

Malignant yet Benign

“Be careful, *parce* [friend]. Getting screened for cancer in Colombia may cause cancer, especially if your patients are rich!”

This is how my friend Sebastian, a janitor who works at a private hospital, reacted when I told him that my partner, Juana, had just been diagnosed with two seemingly incompatible skin conditions: a melanoma and dysplastic nevus.¹ While the former is known for being an aggressive (often lethal) form of skin cancer, the latter is an unusual-looking and benign mole that may (or may not) turn into a melanoma. Because their differences under the microscope or through dermatology goggles are subtle, physicians often disagree on what they see. When medical services are not unrelated to the patients’ ability to pay for them, what emerges through a microscope might be different. This chapter focuses on the ontological indeterminacy of cancer and its relationship to two high-end hospitals and a patient who can, albeit with effort, pay for treatment. How do medical practices, notions of “best care,” and ways of seeing shape how diagnoses are enacted in Colombia? What does it mean that cancer and its absence can coexist in the same tissue?

Building on Sebastian’s words and Juana’s therapeutic journey, I analyze the direct relationship between medical ontological (dis)agreements, social class, and the chances for diagnosing cancer. Unlike those of the low-income cancer patients I followed, Juana’s story emerges at the intersection of two private clinics and health insurance companies for wealthier patients. To discuss her journey I build on STS scholarship, which highlights that statements about realities and the making of those realities are practiced together (see Latour and Woolgar 1986; Mol 2002; Law 2004; Barad 2007; Myers 2015). Observing skin tissue under the microscope, for instance, allowed physicians to do something that was not “out

there” and therefore shaped what they saw. Their ways of seeing and examining Juana’s body allowed for the co-occurrence of cancer and its absence. Thus, I write about *how* physicians saw was not unrelated to *what* they saw and therefore to their practices of medicine in neoliberal Colombia.

My intent is not to criticize physicians but rather to discuss how the 1993 neoliberal reform made certain diseases more easily recognizable than others. Nearly thirty years after the neoliberal reform, Colombia has become one of the most unequal countries in the region, making for an extremely classed practice of medicine (Hernández 2002; Ewig and Hernández 2009). An oncologist at a private hospital in Cali told me, “Poor patients who suffer from high-cost diseases usually waste time and endure burdensome bureaucracy. Prepaid patients, on the other hand, get boutique service.”

“Boutique service?” I asked.

“Yes. This is how we refer to the medical services provided to prepaid patients at high-end hospitals. They get assigned health care concierges who assist them to quickly reach their doctor of choice, get same-day appointments, and fill out burdensome insurance paperwork. Because they rarely have to deal with insurance representatives and bureaucracy, these patients are able to speed up the pace of their own medical services.”

“This means that wealthier patients who suffer from cancer have better chances of getting cured, right?”

“Not necessarily.” He then elaborated: “Attempting to do more screenings and prevention campaigns is not always translated into fewer cancer deaths. Waking up earlier does not mean the sunrise will take place sooner.”

His words not only illustrate the clinical uncertainty permeating the treatment of cancer in Colombia and elsewhere but also the perverse effects of coupling biomedicine and capital.² My friend Sebastian has experienced the consequences of this relationship. On the one hand, he has mopped floors and cleaned sinks and toilets at private hospitals for over ten years and also listened and talked to prepaid insurance patients while performing his job. As an individual who is enrolled in health insurance for low-income Colombians (EPS), on the other hand, he has struggled with the medico-bureaucracy whenever he seeks access to medical services at public hospitals. He is well aware of EPSs’ most common practices to reduce costs: prescribing cheaper drugs, and perhaps drugs of lower quality, and deferring access to expensive treatments such as chemotherapy until patients are often too weak to receive them (see chapter 1).

By contrast, prepaid patients tend to access uninterrupted medical services and leapfrog the bureaucratic lines of EPSs. However, cutting in line may often push patients to overrun the time of their own biology—that is, the time it takes for cancerous cells to grow and the time it takes a body to respond. In the case of Juana, for instance, speeding up the pace of her care prompted doctors to

disagree on what they saw under the microscope. In less than one month, several dermatologists, pathologists, oncologists, and surgeons had reviewed her skin biopsy; palpated her scalp, neck, and armpits to examine lymph nodes; taken measurements of her forehead; and planned for aggressive intervention. Right after scheduling the surgery to excise her lesion, however, Juana chose to slow the pace of her care and sought a second opinion. A new and different diagnosis followed: dysplastic nevus. How can it be that a cancer *is not* anymore?

Despite the seemingly good news, however, the probability that she had a melanoma on her forehead had already been introduced to her. Just as with a two-sided coin, Juana's final diagnosis could only land on one side or the other—not on both. But since her melanoma and dysplastic nevus had similar chances of occurring, both were probable. Thus, uncertainty mounted. If the odds of having either condition should be taken seriously, wouldn't it make sense to play it safe and prioritize the cancer diagnosis before it is too late? Isn't cancer care about immediate action and anticipation? Sometimes yes, sometimes no.

