

Clinical Encounter and the Logic of Relationality: Reconfiguring Bodies and Subjectivities in Clinical Relations

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Abstract

This essay critically examines the significance of relational approaches for sociological understandings of clinical interactions, relations and practices, by exploring the ways in which relational theories and concepts have been employed in the recent sociological accounts of clinical encounters to trouble the classical dyadic models of clinical interaction and the related atomistic conceptions of agency and accountability. Reading this work through the theoretical contributions from feminist science studies scholarship, and particularly the work of Donna Haraway (1988, 1994) and Karen Barad (2001, 2007), the essay proposes an alternative understanding of clinical interactions, relations and practices, where relations are conceived as constitutive of individuals (objects/bodies and their attributes/identities), rather than being constituted by encounters between individuals. Key for this understanding is the reconceptualization of clinical encounter as an apparatus of bodily production through which different agents (patients, clinicians, diseases, healthcare services) are materialised and enacted.

Key words

clinical interaction; relationality; identity; agency

Introduction

In his paper “The Clinical Encounter and the Problem of Context” (2007), Carl May draws attention to the enduring sociological interest in clinical interactions, suggesting that the encounter between healthcare professional and patient has been “one of the basic units of analysis” in medical sociology (29). As he notes, this interaction has mostly been conceptualised as “a dyadic encounter,

defined by asymmetries of power, the negotiation of rational and authoritative *scientific* knowledge, and private, proximal, relations” (29-30, original emphasis). This conceptualisation, he argues, has been unified across different theoretical traditions through the implicit reference to the Parsonian concept of doctor-patient relationship. It is against this long-standing interpretation that May proposes his approach to clinical encounter as a “product of action and interaction across diverse organisational interfaces” (40), and “an assemblage of organisational, institutional and disciplinary resources and practices” (41), which include corporate modes of surveillance, regulation and governance, and related technologies.

Influenced by conceptual contributions from social studies of science and technology and organisational studies of healthcare, May’s work forms part of a broader trend in medical sociology (and cognate disciplines), which seeks to reconceptualise clinical interaction and related notions of agency and accountability. This body of work includes, for example, Rapley’s (2008) account of the “distributed nature of medical practice” and the need for rethinking the models of shared-decision making; Goodwin’s analyses of clinical collectives and the related concepts of distributed agency and accountability (2009, 2014); and more applied frameworks, such as Epstein’s (2013) notions of “distributed cognition” and “shared mind”, or Elwyn et al.’s (2004) model of “collaborative deliberation”. Although differing in their focus and conceptual resources, these various propositions seem to share the dissatisfaction with the notion of clinical interaction understood as a spatially and temporally discrete encounter between autonomous and independent individuals. They also seem to share the tendency for understanding cognition, agency or accountability in increasingly relational terms as distributed across different participants in clinical interactions.

In this essay, I want to critically examine the significance of relational approaches for sociological understandings of clinical interactions, relations and practices, by exploring the ways in which relational theories and concepts have been employed in some recent sociological accounts of

clinical encounters to trouble the classical dyadic models of clinical interaction and the related atomistic conceptions of agency and accountability. Reading this work through the theoretical contributions from feminist science studies scholarship, and particularly the work of Donna Haraway (1988, 1994) and Karen Barad (2001, 2007), I want to propose an alternative understanding of clinical interactions, relations and practices, where relations are conceived as constitutive of individuals (objects/bodies and their attributes/identities), rather than being constituted by encounters between individuals. Drawing on a brief illustrative example from a recent ethnographic study of urological cancer care, I suggest that this understanding can be particularly fruitful in accounting for the varied and unequal configurations of power inherent to clinical encounters.

Relational approaches in social sciences

The concern with relational framing of actions in the clinic can be read in the context of a broader movement within social sciences marked by a growing interest in relations as the key preoccupation and a fundamental analytic category for social theory and research. The notions of relationality are not new in the history of sociology, with the recognition of the importance of social interactions and relations for the understanding of social reality present in the classical writings of Karl Marx, Emil Durkheim or Georg Simmel, and more recent work of Norbert Elias, Michel Foucault and Pierre Bourdieu (Crossley 2011, 2015; Emirbayer 1997). Nevertheless, the developments in social networks analysis and critical realism, and the growing emphasis on the centrality of relation as a basic unit of analysis, have given rise to the calls by some commentators of a “relational turn”, or even a “new relational paradigm” in sociology (Dépelteau, 2015; Donati, 2010, 2015; Prandini 2015). In parallel to these discussions, but not often in a direct dialogue with them (Somers, 1994), the feminist scholarship has also grappled with the issue of relationality, from the early celebrations of relational orientation as a key feature of female psychological and moral development in the work of Carol Gilligan (1982), Nel Noddings (2013), or Nancy Chodorow (1978), to the later

