These discourses also contribute to the constitution of selfhood, or subjectivity, and thus are part of the panoply of ‘practices’ or ‘technologies of the self’” (1999: 88).

The relatively recent surge of risk discourses around cervical cancer (due to the introduction of HPV vaccines such as Gardasil) places a substantial amount of responsibility on girls and young women to ensure they take all measures possible to reduce the risks posed by HPV. The responsibility to manage the numerous risks associated with HPV infection and cervical cancer is just one of the ways in which women are becoming increasingly responsabilized and self-regulatory. Because the main risks that are associated with getting cervical cancer are centered on women’s sexuality, it becomes the girl’s/woman’s responsibility to ensure that she regulates her behavior and her sexuality. She has to subscribe to everything that embodies a ‘healthy lifestyle’, which includes, but is not limited to: making herself aware of her body and of the risks associated with cervical cancer; monitoring and regulating her sexual behaviour and practices; regulating her health through *regular* doctors visits; cervical cancer risk reduction through screening (pap smear) and vaccination.

Similarly the responsibility for knowing the various risks, signs and symptoms associated with breast cancer has become more diffuse and extensive. On the Canadian Breast Cancer Foundation website there is a section entitled “Be Breast Aware”. In this section there is a list of five things that women can do to avoid being another victim of

breast cancer. All of these things that women must do centre on women taking responsibility for not only what they do on a daily basis (everyday healthy lifestyle maintenance) but also make it clear that women have a *duty* to know their breasts and must regularly assess for visual and textual changes in the shape, size, weight, and general appearance. Further, women must ensure that mammography and other screening measures are attended to on a regular basis. According to the Canadian Breast Cancer Foundation,

Current scientific evidence supports a broad ‘be breast aware’ approach. This approach is an attempt to provide tools for people to check their breasts and to know what sorts of changes to look for. Breast awareness encourages people to think about their breast health, to know their own bodies and breasts, and to report any changes in their breasts to a doctor (Canadian Breast Cancer Foundation, 2010a).

This imperative to know one’s health status at all times evokes a notion of vigilance—an almost militaristic vigilance. It is not enough to know that there is a sign or a symptom, but we are told that *we must know* what these signs and symptoms of body irregularity *mean*. According to Stacey “...individuals charged with this onerous responsibility must learn to read their bodily texts through modes of self-knowledge and exploration” (1997: 229).

On the Gardasil website, under the section entitled “Real Life Stories”, there are four short (approximately two minute) “real life stories” of young women talking about HPV and cervical cancer. The discourses which emerge from these ‘real life stories’, centre upon a women’s responsibility to ensure that she is healthy by “knowing her body”. One girl notes:

...it is important to know the state of your body. So to go and get a check-up with your doctor is ultimately the most important thing. As women, our bodies are so fragile and we need to take care of them. And we need to know what is going on. So, I get check-ups every six months, I get pap smears...every woman and girl out there should go get a check-up and know their status at all times (Gardasil, 2010).

Another 'real life story' features a young girl who was diagnosed, and subsequently treated for cervical cancer. As an athlete and self-professed 'picture of health', this young woman expresses an urgency for all women to be responsible; know their risks and ensure they do everything in their power to not have to suffer through what she had to suffer through. She notes:

...so why am I here, and why would I tell someone this? Because it is so important that this happens to nobody else; that you take care of yourself. You go to the doctor, you get your check-ups, you do everything you can to make sure you are healthy. Because it does, it happens to anyone. It doesn't matter age, or what you do, or who you are, it happens, so please take care of yourself, so you don't have to go through what I did (Gardasil, 2010).

One of the main ways that women come to 'know their body' more intimately is through expertise found on the internet. As the epitome of, and ultimate "self-help" guide (for virtually anything that one might need assistance with), the internet provides individuals with the ability to access vast amounts of knowledge which aid in the assessment of almost any sign or symptom of bodily irregularity. As discussed in chapter three, with the fragmentation of expertise it is far easier to get access to expert knowledge and use this knowledge to become experts ourselves. One of the young women in "real

life stories” spoke of the significance of the internet when trying to decide whether to get the Gardasil vaccine or not. After an internal struggle over whether to get the vaccine, numerous consultations with friends and her mother and “tonnes, and tonnes, and tonnes of research about it on the internet”, the girl decided to go ahead with the shot (Gardasil, 2010).

In the case of breast cancer, there has been a substantial surge of narratives that come to make up the ever-expanding array of knowledge that all women have access to and are expected to draw upon. The shelves of bookstores are lined with breast cancer survivor narratives. They are also lined with an immense array of books which give women tips on cancer-fighting foods, diets and physical and mental activities that one can do to reduce her risk of developing breast cancer. These sources contribute to the expanding accumulation of knowledge that inform and encourage practices of the self. What is revealed by these “real life stories,” narratives and seemingly endless amounts of cancer-fighting/cancer risk-reducing resources, is that women today feel an absolute obligation to take responsibility of their bodies through the accumulation of knowledge—both expert and lay knowledge.

Two examples serve to highlight the importance for women to take responsibility for their health via their behavior and practices. The first example is the pamphlet entitled “HPV...What’s That?” (2001) produced by the American College Health Association. This pamphlet outlines what HPV is, how it is treated, where support can be found if one becomes infected, and outlines how HPV infections can be prevented. In this last section of the pamphlet, there are three subsections: “Practice safer sex”, “Have regular check-

ups”, and also “Take care of your body”. This last section in particular identifies three ways that one should take care of their body:

1) As with any other virus, you’re less susceptible to infection when you’re in good health. And, if you have HPV, a strong immune system is important in bringing the disease under control. Keep your immune system healthy by: eating nutritionally, getting enough sleep (especially when you’re under stress), exercise regularly, avoid alcohol and other mood-altering drugs, as well as tobacco. You may also need to pay extra attention to managing your stress, since it can weaken your immune system. 2) Examine your genitals regularly to check for visible warts. If you notice any, contact your clinician. Don’t try to remove them yourself with over-the-counter medications. 3) Urinate and wash and dry your genitals carefully after sexual contact. *By making careful, self-protective decisions about your sexual behavior and sexual partners, you’re protecting and caring for yourself as well as your partners* (American College Health Association, 2001, *emphasis in original*).

The second example is found on the Canadian Breast Cancer Foundation website, under the section “How can I reduce my risks of getting breast cancer?”

Breast cancer is believed to be a result of inherited and environmental factors. However, currently we do not know the precise causes of breast cancer. Therefore, we do not know how to completely eliminate the risk for breast cancer. However, you can make choices that may reduce your risk of developing breast cancer. Many of these behaviours may also help reduce the risk for other conditions. Here are some steps you can take that may reduce your risk for breast cancer:

- Carefully consider the risks and benefits of taking hormone replacement therapy (HRT), especially for more than 5 years.
- Carefully consider the risks and benefits of using oral contraceptives.
- Maintain a healthy body weight.
- Be physically active.
- Limit your alcohol consumption to one drink or less per day.
- Avoid tobacco smoke, both active and passive (second-hand), especially if you are a young woman.
- Eat a healthy diet. For more information about eating well, check out Canada's Food Guide.

- Avoid exposure to carcinogens. (Canadian Breast Cancer Foundation, 2010b).

Both of these examples demonstrate that it is essential for all women to assess the physiological signs and symptoms of disease or illness once they are present, and also promotes preemptive monitoring of *all* facets of one's life.

Much of the literature about women and health is written under the guise of the 'right to health'. According to Herzlich and Pierret, this notion of individuals as having a 'right to health' had undergone a shift with the erosion of the welfare state.

In the 1960s [the right to health] implied the development of a medical infrastructure and the reduction of the inequalities in access to the health-care system; in the 1980s it is a matter of making all individuals responsible for their health and motivating them to modify their behavior and habits. Medicine is playing an instrumental role in this movement, which tends to make health into a supervalue, an end in itself...health is becoming life itself. It therefore becomes necessary, as medicine recommends, to do everything to avoid becoming ill (1987: 52-53).

Gardasil's slogan, "*Spread the word, not the disease*" embodies this notion that women must do everything in their power to avoid becoming ill. Further, this campaign slogan performs a double-responsibilization: first, women are expected to do everything in their power to ensure that they know all about the risks associated with HPV, and "spread the word" to everyone they can. Second, and perhaps most importantly, this slogan conveys the message that it is the sole responsibility of women to ensure that they do everything they can to protect their sexual and reproductive health via disease control methods. This rhetoric places responsibility squarely upon the shoulders of women, but also, by the very

discourse removes men, their sexual practices, sexual history and responsibility for spreading the disease.

Alexandra Howson's article, "Cervical screening: compliance and moral obligation" (1999) breaks away from previous medical and sociological literature that sees cervical cancer screening as a morally neutral, unproblematic consequence of decision-making as it relates to disease prevention. Howson draws from women's accounts of screening experiences and argues that complying with screening strategies "can also be understood as a response to a particular expression of power or a set of normative expectations...compliance with screening cannot be viewed exclusively as neutral, if desirable, outcome but a social practice, which is embedded within a moral framework of responsibility and obligation" (402). This notion highlighted by Howson is just as relevant in the case of women and regular mammograms. Leopold argues that the rise of the once-year physical examination and habitual screening procedures of mammography has substantially increased women's individual and social responsibility (1999:161-169).

