

33. Mark Belko, "Dunn Halts Proposed Transfer of Kanes."
34. Ibid.
35. Joseph Crumb, "Religious Leaders Put Out Call for No Privatization."
36. *Pittsburgh Post-Gazette*, "County's Former Third Wheel Comes Full Circle."
37. Ibid.
38. The figure of \$8.82 an hour was arrived at on the basis of several studies by Ralph Bangs, who analyzed more than two dozen family types and calculated the income requirements sufficient for "minimal" realistic family budgets in Pittsburgh. \$8.82 is the wage required by families with two working parents and two children.

TEN

From Private Stigma to Global Assembly

Transforming the Terrain of Breast Cancer

Maren Klawiter

It was in the fall of 1994 that I began my study of breast cancer activism in the San Francisco Bay Area, inspired by a fellow student in a participant observation seminar—a woman who had just finished chemotherapy treatments for breast cancer. With her encouragement, I began observing a breast cancer support group and, at the same time, entered a volunteer training program at the Women's Cancer Resource Center (WCRC) in Berkeley, the first feminist cancer community of its kind in the country. Through WCRC, a local hub of information and cancer activities, I learned about and became involved in a series of projects, including those that figure prominently in this chapter—Race for the Cure, the Women & Cancer Walk, the Toxic Tour of the Cancer Industry, and the World Conference on Breast Cancer.

For the next three-plus years I conducted multi-sited participant observation in a range of settings: cancer support groups, cancer organizations, cultural events, coalitions; fund-raisers, educational forums, environmental protests, public hearings; early detection campaigns, street theater, and various conferences and symposia. I supplemented this ethnographic data with interviews of cancer activists, experts, survivors, and women living with breast cancer. I discovered that the breast cancer movement was multiple rather than monolithic, and my focus shifted from studying "the" breast cancer movement to analyzing multiple mobilizations around breast cancer. In the summer of 1997, I joined a large contingent of activists from the Bay Area who made the historic trek to

Kingston, Canada, to participate in the first World Conference on Breast Cancer. The Kingston conference signified one of the first steps toward building a global breast cancer movement and it is written about here in that context.

Equally important, as I mapped these social movement formations, I became increasingly fascinated by the larger, historical question of movement emergence and movement-facilitating conditions. I kept wondering how a disease that had been so institutionally privatized and culturally stigmatized could have become an anchor for such dynamic and diverse mobilizations. In this chapter I outline an answer to that question by developing a sort of "ethnohistory" of the breast cancer apparatus and arguing that changes in the medical management of this disease—including the expansion of early detection technologies, the growth of treatment choices and uncertainty, the extension of treatment regimens, and the institutionalization of support groups—had important consequences for the development of social movements. I argue that these changes produced new subjects, solidarities, and sensibilities and, in so doing, laid the groundwork for the development of social movements.

My research strategy—and I think it was more intuitive than deliberate—was one of roving, multi-sited ethnography, full participation, and emotional engagement. As a result, the experiential, relational, emotional, and physical dimensions of my research have served as a central source of my own meaning-making practices and knowledge-production. In retrospect, I don't think it ever occurred to me to strive for distance or to even attempt a stance of objectivity and, in many respects, I have perhaps erred more on the side of participation than observation. Now, four years after having entered the field, as I write about the boundary-blurring transformations of breast cancer and the ways that new subjects, solidarities, and sensibilities have emerged within the Bay Area terrain, I can't help noting the unmistakable convergence of theory and theorizer. The boundaries of the field, and of breast cancer itself, have blurred for me as well. And as I write about the construction of new subjects, solidarities, and sensibilities, I note that I, too, have been caught up in and deeply transformed by the same forces and forms of resistance that I have been studying.

More than twenty years ago the acclaimed novelist and cultural critic Susan Sontag was diagnosed with breast cancer. Deeply disturbed by the reactions

she received to her diagnosis, she began researching the history of cultural meanings—or metaphors—of cancer. In 1977 she published the now classic *Illness as Metaphor*. In this wide-ranging and lyrical essay Sontag described and decried the medical, social, and cultural patterns of response to this disease. She outlined the "conventions of concealment" practiced by physicians and by cancer patients themselves. Physicians concealed the truth from cancer patients, and cancer patients concealed their disease from others, not just because cancer was thought to be a death sentence but because cancer was "felt to be obscene—in the original meaning of that word: ill-omened, abominable, repugnant to the senses."¹ Cancer was a stigma and as such its bearers, in the language of Erving Goffman, were perceived as "blemished," "ritually polluted," and "dangers to the social order."²

In *Illness as Metaphor*, Sontag uses the metaphor of "exile to the subterranean land of the diseased" to describe the effects of a normalizing power that, in the theorizing of Michel Foucault, functions by separating, comparing, evaluating, hierarchizing, and banishing to "the external frontiers of the abnormal."³ In the language of the poet and cancer activist Sandra Steingraber, this normalizing, or stigmatizing, power appears as "the process by which cancer victims [are forced to] adopt the status of the untouchable."⁴ And in the language of medical anthropology, the effects of this stigmatizing power appear as "the disease double, . . . the layers of stigma, rejection, fear, and exclusion that attach to a particularly dreaded disease."⁵ Whether exiled to subterranean lands, banished to the frontiers of the abnormal, forced to adopt the status of the untouchable, or saddled with disease doubles—these social processes, historically, have forced the cancer patient, "twice victimized, further into the cage of his or her illness: now shunned, silenced, and shamed in addition to being very sick."⁶ In *Illness as Metaphor* Sontag does not describe the physical suffering and indignities imposed by cancer. Instead, she paints a picture of the social suffering endured by those who are exiled to "the kingdom of the diseased" and she argues that their suffering is immeasurably compounded by "the lurid metaphors" with which this kingdom has been landscaped by outsiders. Although Sontag vehemently rejects these stigmatizing metaphors, she makes no attempt to replace these with less stigmatizing representations. "It seems unimaginable," writes the artist in 1977, "to aestheticize the disease."

Thus, instead of creating new metaphors to displace the old, Sontag attempts to disband the invading metaphors while issuing a call for cultural silence. In the face of overwhelming stigma and in the absence of an alternative imagination, Sontag places all her hopes for physical salvation and cultural redemption in biomedical science—what she terms "real science." She argues that only scientific understanding and its translation into a medical cure will strip cancer of its lurid meanings, purify it of metaphor, and release its victims from their forced exile to the land of stigma and disease.

