

Managing Uncertainty: Women and Cancer in Contemporary History

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The last decade has witnessed a flowering of interest in the history of women and cancer, alongside studies on the history of cancer and related topics.⁽¹⁾ While there might be historical trends that explain the attention paid to certain topics in medical history at particular times, the literature on the history of cancer deals with an inherently controversial disease, with historians themselves risking being caught up in the controversy. Most diseases can be described as complex entities, but few of them can be defined as having a pre-disease form that has itself become a separate entity, although one with diffused boundaries. The idea of a pre-cancer stage, or the acknowledgement of the existence of pre-cancerous cells, dates back to the end of the 19th century, yet achieving a clear identification of these cells and debating their potential to become cancerous occupied the whole of the 20th century and, in many respects, diagnostic uncertainties persist in today's oncology. All three books under review attest to just how controversial the control of cancer and its precursor stages have been, and in so doing, they provide an insightful historical perspective to current policy debates. This is not a concerted effort to prove history's utility, like that which historians are now compelled to make to prove professional 'impact', which may risk imbuing past events with improbable connections to present problems. However, a historical account can challenge the 'selective' use of history by policy makers, especially when they use past events as a powerful rationale to support programmes that hold a formidable impact on health issues.

From international policy makers to health activists, the resort to historical events, as Anne-Emanuelle Birn rightly affirms, is 'often selectively invoked ? to push forward particular agendas based on (mis)perceived successes of the past'.⁽²⁾ The role of health or medical historians is crucial in these cases as their examination of medical and health interventions can question the validity of specific policies that have been tailored on a distorted appreciation of past events. One of the most alluded-to examples is the 'successful' smallpox eradication programme (1980), which today is often cited to support global health policies that propose technical interventions (vaccines, drugs, diagnostic tests, etc.) as the best approach to deal with countries' main diseases. As shown by Sanjoy Bhattacharya's detailed analysis of smallpox in India, its effective eradication has often glossed over the enormous complexities and diversity of actors involved in the programme.⁽³⁾ These studies suggest that a thorough assessment of past health initiatives could at most assist global policy makers in a more comprehensive reading of what the past can teach, or at least alert them of the existence of a less complacent story of previous health interventions.

By engaging with historical and contemporary analyses of female cancers, the books under review show the value of rounded histories: they show that past health interventions need careful historical contextualisation to be meaningful today and to be fully comprehensive. They also have an additional strength, that unlike many disease-specific histories whose broader implications are sometimes difficult to deduce, cancer appears here as a hub to explore and reflect on contemporary medical practices, policies and technologies, and individuals and patients' groups. This opens up avenues for further enquiries, some of which will be suggested in the next sections.

2. Uncertain entities, tentative diagnosis

All three works focus on female cancers; Bryder and Löwy (2011) exclusively on cervical cancer, and Löwy (2010) on cervical and breast cancer. Beyond the most obvious biological reason that makes these diseases 'women's cancers', the authors provide historical and contemporary insights into how women's

gynaecological tumours are metonyms for cancer in medical, social, and cultural terms. They also exemplify how different women's groups and feminist activists envisioned gynaecological cancers as a site of political ownership, but one that has served to advance multiple and sometimes contesting aims, from specific public health interventions and ascending career opportunities to a broader political agenda.

Women's Bodies and Medical Science. An Inquiry into Cervical Cancer examines the events that led to the development of the 1987–8 Cartwright Inquiry in New Zealand, a government inquiry set up to investigate the responsibility of a group of gynaecologists at the prestigious National Women's Hospital (NWH) in Auckland for the (mis)management of cervical cancer patients between the 1960s and the 1980s. Portrayed by the press as 'the biggest medical scandal of the century', the Inquiry was instigated by an article that appeared in the magazine *Metro* (1987) co-written by feminist activist and journalist Sandra Coney and sociologist Phillida Bunkle. They denounced what they thought was 'an unfortunate experiment' conducted by Dr Herber Green at the NWH in 1966, who in his (supposed) attempt to study the natural course of cervical cancer deliberately withheld conventional treatment in women diagnosed with early stages of the disease [carcinoma in situ (CIS), or CIN3]. The exposé was based on a 1984 medical study – elaborated by doctors in opposition to Green's ideas who retrospectively followed 948 cases of CIS from 1955 to 1976. The study concluded that those women treated by Green's conservative approach which had two years of positive Pap smears were 25 times more likely to develop invasive cancer than those treated by hysterectomy and whose smear tests were negative. In these groups deaths were four and eight respectively (here I deleted text in brackets), a rather low rate considering international statistics of the time. The aim of the medical report was to provide evidence for a prompt surgical treatment of all *in situ* cancers as the authors thought it had a considerable invasive potency. Yet the study had significant consequences when it was reinterpreted by the *Metro* article and the Cartwright Inquiry as an 'experimental study' to 'differently treat' women diagnosed with CIS. The latter was denied not only by Green but by the authors of the study itself.