Instead of framing my discussion as an either/or diagnostic dilemma or misdiagnosis (Jain 2013), I write about the simultaneity of a melanoma *and* a dysplastic nevus. Here I draw inspiration from Marisol de la Cadena and Strathern's *Partial Connections* (1991). In her work *Earth Beings* (2015), de la Cadena discusses how certain beings such as Runakuna and Tirakuna can be human and nonhuman—but not only.³ She explains that this state exists simultaneously; humanness and nonhumanness cannot be disentangled. In Juana's case, melanoma and dysplastic nevus are technically cancer and noncancer, respectively—but not only. They emerge simultaneously in the same skin sample and in partial connection to each other.

In the Euro-American world, where things tend to either be or not, this simultaneity tends to become “phantomatic,” a term I borrow from Astrid Shrader (2010). She relates “phantomatic ontology” to Derrida's (1994) notion of hauntology, “which describes the paradoxical existence of a phantom as neither being nor non-being, neither present nor absent, neither of the ‘past’ nor of the ‘future,’ but which affirms an indeterminate relationship between being and becoming and between ‘past’ and ‘future’” (Shrader 2010, 278). According to her reading of Derrida, phantoms cannot be understood as being different and separate possibilities, where each happens independently from the other and at one particular moment in time. Rather, phantoms can be concurrent, simultaneous occurrences. That is, phantoms may represent more than one object occupying the same space-time. In her piece, for instance, she uses “phantomatic” to refer to a marine dinoflagellate organism commonly known as Dino, which could be fish killers, a benign cyst, or a unicellular amoeba. Dinos emerge from sediments, collectively attack fish, and disappear from the water columns as soon as most of their fish prey are dead. These organisms' phantomic character is characterized not only by their hide-and-seek behavior but also by their ephemeral appearances and disappearances and the very nature of their species. Their multifaceted ontology reacts to temporal configurations and environmental conditions.

Drawing inspiration from the life of this organism, I seek to understand my partner's diagnoses as phantomatic too—as cancer but not only. The differences between her diagnoses are neither epistemological, considering different perspectives on the same object, nor ontological, in the sense that multiple realities coexist at the same time (Mol 2002). Rather, I argue, differences here concern the (im)probability of being cancerous.

With the neoliberalized health care system and the prepaid insurance regime as the background, I start by describing how this (im)probability is shaped by the ways in which doctors use their own bodies, hands, and eyes to recognize *what* they see under the microscope. Next I show how my double relationship with Juana—as fieldwork interlocutor and partner—played a crucial role in her diagnoses. Because I had already spent several months observing the Kafkaesque absurdities of the health insurance for the poor—its bureaucracy and inefficiency—I insisted she enroll in one of the different prepaid insurance plans available. I did not want her to waste time and be seen who-knows-when by who-knows-who. Thus, I introduced her to a dermatologist I had met during my fieldwork.

My double role as ethnographer of cancer and partner would take Juana into multiple examination rooms, where different physicians doing “good” shaped the phantomatic character of her diagnoses. I conclude this chapter by discussing the ethical tensions that emerge when health care providers and caregivers in Colombia enact what is considered the “best good” in the context of prepaid insurance (see also Kleinman 2006; Mattingly 2014).

A MELANOMA PROSPECT

When I first asked Juana about her reasons for visiting a dermatologist, she explained, “Physicians often ask me to monitor my moles and keep track of changes in color, size, or form. It turns out I am at risk for developing skin cancer.” Juana’s skin type, after all, aligns with the most common risk criteria highlighted in dermatology literature. First, she is blonde and light-skinned. Second, when growing up on the Caribbean coast she was exposed to direct sunlight for prolonged periods. And third, there is a history of skin cancer in her family.

She then pointed to her scalp and said, “This is what I am talking about. And since you are conducting your research at hospitals, I thought you might know a good dermatologist!”

“What a coincidence,” I replied enthusiastically. “I have just started following Dr. Rayo as part of my fieldwork. He is a senior dermato-pathologist and the director of a private hospital lab. Why don’t you get an appointment with him? He works with prepaid insurance and seems well known in his field.”

I grabbed my wallet and looked for his business card. “Call his secretary. Tell her that you are my partner and that you want to schedule an appointment with him. A *palanca* won’t hurt,” I confidently said. The English translation of *palanca* is “lever,” a simple machine consisting of a bar that pivots on a fulcrum and

is used to transmit torque. In Colombian Spanish, the word *palanca* is commonly used to refer to situations in which social ties transmit “torque,” for instance, help individuals get a job interview, “cut the line” to access a public service, get a transit fine waiver, or get an appointment with a renowned physician whose examination schedule is usually full.

Juana dialed, and I listened to the conversation.

“I would like to schedule an appointment with the doctor.” The nurse (who is also a secretary) asked, “What is your type of insurance? ¿Viene por EPS o por prepagada? [Are you coming as an EPS or a prepaid insurance patient?].” These questions were intended to redirect my partner to the corresponding examination planner. “I am a prepaid patient and will be paying in cash,” she replied. Because Dr. Masa is outside the primary network of providers, Juana would have to pay out of pocket for her consultation and then wait between thirty and sixty days to get reimbursed by her insurance.

Juana’s case reminds me of how middle- and upper-class women in certain Latin American countries, such as Ecuador, tend to avoid public hospitals, especially to deliver a baby, opting for a costly C section at private clinics (Roberts 2012). Unlike these women, my partner’s main reason for choosing a prepaid insurance was *time*. She was earning a modest salary as a preschool teacher, but she was willing to pay extra to expedite the process and get same-day appointments and access treatments “on time.”