In Sontag's vision, medicine and science are cast as heroic forces of liberation; she believes them capable of conquering cancer and eliminating meanings and metaphors without constituting their own.

Sontag's vision of scientific medicine as a force of liberation may seem a bit fantastical, but it was hardly a flight of fancy. In fact, Sontag's dreamscape merged with what cultural historian James Patterson has referred to as "the official dream."⁷ This dream achieved its greatest development in the United States—materializing institutionally during the postwar period in the expansion of biomedical research on cancer and gathering additional momentum in the 1970s with the establishment and expansion of the National Cancer Program and its officially declared "War on Cancer."⁸ But research on cancer was also enthusiastically pursued by the federally subsidized and increasingly globalized pharmaceutical industry and by networks of privately and publicly funded scientists and research centers dotted across Canada and Western Europe.⁹ Research was also pursued by new international formations. In 1965, for example, the International Agency for Research on Cancer (IARC) was established in Lyon, France, under the auspices of the World Health Organization. The IARC primarily concentrated on cancer epidemiology and the development of cancer tumor registries around the world, but this research agenda was supplemented with biological and chemical research carried out in IARC laboratories and, through collaborative research agreements and subcontracting, in research institutes in various other countries.¹⁰ Indeed, during the seventies and eighties, Sontag's dream of salvationist science was lucidly materialized in a growing global network of scientists, in the expansion and proliferation of cancer-related research programs, in the production and circulation of an ever-increasing body of cancer knowledge, and in the growth of a multinational pharmaceutical industry catering to and helping constitute an ever-expanding global market for cancer treatment drugs.¹¹

THE WORLD CONFERENCE ON BREAST CANCER: PROJECTING THE GLOBAL ONTO THE LOCAL

The tremendous, albeit unequal growth and expansion of cancer research and medicine was in abundant display in July 1997 as more than 650 delegates from fifty countries descended on Kingston, Canada, to attend the first World Conference on Breast Cancer. What was "first" about this conference was not the international character of its scientific discourse but a different set of border-crossings. Instead of bringing together scientists and clinicians who shared disciplinary perspectives, research programs, and conceptual paradigms, this conference sought to bring together scientists and practitioners from a broad range of cancer-related areas and specializations and combine them with health activists, policy-makers, health care professionals

and health educators, public health workers, social scientists, social workers, and, most importantly, women with breast cancer histories—many of whom identified as breast cancer fighters, activists, survivors, and women living with cancer. Many participants wore multiple hats. This blurring of categories was observable, as well, in the organization of panels, plenaries, and workshops, many of which included mixed categories of presenters. But perhaps most significant of all was the fact that, unlike most conferences on cancer, this one was not sponsored by a professional organization with ties to the research establishment or clinical medicine, nor was it underwritten by contributions from the transnational pharmaceutical industry. Instead, it was organized by committed volunteers in Kingston and spearheaded by the efforts of Janet Collins, a lesbian, feminist activist from Kingston who had lost her partner to breast cancer. This organizing cadre was later joined by the resources and sponsorship of the Women's Environment and Development Organization (WEDO)—Bella Abzug's feminist, internationally-active, activist organization. With WEDO's connections and initiative, word of the conference had quickly circulated in international networks of feminist health activists and environmentalists.

The conference was organized thematically. Day One was dedicated to "Research and Medical Treatment," and it focused on biomedical research on medical treatments, as well as breast cancer screening and diagnosis. Day Two was entitled "Caring for the Whole Woman," and it included presentations and workshops on alternative and complementary therapies, social and psychological support, and issues of patient advocacy and empowerment. The theme of Day Three was "Environmental Factors and Breast Cancer," and it addressed many different dimensions of cancer and the environment. There were scientific presentations on electro-magnetic fields, radiation, pesticides, persistent organic pollutants, dioxins, and other endocrine-disrupting chemicals. Other presentations examined the limited abilities of science to address questions of synergy, history, and multiple causation. Still others presented their research on the politics of cancer and analyses of the global cancer industry. The fourth day was devoted to the presentation of testimony to an international public hearing and was conceptualized as the first step in developing and implementing "a global action plan to eradicate breast cancer"—the stated goal of the conference.

As the conference wore on, it was difficult to avoid reaching the conclusion that scientific medicine had failed miserably in its noble quest to conquer cancer. As presentation after presentation made clear, the cancer research establishment, treatment delivery systems, and pharmaceutical corporations were not the only phenomena that had been expanding during the last fifty years. So, too, had the incidence and mortality rates of breast cancer worldwide.¹² Globally, breast cancer was the most common malignancy among women and the number-one killer. The highest breast

cancer incidence rates were reported in Northern European countries and in the United States—with women in the San Francisco Bay Area topping the list. But although the incidence rates were highest in Western, industrialized countries, the rates were rising fastest in the more recently industrializing and chemicalizing countries and among immigrant groups moving to areas with high rates of breast cancer. Although earlier detection was slowing the rise in mortality rates in some population groups, overall and among many populations, mortality rates were either holding steady or continuing to climb. Even in the United States, the country where early detection screening technologies were most extensively used and where investments in cancer research and clinical medicine had been most intense, breast cancer incidence rates continued to rise and could not be fully accounted for by the expansion of screening and early detection. And, although more American women diagnosed with breast cancer were surviving longer after their original diagnoses, the most recent statistics showed that nearly 40 percent of United States women diagnosed with breast cancer had died from the disease within twelve years.¹³ This fact, it was pointed out, was conveniently hidden by standard “survival rate” statistics that defined “survival” in terms of five years. And although overall mortality rates in the United States were no longer rising, they also had not improved significantly in twenty-five years—despite the billions of dollars invested in treatment technologies. And still more alarming, breast cancer mortality rates were actually rising for some groups—especially African-American women. Clearly, Sontag’s dream of cultural redemption and physical salvation had not arrived on the wings of scientific medicine.