A core aim of Bryder's book is to explain this misunderstanding. In Green's conservative treatment of CIS, there was no experiment, nor a division between two groups of patients that were treated differently in order to prove a medical hypothesis or 'personal belief' about the nature of CIS. Beyond the controversies arising in the 1980s from this specific group of patients, and the extended repercussions it had in ethical terms, one of the elements that Bryder as a medical historian successfully contributes in her thorough reconstruction of the case, is the historical context in which Green's ideas were framed and developed. One allegation in the Cartwright Inquiry was that Green and his colleagues at NWH were aware of and dismissive of a 'world view that CIS was a precancerous condition' (p. 26). Bryder's detailed research demonstrates that, on the contrary, the Inquiry had 'inadvertently revealed a profession divided' (p. 74), because from the 1960s until the 1980s there was no such thing as a 'universally accepted' or a 'world consensus' about the diagnosis or the treatment of CIS. Throughout chapters one to six, the book provides a rich body of medical literature that points to this disagreement within the medical profession, from pathologists and gynaecologists to epidemiologists and cytologists, revealing a long-simmering controversy over the potential of CIS to become invasive. Löwy's books also elaborate extensively on the conundrums of identifying and legitimating a specific pre-cancerous lesion of the cervix and the breast, thus confirming from a historiographical point of view that the quest for cancer diagnosis has provided an impetus for scholarly research on the history of this disease, and constituting indispensable reference works for every scholar of the subject.

At an international level, discrepancies about CIS were on three significant levels, a) on diagnosing (classifying) intraepithelial lesions of the cervix into a series of borderline categories (mild, intermediate, or severe dysplasia, and CIS); b) the prognosis from CIS to invasive cancer; and c) the management of CIS lesions. An eminent American pathologist, Leopold Koss, made a legendary comment in 1979 that summarises the differences observed amongst pathologists when assessing abnormal lesions of the cervix: 'one man's dysplasia is another man's carcinoma *in situ*' (p. 75). Long-term follow-up studies of women with *in situ* cancers that were not treated but under careful observation returned inconclusive responses as to the natural course of the disease: In one study conducted in Denmark (1955) 35 per cent of women developed invasive cancer, leading the author to consider CIS as slow-evolving disease, for which

immediate treatment was not necessary. Another 1963 American study considered that in 25 per cent of cases the lesion disappeared, while in 6 per cent of cases it developed into invasive cancer. Yet in the latter the performed biopsy was thought to be an important cause for the lesion's disappearance thus suggesting that a minor intervention could be sufficient to deal with this type of cervical lesions. This view was shared by Green when he proposed a protocol to treat women with CIS by 'lesser procedures' which included follow up with Pap smears, colposcopy and punch biopsy, that is, a lesser surgical excision than the most common cone biopsy, which had a higher associated morbidity.

