



#### ANNUAL REVIEWS **Further**

Click [here](#) to view this article's online features:

- Download figures as PPT slides
- Navigate linked references
- Download citations
- Explore related articles
- Search keywords

# Cancer

Juliet McMullin

Division of Clinical Sciences, School of Medicine, University of California, Riverside, California 92521; email: [juliet.mcmullin@ucr.edu](mailto:juliet.mcmullin@ucr.edu)

Annu. Rev. Anthropol. 2016. 45:251–66

The *Annual Review of Anthropology* is online at [anthro.annualreviews.org](http://anthro.annualreviews.org)

This article's doi:

10.1146/annurev-anthro-102215-100217

Copyright © 2016 by Annual Reviews.

All rights reserved

## Keywords

cancer, inequality, narrative, stigma, global cancer

## Abstract

Previous work in the anthropology of cancer often examined causes, risks, and medical, familial, and embodied relationships created by the disease. Recent writing has expanded that focus, attending to cancer as a “total social fact” (Jain 2013) and dissecting the landscape of “carcinogenic relationships” (Livingston 2012). Cancer-driven relationships become subjectively real through individual suffering, stigma, and inequality. This article traces concepts developed from a primarily US-centered discourse to a global cancer discourse, including cancer-related issues continuing to raise concern such as stigma, narrative moments of critical reflection on the dominance of biomedicine, and processes by which individuals and communities manage inadequate access to biomedical technologies. Beyond the medical relations and politics of cancer, this article considers the ways in which ethnography addresses local moral worlds and differences that come to matter in attending to the disease, the person, and consequent social and material relations.

## INTRODUCTION

*When we saw the image it had a foreboding quality, and yet we also thought that it was beautiful. "Too bad," she said. "Too bad it can also kill you."*

—D. Weiner (personal communication)

A breast cancer cell can be beautiful: Ridges give the cell texture and tendrils reach out to search for another cell with which to continue its spread through the body. Cancer creeps into our lives, as both a biological phenomenon and a social relationship, inspiring seemingly contradictory states of hope and despair, revival and ruin. Resulting in a multitude of diseases that can potentially affect any part of the body, cancer cells pathologically and uncontrollably multiply and metastasize, moving people from the kingdom of the healthy into that of the sick, dividing individuals into those who wage war and those who succumb. Populations with higher rates of cancer can be further differentiated from those without using discourses from statistics, health professionals, policy makers, and genetics. Cloaked in its potential to hasten death, cancer is a single word that marks our notions of difference in physical, social, and material worlds while simultaneously connecting cells, people, communities, and populations.

Recent anthropological work in cancer has focused on the sociality of the disease by emphasizing complex "carcinogenic relationships" (Livingston 2012), "cancer's culture" (Jain 2013), cancer's integration into intimate life, and the "medical imaginaries" pushed forward by a "biotechnical embrace" (DeVecchio Good 1996), marking cancer as a disease of technology. These relationships become subjectively real through individual suffering, stigma, and inequality. This article traces concepts developed from a primarily US-centered discourse to a global cancer discourse, with a specific concern toward issues of inequality and stigma, moments of critical reflection on the dominance of biomedicine, and the processes by which individuals and communities manage inadequate access to biomedical technologies in the face of this death-hastening disease. This article considers not only the biomedical relations and politics of cancer, but also the ways in which ethnography addresses differences that come to matter in attending to the disease, the person, and consequent social and material relations.

## RELATIONS OF CANCER AND CANCEROUS RELATIONS

Because cancer-as-disease is a leading cause of individual mortality (Stewart & Wild 2014), we tend to highlight it over cancer-as-social interaction. Livingston (2012) reminds us that "cancer is something that happens between people" (p. 6). These "carcinogenic relationships" connect individual lives to institutions and narratives, creating expectations of inclusion in discourses and material exclusions. Drawing on Mauss's (1923) concept of the "total social fact," Jain (2013) argues that cancer is a concern in almost every facet of life in the United States.

Like a Maussian gift, cancer has entered our collective imagination at all of these levels. Not only does it work through the metaphors of metastasis, recurrence, and remission, but it is also at one moment a paper trail and at another an identity, at one place a statistic and another a bankruptcy; here, a scientific quandary, there a transcendent image of a cell. One person's losses offer another a chance to leave a mark on humanity. A body image taken offers another to be found. The project of making cancer—as plural as it is singular, as vast as it is microscopic, as diffuse and discrepant as it is descriptive—resonates under one word. The simple noun cancer consolidates this collective achievement. (pp. 13–14)

In the trail of relations from researchers and the diagnosed, Jain conceptualizes cancer's excess and contradictory meanings (e.g., scientific, financial, subjective, and physical) being understood primarily through its conception as a singular noun. Indeed, our own anthropological writing often acknowledges the different types of cancer, and yet our ethnographic understanding—a more emic perspective if you will—suggests that we speak of “cancer” more generally (Balsheim 1993, McMullin & Weiner 2008a, Livingston 2012, Jain 2013). In its singularity, cancer is a well-developed, yet contradictory, conversation in the United States, with many individualized moments of hope and of military metaphors for waging war against cancer and surviving the battle (Sontag 1977, Erwin 1987, Ehrenreich 2001, Garrison 2007, McMullin & Weiner 2008a). Recently, Mathews & Burke (2015) revived Manderson's (1999) and Weiner's (1999b) earlier calls for more cross-cultural understandings of cancer and themselves have argued for increased global ethnographic work to draw out US and biomedical-centric assumptions of treatment and care and have provided in-depth knowledge of the individual and social contexts of people affected by cancer. In this growing body of non-US-based ethnographic cancer research, we can begin to trace how ethnographic specificity raises questions about difference and exclusion, the totality of cancer as a social fact, the material conditions that prevent it from becoming such a fact, and the need to find new ways to communicate local moral worlds impinged on by these cancers.

## TECHNOLOGY AND HOPE

From diagnosis to treatment and remission, cancer is identified and defined by biomedical practitioners and technologies. They are entwined in a “medical imaginary” [DeVecchio Good et al. 2007 (1996)] that links technological advances to a discourse of hope. DeVecchio Good et al. [2007 (1996)] document the production of a discourse of hope between physician and patient (moments wherein such biotechnical embraces can be emplotted), and ambiguities in cancer treatment plans (e.g., available treatments, expectations of treatments, survivability) are offered to maintain hope. Hope and the “biotechnical embrace” drive much of the relations of cancer, wherein cutting-edge biotechnologies, global corporations, and popular culture join forces to offer hope for both a cure and a prolonged life (DeVecchio Good 2001). This imaginary is pervasive and dominates cancer discourses in countries where such biotechnologies and practices of biomedicalization (Clarke et al. 2010) are available.