critical re-evaluations of relational conceptions of the self and autonomy in feminist psychology, ethics, political and legal theory, and bioethics (e.g. Downie and Llewellyn, 2012; Keller, 1997; MacKenzie and Stoljar, 2000; Radden 1996). The concern with relationality has also characterised various strands of science and technology studies. Actor network theory, and its extension into broader traditions of material semiotics, has been linked to a particular “logic of relationality” (Law 2009), and its key preoccupation with networks and webs of relations as constitutive of social actors and phenomena has been compared to (some versions of) relational sociology (Mützel 2009). This understanding of relationality as a fundamental mode of being as becoming-in-relations has also been central in the work of feminist science studies scholars (Barad, 2003, 2007, 2012; Haraway, 1997, 2008; Kirby, 2011; Puig de la Bellacasa, 2011, 2012), linking earlier feminist traditions of the ethics of care and standpoint theory with Foucauldian discourse, Derridian deconstruction and insights from the philosophy of natural sciences.

The interpretations of relations and relationality differ widely across these diverse literatures. For example, in feminist ethics and bioethics scholarship the relational understanding of the self proposed by writers, such as Catriona Mackenzie and Natalie Stoljar (2000), sees the individual as socially embedded, and her identity as formed in the context of social relations and on the intersection of various categories, including race, class, gender and ethnicity. While the relationships are central for the constitution of the self, and the focal point for analysis, the individual remains here the ultimate locus for agency, as she reflects on and acts within various intersecting relationships. On the other hand, posthumanist feminist approaches to science studies propose a radical conceptualisation of relational ontology, where relations are conceived as taking not only analytic, but also ontic, priority over individuals. For example, in the work of Karen Barad (2007), the notion of “intra-action” is used to characterise the mutual constitution of objects, and objects and subjects within phenomena (33). Unlike “interaction”, which assumes the existence of separate individual agencies prior to their relation, “intra-action” recognises the inherent

inseparability within phenomena and sees specific entities not as given, but as emerging through their relations in the process of differential becoming. Phenomena are thus seen not as gatherings of bounded and propertied entities, but rather as ontologically inseparable relations, “relations without pre-existing relata” (333). As I will illustrate, recent sociological accounts problematising the atomistic notions of agency and accountability within clinical interactions have been largely consistent with the first of the conceptualisations described above. It is the latter, I want to argue, that offers a particularly fruitful analytic tool for rethinking and intervening in clinical encounters and the power relations inherent to them.

In the following sections of this essay, I will undertake a close reading of the work of three scholars: Carl May (May 2007, 2011, May et al. 2014), Tim Rapley (2008) and Dawn Goodwin (2009, 2014), drawing attention to their theoretical commitments, and to their treatment of the notions of clinical decisions, agency and accountability in relational terms as distributed practices. The aim of this discussion is not to offer a complete overview of relational approaches in medical sociology, but rather to conduct an in-depth conceptual analysis. Given the significant plurality of the notion of relationality, such a careful work of articulation is necessary. In reading the work of these authors through one another, and through the lens of a radically performative conception of relationality as proposed by posthumanist, feminist science studies, I want to suggest a new relational conceptualisation of clinical encounter, one that offers new insights, as well as a new potential for intervening, into the politics of clinical relations and practices.

Clinical encounter beyond dyadic interactions

The starting point for May’s discussions (2007, 2011) of the concept of clinical encounter is the recognition of the persistent influence of the classical understanding of doctor-patient relationship originating in the work of Talcott Parsons (1951). The Parsonian paradigm pictures medical practice as dyadic system grounded in the distinct and complementary roles of patients and

professionals, and in individual, proximal relations between them. As May argues, despite the frequent criticisms levied against Parsons' understanding of medical practice, this conceptualisation "has continuously sedimented into sociological research and practice" (May 2007: 32), finding expression in, and providing a common vocabulary to, a range of theoretical and disciplinary perspectives. This common vocabulary introduces two important conceptual separations. The first is the deliberate "segregation of the context of clinical practice from other contexts" (Parsons 1951: 457), including the organisational, the managerial and the institutional. The second is the distinction between the patient and professional roles, and the associated asymmetries of knowledge and expertise. Taken together these conceptual divisions contribute to a particular understanding of the clinical encounter as enacted in localised and privately framed interactions.

As May argues, this understanding fails to account for the increasingly complex interactions between the clinic and the broader technocratic systems of healthcare organisation and management. As such, it should be replaced by a new conceptualisation of the clinical encounter in terms of "the multiple interactions between [its] *context* and *content*" (May 2007: 41, original emphasis), which reframes it from the private, autonomous, temporally and spatially localised interactions to the increasingly corporate, organisationally framed and deprivatised relationships. Drawing on the conceptual vocabulary of science and technology studies, May suggests picturing the clinical encounter as part and element of a larger assemblage, the one that would incorporate and account for various practices and resources constituting contemporary healthcare, such as corporate modes of governance, technocratic management systems, patterns of knowledge production and distribution, or normative models of patienthood (May 2007, May et al. 2006).