Although in the 1950s and 1960s many doctors took a radical approach by treating CIS with hysterectomy, the idea was far from being ubiquitous. Bryder's analysis focuses mainly in the literature that circulated in the Anglo-Saxon world to support this view. What strikes this reviewer as being less evident, is not the conservative treatment and follow up in itself, but the use of colposcopy as a diagnostic tool, a technique that in Anglo-Saxon countries was far less widespread at the time. Increasing attention to CIS and dysplasia was due to the dissemination of diagnostic tools for the early detection of cervical cancer. The Pap smear test was heavily promoted by the American Cancer Society from 1945, and its rapid internationalisation was secured by training programmes for foreign doctors alongside the availability of American grants. Parallel to the growing enthusiasm for the Pap test, another diagnostic technique, colposcopy, was being disseminated in South America. Both diagnostic tools aimed at detecting cancer of the cervix in its early stages, but they differed greatly in the way they were performed, the people involved, and the skills required, all of which induced a different management of the disease. By the mid 1950s, in parts of Germany, Austria, Switzerland, Brazil and Argentina, colposcopy became routinely used in gynaecological clinics, while in the main European and United States centres the Pap test was the preferred tool. Interestingly enough, since the 1950s onwards, what we see in those countries that adopted colposcopy is a conservative treatment of CIS. Follow up using the colposcope alongside a rigorous histopathological analysis of the removed tissue, gave gynaecologists trained in colposcopy a confidence in the management of CIS that the Pap test alone lacked. In times of uncertainty about the diagnosis of CIS, those who became familiar with the colposcope thought that they had a safer scientific instrument for monitoring the status of those ambiguous cells, in most cases with the added reassurance of a Pap test. Those who thought that colposcopy training was too demanding and time-consuming relied on the simplicity and growing popularity of the Pap test, and managed the disease following the cytologist's dictum. In the case of the NWH, Bryder notes that there existed personality clashes and strong rivalries between the pathologist, and crucially the colposcopist, and Dr Green who was leading the treatment. It seems there existed a division in the work of diagnosis that simply did not work. For historians interested in medical technologies and their competitive introduction into hospital services, as in this case with the Pap test and colposcopy, a focus on personal disputes may fall short as an explanation. From this perspective, Bryder leaves one wondering if the aura of hope, confidence and technical zeal that colposcopy inculcated in its users in other parts of the world would apply too to its adoption in New Zealand, and if so, whether that was a triggering factor for the controversies that followed or something that precipitated a pre-existent awkward scenario (that is, divided diagnostic labour and personal rivalries).

3. Women and cancer

As Bryder documents, the perception that Green experimented on women's bodies was all-pervasive after the *Metro* publication and was judged against somewhat extemporaneous notions of medical ethics, patient's informed choice, and doctor-patient relationships which she analyses in chapter four. These notions were increasingly debated from the 1970s, which saw the rise of the international consumer movement, driven by patient groups and women's health activists, and paved the way for the figure of the patient-consumer. In addition to the investigation of the alleged ill-treatment of carcinoma *in situ*, several aspects were included in the terms of reference of the Inquiry, namely, the protection of patient rights in any research conducted at the NWH, patient information about treatment options, the training and teaching of medical students about CIS, doctors' perspectives on cervical cancer screening, and vaginal examinations on anaesthetised women without consent. These are analysed in chapter eight. The broadening of issues thus discussed at the Inquiry,

according to Bryder, 'suited the feminist lobby who saw it as a unique opportunity to canvass those issues relating to women's health for which they had been campaigning and about which they felt so passionate' (p. 127). The report concluded that the medical profession had failed patients, and many important recommendations were subsequently implemented, most notably patient advocacy and a national screening programme for cervical cancer. In relation to the former, it is instructive to see certain developments that took place at the time in the UK, a comparison maintained elsewhere by the book given New Zealand's close relationship and integration within British medical professional bodies. While in the 1980s patient consumer groups in the UK campaigned for more information about health services and disease prognosis, in order to become active partners in their own treatment, statutory acknowledgement was not straightforward. When the *Patient's Charter* was sanctioned by the UK government in 1991, it reflected less the principles of patient's rights and choice as a collective group and more the figure of the patient as an individual consumer of health services within the internal market introduced by the Conservative government. As explained by Alex Mold, both the changing nature of the concept of the patient-consumer and the different groups that historically have represented them should 'raise doubts about any authority that claims to know what patient-consumers 'really' want'.⁽⁴⁾ Bryder paints a similar picture in New Zealand, when she argues that the different feminist groups that supported the Inquiry did not represent all women's voices in relation to the services provided at NWH or to Green's treatment, nor were unified views the ones offered by organisations representing nurses and Maori women. While in chapter seven Bryder frames the demands of Coney and Bunkle as part of a longstanding battle of feminist health activists against male dominance at NWH, rather more consideration about the development of other patient groups acting in New Zealand, beyond women's hospitals, would have been welcomed, as would greater reflection on the extent to which the patient-consumer was shaped by the Cartwright report alone.