“By the way,” Juana added, “I am Camilo Sanz’s partner—the anthropologist who works with Dr. Rayo.” The nurse said, “Oh, yes, Camilo, of course. Please send my regards to him. Now, let’s see. [Long silence.] If you are a prepaid patient, the doctor may be able to see you tomorrow, Thursday, or the day after tomorrow. When do you prefer? It will be 130,000 pesos [US\$65] for the consultation. Cash only.”

NEXT DAY: DERMATOLOGY CHECKUP

Unlike most doctors in the EPS regime who must limit their consultations to fifteen minutes, Dr. Rayo was not in a hurry. After an ice-breaking conversation, the physician logged into his computer and opened a blank clinical history. “What can I do for you?” he asked. Juana grabbed her hair with both hands and uncovered the two-inch mole that extended from scalp to forehead. “I am concerned about this mole,” she said.

“Could you sit down on the trolley?” the doctor asked, while putting on magnifying glasses and zooming in on her skin. He palpated the mole and rubbed his index finger against it, as if trying to feel its contour, its texture. There was silence in the office. Dr. Rayo engaged his body in his work, assuming different postures: he stepped back and forth and looked at the mole from different angles and distances; he tilted his head slightly to the left, then slightly to the right. The way this physician used his body reminds me of Natasha Myers’s *Rendering Life Molecular*

(2015), in which she shows the role played by body movements in crystallographers' protein representations at a lab. Clinicians I followed must also cultivate bodily dexterity in order to render visible and recognize skin and cellular structures. Recognition, as I understand it, is about mapping anatomical knowledge learned from a book or dissection corpse, for instance, onto a living body (Park 2006; Saunders 2008; Prentice 2013).

Finally, the physician took a deep breath. While exhaling he uttered, "Have you noticed other similar moles on your body?" "I don't think so," she replied. The doctor palpated her scalp, turning her hair all around. Then he palpated the facial area next to her ears, where the jaw articulates with the skull. The physician performed circular movements with his index fingers. Then he repeated the same procedure on the back of her head and around her neck. He was looking for suspicious ganglions.⁴

Dr. Rayo said, "I don't want to alarm you, but we have to conduct a biopsy of your mole ASAP." He was warning Juana about the urgency of the situation. He took another deep breath followed by a short exhalation. "It looks like malignant tissue."

"What do you mean?" Juana asked, with evident anxiety.

"There are high chances it's a form of cancer," the doctor replied.

There was silence in the office. He then made eye contact with me and said, "Camilo, you might find this interesting for your research."

This whole situation took me by surprise. I must admit I had difficulty thinking about my research at this moment, let alone following Juana and her "aggressive cancer." I had been interacting with cancer patients for several months, seeking to understand how oncology is practiced at hospitals in Cali. But it never occurred to me that I would end up following my partner as she was diagnosed with the same disease I was studying. I was simply not prepared for it. Yet I also knew I had to pay attention to the doctor's words. I was, after all, Juana's partner—but not only.

The doctor asked me, "Why don't you get closer and take a peek at her lesion?"

I stood up and walked toward the trolley. Juana stared at me as if waiting for some sort of comforting gesture. I grabbed her hand firmly, yet continued listening to the doctor's instructions.

"Use your naked eyes first," said the doctor. "You will see there is an intense black tone; this is a bad sign. Now look at its size. Moles bigger than five millimeters should be considered very suspicious, and hers is definitely bigger than that! Take a look at its form and contour. It's totally irregular and has multiple indentations, right? It's asymmetrical. Unlike benign lesions, it does not have a circular shape or homogeneous color." Dr. Rayo was following dermatological classification guidelines, such as the ABCDE,⁵ which provide physicians with standardized diagnostic criteria. It teaches them how to recognize possible cancers.

Since I have no medical training, the doctor not only had to teach me how to use my body but also how to interpret the ABCDE diagnostic guidelines in order

to recognize cancer. Seeing is crucial. Yet seeing should not be solely understood as an image-centered activity, but as a learning process that involves hands, repetitive movements, body postures, and questions (Prentice 2013; Halpern 2015; Myers 2015).

In trying to master this process, I recall Bruno Latour's (2004) essay on learning to recognize different smells in the perfume industry. Latour describes how trainees become a "nose," that is, someone able to discriminate subtle odor differences and tell them apart even when they are masked by or mixed with other odors. Before the teaching session, Latour writes, "odors rained on the pupils without making them act, without making them speak, without rendering them attentive, without arousing them in precise ways: any group of odors would have produced the same general undifferentiated effect or affect on the pupil" (207). Each of these trainees viscerally learned to be affected by seemingly unidentifiable differences through the mediation of the kit.

Similar to the trainees' experiences, I was learning to be sensitive, affected, moved, put in motion by the mediation of instruments and their relations with moles. I put on the dermatology goggles and looked at her skin. "Can you see its structure?" Dr. Rayo asked me. I must admit I wasn't able to see anything at all. This was my first time using dermatology goggles. "I can only see blurred images, dark shades," I replied. He grabbed my arm impatiently and pulled me over. "You need to come closer, closer. Can you see it now?" "Only a blackish spot, though," I responded with frustration. "Can you see the internal structure? Look at the skin, the pores." After assuming different postures and coordinating them with Dr. Rayo's instructions, the mole suddenly "appeared" before my eyes. It had different tonalities of brown and black. There were pores, indeed, some sort of black filaments all over and lines randomly intersecting one another. Crucially, the mole was not "out there" waiting for me to discover it. It emerged through a coordinated effort of eyes, body, and hands.