In his later contributions (May 2011, May et al. 2014), May moves away from the vocabulary of science and technology studies, but he retains his concern with portraying the "dynamic relations between *agents* (the individuals or groups that interact with each other in relation to healthcare

systems), in *contexts* (the diverse technical, professional, and organisational structures that make up healthcare systems and shape opportunities to utilise them)” (May et al. 2014: 283; original emphasis). Extending his earlier conceptualisation of clinical encounter, this work pictures agents, and their interactions with each other and with healthcare systems, not in terms of autonomous actions of isolated, rational individuals, but rather in terms of multiple relationships within diverse relational networks, where knowledge is shared, and decisions and, crucially, agency – “distributed among multiple participants in a social process” (May et al. 2014: 284). These distributions are expressed in relation to the diverse and often combined effects of multiple co-morbidities (and other factors, such as poverty), and the different ways in which those might be compensated for by actions of groups of people involved in specific relational networks. As such, they might not be equal or symmetrical, but positioned variously on the continuum of agency and different kinds of dependence (283).

Collective-patients and distributed decision-making

The concern with the distributed nature of clinical decision-making, and of medical practice in general, is key for the understanding of the clinical interaction proposed by Tim Rapley (2008). The starting point for Rapley’s analyses is his dissatisfaction with earlier conceptualisations of clinical encounter, particularly those linked to the increasingly influential literature on shared decision-making as a guiding principle, or even a model, for clinical practice. According to Rapley, the attractiveness of this model resides in the way in which it has been able to bring together and reconcile two leading political movements in the contemporary medical practice: the promotion of patient-centredness and different forms of active patienthood on the one hand, and the aspiration for grounding treatment decision-making in research-based evidence on the other hand. In this context, the key commitment of the model has been to reframe the role of healthcare professional from that of “information provider, or paternalistic adjudicator” (consistent with the classical, Parsonian concept) to a more collaborative one, “which distributes rights and responsibilities between the

parties” (Rapley, 2008: 430). Despite these intensions, the literature on shared decision-making has consistently ignored the insights from sociological accounts of everyday practices of patients and professionals in and outside of the clinic, and the ways in which those variously shape expertise and autonomy, and has tended to conceptualise clinical decisions as “‘solo’ cognitions and actions of individual, rational, autonomous human actors that occur in relatively atemporal and ahistorical consultations” (431).

Drawing on the theoretical contributions from actor network theory and ethnomethodology, Rapley proposes an alternative conception of “distributed decision-making”, where decisions are seen as “routinely distributed ‘over’ people ... in and through *multiple interactions* with *multiple others*, significant or otherwise, *over a period of time*” (436, original emphasis). In this conceptualisation, the temporality of decisions is reconfigured to account for the long history of clinical (and non clinical) encounters involved in any single “decision-in-a-series”, and for the multiple temporal orientations of each of these “episodes” simultaneously towards past, present and future. The notions of subjectivity and agency undergo similar reframing with the figure of the patient conceived not simply as an individual, but rather as a “collective-patient”, “one, albeit central node, in a configuration” (436), which includes various people, but also documents, artefacts, and technologies. This understanding of clinical decisions, and medical practices in general, as distributed over time and over different actors, is closely linked to a particular notion of relational autonomy, where any action is seen as emerging out of “a web of interdependency in encounters”, and where subjects of these encounters are “patient collectives ... formed in and through interdependencies between human [and nonhuman] actors” (438).

Rapley’s conceptualisation of clinical decisions, and encounters in which they are embedded, recognises that their distributions might be asymmetrical and that the level of contribution afforded to different participants in the collective might vary in relation to time (e.g. with early encounters

and decisions typically involving a smaller number of actors, and later interactions distributed across multiple spatially and organisationally diffused participants) and in relation to the nature of the encounter (e.g. with hyper acute emergency situations affording unconscious patients, and their absent significant others, very limited possibility for action and participation in the decision-making process).

Cyborg relationships and distributed agency and accountability

The recognition of the distributed nature of clinical decision-making and agency, and of the asymmetries intrinsic to them, is a starting point for Dawn Goodwin's discussion of clinical encounters in anaesthetic practice (2009, 2014). Referring to the work of Rapley among others, she argues that the understandings of medical practice as distributed have yet to penetrate into the professional discourses of clinical accountability. These discourses, as Goodwin notes, still seem to be based on the notion of individual agency that "emphasises independence of thought and autonomy of actions, ... posits decisions as discrete moments of an individual's cognition, and ... punctuates practice with moments wherein diffuse accountabilities crystallise on particular actors at particular times" (57).