The belief that women are empowered enough to make their own choices about their personal health has come to define and enable neoliberal governmentality. Responsibilization and self-regulation taken up by the individual on a daily basis and repeated numerous times throughout one's life, has become normalized and therefore rarely unquestioned. According to Lupton, "...the acceptance of personal responsibility is presented as a practice of freedom, relief from state intervention, and opportunity for the entrepreneurial subject to make choices about the conduct of her or his life" (1999: 99-100). This argument put forth by Lupton is particularly telling when we consider another

‘real life story’: “After it was done, I had this huge sense of relief. I was so glad that I had done it because I really felt empowered about something that was bettering my health for the future, and I wouldn’t change it for the world” (Gardasil, 2010).³

The proliferation and diffusion of risk and responsibility discourses over the last 40 years has become exacerbated; so much so that Westerners are almost virtually unable to escape the abundance of daily reminders. Risk is no longer just about economics: making a tough financial decision that could ‘make or break’ someone. The successful management of risks has come to define the ‘type’ of person we are and if the wrong decision is made, individuals are subject to a range of moralizations based upon their “lifestyle failures” (Leopold, 1999: 258-259).

In this section I have presented the discursive constructions of risk and responsibility as they relate to women and cancer. What I have failed to highlight, however, is the notion that there is a disparity in these discourses in terms of sexuality and causation. Because the cause of breast cancer is still largely unknown and could be caused by any number of risk factors, discourses of breast cancer tend encompass almost everything that could *potentially* pose a risk to women’s health (diet, exercise, consumption habits, hormone levels, exposure to chemicals, etcetera). Further, because many of the theories I addressed in the previous chapter (which saw a correlation between limited-to-no sexual activity and the presence of breast cancer) have been disregarded, the focus on female sexuality as a contributing risk factor to the development of the disease, has largely fallen to the wayside.

³ The final section of this thesis will address the cultural and political significance that is tied to women’s cancer ‘empowerment’ movements.

Alternatively, the biggest risk factor, and cause of almost all cervical cancer cases has been linked to women's exposure to HPV. As a result, three significant insights have emerged from my inquiry. First, because there is 'scientific proof' that cervical cancer is caused by unsafe sexual practices, thus establishing 'the risk', there is a greater emphasis for women to control, manage, regulate and be solely responsible for their sexuality and sexual practices. Second, and perhaps related to the first, these risk and responsabilization discourses work within in a general discursive framework which constructs women's bodies and sexuality as inherently dangerous, risky, and in need of containment. Finally, because this risk of developing cancer from HPV is 'known' and 'scientifically proven', the failure to manage the risks associated with 'unhealthy' sexual practices results in victim-blaming rhetoric and moralization. When a woman who eats right, exercises, limits her consumption of alcohol and cigarettes, and is generally regarded as the epitome of a 'healthy woman' suffers from breast cancer, she is not blamed to the extent that a woman who knew the 'scientifically proven risk' of HPV and unhealthy sexual practices would be. Similarly, if a woman who did not eat right, did not exercise, smoked cigarettes and drank to her heart's content was diagnosed with breast cancer, she would experience the 'blame the victim' rhetoric and moralization more so than a woman who was diagnosed with cervical cancer who vigilantly practiced safe sex and had a 'healthy lifestyle'. In essence, the argument I am attempting to elucidate here is the way our bodies are perceived, talked about and treated in 'the new public health' is almost invariably contingent on how we 'deal' with the risks posed to our bodies and the responsibility we take to manage these risks.

Contemporary discourses of smoking and lung cancer

Due to the causal link that has been established between cigarette smoking and the incidence of lung cancer, the importance of uncovering the discourse around smokers proves invaluable when revealing the discursive construction of the lung cancer sufferer. The discourses of risk, responsibility and morality that surround the cigarette smoker primarily inform the discourses that enfold the lung cancer victim. In this section I will explore the contemporary discursive constructions of risk, responsibility, lifestyle, and morality of the cigarette smoker and the lung cancer sufferer in contemporary Western society and culture.

The bombardment of negative images, metaphors, and discourses of the cigarette smoker today did not really begin until relatively late in the 20th century. As addressed in the previous chapter, many of the historical discourses associated with cigarette smoking were ambiguous: cigarettes were often seen as a symbol of sexuality, liberation, freedom, intellectual and artistic vigor, elitism and a symbol of patriotism and nationalism during times of war. Although few scientific and epidemiological publications in the early 20th century speculated there to be a causal link between smoking and lung cancer (Patterson, 1987: 201-216), it was not until the publication of the *Surgeon General's Report on Smoking and Health* in 1964 in the United States which proved to be the first definitive scientific pronouncement of the causal link between cigarette smoking and lung cancer. This report drew upon scientific and medical experts who showed a positive correlation between individuals who smoked cigarettes and the prevalence of lung cancer.

[The report] concluded that cigarette smokers in particular faced a high risk of serious disease, a risk that could be substantially reduced by discontinuing their use of tobacco. It marked an important 'stage' in the development of tobacco use in the West not merely because [it]

constituted the point at which the link between tobacco and disease had been officially accepted as 'true' by the medical profession but also because [it was] indicative of the increasingly successful *medicalization* of tobacco use (Patterson, 1987: 112, *emphasis in original*).

Although the findings of the report had little effect on individual cigarette consumption through the mid-to-late 1960s (Brecher, 1972) a growing number of public health initiatives, governmental committees and scientific research based groups, emerged with full force and began to ardently take an anti-tobacco stand. However, it was also at this time that many governments were struggling with the ambiguities associated with the sale and consumption of tobacco. One of the guiding principles of neoliberalism, the 'freedom of choice', proved to be one of the central sources of governmental ambiguity regarding tobacco use. Soon after the release of the Surgeon General's 1964 report, many governments began to seriously interrogate not only the health effects of cigarette smoking, but the ensuing costs and *benefits* to the state and the public health care system. In the Canadian House of Commons session from 1969-1970, the House released a 53 page report entitled: *Report of the standing committee on health, welfare and social affairs on tobacco and cigarette smoking*. This Federal document addressed many of the main concerns presented in the 1964 Surgeon General's report. The document outlined not only recent anti-tobacco associations unwavering support of the 1964 report, but also recent health and tobacco regulations proposed and enacted by many of the world's largest countries "health authorities"(Government of Canada, 1969: 8). Moreover, this was the first major document at the Federal level in Canada which addressed not only the presentation of findings by the experts, (in the form of statistics

and conflicting evidence) but most interestingly, outlined the *benefits* of cigarette smoking: chiefly its “contribution to the national economy” (Government of Canada, 1969: 27). The governmental and legislative ambiguities surrounding tobacco did not dissolve until well into the 1980s.

It was not until 1986, with the discovery of second hand smoke that the sense of immorality surfaced strongly. The harm caused to others by one’s own tobacco smoke was made explicit; not only in scientific and medical literature but also within the social and legal realms (Sullum, 1998: 140). The rights of smokers to smoke (free from regulation) swiftly ended, post-1986, when their smoking was deemed to affect the health, wellbeing and safety of others. Cigarette smokers were not just seen as doing physical harm to non-smokers, but also financial harm, especially in places such as Canada and the U.K. who had (and still have) a social healthcare model.⁴

One of the chief implications of the two moments mentioned above was the legislative regulation of tobacco sales and advertisements. In Canada in June 2000, legislative regulation dictated that tobacco companies be subject to the labeling of all cigarette packages and tobacco products with mandatory warnings explicitly stating the harms caused by cigarette smoking (Health Canada, 2010b). The gruesome and often terrifying visual and textual package warnings have contributed to risk and responsibility discourses which conflate the physiological and moral implications of engaging in such an act. For example, cigarettes products in Canada contain labels which read: “Children

⁴ There is an extensive history behind the legislative and governmental history of the regulation of cigarette smoking in North America. However, for the sake of space, and also for the trajectory of this chapter, I am unable to provide a comprehensive overview of these two decisive moments in tobacco control history. The focus of this chapter only allows for the brief mention of these moments which serve as the basis for the larger exploration of discourses which *emerged as a result of these moments*.

see, children do” (with an image of a mother smoking a cigarette and her daughter mimicking her smoking action); “Cigarettes hurt babies” (accompanied by an image of a pregnant woman smoking a cigarette); “Don’t poison us” (with an image of two sullen and worrisome looking boys); and “Tobacco smoke hurts babies” (accompanied by an image of a incubated newborn baby) (Appendix C). These visual warnings situate the cigarette smoker as embodying a sphere of riskiness, irresponsibility, and moral laxity. Cigarettes do not just cause harm to the smoker, they also cause great harm to loved-ones, family, friends and bystanders. The fear and threat of death that are imposed on the smoker (and non-smokers) via the visual and textual warnings, speaks volumes when one considers the personal repercussions these warnings have on the smoker. The sense of guilt, blame, riskiness, and irresponsibility that are imbued with these messages demonizes, if not to say, moralizes the smoker for an act that most often brings them pleasure, stress reduction, and for many, a feeling of self control.

In Ontario on May 31, 2006, the *Smoke-Free Ontario Act* came into effect. This Act, “prohibits smoking in enclosed workplaces and enclosed public places in Ontario in order to protect workers and the public from the hazards of second-hand smoke” (Government of Ontario, 2006). The outright banning of all cigarette smoking in *all* public places in Ontario sees local municipalities and public health units charged with the implementation of the Act, as well as the continual policing and enforcement of all aspects of regulation pertaining to the Act. As a result of this Act, there is a further stigmatization and moralization of the smoker. The regulation of the smoker through the confinement of geographical space perpetuates the discourse that smokers are detrimental to themselves and contaminates the health of others, and therefore must be confined to

spaces where they can engage in their risky and irresponsible behavior away from non-smokers who might eventually be paying for their irresponsible and unhealthy lifestyle.

One of the very few lung cancer assessment tools online focuses almost exclusively on the consumption of cigarettes (Memorial Sloan-Kettering Cancer Centre, 2009). Age (only assesses a person between the ages of 50-75), sex, number of year smoking, average per-day consumption, if one has quit smoking and if so, for how many years, and being exposed to asbestos, make up the six question risk assessment (Memorial Sloan-Kettering Cancer Centre, 2009). What is pertinent about this risk assessment tool for lung cancer is that it makes yet another contribution to the discourse that lung cancer is almost always conceived of as a cigarette smoker's disease. It does not ask questions pertaining to the type of labour one does, or the chemicals one could have been exposed to over their lifetime. What risk assessment tools such as this do is add to the conflation of cigarette smoking and disease and solidifies a stigmatized subject who is irresponsible, risky and immoral.

