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Living in Prognosis: Toward an Elegiac Politics

MAURICE BLANCHOT, THE FRENCH PHILOSOPHER whose life spanned nearly the entire twentieth century, wrote a short piece about World War II in which he poses, in a brief two pages, the genealogy of what he calls in the story's title: "The Instant of My Death." In it, a band of roving soldiers removes the main figure from his chateau and places him in front of a shooting squad. Seconds before he is to be shot, some confusion in the bushes demands the attention of the lieutenant, and the soldiers disband before firing. Blanchot considers his protagonist's life afterward posthumous, supplemental: "as if the death outside of him could only henceforth collide with the death in him."

"I am alive. No, you are dead."¹

The pronoun shift: *I* am alive, No, *you* are dead, marks a moment of interpellation that can provide insight into cancer culture.

The term "cancer survivor" references this simultaneous sense of life and death. A friend and attorney, Mary Dunlap, who died in 2003, wrote a book-length manuscript while living with cancer, "Eureka! Everything I Know About Cancer I Learned From My Dog." In the last chapter she handwrites: "On Monday, Maureen and I were confronted with the news—predictable to many, but surprising to us—that the cancer discovered in my pancreas has moved into my liver. Today I am an asymptomatic person with an almost invariably deadly cancer."² Mary was an optimist and thus surprised by news that was perhaps predictable to others. To her, the aggregate number of prognoses for pancreatic cancer offered a measure of hope: a 5 percent chance of survival was still 5 percent.³ When she found that her cancer *had* spread (had, indeed, been spreading during the interim of hope, of "survivorship"), she transmuted into a *seemingly* healthy person: asymptomatic but harboring a deadly disease. For others, learning the news

ABSTRACT This essay examines how prognosis serves as a representational space for people living with and dying of cancer. It argues that as one of a series of means by which an elusive disease is made material, the prognosis also holds fantasies about the future, the past, and counterfactual futures and pasts. / REPRESENTATIONS 98. Spring 2007 © 2007 The Regents of the University of California. ISSN 0734-6018, electronic ISSN 1533-855X, pages 77-92. All rights reserved. Direct requests for permission to photocopy or reproduce article content to the University of California Press at <http://www.ucpressjournals.com/reprintinfo/asp>. DOI: 10.1525/rep.2007.98.77.

about their cancer already feels like being “diagnosed with death.”⁴ In each of these senses—the statistics, the mystifying embodiment of life and death, and the subject shift marked in the transition from healthy to ill—cancer diagnosis offers the collision posed by Blanchot.

This culture, for the person trying to live within it, seemingly revels in confusion. One blogger, who identified herself only as “cancerbaby,” wrote this about her experience with ovarian cancer: “The vernacular drones constantly. And for those who speak it, the talk is loose, as it should be. Rendered mute, you can only listen to the din. It swirls around you, looping endlessly in patterns and figures you can’t quite recognize—a language you once studied, but cannot speak or master.”⁵ Virtually every person I have spoken to who has gone through cancer diagnosis has echoed this sentiment about the loss of cohesive language. Much of this linguistic confusion, I think, results from the quasi-mystical nature of cancer. Not only does it have a rich history, as Susan Sontag wrote, contoured by “lurid metaphor,” but astonishingly little is known about the disease, how it is caused, how it spreads—or even how many separate diseases might fall under the same term. Cancer (the Latin word for crab) materializes as much in cultural interchanges as in its biological form; it can only be located in, culled from, cultural interstices: not only from pathology reports but also in conversations with oncologists, support groups, get-well cards, coffee shop gossip, wig shops, clinical trial reports, medical malpractice opinions. The struggle to locate “cancer” within this din of meaning, this slippery culture in which cancer is constituted, I surmise here, is what cancerbaby is referring to.

The biomedical prognosis, as one of these technologies of presencing, stands out in this dispersed set of cancer culture’s materializing practices. Many patients receive prognoses at a doctor’s visit, some look them up in books and charts, and others may not want to know, but cancer and prognosis form oncology’s double helix. After treatment, the cancer patient often cannot know if treatments have ended—or if the next time the “palliative” box, rather than the “cure” box will be checked on the medical treatment forms. But the statistical prognosis poses both a stunningly specific (one has x percent chance of being alive in five years) and bloodlessly vague (you, yourself, will either be dead or alive) fact about the future. Prognosis offers a meager tease toward knowledge about cancer where there can often be little else. In this paper I take Blanchot’s pronoun shift as a representational space (the “firing squad of aggregate statistics”) that I will call “living in prognosis.”⁶

The prognosis activates terror—the shock of having harbored cancer, the fear of an unknown future seemingly presented through survival-rate numbers, the brush with a culture of death. But bizarrely, at the same

moment, it dissolves that very terror in the act, its very function, of aggregation. The number itself imbricates one's life into the inevitable and the universal; the number becomes the backdrop against which one can no longer locate the shape of one's own life. One is moved into an abstraction that *seems* explanatory through its gesture toward universality, yet one will only ever live or die. Either way, one's future will only be absorbed into the truth of prognosis, a truth that recursively projects a future as it acts as a container for a present. The prognosis offers an abstract universal, moving through time at a level of abstraction that its human subjects cannot occupy, and in so doing it threatens to render us all (for we are all moving through the culture of cancer) inert. Simply a structure of and for our fantasies, the prognosis itself has no time for the human life and death drama. Thus, the double action of the prognosis. And so, who is the subject of prognosis? What is it to live in prognosis?

