



## Breast Cancer: A Cultural History

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### 12<sup>th</sup> December 2023

In September 1971, *Ebony* magazine published an article that broke a major taboo: a survivor of breast cancer wrote candidly about her diagnosis, undergoing a radical mastectomy, and her journey of recovery afterwards. As the leading magazine for African American communities, it was an extraordinary article due to the way it addressed Black women's experiences of breast cancer at a time when cancer charities and professional medical organisations were almost exclusively white.

The title of the article stated that 'I Was a Cancer Coward', and was authored by 66-year-old Era Bell Thompson, an editor at *Ebony*. She was scathing about physicians who were reluctant to tell their patients that they had breast cancer. She noted that some doctors even admitted to telling patients 'deliberate medical mumbo-jumbo'. Others broke the news not to their female patients but their *husbands*. One husband who was told of the diagnosis responded by shouting, 'You're not going to cut up my wife!' The preferences of the women themselves were too often ignored.

Clearly, physicians were 'cancer cowards', but this moniker was not theirs exclusively. The 'Cancer Coward' in the title of her article was Thompson herself. She admitted that her overwhelming emotion when she was diagnosed with breast cancer was shame. She felt 'unclean, guilty of some unknown sin'. She furtively booked herself into the surgical ward of a hospital, taking pains to ensure that she 'would not be recognized' and hanging a 'no visitors' sign outside her hospital door.

Thompson's article was unique for the time, not only because of her willingness to speak openly about her emotional responses to breast cancer and radical mastectomy. She was also sensitive to questions of gender and sexuality. Unusually, she wrote about African American *men* who had been diagnosed with breast cancer. In defiance of the stigma attached to male breast cancer sufferers – due to the fact that the disease is sometimes seen as effeminizing – she even publishing their names and photographs.

Sexuality also haunts her article. Thompson's account of surviving breast cancer is preoccupied by heteronormative concerns about sex. She spoke to numerous other Black women who had been diagnosed with breast cancer and, as a result, claimed that one of their central anxieties was whether a mastectomy would make them 'less sexually attractive to men'. This anxiety was often followed by 'What will she tell her children?' In a revealing passage, Thompson described how women who had a breast removed would 'religiously wear a padded bra around the house'. Thompson then described how a 'small son of one mastectomee' (a term that was commonly used at the time, alongside other harsh words such as 'amputee') had 'looked over the shoulder of his dad who was reading *Playboy*' and 'pointing to a covey of voluptuous Bunnies', cried out 'Look!.... They've got two!' The anecdote was intended as a bit of light-hearted relief for readers, rather than as a critique of heteronormative standards of female beauty or male consumption of pornography. Thompson's intellectual vision did not extend to sexual or gender minorities.

However, Thompson's 1971 confessional account of breast cancer and mastectomy did break a taboo relating to that constructed category of 'race'. It is the earliest examples of a woman of colour speaking in a very public forum about breast cancer. Historians have uniformly given this accolade to singer Minnie Riperton, who was diagnosed with breast cancer in 1977 and, in the two years before her death, was the public face of the disease. [See You Tube video <https://www.youtube.com/watch?v=QGWLjRcGTOY>]. The attention paid to musical star Riperton (who died at the peak of her career, aged only 31) rather than *Ebony* editor Thompson (66 years of age when she published her article and she lived to the age of 81 years) is a

reminder of the politics of voice. Thompson distinctive writing style was appreciated by readers of *Ebony*, who were almost exclusively people of colour. Riperton's voice was that of a singer at the top of the pop charts. Indeed, many of her listeners were not even aware that she was Black, since her musical genius did not lie with soul and blues – thought to be 'Black' genres. It is Riperton's voice, not Thompson's, that has echoed through time.

But let us now take a little detour, before returning to the politics of 'race', gender, sexuality, and voice. Why should we be interested in the cultural history of breast cancer? The most obvious answer is that it inflicts one in eight American and British women over their lifetime. Breast cancer takes a great many forms: it can be located in the ducts or lobules; be invasive or non-invasive; detected early or at a late stage; and responds very differently depending on a patient's age and menopausal status. The ancient Egyptians certainly knew about it: eight of the 48 cases described in the 'Edwin Smith Surgical Papyrus', written around 3000 BC, are related to breast tumours or ulcers. This unknown surgeon contended that there were no treatments for this affliction. The 'crab' – cancer's etymological root is *karkinos*, or the claws of a consuming crustacean – has always excited fear. In the words of Pierre Dionis in *A Course of Chirurgical Operations, Demonstrated in the Royal Garden at Paris* (1710), 'though Wars and Plagues kill in less time, they don't yet, to me, seem so cruel as the Cancer, which as certainly, though more slowly, carries those afflicted with it to the Grave, withal causing such Pains as make them every day wish for Death'.