In the attempt to reconfigure these conceptions, Goodwin pictures the interlacing of actions of various agents involved in the anaesthetic work, drawing conceptually on science and technology studies, sociology of work, and ethnomethodological notions of situated action. In this account, anaesthesia is seen as a collaborative, relational practice, which helps to reconfigure relationships among humans (patients and various health professionals) and nonhumans (various machines and devices), while transforming and redistributing knowledge and capacity for action. At the same time, it helps to reconfigure the notion of agency, away from "the figure of rational, intentional agent" towards relational positions, which recognise that "capacities for action are produced in the

interactions of practitioners and patients together with technologies, machines and devices”

(Goodwin, 2009: 25-26).

Interestingly, Goodwin’s discussion of “acting in anaesthesia” does not exclude the possibility of agency of an unconscious body. In her account, the body of an anaesthetised patient, through its connection with the anaesthetic machine, is rendered communicative, able to convey its status and affect particular actions from various health professionals. This connection between a patient and a machine is conceptualised in terms of cyborg relationships: not only is the patient reliant on the machine for supporting her key physiological functions, she is “technologically extended and augmented” through the relationship with the machine. As Goodwin observes, “In a very practical and material sense, the patient becomes a mix of organic and technological components, in other words, a cyborg” (2009: 34).

This framing of the patient as a cyborg allows Goodwin to reconceptualise the agency in clinical practice to include actions of those agents, such as unconscious patients, anaesthetic machines and other technologies, which lack intentionality, but “may still provide a dynamic contribution to the shaping of events”, problematising, but not negating, the ability of health professionals “to define, determine and control events” (39). In order to be effective, the communicative actions of the anaesthetic cyborg have to be matched with appropriate (re)actions from the anaesthetic team. These, in turn, need to be positioned within a larger clinical collective, which includes the activities of surgical, nursing, and auxiliary staff present in the operating theatre, but also local practices, organisational routines and professional codes of conduct, which guide and shape those activities. Rather than being contained in any single device or body, even a cyborgian one, agency is seen as enacted in relations of various bodies, devices and organisational settings (57).

Clinical encounter and the logics of relationality

The discussions of medical practices and relations presented in the work of Carl May, Tim Rapley and Dawn Goodwin problematise and challenge the classical notions of clinical interaction understood as a spatially and temporally discrete encounter between autonomous and independent individuals. They do so in several ways. Firstly, they draw attention to the distributed nature of medical practices, where specific decisions, actions and encounters involve multiple participants, both human and nonhuman, across multiple times and spaces. Secondly, they picture those distributed practices as positioned within, and reliant upon, the broader organisational and institutional contexts, or, in other words, as elements of wider collectives or assemblages, which include policies, regulations and technologies. Thirdly, they demonstrate that capacity for action in clinical encounters and practices does not simply reside in individual actors, bodies or devices, but rather is expressed, or enacted, in networks and webs of relations. These conceptual reconfigurations are made possible through the reference to relational notions of agency. While all three authors make use of such notions, their articulations of agency and relationality differ significantly.

In May's account, agency is characterised both as the practice of engagement (what patients do in order to engage with healthcare services and with others) and as the property of patients, or "the general potential" to act (May et al., 2014: 283). Relationality is here understood as the presence of specific social networks, which allow for the personal agency to be expressed and distributed. The exact nature of these distributions is not fully elaborated, but they seem to be pictured in terms of the increasing levels of dependence, or the decreasing levels of individual capacity, which need to be compensated for through the actions of social, relational networks. While emphasising the importance of relations, May's conceptualisation of clinical encounters sustains the separation between agents and contexts in which they relate, and between agents and social relations, which mediate or constrain their capacities for action.

Rapley's discussions picture agency not as a property, of individuals or of groups of people, but rather as an emergent phenomenon, coming into being "in and through a web of intersubjectivity and relationality" (2008: 436). In this account, agency is not contrasted with dependence or lack of capacity, but rather is characterised as something achieved through multiple relationships of mutual interdependence between actors. Consequently, the understanding of relationality extends from the appreciation of the importance of relations in enabling or constraining decisions and actions of social agents, towards recognition that – in contrast to classical Kantian conceptions of subjectivity and autonomy – these agents do not exist apart from their relationships, but are shaped in and by them (434-435).¹ Still, within the "webs of intersubjectivity and relationality", individual patients, family members, health professionals and specific devices and technologies are seen as interacting, but, nevertheless, separate and separable entities.