"Living in prognosis" might serve as an alternative to the identity politics that has infused disability studies—and indeed, if pressed, I would argue that all of us in American risk-culture live to some degree in prognosis. Nevertheless, for several reasons cancer provides a particularly rich venue through which to examine this concept and its relation to time, the counterfactual past and future, and the ways these shape the prognostic subject. First, there is the prevalence of cancer: one in two American men and one in three American women will experience an *invasive* cancer in their lifetimes;⁷ it is the largest killer of at least one demographic group, women between the ages of 34 and 54; and it is the primary cause of death in several states. Living in the cancer prognosis is a Common American Experience, as well as a particularly potent form of living chance. Second, cancer has a unique and rapidly transforming cultural history. Despite the enormous numbers of sufferers, cancer is still taken to be a tragic exception—a veer off a "natural" life course rather than the predictable consequence of American-style industrial production. And third, despite (or because of) the cultural fear and ignorance that surround the disease, people undergoing cancer treatment are expected—at least in public—to disguise themselves with wigs, take on the mantle of "survivorship," consider the "gift" of cancer, and increase their life chances with positive attitudes. In an experience rife with contradiction and confusion, the prognosis appears as a concrete scientific fact. Thus, in living cancer, living in prognosis takes on a particularly potent form. Fourth, the treatments and the prognoses for many types of cancer remain remarkably inaccurate and even rote. Consider the fact, for example, that for breast cancer (which some physicians consider an umbrella term for perhaps two hundred diseases), chemotherapy increases survival rates by a mere 3 to 5 percent, and little is known about whom it will help. Of the seventy thousand women each year who undergo

the treatment, five thousand may increase their survival time. The prognostic subject and the cancer object live with each other's ghostly presences—threatening to absent one another, haunted by the possibilities of the future self.⁸

Living in prognosis, then, is about living in the folds of various representations of time. I would like to spend the next pages thinking through temporality in cancer to better understand the formation of the subject living in prognosis. I do this by turning, in the first part of the essay, to the cultural productions of people with cancer and representations of cancer in the United States, thinking specifically about Margaret Edson's play *W;t*; Hannah Wilke's photography; Lucy Grealy's memoir; and my own multi-sited ethnographic work, part of which was completed at a weeklong retreat for people with cancer. At stake in these representations is not only the unfolding of truth in time, and thus the revelation that the past was not what it seemed, but also the difficulty of accounting for alternative histories: the counterfactuals of both the past and the future.

In the last part of the essay, I look at cancer culture's counterfactuals through the lens of medical malpractice law. If the prognosis holds both the future-factual and the future-counterfactual, the medical malpractice suits involving misdiagnosis offer the promise of the past counterfactual, the possibility of taking back time. The compensatory award in a successful lawsuit can, representationally at least, fulfill the fantasy of an alternative past. But to do this, cancer misdiagnosis suits must enter the slippery territory of measuring biomedical logics of the aggregate against the legal necessity of finding the cause of a death or illness in an individual. In light of these competing logics, courts must configure a third logic to determine whether a death is determined by a medical error of missed diagnosis or the preceding illness. Since ultimately the cause can never really be known biomedically, medical malpractice courts set out their own logics of time, chance, and cause to determine how fault, cost, and compensation for missed diagnosis will be distributed. These "lost chance" opinions offer several interpretations of life and death in prognosis.

Cancer is creepy. After it shows up one realizes that it must have been there for a while, growing, dispersing, scattering, sending out feelers and fragments. After the treatments, often one hasn't any idea if it is still there, slinking about in organs or through the lymph system—those parts of the body you can't really even visualize. But the apparent definitiveness of the prognosis, which seems at first counterposed to the unpredictability of the disease, can be as mysteriously tricky as the errant cells.

For one thing, living in prognosis severs the idea of a time line and all the usual ways one orients oneself in time: one's age, generation, and stage

in the assumed lifespan. If you are going to die at 40, should you be able to get the senior discount at the movie when you're 35? (Is the discount a reward for long life or for proximity to death?) This relation to time makes death central to life in prognosis, death as an active loss—as if there were some right to a certain lifespan—rather than just something that happens to everybody at the end of life. Furthermore, prognostic time constantly anticipates a future. In this sense, it offers us a similar logic to the one that bids us to sock away money in retirement plans. But despite this familiarity, it is offered at a level of abstraction that is virtually impossible to grasp. Once you enter the population, you will only die or not die; you will not 70, or 42, or 97 percent die. And there is always the chance that a cure could change one's number at the last minute, as happened to several people with HIV/AIDS after they had cashed out life insurance policies. In some sense, then, prognostic time demands that we adopt its own outside “pre-posterous” viewpoint, one in which the end, or *posterior*, seems to *precede* the story. Thus, if your five-year survival statistic is 5 percent, you are apparently worse off than if it were 80 percent, though you still do not know which side of the line you'll be on in five years.