The implementation of a national screening programme in 1990 was another measure celebrated as a direct result of the Inquiry, but this is too subject to historical scrutiny. On the one hand, Bryder argues, New Zealand's Health Department had been planning the implementation of screening programmes before the Inquiry, and on the other, discussions of the pros and cons of Pap smear screening (discussed in particular in chapter six), and to which Löwy (2011) too offers a rich international literature, were concealed at the time due to feminists' portrayal of any questioning of screening as being against women's interests. In addition, feminist views in the late 1980s of screening programmes were not uniform. Many viewed it as a paternalistic medical intervention, which ignored women's choice and championed the lab's commercial interests over the physical and emotional effects of the test in women; other groups, as in the case of New Zealand, embraced it as a woman's right, and blamed an already under fire male medical profession for its lack of sensitivity towards the prevention of the disease. It is true, however, that at that time, cervical cancer was not perceived as a woman's scourge because of the persistent decline of morbidity and mortality rates in Western societies. Unlike breast cancer, which remained high in the statistics of industrialised countries and led to the formation of powerful women's movements in the 1990s, cervical cancer plausibly lacked representativeness, but with it too, it obscured debates around pre-cancer management (screening and treatment) and its likely outcomes: discomfort during the test, anxiety, preterm birth, and loss of quality of life.

In recent years, the consolidation of consumer groups and the incorporation of guidelines directing clinicians to involve the patient's decision in their care, alongside studies on women's preferences and perspectives in breast cancer screening have promoted awareness on the importance of incorporating the patient's view in the evaluation of screening programmes.⁽⁵⁾ Surprisingly, this has such a short history thus far that to unravel its implications in a comprehensive way is still a task for historians in the future. The issue of informed consent for screening (providing patients with information about both benefits and potential harms) is being discussed in some industrialised countries and subject to contested views. Since 2009, women can express in writing 'informed dissent', in order to withdraw from cancer screening programmes in the UK, and it is possible that other countries will follow suit and mandate balanced information available to patients.

The last two chapters of *Women's Bodies and Medical Science* foreground the implementation of the Cartwright Inquiry and the enduring impact this exemplary case had, and still has, for the protagonists and

the medical profession more broadly. Both chapters demonstrate that the relationship between consumerism, women's health movements and the medical profession can enhance, as well as detract from more conventional patient-doctor relationships. Polarized attitudes, as analysed by the book, namely, a complete mistrust of the medical profession, or a blind confidence in medicine and technology, increase the difficulty of elaborating a constructive, balanced and rounded critique of medical interventions and health care practices, but, as Bryder's account shows, they do not render it impossible.

4. Breast cancer genetics: from family to ethnicity

The analysis of the notion of CIS and borderline lesions that troubled pathologists, cytologists and gynaecologists constitutes the core theme of Ilana Löwy's book *Preventive Strikes. Women, Precancer, and Prophylactic Surgery*. She offers a holistic and formidable account of pre-cancer in comparative perspective, including Britain, USA and France. Her register is less an illustration of different approaches and more a reflection on the local basis of a presupposed universality of medical knowledge and its hegemonic claims. 'Medical cultures vary as least as much as national cultures do' (p. 35), she anticipates. In her study of cervical cancer, French gynaecologists, for example, appeared less prone to perform hysterectomies in cases of CIS, because the sterilisation of fertile women was not a welcome idea in a country that endorsed pro-natalist policies. The development of X-ray and curietherapy technology in the Radium Institute of Paris, which soon became a world renowned specialised institute, provided radiologists with a share in the treatment of cancer which largely differed from the surgical-oriented management observed in the US. In France, the combination of therapy (surgery and radiotherapy) led specialists on occasions to perform radiotherapy as the treatment of preference, especially for cervical cancer, which unlike breast cancer, proved to be highly radiosensitive.