This apparent separation within interactions and relations is challenged in Goodwin's accounts of anaesthetic cyborgs and clinical collectives. Here, agency is conceptualised as "an effect generated through collaborative sociotechnical practices" (2009: 169), where boundaries between the unconscious body and the machine that supports and sustains it, and between the body-machine complex and the anaesthetist that reacts to its communicative actions, are not easily drawn; and where possibilities for acting are not ascribed solely to rational, intentional subjects, but extended to include vital, energetic and dynamic contributions from inanimate and unconscious agents. In Goodwin's understanding of relationality, agency is not seen as simply distributed in relations, but rather it is conceived as relation in and of itself (167). In order to elaborate a model of accountability, which would correspond to this conception of agency and "address relations rather than individuals", Goodwin traces various ways in which "relatively independent individuals" (4) come to form and act as cyborg bodies within larger clinical collectives. What she does not question in her analyses is the ways in which those "relatively independent individuals" become what they are, that is, individuals, in the first place.

This is precisely the concern of the posthumanist feminist science studies scholars, and particularly Karen Barad (2001, 2003, 2007) in her conceptualisation of relationality as ontological inseparability. As illustrated in Barad's analyses of foetal ultrasonography (2007: 212-217), clinical objects and subjects, such as the foetus, the pregnant woman, or the ultrasound technician, are not pre-existing entities with inherent properties, but rather parts of ontologically inseparable phenomena, made determinate as separate, bounded and propertied "components", as one and not the other, only in relation to particular apparatuses and "agencies of observation". Agency, in this context, is seen as "an enactment, not something that someone or something has" (214); not as shared or distributed between different agents, but as differentially enacted and materialised in specific actions and practices, which are also responsible for the enactment and materialisation of their agents.²

This understanding of relationality and agency offers useful insights for sociological analyses of clinical interactions and practices. The relational interpretations of medical practices discussed above have sought to challenge the traditional conceptions of clinical encounters, with their assumptions of individualism, rationality and autonomy. They did so in order to account for and intervene into the often unequal distributions of power, agency and accountability inherent to these encounters and practices. Taking seriously Barad's notion of relations as ontologically prior to individuals, I want to suggest that in order to make such interventions, we need to understand not only how power, agency and accountability are distributed, or configured, in relations and practices involving different agents, but also, and more importantly, how those different agents come to be articulated, enacted and materialised in relations and practices, which make these distributions and configurations possible.

In the remainder of this essay, I propose one way of attending to such performative nature of clinical relations and practices. Engaging with Haraway's (1988, 1994) and Barad's (2001, 2007) concepts, I suggest that we look at clinical encounter as an apparatus of bodily production in which different agents (patients, clinicians, diseases) are differentially enacted and materialised. Or, more precisely, I suggest that we look at clinical encounter in terms of the intra-actions of multiple apparatuses, which include medical procedures, professional guidelines, medical research findings, clinical interaction and decision-making models, and multiple others.

Clinical encounter as an apparatus of bodily production

In Haraway's work the concept of the apparatus of bodily production characterises a material-semiotic, meaning generating matrix, which allows for the mapping and materialisation of boundaries (1988). In Barad's elaboration, it is understood as "an instrument of power through which particular concepts and material-discursive boundaries are produced" (2001: 80).

Both iterations of the concept draw attention to the provisional and generative nature of boundaries, and to the mutual entailment of matter and meaning.

In Haraway's reading, objects of knowledge, including bodies, are "boundary projects", which do not pre-exist, but materialise, together with their specific boundaries, in social interactions.

Boundaries are never drawn once and for all, but "shift from within", and remain "productive of meanings and bodies" (1988: 595). In Barad's understanding, apparatuses are specifically boundary-making practices, which produce particular "differences that matter" (2007: 146). It is only in relation to particular apparatuses that objects or bodies are made meaningful and materialised as distinct and propertied entities. Importantly, apparatuses themselves are boundary projects or phenomena. They do not exist independently as bounded objects or structures, but are constituted through specific practices "perpetually open to rearrangements, rearticulations, and other reworkings" (170). As such, apparatuses are never singular, but "always in the process of

intra-acting with other apparatuses” (170), contributing to the ongoing reconfiguration of phenomena.

Important for this understanding of bodies, meanings and boundaries as materialised in particular practices is the specific conceptualisation of matter and meaning as mutually constituted and articulated. For Haraway, the concept of the apparatus of bodily production is linked to a particular way of critically engaging with the world, the one that helps to “implode metaphor and materiality” and to “reconfigure what counts as knowledge in the interests of reconstituting the generative forces of embodiment” (1994: 105). Here, reality is figured as made of material-semiotic objects, which are both “eminently material and solid” and “sedimented out of technologies of observation/representation [that] are radically contingent” (1997: 302). Barad’s reading of the apparatus of bodily production proposes a similar understanding of the relationship between matter and meaning, picturing the world in terms of material-discursive phenomena. Crucial here are the reworked notions of discourse and matter. The former is not considered as synonymous with language, but as constituting “the material conditions for making meaning” (2007: 335), while the latter is not seen as a fixed substance, or an inherent property of independently existing objects, but rather as referring to “phenomena in their ongoing materialisation” (151). Both involve the dynamic articulations of specific properties, meanings and boundaries within material reconfigurations of the world. Discursivity and materiality are thus conceptualised in terms of the relationship of mutual entailment, rather than of externality.