Unlike most scientific conferences, the point of this conference was not to celebrate the development of science and medicine but to make a sober assessment and begin outlining a new direction and a global vision. This was a critical and skeptical assembly of very active participants who did not genuflect to the established cancer orthodoxies. Time and again, they sought to pry open and reconsider the thinking hidden within the black box of biomedicine, and they tirelessly pushed for a broader research vision. They demanded greater access to early detection technologies but at the same time criticized their inadequacy, challenged the dumping of high-radiation mammography machines in third world countries, and questioned the usefulness of high-tech approaches to early detection for countries that lacked the health care infrastructures to make these technologies widely available. And they repeatedly challenged established approaches to public health that focused exclusively on individual bodies while ignoring their toxic environments. They called for policy-makers to adopt “the precautionary principle” and act preventatively on the basis of compelling evidence to end “this uncontrolled human experiment” in which all of the earth’s inhabitants were being involuntarily and repeatedly exposed to toxic chemicals and carcinogens.

Indeed, what was in evidence in Kingston, in addition to the incredible buildup of biomedical research, epidemiology, and clinical medicine, was the proliferation of political projects that had developed outside of the institutions of the cancer establishment and biomedicine yet were seeking to transform them. But how in the world did we get from Sontag to Kingston? How did we move from exile and invisibility to the beginnings of a global movement? That is the puzzle this chapter seeks to explain.

The first step toward answering this question begins with the recognition that, although the Kingston conference was a world conference, it was propelled forward by North American breast cancer activism. This does not mean that the conference lacked a global perspective. Indeed, the global vision of the conference was apparent in the attention given to the borderless circulation of dangerous chemicals and carcinogens and the conference’s commitment to developing a “Global Action Plan for the Eradication of Breast Cancer.” Nor did the conference lack an international perspective. Throughout the conference speakers emphasized that the conditions under which women experienced and made sense of breast cancer varied tremendously both across and within nations and communities. But whereas many North American participants were already linked into national and local movements, many of the participants from outside of North America came to the conference as isolated breast cancer activists in search of information and connections rather than as already networked participants in locally and nationally developed movements.

What became clear was that the conditions for the development of movements around breast cancer did not exist in most places. In most parts of the world, women lacked access to basic health care and faced a broad range of serious health problems exacerbated by poverty. Breast cancer, often considered a disease of old age, was not seen as a top priority. Moreover, in many “developing” countries, cervical cancer posed a far more lethal threat to women than did cancer of the breast. But the obstacles to organizing around breast cancer extended beyond poverty, the demographics of disease, and the structures of health care systems. Even in nation states with elaborate public health and medical care systems, obstacles to addressing the growing epidemic of breast cancer persisted. Beyond the demographics of disease and the political economies of health, the stigma of breast cancer consistently intensified barriers to treatment and early detection. And, although this stigma was differently inflected in different cultures and communities, it uniformly functioned to enforce a code of silence and invisibility. Thus, in addition to these other factors, the stigma of breast cancer presented overwhelming obstacles to mobilizing and globalizing a breast cancer movement.

In order to explain the movement from Sontag to Kingston we need to examine how North American breast cancer movements overcame the obstacle of stigma in order to develop within specific, local conditions.

Indeed, the political visions and activism at the World Conference on Breast Cancer did not emerge, initially, within the context of global connections but at the grassroots level and within local fields of action. What made Kingston possible was the emergence of grassroots activism that *itself* was made possible through the restructuring of stigma. And what gave the Kingston conference its particular three-pronged agenda—biomedical research and early detection; caring for the whole woman; breast cancer and the environment—was the elaboration and crystallization of these issues in specific, largely North American, contexts.

The San Francisco Bay Area offers a unique opportunity to explore both of these dimensions—the restructuring of breast cancer stigma and the development of movements around breast cancer. For the past twenty years, the Bay Area has reported the highest rates of breast cancer in the world and has become known as “the breast cancer capital of the world.”¹⁴ In addition to its demographic infamy, however, the Bay Area is known as one of the most vibrant centers of breast cancer activism, and it is one of the first places where women with cancer first began creating the networks and forms of community and began reshaping and publicly resignifying the meanings of this disease.¹⁵ And, although Bay Area activists did not organize the Kingston conference, it was from the Bay Area in particular, and California in general, that the World Conference on Breast Cancer drew one of its largest and most active groups of presenters and participants. Finally, if we turn to the Bay Area, we can see how the three themes that the Kingston conference was organized around have been locally elaborated into three different logics of action.

The remainder of this chapter is divided into two parts. The first part links the development of breast cancer movements to the growth of the United States cancer establishment and the medical-industrial complex. In order to understand the emergence of breast cancer activism, we need to identify and analyze the specific practices that changed the way that breast cancer was experienced and administered. I argue that historical changes in the medical management of women with breast cancer and expansion in the surveillance of healthy populations created new relationships to this disease and that these new relationships—appearing in the form of new subjects, solidarities, and sensibilities—transformed the structure of breast cancer stigma. In transforming the structure of stigma, they created the facilitating conditions for the emergence of breast cancer movements.¹⁶

In the second and longer part, I explore the specific ways in which these new subjects, solidarities, and sensibilities were drawn upon, reshaped, and resignified within three different Bay Area mobilizations. The first, represented by Race for the Cure®, mobilized the resources of corporate capital, scientific medicine, and the health care industry behind an individualizing biomedical discourse of research and early detection. The second, repre-

sented by the Women & Cancer Walk, mobilized a multicultural assortment of women's health organizations behind a feminist discourse that repositioned breast cancer within a broader continuum of women's health concerns, promoted social services for women with cancer, and supported treatment activism. The third, represented by the Toxic Tour of the Cancer Industry, mobilized a network of environmental justice and feminist cancer organizations behind a discourse of cancer prevention. This discourse mapped the global cancer industry as a distinct entity and, in so doing, directly challenged the biomedical focus on research and early detection. Thus, the ingredients that constituted the preconditions of the breast cancer movement reappeared, reshaped, as the foundation of different mobilizations. It was, in other words, the restructuring of stigma that made possible its resignification. I conclude by reflecting on the relationship between local and global movements and outlining two different trajectories of global breast cancer activism.