This temporal puzzle is perhaps *the* effect offered through the dramatic narrative: we know the end of a familiar Shakespeare play from its beginning; we anticipate it, and its ineluctability offers pleasure. Margaret Edson's play *W;t* builds in the view from the end when the protagonist, Vivian Bearing, discloses at the outset that she will die of ovarian cancer. The play offers the omniscient opportunity to witness her journey into that knowledge. In this way, the time-scheme of the play mimics other artifacts of cancer culture: the clinical trial report states survival statistics, the medical malpractice archive documents injuries and death. In these archives, the end comes first, the punch, the punch line of the future is dissipated, dissolved into the past—we know the end of the story even as we read through it from the beginning. The temporality echoes the double action of prognosis: causing and evacuating the terror of a potential future.

Bearing offers an alternative grammar of death. She speaks about Donne's Holy Sonnet Six, in which death is “nothing but a breath—a comma—separates life from life everlasting. . . . death is no longer something to act out on a stage, with exclamation points. It is a comma, a pause.”⁹ The pause indicates the blip between time lines—the one that leads toward an ineluctable death, and the other in which there ineluctably is no death. Amid all the ways illness is marked—the check boxes on forms, the numbers, the stats, all the things that purport to carry meaning but instead seem to occlude it—the comma, for Bearing, simultaneously carries significance and mystery equal to impending death. Punctuation provides comfort, allows language. In Donne's poem, where death merely interrupts between

two forms of life, punctuation provides the structure of inevitability and means of mourning. But in its own ambition toward timelessness, it provides the structure for the narrative of life passing into death through the meter of time and the materiality of recitation.

The work of Hannah Wilke, who died of lymphoma in 1993, challenges the viewer to ask related questions about destiny, the future, possibility, and ineluctability through a similarly time-arresting medium: photography. She began taking photographs of herself in the early 1960s, as her mother was dying of cancer. She took many, donning Greek robes and photographing herself in sensuous poses, or sticking chewed gum on herself and photographing it as only a female artist in the 1970s New York art scene could have. But if these images portray a stunning version of Western archetypal beauty, their meaning shifts dramatically in light of the two-decade series of images that ends with larger-than-life photographs of her middle-aged, positively not-beautiful self in hospital gowns, receiving chemotherapy, and losing her hair.

Only within that context does the image set come full circle; Wilke foreshadowed the end at the beginning, when she juxtaposed her self-portrait with an image of her dying mother (fig. 1). The artist is young—youthful and white as a sixteenth-century Bronzino painting, her eyebrows plucked high and perfect, her stereotyped red-rose lips puckered with half a smile triangulating the nipples of her breasts, her mass of dark hair tumbling to the sides as if she is aroused. She looks directly at us. She is coy. She is challenging. She is reiterating a scene—an icon—a platitude. She is smart.



FIGURE 1. (Left) Hannah Wilke, *Portrait of the Artist with Her Mother, Selma Butler, 1978–81*. © 2006 Donald Goddard. Photo: Dennis Cowley. Courtesy Ronald Feldman Fine Arts, New York. (Right) Hannah Wilke, *July 26, 1992/February 19, 1992: #4* from *INTRA-VENUS* Series (detail; one of two panels). *Performatist Self-Portrait with Donald Goddard*, © Donald Goddard. Photo: Dennis Cowley. Courtesy Ronald Feldman Fine Arts, New York.

Her mother, in contrast, looks down and across, as if toward Wilke's right breast. That gaze is triangulated again between Wilke's right nipple and her own vertical mastectomy scar hot and rutted against her dark skin with the cluster of red welts, which must be skin metastases, that edge into the taut skeleton of her shoulder. Her hair—wig—black, unkempt, matches the dark red lips—both out of place, ersatz health, on the emaciated chest and shoulders. Thirty years later, Wilke's final hyperstaged photos cite the Madonna theme again. In one she uses a pale blue hospital blanket as a shroud that covers both her bald, tilted head and her now sagging breasts. No child is held within the depths of this image: the cancer legacy stops here. Taking the photos as a narrative, did Wilke see her cancer future/history as her destiny? We can read the first photo, now, only in light of the later one; we know what future they embodied: Wilke haunts us with a near inevitability.¹⁰

But if her ironically posed grace in the Madonna photo shows the inevitability of disease and death, it also iterates the mocking of time offered by photography. Photography, as Roland Barthes theorized, demonstrates that we all live in prognosis. A short time before he was killed by a truck as he left his class at the Sorbonne, he wrote:

One day, leaving one of my classes, someone said to me with disdain, "You talk about Death very flatly."—As if the horror of Death were not precisely its platitude! The horror is this: nothing to say about the death of one whom I love most [his mother], nothing to say about her photographs, which I contemplate without ever being able to get to the heart of it, to transform it. The "thought" I can have is that at the end of this first death, my own death is inscribed; between the two, nothing more than waiting; I have no other resource than this *irony*.¹¹

Here again, as with Bearing's comma, the stillness, the seeming timelessness of the photograph counters the time—the waiting—of life's passage.