In this volume Löwy introduces a very detailed analysis of cervical and mainly breast cancer, their changing histological notions, their modus of detection and treatment. Chapters one and two trace the definition of premalignant lesions by pathologists and with them the notion of cancer as a disease of transformed cells and tissues, that spurred in turn the dogma of 'early detection'. Radical surgical treatments, which also pervaded the field of breast cancer diagnosis when mastectomy was performed as a diagnostic technique (chapter three), corresponded to an era that conceived cancer as a localised disease that later expanded, invading distant organs. The generalisation of the notion of *in situ* cancers discussed in chapter four highlights the different approaches that informed treatment: while in the case of cervical cancer hysterectomy was gradually abandoned in favour of conservative methods, *in situ* breast cancers continued to be treated with radical interventions (mastectomies) well on until the 1980s. The role of screening methods such as the Pap test led to an increase in overtreatment which both transformed the meaning of the test, from diagnosing cancer, to a pre-diagnostic test that indicates the existence of cell abnormalities, whose extirpation concealed in turn the need to establish an accurate diagnosis. These aspects alongside the development of screening campaigns are the subject of chapters five and six, which also introduce the use of mammography screening alongside the controversies arising from the setting up of programmes at population level. Emphasis on the latter leads the author to a broader discussion of screening extending the analysis to three other cancers (prostate, lung, and colon), which appears as a departure from the focus of the book. The section on mammography, on the other hand, offers little discussion in terms of what the technology, as a diagnostic tool, was introducing, and in terms of the novel cancer notions radiologists incorporated as they entered into the field of cancer diagnosis.

Overall Löwy's well-selected case notes extracted from pathology records of different hospitals in the US, UK and France add depth and detail to a history that has been reconstructed at a national level, most successfully by Barron Lerner (2001) and Robert Aronowitz (2007) in the case of the US. Her attention to local variations allows Löwy to formulate a critical and more nuanced perspective on the foundations of cancer diagnosis. Yet variations in diagnosis, and the divergent ways in which pathologists working in different settings have correlated breast lesions with a prediction of their malignancy, it is only part of the story. There were also the series of strategies that have variously attempted to curb a breast cancer death toll

that for decades has remained stubbornly high, but not without consequences for those who became survivors of the disease. 'Preventive strikes' could be read as a series of reactions/responses to the fear of a devastating disease whose course and exact development could not be anticipated accurately even in the era of evidence-based medicine. In case of doubt, doctors often stated: 'we cut it out' or 'burn it out', or it is 'better to err on the side of caution'. These ideas underpinned the professional attitudes that somehow entered in the deontology of medical practice unsettling the balance of decision making: it presupposed medical intervention as radical 'action' as opposed to conservative treatment and follow up as 'negation'. This is not to say that conservative treatment and watchful care of cancer patients did not exist as an acceptable treatment at particular points in time. It is simply that the latter, as demonstrated by the case of the NWH in New Zealand, was far more questioned than the former. The idea of agency behind an anticipated response to an unexpected outcome of the disease has engulfed patients too, who were also induced to develop 'preventive strikes' to tame risk. This is more clearly revealed in the last two chapters of the book through a focus on the developments of oncogenetics in the 1980s and 1990s, which transformed the hereditary suspicion of breast cancer from a disease that ran in the family to an identified localised gen mutation: BRCA (1) and (2). Women carriers of these mutations have a higher than average risk of developing a tumour early in life, bilateral tumours and ovarian cancer. BRCA-positive women are encouraged to undergo prophylactic surgery (bilateral mastectomies, ovariectomy) or to live a life of constant follow up tests (mammography) and above all, live with the threat and anxiety about the 'higher than average' appearance of the disease. Their prospectus does not differ much from those diagnosed with CIS, as Löwy puts it, they:

'enter a limbo between health and disease (becoming a "healthy ill"), which change the way they feel about their dangerous body parts ("living with a ticking time bomb"), and lead to a split between the self and the treacherous part of the body' (p. 4).