THE RESTRUCTURING OF STIGMA: NEW SUBJECTS, SOLIDARITIES, SENSIBILITIES

Beginning in the 1970s, the way in which breast cancer was managed—both within and outside of the medical clinic—began to undergo a series of transformations. Within the medical clinic, three sets of analytically distinct, although chronologically overlapping, changes in the diagnosis, treatment, and rehabilitation of women with breast cancer redefined the role of breast cancer patient-subjects and repositioned them within the medical care system. And, within the vast expanse of terrain that lay outside the medical clinic, a fourth process expanded and accelerated into the healthy, or “asymptomatic” populations of women, changing the way that breast cancer was surveilled, administered, and anticipated. Taken together, these changes both within and outside the walls of the medical clinic transformed the structure of stigma in ways that facilitated the development of breast cancer movements. These four processes and their significance are outlined below.

Prior to the 1980s, when a woman was diagnosed with a suspicious breast lesion, she would enter the hospital for a surgical diagnostic biopsy and, if the surgeon determined with the aid of the pathologist that the lesion was malignant, the surgeon would proceed with an immediate breast amputation—a mastectomy—while the patient was still under general anesthesia. This was known as the one-step procedure, and it meant that a woman—often reassured of the implausibility of breast cancer before undergoing surgery—awoke afterwards to face not only a diagnosis of breast cancer, but an already performed radical breast amputation. During the eighties, however, this procedure began to change. Prompted by the activism of an ex-

breast cancer patient, Rose Kushner, and the public testimony of others, breast cancer informed-consent legislation was proposed in twenty-two states and adopted, during the eighties, in fourteen.¹⁷ California was the second state to adopt such legislation and did so in 1980—one year after the National Cancer Institute issued an official advisory recommending that surgical biopsies be separated from surgical treatment.¹⁸ The separation of breast cancer diagnoses from surgical treatment within the space of the clinic helped reconstitute breast cancer patients as medical citizens. Instead of being positioned as the passive and anesthetized objects—the “docile bodies”—of the omnipotent surgeon’s gaze, breast cancer patients gained the right to “gaze back” at their physicians and to participate in their treatment as conscious, speaking subjects.¹⁹

During the mid-eighties, the space that had opened up for patient participation continued to expand. Halsted radical mastectomies gradually gave way to less radical mastectomies and expanded further to include a variety of breast-conserving surgeries.²⁰ As in other things, the Bay Area was at the forefront of the trend toward breast-conserving surgeries.²¹ The expansion of surgical repertoires created, for growing numbers of women, the possibility and even the obligation of making choices about their surgical treatment.

Also during the eighties, treatment shifted away from surgery alone, or surgery followed by radiation therapy, and began increasingly to incorporate chemotherapy. Although chemotherapy had long been used to treat women with advanced (metastatic) breast cancer, it was increasingly incorporated into the treatment regimens of women with earlier stage disease.²² The increasing incorporation of adjuvant therapies—namely, radiation, chemotherapy, and hormone therapy—not only multiplied the treatment possibilities, but also prolonged the treatment experience. No longer did women enter the hospital for a single surgical procedure and leave, several days later, as officially rehabilitated ex-patients. Now, in addition to undergoing a mastectomy or breast-conserving surgery, breast cancer patients could expect to return to the medical facility for repeated follow-up sessions. Several weeks of daily radiation were often added to months and months of systemic chemotherapy. Tamoxifen, a hormone therapy developed by Zeneca Pharmaceuticals and originally used to treat women with metastatic breast cancer, was increasingly incorporated into the treatment regimens of women with earlier stage disease and prescribed, either with or without chemotherapy, for a period of between two and five years.²³ These adjuvant therapies not only involved the penetration of treatment further into women’s bodies and the production of often debilitating side-effects, especially with chemotherapy, but they also further deepened the role of the breast cancer patient by prolonging it, expanding it into new terrain, and demanding its repeated re-enactment.

As the role of the breast cancer patient underwent redefinition, it also underwent a process of repositioning. The incorporation of adjuvant therapies into standard treatment regimens resulted in the multiplication of cancer specialists and health care professionals. As this occurred, breast cancer patients were repositioned at the hub of a much larger circle of activity. Now, instead of a relationship with her breast cancer surgeon alone, breast cancer patients became involved in a much larger network of relationships. Patients moved from site to site and from appointment to appointment, consulting with surgeons, hematology oncologists, and radiation oncologists. They interacted, as well, with a wider array of nurses, technicians, and even social workers. And, in the Bay Area, the proliferation of cancer specialists and health care professionals was further complicated by the rise of alternative and complementary therapies and practitioners. As a result, for growing numbers of women, being a breast cancer patient became, at least temporarily, a full-time occupation. Taken together, the proliferation of specialists and treatment modalities further undermined the omnipotence of the breast cancer surgeon and repositioned the breast cancer patient-subject within a much more complex series of linkages and flows of information. Thus, the subjectivity of the breast cancer patient, instead of being produced through brief interactions with her surgeon, was reconfigured within a broader set of relationships. The omnipotent gaze of the surgeon was replaced with a polyvalent gaze that included different specialists, but included, as well, the coordinating gaze of the breast cancer patient.

And finally, the space of patient participation, once created, continued to expand as the medical management of women with breast cancer changed in a third and perhaps even more significant dimension. In addition to the aforementioned changes in diagnosis and treatment, a significant shift occurred in approaches to patient rehabilitation. In the mid-eighties, cancer support groups began to proliferate in the San Francisco Bay Area.²⁴ First developed outside of and at the margins of biomedicine, support groups gradually became institutionalized as an adjuvant therapy and rehabilitative technology in the Bay Area medical care system.²⁵ If we think of breast cancer informed-consent legislation as establishing the rights of breast cancer patients to be informed consumers and decision-makers, then the proliferation of support groups and their institutionalization signified the actual expression of that right.