Once the improvised teaching session was over, he said to Juana with a sense of urgency, "Talk to my assistant and schedule a biopsy appointment. Moles that have an orderly crisscrossing structure are usually benign, but yours has no symmetry whatsoever."

The study of what medicine discovers about bodies cannot be separated from the way we look at them. The act of "looking" requires the observer to formulate questions and assess preliminary data and probabilities (Juana's family history and skin type, visual features of the mole, etc.) in order to hypothesize about diagnoses. When I asked pathologists about the diagnostic protocols that help them identify cancer in their daily practice, their explanations often boiled down to the importance of knowing how to see and formulate the right questions.

By "right questions," I mean the hypothesis-driven modes of inquiry that test probable answers in controlled experiments. When formulated, these questions are expected to match tentative answers. In other words, specific ways of seeing set the conditions for different ways of arranging biostatistical data and probabilities

and produce different diagnoses and interpretations (Bowker and Star 2000; Saunders 2008; Roberts and Sanz 2018). Scientific representation, after all, hinges on modes of intervention, Ian Hacking (1983) notes. For example, one cannot simply look under the microscope and see cellular patterns. A microscopist must intervene directly in the optical system by applying dyes, for instance. And the image changes as the microscopist manipulates the material on the slide. Thus, the rules and practices of a given methodology serve not only to describe but also to *enact* the reality that they seek to understand (Mol 2002; Law 2004).

Yet medical practice, ways of seeing and asking questions, are not the only elements that enact a diagnosis. Juana's prepaid insurance also paved the way for her melanoma. By reducing the bureaucratic procedures and waiting times, for instance, prepaid patients like her get prompt access to treatments and drugs and more tests, which lead to answers and new series of tests. This acceleration may encourage doctors to prefer certain diagnoses over others—or to come across cellular structures that look like cancer (Welch 2006). Thus, the ethics of “playing it safe” becomes a common rationale at this intersection of high-end hospitals and prepaid insurance regimes. It shapes how physicians “see” biopsies and ask questions. Juana's case shows that there is no separation between clinical facts and socioeconomic status, on the one hand, and ways of seeing, on the other. These seemingly different domains of practice emerge together as doctors cared for Juana and observed her skin tissue under microscopes and through goggles.

THE FIRST BIOPSY

As Dr. Rayo cut through the skin, blood flowed down Juana's eyebrows. Gently he grabbed gauze and dried it. Using a pincer, the doctor took a tiny skin sample and placed it inside a small glass container filled with alcohol. The surgical wound was then closed with three stitches, and the skin tissue was sent to his pathology laboratory for microscopic examination.

For the medical world in general, pathology is a subfield that studies and provides diagnoses through examination of whole bodies or surgically removed organs and tissues. In the latter case, pathologists who specialize in cancer observe the tissue's cellular pattern under the microscope and determine whether it is malignant. To do so, they typically follow cell morphology criteria. In other words, pathologists compare what they see under the microscope with biomedical descriptions of normalcy. As Gilbert Welch explains in his book *Should I Get Tested for Cancer?* (2006), the likelihood of cells being cancerous increases when they deviate from these descriptions. Furthermore, cells that exhibit a greater variation in size and shape are more prone to be cancerous. And the higher the number of these cells undergoing division, the greater the chances they are cancer. Pathology is, after all, considered the gold standard for providing cancer diagnoses. It is expected to *black box* cancer. Drawing on Latour (1987), a black box represents knowledge

or categories that have become stable. A black box, hence, transforms a cloud of data and mere probabilities into facts—the basis for future theories. In a similar way, pathologists black box data and preliminary observations, setting the basis for future treatments and prognosis too.

A week later, Juana and I returned to Dr. Rayo's office. Dr. Rayo sat down and explained the diagnosis to us: "It wasn't easy to come to a final decision; we had several disagreements along the way. Half of my colleagues thought your lesion is merely a dysplastic nevus. The other half, however, prefer to see it as a melanoma."

The physician paused for a few seconds.

"Let me clarify my point. Given your family history and your skin type, I think it's better to play it safe and go with the cancer diagnosis. It's always advisable to think about the future and prepare for the worst-case scenario. The good news, however, is that we haven't found conclusive evidence to confirm a metastasis, yet we still need to conduct further studies. I will refer you to a surgeon oncologist, who can excise your lesion and assess whether your lymphatic nodules have been compromised."

The doctor paused for a moment. Disconcerted, Juana and I looked at each other.

"I am aware you might need time to digest the news," the physician went on to say. "But we should move forward with the plan. A prompt intervention guarantees a much better prognosis."

Dr. Rayo and colleagues had agreed that the tissue's cellular structure looked atypical under the microscope. However, there was a "tie" between physicians who cast their votes in favor of a melanoma and those who did so for a dysplastic nevus; each condition had a similar occurrence probability, and both were more or less equally possible. Yet how could cancer and noncancer coexist in the same tissue? Doctors would need to pick just one option.