Wilke's images suggest that prognosis affects every dimension of time, not just the future; the past becomes equally mysterious and unknowable. Lucy Grealy makes this point explicitly in her *Autobiography of a Face*. Grealy captures the eeriness of the past under life in prognosis, the sense of how its truth and relevance might be "revealed" through diagnosis. In the memoir of her treatment for Ewing's Sarcoma in her jaw as a child, and the years of subsequent harrowing surgeries attempting to reconstruct her face disfigured by radiation treatments before she died of a drug overdose when she was 39, she writes of a childhood, precancer recollection.

As I sat there on the playground's sticky asphalt I experienced time in a new way. . . . A year before, my class had gone on a field trip to a museum where I became fascinated with a medieval chart showing how women contained minute individuals, all perfectly formed and lined up like so many sardines in a can, just below their navels. What's more, these individuals contained more minute versions of themselves, who in turn held even more. Our fates were already perfectly mapped

out within us. . . . It's impossible for me not to revisit this twenty-year-old playground scene and wonder why I didn't go right when I should have gone left, or alternatively, see my movements as inexorable. If the cancer was already there, it would have been discovered eventually, though probably too late. . . . Sometimes it is as difficult to know what the past holds as it is to know the future, and just as an answer to a riddle seems so obvious once it is revealed, it seems curious to me now that I passed through all those early moments with no idea of their weight.¹²

Trying "to know what the past holds," what alternatives and what necessities it contained, can become a near obsession for a person with advanced cancer faced with the slender pages of a medical report. Learning, for example, that cancer was there and went undetected in earlier tests, unannounced in earlier reports, turns the faulty reports into the material remnants of lost opportunities—of times when treatments may have been less invasive, more efficacious. Because cancer is always about time. Its progression is marked by stages; the staging is not exactly arbitrary, but neither is it terribly precise. It is mathematical (based on tumor size, number of positive nodes, and how far it has spread). In breast cancer, for example, Stage I has very high survival rates, while Stage IV is considered terminal, albeit with second-, third-, and fourth-line treatments. Cancer spreads over time, but no one knows how or when: it is possible to have metastasis after Stage I cancer, or none with Stage III. But no matter what one's stage, virtually everybody wants to have been diagnosed sooner.

At a retreat for people with cancer that I attended in 2005, women talked about the counterfactual in many ways: the shame of not having done self exams, delaying mammograms because of being too busy, or not wanting to ask more of already overworked people. Sharon said: "I wasn't politicized enough and aware enough to ask." Liz talked about the junctures in her life when her reports of symptoms were not being believed, when she almost didn't believe them herself, so she decided to collect medical evidence of the symptoms of her undiagnosed leukemia. She stored blood in her refrigerator and documented blood loss with Polaroids. Yet after the diagnosis, she was filled with regret and shame: "How could I have just let it all happen, with all these signs—how could I have, you know, gone for my course in Toronto when I had to get up five times because I was bleeding so much. And how could I have not known about my tumor?" Alice asked, "How could they have missed two tumors 11 cm and 10 cm that were fused together? On my CT scan they thought my tumor was my uterus." Tina, the nurse, asked, "How could I have had so much trust—how could I have been so lackadaisical about my own health?" When she needed to book her surgery her nurse-colleagues told her not to book it for the fall since they were short-staffed. So she delayed and later mused: "I'm a nurse, for god's sake, why couldn't I advocate for myself?"

The discussions about “how could I” and “how could they” were intense expressions of grief, anger, betrayal, and regret; a yearning for a different story that offered better odds. They contained moments imagined or recalled as nexes—as places at which things could have been different had different actions been taken, places at which the stories could have turned out differently. They were times that might have saved one’s life, times when a culture of disavowal had betrayed them, for despite the overwhelming statistics on how many North Americans will die of cancer, not one of those women perceived herself as at risk. The women on the retreat felt simultaneously betrayed by those who were supposed to know better and stupid for not themselves having adequately understood the risks.

Statistics seem to present us with a certainty, such as “1 in 207 women who are 35 years old will be diagnosed with Stage III breast cancer.” But it says nothing about who will represent the one, so it also carries the counterfactual hint that it might be somebody else (“why me?”). If it hadn’t been Sharon who was the “1 in 207” at our retreat, would it have been someone else who didn’t do self-exams, whose physicians were careless or homophobic, who delayed her medical checkup, or who had no medical insurance? Like car-crash deaths or suicides, the individuated counternarrative folds into the magical inexorability of the aggregate. It is as if the statistics hold within them also all of the mistakes, the systematic lapses and failures of medical treatment, the misunderstandings, the delayed tests, and factors that lead to the late discoveries of cancers that always already could have been discovered sooner. In this sense, the statistic is communal in two ways, both because it harbors the group among which apparently anyone could be the one chosen for cancer and because it holds the culture and biology of cancer in one number. Nevertheless, despite the ever-present counterfactual, Sharon lives the subjective inevitability of cancer.