Support groups, initially resisted by physicians, marked a sea change in institutionalized approaches to breast cancer patient rehabilitation. Earlier rehabilitative programs, such as Reach to Recovery and Look Good/Feel Better, were implemented by the American Cancer Society and were dependent upon the approval of an attending physician.²⁶ These programs emphasized a cosmetic approach to dealing with the disease, discouraged the formation of ongoing relationships with other breast cancer patients

and "mastectomees," trained women to hide the evidence of their breast cancer treatments and histories, and encouraged women to quickly return to their former identities and rejoin the "normal" population of women. Within these programs, ACS volunteers were forbidden from offering medical advice to their clients, passing on information about treatments or physicians, or sharing their opinions.²⁷

During the late eighties and nineties, while the Reach to Recovery and Look Good/Feel Better programs continued to expand, support groups appeared alongside them and, without displacing them, began to disrupt certain aspects of the normalization process that these ACS programs were designed to produce. Support groups expanded and deepened the space available for the formation of patient subjectivities, but they did so in a radically new way. For the first time, spaces were created that directly challenged and reconfigured the structures of patient individualization, isolation, silence, and invisibility. They did so through the simple act of bringing patients together in a common space and time and thus facilitating the creation of multiple, ongoing, lateral ties among breast cancer patients. Support groups repositioned patients within an even larger hub of activity and further multiplied an already polyvalent gaze—changing its direction from exclusively up and down, to up and down and sideways.

Support groups pooled the knowledge and experience of their members and facilitators. Participants exchanged information about doctors and treatments, shared experiences, thoughts, feelings, and reactions; validated and affirmed one another's struggles and successes; encouraged each other to get second and third opinions, and to challenge their physicians, insurance companies, and health care providers. Through support groups, breast cancer patients learned how to navigate their way through administrative barriers and mystifying procedures. They learned about clinical trials, experimental procedures, scientific studies, medical databases, alternative treatments, and complementary therapies. They learned about cancer web sites, electronic discussion groups, and listserves. In short, what they acquired, in these spaces, was a sense of being part of a group, a body of knowledge and a set of skills for acquiring information, and a sense of entitlement as breast cancer patients.

Although support groups differed along a number of dimensions and individual women turned to them and away from them for different reasons, it would be difficult to overestimate the significance of their existence, their proliferation, and their gradual institutionalization within the Bay Area medical care system. Support groups shattered the institutionalized barriers that separated women with breast cancer from one another and replaced these with new relationships, emotional support, social connections, flows of information, the development of new languages and bodies of knowledge, a sense of "groupness," solidarity, and new sensitivities.

Unlike the practices of individually-oriented rehabilitation programs which encouraged women to dis-identify, dissociate, and distance themselves from their experience as breast cancer patients, support groups were oriented toward integration in a double sense. First, isolated patients were integrated into one space and time, but second, the experience of breast cancer was integrated into the self—or subjectivity—of the breast cancer patient. Instead of being positioned as an isolated event that was left behind, breast cancer was woven into new relationships, many of which endured beyond the space and time of treatment. And, as disavowal and dissociation were replaced with connection and integration, the institutionalization of support groups created an ever-widening circle of women with new and enduring group identities.

In addition to the transformation of the breast cancer patient-subject within the space of the clinic, an equally significant transformation occurred outside the walls of clinical medicine. In the 1970s, mammography—an X-ray technology that had been used erratically since the fifties to visualize already identified breast lesions—began being used as a technology for screening asymptomatic populations of women.²⁸ In 1973 the American Cancer Society (ACS) and the National Cancer Institute (NCI) launched the Breast Cancer Detection Demonstration Project (BCDDP), the first major "field campaign" in the newly declared "War on Cancer."²⁹ Designed as a mammography public relations and educational campaign rather than a scientific study, the "demonstration project" enrolled over 275,000 women over the age of thirty-five for five years of free clinical exams and screening mammograms at twenty-seven medical centers around the country.³⁰ By the time it concluded in 1978, the BCDDP had received both positive and negative publicity and it had ignited a series of public debates and controversies about mammography, some of which are still with us today.³¹ But it also, and most importantly—despite the volatile debates it engendered—introduced growing segments of the female population to the concept, and increasingly the practice, of self-surveillance and mammographic screenings for breast cancer.

Although the movement of the "mammographic gaze" into the public sphere was initiated during the seventies, the mammographic screening of healthy populations expanded rapidly during the eighties and nineties.³² A two-pronged campaign initiated by the ACS directed educational efforts to physicians, on the one hand, and women as consumers of medical services, on the other. Both prongs emphasized the holy trinity of early detection practices—breast self-exams, clinical breast exams, and screening mammograms.³³ While this was underway, private industry developed its own early detection campaigns. During the mid-eighties, mammography equipment companies such as General Electric and DuPont (manufacturers of mammography machines and the film that they use) initiated their own series of

campaigns, advertising in women's magazines, newspapers, and other media.³⁴ And, in 1985, National Breast Cancer Awareness Month (NBCAM) was invented by Imperial Chemical Industries (ICI)—a British manufacturer of plastics, pesticides, and pharmaceutical drugs. NBCAM was later taken over by its subsidiary Zeneca Pharmaceuticals, manufacturers of tamoxifen, the best-selling breast cancer treatment drug in the world. Every October since 1984, NBCAM—which is now supported and endorsed by more than seventeen governmental, professional, and medical organizations, including the National Cancer Institute, the American College of Radiology, and the Susan G. Komen Breast Cancer Research Foundation—organizes a massive campaign and media blitz that promotes the message of mammographic screenings and early detection. Although, over the years, NBCAM and other early detection campaigns have made exaggerated claims about the benefits and dependability of mammography, used misleading slogans that substituted the language of prevention for the possibility of earlier detection, and have targeted younger women—the group for which no benefit of screening has ever been definitively established—the circulation of the discourse of early detection has been very successful in reaching an ever-widening audience of women.³⁵

During the eighties, the expansion of mammography as a screening technology was particularly successful in the Bay Area and particularly among middle-class white women. As in other parts of the country, breast cancer incidence rates jumped suddenly during the mid-eighties as more women began getting screened. The rates then settled back down to a slow but consistent creep upward.³⁶ And between 1987 and 1994 in California, the rates of screening mammography continued to rise steadily among all racial categories.³⁷