The question that all these physicians asked was: what caused this affliction? Well into the eighteenth century, the views of ancient Greek and Roman physicians and philosophers Hippocrates and Galen were influential. Their views cannot be understood without knowledge of humoral theory, which continued to hold sway up until the nineteenth century. The humoral body consisted of four fluids—phlegm, black bile, yellow bile, and blood. Disease was the result of disequilibrium or imbalance. In the context of breast cancer, Galen concluded that cancer was caused by an excess of black bile or melancholy. This was why women were so susceptible to the disease: their cold, moist bodies made them vulnerable because their bodies were prone to 'soak up' bad humours. Excessive black bile was normally flushed out of women's during menstruation, explaining why vulnerability to breast cancer increased after menopause. As *The Compleat Midwife's Practice* explained in 1698,

*"The Canker proceeds from a feculent and gross humour, which being gathered together in the spleen, is chased away from thence after it grows too hot; which when Nature cannot void, it most commonly in Women empties it self upon the Breasts, by reason of their cavernous and spongy nature: the matter of it is a hot melancholy blood, and it is known by the crooked windings, and retored [sic] veins that are about it, stretching out long roots a good way from it, being sometimes blackish, and sometimes inclined to black and blue."*

Although surgery was an option (mastectomy was mentioned by Aetios as early as the sixth century), it was exceptionally hazardous at the time, not only because of infection and shock (both of which were common in a period prior to anaesthetics and anti-septic agents) but also because many surgeons believed that cutting into a tumour risked spreading the disease. This was why Dionis reminded his readers of Hippocrates's warning that 'Cancers are not to be touch'd, for in touching them... you aggravate the Evil, and hastened the Death of the Patient'. Instead of surgery, specific plants that were believed to expel the humour 'melancholy' were recommended. The body could also be purged using poisons and other purgatives. Bloodletting was recommended; strong or salty foods, wine, and 'hot' foods, shunned. Because eighteenth-century physicians (literally) believed that cancer was a sentient being – wolves or worms, for example – one treatment was to 'feed' the internal beast. Dionis's *Course of Chirurgical Operations* provides a good example of this view. In his words,

*"Some believe, that the ulcerated Cancer is nothing else but a prodigious Multitude of small Worms, which by little and little devour all the Flesh of the Part: What made room for this Opinion, is, that with the Microscope we have sometimes discerned some of those Insects in Cancers."*

Consequently, he continued, 'putting a bit of Veal on the Ulcer' will result in the patient feeling 'less Pain; because, say they, these Worms then feeding on the Veal, leave the Patient at Rest for sometime'. Dionis was less convinced. Like other physicians, he debated whether breast cancer was contagious or hereditary. What were the causal factors? Menopause, hysteria, breastfeeding, and 'barrenness' were all suspected. While physicians might turn to the use of mercury, carbonic acid, and (later) electricity, women themselves often shared unorthodox recipes, some of which included poisonous chemicals.

In the nineteenth century, a major shift occurred when constitutional explanations for cancer gave way to more localized ones. When physicians increasingly understood cancer not as a disease of the entire body

(for example, an imbalance of humours or physiological disruptions caused by menopause) but confined to particular organs, then excising those organs through surgery became more attractive as a cure. Surgery had also been made safer by the development of antibiotics to prevent post-surgical infections, combined with the increased safety of blood transfusions, especially after 1900 when Austrian physician Karl Landsteiner discovered the first three human blood groups, A, B, and C (O). Surgeons themselves were keen to promote their discipline and raise their status: promoting surgical operations was a means to a (profitable) end.