Medical malpractice law mirrors the logic of prognosis in its potential for an objective counterfactual, one that’s experienced as if from some perspective outside the diagnosed patient’s. In individual cases, the law’s conjuring trick resides in rewriting history, imposing the counternarrative, through the transfer of money, through a more comfortable object life. The damages paid, of course, only represent the injury, and as such they can’t really assuage grief or get at the sense of betrayal, dismay, rage, or terror felt by the plaintiff. One might think of malpractice suits as attempts to tack more satisfying conclusions onto narratives of error, suffering, and death. They try to replace stories of ineluctable fate with those of possible healing.

Additionally, by offering a latently political space in which standards of practice can be set and upheld, medical malpractice law has the power to

denaturalize and change the aggregate statistic of prognosis. In one case, for example, a judge examining a case in which a surgical clamp had been left in the body of a patient determined that it “requires no expertise to count” the clamps even though it was not the usual practice.¹³ Medical malpractice law can also be used to counter what amounts to discrimination in healthcare.¹⁴ In one case, the plaintiff Merle Evers had been told to “stop worrying and go home and rest” when she presented her doctor with a breast lump. Six months later she had a radical mastectomy, and five years after that she had metastasis to her lung.¹⁵ Similarly, when another plaintiff, Myra Kennedy, had presented a lump to her doctor in 1983, she was also told “not to worry,” and that advice was repeated a year later. By 1985 the cancer had metastasized.

Though proponents of medical malpractice laws consider their activist function—in these instances the attempt to insure that doctors will not dismiss women’s concerns—to be a main function of the law, cases with this intent can be difficult to bring. Medical malpractice cases rely on the testimony of other doctors, and one study found that only 30 percent of surgeons would be willing to testify against a physician who had removed the wrong kidney from a patient.¹⁶ Moreover, in California damages for *any* injury caused by medical error are capped at \$250,000. This means that plaintiffs’ attorneys cannot afford to take on cases that do not also include claims for losses well over and above the injury itself, such as lost income.¹⁷ As many commentators have noticed, this legal framework disadvantages people who take time off to raise children or who have low incomes and so are unable to bring malpractice suits.¹⁸

The malpractice suits that have to do with cancer attempt to distinguish the injury rendered through error from that of the potentially lethal underlying cause. These suits reveal how law attempts to locate the *fact* of causation in any given case, while oncology only presents future *possibilities* delivered through prognoses and statistics as they appear in populations of individuals whose medical histories have various degrees of similarity to the plaintiff’s. The slim archive of medical malpractice law devoted to missed diagnosis focuses on a concept called “lost chance.” The idea is that a patient can sue a doctor for the chance of life that is lost when, presented with symptoms of a disease, the doctor does not follow the usual standards of care and thereby fails to accurately diagnose the patient. Courts have varied dramatically on how they have interpreted the lost-chance claim, some requiring the patient to have died, others accepting that the loss of a chance itself can be injurious. In one lost-chance case, the judge decided that the benefits to the patient of not knowing about the cancer outdid the injury of late diagnosis.¹⁹

Because of these difficulties, judges in states that accept the lost-chance doctrine have set up frameworks for adjudicating when numbers about probability are considered to matter and to determine how probability of

plaintiff death by the preceding cancer will weigh in against probability of medical fault of delayed diagnosis. In courts that accept lost chance, the plaintiff has to have suffered a more than 50 percent loss of survival chance, and that has to bring the patient from a more than 50 percent chance of survival to one less than 50 percent.²⁰

Lost-chance plaintiffs encounter several temporal problems. In the first place, cancer spreads over time, but no one knows precisely when time matters and for whom. Perhaps cancer metastasizes at a certain moment after which treatments will no longer work; or perhaps as many types of cancer exist, with as many behaviors, as people who have it. Even the staging indices—useful in general to decide on treatments and measure prognosis (or chance)—reflect loose clusters of similar indices. In the instant that a tumor moves from being 4.9999 cm to 5.00 cm the life chance of its host does not necessarily diminish by 25 percent. In fact, tumors cannot be measured with such accuracy; staging and the prognoses that they occasion offer mere estimates at every vector. Thus, doctors disagree about whether a six-month delay in diagnosis will make a difference. On the other hand, if the delay is several years it becomes harder to prove that the symptoms were related to the disease that later emerged. Indeed, the lack of proof of disease can be precisely the alleged cause of injury. If the doctor *had*, for example, biopsied a lump, then it would be known whether or not it was malignant. If he or she did not, the doctor can now claim that it wasn't there. Even if the doctor agrees that things should have been otherwise (and a malpractice suit is never about intent), her role in court is to defend time as it unfurled—to argue in various ways that things could not have been different: the right procedures were followed, the patient would have died even if the cancer were treated sooner.