The health status of a smoker will almost always be perceived as a failing, or failed health status. Even though everyone who smokes cigarettes will not necessarily get lung cancer, the risk of getting lung cancer is far greater for those who do smoke. The risks associated with cigarette smoking extend far beyond the primary risk of getting lung cancer. Stroke, heart disease, oral cancer, stomach cancer, emphysema, asthma, impotence, problems conceiving and advanced aging place smokers in the highest health risk category. Because all of these risks can be substantially reduced simply by the act of 'butting out', many medical, public health, scientific, political and lay observers continually question *why* it is that people continue to smoke (other than assigning limited

blame on the addictive ingredients and clever marketing tactics). The conception of the smoker as ‘a failure’ has become a widely held notion throughout the Western world. The amplification and diffusion of the ‘health movement’ situates the smoker’s body as a body out of control: lacking discipline, rational calculable thought, self-regulation and most importantly, morality. Lupton asserts that, “in late modern societies, not to engage in risk avoiding behavior is considered a failure of the self to take care of itself—a form of irrationality, or simply a lack of skillfulness” (Lupton: 1999, 90-91).

As I addressed in the previous section of this chapter, where there are risks, there is responsibility to manage these risks. Because no one has the right to tell a smoker to not engage in the act, they are expected to be responsible enough to know the numerous risks associated with smoking, and thus manage these risks by making the responsible decision to quit (or at the very least conform to the regulations set forth in law). One of the main risks that smokers pose to non-smokers (other than their second-hand smoke) is the risk of jeopardizing a stable and affordable health care system. In his article, “Why I don’t treat cigarette smokers” (1993) Jameson argues,

People have a right to smoke cigarettes and people also have a right to health care. However, these two rights are incompatible; a person cannot claim both rights...Should physicians ignore patients’ personal behaviours that are harmful to the public? I think not. Physicians have a duty to the public as well as to their patients. Traditionally, physicians are trained to be patient advocates. However, advocating for cigarette smokers is advocating irresponsible behavior and endangerment to others (236).

This sentiment by Jameson reflects a broader socio-cultural discourse of health care and smokers—especially in countries that have socialized health care. The fact that

smokers know their risks, and ignore those risks, places them as the ultimate irresponsible citizen. Many non-smokers feel that their health care could be jeopardized due to the ever-expanding expense of attending to the health care needs of smokers. When a smoker is diagnosed with lung cancer, there is a sense that, yes, what a terrible disease to be afflicted with, but why are non-smoking tax-payers made responsible for incurring the costs of the smoker's irresponsible behavior? All citizens are expected to not smoke, eat right, exercise, limit their consumption of alcohol, avoid drugs and partake in strict health regimens which contribute to the overall health and well being of any population. Many non-smokers feel they simply should not have to pay for those who do not conform to the 'normal' health routine in which the majority of the citizens are expected to practice. Again, citing Lupton,

The moralism that is extended to people who become ill because they have allowed themselves to be 'invaded' is also extended to those who allow the entry of disease by failing to regulate their 'lifestyle' with sufficient discipline. Similarly, the notion of the individual body besieged by self-destruction is expanded in public health discourse to the concept of the social body, the health of which must be protected by its individual members acting responsibly to keep disease out (1995: 75).

The general consensus that is formed among many non-smoking citizens about the failure of the smoker to manage risks properly and engage in responsible acts of citizenry, does not just appear from thin air. Driven by numerous state sponsored initiatives, this consensus is in large part due to many of the constructions and rhetorical strategies promoted through neoliberal governmentality and found within public health initiatives. According to Lupton,

The continued use of fear appeals and the construction of subjects as apathetic, ignorant and uncontrolled serve to represent health promotion agencies, and through them, the state which funds them, as authoritative and active. Ill-health states and individual lifestyle choices are constructed as problems through media campaigns, and the health promotional agency is represented as the paternalistic educator providing the solution, identified by the logo accompanying the advertisement. The rhetorical strategies of risk, of impending doom, of the importance of physical attractiveness, are used to justify the incursion of the state into individuals' private lives (1995: 125).

This year the World Health Organization (WHO) implemented the “Tobacco Free Initiative”. This initiative targets women and girls who are at great risk of becoming victims of tobacco and tobacco advertisements; which promotes smoking as a sexy, liberating act for women all across the world. It has become the WHO's new mandate to curb tobacco companies from aggressively marketing tobacco directly to women through their advertising campaigns (World Health Organization, 2010). The WHO argues that advertisers are aggressively marketing their products to women because, “women are gaining spending power and independence. Therefore, they are more able to afford tobacco and feel freer to use it” (World Health Organization, 2010). They claim that they must “protect women from tobacco marketing and smoking” because,

the epidemic of tobacco use manifests itself differently among women. Why? Because women's reasons for smoking differs from men [sic]. The tobacco industry dupes many women into believing that smoking is a sign of liberation, and many women wrongly view smoking as a good way of keeping 'slim'...advertisements falsely link tobacco use with female beauty, empowerment and health...in fact, addiction to tobacco enslaves and disfigures women (World Health Organization, 2010).

The risks posed by smoking are said to be greater for women, as they can experience infertility, delays in conceiving, they risk premature delivery, stillbirth, newborn death, and may experience a reduction in breast milk (World Health Organization, 2010). What is most salient about this WHO initiative is that it appears to be evoking the predominant discourses which surrounded women and cigarette smoking in the early 1900s. The notion that women are fragile, easily influenced and seduced by tobacco's firm clutch and have to be "protected" from the marketing of cigarettes (as if cigarettes are some sort of tangible, material and active pursuer of women) is made passionately clear through WHO's rhetoric: "smoking is ugly" and "protect women from tobacco marketing and smoke". The only part of the discourse which appears to be absent today from the WHO's "gender-specific tobacco control strategies" (World Health Organization, 2010) is that tobacco use causes hysteria and mental illness.

Risk discourses within public health, as well as anti-tobacco initiatives such as the one offered by WHO, often present cigarette smokers as embodying the antithesis of beauty, femininity, masculinity, sexuality, liberation and freedom. Lupton discusses how 'successful' public health campaigns often contrast the images of the grotesque and the civilized body (Appendix D through G).

The grotesque body is commonly vividly represented, often visually, as a horror of flesh-out-of-control: the beer belly, the ugly, wrinkled face, the distorted lip, the helpless, disabled body in the wheelchair, the entrapped addict. These images provide visual evidence to support a moral tale: this is what will happen to *your* body if you are not careful. In contrast, the civilized body is that which will be achieved and preserved through the regimens of health promotion, with due application of personal control and continuous attention and awareness of the potential of the body to revolt (Lupton, 1995: 120, *emphasis in original*).

The outcome of such campaigns clearly delineates the good from the bad, the sexy from the obscene, the healthy from the ill, the civilized from the grotesque, the risky from the less risky, the responsible from the irresponsible, and most importantly, the moral from the immoral. What concerns me most about the messages found within these anti-tobacco campaign advertisements is that they entrench the idea that all smokers are bad, irresponsible, risky and immoral persons. If the smoker is unfortunate enough to be diagnosed with lung cancer the implications are more severe than stigmatization and blame. Because smokers are said to be committing a form of ‘slow-suicide’, lung cancer is one of the most highly underfunded cancers in terms of research dollars and lacks adequate community support services.

In her article, “Psychosomatic subjects and the ‘duty to be well’: Personal agency within medical rationality” (1993), Greco argues that disease has become linked to the state of one’s moral qualities rather than the individual’s constitution (359-360). Although I most certainly take great stock in Greco’s observation (as historically and in the contemporary era disease has been viewed as a sign of personal failure and thus likened to moral failure) I argue that today, due to the proliferation of risk discourses around health, lifestyle and disease, we are witnessing a designation of ‘moral qualities’ based on *particular* diseases, and not just “disease” in general.

In this chapter I have explored risk, responsibility, lifestyle, and moral discourses of breast cancer, cervical cancer and lung cancer. However, what I have failed to explicate here, but will do so in the next chapter, is to address the notion that some

cancers are seen to be ‘more acceptable’, and thus, more moral than others. Further, by virtue of a particular cancer’s designation as ‘acceptable’ there is the perception that there are more acceptable ways to *experience* particular types of cancer. I will argue that typically these ways are to be in-line with dominant metaphors, discourses, and narratives of the healthy, virtuous, heroic, normal, self-regulating neoliberal citizen.

Chapter 6

'The Cancer Hierarchy' and its Implications

By examining the historical and contemporary discursive constructions of risk, regulation, lifestyle, and morality of three different cancers, I have shown how bodies are moralized, and thus placed on a hierarchy (and specifically for the purposes of this thesis, a 'cancer hierarchy') by arguing that the placement of individuals within this hierarchy is contingent upon their adherence to practices of the self, via risk management and responsabilization. I want to now suggest that the place embodied by particular bodies within this hierarchy is also contingent upon the adherence to normalized understandings of the 'ideal neoliberal citizen'. The conception of the ideal neoliberal citizen includes attending to individual practices of the self but also includes such acts as civic empowerment, engagement and dutiful participatory action. Individual practices of the self, while simultaneously adhering to neoliberal ideological conceptions of normalized citizenship, entrenches a notion of worthiness as it relates to the body and health. As practices of the self, in large part, make up the 'success' of neoliberal governmentality, the failure to engage in either normalized practices of the self or appropriate neoliberal civic engagement can have distressing implications for those who cannot, or will not, fulfill these obligations.