The most influential proponent of surgery for breast cancer was William Stewart Halsted, based at the Johns Hopkins University. Today, his late-nineteenth century operation for breast cancer sufferers is known as the 'radical mastectomy' because it involved removing not only the breast itself but axillary lymph nodes and the pectoral muscles (both major and minor) behind the breast. The removal of such a large amount of tissue was explained by his belief (held, as I mentioned earlier, by ancient physician Hippocrates) that when cancerous tissue was cut, it released cancerous cells into the rest of the body, thus causing the cancer to spread. This was also the rationale for his promotion of 'one-step' surgery under Halsted's operation: that is, a woman would be anesthetised, a biopsy taken and tested and, if it proved cancerous, then the mastectomy would take place before the patient woke up. In other words, women would not know *in advance* if they were going to wake up from surgery with or without a breast. Radical mastectomy and 'one-step' procedures were dominant for eighty years, even into the early 1980s.

Much critical ink has been spilt about the physiological and emotional costs of radical mastectomies and 'one-step' surgery. The keenness with which some surgeons wielded the knife against women's breasts (especially the breasts of older women) has been widely condemned. Often cited is surgeon George T. Pack's 1951 statement that surgeons had a *duty* to 'divorce the patient from his [sic] cancer' and should be constrained 'solely by the ability of the human remnant to survive'. Pack was known as 'Mack the Knife'. For many surgeons, even at the time, this was nothing short of 'humanectomy'.

Why did an operation that left millions of women barely able to comb their own hair continue to be performed for so longer? Halsted's personal influence played a role: he had the institutional backing of the prestigious Johns Hopkins University and was responsible for the most important surgical training courses in the U.S. In *The Breast Cancer Wars* (2001), historian Barron. H. Lerner also points out that Halsted was less than fully transparent about the operation's survival rates. At the very least, Halsted's definition of 'cure' was broad: it meant survival for only three years after diagnosis. The ideological milieu of the time was another factor. The radical procedure was consistent with the militarism unleashed by the two world wars and then the Cold War. In the U.S., the power of the insurance industry meant that surgeons were often too timid to attempt fewer radical procedures, fearing that they might be sued if a more minimalist operation resulted in a recurrence of the disease. It was financially advantageous to engage in invasive procedures.

From the 1970s and 1980s, however, the radical mastectomy came under sustained attack, led by surgeons George Crile Jr. and Bernard Fisher, but also by patients, feminists, and activist campaigners. Fisher carried out randomized controlled trials, which enabled him to prove that lumpectomy, in combination with radiotherapy, chemotherapy, and/or hormonal treatments, were as effective as radical mastectomies. There was a move in surgery more widely towards employing 'minimally invasive' techniques – promoted most effectively by urologist John Wickham from the late 1980s.

However, the status of the radical mastectomy was most effectively countered by new social movements focusing on the rights of patients (the Patients' Association was started as early as 1963), the injustices of racial inequalities, and the political demands by women to be liberated from paternalistic healthcare practices. This was all helped by the fact that women started training in the surgical profession in larger numbers: they proved more sensitive to the needs of their female patients. Consumer protections and concerns about ethics also rose to the top of medical agendas. Like Thompson and Lorde, activist Rose Kushner came to public prominence by fighting to be allowed to disrupt the 'one-step' procedure. She is credited with igniting a huge debate about informed consent for patients undergoing surgery: they had a right to be told of all options. In Kushner's words, 'we women should be free, knowledgeable. And completely conscious when the times comes for a decision, so that we can make it for ourselves'. She added: 'our lives are at stake, not a surgeon's'.

It is hardly surprising to observe that a racist imaginary of 'race' was at the heart of these debates. Socially dominant medical professionals were white and shared the racist prejudices of their peers. This included beliefs that women of colour were not susceptible to breast cancer, because cancer was a 'disease of civilization'. The explanation was due to three racist dogmas: women of colour possessed more 'primitive'

bodies, were 'closer to nature', and were physiologically robust. While white women with breast cancer could be made into heroic figures, individual warriors waging a courageous war against the disease, Black women were thought not to possess a complex interior life worthy of noble warriors.