The dissonance generated between a discourse of hope and inequalities in access to cutting-edge biotechnologies affects poor people and migrants and can be found in most global contexts. Livingston (2012) and Mulemi (2010, 2015) argue that there is an invisibility around cancer in most African nations. The lack of institutional and individual discourse leads to a false impression that cancer mortality rates are not as high as those of infectious diseases, particularly HIV/AIDS. This absence of discourse renders cancer as invisible, despite that actual cancer rates indicate otherwise (Livingston 2012, Mulemi 2015). Diagnosis comes only once there are visible signs of the disease, making treatment (where available) less effective and a conversation about hope neither materially nor imaginatively sensible. Livingston's (2012) ethnography of a cancer ward in Botswana elaborates on how physicians, in a context of universal care, must improvise treatments to provide even the most basic and often traumatizing care to delay the spread of cancer. In global contexts where universal care is not available, e.g., Kenya (Mulemi 2010) or Delhi (Banerjee 2015), the alleviation of pain and suffering through palliative care is paramount. Most patients in resource-poor contexts are not concerned with biomedicine giving them hope. Instead, their concerns involve dealing with the needs of their family, addressing questions of accessing care, and managing the cost of long-term treatment and support (Smith-Morris 2010). Thus, as Livingston (2012) suggests, it is pain that is a total social fact (p. 142). Cancer's culture in its entire heterogeneous

global context has yet to create an imaginary that supports hope for cancer treatment, much less hope for a cure.

Although the scarcity of access to cutting-edge biotechnology is a key factor in diminishing hope, the details of physician/patient encounters have a host of practices around nondisclosure and assumptions of who actually gets cancers to maintain its invisibility in global contexts. Questions of disclosure prompt inquiry about what constitutes hope—e.g., does knowing that you have cancer interfere with the will to survive? Likewise, ethical questions emerge over the rights of the patient to know their own test results (DeVecchio Good 1996, Gordon & Paci 1997, Bennett 1999, Elwyn Fetters et al. 2002, Markovic et al. 2004). Ethnographic details of physician/patient conversations show that health professionals can, at times, be indifferent to or do not recognize symptoms of cancer (Balshem 1993, McMullin 2008, Mulemi 2010, Sand Anderson et al. 2014). Undiagnosed cancers frequently occur in young adult patients because physicians believe cancer affects primarily older individuals (Martin et al. 2007, Jain 2013). Even the production of knowledge about the potentials of pharmaceutical therapies do not necessarily lead to hope. Livingston argues that cancer in Africa becomes a site for philanthropy and the further creation of knowledge and pharmaceutical markets. She suggests that this work can happen only if the pharmaceutical markets entwine themselves with existing infrastructures and health frameworks that are designed around infectious diseases and HIV. This expansion of knowledge about cancer comes through cervical cancer and human papillomavirus infections, rendering cancer “as another sexually transmitted disease” (Livingston 2012, p. 33), and thus becomes part of the racialization of legible infectious diseases, such as cholera, tuberculosis, hepatitis C, Epstein Barr, and HIV in Africa. The process of orienting institutions and people toward making cancer visible and having any possibility of hope is framed in ethical, economic, and racialized questions of power and the valuing of lives.

## CARCINOGENIC ENVIRONMENTS

Polluted and toxic environments, not surprisingly, are “carcinogenic relationships” that contextualize the exercise of power toward valuing some lives and not others through the visibility of the disease (see Davis 2009 for an epidemiological history of efforts to obscure the effects of environmental pollution on cancer risk). Anthropologists are as likely to write about the carcinogens as they are to write about how producers of carcinogens dismiss the detrimental effects of their products (see Michaels 1988, Balshem 1993, Anglin 2005, Kohrman 2010, Jain 2013, Karakasidou 2015) and employ neoliberal discourses to blame individuals and communities for poor lifestyle choices. This literature includes ethnographic details on decisions to use pesticides to increase farm production in Greece (Karakasidou 2008) and China (Lora-Wainwright 2009), options to obtain better jobs and safer places to live (Singer 2011), contradictory messages that promote test-driving BMW sports cars in support of breast cancer research (Jain 2007), or activists working toward exposing harms in breast cancer screening (Klawiter 2008). This work fosters the need to consider the “chemical regimes of living” in the twenty-first century (Murphy 2008): how “molecular relations extend outside of the organic realm and create interconnections with landscapes, production, and consumption, requiring us to tie the history of technoscience with political economy” (Murphy 2008, p. 697).

Cancer inequalities can be traced using the material links of our chemical transformation through biomedical technologies and the impacts of industrial contamination on populations. Effects of power and subjugation are evident in communities that, because of historical domination, live near and work in industries that generate chemical waste. Singer’s (2011) study of a community in Louisiana that lives near a chemical factory found that individuals in the community were 2.1

times more likely to develop rectal cancer when they received their water from the Mississippi River as opposed to water from other sources, and individuals were 4.5 times more likely to develop lung cancer if they lived within one mile of the factory (Singer 2011). Of the community's residents, African Americans' lives and livelihoods were most likely to be positioned precariously by their unequal relationship with the factory. These community members needed work from the factory and were paid so little that they could not afford to live farther away from the factory. This scenario plays out regularly in global interactions with the production of oil in Latin America (see Auyero & Swistun 2009 for an example in Argentina), chemical production in India (see Fortun 2001), and nuclear disasters such as Chernobyl in Ukraine (see Petryna 2013). Kohrman's (2010) innovative work on "cigarette citadels," which began in China and now spans the globe, demonstrates how cigarette manufacturers successfully conceal the work of their factories. In focusing on the behaviors of smokers, we miss the impact of the production of cigarettes on the global increase in cancer mortalities (Kohrman & Benson 2011, Kohrman 2015). The causes and treatment for cancer are a materialization of the "chemically transformed being" that is molecularly connected to a political economy, the hope of technoscience, and the production of toxins and carcinogens.

## STATISTICAL ANCHORS

Cancer's conversation continues to move across the globe, bearing the weight of its statistics. World Health Organization (WHO) records indicate that there were approximately 14 million new cases and 8.2 million cancer-related deaths in 2012. Moreover, the WHO anticipates more than a 70% rise in new cancer cases over the next two decades. These statistics sound a warning bell that people are dying slow and painful deaths and that collective action must be taken to stop it. Indeed, part of the impetus to create the National Cancer Institute (NCI) in the United States was due to Senator Homer Bone's 1937 congressional statement linking the "dread disease" to American loss of life in all the previous foreign wars: "If 140,000 persons in this country were burned over slow fires every year . . . it would stagger the moral conscience of the world" (Patterson 1987, p. 114). And yet, if we consider cancer as it "comes into being" in Botswana as a result of the country's having too few oncologists, inadequate labs and technologies for early detection and treatment, and "pressing pain, disfiguring growths, and the stink of rotting tissue" (Livingston 2012, p. 57), it is clear that statistics do not carry the same power to motivate action. Statistical warnings are muted by race, class, and gender discrimination across global contexts, and we must continue to raise questions about how these facts come to matter in the politics of life and death.