Under conditions of uncertainty, pathologists often need extra confidence to "tip the diagnostic balance." In his article "Making Moves in a Cardiac ICU" (2020b), Scott Stonington uses "tipping the balance" to describe the process by which physicians reach a state of self-confidence that allows them to make initial moves at a busy hospital. This state of self-confidence, he observes, is often reached by considering any new information that has become available. In the case of Juana, this information is represented by her type of insurance, light skin, and family history of skin cancer. It allowed pathologists to feel confident about tipping the diagnostic balance. Dr. Rayo, the senior pathologist, would be the person in charge of tipping the balance. He would treat the lesion as if it was a melanoma—as if it was cancer.

This is the moment when the creation of equivalences or similitudes acquires a central role in my argument and in Juana's story. In *The Order of Things* (1994), Foucault introduces sympathy as one of the four "similitudes" that shaped the logics of representation in the classical period. According to him, sympathy "has the

dangerous power of *assimilating*, of rendering things identical to one another, of mingling them, of causing their individuality to disappear—and thus of rendering them foreign to what they were before” (26). Sympathy transforms and creates. In Juana’s case, for instance, assimilating a dysplastic nevus with a melanoma transformed her “atypical” cellular structures into malignant ones. By rendering them equivalent, Dr. Rayo pledged to play it safe and exported the atypical cells into the terrain of cancer. According to this logic, if a mole looks like a melanoma, then it must be cancer and should be treated like cancer. The clinical protocol for treating an early-stage skin melanoma tends to be clearly defined: conduct biopsy; excise tumor, including tissue beyond its margins; scrape bone; check for the nearest ganglions and excise. In this context, doctors, who do not want to be held responsible for failing to prevent a death, prefer to tip the balance toward cancer and be cautious, to err on the safe side.

In the prepaid insurance world, however, this rationale encourages preventive testing for particular cancers, and there is often a strong incentive to overdiagnose. Some of these efforts are undoubtedly motivated by the best intentions (see Jain 2013), believing that testing for early cancer is in the patient’s best interest rather than waiting until it is too late. Recall that melanomas are often asymptomatic until they metastasize. When in doubt, therefore, treating a suspicious mole *like* a melanoma makes sense in terms of biomedicine’s goal to cure patients or extend their lives (Kaufman 2005).

Dr. Rayo typed a referral note for the surgeon and attached a copy of the biopsy report.

Diagnosis: Melanoma.

Consider doing a radical excision of entire lesion.

Extension studies needed to confirm possible metastasis.

The physician erred emotionally on the diagnosis, the medical fact. He knew that a sense of urgency, and anticipation, needed to be instilled in Juana. And because her melanoma would require a rather large-scale intervention, she was immediately referred to a surgeon oncologist.

Wouldn’t worrying too much about what may matter in the future distract doctors from what matters now?

THE SURGEON ONCOLOGIST (SAME DAY, AFTERNOON)

Using goggles, the doctor looked at the melanoma and, with a ruler, took measurements. His job as a surgeon would be to choose the most radical yet least disfiguring surgical procedure possible. The focus of medical attention had now officially shifted into the realm of cancer. After all, her diagnosis had been successfully black boxed. At this point physicians would rarely look back. Black boxed categories

become so accepted that they become invisible, and only pop into focus again when an outsider questions them (Bowker and Star 2000).⁶

"Have you noticed changes in your eating habits? Any nausea or sudden weight loss? Is there anything in particular you want to share with me?" asked the surgeon.

"Not really," Juana replied.

"Could you please move your head down? I will check your posterior ganglions." The surgeon palpated her neck, then the area between her jaw and ears.

"Could you stand up?" He palpated her armpits and breasts. "I just want to make sure there are no ganglions or suspicious lumps anywhere in your body."

He then explained his plan. "I would excise the whole lesion, and include a margin of 1 centimeter beyond its contour. If the dimensions of the lesion are currently 2.5/1.5 centimeter, I will need to cut almost a centimeter beyond them. The incision might end up being approximately 3.5/2.5 centimeters. And I would also have to scrape the bone tissue itself to make sure no traces of melanoma are left behind. Then, depending on the biopsy report, we would know for sure whether you are a good candidate for ganglionic emptying."

The doctor grabbed a sheet of paper and provided Juana with what looked like a quote. "Let's see. For excising a melanoma like yours I usually charge 1,500,000 pesos [US\$750] plus 600,000 [US\$300] for my anesthesiologist and 400,000 [US\$200] for my assistant. In total, everything adds up to 2,500,000 [US\$1,250]. Needless to say, this amount does not include the hospital fees and supplies." Because Juana would pay out of pocket, she needed to get an accurate quote of all the costs involved. The care of explaining the surgery to her goes with the care of explaining the cost. Melanomas, skin measurements, and ganglions emerge together with hospital fees, anthropologists' palancas, physicians' honorariums, and insurance reimbursement policies.

The surgeon grabbed another sheet of paper and sketched something that looked like a facial silhouette—Juana's face. He used it to explain the surgical procedure.

"Excising your melanoma would leave a large scar on your forehead." He then colored an upper area in his drawing. "I would need to pull as much skin as possible from your forehead and your scalp in order to close the wound and put some stitches. The problem is that there is not much skin I can pull without disfiguring the left part of your face. If I pull skin from your forehead, your left eyebrow would inevitably move up, and your eyelids too. And you wouldn't be able to close your left eye for several months until the skin regains elasticity." Using his finger, the physician pointed to Juana's scalp. "Pulling skin from the scalp is even harder." There was a deep silence in the office. Juana and I were staring at the physician's drawing.