No-one has done more to help us understand this dynamic than historian Keith Wailoo. If there is only one book you should buy, read, and talk about in connection to these debates it is his *How Cancer Crossed the Color Line* (2011). In it, he explains that racist tenets included the belief that 'primitives and savages had neither the modern cancer-causing dangers to dodge, nor the inner capacity to address their new situation'. As we saw in the last lecture on polio, people of colour were assumed to be immune from diseases such as polio and breast cancer. Scientific racists insisted that the risk to Black bodies only increased when they migrated to northern cities, where they 'caught' cancer because their bodies were not adapted to urban lifestyles. Such prejudices were effectively challenged during the Civil Rights era, but knowledge that cancer was a racially democratic disease did not automatically translate into greater representation of people of colour in cancer literature or treatment regimes, let alone in mainstream activist movements and charity organisations. Talented editors like Thompson could write all they wanted in *Ebony* and Audre Lorde (whom I will say more shortly) could rail against racial injustices in her diaries, but breast cancer awareness remained conspicuously white, especially in the medical specialism of oncology. Of course, it was not unique in resting on racism foundations, despite its appearance of objectivity, statistical rigour, and carefully constructed hypotheses and empirical methodologies.

What makes this remarkable is the fact that it was obvious to anyone who thought about it that people of colour, the poor, and other minoritized groups have higher than average levels of breast cancer morbidity and mortality. All forms of cancer disproportionately affect the poor and disenfranchised, specifically because they tend to live in hazardous environments. Take, for example, 'cancer alleys' – towns such as Convent in Louisiana, home to petrochemical and industrial factors, populated mainly by African Americans and Latino/a. Cancer morbidity and mortality there is exceptionally high. Similarly, in Bayview Hunters Point in San Francisco, populated by predominantly non-white and severely impoverished residents, women are 87 per cent more likely to die of breast cancer than women living elsewhere in the city. Environmental pollutions are to blame, combined with the fact that residents' racialized identities and poverty means that they are more likely to be diagnosed with the disease at later stages, less likely to possess high quality medical insurance, and only have access to poorly-equipped clinics and hospitals.

No-one understood these inequities better than writer and civil rights activist Audre Lorde. For Lorde, oppression cannot be understood through concentrating on only one vector of identity. Intersectionality is crucial. One of the earliest expositions of this insight was the statement by the Boston-based Combahee River Collective, a Black feminist, lesbian group established in the 1974. In their defining statement, they declared themselves

*“actively committed to struggling against racial, sexual, heterosexual, and class oppression, and see as our particular task the development of integrated analysis and practice based upon the fact that the major systems of oppression are interlocking. The synthesis of these oppressions creates the conditions of our lives. As Black women[,] we see Black feminism as the logical political movement to combat the manifold and simultaneous oppressions that all women of color face.”*

In her influential article 'Demarginalizing the Intersection of Race and Sex' (1989), critical race theorist Kimberlé Crenshaw named this integrated analysis 'intersectionality'. She argued that it is not enough to simply add Black women to 'an already established analytical structure'. This is because 'the intersectional experience is greater than the sum of racism and sexism' so

*“any analysis that does not take intersectionality into account cannot sufficiently address the particular manner in which Black women are subordinated.”*

In other words, in order to understand inequities in illness acquisition and management, attention must be paid not simply to sex discrimination or racial prejudices, but the *compounding* effects of 'race', sex, gender, class, caste, religion, (dis)ability, age, generation, and so on.

In relation to breast cancer activism, this was Lorde's central insight. Her accounts of breast cancer – *The Cancer Journals* (published in 1980, after her 1978 mastectomy) and *A Burst of Light* (1988, after her cancer had metastasized to her liver) – remain classics. When she was first diagnosed with breast cancer, Lorde reflected on the middle-class, heterosexual, *whiteness* of nearly all commentary about the disease (I have no idea whether she had read Era Bell Thompson's 1971 reflections in *Ebony*, but she would probably not have been impressed by its heteronormativity). In her celebrated *Cancer Journals*, Lorde admitted that 'Off



and on I keep thinking. I have cancer. I'm a black lesbian feminist poet, how am I going to do this now? Where are the models for what I'm supposed to be in this situation? But there were none. That is it, Audre. You're on your own'. As Lorde states in her later book entitled *A Burst of Light* (1988), 'When I say I am a Black feminist, I mean I recognize that my power as well as my primary oppression comes as a result of my Blackness as well as my womanness, and therefore my struggles on both these fronts are inseparable'. Subjectivities are multiple, complex, and interwoven.

But Lorde did more than draw attention to the compounding injuries inflicted because of her intersectional identities. She also had powerful things to say about the privatisation of cancer – that is, the tendency to view it solely as a *personal* or *individual* trauma while ignoring the 'function of cancer in a profit economy'.