Cancer statistics play an important yet problematic role in anthropological research. They have the potential to identify need and direct resources to areas of the globe and to communities that have been made invisible to cancer prevention and treatment (McMullin & Weiner 2008a). Although the WHO collects global rates of cancer, the data are inconsistent and nonexistent in many areas. Livingston (2012) reports that the numbers for Africa are unreliable and sporadic at best. We must also consider the meaning of the statistics, particularly as they are reported by race/ethnicity. For example, Craddock Lee (2009) showed that NCI research proposals in the United States, even those submitted by social scientists, are more likely to compare groups by race than to examine the local economic and political contexts for cancer interventions. In contrast, Sargent & Benson (2017) report that cancer statistics in France are organized by age, sex, and occupation and exclude nationality, ethnicity, religion, or immigration status. With reference to clinical trials, Jain (2010) argues that statistics carry a kind of "nowhere and everywhere quality" (p. 90). As the potential for successful medical intervention increases, the biotechnical embrace gives rise to hope and to the statistics of survival. Jain (2010) refers to this phenomenon as the

mortality effect: a “ghosting of lives” where the patient may or may not be one of the 5% of those who survive, such that the potential for life is in the statistic but not necessarily in the life of any particular cancer patient (p. 90). What does it mean to say that there will be a 70% increase in new cases over the next two decades? Exactly who is at risk, and in what ways? Even when the statistics and cancer risks are disaggregated by ethnicity or gender, and very rarely by income in the United States, we could follow Hacking’s (1999) argument that the numbers insidiously contribute to the questioning of one’s genetics and the determination that some people’s lives should be subjected to more medicalization or that still others should be singled out for being genetically prone to the disease or blamed for making unhealthy lifestyle choices (DiGiacomo 1999, Gibbon 2007; see Gibbon & Novas 2008, Joseph 2014 for a discussion on genetics and biosociality). Notably, the global cancer rates in the majority of countries (more-developed and less-developed regions) show that men have higher incidence and mortality rates than do women (WHO 2015). However, from *BRCA* genes to the whole of the cancer continuum, the majority of anthropological writing on cancer is about female cancers and cancer experiences. In examining the global impact of *BRCA* mutations, Gibbon et al. (2014) acknowledge that this work is at the forefront of genomic research but note that it is an example of “gendered and gendering” (p. 2) medical research. The relative invisibility of cancer work in Africa (where, in many areas, cancer rates are slightly higher for women) or in the lives of men despite the statistics begs for a more critical examination of our methods as we choose new directions for the anthropology of cancer.

The ubiquity of cancer statistics produces a discourse that purports that all humans have an equal chance of getting cancer, yet statistics also suggest that some people exhibit higher rates of having a biological or social failing. Better living (e.g., cessation of smoking, decreased alcohol intake, and improved nutrition) is subsequently touted as the key to prevention (Patterson 1987, Balshem 1993, Chavez et al. 1995, Bell & Ristovski-Slijepcevic 2015). This public health refrain has been critiqued for drawing our attention away from structural forces, including the lack of access to health care and healthy environments, nutritious foods, adequate technologies for detection and treatment, and, importantly, detection of systematic exposure to social determinants of health (Krieger 1994, 2002; Panter-Brick 2014). Statistics focus our gaze in a particular direction—toward medical interventions to improve population-based survivorship, toward the transformation of individual behaviors to prevent the onset of cancer, and away from structural and environmental factors. To talk about cancer incidence and mortality is to engage in a concern over difference, orienting us toward comparing, categorizing, and making judgments about whose lives matter and allowing us to imagine that we can control our own deaths. Not everyone has an equal chance of dying of cancer. In much of the anthropological work on cancer, we dutifully report cancer statistics to demonstrate human suffering or as a justification for engaging with this topic, but rarely do we include a critical discussion regarding how the statistics orient us toward seeing difference as problematic in specific ethnographic contexts.

## THE POLITICS OF CANCER AWARENESS AND INEQUALITY

High cancer mortality rates raise questions about individual and population knowledge of causes, risk, and access. What do people know about cancer? What is keeping them from seeking cancer screening or treatment upon diagnosis? The political economy of health is woven through much of the early detection and treatment conversation. Structural violence and fears of stigmatization due to racism, an inability to pay, or perceived judgment for unhealthy lifestyle behaviors are among the significant barriers to early detection. Patients lost to medical follow-up report that their physicians did not tell them to make another appointment, that their partners would not allow them to return (McMullin 2008, McMullin et al. 2005), or that they would not take



scarce resources from their families (Salzberger 1976, Armin 2015). The intersection between what oncologists provide as information and the social context of the patient produces important insight into how patients see their role in the course of their cancer treatment (Craddock Lee 2010, Høybe & Tjørnhøj-Thomsen 2014, Craddock Lee et al. 2015). Adding to narratives of inequity, ethnographic details are increasingly turning toward an examination of the documents that create structural vulnerability and diminish access to care (Bullon et al. 2011, Chavez 2012). Armin's (2015) ethnography focuses on the details of medical paperwork: documents determining eligibility for public insurance (e.g., immigration and citizenship documents), financial forms, and medical records, which further marginalize immigrants in Arizona. Sargent & Benson's (2017) ethnography details the therapeutic itineraries of Malian immigrants in France who, despite the existence of universal coverage, must navigate complicated residency and insurance documentation wherein some public insurance provides inadequate coverage for cancer treatment. Through word of mouth or the assistance of a generous health professional, and having the right documents, additional public insurance can be obtained that may provide more coverage. This bounty of paperwork and scaffolding of eligibility create contradictory contexts and expectations, particularly for migrants, wherein they are still unable to receive full treatment despite public programs that serve individuals without insurance or citizenship documents. In countries that have biomedical technologies for treating cancer, the global experience on access to care mirrors many of the structural vulnerabilities in the United States.

Anthropological responses to questions related to cancer awareness and early detection are entangled with critiques of the dominance of biomedical assumptions of individualized care and responsibility as well as the primacy of medical interventions. Anthropologists have contributed to the breadth of knowledge about cancer causes (see Csordas 1989; Balshem 1993; Weiner 1993, 1999a; Chavez et al. 1995, 2001; Hunt 1998; Manderson et al. 2005). Searches for cancer's ambiguous causes give rise to narratives of blame wherein, similar to Sontag's list of stigmas, people are said to have smoked too much, to have drunk too much, to have had too much sex, or simply to have immoral, depressed, or repressed personalities (Sontag 1977). Writing about cervical cancer, in particular, results in a series of moral blaming by physicians who tell women they have the disease because of their many sexual partners (see Martinez 2005 for work in Venezuela), social stigmas and moral expectations around women's place in the home or "in the street" (see Gregg 2003 for work in Brazil), or reluctance to talk explicitly about cervical cancer because of its location in the body (see Wray et al. 2007 for work in Australia). Pollution as a cause extends the links of blame to a system of inequality wherein individual lives of workers are not valued (Anglin 1998, Lora-Wainwright 2015). Although we often see these larger categories of cause, we can also trace the historical processes and effects on individual lives that create profound differences in what constitutes blame. Kohrman (2008) has argued that smoking, even among surgeons in China, is a form of "male performativity *fayan* (literally, 'to distribute smoke')" (p. 19). This sociality demonstrates inclusion within the community of surgeons, hierarchy, and professional ethics. Similarly, Lora-Wainwright (2013, 2015) argues that smoking and drinking can be marshaled as sources of cancer causation, in Langzhong, China, wherein individuals could be blamed for their cancer diagnosis yet are not. In China, however, social drinking and smoking are a necessary part of building social relationships. Therefore, a cancer diagnosis is more likely to be explained as a form of sociality and not a source of blame (Lora-Wainwright 2015).