He continued, "I need to be assisted by a plastic surgeon during the procedure." He stood up and grabbed Juana's forehead. "The plastic surgeon would pull

here, take a bit from down there, push on this side, and move your scalp a bit, if necessary. Do you see what I mean?"

This sort of professional collaboration is feasible in the world of private insurance. As long as Juana can pay out of pocket and is willing to discuss her finances with physicians, there are virtually no obstacles between her skin lesion and physicians' scalpels, and no waiting in line or wasting time with the insurance bureaucracy. By contrast, the insurance companies for the working class and poor would rarely authorize such intervention. Plastic surgery, after all, is often considered an ancillary and luxurious medical procedure.

THE PLASTIC SURGEON

The clinical focus now shifted from the realm of cancer into the world of aesthetics. "I can definitely do it," said the surgeon. "However, I would need to get a flap of skin from your thighs or buttocks to cover the hole after the excision is done. I guarantee the scar will heal nicely, though," he added.

Apart from the technicalities of the procedure, a detailed account of the financial costs was required. "How much would that procedure cost?" Juana asked, yet immediately felt compelled to clarify her question: "I am asking because I have a reimbursement policy. I would pay in cash for the surgical procedure and then wait until my insurance pays me back." "Okay, I see," the physician said, while opening a drawer. He grabbed a sheet of paper and did some math calculations. "Just working on your forehead, I charge 2,500,000 [US\$1,250], and my anesthesiologist's rate is 700,000 [US\$350]. That means the total cost for the plastic surgery would be 3,200,000 [US\$1,600], without including hospital fees and materials."

This simultaneous care of explaining the money and treating her body had now reached a tipping point for Juana. Only fifteen days had passed since we first visited Dr. Rayo, yet four more doctors had rapidly joined: one oncologist, two dermatologists, and one plastic surgeon.

The more tests required and the larger the number of doctors who became enrolled in her case, the higher the chances for disagreements and for recognizing diagnoses that may seem to cancel each other out. I must acknowledge the role I played in her diagnosis and how my own plan for accelerating the pace of medical services had pushed Juana into a confusing whirlpool of anticipation and multiple physicians doing "good." Her interaction with the insurance company was limited to a few phone calls and emails during these hectic weeks. Her biopsies and examinations were conveniently authorized over the phone; Juana had no need to stand in line or wait at the insurance office—unlike the majority of Colombians (Abadía and Oviedo 2009). What would she do? In what follows I describe the physicians'

different ethical grounds that allowed her melanoma and benign mole to become phantomatic diagnoses.

DYSPLASTIC NEVUS: A SECOND DIAGNOSIS, A SECOND PALANCA

Juana had decided to seek advice from a cousin, who happens to be a renowned rheumatologist in the country. Her cousin reacted with surprise after listening to her convoluted story and introduced her to a different group of dermatologists and pathologists at Valle del Lili hospital, another private medical setting. It was clear to him that a second look at her skin would be necessary before moving any further with the medical plans. The following is a short excerpt from that conversation.

“First of all, please calm down,” said Juana’s cousin. “Was it really necessary to visit all these doctors in such a short period? In medicine, I believe, it is important to keep things as simple as possible, especially when our health care system has been designed to follow the money, not the patients. You have to stop this chaotic chain reaction and get a second opinion about your lesion ASAP! You need a physician who has not been involved in your case, an outsider, a doctor who can see things from a different perspective. Here’s the phone number of a dermatologist I know personally. Her name is Dr. Prudencia. Tell her that we are cousins.”

Juana felt optimistic. She was being guided by someone who is not only a medical expert but also a close relative. This relationship became a *palanca* because it would allow her to immediately connect to a different group of physicians. Doctors like to help other doctors, after all, especially when they know each other and have worked together in the past. As a result, new relationships with dermatologists, pathologists, and the time of treatments were being established, which would be less defined by money and health insurance reimbursement policies than by family ties and professional links of trust.⁷

The appointment with Dr. Prudencia was scheduled in no time. The day of her visit, Juana brought a complete copy of the clinical history, exams, and plans for intervention. The physician, however, did not bother looking at any of these. “If a second opinion is needed I won’t really need to get bogged down with the details. Rather, I would need to start from scratch and send the tissue to our lab.”

The dermatologist immediately focused her attention on Juana’s forehead. Without using magnifying goggles, she looked at it, rubbed her index finger against it, and, after a long silence, shared some preliminary thoughts.

“At first sight it does not look like a melanoma. To make sure, however, we need a biopsy. Then we will go from there. Are you okay if I take another sample of tissue right now?” asked Dr. Prudencia.

At this point, her question sounded like a mere formality. We all knew what needed to be done. After all, Juana was really hoping her skin would get a second chance.

"Yes, please do so," Juana replied.

"Great. Could you please sit down on the trolley?" Dr. Prudencia put on dermatological goggles and latex gloves. "I will clean the area and inject some local anesthetic before excising a small chunk of your lesion."

Taking a second skin sample from her forehead took a few minutes. When he was finished,⁸ Dr. Prudencia said with evident enthusiasm, "The roots of the mole seemed quite superficial, and that's a great sign. But let's wait for the biopsy report. If pathologists conclude the skin sample is merely a benign lesion, you wouldn't need further treatment. If, on the contrary, the melanoma diagnosis gets confirmed, I would just reopen the wound, widen the surgical area and excise any cancerous tissue that may have been left behind. But I wouldn't need a plastic surgeon to do that!"