In the previous chapter I focused on risk, responsibility, lifestyle and morality discourses. My exploration of the contemporary discourses of three cancerous bodies (and 'soon-to-be' cancerous bodies) uncovered many interesting insights; chief among them was the duty and necessity to attend to practices of the self. Included in these

practices of the self, I argued, was risk management and the individual responsibility imbued within proper risk management techniques. These practices of the self induce a compulsion to self-regulate and self-survey daily lifestyle practices. Discursive constructions of risk, responsibility, and lifestyle construct a general and increasingly diffuse conception of what being healthy is and what it is not. More importantly, these discourses have an implicit moral valence. As pointed to previously, to ignore risks to our health and responsibility to manage these risks is not just imprudent, but morally culpable. Rosenberg argues that, “the very words ‘risk reduction’ and their aura of impersonal distance from the coarse realities of sickness, pain, and premature death reflect precisely a contemporary style of reassuring public discourse—while at the same time fostering guilt and the need for control in its traditional emphasis on lifestyle and regimen” (1997: 47).

Another practice of the self that we must attend to in contemporary neoliberal governance is civic empowerment, participation and engagement. King (2006) as well as Ehrenreich (2001) argue that the breast cancer movement, and other such movements that use “cause-marketing strategies”, act as a vehicle for instilling civic, moral and self-responsibility (King, 2006: 4). Engagement in such action, which is most visible in the breast cancer movement (although many who participate do not necessarily see this as political, for fear they might be labeled as feminist, or perhaps even worse, feminist activists (Blackstone, 2004: 357-359)) has, according to King,

helped fashion a far-reaching construction of public life, of the meaning of citizenship and political action, and of notions of responsibility and generosity. At the same time, these shifts have played a significant role in the emergence of a reconfigured ‘neoliberal’ state formation in which

boundaries between the state and the corporate world are increasingly blurred as each elaborates the interests of the other, often at dispersed sites throughout the social body and through practices that misleadingly appear to be outside the realms of government or consumer capitalism (2006: xi).

Neoliberalism's 'duty to be well' embodies a series of daily practices which focuses on an individual's physical and mental well-being. Mental well-being in the contemporary era is representative of a positive attitude and a preserving spirit which is cultivated through such broadly defined notions as 'self-esteem'. The important function that self-esteem plays in the construction of the healthy neoliberal citizen is most clearly understood through the insights put forth by Barbara Cruikshank. According to Cruikshank,

Self-esteem is a social movement that links subjectivity and power in a way that confounds any neat separation of the 'empowered' from the powerful. Most importantly, the self-esteem movement advocates a new form of governance that cannot be critically assessed by mobilizing the separation of the public from the private, political from personal. Too much is left out by critics of the self-esteem movement who continue to think of power as resistance in paired opposition: individual and collective, public and private, personal and political. What these criticisms omit, I contend, is the extent to which the self is (like inequality, poverty and racism) not personal, but the product of power relations, the outcome of strategies and technologies developed to create everything from autonomy to participatory democratic citizenship (1996: 248).

Thus, self-esteem is not just a technology of the self; it is also a technology of the state. If we think about my formulation of the cancer hierarchy and the bodies therein, it becomes apparent that there are particular people who will ascend fairly quickly to the top of this hierarchy by acts of proper citizenship and the cultivation of a definitive 'self'. However,

and perhaps more importantly, placement is applicable to persons that have the opportunity for engagement in these empowered civil acts.

For the breast cancer sufferer, there is ample opportunity to engage in individual and collective acts of citizenship. What is unsettling is that sufferers of lung cancer are not afforded the opportunity to take part in this civic engagement and are relegated to private, stigmatized suffering. What is even more unsettling is that because there is such a wide and strong cultural association between lung cancer and smoking, many lung cancer victims who have never smoked in their lives, or people who are suffering due to chemical or irritant exposure, do not get the opportunity to engage in these empowering acts that could potentially raise awareness and funding for lung cancer research (which is so desperately needed).

Gender also plays a very significant role in dictating which bodies are near the top of the hierarchy and which are not. In chapter four I discussed the historical conception and role of the woman's body socially, politically and most important, medically, and argued that women's bodies and their place within public and political life have long been ambiguous. The emergence of the 'breast cancer movement' aided in transforming women with breast cancer from an isolated, private, silent suffering, to heroic public suffering through acts of civic engagement and participation. My investigation of gender and cancer in the contemporary era has revealed a very interesting insight, where a typical representation of gender is rendered rather incoherent. For it is now the case (in large part due to the enormity and acceptability of the breast cancer movement) that women not only figure as innocent victims but also at the same time view themselves (and are also publically viewed) as battling, fighting, heroic warriors.

Near the end of *Illness as Metaphor* (1978) Sontag makes a prediction that cancer metaphors will be made obsolete as science and medicine progress. She notes, “the cancer metaphor will be made obsolete, I would predict, long before the problems it has reflected so vividly will be resolved” (87). This prediction by Sontag has proven to be anything but true. There seems to be something very odd going on involving the evocation of militaristic metaphors within the breast cancer movement. Instead of these metaphors being dissolved, the Western world has seen a substantial increase in the association between militaristic metaphors and breast cancer discourses and narratives, perhaps in part due to “America’s war on terror”. The notion that cancer is evil, terroristic and invasive is very reflective of the general discourse about America being at war with ‘terrorism’.

Breast cancer sufferers, like soldiers, must battle, fight and be warriors to ward off the enemy. Masculinity and military are highly associative, if not conflated. Protection, battle, fight, warrior, strength, perseverance, invasion and conquer are all (typically) masculine militaristic metaphors, and are all found within the discursive and narrative constructions of the breast cancer movement since the early 2000s. One glaring example of these metaphors within the breast cancer movement is found in the Ford Motor Company’s partnership with the Susan G Komen Foundation.

When opening the web page entitled “Warriors in Pink. Powered by Ford”, the visitor is instantly bombarded with loud drumming ‘tribal’ music accompanied by a flash version of text stating: “In Every Woman There is a Warrior in Pink”. Soft pink and green hues fill the viewer’s eyes, while birds carry a banner across the screen which reads, “Believer. Survivor. Fighter” (Ford Motor Company, 2010). The website also

features a section tab entitled: “Which symbol tells your story?” and offers “warrior symbols” (with accompanying tag lines) from which one chooses from 12 warrior symbols which best represents their story (Appendix H). Along with choosing a symbol, visitors are encouraged to provide a brief description of their story in text form, and also submit a short video of themselves talking about joining the ‘fight’ against breast cancer. The intriguing aspect of these ‘warrior narratives,’ is that they are situated alongside various pink-coloured products, which is historically and symbolically associated with femininity, softness, docility and innocence.

Barbara Ehrenreich in *Welcome to cancerland: A mammogram leads to a cult of pink kitsch* (2001) is quick to point out the highly gendered landscape of the breast cancer movement. She notes how the colour pink is representative of women’s passivity, and also a suspended state of childhood in which infantilization (via pink ribbon teddy bears, crayons and paper sent in breast cancer survivor care packages, and pink blankets, among a host of other ‘pink products’) signals the normal and acceptable way to suffer (46). Ehrenreich further asserts that, “although we may imagine ourselves to be well past the era of patriarchal medicine, obedience is the message behind the infantilizing theme in breast-cancer culture...you are encouraged to regress to a little-girl state, to suspend critical judgment, and to accept whatever measures the doctors, as parent surrogates, choose to impose” (2001: 52).

How do we begin an interrogation of these two seemingly dichotomous gender norms fashioned in one (now global) health movement and what does this say about gender and health in the contemporary era? Cancer has become such a highly gendered disease and for many there is a sense that “...motherhood and family must be protected

from a disease that threatens not just individual lives but also the normalized socioeconomic identities and relationships that constitute the nuclear family” (King, 2006: 45). Although Ehrenreich focuses on breast cancer, this same sense of ‘obedience’, and acceptance of various medical measures is also very much applicable to the case of women and cervical cancer. It is hard to say what metaphors are evoked by women suffering from cervical cancer (as there is not an empowerment movement that is as public and ubiquitous as the breast cancer movement) but it is more than likely safe to assume that if there was a movement for cervical cancers that would parallel the breast cancer movement, we would see the same metaphors evoked.

The point I am trying to make clear is, especially in the case of cancer in the contemporary era, gender and neoliberal citizenship are highly associative. The link between women and militaristic metaphors of cancer, have much to do with the notion of the ideal neoliberal citizen. Women, who figure as obedient, self-regulatory, empowered, dutiful, consumptive, volunteers, share many of the same admirable qualities of a soldier who is fighting for *his* country. The evocation of these metaphors by women suffering from cancer solidifies the relationship between citizenship, illness and gender and to perform each of these in accordance with neoliberal ideology and discourse, speaks volumes when we consider how different diseased bodies are subject to different moralization. The implications of this cancer hierarchy could prove more significant upon closer inquiry.

The final section of this chapter is devoted to the exploration of the implications that the cancer hierarchy has for individual bodies in terms of research funding; the significance of disproportionate risk assessment; the normalization of particular diseases;

political/public engagement and the de-responsibilization of the state in matters of health, through the increased responsabilization and self-regulation of individual bodies.

Perhaps one of the most glaring and troubling implications of moralizing particular cancerous bodies lies in the disparity of public and political support and research funding for cancer. I argue, and as I have tried to make clear throughout this entire thesis, that because lung cancer induced by cigarette smoking is widely conceived in the Western world as risky, dangerous, irresponsible and a plague on public resources, it has received far less public, private and political support in terms of research funding.