For the most part, however, cancer awareness is plagued by attention to differences that reflect and contribute to the productions of inequality, shame, and stigma. In the United States, cancer awareness campaigns created a long-lasting racial divide; cancer messages in the 1910s to 1950s, "resonated with broader ideas of white vulnerability and risk in an era marked by hardening Jim Crow, the exclusion of Chinese immigrants, angry white supremacy movements, and contests for

fitter families through good breeding and eugenics” (Wailoo 2011, p. 4). This time period viewed cancer as a disease of civilization and particular of white people, characterizing minorities as “naturally” immune owing to their presumed difference on a fictive social evolutionary scale. Cancer awareness was deemed unnecessary for blacks or any other nonwhite or migrant populations. It was acceptable not to include others because, according to the statistics, “these” people did not die of cancer. Heurtin Roberts (2008) extends this conversation into the discourses of the melting pot and cultural competency, wherein minority populations are now targeted for cancer awareness but are still expected to be brought into the dominant cultural and biomedical discourse without consideration of how to overcome legacies of historical racism and economic inequality.

The politics of cancer and how we let people die through constructions of cause, risk, and vulnerability could be viewed through Fassin’s (2009) concept of biolegitimacy (McMullin 2016). Moving within and beyond Foucault’s concept of biopower as the art of governing, Fassin (2009) argues that foundations of biolegitimacy, and the sacredness of life as such, outweigh the politics of how we let people die. Biolegitimacy suggests a study of meanings and values and ultimately a study of inequality because of the preference toward favoring intervention for some and neglect for others, or how we “make live and let die” (Agamben 1998, Foucault 2003). Examining biolegitimate lives in the context of cancer shows shifts between whose lives are valued in terms of how we interpret causes of cancer, create access to life-saving technologies, and provide early detection, treatment, and palliative care. In the global context of cancer, this inequality also plays out in contrast with other diseases. For instance, infectious diseases (e.g., HIV/AIDS) have been the dominant focus of health campaigns. Notably, it is only as antiretroviral (ARVs) therapies become available in Africa that we see associated cancers skyrocket, as HIV survivors live longer and develop next-stage diseases (Livingston 2012, Singh et al. 2014). Banerjee (2012) in India and Livingston (2012) in Africa have documented the lack of biotechnical treatments and public health discourses about cancer. They argue that the differences in these campaigns are fundamentally discriminatory/racist arguments for allowing people to die of cancer so long as they do not have to die of infectious disease. In this way, cancer awareness works alongside infectious disease awareness to justify some deaths while obscuring others.

In the face of inadequate biomedical therapies, the public health framings of cancer work to individualize cancer rather than explore the racial and cultural assumptions being made about what the patient may or may not want, need, or be able to afford. Anthropology allows us to be critical of assumptions that support or critique cultural or medical knowledges and practices. Current work is increasingly demonstrating a greater need to engage the patients and understand the values and resources in their local moral worlds and contexts (Burke et al. 2009, Bell 2014, Bright 2015).

## STIGMA AND SILENCE

Sontag’s classic *Illness as Metaphor* is regularly cited as an example of the multiple narratives that form the discourse of cancer and create stigma. This history is full of silences and whispers about the “big C” or the “dread disease,” “cruel disease,” and “silent death” (Sontag 1977, Patterson 1987). Much of the dread around cancer involves its status as a death sentence and painful treatments (Gordon 1990a,b; Chavez et al. 1995). Silence about cancer also reveals the power of language, for some fear that speaking about the disease may bring it into existence (Trawick 1991, Weiner 1999a, Macdonald 2015).

Silence around the ethics of disclosing diagnoses and the autonomy of patients’ ability to make informed decisions are entwined with concerns about the larger social life of families, partners, and economic relations of someone diagnosed with cancer. Gordon & Paci (1997) have argued that “social-embeddedness” plays a significant role in these decisions. For instance, Macdonald



(2014, p. 87) developed the concept of an “ethos of concealment” to describe the threat of losing potential marriage partners and economic stability as a reason for women’s silence regarding a breast cancer diagnosis in India. The economic threat is underpinned with a popular understanding that cancer can be transmitted through touch, through intimate partners, and across generations, formalizing the belief that a diagnosed family member will increase the risk of cancer for the whole. To protect the economic future of female kin, the diagnosed member must remain silent. Likewise, Banerjee (2015) describes the fear and anxiety that cancer creates over being ostracized in Delhi. Even crematoriums may refuse to take the body of a cancer patient for fear that it would contaminate the building. Silence is necessary for retaining social-embeddedness even beyond death.

Silence from cancer patients, families, and caregivers dances around acknowledgments of death. Harris’s (2015) work in Scotland notes patients’ frustration with not being able to discuss their impending death. Caregivers in Argentina, exhausted from the physical and emotional intensity of caring for their loved one in hospice, secretly hope for a hastened passing (Luxardo 2015). These caregivers invoke God as a “kind of alter ego” to express their confusion over the suffering of their loved one; they ask why “God makes it last so much” or beg for God’s mercy in bringing a quicker death (Luxardo 2015, p. 202). Banerjee’s (2015) ethnography in Delhi, a context with insufficient resources for care, gives insight into how cancer patients and caregivers maintain silence around a cancer diagnosis, which in his work almost certainly means death. In this context, both family members and doctors hide cancer prognoses from patients and isolate them from the community and family. Indeed, Banerjee found that out of 600 patients, less than one-fifth were aware of their diagnosis. Reasons for this silence varied from a desire to hide their loved one’s impending demise to a lack of diagnostic clarity by physicians. Banerjee’s ethnographic work with the cancer nongovernmental organization Cansupport allows him to tease out the complicated intimacies of easing the pain and enacting a moral death. Ethnographies that examine silences are concerned with not only how cancer is made invisible, maintaining difference, but also about maintaining social connections.

## CANCER NARRATIVES

Cancer narratives are a key feature of the disease in popular culture and for anthropology. Attending to cancer narratives provides a way to give meaning to and tell a different story about the cancer experience. Narratives allow us to consider questions of risk, meaning-centered perspectives of cancer (Saillant 1990, Good 1994, Frank 2010), and questions of subjectivity and governmentality (Biehl et al. 2007). Illness narratives in anthropology often reveal individual subjectivities and suffering as well as the attendant social suffering produced by inequality (Kleinman 1989, Mattingly & Garro 2000). Illness narratives help us connect to others and to construct social worlds (Mattingly 1998). At the core of many narratives is the search for meaning and new subjectivities (Foucault 1978) transformed by the diagnosis and the “ordinary, chronic, and cruddy” of everyday life (Povinelli 2010).