Despite the standardisation of genetic tests, 'the meaning of hereditary risk of breast cancer risk is shaped locally' (p. 181), Löwy argues, depending on the organisation of health services, the existence or not of a universal healthcare system, intellectual property rules, and the broader configurations of cancer management in particular places. The discovery that women of Ashkenazi Jewish origin had a higher incidence of a specific mutation of BRCA led, however, to different approaches about the role of ethnicity in medical testing. In the US, home to the first laboratory that patented the BRCA genes and subsequently its test, the combination of an aggressive testing campaign – initiated by the laboratory which also offered a cheaper test to scrutinise Ashkenazi mutations in Jewish women – is coupled with a perceived anxiety within this community about the predisposition to certain diseases. Thus, medical intervention counted on the support of the Jewish community and health groups that embraced a screening culture for breast cancer grounded in their ethnic traits. By contrast, in France, ethnicity does not feature as an independent category in risk assessment, and (any) woman with a strong family history of breast cancer can be deferred to a cancer genetic service for a test. A similar pattern is followed in the UK.

The persistence of the association of breast cancer genes with ethnic groups in the US, however, points to further directions making the one analysed by Löwy and the Jewish community merely a start. Observation that Hispanic-Latino women in the US have a higher mortality rate compared to white women, led to population studies seeking to elucidate the ethnic profile that helps explain differences in breast cancer outcomes: they found that Latinas have a higher incidence of advanced stages of the disease, tumours of a larger size, developed at a younger age, and with a higher incidence of triple-negative breast cancers (are negative for hormone therapy, and have a poorer prognosis), and a higher incidence of pathogenic BRCA1 mutations.⁽⁶⁾ These studies have prompted the analysis of the genotype of breast cancer in Latino woman, currently being investigated by a multi-site study sponsored by the Susan G. Komen for the Cure® – the world's largest charity devoted to the fight against breast cancer – the National Cancer Institute and five Latin American countries. Other studies, on the contrary, have pointed to the existence of health inequalities as an essential factor behind differences in health outcomes. More specifically, Latino women living in the US have higher poverty rates, are less educated, are largely uninsured and in many, their undocumented status prevents them from access to health care at all compared to white women.⁽⁷⁾ If, as Löwy has noted for

the case of Ashkenazi Jewish women ‘the relative wealth of this population, its elevated level of education, and its high level of health consciousness, made it an excellent target for the marketing of tailored services [BRCA test]’ (p. 192), one may presume that the same will apply to a selected group of Latino women, while in the vast majority it may lead to an increase in health inequalities. In addition, the impact on employability and in access to life and health insurance has been noted by various observers that cautiously look at the surge of genetic tests and the increased commodification of genome products within the broader context of health inequalities in specific healthcare systems. At this juncture, historians such as Daniel Kevles have drawn a connection between new genetic screening policies and the long history of eugenics.⁽⁸⁾ Social and medical historians have yet to contribute much to this new association of medical genetics and ethnicity and its impact on health policies, public and lay perceptions of immigration, risk, and identity, and crucially, in bringing to the fore discussion on the social determinants of health alongside (re-)emerging propositions of biological determinism.

5. Secrecy, exposure, and locality: cervical cancer and the politics of visibility

Löwy opens her latest book, *A Woman’s Disease. The History of Cervical Cancer* (2011), by reviewing the story of three famous figures of the 19th, 20th, and 21st centuries: mathematician and computing pioneer Ada Lovelace, politician and First Lady Eva Perón, and TV celebrity Jade Goody. Women of completely different traditions, they share a young and painful death of cervical cancer, whose distinct experiences with the disease provide the author with a springboard to reflect on the changing perception of cervical cancer at different historical times: from a trait of women’s weak constitution, to denial and secrecy, to TV and media exposure. The public perception of the disease mirrors the forms of medical knowledge as well as the fate of its victims.