By the early 1990s, early detection campaigns had moved the possibility and even the anticipation, of breast cancer into the psyches and practices of growing numbers of women, especially middle-class white women. The expansion of early detection practices transformed normal breasts into suspect purveyors of disease, healthy women into asymptomatic patients, and entire female populations into populations "at-risk." As the imaging technology of mammography improved, it also repositioned growing numbers of screened women who received "suspicious" or "abnormal" mammograms within ambiguous categories. Some of these women watched and waited, others underwent further diagnostic procedures and biopsies of their lesions—most of which turned out to be benign. But some of these biopsies resulted in the diagnosis of conditions that were not well understood and for which clinical treatment was uncertain.³⁸ Increasing numbers of women thus entered into liminal sorts of "higher risk" and "precancerous" statuses in which they were forced to choose between prophylactic treatments such as mastectomy and/or hormone therapy, or years of intensified surveillance, anxiety, and waiting.³⁹

Thus, the effects of mammographic screening extended far beyond the thousands of women whose breast cancers were ultimately discovered. The millions of women who received "normal" mammograms were reconstituted as always at risk and taught to practice self-surveillance and hyper-vigilance. Every suspicious mammogram and each benign breast condition and every diagnosis with an unclear prognosis created another woman *without* breast cancer but whose life—whose psyche and body—had become more deeply entangled in the breast cancer apparatus. The acceptance and practice of breast cancer screening in the Bay Area thus made more permeable and ambiguous the rigid borders that had formerly separated the relatively small numbers of women who were *inside* the medical machinery of breast cancer from the vast majority of women who remained *outside* of it. Ultimately, then, what emerged were new relationships to breast cancer: rigid separations were replaced by shifting positions on a disease continuum and the future that every woman sought to avoid was searched for and anticipated within the lived present.

Together, these new relationships carved out a space for the formation of new subjectivities. They created new flows of information, new social connections, and new forms of solidarity. And they created new sensibilities—a heightened sense of risk and vulnerability and a greater involvement in the practices of breast cancer surveillance and risk management among ostensibly cancer-free women. It was these developments that restructured the stigma of breast cancer and created fertile soil for the grassroots mobilizations that ensued. As the decade of the nineties wore on, federal and state programs were developed and implemented in California that extended early detection campaigns into populations of medically marginalized women, especially within the overlapping categories of poor and uninsured women, older women, and women of color.⁴⁰ These developments further expanded the populations of asymptomatic women incorporated into the breast cancer apparatus and reconstituted them as risky subjects.

Out of these conditions emerged dedicated activists, concerned participants, and receptive audiences. Each strand of activism in the Bay Area—represented by Race for the Cure, the Women & Cancer Walk, and the Toxic Tour of the Cancer Industry—built upon the foundation created by these changing breast cancer and breast health practices and drew upon the material and discursive resources of pre-existing industries and social movement communities. Race for the Cure drew upon the medical-industrial complex, corporate cultures, and the beauty, fitness, and fashion industries. The Women & Cancer Walk drew upon the women's health movement and AIDS activism. And the Toxic Tour drew upon feminist cancer activism and joined it to the environmental justice movement. Each form of activism sought to appeal to and reshape these emergent subjectivities, solidarities, and sensibilities, and each movement defined itself according to the different ways in which it did so.

THE SAN FRANCISCO RACE FOR THE CURE

It is a beautiful October morning in San Francisco and, over the next few hours, nine thousand individuals, families, friends, corporate running teams, and corporate sponsors will gather together and engage in a participatory public ritual that honors and celebrates the lives of women with breast cancer—from past, present, and future generations.⁴¹ As they do so, they will raise \$400,000 as a symbol of their support for scientific research and breast cancer early detection practices. By the end of 1996, more than sixty Race for the Cure events will have been held across the country. This one, like many others, falls during National Breast Cancer Awareness Month and complements the NBCAM agenda.⁴²

In Golden Gate Park, the atmosphere of a carnival prevails. The sixth annual Race for the Cure, sponsored by the Susan G. Komen Breast Cancer Foundation, is coming to life. Corporate booths line the outskirts of Sharon Meadow. Inside the booths, staffers hawk their wares. Dressed in running attire, thousands of women, children, and men meander about. The crowd is about three-quarters white and three-quarters women, most of whom are towing clear plastic *Vogue* bags that contain free hair products, cosmetics, lotions, and perfumes. The bags are rapidly filling up with more free items—pins displaying the newly issued breast cancer awareness postage stamp, pink ribbons, and breast self-exam brochures. A brochure from Tropicana Orange Juice, one of the national sponsors of the Race, offers some encouraging news about how to avoid breast cancer. We're told: "Don't gamble with the odds. If you play it smart, you can beat them." Tropicana even provides a set of diet tips and orange juice recipes to help us do it. The brochure explains that being overweight and not getting enough vitamin C are "risk factors" for the development of breast cancer.

In addition to the booths of the corporate sponsors (Chevron, Genentech, J. C. Penney, American Airlines, Ford, Pacific Bell, *Vogue*, Nordstrom, Wells Fargo, BankAmerica), the medical care industry is in attendance: Kaiser Permanente, California Pacific, Davies Medical Center, UCSF (University of California, San Francisco)—Mount Zion Hospital, the UCSF Mobile Mammography Van, Marin General Hospital, and others. In an increasingly competitive industry and in the breast cancer capital of the world, breast cancer is a big-ticket item. The last few years have witnessed a whirlwind of sales, closures, and mergers, and many of the medical centers that remain have reorganized their services and repackaged their messages to better appeal to the concerns and demands of these female baby-boomer consumers. One "breast health" center distributes an eleven-page handout listing thirty-four services, groups, and programs for women with breast cancer and breast health concerns.

Last but certainly not least, the fitness, nutrition, beauty, and fashion

industries are here in spades. They offer an amazing array of services and top-of-the-line accessories tailored to the special needs of women in treatment for cancer and women who have survived breast cancer treatments. There are nutrition consultants, fitness experts, and hair stylists. There are special lotions and cremes. There are special swimsuits, wigs, scarves, make-up, clothing, and vitamins. There are customized breast prostheses, beginning at \$2,100, that are created from the cast of a woman's breast before it is surgically removed. There are partial prostheses for women with less radical surgeries. And, for the more active crowd, there are sports bras, biker pants, and baseball caps—with or without attached ponytails. There is a lot of sexy lingerie. And in a stroke of marketing genius, one women's fashion catalogue weds the breast cancer patient's pursuit of femininity to the baby boomers' feminist sensibilities. The cover of the catalogue features a quote attributed to Simone de Beauvoir: "One is not born a woman, one becomes one." Inside the catalogue are means of (re)becoming a woman—prostheses, lingerie, ponytails, and fitness wear.