Over the past 30 years personal cancer narratives have increased, including those of anthropologists and other academics (e.g., Lorde 1980, DiGiacomo 1987, Frank 1991, Stacey 1997, Stoller 2005, Jain 2013). These narratives give us unique insights into the details of the author’s cancer experience and formation of new subjectivities. Stoller’s (2005) experience provides a moment to revisit earlier fieldwork in Niger to reconsider the ambiguities of life and how a cancer diagnosis might teach about living with difference. Recalling the lessons of his earlier fieldwork, Stoller now finds a more nuanced, ecological conceptualization around liminality, suffering, and healing. From a feminist perspective, Stacey (1997) draws on her experience in the United Kingdom to critique

the stigma that biomedicine and alternative healing systems impose. Both treatments demand responsibility from the individual; whether obtaining high-tech therapy or assuaging her own stress so that her body can heal, she is responsible. Her narrative on teratology is sophisticated and highly descriptive, considering the host of monstrous metaphors, drawing on Foucault to understand the spatial aspects of cancer as a biomedical object and social stigma, the implications of being diagnosed for one's sexual identity, and ultimately the uniqueness of a narrative. These theorized cancer narratives offer detailed explanations of how dominant biomedical and popular narratives of the "cancer complex" (Jain 2013) work to create subjectivities that obscure the connections of pollution research and pharmaceutical company practices that may cause/treat/cure cancer. Jain (2013) suggests that we engage in an elegiac politics that acknowledges the contradictions of cancer deaths, and "demands the recognition of both enormous profits and enormous personal and cultural losses" (p. 223) associated with cancer. Both Stoller and Stacey turn to writing the acknowledgment of death in the face of medical (alternative and biomedical) and social practices that deny the stigmatization of a cancer death. We are offered an "imaginative landscape" (Jain & Stacey 2015), wherein the construction of the subject is called into question and contradictions and carcinogenic relationships are acknowledged. The cancer death is then reimagined, not as individual cells and bodies out of control but rather as premeditated (Jain & Stacey 2015). If the goal of narrative is to provide moments for people to empathize with one another and to reimagine the world differently, then reconfiguring the dominant narratives from individual behaviors to social and political practices becomes a powerful instance and tool.

## SUPPORT GROUPS IN GLOBAL CONTEXTS

Narratives are also critical in considering the role of cancer support groups in the United States and globally. To be worthwhile to participants of a support group, ethnographic work in the United States and other countries with access to biomedical technologies has repeatedly demonstrated the need to engage with the meaning, experience, and social context of patients' and their caretakers' lives. The Witness Project, which enlisted African American breast cancer survivors to share their experience with their peers, demonstrated the value of embedding cancer narratives in meaningful institutions such as churches (Erwin et al. 1992, 1996). Similarly, the use of barbershops for educating African American men about prostate cancer (Luque et al. 2015) increases cancer-screening participation. Mathews (2000) reports that communities of African American breast cancer survivors rejected military and sports metaphors in favor of religious and familial imagery when questioning the effectiveness of prolonged therapy. They recognized the need to allow themselves and those around them to feel poorly. Also of concern to many survivors are their families: Who will take on more responsibility for patient care, who will care for the children, and how will familial roles will be reshaped (Hunt 2000, Bell & Ristovski-Slijepcevic 2011)? Ethnographies of support groups, like other narratives, offer opportunities for people to reflect on their lives. Some people consider the cancer diagnosis a "blessing in disguise" (Coreil et al. 2004); Dyer (2015) reports that families in Puerto Rico see cancer as a "second chance" or just another trial of life that they are "passing through." In-depth ethnographic work demonstrates the importance of social relationships beyond biomedicine and the need to examine the meaning-centered needs of the local community (Mathews 2008, Burke et al. 2012).

Macdonald's (2015) work in Mumbai is particularly intriguing with regard to the role of family in cancer treatment and support. In addition to the stigma surrounding a cancer diagnosis, as previously discussed, the adoption of psycho-oncology language and notions of "counseling" by volunteers in cancer support groups can be doubly stigmatizing. Macdonald (2015) reports that psychiatric illness is not recognized as a real problem. Moreover, once diagnosed, many individuals

state that they have no need for support groups because they “find better support at home” (p. 122). Moreover, talking about cancer marks the individual patient, suggesting some moral transgression by the diagnosed or their family. Keeping a diagnosis and care for the sick individual within the family, then, is a matter of local moralities. Despite this stigma and perceived threat to the family, Macdonald notes that there are “Survivor Volunteers,” who, after surviving their own trauma and sometimes seeing other family members die with cancer, view their role as in service to others—not to sit at home with their families, but to talk with women about breast prostheses, wigs, and the prevention and management of lymphedema (Macdonald 2015, p. 124). Macdonald argues that increasing the visibility of survivors coincides with the importance of vision, “seeing and being seen” in Hinduism. Despite the stigma associated with cancer and support groups, Survivor Volunteers turn their proclamations and practices into a form of patient solidarity. This transformation is similar to the work by Erwin et al. (1996) on the Witness Project, in that ethnographic work can determine what is contextually important for opening up a conversation around cancer to ameliorate suffering, particularly in resource-poor contexts.

The issue of solidarity around cancer risk and cancer support groups has engendered important conversations around identity and biosociality (Gibbon & Novas 2008, Mathews & Burke 2015). The global rise of genomic medicine, and testing for *BRCA1* or *BRCA2*, in particular (see Gibbon et al. 2014 for global ethnographic discussions of this testing), has led to the creation of a biosociality around cancer—biological identities that are entwined in the politics of managing life (Gibbon & Novas 2008, Gibbon et al. 2014). Rather than attending to a biological identity, Stoller (2013) considers this solidarity a kind of *communitas*, the sense felt by a group of people when their life together takes on full meaning through the constant liminality of remission. Burke (2015) notably asks us to consider another perspective on bringing solidarity to a biological identity. On the basis of her work with a Filipina community in San Francisco, she argues that this community and others can come together around cancer activism or any other disease not by identifying with the disease, but rather as Filipinas concerned about the well-being of their community (Burke 2015). As we see in Mumbai (Macdonald 2015), engaging local moral worlds—to attend to the nonindividualistic needs of communities—that can meaningfully support the cancer experience is imperative.

## CONCLUSION

To engage in an anthropological study of cancer is to immerse oneself in a host of ambiguity and endless connections creeping across social and physical bodies. Manderson (2015) recently suggested that we need to pay more attention to differences in cancer. Considering that cancer is fundamentally a disease about often-observed differences (McMullin 2016), Manderson’s assertion, about cancer anthropologists’ inattention to the differences in types of cancers and, importantly, their tendency to write mostly about women’s experiences and women’s cancers, is accurate. An intersectional study of cancer, domestically and in a global arena, will provide insights into taken-for-granted relations between the production of the disease and the value of life. Beyond specific types of cancer, increased examination around men’s and/or transgender individuals’ experiences within local economies has the potential to further parse questions of cutting-edge biotechnologies and hope, and the importance of local moral worlds. This intersectionality might even go deeper into the imaginary of researchers and the visual intersections of race and cells (see Singh et al. 2014), the infrastructure of “cigarette citadels” (Kohrman 2010, 2015), or the intimate relations between graphic narrative and cancer’s objects (McMullin 2016).

The recurring conceptualizations of stigma, inequality, and narratives allow us to rethink our world or create moments of solidarity. What the scholars in this conversation also repeatedly

attend to is the need for ethnographic contextualization—to valorize the lived experience, history, politics, ethics, and economics that create carcinogenic relationships. Often this contextualization means pushing aside the dominance of biomedicine, the biotechnical embrace that punctuates cancer’s culture. The economics of cancer make this a difficult situation, as Livingston (2012) aptly states:

[B]iomedicine is an incomplete solution. It can simultaneously be redemptive and exacerbate existing health inequalities. In other words, there will be no quick techno-fix for African health. And yet biomedicine functions as a necessary, vital, palliative institution in a historically unjust world. (p. 7)

As we insist on looking beyond biomedicine, we might more thoroughly interrogate the differences that increase suffering and those that may enhance community and individual resilience. For anthropologists, the alleviation of human suffering is not derived primarily in the potential of technology, but rather in what ethnographies can tell us about the diverse modes of community response to suffering.