I suggest that adopting the concept of the apparatus of bodily production as an analytical tool for sociological enquiry into clinical encounters allows us to account more adequately for the complex relations and practices which constitute healthcare. More specifically, it allows us to treat seriously the relational nature of medical work, its ongoing reconfiguration within specific practices and instances of relating, while acknowledging its embeddedness and enfolding within the broader

collectives, or webs of phenomena, which might include – among others – institutional and organisational systems and policies.

In the following and final part of this essay, I briefly illustrate the analytic potential of this concept, drawing on ethnographic data from a recent study of urological cancer services (Kazimierczak and Skea, 2015). I consider one instance of clinical interaction – a discussion of different management plans for localised prostate cancer – and indicate how in this particular practice, which nevertheless intra-acts with other practices and apparatuses, specific identities (of cancers and cancer management plans, cancer patients and cancer specialists) are intra-actively materialised.

Intra-actions in prostate cancer care

After telling Frank that his cancer is most likely confined to the prostate gland, Mr Swift explains to him the available treatment options.³ The first option would be just to observe if cancer is not developing. This is easy to do with the PSA blood test. If the blood test [result] rises, they could consider another treatment. Other treatment options are the surgical removal of the prostate gland and radiotherapy. These two options would be undertaken with the intention to cure Frank. Frank notes that he knows that cancer can now be treated successfully, but he also heard that it could get worse, if it was not operated. Not this type of cancer, replies Mr Swift. He explains again that surgery and radiotherapy options are meant to cure the cancer, if they believe that it is aggressive. But not all cancers are aggressive, some of them just linger. The first option – to watch it – would help to determine what type of cancer it is. You are the expert, exclaims Frank, and he asks Mr Swift what to do. Mr Swift replies that they can watch it for a while and make PSA tests. If there is any sign of PSA going up, they can go for an active treatment. But at least it will let them know if it is a tiger or a pussycat.

This instance of clinical interaction is most immediately concerned with different ways of treating or managing localised prostate cancer. Three main management regimens are discussed here: active surveillance (referred to as “observing” or “watching” the cancer), radical prostatectomy, or the surgical removal of the prostate, and radiotherapy. The latter options, surgery and radiation therapy, are presented as “active” treatments intended to cure the cancer. But this figuration is conditional on the differential enactment of the first option, the seemingly passive “watching” of cancer, simply monitoring its progression. The categories of “active” and “conservative” treatments are thus mutually articulated. They are also contingent on specific procedures, and the notions of cancer control and invasiveness that they entail. In the case of surgery and radiotherapy, which clearly involve the radical interventions into bodies in the form of cutting and irradiating, the notion of control is defined in terms of a cure, or a possibility of completely removing or eradicating cancer cells before they can spread beyond the prostate gland. In case of active surveillance, control is figured in a more modest way: as monitoring of the disease, checking whether it is not progressing, and deferring more invasive interventions to the time when it shows signs of progression and proves to be more aggressive. But, like all boundaries, these distinctions are not drawn once and for all. While surgery and radiotherapy may be performed with the intention to cure the disease, in cancer care the notion of cure is routinely configured as a specific period of time over which the recurrence of cancer cannot be detected. In this perspective, the restoration of health is treated as conditional and time specific, and the presence/absence of a disease is predicated upon its detection rather than its eradication. The notion of invasiveness of particular procedures is also not self-evident. Active surveillance – while in principle focused on the monitoring of cancer’s progression – includes as its constituting elements a number of invasive interventions: in the form of a temporarily deferred radical treatment, and as a part of diagnostic process which makes use not only of blood tests, but also of repeated biopsies. What constitutes cure and what might be considered invasive is thus contingent and changing. The categories of active and conservative treatments are not stable and

permanent, but rather continuously reconfigured, often in incoherent ways, through specific practices and procedures.