The burden of proof falls on the plaintiff, since the plaintiff claims that things should have been otherwise; the plaintiff yearns for validation of the counternarrative by the court in the form of awarded damages, even knowing that such a validation will not make the counterfactual narrative any less a fantasy arising from the now inevitable fact of the past injury. The plaintiff's quest for a validated counterfactual narrative, however, meets resistance from the nature of the prognoses adduced as evidence in these cases. For, whereas the law requires proof of causality, biomedicine can only generate statistical probabilities.

One decisive California case makes this conflict clear. In the 1991 case *Elaine Dumas v. Davis Cooney*, the court presumed that accepting the loss-of-chance doctrine would destroy the integrity of the tort system, which “attempts to ascertain facts to arrive at the truth.”²¹ The court held that, “If the acts of the defendants did not actually cause plaintiff's injury, then there is no rational justification for requiring defendants to bear the cost of plaintiff's damages.”²² In this case, the plaintiff was the wife of a man who

died of lung cancer. Had his tumor been discovered at the moment of misdiagnosis, his survival chances would have been 67 percent. When his tumor was discovered, his chances were 33 percent, and he died. This judge wanted specific facts to prevail, and since certainties of causation were simply impossible to determine in this case, he dismissed it. But, of course, his decision does not serve the cause of truth any more than a decision the other way would have; it merely claims that prognoses cannot be thought of as containing legal truths applicable to specific cases.²³ The outcome of this lawsuit was no more or less arbitrary than prognosis itself. In any individual case, it is as impossible to know what the past holds as it is to know the future.

I suggested earlier not only that the prognosis cannot be accurate for an individual (indeed accuracy is simply an illegible concept for the individual living within its parameters) but also that, along with other aspects of cancer culture, with this disease that is so elusive, prognosis concretizes cancer, seeming to make it more solid and visible. In this sense, cancer is only known, is only brought into being—through technologies such as that of the prognosis. In relying so heavily on this collective statistical number, and imagining that this number should make sense of an individual's case—legal logic partakes in the slippage between the collective and the individual, rendering cancer more obscure, more mystifying, even as it purports to be discussing it. One must admit, then, that both the patient bringing a loss-of-chance suit and the judge who decided *Dumas v. Cooney* are mystifying cancer.

Law by necessity individuates—it looks only at one case at a time, one case in which earlier diagnosis might have been possible. But these individuated possibilities serve also to disavow, or at least to shadow, the collective sacrifice of cancer, the political and economic decisions that trade the costs and benefits of the disease.²⁴ Of course the companies that manufacture carcinogenic products and the government agencies that permit their use do not mean for any particular individual to get cancer (fig. 2). For the producers of a disease-causing environment, too, consider risk only in the abstract. Nor does anyone *intend* for cancer to exist. When we fill our tanks with gas and drive our cars we rarely think about the collective violence rendered by pollutants. Even tobacco companies would prefer that their customers kept returning for more cigarettes rather than dying of lung cancer: if prolonged illness is good for the economy, death is not, necessarily. But even though cancer is a social decision, real people live that sacrifice. Medical malpractice law serves only to strengthen the aura of cancer as a quasi-mystical, ungraspable, cultural and biological phenomenon.

In the book-length study from which this paper evolves, I develop a notion of “elegiac politics.” My colleague Derek Simons writes about elegy in his work on concrete. He writes about the mystery of mundane and ubiquitous

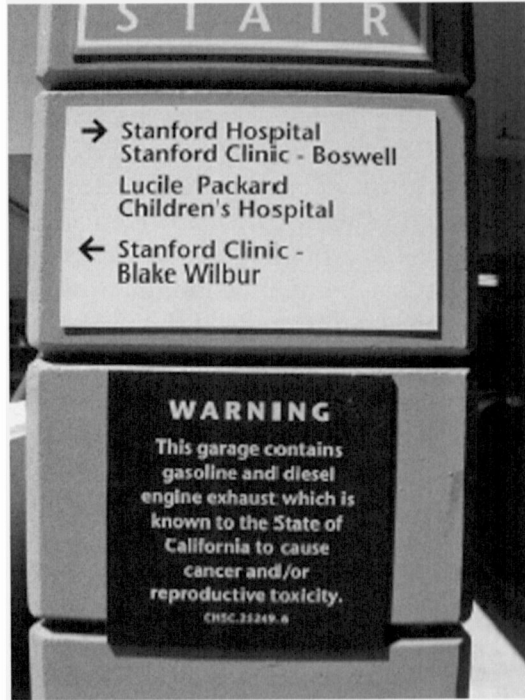


FIGURE 2. Sign at the parking lot of the Stanford Cancer Center: “Warning: This garage contains gasoline and diesel engine exhaust which is known to the State of California to cause cancer and/or reproductive toxicity.” Photo: Sarah Lochlann Jain.