Lorde challenged her physicians, insisting that they take seriously her ownership over her own body. Her initial attack focussed on the 'one-step' process, which meant that the decision of whether or not to remove a woman's breast was taken by the physician while the patient was unconscious. In *A Burst of Light*, she complained that doctors were treating her 'resistance to their diagnosis as a personal affront. But it's my body and my life and the goddess knows I'm paying enough for all this, I ought to have a say'. She observed that medical power was further alienating women from their own bodies. She was particularly incensed by the American Cancer Society's 'Reach for Recovery' program, a representative of which encouraged her to pad out her bra with a wad of white lamb's wool. As she put it,

*"I came around my bed and stood in front of the mirror in my room, and stuffed the thing into the wrinkled folds of the right side of my bra where my right breast should have been. It perched on my chest askew, awkwardly inert and lifeless, and having nothing to do with any me I could possibly conceive of."*

She swore that 'Either I would love my body one-breasted now, or remain forever alien to myself'.

For Lorde, the cultural fetishization of the breast had negative effects for women who underwent mastectomies – and were an additional insult for women from minoritized communities because the 'ideal' breast was imagined as white. Lorde was defiant, stating that 'I refuse to hide my body simply because it might make a woman-phobic world more comfortable'. This was political statement as much as an aesthetic one. She contended that 'By accepting the mask of prosthesis, one-breasted women proclaim ourselves as insufficients dependent upon pretense'. The result was a reinforcement of women's 'isolation and invisibility from each other, as well as the false complacency of a society which would rather not face the results of its own insanities'. She observed that the 'socially sanctioned prosthesis is merely another way of keeping women with breast cancer silent and separate from each other'. Women are therefore made to feel responsible for their own illness. 'Women have been programmed to view our bodies only in terms of how they look and feel to others', she complained, adding that she had to 'consider what my body means to me'. Lorde acknowledged that this was not a problem unique to sufferers of breast cancer. Rape victims, too, were 'accused of enticing the rapist. The battered wife is accused of having angered her husband'. Like these forms of violence, 'a mastectomy is not a guilty act that must be hidden'.

Lorde has been criticised for sometimes framing her diagnosis in the context of a 'war against cancer'. When a nurse admonishes her for not wearing a prosthetic breast (the nurse informed her that appearing without a fake breast was 'bad for the morale of our office'), Lorde insisted that

*"When Moishe Dayan, the Prime Minister of Israel, stands up in front of parliament or on TV with an eyepatch over his empty eyesocket, nobody tells him to go get a glass eye, or that he is bad for the morale of the office. The world sees him as a warrior with an honorable wound..... well, women with breast cancer are warriors also. I have been to war, and still am...."*

However, she immediately politicised this 'war'. As she states:

*"For me, my scars are an honorable reminder that I may be a casualty in the cosmic war against radiation, animal fat, air pollution, McDonald's hamburgers and Red Dye No. 2, but the fight is still going on and I am still part of it."*

*She refused 'to be reduced in my own eyes or in the eyes of others from warrior to mere victim'."*

Part of the problem Lorde identified was the prioritization of aesthetics over health. She was offended by the assumption that 'you are as good as you were before because you can look exactly the same. Lambswool now, then a good prosthesis as soon as possible, and nobody'll ever know the difference'. This was abhorrent to Lorde, not only because of the assumption that beauty was dependent on looking two-breasted, but that the beauty being promoted was white or light-skin coloured. The intersectionality of Lorde's identities

compounded her oppression: 'race' (black); femininity (one-breasted); and sexuality (lesbian and queer).

Like Thompson and Riverton, Lorde's words are powerful reflections on illness, 'race', and harmful assumptions about women's bodies, femininity, and beauty. These women transformed the visibility of the disease amongst Black women and men – and encourage the acknowledgement that visibility is a political and ethical act – but *never enough*. More is needed: activism.