This instance of clinical interaction is also concerned with determining what cancer is and how it can be classified. Different types or attributes of cancer are proposed here: aggressive cancers and lingering ones, cancers that need to be treated actively and those that need to be watched, or – to use a popular clinical metaphor – tigers and pussycats. Crucial for making these properties of cancer determinate, that is, intelligible as one and not the other, is “the watching of cancer”, or active surveillance, which – true to its visual metaphor – involves various visualisation apparatuses, which need to be understood in the sense suggested by Haraway and Barad as material-semiotic objects, or material-discursive phenomena. These include, among others, biochemical tests measuring the level of prostate specific antigen (PSA) in the blood; ultrasound imaging of the prostate gland; histologic analyses assessing the level of cell differentiation on the Gleason scale; or clinical examination establishing the size and possible spread of cancer beyond the prostate gland. Intra-acting with different practices in the clinic (taking blood or tissue samples, performing a digital rectal examination), and in the laboratory (performing biochemical or microscopic analysis), and with different “agencies of observation” (an ultrasound probe and a biopsy needle, a doctor’s finger, a microscope, an immunometric assay kit), these apparatuses are involved in the materialisation of specific figurations of cancer: as presence of particular serum biomarkers detected through biochemical tests; as particular patterns of cell differentiation visible under the microscope; as presence of a mass noticeable to the touch. Different clinical and scientific practices and apparatuses, and the multiple, incoherent materialisations of disease they help constitute, become entangled in the stratification of cancer into low-, intermediate-, and high-risk categories, or into pussycats and tigers. What cancer is and how it is managed are thus mutually constituted.

This mutual constitution and articulation has further material consequences. The classification of cancers, their differential enactment into distinct categories, is made meaningful in relation to, and intra-actively produces, particular classifications of bodies that these cancers affect as belonging to different risk categories, and commits them to specific management plans. Each of these classifications, and procedures that help to constitute them, leaves specific marks on the bodies of patients. These may include scarring, pain, anxiety, infection, loss of physiological function, tiredness, nausea, as well as changes to multitude of everyday practices, from driving, to relating to loved ones, to being able to retain one's job. In enacting and materialising particular cancers, and particular bodies that these cancers affect, different treatments and clinical procedures also help to configure specific subjectivities of cancer patients and cancer specialists, and the related relations of power. Whose eyes are "watching" the cancer, and whose bodies are constructed as "objects under the watchful eye of scientific and medical surveillance" (Barad 2007: 216)? Which (and whose) classifications of cancer are figured as scientific facts, and which are constructed as representing personal preferences? Which of those are given greater authority, and material consequence, and involved in configuring cancer management plans, and specific bodies and lives? And, crucially, what specific practices and apparatuses are involved in the materialisation of these differences? These and similar questions are important for the understanding of power relations in clinical encounters; not in terms of the predefined and stable asymmetries of knowledge and authority between doctors and patients (as suggested by the Parsonian model); nor in terms of the distributions of power and agency among different participants of clinical interaction, where power and agency are considered as properties attributable to distinct, if multiple, agents (as suggested by the critiques of the dyadic model of clinical encounter); but rather as intra-actively constituted and differentially materialised within specific practices. The categories of "patients" and "healthcare professionals", as those of "cancer" and "cancer management plans", are not fixed and stable, but are configured and reconfigured in particular instances of relating and through specific apparatuses, which also reproduce particular and changing relations of power.

Clinical interaction is thus implicated in the materialisation of specific objects/bodies and attributes/identities of cancers, patients and healthcare professionals. But it does not do so independently. As suggested by the above examples, specific treatments and medical procedures are intra-actively involved in this process. And so are other apparatuses. Entangled within these encounters are clinical guidelines and protocols, which – in intra-actions with specific clinical and scientific practices and apparatuses – differentially enact particular classifications of cancers and related risk groups:

Several factors have been shown to predict the risk of recurrence after treatment of localised prostate cancer. These include the Gleason score, the serum PSA level, and the T-stage. These predictive factors have been used to classify localised prostate cancer into risk groups... (NICE 2008: 23)

Implicated in these classifications are also the “natural history” of prostate cancer and the medical research, which contributes to its configuration. These figure prostate cancer as a largely indolent disease, which often remains asymptomatic over an extended period of years, but in the minority of patients – particularly the younger ones – may turn into an aggressive and potentially fatal condition (Johansson et al. 2004). This distinction between the majority of the indolent cancers and the small proportion of the aggressive ones is contingent, not only in its relation to specific procedures, but also in the uncertainty of its prognostic potential:

In urological cancer in general, and prostate cancer in particular, the appropriate management strategy for an individual patient may depend crucially on that individual’s values and attitudes. Because of the nature of the disease and the unpredictable rate of progression, the optimum strategy is often unclear. ... In this situation, shared decision-

making is essential. (NICE 2002: 52)

Involved in the ongoing materialisation of bodies and identities are thus also the normative models of clinical interaction and decision-making, such as the notions of patient-centred care and shared decision-making, which help to produce particular subjectivities of “active” patients and “collaborative” healthcare professionals within changing relations of power, where “rights and responsibility” are seen as being distributed “between the parties” (Rapley 2008: 430).