A 2009 Canadian report, compiled by The Canadian Breast Cancer Research Alliance, comprised of corporate/private members and governmental and public agencies, is a broad-based research collaborative, outlining, identifying and recommending key strategies in breast cancer research. In the report, one figure breaks down a total investment in cancer research (\$402,448,190) and divides the research investment by cancer site. The pie-chart indicates lung cancer's estimated allotment to be \$13.8 million, while breast cancer's estimated allotment is roughly four times greater than lung cancer, at \$54.6 million (National Breast Cancer Research Framework, 2009: 20). Further, a report published by The U.S. Department of Health and Human Services entitled *Estimates of Funding for Various Research, Condition, and Disease Categories (RCDC)* lists a table of 218 diseases which "displays the annual support level for various research, condition, and disease categories (RCDC) based on grants, contracts, and other funding mechanisms used across the National Institutes of Health" (U.S. Department of Health and Human Services, 2010). According to this report, the fiscal year of 2009 saw funding for breast cancer at \$722 million dollars, and an expected funding for the 2010 fiscal year

at \$741 million dollars. Alternatively the fiscal year of 2009 saw funding for lung cancer at \$178 million dollars, and an expected funding for the 2010 fiscal year at \$183 million dollars (U.S. Department of Health and Human Services, 2010). These numbers are significant and disconcerting when we compare the funding figures to incidence rates.

Published by the American Cancer Society, *Cancer Statistics, 2009*, presents an overview of cancer incidence, mortality and survival rates in the United States in 2009. Table 1 of the study displays disaggregated data which lists the new cases and estimated deaths of 45 types of cancer appearing in both men and women. The importance of this study for my inquiry is found within the data presented for the mortality rate of the “respiratory system” (which includes lung and bronchial cancer, larynx and “other respiratory organs”) and breast cancer (Jemal, et.al. 2009: 226). According to this table, the estimated mortality of the “respiratory system” for both genders in the United States is 163,790 per year and the estimated mortality rate of both genders for breast cancer is 40,610 (40,170 for women) per year, which is a difference of 123,180 (Jemal, et.al, 2009: 226).

Echoing these figures, but from a global perspective, the World Health Organization indicates that out of the 7.4 million cancer deaths per year globally, 1.3 million people die of lung cancer per year, compared to 519,000 breast cancer deaths globally (World Health Organization, 2010). This data is representative of global trends which sees lung cancer as having a significantly higher incidence and mortality rate over breast cancer (Mathers, et.al., 2001: 4). Thus, there appears to be an obvious, and rather troubling underlying message garnered from these statistics: *breast cancer is more important than lung cancer*. Given that globally, lung cancer has the highest mortality

rate, yet is one of the most decidedly underfunded cancers in terms of research dollars allocated and spent, speaks to the exceedingly gendered, corporate and philanthropic nature of cancer in the contemporary era.

The statistics presented above appear to have a limited impact on how we conceive of cancer and its associated risks in ‘reality’. Although the breast cancer movement in particular has brought ‘the cause’ into the public’s eye—it has substantially augmented awareness for women and men (increasingly global awareness), considerably increased the amount of research funding and has worked to de-stigmatize those living with breast cancer—it has also been (perhaps unwittingly) successful at creating what I would like to refer to as disproportionate risk assessment. The problem here is, if women are constantly bombarded with pink ribbons (the foremost cultural symbolic reminder of breast cancer); pink products of almost anything imaginable (a startling example can be found in the recent partnership between the Komen foundation and Kentucky Fried Chicken, which raised funds for breast cancer through their “pink bucket” campaign) and breast cancer risk assessment tools and continual reminders to “be breast aware”, many other threatening and perhaps more severe health issues could be, and in actuality, are neglected. For example, and as I alluded to in chapter three, heart disease is the leading cause of death among all women globally and many women are oblivious to this data. The same can be said about skin cancer, as it is has the highest incidence rate of any cancer globally and far outweighs the threat posed to women by breast cancer.

Breast cancer narratives also contribute to the creation and promotion of disproportionate risks. These narratives have—individually, socially and politically—affected the way women and men conceptualize the disease. Because breast cancer

narratives are increasingly abundant, and readily available for public consumption, they contribute to a generalized understanding of the disease as beatable, and most importantly, curable. The importance of 'appropriate' and 'acceptable' narratives born out of the breast cancer movement prove very valuable when we consider the concept of normalization. Narratives and metaphors that emerge as a result of the breast cancer movement are of a specific, inspiring, heroic and warrior-type nature which centre on self-esteem, empowerment and survivorship.

These narratives which line the shelves of book stores, are found within online forums and blogs, and shared in a community, contribute to a *breast cancer specific meta-narrative* where, "a particular self is constituted through these narratives, occasioned by the presence of a listener, her questions and comments. Typically, the moral character of the protagonist is sustained" (Reissman, 1990: 1195). Further, and perhaps most significantly, illness narratives, and breast cancer narratives in particular, see that "participants contribute to a single over-all definition of the situation which involves not so much a real agreement as to what exists but rather a real agreement as to whose claims concerning what issues will be temporarily honored" (Goffman, 1959: 9-10).

The honoring of particular narratives over and over again not only establishes a 'status quo' of narratives, but also serves, in conjunction, to *normalize* the narratives and in the case of breast cancer, the disease and the 'movement'. Normalization of disease, its narratives and its related movements leave little room for other, less acceptable narratives. King notes that,

while it is quite common for illness to function as a transformative experience on an individual basis, often in positive ways, the dominant discourse of breast cancer survivorship...leaves little room for alternative, less positive, understandings of the disease experience and its long-term effects, or, relatedly, of the political-economic context in which the fight against the disease is being waged (2006: 102).

Narratives that lie outside the confines of what is acceptable publicly, rarely, if ever, see the light of day. Narratives about the struggle, heart-ache, depression and the horrific physical, emotional, and intellectual effects of cancer treatment, are anything but appropriate and inspiring to any individual. Stories of anger, frustration and hatred toward the disease, the treatment and the doctors, do not 'fit' with the over-all discourses of breast cancer.

Often times these narratives that we see within the breast cancer movement are not just focused solely on telling an individual's story, where one re-creates for the reader the journey that cancer had taken them on and the triumph, strength, and personal transformation that results from this 'journey'. Rather, many of these narratives situate triumph, strength and personal transformation alongside notions of personal responsibility, self-regulation, bodily awareness and vigilance. These narratives serve to further entrench the ideal image of the participatory, empowered, self-regulatory neoliberal citizen: they did all they could have done to ensure that their physical and mental health was attended to. All doctor's visits were kept, follow-up screening and testing was done, proper diet and exercise was maintained, family and friends were cautioned to be vigilant about what they put into their bodies and the list goes on and on.

When we think about narrative in this way, as contributing to an over-all “cancer culture”, it becomes apparent that these narratives about cancer, alongside public health and medical expertise messages about cancer prevention, form a general and diffuse discourse of cancer prevention that centers on individual responsibility and self regulation. The result of making citizens responsible for nearly all matters related to health and the body serves to detract our attention away from the *cause(s)* of the disease and in so doing, deresponsibilizes the state. In a rather controversial, but unquestionably accurate critique of the breast cancer movement, Ehrenreich argues that “America’s breast-cancer cult can be judged as an outbreak of mass delusion, celebrating survivorhood by downplaying mortality and promoting obedience to medical protocols known to have limited efficacy” (2001: 52).

In her chapter “Doing Good by Running Well” King suggests that the some scholars of the contemporary breast cancer movement (she names Barbara Christian, 1999) have argued that the ‘innocence’ that is found within the breast cancer movement is indicative of women’s “refusal to know” (2006:43). King contests this argument by stating that there is much more involved, in terms of power, gender, and citizenship in the contemporary breast cancer movement and refutes this simplistic claim by arguing that,

...it is precisely a refusal to know that has itself been taken up as an ethical practice in the government of the self in the latter part of the twentieth century and beyond. This is not to suggest that the era in which we live is marked by a refusal to know, period, but rather that it is characterized by a shift in the appropriate *focus* for knowing. In the age of ‘intimate citizenship’...in which politics via mass anger and disruption is dismissed as silly, dangerous, and futile, an ethic of self-government has emerged that encourages people to turn their critical selves inward and to question and work upon their psychic health and self-esteem (2006: 43).

This notion highlighted by King serves a very important purpose when we consider the responsibility that is placed on individuals at the expense of governmental responsibility.

As I alluded to in chapter three, individual practices of the self serve to divert our attention away from the inaction of the state. Vigilance for bodily practices places the responsibility of cancer prevention and cure on the individual. Very few individuals and groups to date have criticized the government for their lack of environmental protection legislation and inaction when it comes to corporate/private industry's responsibility for carcinogenic products and emissions.¹ Movements which focus on finding a *cure* without knowing the *cause*, and being complacent and accepting current (and many would argue not very successful) methods of detection and treatment, promote what King calls, a "tyranny of cheerfulness" (2006:101-105).

Purchasing 'pink products' from companies which use carcinogens in their products, such as cosmetics, and buying Ford vehicles which contribute cancer-causing emissions, appears rather antithetical. What progress can be made when the people who have suffered, or who are currently suffering from a disease, are told that the best thing, the right thing, and the most dutiful thing to do is to purchase products that are 'pink' in order to find the (still allusive) 'cure'? What if these millions of people around the world who 'pink wash' and participate in runs and walks for 'the cure' were to devote their energy, time and money towards making corporations, private business and the

¹ The grassroots activists in Breast Cancer Action (BCA), based out of California, have been working since the early 1990s to create awareness about policy regulations limiting carcinogenic products and emissions, governmental inaction and corporate irresponsibility in 'the fight against breast cancer'. Further, they have criticized not only the government, but also organizations such as the Komen Foundation for 'pink washing' and down-playing the severity and realities of breast cancer for *all women*, regardless of age, race, sexual orientation and socio-economic status.

government responsible for negligent regulatory action? What if women who are not White, not middle-class, and not heterosexual—whose narratives differ from the ‘narrative status quo’—could have their voice heard? Would they speak to the lack of community support services, access to proper and effective medical care and treatment options, having to pay to become ‘empowered’ through runs and walks for the cure?