Adding to the festive atmosphere are the shiny new automobiles parked in the middle of the meadow and adorned with balloons, courtesy of Ford and Lincoln-Mercury dealerships—national sponsors of the Race. In every direction, purple and aqua balloons dance in the air. Also bobbing about in the crowds and easily noticeable from a distance are women in bright pink visors. These visors signal a special status and are worn with pride. On each visor, below the corporate logos, the following message is stitched in black: "I'm a survivor." The visors are being distributed from a special booth, situated in the center of the meadow—the Breast Cancer Survivors' Station. Here, more than a dozen queues have formed with women standing six deep, chatting, socializing, and awaiting their turn to receive the complimentary pink visors that mark them as breast cancer survivors. As each woman dons her visor and mingles with the crowd, she proudly, voluntarily, and publicly marks herself as a breast cancer survivor. This is an act of social disobedience—a collective "coming out," a rejection of stigma and invisibility. Later, after the Race has been run and walked, there is an official ceremony during which all the breast cancer survivors who wish to be recognized are asked to ascend the main stage. They are honored for their courage in fighting breast cancer and for their willingness to demonstrate to other women, through their rejection of the cultural code of silence and invisibility, that breast cancer is not shameful, that it is survivable, and that it is not disfiguring or defeminizing.

One way of publicly remembering and honoring women with breast cancer is provided at the registration tables. Instead of the standard numbered forms pinned to the backs of the contestants, participants can choose to wear "In Honor of" and "In Memory of" forms displaying the names of women—both living and dead—whom they wish to publicly honor and

acknowledge or mourn and remember. These forms are pink instead of the standard white. They mark their wearers with a particular status. In choosing to display these forms, the exhibitors identify themselves as part of the expanding circle of those whose lives have been touched by breast cancer. These moving exhibits generate powerful effects. Watching, running, or walking in the Race, one encounters the pink signs here, there, and everywhere. They are powerful visual reminders of the pervasiveness of this disease. They are symbols that generate strong emotions and solidarity. The practice of wearing a sign is a way of enacting community, including oneself in this sea of runners who have suffered, personally or vicariously, from this disease and who are working together to raise awareness of breast cancer and money for mammograms and a cure. These signs embody the public display of private triumphs and losses. Wearing them is a collective act at once painful, brave, and hopeful.

There are three more ways in which breast cancer is visually coded, packaged, and displayed. All three are stationed at one end of the meadow, apart from the booths. The first display is in the form of a large vertical cloth banner. The banner is imprinted with thousands of pink ribbons—the symbol of breast cancer awareness. Many of these ribbons are filled in with handwritten names. Everyone is invited to write a name on a ribbon. The second display is “The Breast Cancer Quilt.” Modeled after the AIDS Quilt but in smaller dimensions, the project consists of many quilts—and there are several on display—each containing approximately twenty twelve-by-fourteen-inch panels. Unlike the AIDS Quilt, however, which recognizes those who have died, the Breast Cancer Quilt recognizes survival. Each panel is created by a breast cancer survivor—or by a woman who, at least at the time of the quilt-making, was a survivor. Not far from the Breast Cancer Quilt is the “Wall of Hope.” This display contains a long series of panels. Each panel is comprised of fifteen eight-by-ten-inch “glamour photos” of breast cancer survivors. The survivors are photographed in full make-up and adorned in brightly colored evening gowns, sparkling jewelry, and even feather boas. Almost all of the survivors are white. Dark-skinned women stand out in a sea of light faces, their visages poorly captured by a photographer accustomed to working with lighter hues. Each woman is identified by name and by year of diagnosis or by number of years of survival. Frozen in time, all of these women are “survivors”—even those, unidentified, who are now dead.

The message of the official program, conducted on a stage by a woman in a pink visor, is clear and concise: the cure for breast cancer lies in two directions—bio-medical research and early detection. The audience is informed that the San Francisco chapter of the Komen Foundation—sponsors of this Race and sixty-six others being organized by local chapters throughout the country—has contributed more money for breast cancer research, screening, and early detection than any other private organization dedicated solely to breast cancer in the world. The audience learns that the

Susan G. Komen Breast Cancer Foundation was established in 1982 by Nancy Brinker in memory of her sister, Suzy, who died from breast cancer at age thirty-six. “Back then,” says the speaker, “there was no follow-up therapy, no radiation, no chemotherapy, no pill.” Those were the dark ages of medicine.

The speaker continues with her story of individual control and medical progress: Nancy Brinker learned from her sister’s experience “that early detection is the key.” This knowledge served her well. As a result, she was vigilant and proactive in her own “breast health practices” and was soon thereafter diagnosed with early-stage breast cancer. She is now a survivor. This is a success story. The speaker concludes: “This is what every woman here needs to know. All women should get a baseline mammogram at age thirty-five, every two years after age forty, and yearly after age fifty. And every woman should practice monthly breast self-exam.” The message here is clear: bio-medical research has led to advances in breast cancer treatments that, in combination with breast self-exam and mammography, are saving a new generation of breast cancer patients and transforming them into breast cancer survivors.

This is the archetypal story of Race for the Cure and Breast Cancer Awareness Month. It is a story of individual triumph and agency. There is nothing sad or tragic about Brinker’s encounter with breast cancer. Responsibility exists solely in the context of detection, not within the realm of causation. In fact, questions of causality are unspeakable within the terms of this discourse. The Brinker narrative is a story of unqualified success. It is also, of course, a story of failure, and in this sense it serves as a cautionary tale. Brinker’s sister Suzy was not aware of or did not practice early detection. Suzy’s breast cancer was diagnosed too late. She did not receive radiation or chemotherapy. She died. In this morality tale the proactive survive and the irresponsible and unaware die. In the discourse of the Race, survival is a matter of individual choice and responsibility. Mammograms never fail to diagnose breast cancer early and women diagnosed early never die. And for those who practice breast health, breast cancer may constitute a momentary setback, but it is no longer 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. Thus the story told by Race for the Cure to the participants gathered together is a story of individual control and empowerment, a narrative of hope, and a declaration of faith in the steady progress of science and medicine.