concrete, which makes manifest a kind of boundary between presence and absence, where the sidewalk indicates precisely where footprints can leave no trace, a small monument to absent pedestrians. This concrete rendering of absence, with its origins in the increasing prevalence of a projectile economy, writes Simons, offers a kind of ongoing mourning.²⁵ The cancer complex is also about mourning, about the work of absencing and presencing, and all of the parts of that work that make it hard and emotional and profitable. The cancer complex both gives us the inevitable (we’ll die, why *not* of cancer?) and holds the possibility of the counterfactual through the promises of early detection and cure. In this sense, I don’t believe that cancer, or suffering more generally, can be understood cleanly through a politics that tries to disavow death (as the survivor politics does), or cheer it up (as the pink-ribbon rhetoric does), or deny or defer cancer suffering (as does the “drive for the cure”). An elegiac politics argues for pushing the private face of cancer cultures—grief, anger, death, and loss into the public cultures of cancer—perhaps even if only alongside of LiveStrong, or sipping, driving, and walking for the cure—with the recognition of the enormous economic profits and gains that parallel these losses.²⁶

An elegiac politics analyzes how the private and public aspects of the rhetorics of loss and profit both disavow and necessitate each other in the cultural sacrifice of cancer. It also recasts inevitability, recognizing that the counterfactuals offered by legal promises of justice or biomedical promises of cure, can only ever be irrelevant to patients' internal state, can only act as social icons, whereas lives are lived in time that folds around subjective inevitability. Instead of focusing on hope, cure, and the survivor figure, elegiac politics yearns to account for loss, grief, betrayal, and the connections between economic profits, disease, and death in a culture that is affronted by mortality. If the term "survivor" offers a politics steeped in an identity formation around cancer, "living in prognosis" offers an uneasy alternative, one that inhabits contradiction, confusion, and betrayal.

In elegiac politics, prognosis emerges as a technology of mourning, holding together the future and the past. Prognosis stands as a small monument to those who will not make it through the five- and ten-year marks. Offered in factual form, prognosis holds the counterfactual: life or death. But for all the promise of validated counterfactuals, time in elegy wraps itself around the subjective life *and* death of each of us who passes through the timeless grammar and promise of cure, compensation, and the captured youth of a photograph.

Notes

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1. Maurice Blanchot, *The Instant of my Death*, and Jacques Derrida, *Demeure: Fiction and Testimony*, trans. Elizabeth Rottenberg (Stanford, 2000), 9.
2. Mary Dunlap, "Eureka! Everything I Know About Cancer I Learned From My Dog," unpublished manuscript.
3. The *Oxford English Dictionary*, 2nd ed. (Oxford, 1989), s. v. "prognosis," defines the word thus: "Med. A forecast of the probable course and termination of a case of disease; also, the action or art of making such a forecast": http://dictionary.oed.com/cgi/entry/50189613?single=1&query_type=word&queryword=prognosis&first=1&max_to_show=10 (accessed October 28, 2006).
4. Quote from a colleague who was diagnosed with non-Hodgkins lymphoma. A note on my citations: those cancer patients cited through their written or published work, I cite by name. Those with whom I have spoken remain either anonymous or are cited by pseudonym. This work is based on an eighteen-month ethnographic study that included patient and physician observation; participation in support groups and retreats for people with cancer; and interviews with patients, physicians, attorneys, and counselors.