They were joined in their endeavours by the explosion of pathologies (illness narratives) and autobiographies written by breast cancer survivors. These included the memoir written by Betty Rollin, whose *First, You Cry* (1976) embraced a 'feminist bile', and Rose Kushner whose *Breast Cancer: A Personal History and an Investigative Report* (1975) railed bitterly against the 'malevolent... male-dominated medical profession'. In later years, it includes Eve Kosofsky Sedgwick, author of 'White Glasses' (1999), and Barbara Ehrenreich, author of 'Welcome to Cancerland' (2001). These writers insisted that breasts and breast cancer were political issues. They castigated political and medical elites for ignoring the ways that women's bodies were being poisoned by corporate interests that contaminated the environment, added toxins to food and drink, and created industrial waste. They also critiqued the 'cancer industry', which reaps huge profits from women's suffering. Together, they attacked what Lorde dubbed 'Cancer Inc.', or the Corporate Cancer Industry.

The works of such writers are in stark contrast to the highly individualised accounts of breast cancer that have emerged in more recent decades. This genre assumes that women are living in a post-feminist world, where consumer choices related to their breast cancer diagnosis are part of their liberation. In these pathographies, breast cancer is tightly linked to beauty and fashion industries. A fairly typical example includes Geralyn Lucas' *Why I Wore Lipstick to my Mastectomy* (2004) which encourages readers to also perform this 'act of courage': that is, wearing red lipstick to their mastectomy. In some editions, Lucas asks 'Isn't attitude everything?' on the front cover and words like 'guts' appear on the back cover. For those of you who have followed my lectures, in the one of polio, I also discuss 'guts' and the importance of comportment.

Pathographies tend to follow a particularly invidious narrative of 'quest', implying that self-knowledge is acquired through undergoing various trials. Patients are required to perform a kind of stoicism, or even positivity. As activist Rose Kushner put it, patients are expected to enact the 'red-badge-of-courage': they are told they should 'Glue a stylish wig on your pate, chew some Roloids, and grin and bear it. Never hint to the doctor that the breast cancer medicine is the reason you feel so sick'. Or, as Barbara Ehrenreich expressed it in 'Welcome to Cancerland', 'so pervasive is the perkiness of the breast-cancer world that unhappiness requires a kind of apology.... Cheerfulness is more or less mandatory, dissent a kind of treason'. Those who did not survive are somehow responsible for their death: they lacked the 'right attitude' or will-power. Or, perhaps, they simply lacked access to good medical care, generous health insurance, and adequate support systems.

Anthropologist Maren Klawiter was particularly incensed by these narratives. In her ethnography of the Susan B. Komen Foundation's 'Race for the Cure', she shows how this initiative was firmly tied to the interests of the biomedical establishment, actively distancing themselves from women like Lorde and other 'noisy' Black, lesbian feminist, and social critics. Klawiter observed that

*"In the discourse of the Race [For The Cure], survival is a matter of individual choice and responsibility. Regular mammograms never fail to diagnose breast cancer early and women diagnosed early never die. For those who practise breast health, breast cancer may constitute a momentary setback but it is not a debilitating, recurring or chronic disease. In the discourse of the Race, breast cancer is part of each survivor's historical biography. A finished chapter. In this discourse, breast cancer is a disease of universal, individual, ahistorical, resilient, reconstructable, heterofeminine, biologically female bodies."*

Erased from the narrative is chronicity, fear, and anger. For such groups, the emphasis was on the return to 'normality'; rather than a political identity, women who had experienced breast cancer were expected to return to their safe, suburban lives afterwards.

As such exhortations suggest, suffering from breast cancer could be stigmatizing – similar to other diseases such as syphilis and HIV/AIDS (although for very different reasons). Women could be blamed for refusing to fulfil their 'natural' and eugenic destiny as mothers, or for having been so obsessed with beauty that they did not breastfeed. Chemotherapy caused many to lose their hair – women's 'shining glory'! As Catherine Lord put it in *The Summer of Her Baldness*, 'on a woman of my age[,]pate spells invalid. InVAlid [sic]'. Even admitting to feeling pain could be seen as shameful or humiliating. In the late 1970s, for example, a survey of patients experiencing progressive diseases such as cancer found that more than one-third admitted that

they disliked speaking about the pain because it led to ‘negative social labeling’. They admitted that ‘I rarely discuss [pain] unless someone asks me. I am not one of those hypochondriacs’ and ‘No one likes a complainer’. Much of the self-help literature conveys the message that a survivor of breast cancer must work hard to ensure that she didn’t appear to be a ‘troublemaker’ – that is, a ‘noisy’ feminist, ‘butch’ lesbian, ‘gender-subversive’ trans, or ‘confused’ non-binary person. Even organisations dedicated to helping women suffering from breast cancer could perpetuate harmful, sexist messages. Take a breast-awareness advertisement created by the Breast Cancer Fund of Canada: it shows an adolescent boy called Cam who offers to examine women’s breasts [see <https://www.adforum.com/creative-work/ad/player/16436/cams-breast-exam/breast-cancer-society-of-canada>]. Joking about and sexualising breast cancer is not rare, but even more serious documentary films are often patronising, showing male doctors as the authorities about female bodies, with their female patients respectfully and passively following their advice.