## DISCLOSURE STATEMENT

The author is not aware of any affiliations, memberships, funding, or financial holdings that might be perceived as affecting the objectivity of this review.

## LITERATURE CITED

- Agamben G. 1998. *Homo Sacer: Sovereign Power and Bare Life*. Stanford, CA: Stanford Univ. Press
- Anglin MK. 1998. Dismantling the master’s house: cancer activists, discourses of prevention, and environmental justice. *Identities* 5:183–217
- Anglin M. 2005. Whose health? Whose justice? Examining quality of care and breast cancer activism through the intersections of gender, race, ethnicity, and class. In *Health at the Intersections of Gender, Race, and Class*, ed. A Schulz, L Mullings, pp. 313–41. New York: Jossey-Bass/Pfeiffer
- Armin J. 2015. Managing borders, bodies and cancer: documents and the creation of subjects. See Mathews et al. 2015, pp. 86–103
- Auyero J, Swistun D. 2009. *Flammable: Environmental Suffering in an Argentine Shantytown*. Oxford, UK: Oxford Univ. Press
- Balslem M. 1993. *Cancer in the Community: Class and Medical Authority*. Washington, DC: Smithsonian. Inst. Press
- Banerjee D. 2012. The social constructions of cancer, *Literature, Arts and Medicine* (blog), ed. L Bruell, Nov. 2. <http://medhum.med.nyu.edu/blog/?p=3263>
- Banerjee D. 2015. *Living in prognosis: cancer and pain in contemporary India*. Book prospect. [http://media.wix.com/ugd/9c6e12\\_37650aa1d78c44c2af0be9d6a7edb4ca.pdf](http://media.wix.com/ugd/9c6e12_37650aa1d78c44c2af0be9d6a7edb4ca.pdf)
- Bell K. 2014. The breast-cancer-ization of cancer survivorship: implications for experiences of the disease. *Soc. Sci. Med.* 110:56–63
- Bell K, Ristovski-Slijepcevic S. 2011. Metastatic cancer and mothering: being a mother in the face of a contracted future. *Med. Anthropol.* 30(6):629–49
- Bell K, Ristovski-Slijepcevic S. 2015. Communicating “evidence”: lifestyle, cancer and the promise of a disease-free future. *Med. Anthropol. Q.* 29(2):216–36
- Bennett E. 1999. Soft truth: ethics and cancer in northeast Thailand. *Anthropol. Med.* 6(3):395–404
- Biehl J, Good BJ, Kleinman A, eds. 2007. *Subjectivity: Ethnographic Investigations*. Berkeley: Univ. Calif. Press
- Bright K. 2015. Love in the time of cancer: kinship, memory, migration and other logics of care in Kerala, India. See Mathews et al. 2015, pp. 135–55

- Bullon A, DelVecchio Good M, Carpenter-Song E. 2011. The paper life of minority and low-income patient care. In *Shattering Culture: American Medicine Responds to Cultural Diversity*, ed. M DelVecchio Good, SS Willen, SD Hannah, K Vickery, LT Park, pp. 200–16. New York: Russell Sage Foundation
- Burke N. 2015. Filipina, survivor or both?: Negotiating biosociality and ethnicity in the context of scarcity. See Mathews et al. 2015, pp. 104–18
- Burke NJ, Joseph G, Pasick RJ, Barker JC. 2009. Theorizing social context: rethinking behavioral theory. *Health Educ. Behav.* 36(Suppl.):55S–70
- Burke NJ, Villero O, Guerra C. 2012. Passing through: meanings of survivorship and support among Filipinas with breast cancer. *Qual. Health Res.* 22(2):189–98
- Chavez LR. 2012. Undocumented immigrants and their use of medical services in Orange County, California. *Soc. Sci. Med.* 74:887–93
- Chavez LR, Hubbell FA, McMullin JM, Martinez RG, Mishra SI. 1995. Structure and meaning in models of breast and cervical cancer risk factors: a comparison of perceptions among Latinas, Anglo women and physicians. *Med. Anthropol. Q.* 9:40–74
- Chavez LR, McMullin JM, Mishra SI, Hubbell FA. 2001. Beliefs matter: cultural beliefs and the use of cervical cancer screening tests. *Am. Anthropol.* 103:1–16
- Clarke AE, Mamo L, Fosket JR, Fishman JR, Shim JK. 2010. *Biomedicalization: Technoscience, Health, and Illness in the U.S.* Durham, NC: Duke Univ. Press
- Coreil J, Wilke J, Pintado I. 2004. Cultural models of illness and recovery in breast cancer support groups. *Qual. Health Res.* 14:905–23
- Craddock Lee S. 2009. Science, surveillance, and the politics of redress in health disparities research. *Race Ethn.* 3(1):51–74
- Craddock Lee S. 2010. Uncertain futures: individual risk and social context in decision-making in cancer screening. *Health Risk Soc.* 12(2):101–17
- Craddock Lee S, Marks EG, Sanders JM, Wiebe DJ. 2015. Educating patient-perceived role in “decision-making” among African Americans receiving lung cancer care through a county safety-net system. *J. Cancer Surviv.* 17:435–47
- Csordas TJ. 1989. The sore that does not heal: cause and concept in the Navajo experience of cancer. *J. Anthropol. Res.* 45(4):457–85
- Davis D. 2009. *The Secret History of the War on Cancer*. New York: Basic Books
- DelVecchio Good M. 2001. The biotechnical embrace. *Cult. Med. Psychiatry* 25:395–410
- DelVecchio Good M. 2007 (1996). The medical imaginary and the biotechnical embrace: subjective experiences of clinical scientists and patients. See Biehl et al. 2007, pp. 362–80
- DelVecchio Good M, Good BJ, Schaffer C, Lind SE. 1990. American oncology and the discourse on hope. *Cult. Med. Psychiatry* 14:59–79
- DiGiacomo SM. 1987. Biomedicine as a cultural system: an anthropologist in the kingdom of the sick. In *Encounters with Biomedicine. Case Studies in Medical Anthropology*, ed. H Baer, pp. 315–47. Philadelphia: Gordon and Breach
- DiGiacomo SM. 1999. Can there be a “cultural epidemiology”? *Med. Anthropol. Q.* 13(4):436–57
- Dyer KE. 2015. “Surviving is not the same as living”: cancer and *Sobrevivencia* in Puerto Rico. *Soc. Sci. Med.* 132:20–29
- Ehrenreich B. 2001. Welcome to Cancerland: a mammogram leads to a cult of pink kitsch. *Harpers Mag.*, Nov.:43–53
- Elwyn TS, Feters MD, Sasaki H. 2002. Responsibility and cancer disclosure in Japan. *Soc. Sci. Med.* 54:281–93
- Erwin DO. 1987. The militarization of cancer treatment in American society. In *Encounters with Biomedicine: Case Studies in Medical Anthropology*, ed. H Baer, pp. 201–28. New York: Gordon and Breach
- Erwin DO, Spatz TS, Stotts RC, Hollenberg JA, Deloney LA. 1996. Increasing mammography and BSE in African American women using the Witness Project model. *J. Cancer Educ.* 11(4):210–15
- Erwin DO, Spatz TS, Turturro CL. 1992. Development of an African-American role model intervention to increase breast self-examination and mammography. *J. Cancer Educ.* 7(4):311–19
- Fassin D. 2009. Another politics of life is possible. *Theor. Cult. Soc.* 26:44–60
- Fortun K. 2001. *Advocacy After Bhopal: Environmentalism, Disaster, New Global Orders*. Chicago: Univ. Chicago Press