As these examples suggest, clinical interactions are entangled with a multitude of other apparatuses of bodily production, and are responsible for making determinate and materialising specific configurations of cancers and cancer management plans, and particular subjectivities of patients and healthcare professionals.

Conclusion

Sociological accounts of medical practice have come to rely increasingly on relational conceptions of cognition, agency and accountability in their challenge to the classical notions of clinical interactions, with their assumptions of individualism, rationality and autonomy. By drawing attention to the distributed nature of clinical decisions and actions, these relational interpretations have tried to account for and intervene into the often unequal distributions of power, agency and accountability inherent to clinical encounters and practices. Reading this work through the theoretical contributions from feminist science studies scholarship, in this essay I have suggested that for such interventions to succeed we need to understand not only how power, agency and accountability are distributed, or configured, in relations and practices involving different agents, but also how those different agents come to be articulated and materialised in relations and practices, which make these distributions and configurations possible. Engaging with the work of Donna Haraway (1988, 1994) and Karen Barad (2001, 2007), I have proposed one way of attending

to this issue by conceptualising clinical encounter as an apparatus of bodily production or, more precisely, as mutual entanglements and materialisations of various apparatuses. As I have argued, this conceptualisation allows us to account for the relational nature of medical work, its continuing reconfiguration within specific instances of relating, while recognising its embeddedness and enfolded within the broader collectives, or webs of phenomena, such as clinical protocols and guidelines, medical research findings, normative models of clinical interaction and decision-making, and many others.

This conceptualisation has important consequences for sociological understanding of relations and identities in the clinic, and for the broader discussions of subjectivity and agency. As I have illustrated, thinking of clinical encounter in terms of mutually entangled and materialised apparatuses of bodily production draws attention to the ways in which clinical interactions are generative of objects and meanings, bodies and identities. But, unlike many other accounts, it does not assume that what these objects/bodies/identities are and mean is given in advance or predefined, but rather sees them as enacted and materialised in their differential becoming. This suggests new and reworked notions of identity and subjectivity, which do not assume the inherent separability of objects and their contexts, objects and their representations, or objects and subjects. In this view, identities are not treated as pre-existing properties of discrete subjects or objects, such as patients, healthcare professionals, or particular diseases. Nor are they viewed as relations between already established entities – between patients and professionals, between diseases and the bodies they affect, or between diseases and the means for their management – where these are understood as preceding their relating. Rather, these identities are figured as the effects of particular exclusions, in which specific subjects and objects are differentially enacted. This is not to say that the identities of patients and professionals, and specific designations and properties of diseases emerge, *ex nihilo*, during clinical interactions; but rather, that they can only become intelligible, that is, articulated and materialised, within various practices, which constitute clinical encounter. In other words, we

cannot meaningfully talk about patients, professionals, or diseases outside specific practices, which make their identities possible.

This conceptualisation also has consequences for any potential interventions into the politics of clinical encounters, with their varied and unequal configurations of power. With agency reconceptualised in terms of ongoing reconfigurations of boundaries and exclusions within specific practices, the possibility of intervention resides not in the potential for redistributing power and agency between different participants in the clinical encounter, but rather in finding different possibilities for acting, different apparatuses of bodily production, which enable different boundary articulations and exclusions. All too often the models of clinical interactions conceived to challenge traditional roles and responsibilities, such the notions of shared-decision making or patient-centred care, enact and materialise specific configurations of doctors, patients, diseases, or medical technologies, which help reproduce the boundaries and distributions of power that they embarked to overrule. The notion of the apparatus of bodily production provides a useful analytic tool for rethinking clinical encounters and the power relations inherent to them, by imagining different practices in the clinic (and elsewhere), which might help to enact different cuts and enable different identities and attributes to materialise. How this might look in practice requires further investigation, but some already existing healthcare practices, such as the use of design methods in service improvement, could perhaps serve as useful points of entry for a future enquiry. Such an enquiry would be concerned with and trace, what Barad (2007: 474) calls after Foucault, the “conditions of possibility” for different practices and apparatuses, which constitute specific instances of service improvement / redesign, and which help articulate particular notions of clinical agents – clinicians, patients and managers – as users, designers, or co-designers, and the associated relations of power.

Notes

(1) A similar understanding of relationality characterises the work of other authors in the field, for example, Ingunn Moser's (2011) explorations of the issues of subjectivity in dementia or Rita Struhkamp's (2005) discussions of patient autonomy in rehabilitation care.

(2) Annemarie Mol's (2008) discussion of subjectivity as conceptualised through the metaphor of eating seems consistent with this understanding of agency. However, her analysis does not articulate explicitly its underlying notion of relationality.

(3) Names have been replaced with pseudonyms.

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