Although there may be no easy answers to these questions, the importance lay in asking the questions, period. Uncovering why certain bodies, all suffering from the same cellular mutation, are subject to different discourses, regulations, intervention and moralizations, and how the implications of these could prove just as destructive as the disease itself, certainly warrants a close examination. And this is what I have attempted to do in this thesis.

Conclusion

It is difficult to pin-point *when* I first conceptualized this project, but it is not difficult to pin-point *why* I began this project. Bombarded by pink ribbons on a daily basis, I began to wonder why there were no ribbons for lung cancer, skin cancer, brain cancer, etc. Why was it that everywhere I looked there were pink products, whose proceeds were said to go to the fight against breast cancer? My initial question of ‘why’ lead me down a path of examining cancer literature and it was here that I realized the questions I had could not be easily answered.

I was baffled to learn that no one had yet to ask, how and in which ways, different cancerous bodies were discursively constructed. No one had asked where these discourses came from and why. And perhaps most importantly, no one questioned what the implications of discursively constructing an individual based on the location of a cancer could be. I knew for certain that I had particular conceptions of different cancerous bodies and perhaps everyone around me would share my conceptions, if I dared to ask their opinion. This is when I realized that it should be my task to uncover the ‘why’ and the ‘how’ and the implications therein.

At the beginning of this thesis I suggested that the physiological location of cancer within the human body says much about who we are as individuals. I argued that the socio-cultural literature about cancer has tended to ignore this notion, and has been primarily interrogated and written about as ‘cancer writ-large’. I suggested that the problem with the type of interrogation is its failure to uncover the complex and uneven distribution of power/knowledge/discourse that accompanies *different types of cancer*.

Further, I argued that by breaking away from the tendency to interrogate and discuss ‘cancer writ-large’ through an analysis of the discourses of particular cancerous bodies in relation to other cancerous bodies, what is revealed is a ‘hierarchy of cancer’ where cancerous bodies, and soon-to-be cancerous bodies placement is contingent on the adherence to normalized practices of the self.

Chapter one began with the suggestion that the Western world is experiencing a new phenomenon of ‘cancer anxiety’. This anxiety, I argue, has manifested itself as a ‘continual, low-grade, diffuse, ever-present sense of anxiety’. Unlike the quick outbursts, or more prolonged feeling of anxiety that is brought about by political or economic unrest, cancer anxiety today has mobilized millions of people into action. The manifestation of this unique type of anxiety has put us on guard; it has altered the relationship that we have with our bodies and the bodies of people around us. The presence of this anxiety has made us fearful and it has made us insecure—fearful of what lies ahead for our bodies.

The individual body and the social body are always caught up in a network of power/knowledge/discourse relations. To uncover these intricate relations, we must utilize theoretical and methodological tools that aid us in understanding both the micro and macro relations of power/knowledge/discourse. Michel Foucault has taught us the importance of history when exploring questions around ‘the body’. In chapter two I employed Foucault’s theories of governmentality and biopolitics, and argued that these theories best serve an investigation that takes ‘the body’ as its locus of inquiry. How and why bodies are intervened upon and in what ways this is made possible, is best understood through Foucault’s theoretical frameworks. Foucault’s work proves

invaluable when pursuing a sociological investigation, such as the one that has taken place here.

It was also in this chapter that I outlined my methodological approach of discourse analysis and argued that this is the best tool for investigating the numerous ways bodies and cancer have been discursively constructed historically and in the contemporary era. Uncovering the way we talk about bodies has a substantial impact on the way these bodies are treated. Discourse analysis provides us with the tools to examine history and the present. It has allowed us to uncover and begin to understand how and why particular discourses function and operate and it allows us to seek out affinities and formations that aid in understanding our individual and social lives.

Chapter three was devoted to an examination of how and why discourses of particular bodies emerge. My exploration of the role of medical expertise since the 1970s highlighted the role of expertise in informing and compelling individual practices of the self. Discursive formations that result from medical expertise have come to shape our primary understanding of our bodies and the bodies which constitute a population. Even though medical expertise has become somewhat fragmented in the last 40 years, we still seek out the knowledge and truth capacities that science and medicine have to offer. How we get access to this knowledge and truth, I argued, was through public health which has acted as the primary vehicle for the dissemination of the discourses of risk, responsibility, lifestyle and morality, as they relate to cancer and cancer prevention. I used this chapter as the foundation for my case study, which appeared in chapters four and five.

Chapters four and five explored the historical and contemporary discourses of risk, regulation, lifestyle and morality of three cancerous bodies. These chapters revealed many interesting insights, which chiefly centered on the imperative of practices of the self. In chapter four I examined the cigarette smoker's body in conjunction with the body of the lung cancer sufferer, and also explored the discourses of women and cancer in a historical context. This chapter served as a basis for chapter five, where a discussion of the contemporary discourses of lung cancer, cervical cancer and breast cancer took place. Investigated thorough the examination of public health literature and documents, chapter five revealed that practices of the self, along with notions of a dutiful and participatory neoliberal citizen, shaped the way we think of and talk about different cancerous bodies. These case studies brought to the surface very important observations and questions.

It was in the sixth and concluding chapter where I tackled some of these important observations and questions by making connections through addressing the significance of the moralization of different cancerous bodies, via the cancer hierarchy. I argued that the placement of particular cancerous bodies, and soon-to-be cancerous bodies, within this hierarchy is the result of an individual's adherence to, and embodiment of, the neoliberal ideological conception of appropriate citizenship and practices of the self, and the significance of gender and its relation to illness and citizenship in the contemporary era. The latter part of this chapter was dedicated to an examination of the implications that this cancer hierarchy has in terms of funding disparities, disproportional risk assessment, the normalization of particular diseases, and how the responsabilization of citizens via practices of the self, serves to de-responsibilize the state in matters of health and illness.

Taken as a whole, this examination had revealed many important insights. Chief among them is the notion that all cancerous bodies, and soon-to-be cancerous bodies, are not seen, assessed and discussed the same way. Although this thesis only examined three types of cancerous bodies, it is important to recognize that an examination of other cancerous bodies could very well yield similar results. The importance of revealing how different cancerous bodies are researched and discussed could have substantial impacts on the way people not only experience cancer individually, but the way soon-to-be cancerous bodies, all bodies, think about cancer and the bodies in which it resides.

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Appendix A

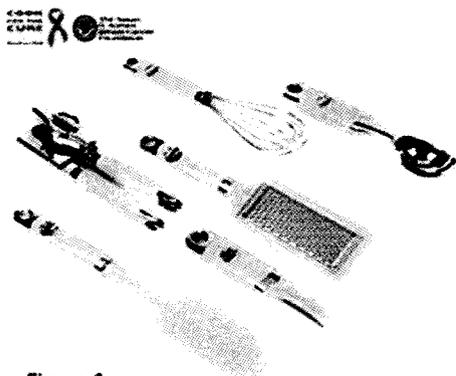


Figure 1

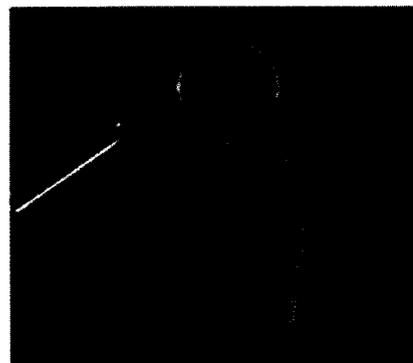


Figure 2

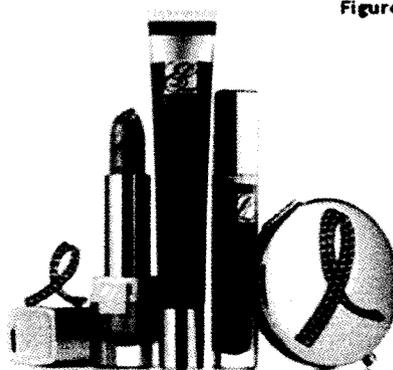


Figure 3

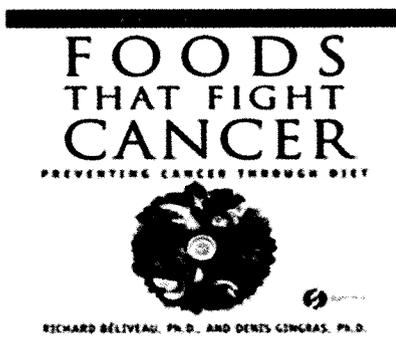


Figure 4



Figure 5

Sources:

Figure 1: "Cook for the cure". Kitchen Aid. <http://kitchenaid.com>

Figure 2: "Cancer key chain"

http://1.bp.blogspot.com/_4dODHkS8nfW/Sx9201KdguI/AAAAAAAAAD14/V10rW5z4UfI/s200/Cooking+with+Foods+that+Fight+Cancer.jpg

Figure 3: Marie Claire make up

http://1.bp.blogspot.com/_4dODHkS8nfW/Sx9201KdguI/AAAAAAAAAD14/V10rW5z4UfI/s200/Cooking+with+Foods+that+Fight+Cancer.jpg

Figure 4: "Foods that fight cancer" <http://www.grampasattic.ca/grampasattic/products/books/Health/foods-that-fight-cancer.bmp>

Figure 5: "Cooking with foods that fight cancer".

http://1.bp.blogspot.com/_4dODHkS8nfW/Sx9201KdguI/AAAAAAAAAD14/V10rW5z4UfI/s200/Cooking+with+Foods+that+Fight+Cancer.jpg

Appendix B

JAIL FOR SMOKING MOTHER.

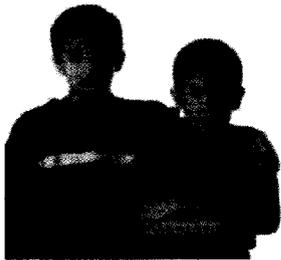
Mrs. Lasher Used Cigarettes in Presence of Her Children.