- Foucault M. 1978. *The History of Sexuality*. Vol. 1. New York: Pantheon Books
- Foucault M. 2003. *Society Must Be Defended. Lectures at the Collège de France 1975–1976*. New York: Picador
- Frank AW. 1991. *At the Will of the Body*. Boston: Houghton Mifflin
- Frank AW. 2010. *Letting Stories Breathe: A Socio-Narratology*. Chicago: Univ. Chicago Press
- Garrison K. 2007. The personal is rhetorical: war, protest and peace in breast cancer narratives. *Disabil. Stud. Q.* 27:114–18
- Gibbon S. 2007. *Breast Cancer Genes and the Gendering of Knowledge: Science and Citizenship in the Cultural Context of the 'New' Genetics*. London: Palgrave Macmillan
- Gibbon S, Joseph G, Mozersky J, zur Nieden J, Palfner S, eds. 2014. *Breast Cancer Gene Research and Medical Practices: Transnational Perspectives in the Time of BRCA*. London: Routledge
- Gibbon S, Novas C. 2008. *Biosocialities, Genetics and the Social Sciences: Making Biologies and Identities*. London: Routledge
- Good BJ. 1994. *Medicine, Rationality, and Experience: An Anthropological Perspective*. New York: Cambridge Univ. Press
- Gordon DR. 1990a. Culture, cancer, and communication in Italy. *Anthropol. Med.* 7:137–56
- Gordon DR. 1990b. Embodying illness, embodying cancer. *Cult. Med. Psychiatry* 14:275–97
- Gordon DR, Paci E. 1997. Disclosure practices and cultural narratives: understanding concealment and silence around cancer in Tuscany, Italy. *Soc. Sci. Med.* 44(10):1433–52
- Gregg JL. 2003. *Virtually Virgins: Sexual Strategies and Cervical Cancer in Recife, Brazil*. Stanford, CA: Stanford Univ. Press
- Hacking I. 1999. Making up people. In *The Science Studies Reader*, ed. M Biagioli, pp 161–71. New York: Routledge
- Harris FM. 2015. Dying to be heard: cancer, imagined experience and the moral geographies of care in the UK. See Mathews et al. 2015, pp. 229–40
- Heurtin-Roberts S. 2008. Self and other in cancer health disparities: negotiating power and boundaries in U.S. society. See McMullin & Weiner 2008b, pp. 187–206
- Høybe MT, Tjørnhøj-Thomsen T. 2014. Encounters in cancer treatment: intersubjective configurations of a need for rehabilitation. *Med. Anthropol. Q.* 28(3):305–22
- Hunt LM. 1998. Moral reasoning and the meaning of cancer: causal explanations of oncologists and patients in southern Mexico. *Med. Anthropol. Q.* 12(3):298–318
- Hunt LM. 2000. Strategic suffering: illness narratives as social empowerment among Mexican cancer patients. See Mattingly & Garro 2000, pp. 88–109
- Jain SL. 2007. Cancer butch. *Cult. Anthropol.* 22:501–38
- Jain SL. 2010. The mortality effect: counting the dead in the cancer trial. *Public Cult.* 22:89–117
- Jain SL. 2013. *Malignant: How Cancer Becomes Us*. Berkeley: Univ. Calif. Press
- Jain SL, Stacey J. 2015. On writing about illness: a dialogue with S. Lochlann Jain and Jackie Stacey on cancer, STS, and cultural studies. *Catalyst: Fem. Theory Technosci.* 1(1):1–29
- Joseph G. 2014. Genetics to the people: BRCA as public health and the dissemination of cancer risk knowledge. See Gibbon et al. 2014, pp. 57–72
- Karakasidou A. 2008. The elusive subversion of order: cancer in modern Crete, Greece. See McMullin & Weiner 2008b, pp. 83–103
- Karakasidou A. 2015. Foreword: The emperor of all terrors: forging an alternative biography of cancer. See Mathews et al. 2015, pp. ix–xii
- Klawiter M. 2008. *The Biopolitics of Breast Cancer: Changing Cultures of Disease and Activism*. Minneapolis: Univ. Minn. Press
- Kleinman A. 1989. *The Illness Narratives: Suffering, Healing, and the Human Condition*. New York: Basic Books
- Kohrman M. 2008. Smoking among doctors: governmentality, embodiment, and the diversion of blame in contemporary China. *Med. Anthropol.* 27:9–42
- Kohrman M. 2010. *Cigarette citadels: the map project*. Stanford Univ., Stanford, Calif. <https://web.stanford.edu/group/tobaccoprvcgi-bin/wordpress/>
- Kohrman M. 2015. Cloaks and veils: countervisualizing cigarette factories in and outside of China. *Anthropol. Q.* 88:907–40