Feminine heteronormativity is only one of the themes. Another is the use of militarised languages. This is not unique to breast cancer but to the other diseases discussed in my series of lectures – for example, tuberculosis, polio, HIV/AIDS – and was particularly prominent in the post-Second World War and then Cold War periods. For the biomedical establishment, war was already being waged within the body, which made a counterattack the ‘natural’ response. For example, the Women’s Field Army, established in 1936 by the American Society for the Control of Cancer (now, the American Cancer Society), even promised to mobilise a form of ‘trench warfare with a vengeance against a ruthless killer’. ‘Defeat the Silent Enemy’, declared an advertisement in 1940, seeking donations for the Royal Cancer Hospital in order to ‘swiften the attack on Cancer wherever it raises its hideous head’. Invidiously, breast cancer charities announced that ‘Cancer attacks without declaring War’. Cancer was an ‘enemy’ to be fought and ultimately defeated. It was a language that even patients who were relentless in critiquing conventional cancer narratives might adopt – as we heard earlier, Lorde frequently referred to her ‘battle’ with cancer. However, she also recognized that violence was not the *only* way to look at sick bodies. She observed that she had expected her chest after surgery to ‘look like the ravaged and pitted battlefield of some major catastrophic war’. Instead, she simply saw a scar which was not only ‘smooth and tender and untroubled’, but also an integrated part of her ‘same soft brown skin’.

It is also important to point out that while Western biomedicine claims that it operates as a military weapon that operates by effectively attacking and disarming dangerous illnesses, this is not the case in all systems of medicine. In *The Web That Has No Weaver: Understanding Chinese Medicine* (2000), Ted J. Kaptchuk argues that while Western medicine ‘is primarily concerned with isolable disease categories or agents of disease, which it zeroes in on, isolates, and tries to change, control, or destroy’, Chinese medicine focusses on ‘the complete physiological and psychological individual’, trying to identify imbalances or ‘patterns of disharmony’. In other words, in that branch of medicine, militaristic languages would be highly inappropriate, if not nonsensical.

How have American and British authorities, charities, and activists sought to educate people about breast cancer? Historically, we can identify two very different official responses. In the U.S., the emphasis was on public education, with the chief mantra being ‘don’t delay’. In the 1930s, the Society for the Control of Cancer established the Women’s Field Army (as said earlier: now, the American Cancer Society) to engage in campaigns focussing on teaching women to self-examine their breasts with the aim of early detection. In contrast, in the UK after the founding of the NHS (which was then free at the point of access), there were fears that a similar approach would overwhelm the NHS, with women panicking about whether they might have cancer. Would public information inflame anxieties, hypochondria (a ‘British affliction’), and cancerphobia? Would it encourage unrealistic expectations from physicians and surgeons? Instead, officials in the UK focussed on educating physicians (rather than the general public) to spot the signs. This also meant that British organisations, such as the Imperial Cancer Research Fund and the British Empire Cancer Campaign, were more committed to research over public education compared with their U.S. equivalents.

In terms of public activism, it is possible to distinguish between two very different forms of advocacy. In shorthand, these are ‘green’ versus ‘pink’ approaches. ‘Green’ advocacy emphasises prevention through environmental change. They have developed trenchant critiques of pharmaceutical and chemical corporations, and often have strong ties with global feminisms and AIDS activism. An example is Zillah Eisenstein’s *Manmade Breast Cancers* (2001), in which she lambastes the ‘postindustrial-medical complex’. Eisenstein observes that breast cancer is ‘big business’, pointing out that

*“Many of the same companies that contaminate our bodily environments sell the drugs that are supposed to prevent malignancy. Zeneca manufactures pesticides at the one end and markets tamoxifen at the other.”*