Dr. Prudencia had chosen to give Juana's forehead the benefit of the doubt and revise the initial diagnosis. By doing so, she would avoid the trap of "diagnostic anchoring," that is, "believing one's own or someone else's prior diagnosis too strongly and thus failing to re-write the past as new information becomes available" (Stonington 2020b, 14–15).

This act of revision could also be understood in terms of Stengers's *Idiot* (2005a). The figure of the *Idiot* represents someone who resists the consensual way in which a particular situation is presented. In clinical encounters and phantomatic diagnoses like the ones described in this chapter, the *Idiot* would demand that we slow the pace of medical care, "that we don't consider ourselves authorized to believe we possess the meaning of what we know" (Stengers 2005a, 995). Thus, Dr. Prudencia set loose previous clinical definitions, allowing other possibilities—other ontologies—to exist.

She placed the skin tissue inside a small glass container and sent it to the pathology lab downstairs. This time I followed behind. The sample was a black chunk of skin, the size of a kidney bean, with traces of pink flesh and blood. My partner's name was written on it: "Mrs. Juana; September 10, 2012." Next to it there was a brief description of the sample: "Skin tissue taken from forehead and scalp." On separate hospital letterhead the dermatologist attached the following request for pathologists: "Assess and compare melanoma vs. dysplastic nevus." This particular request, as explained earlier, was intended to guide or "move" physicians' cognitive process, assisting them in narrowing down the field of diagnostic possibilities and making them attentive to specific cellular structures and not others (Prentice 2013).

A technician placed the container on a plastic tray, along with other samples. "Are you Camilo?" she asked. I nodded. "Please follow me." After last-minute phone calls to the lab manager and multiple explanations about my research, I had finally managed to get access to the lab where pathologists would study my partner's skin tissue.

"Please put these on," the technician said, handing me a pair of latex gloves and a surgical mask. She scanned the labels attached to each of the containers on the tray and distributed them to the different units in the lab.

Juana's mole was being taken to the histopathology unit, where solid tissues removed from bodies are studied at the microscopic level. There the container was once again scanned and immediately assigned a numerical code. An hour later and according to lab protocols, it was taken out of the container by a different technician and sliced thinly, placed on slides, and stained with dyes before it could be examined by pathologists. I sat on a metal bench and waited two more hours.

Finally, I greeted the senior pathologist, who introduced me to three of his students and one dermatology resident. Following our brief introductions, they immediately gathered around the microscope and zoomed in to Juana's tissue. I was about to observe both the construction of facts and new scientists (Traweek 1992; Myers 2015). After each of the students had taken several turns looking through the microscope, they sketched their observations on sheets of paper. The senior pathologist silently observed. Meanwhile I leaned toward the table and saw geometric figures of some sort. The following is a short excerpt of their conversation.

Student 1: "There is surely a pronounced dysplasia. The structure is indeed atypical."

Resident: "See the cytological architecture? There is an isolated proliferation of melanocytes. They are located somewhere here [points with his finger] in the nest, next to the basal area. Some cells have scarce cytoplasm. But they are quite large."

Student 2: "How big?"

Resident: "Large enough. They may even have elongated hyper chromatic nuclei. At first sight you won't see this elongation, though. You need to look carefully."

The senior pathologist pulled over a metal stool and sat down. He looked through the microscope, observed one of the drawings, and immediately commented, "This representation shows a high degree of atypia. Don't forget that there is also a lamellar fibroplasia close to the papillary dermis."

After a considerably longer discussion, the senior pathologist knew it was time to make a decision based on the two diagnostic possibilities provided by Dr. Prudencia.

"Should we classify this lesion as a melanoma or dysplastic nevus?"

Student 1: "I have the strong feeling this specimen is merely a dysplastic nevus."

The senior pathologist responded, "But tell us why you wouldn't consider it a melanoma."

Student 1: "Even though there is a high degree of dysplasia, the type of cellular architecture does not entirely match what you would expect to see in a melanoma."

"Is that all?" the senior pathologist asked with evident impatience. "We have already talked about the cellular architecture, right? What have we learned about rapidly growing cells like the ones you may find in melanomas?"

Student 3: "That they may quickly spread beyond their initial site."

Senior pathologist: "That is right. It means you need to pay close attention to the margins. Now take a look under the microscope. Zoom out a bit, if necessary! Can you see? Can you find evidence of atypia beyond its margins?" He

immediately answered his own question: “Not at all! The neighboring tissue looks quite normal.”

In this teaching interaction, both the senior pathologist and the resident were training the students in proper ways of reasoning and seeing so they would be able to “recognize” cancer under the microscope. The senior doctor had them look several times at the sample and sketch the structures they saw. Graphic renderings and repetitions are often crucial for this type of learning. And it is through a repetitive sequence of observations, bodily postures, sketchings, and discussions that a particular cellular architecture came to be recognized and effected by pathologists.