- Kohrman M, Benson P. 2011. Tobacco. *Annu. Rev. Anthropol.* 40:329–44
- Krieger N. 1994. Epidemiology and the web of causation: Has anyone seen the spider? *Soc. Sci. Med.* 39:887–903
- Krieger N. 2002. Is breast cancer a disease of affluence, poverty, or both? The case of African American women. *Am. J. Public Health* 92:611–13
- Livingston J. 2012. *Improvising Medicine: An African Oncology Ward in an Emerging Cancer Epidemic*. Durham, NC: Duke Univ. Press
- Lora-Wainwright A. 2009. Of farming chemicals and cancer deaths: the politics of health in contemporary rural China. *Soc. Anthropol.* 17:56–73
- Lora-Wainwright A. 2013. *Fighting for Breath: Living Morally and Dying of Cancer in a Chinese Village*. Honolulu: Univ. Hawaii Press
- Lora-Wainwright A. 2015. The ambiguity of blame and the multiple careers of cancer etiologies in rural China. See Mathews et al. 2015, pp. 37–52
- Lorde A. 1980. *The Cancer Journals*. San Francisco: Aunt Lute Books
- Luque JS, Roy S, Tarasenko YN, Ross L, Johnson J, Gwede CK. 2015. Feasibility study of engaging barber-shops for prostate cancer education in rural African-American communities. *J. Cancer Educ.* 30:623–28
- Luxardo N. 2015. “As God Is My Witness...”: what is said, what is silenced in informal cancer caregivers’ narratives. See Mathews et al. 2015, pp. 193–211
- Macdonald A. 2014. Situating breast cancer risk: gender, temporality and social change. See Gibbon et al. 2014, pp. 83–94
- Macdonald A. 2015. Revealing hope in urban India: vision and survivorship among breast cancer charity volunteers. See Mathews et al. 2015, pp. 117–32
- Manderson L. 1999. Introduction: New perspectives in anthropology on cancer control, disease and palliative care. *Anthropol. Med.* 6(3):317–21
- Manderson L. 2015. Afterword: Cancer enigmas and agendas. See Mathews et al. 2015, pp. 241–54
- Manderson L, Markovic M, Quinn M. 2005. “Like roulette”: Australian women’s explanations of gynecological cancers. *Soc. Sci. Med.* 61(2):323–32
- Markovic M, Manderson L, Wray N, Quinn M. 2004. “He is telling us something”: women’s experiences of cancer disclosure in Australia. *Anthropol. Med.* 11(3):325–39
- Martin S, Ulrich C, Munsell M, Taylor S, Lange G, Bleyer A. 2007. Delays in cancer diagnosis in underinsured young adults and older adolescents. *Oncologist* 12(7):816–24
- Martinez RG. 2005. “What’s wrong with me?”: cervical cancer in Venezuela—living in the borderlands of health, disease, and illness. *Soc. Sci. Med.* 61(4):797–808
- Mathews H. 2000. Negotiating cultural consensus in a breast cancer self-help group. *Med. Anthropol. Q.* 14(3):394–413
- Mathews H. 2008. Cancer support groups and health advocacy: One size doesn’t fit all. See McMullin & Weiner 2008b, pp. 43–62
- Mathews HF, Burke NJ. 2015. Introduction: Mapping the landscape of transnational cancer ethnography. See Mathews et al. 2015, pp. 1–34
- Mathews HF, Burke NJ, Kampriani E, eds. 2015. *Anthropologies of Cancer in Transnational Worlds*. London: Routledge
- Mattingly C. 1998. *Healing Dramas and Clinical Plots: The Narrative Structure of Experience*. Cambridge, UK: Cambridge Univ. Press
- Mattingly C, Garro L, eds. 2000. *Narrative and the Cultural Construction of Illness and Healing*. Berkeley: Univ. Calif. Press
- Mauss M. 1966 (1923). *The Gift: Forms and Functions of Exchange in Archaic Societies*. London: Cohen and West
- McMullin J. 2008. Experiencing diagnosis: views from Latina cervical cancer patients. See McMullin & Weiner 2008b, pp. 63–82
- McMullin J. 2016. Comics and cancer: graphic narratives and biolegitimate lives. *Med. Anthropol. Q.* 30:149–67
- McMullin JM, Chavez LR, DeAlba I, Hubbell FA. 2005. Influence and beliefs about cervical cancer etiology on pap smear use among Latina immigrants. *Ethn. Health* 1:3–18
- McMullin J, Weiner D, eds. 2008a. An anthropology of cancer. See McMullin & Weiner 2008b, pp. 3–25

- McMullin J, Weiner D, eds. 2008b. *Confronting Cancer: Metaphors, Advocacy and Anthropology*. Santa Fe: Sch. Adv. Rese.
- Michaels D. 1988. Waiting for the body count: corporate decision making and bladder cancer in the US dye industry. *Med. Anthropol. Q.* 2(3):215–32
- Mulemi BA. 2010. *Coping with Cancer and Adversity: Hospital Ethnography in Kenya*. Leiden: Afr. Stud. Cent.
- Mulemi BA. 2015. Cancer crisis and treatment ambiguity in Kenya. See Mathews et al. 2015, pp. 156–76
- Murphy M. 2008. Chemical regimes of living. *Environ. Hist.* 13(4):695–703
- Panter-Brick C. 2014. Health, risk, and resilience: interdisciplinary concepts and applications. *Annu. Rev. Anthropol.* 43:431–48
- Patterson J. 1987. *The Dread Disease: Cancer and Modern American Culture*. Cambridge, MA: Harvard Univ. Press
- Petryna A. 2013. *Life Exposed: Biological Citizens After Chernobyl*. Princeton, NJ: Princeton Univ. Press
- Povinelli E. 2010. *Economies of Abandonment*. Durham, NC: Duke Univ. Press
- Saillant F. 1990. Discourse, knowledge, and experience of cancer: a life story. *Cult. Med. Psychiatry* 14(1):81–104
- Salzberger S. 1976. Cancer: assumption and reality concerning delay, ignorance and fear. In *Social Anthropology and Medicine*, ed. J Loudon, pp. 150–89. London: Academic
- Sand Anderson R, Tørring ML, Vedsted P. 2014. Global health care seeking discourses facing local clinical realities: exploring the case of cancer. *Med. Anthropol. Q.* 29(2):237–55
- Sargent C, Benson P. 2017. Cancer and precarity: rights and vulnerabilities of West African immigrants in France. In *Negotiating Structural Vulnerability in Cancer Control: Contemporary Challenges for Applied Anthropology*, eds. J Armin, N Burke, L Eichelberger. Santa Fe, NM: Sch. Adv. Res.
- Singer M. 2011. Down cancer alley: the lived experience of health and environmental suffering in Louisiana's chemical corridor. *Med. Anthropol. Q.* 25(2):141–63
- Singh P, Cartwright L, Visperas C. 2014. African Kaposi's sarcoma in the light of global AIDS: antiblackness and viral visibility. *J. Bioeth. Inq.* 11:467–78
- Smith-Morris C. 2010. The chronicity of life, the acuteness of diagnosis. In *Chronic Conditions, Fluid States: Chronicity and the Anthropology of Illness*, ed. L Manderson, C Smith-Morris, pp. 21–37. New Brunswick, NJ: Rutgers Univ. Press
- Sontag S. 1977. *Illness as Metaphor*. New York: Farrar, Straus & Giroux
- Stacey J. 1997. *Teratologies: A Cultural Study of Cancer*. New York: Routledge
- Stewart BW, Wild CP, eds. 2014. *World Cancer Report 2014*. Lyon, Fr.: Int. Agency Res. Cancer
- Stoller P. 2005. *Stranger in the Village of the Sick: A Memoir of Cancer, Sorcery, and Healing*. Boston: Beacon Press
- Stoller P. 2013. Cancer rights and the remission society. *Harvard Divinity Bull.* Vol. 41. <http://bulletin.hds.harvard.edu/articles/winterspring2013/cancer-rites-and-remission-society>
- Trawick M. 1991. An Ayurvedic theory of cancer. *Med. Anthropol.* 13:121–36
- Wailoo K. 2011. *How Cancer Crossed the Color Line*. Oxford, UK: Oxford Univ. Press
- Weiner D. 1993. Health beliefs about cancer among the Luiseno Indians of California. *Alaska Med.* 35(4):285–96
- Weiner D. 1999a. American Indian discourse and the prevention of illness. In *Preventing and Controlling Cancer in North America: A Cross-cultural Perspective*, ed. Diane Weiner, pp. 55–68. Westport, CT: Praeger
- Weiner D, ed. 1999b. *Preventing and Controlling Cancer in North America: A Cross Cultural Perspective*. Westport, CT: Praeger
- WHO (World Health Organ.). 2015. *GLOBOCAN 2012: estimated cancer incidence, mortality and prevalence worldwide in 2012*. Fact sheet, WHO, Geneva. [http://globocan.iarc.fr/Pages/fact\\_sheets\\_cancer.aspx](http://globocan.iarc.fr/Pages/fact_sheets_cancer.aspx)
- Wray N, Markovic M, Manderson L. 2007. Discourses of normality and difference: responses to diagnosis and treatment of gynaecological cancer of Australian women. *Soc. Sci. Med.* 64:2260–71