In contrast, 'pink' advocacy is consumer-based, focusing on raising funds for research and treatment of breast cancer. They have generated some powerful critiques. Pink bows and balloons, cuddly pink teddy bears, pink coffee mugs, pink brooches, and colouring-in books (complete with crayons) not only infantilize women but present consumption as a solution for breast cancers often caused by the same companies donating a (usually miniscule) share of their profits to cancer projects. This has been termed 'pink-washing' – that is, the corporate exploitation of breast cancer in the name of profit. 'Pink-washing' was the main focus of the 'Think Before You Pink' campaign, launched by the Breast Cancer Action (BCA: it was founded in 1990 and modelled itself after ACT UP) in 2002 and continuing to this day. In 2022, for example, their campaign promises to scrutinize

1) the Manipulation of Media, Marketing, and Advertising, 2) Disinformation and the Suppression of Scientific Evidence, and 3) Political Influence and Interference, the campaign exposes strategies by which profit is put before public health across industries, allowing for bad actors to line their pockets as the breast cancer crisis continues.

The unholy alliance that BCA identifies between corporate greed and breast cancer has a medical component: the breast reconstruction or plastic/cosmetic surgery industries make huge profits by playing on heterosexist, patriarchal ideals about 'normal' women's bodies. These industries are heavily promoted by professional cosmetic surgical organizations, as well as companies that manufacture breast implants. Surgeons are influential in deciding what constitutes the 'ideal' breast. Ignoring the vast differences in the 'normal' appearance of breasts, these surgeons laud precision and uniformity. As Richard B. Aronsohn and Richard A. Epstein explained in their 1970 textbook entitled *The Miracle of Cosmetic Surgery*,

*“The breasts should be situated vertically between the third and seventh ribs and horizontally between the edge of the breast plate and the side of the chest.... A conic shape is preferred with the nipple at the apex and at the level of the fourth or fifth rib; each nipple should project slightly upwards and outwards. Breast thickness should be about 8 to 10 centimeters measured from the chest wall; bust measurement should approximate equal hip measurement. In relation to the body, the nipples should be separated by 1 head width and should describe a line separated from the chin by 1 head length.... In appearance, the ideal breast is well-fleshed, rose-tinted white in color (for Caucasians), and is semi-rigid, floating gently on its frame; it should be slightly resilient to the touch.”*

The risks of cosmetic surgery are downplayed. Operations last between one and two hours, leaving a two- or three-inch scar under each breast. Implants can leak or rupture. Indeed, according to one survey, this happens to 70 per cent of implants within 10 years. They often cause scar tissue, autoimmune disorders, nerve damage, fatigue, flu-like symptoms, swelling, loss of nipple sensation, and chest pain. Despite these risks, reconstruction after breast cancer grew in importance when radical mastectomy declined (this is because radical surgery made reconstruction almost impossible because it removed the muscles) and as survival rates increased. Today, around 60 per cent of U.S. women who experience a mastectomy have breast reconstruction.

To conclude: we don't need Foucault to tell us that knowledge is power. As he put it, power 'produced effects... at the level of knowledge. Far from preventing knowledge, power produced it'. In the context of breast cancer, it is important to look at *who* and *what* are invested in the knowledge about this disease? What are the effects of the types of knowledge produced? Specifically, the fact that the biomedical establishment today focus on risk factors communicates a great deal about power and vulnerability. Risk is individualised – that is, it assigns culpability to the patient who 'fails' to regulate diet, eliminate toxins (such as nicotine or alcohol) entering the body, remain skinny and exercise, reproduce at a young age, and breast-feed infants. Many of these risks are tightly tied to notions of being 'truly' female and feminine. Most obviously, they are tied to notions of feminine beauty (slender) and the 'natural' female body as the reproductive one. In its most invidious form, it stigmatises lesbians and other women who stand against heteronormativity. It relegates other causes of breast cancer – such as environmental toxins –to a lesser position. In the words of one woman writing to Betty Ford 'Remember that your attitude is most of the battle.... Never even think about defeat, only about winning and you will win!'

These were what Era Bell Thompson, Minnie Riperton, and Audre Lorde were protesting when they stepped out of the cancer closet and changed their worlds. They were important in the movement from the foucauldian 'docile bodies', subjected to the disciplining regimes of medicine, to being subjects engaged in their own illness, recovery, or dying. Their history can inspire the future.



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