5. Post on the Web site *Cancer, Baby*, http://cancerbaby.typepad.com/cancerbaby/mother_may_i/index.html (accessed October 17, 2006).
6. The “firing squad of aggregate statistics,” as my colleague Rebecca Herzig put it.
7. “Probability of Developing Invasive Cancers Over Selected Age Intervals, by Sex, US, 1999–2001,” American Cancer Society, Surveillance Research, 2005.
8. Prognostic logic continues to gain power and legibility through the creation of new groups of risk subjects: those encouraged to understand themselves as “at risk” for various diseases and thus to take prophylactic drugs such as statins and tamoxifen in the hope of countering their risky futures.
9. Margaret Edson, *W;t* (New York, 1999), 14–15.
10. See Carla Freccero, “De-Idealizing the Body: Hannah Wilke, 1940–1993,” in *Bodies in the Making: Transgressions and Transformations*, ed. Nancy Chen and Helene Moglen (Santa Cruz, 2006), 12–18.
11. Roland Barthes, *Camera Lucida: Reflections on Photography*, trans. Richard Howard (New York, 1981), 124.
12. Lucy Grealy, *Autobiography of a Face* (Boston, 1994), 27–28.
13. Marc Franklin and Robert Rabin, *Tort Law and Alternatives: Cases and Materials*, 7th ed. (New York, 2001), 116.
14. On discrimination in medical care, see, for example, K.A. Schulman, J.A. Berlin, W. Harless, et al., “The Effect of Race and Sex on Physicians’ Recommendations for Cardiac Catheterization,” *New England Journal of Medicine* 340, no. 8 (Feb. 25, 1999): 618–26, and M. Loring and B. Powell, “Gender, Race, and DSM-III: A Study of the Objectivity of Psychiatric Diagnostic Behavior,” *Journal of Health and Social Behavior* 29, no. 1 (1988): 1–22.
15. *Merle Evers and Richard Evers v. Kenneth Dolliner MD and Livingston Obgyn Group P.C.*, Supreme Court of New Jersey, 95 NJ 399; 471 A.2d 405; 1984 NJ LEXIS 2395. In my ethnographic work, I met many, many people who claimed that symptoms that were later found to be caused by cancers were initially dismissed by physicians, primarily because they were told that they were too young to have cancer.
16. Franklin and Rabin, *Tort Law*, 116.
17. One reason that Americans tend to use the tort system more than citizens of other Western nations is the high cost of healthcare when one is injured. Tort law offers one way that in certain situations one can cover these costs, even when one may not have been inclined to sue. People with cancer usually suffer severe economic loss, through loss of income and as a result of prohibitively expensive treatments. Some medical insurance plans, such as Medicare or Medicaid (covering 27 percent of Americans) provide for care, but 15 percent of Americans have no medical insurance whatsoever, while about thirty-five million have coverage that would not cover—and not cover by thousands of dollars—standard cancer treatment. Gurney Williams III and Pamela Weintraub, “Mamm Special Report: The New Have-Nots, Are You One?” *Mamm* (Jan./Feb., 2006): 29–35. If one can show that one was misdiagnosed, in certain situations some of these costs can be recuperated.
18. For more on this issue, see Sarah Jain, *Injury* (Princeton, 2006) or Tom Baker, *The Medical Malpractice Myth* (Chicago, 2005).
19. This judge was clearly unaware that cancer treatment has progressed somewhat since the 1950s, and he brought an egregiously outdated version of medical ethics to the table. In 1961, a survey showed that 90 percent of physicians did not tell their patients a diagnosis of cancer, but by 1971 the same survey indicated

- that 97 percent did inform their patients. Dennis H. Novak MD, Robin Plummer et al., "Changes in Physicians' Attitudes Toward Telling the Cancer Patient," *Journal of the American Medical Association* 241, no. 9 (March 2, 1979): 897–900.
20. While both medical and legal rhetoric accepts the ultimate "truths" of survival or death, neither seems to recognize that the numbers harbor a grand misrepresentation: a fetishization of life. When one comes into the system in a late stage, one faces the additional chronic illness of endless cycles of chemotherapy.
 21. *Elaine Dumas v. David Cooney* (1991) 235 Cal. App. 3d 1593, 1609.
 22. *Ibid.*
 23. Despite the slipperiness of the concept, the confusion about what might be meant by cause, prognosis, and chance, the tort of "lost chance" does maintain the notions that (1) early detection is important, (2) doctors should be accountable when their practice falls below the standard of care and, (3) patients should have a way to hold their doctors accountable to them. Alas, in California and other states that have followed its lead, patients whose doctors failed to diagnose their cancers even though they presented clear symptoms in a timely fashion have lost the social recognition that accompanies legal recovery. For an excellent outline of the politics of medical malpractice law, see Tom Baker, *The Medical Malpractice Myth* (Chicago, 2005).
 24. The numbers really are staggering. Just to take an example of one cancer: two hundred thousand new diagnoses and forty-one thousand annual deaths of breast cancer each year in the United States, a million or more American women living with it who have no idea they are ill. More than six thousand women under the age of 49 dead of the disease each year—more than the number of AIDS-related deaths at the height of the crisis, and twice that of the annual deaths of polio at the height of that crisis. And yet the response has not been to reconsider the costs of our economic and environmental decisions but to concentrate on that elusive thing: the Cure. The promise of the curable disease, the triumphant figure of the survivor, and the rhetoric of hope all serve as part of the rhetorical work of maintaining a belief in the preciousness of each individual life. The bad faith, though, reveals itself in contradictions: the statistics built from drug trials on the one hand point out how far we are from a cure and on the other harbor the possibility that cure is possible. And yet, as researchers such as Robert Proctor argue, very little basic research on cancer is being done. One might reasonably conclude that the rhetoric of hope for a cure papers-over the actuality that after all these years, for many cancers chemotherapy treatments have improved very little, and they have improved survival rates only marginally, if at all. Robert Proctor, *Cancer Wars: How Politics Shapes What We Know and Don't Know About Cancer* (New York, 1995). See also Gerald Markowitz and David Rosner, *Deceit and Denial: The Deadly Politics of Industrial Pollution* (Berkeley, 2003), and the extensive Web site of the San Francisco-based political organization Breast Cancer Action (www.bcaction.org).
 25. Derek Simons, "The Will to Concrete and the Projectile Economy of Cities," in *The Cultural Mechanics of Urban Form in Vancouver* (PhD diss., Simon Fraser University, forthcoming).
 26. The larger goal of that work is to rethink what analysis means in the face of cancer; that project gropes toward something else, a new style of analysis that comes out of confusion rather than clarity, bewilderment rather than surety, and toward a new kind of politics.

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