The political secrecy that surrounded Eva’s illness (she was never told she had cancer) seems to escape comparison with the mediatisation of Goody’s disease, whose chemotherapy sessions featured in the media on a daily basis until her death. She was not immune to a political touch when PM Gordon Brown expressed his sympathy with the ‘courageous woman’. Just fifty years or so separates her case from Eva’s, but the formulations of Western medicine and patients’ attitude (cancer-fighters) seem to have changed dramatically. During the 20th century it was not uncommon to withhold diagnosis of cancer from patients, yet it is difficult to think that had Eva been diagnosed with any other deadly disease, her illness would have had a different patient/public treatment. Eva’s corporality in Argentina was as present in life as in death. Her body did not ‘leave’ political life, initially, as a part of the unprecedented ritualisation that characterised the paraphernalia of *peronismo* which secured her posterity by the technique of embalmmment. Subsequently, her body fell prey to the country’s political instabilities feeding Argentinian political divisions during the 25 years in which it was lost (stolen and hidden), until finally buried in a family pantheon in Buenos Aires. Secrecy about her disease and the most advanced treatment she received – she is reported to be the first patient treated with chemotherapy in Argentina – endured in the medical profession even after her death. Revealingly, the First International Congress in Antibiotics and Chemotherapy was held in Buenos Aires just months after Eva’s death in 1952, and although her portrait presided over the inaugural session, no reference was made to the pioneering chemotherapy treatment she received.⁽⁹⁾ The politics of secrecy in Eva Peron’s case may not epitomise that for women in general at the time, but it does serve to illustrate how cancer was perceived as a fatal, outrageous disease as opposed to the contemporary notion of pre-cancer as a disease that can be diagnosed and prevented. To explore the meaning of these transformations, Löwy engages with the longer history of cervical cancer, offering a review of one-and-a-half centuries of preventive policies, treatments, and changing explanatory theories, balancing ruptures and continuities while offering a perspective to interpret its successes and failures in a convincing and much needed elaboration for current debates. The book is shaped in a very readable way and remains accessible to any newcomer to the field.

The first three chapters are devoted to cervical cancer conceptualisation (irritation theory) and treatment (surgery and radiotherapy) and the expectations and frustrations that therapeutic approaches generated in the

European and US context until the 1930s. Although chronic irritation as an explanatory theory for cancer waned in the post-Second War World era, the real breakthrough came in the mid 1960s from the field of virology. The relationship of viruses as causal agents of cancer in humans was first established after a tumour virus was identified (Epstein-Barr Virus) from a common childhood tumour in central Africa (Burkitt's lymphoma). Since then, six human viruses have been identified as etiologic agents of human cancers, including *human papilloma virus* (HPV) and cervical cancer in the early 1980s. The latter inaugurated a new era for the perception of the disease, transforming cervical cancer into a sexually transmitted disease. 'In the 1980s, as in 1826, this disease was linked with a 'greater moral laxity' – or, in today's terms, 'promiscuity' – of women from lower social classes' (p. 141), says Löwy. Although the 'promiscuity' hypothesis has lost its class-association after the sexual revolution, it has retained its explanatory value for deprived women who show a tendency of both earlier and more numerous pregnancies.

Today experts agree that HPV strains 16 and 18 account for around 70 per cent of cervical cancer, that only a percentage of women infected with HPV will develop the disease, while in the majority of cases the infection regresses spontaneously; that between the detection of premalignant lesions and the development of invasive cancer elapses a period of ten to 15 years. Statistics show that in industrialised countries, the incidence and mortality of cervical cancer has declined to the extent that its prominence no longer constitutes a serious public health problem. Yet the perspective for women, Löwy argues, is still somber. The new visibility provided by HPV infection and the presence of 'atypical squamous cells of unknown significance' (ASCUS) only triggers further examinations, HPV test, Pap tests, colposcopy and biopsies, which extend the uncertainty of diagnosis to women's perception of their body as a nebulous health-ill state. The visibility of diagnostic tests and screening programmes from the 1950s onwards (explored in chapters four and five) contrasts with the less publicised psychological and physical effects on women's lives. In this sense, *A Woman's Disease* seems to retain, and single out from its title, the individual, personal account behind the more general, statistic, average, idea of cervical cancer as 'a women's disease'. The book is intercalated with stories and narratives of women that navigate the sequence of diagnostic tools in search for the illumination of a clear diagnostic, while others, despite their loyal compliance to tests, succumb to the disease.

Cervical cancer and the politics of visibility can easily be extended to Bryder's account of the NWH and the Cartwright Inquiry, not least because of the role of the media in conveying simplified and distorted versions of the events, but more broadly, because the whole case seems to cast a shadow on cervical cancer and the politics of visibility, one that synthesises the encounter of two temporalities. On the one hand, the incessantly promoted effectiveness of diagnostic tools, screening, prevention, treatment, evidence-based medicine, and ethical (and shared) decision-making; and on the other, the nature of the medical encounter, where doctors and patients reach decisions, sometimes together and at other times unilaterally, balancing different fears and hopes, elaborating on risk, and living with their life-changing decisions. The latter points to an increasingly occluded story, and an altogether alternative, less progressive, history. An excessive confidence in the former can easily make the latter sound arbitrary, backward or unreasonable.