Special to The New York Times.

BINGHAMTON, N. Y., Oct. 17.—Charged with smoking cigarettes in the presence of her children, Mrs. Jennie Lasher of Philadelphia has been sentenced to thirty days in the county jail for endangering their morals. The complaint was made by her husband after a family dispute over the morality of the act.

When sentence was pronounced Mrs. Lasher almost swooned. The seven-year-old boy tried to cheer her and pleaded with the officer "not to take mamma away." The five-year-old girl clung to her skirts, but she bade them good-bye at the jail door and told them to be good children until she returned to them. This is the first conviction of the kind under the State law which makes it a misdemeanor for a mother to smoke cigarettes in the presence of her family.

Appendix C



DON'T POISON US

WARNING: Second-hand smoke contains carbon monoxide, ammonia, formaldehyde, benz(a)pyrene and nitroamines. These chemicals can harm your children.

Health Canada



WARNING TOBACCO SMOKE HURTS BABIES

Tobacco smoke during pregnancy increases the risk of preterm birth. Babies born premature are more susceptible to death, illness and disability.

Health Canada



CIGARETTES HURT BABIES

Children are born with a higher risk of death if their mothers smoked during pregnancy. These children are also more likely to be born premature and have a higher risk of death, illness and disability.

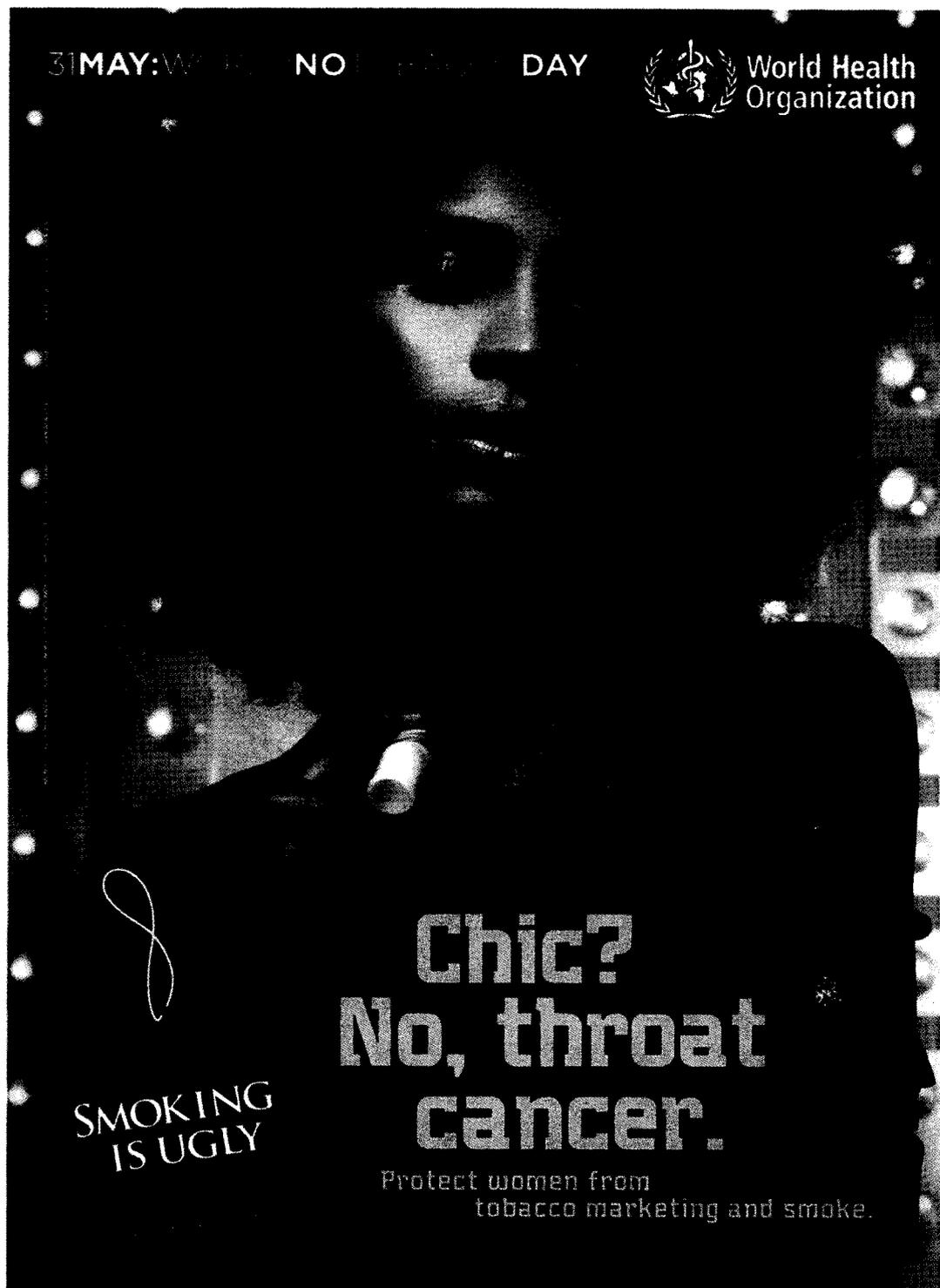


CHILDREN SEE CHILDREN DO

More than 10 million children are likely to see their parents smoke. But the children's deaths from smoking-related illnesses result from tobacco use.

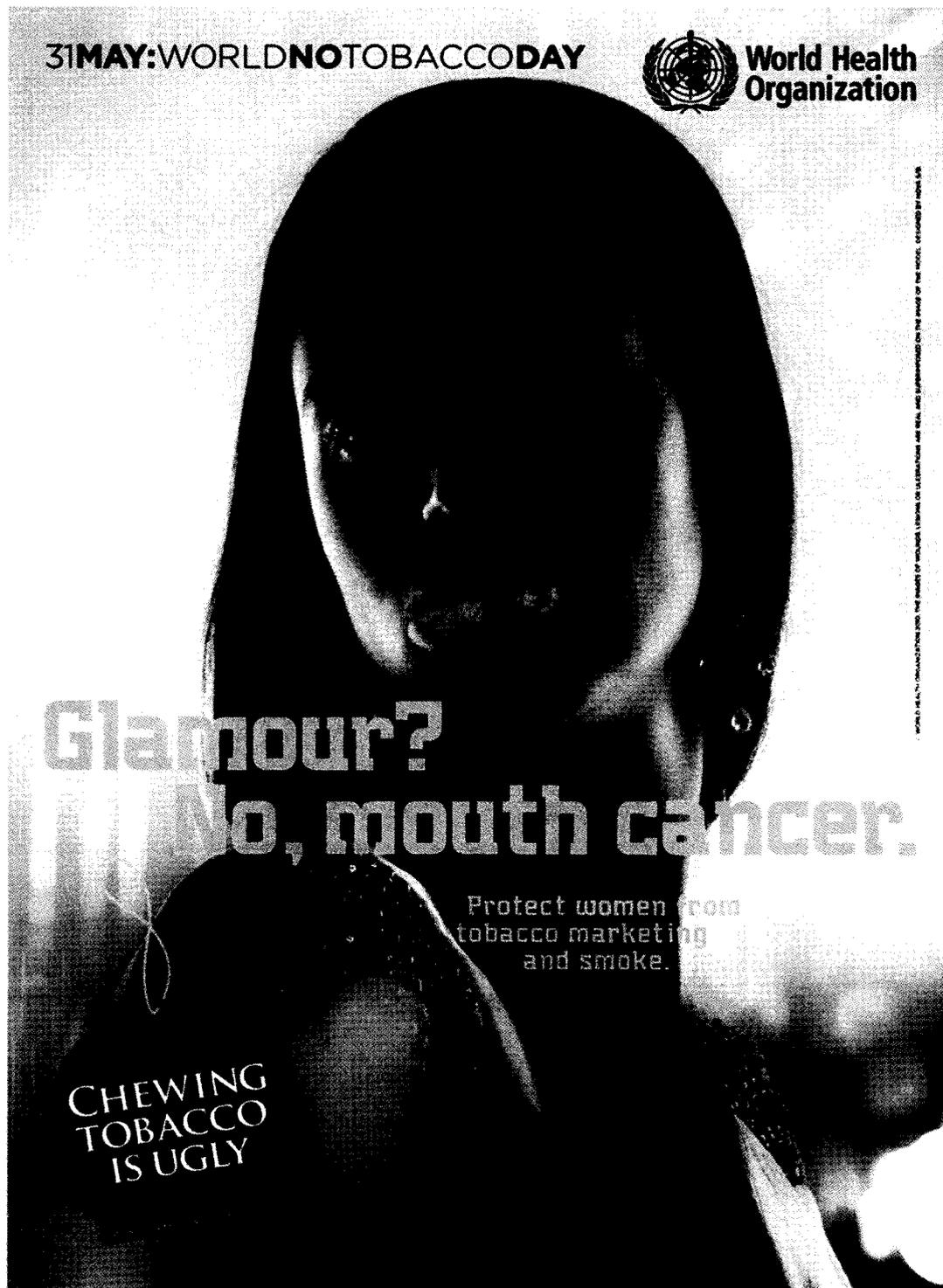
Source: <http://www.hc-sc.gc.ca/hc-ps/tobac-tabac/legislation/label-etiquette/graph/index-eng.php>