The senior pathologist typed in the computer: “Dysplastic nevus, thoroughly excised.”⁹ A revised diagnosis had now been provided, and according to it, Juana would not require further treatment; the cells once labeled “cancerous” were now being considered “normal”—yet atypical-looking. This new diagnosis, however, seemed to be in stark opposition to the melanoma enacted by Dr. Rayo. Juana and I were confused. The doctors were having difficulties labeling what they saw under the microscope. Whom should Juana follow? In cancer there is not always a clear answer; it all depends. Despite the seeming differences, Dr. Rayo and Dr. Prudencia were both sincerely concerned about my partner and did their best to care for her. Their notions of “good care,” however, were not homogeneous. Being a “good” doctor, after all, is not a static matter (Kleinman 2006). What does it mean for Colombian physicians to “do good” in the context of cancer and prepaid insurance?

. . .

I conclude this chapter with a brief discussion about the ethical pluralism that emerges when health care providers and caregivers enact what they consider the “best good” (Kleinman 2006; Mattingly 2014). In her book *Moral Laboratories*, Cheryl Mattingly writes about the daily life of children with cerebral palsy and their parents in Los Angeles. She describes how the parents often found themselves propelled into complex reasoning tasks shaped by ethical deliberations, evaluations, and experiments as they strived to create the best life possible for their children.

As parents move through nonhomogeneous spaces (schools, parks, churches, clinics, soccer fields), “they navigate multiple moral activities and authorities, including ones that clash with their own sense of a ‘good life’ for their children and for their families” (Mattingly 2014, 8). The decisions they may make at a school, for instance, may be in conflict with what they choose to do (or not) at a soccer field. Ethical pluralism, after all, is what characterizes ordinary life.

In the clinical context described in this chapter, ethical pluralism helps us analyze how two groups of physicians enacted phantomatic diagnoses. From the very beginning, Dr. Prudencia and Dr. Rayo had their own expectations about Juana’s skin; each of them had their own understandings of “good care.” Their ideas, therefore, shaped what was possible to see at examination rooms and under

microscopes. When Dr. Prudencia sent Juana's tissue to the lab, for instance, a special note was attached to the container: "Assess melanoma vs. dysplastic nevus." A black box was being reopened. This note sought to narrow the diagnostic possibilities and guide pathologists' vision. Dr. Prudencia had been in charge of looking for an alternative to the melanoma diagnosis. Surprised by Juana's therapeutic journey, Dr. Prudencia accepted the challenge of seeing with fresh eyes. Her notion of "good care" was about questioning a diagnosis and slowing the pace of medical interventions. In this context, being a "good" doctor may be about "waiting and seeing," limiting aggressive and disfiguring interventions.

In the case of Dr. Rayo, however, his motivations for "seeing" and practicing medicine seemed to be informed by the drive to move faster and anticipate cancer. And he did not want to be held responsible for failing to act "on time." He constantly emphasized the importance of excising the alleged melanoma before it metastasized beyond Juana's forehead. Once it undergoes metastasis, he had explained, the chances for curing her would be nil. He was just being honest, though. And since he was playing the double role of dermatologist and pathologist, his own expectations about the melanoma were immediately transferred from the examination room into the biopsy report—black boxing his naked eye suspicions. This allowed him to "do good" by speeding up the pace of treatments, enrolling other physicians in the process, and choosing aggressive and invasive interventions to kill a growing cancer. In the context of cancers, sometimes it makes sense to excise several centimeters beyond the lesion's margins, scrape bone tissue, and even do a ganglionic emptying—just in case, just to play it safe.

In choosing to play it safe and diagnose a melanoma, prepaid insurance and boutique service allowed Dr. Rayo to bypass burdensome bureaucratic requirements and get immediate access to treatments and drugs. For doctors like him, being a good doctor could mean staying ahead and acting in the flow of time (see Stonington 2020b). Under these conditions, therefore, "doing good" becomes a matter of staying in motion and making decisions—even when clinicians must guess and speculate about the future. This ethical rationale in the context of cancer may often be translated as the need to look more to find more (Dumit 2012). Yet looking more thoroughly may increase the chances of disagreements and unnecessary interventions, allowing *what* emerges to be cancer but not only.

Ten years later after her incident, Juana remains as healthy as she was then and aligned with the conditions of possibility presented to her by the second biopsy and benign diagnosis. The multiple encounters with physicians at the intersection of a private hospital and prepaid health insurance (largely unleashed by the anthropologist who writes these lines), transformed her and the ways in which she would interact with destiny-making technologies like biopsies. As Alice Rivières (2021, 29) has noted regarding her testing for Huntington's disease, "Revelation does not inform you. Quite the contrary: it transforms you. It can either make you sick or make you better: it all depends on what you do with it."

With neoliberal medical reforms in my home country as background, this chapter sought to discuss the ontological indeterminacy of cancer and its relation to a patient who paid for the treatment—not without effort. Inspired by my friend Sebastian’s words and my partner’s therapeutic journey, I analyzed how medical practices and ways of seeing bodies entered into physicians’ understandings of “doing good,” the prepaid health insurance regime, socioeconomic conditions, and *palancas*. Thus, I wrote about how *how* physicians saw was not unrelated to *what* they saw and therefore to their practices of medicine in neoliberal Colombia.

In the next chapter, I return to HUV, where I conducted the bulk of my fieldwork, and focus on the pharmaceutical market for chemotherapy drugs. I discuss the ethical conundrums navigated by oncologists as they are caught between the mandate to prescribe generics, which often are scarce, and the abundance of branded, overpriced bioequivalents.