The last chapter of *A Woman's Disease* addresses the persistent burden of cervical cancer in developing countries, where management and prevention programmes reflect a quite different debate. Focussing on Brazil, Löwy provides a further reminder of the limitations that new interventions may have in the population. As Pap smear screening is considered to have failed in low-resource settings, new approaches to cervical cancer screening are being tested (HPV test, visual inspection with acetic acid and treatment with cryosurgery) which reveal a global, technical approach instead of the delineation of health policies that will 'act upon economic and social conditions that hamper the diffusion of preventive measures' (p. 173). Arguably, there is much more historical work needed in the assessment of Pap smear 'failure' in developing countries. Although there is some substance to this repeated claim by policy makers, they paint a very partial picture. As historians came to recognize, and as all three books here attest, the diversity and dynamism of local contexts, issues such as ethnicity, health inequalities, and local medical configurations amount to a more complex scenario for the adoption of technological interventions. And, as in the case of the selective historical 'success' of smallpox eradication, it seems that the past 'failure' of Pap smear screening in

developing countries merits too a closer historical examination.

There is a great additional value to be garnered from reading these books collectively. Considered side-by-side these volumes point to a much deeper understanding of the complex interdependencies that exist between women's bodies, medicine, technologies, policy makers, health activists, the health industry, and the press. Their work is clearly of relevance to scholars in a number of fields, certainly beyond that of medical history.

Notes

1. On women and cancer, see for example, Barron Lerner, *The Breast Cancer Wars: Hope, Fear, and the Pursuit of a Cure in Twentieth-Century America* (New York, NY, 2001); James Olson, *Bathsheba's Breast: Women, Cancer, and History* (Baltimore, MD, 2005); Robert Aronowitz, *Unnatural History: Breast Cancer and American Society* (Cambridge, 2007); Kirsten Gardner, *Early Detection: Women, Cancer, & Awareness Campaigns in the Twentieth-Century United States* (Chapel Hill, NC, 2006); *Three Shots at Prevention: The HPV Vaccine and the Politics of Medicine's Simple Solutions*, ed. Keith Wailoo *et al.* (Baltimore, MD, 2010) Keith Wailoo, *How Cancer Crossed the Color Line* (New York, NY, 2011); *Cancer in the Twentieth Century*, ed. David Cantor (Baltimore, MD, 2008).[Back to \(1\)](#)
2. Anne-Emanuelle Birn, 'The stages of international (global) health: Histories of success or successes of history?' *Global Public Health*, 4, 1 (2009), 50–68, 51.[Back to \(2\)](#)
3. Sanjoy Bhattacharya, 'The World Health Organization and global smallpox eradication', *Journal of Epidemiology and Community Health*, 62, 2008, 909–12.[Back to \(3\)](#)
4. Alex Mold, 'Patient groups and the construction of the patient-consumer in Britain: an historical overview', *Journal of Social Policy*, 39, 4 (2010), 505–521, 518.[Back to \(4\)](#)
5. Jolyn Hersch, *et al.* 'How do we achieve informed choice for women considering breast screening?', *Preventive Medicine*, 53, 3 (2011), 144–6.[Back to \(5\)](#)
6. Tejal Patel *et al.*, 'Breast cancer in Latinas: Gene expression, differential response to treatments, and differential toxicities in Latinas compared with other population groups', *The Oncologist*, 15 (2010), 466–75.[Back to \(6\)](#)
7. *Ibid.*[Back to \(7\)](#)
8. Daniel Kevles, 'From eugenics to patents: genetics, law, and human rights', *Annals of Human Genetics*, 75 (2011), 326–33.[Back to \(8\)](#)
9. *Primer Congreso Internacional de Antibióticos y Quimioterápicos* (Buenos Aires, 1953).[Back to \(9\)](#)

Ilana Löwy is happy to accept this review and does not wish to comment further.

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