Appendix D



Source: <http://www.who.int/tobacco/wntd/2010/posters/en/index.html>

Appendix E



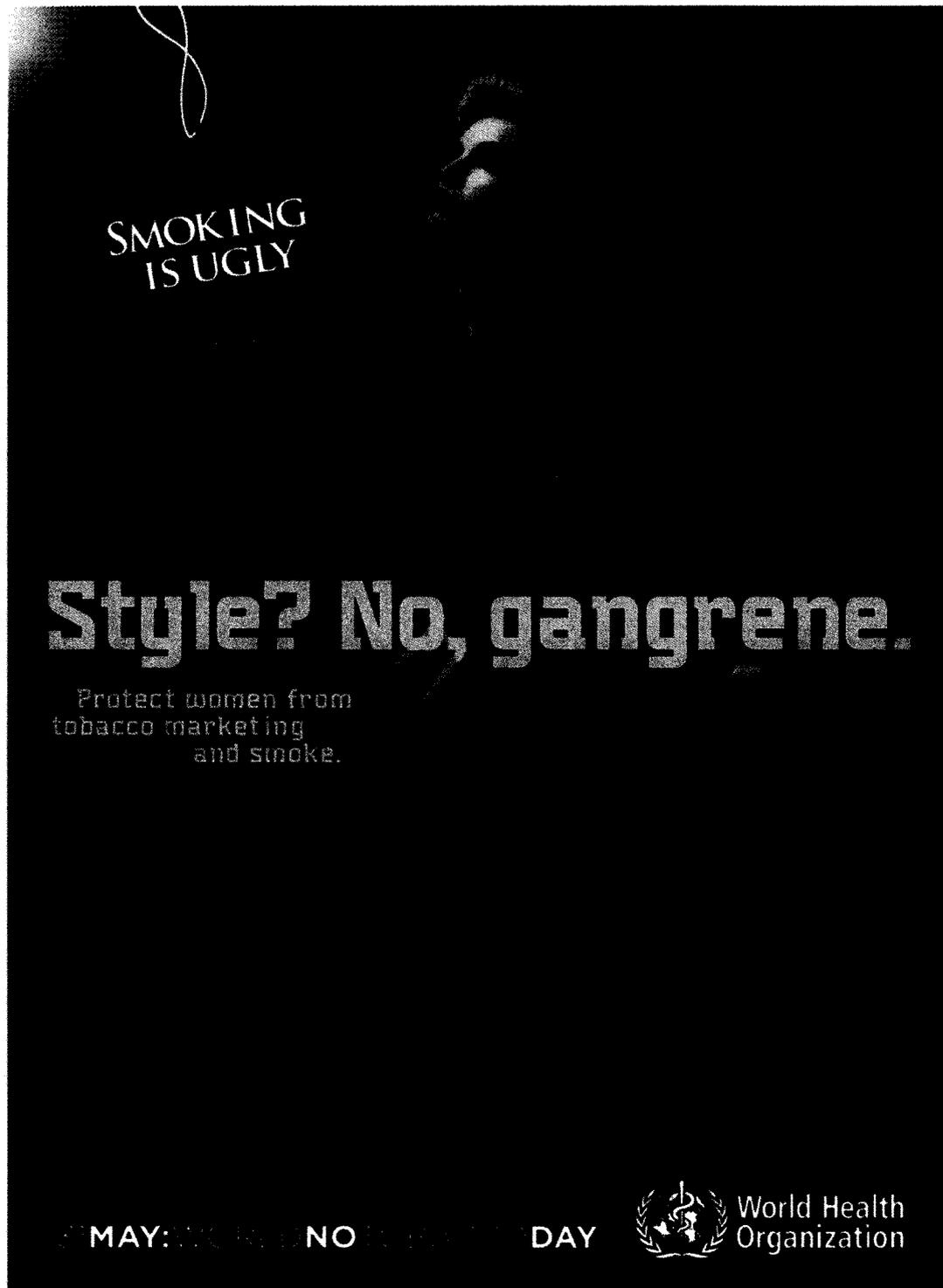
Source: <http://www.who.int/tobacco/wntd/2010/posters/en/index.html>

Appendix F



Source: <http://www.who.int/tobacco/wntd/2010/posters/en/index.html>

Appendix G



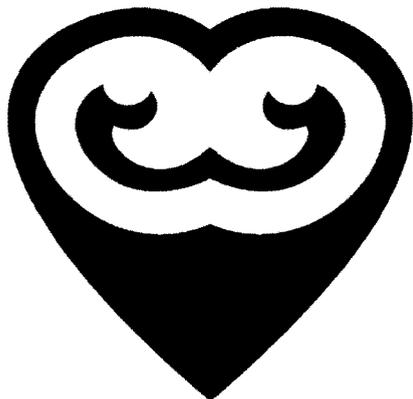
Source: <http://www.who.int/tobacco/wntd/2010/posters/en/index.html>

Appendix H



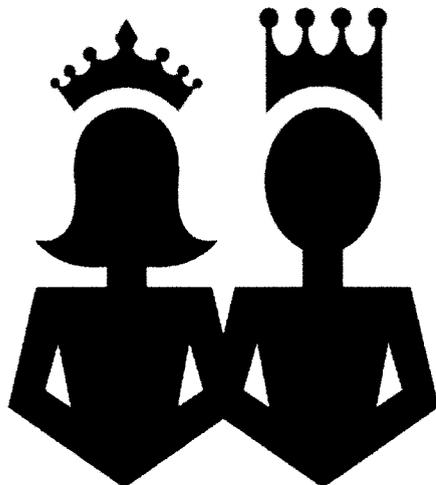
The Warriors

Represent the powerful and the courageous who fight against breast cancer. *Yours is a story of courage.*



Heart

Represents those who stand strong with loved ones who battle the disease. *Yours is a story of love and devotion.*

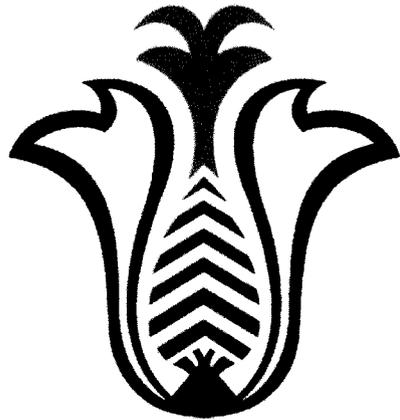


Crowned Warriors

Remind us that breast cancer touches the lives of both genders. *Yours is a story of compassion.*

Source: <http://stories.fordcares.com/story/add/warriors>

Appendix H Continued



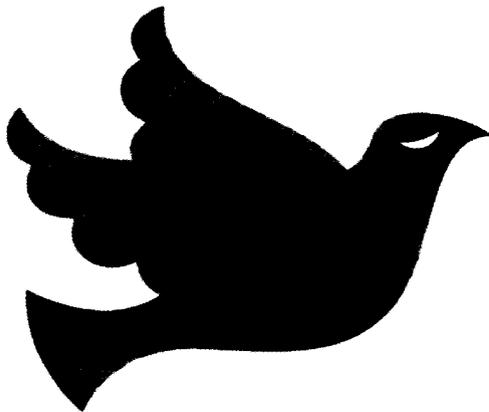
Plants

Represent life, growth, and survival. *Yours is a story of growth and resilience.*



Feather

Represents kinship. Also, traditionally used in times of battle. *Yours is a story of growing closer to someone or creating new bonds.*

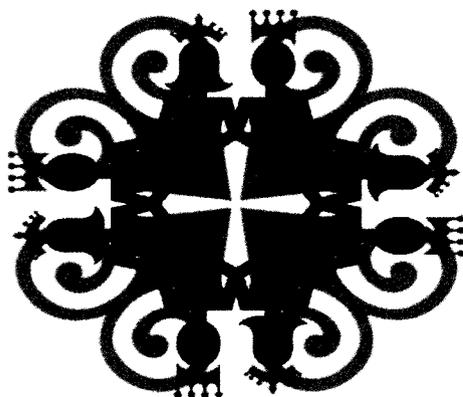


Dove

Represents the wish for a quiet peace during the heat of battle. *Yours is a story of finding peace and renewal.*

Appendix H Continued**Spiral**

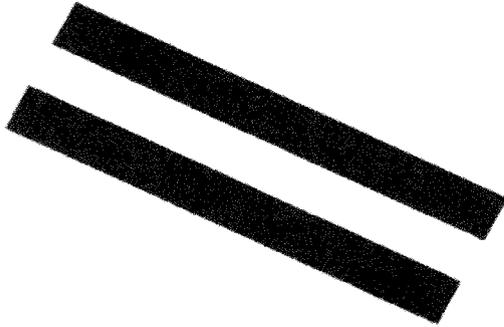
Represents life. A conduit through which physical and spiritual energies flow. *Yours is a story of hope.*

**Warrior's Circle**

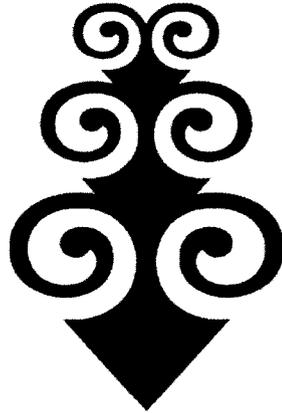
Represents the power of thousands of Warriors uniting together. *Yours is a story of commitment to the cause.*

**Angel Wings**

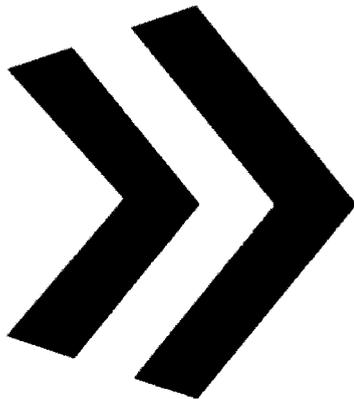
Honor the angels who have passed after their fight against breast cancer. *Yours is a story of love and remembrance.*

Appendix H Continued**War Paint**

Worn by Warriors ready to enter battle.
*Yours is the story of bravery during
difficult physical and emotional times.*

**Tree of Love**

Represents those who grow and
stand tall together through adversity.
Yours is a story of dedication.

**Chevron**

A French word meaning "rafter," it
signifies protection. *Yours is a story
of finding strength.*