THE BAY AREA WOMEN & CANCER WALK

It is a cold fall morning in San Francisco.⁴³ Gradually a crowd of between six and eight hundred assembles in front of a makeshift stage in Golden Gate Park. This is the fifth annual Women & Cancer Walk. Like the Race for the

Cure, this is a fund-raiser and a celebration of community and solidarity. The money raised by these walkers, however, does not go to breast cancer research or to fund the UCSF Mobile Mammography Van. Instead, the proceeds—which totaled \$115,000 the previous year—are evenly divided among a multicultural set of health organizations, twelve in all, and are loosely earmarked for any project or purpose that benefits women with any type of cancer, not just cancer of the breast. Like Race for the Cure, the Women & Cancer Walk is held in Sharon Meadow. But in such an expansive meadow, eight hundred feels like a small group. At the Race, this meadow easily accommodated nine thousand participants.

But this crowd is different from the Race crowd in other respects as well. Like those at the Race, the vast majority of the participants, perhaps three-quarters, are white women. But although the Race crowd appears to draw most of its participants from the corporate sector, most of the participants of the Women & Cancer Walk do not look like middle-class married professionals. Both the Race and the Walk are dominated by white women in their forties and fifties, but the majority of the women at the Walk appear to hail from different political and cultural locations. This event has a different feel to it and a different visual impact. At the Walk, there is a strong feminist, lesbian, queer, and countercultural presence. It is signaled by styles of dress, hair, adornment, and body language, and by the decentering of emphasized Anglo heterofemininity. At the Walk, there are women with obvious disabilities, large women, women for whom walking a mile will be an effort and for whom running a race would be out of the question. There are relatively few women in brand-name fitness wear. There are women with multiple piercings and women with tattoos. There are women with dreadlocks, very short hair, and no hair at all. There are couples and some children in evidence, but the children are just as likely to be accompanied by two moms as by a mom and a dad. Unlike the Race, at the Walk women of color are visible as volunteers, performers, and participants, although their numbers are small for a city as racially and culturally diverse as San Francisco.

Several folding tables line one side of the meadow with signs crowded together that are blowing over repeatedly, each identifying one of the thirteen beneficiary organizations. The beneficiaries include three feminist cancer organizations and six women's health advocacy organizations—two Latina, two African-American, one Vietnamese, and one older women's. The beneficiaries also include three community health clinics—one lesbian, one Native American, and one serving a cross-section of poor people in San Francisco's Mission neighborhood. But, although the Walk tries to construct a multicultural and multiracial community, the links within this community are visibly weak. Several of the beneficiary organizations are present in name only.

Except for a small Kaiser Permanente table set off by itself, the health

care industry is entirely absent. There is no trace of the beauty, fashion, fitness, banking, chemical, and pharmaceutical industries. Although one panel of the Breast Cancer Quilt is on display, the Wall of Hope exhibit of glamour photos is absent. Pink ribbons signifying breast cancer awareness are not in evidence, although a number of women are wearing the "Cancer Sucks" button distributed by Breast Cancer Action. There are no pink visors. What seems to be emphasized in the context of the Walk is not the specialness and separateness of women with cancer histories, but their unremarkable typicality. Nonetheless, it is possible to identify some women who have experienced cancer treatments. Beneath the T-shirts and sweat-shirts of these women it is possible to discern the outline of one breast, but not two.

Even to the untrained eye, it is impossible to miss the lingering evidence of breast cancer inscribed on the body of one participant. RavenLight, a local activist who was honored last year as one of five "Walkers of Courage," moves about greeting friends and fans. She is bedecked in a tight white and black dress with a red belt, black hose, and high heels. Hardly a display of normative femininity, however, one side of her bodice is pulled down and secured in back to reveal a smooth surface traversed by a thin scar where her right breast used to be. The absence of one breast is exaggerated by the fullness of the breast that remains. She is a lesbian breast cancer activist and an ambassador of exhibitionism. In a manner quite different from the way that Race for the Cure connects breast cancer to femininity and heterosexuality, RavenLight unabashedly displays and celebrates the enduring sexuality of one-breasted women.

For the past couple of years, Walkers of Courage have been named and honored on stage. Sometimes they are women with breast cancer in their recent history. Just as often they are women currently living with advanced disease. But always, they are women who are singled out for their service and activism rather than for their survival. Last year, Gracia Buffleben, a woman then living with advanced metastatic breast cancer, was honored as a Walker of Courage. During the previous year, Buffleben and a handful of local breast cancer activists had worked with AIDS activists from ACT UP Golden Gate (AIDS Coalition to Unleash Power) to graft ACT UP tactics onto breast cancer activism.⁴⁴ In December they had organized an act of civil disobedience against Genentech, a powerful Bay Area biotech company, in order to win access, on the principle of "compassionate use," to a promising new drug then in the final phase of clinical trials. When Buffleben ascended the Women & Cancer Walk stage to accept her award, ACT UP activists, dressed in their uniform of black T-shirts, stood behind her holding signs emblazoned with rows of gravestones. The signs read: "Don't Go Quietly to the Grave. Scream for Compassionate Use!" In form and structure, this ceremony was no different from Race for the Cure's on-

stage recognition of breast cancer survivors. The contrast in images and meanings, however, was striking: black replaced pink; death replaced life; anger replaced gratitude.

As in previous years, the Walk's program is deliberately multicultural and multiracial—more so than the audience. Sign language interpretation is provided on stage. Music is provided by Tuck and Patti—a mixed-race couple, performers in the jazz music scene. The program is kicked off by an Afro-Brazilian dancer and masseuse who leads a pre-walk warm-up. San Francisco Mayor Willie Brown is next, and he begins by promoting the upcoming Mayor's Summit on Breast Cancer and ends by promoting prostate cancer awareness. He is followed by a speaker from the Native American Health Center—one of two main speakers. She speaks about the large Native American community in Oakland, a community that she is a part of, and she describes the lack of access to basic health and cancer support services. She then describes the uses to which the money donated to her health center by the Women & Cancer Walk has been put. These funds paid for cab fare to the hospital for a woman receiving chemotherapy who was too sick to take the bus across town to the public hospital. They paid for phone service for a woman dying of cancer so that she could talk to her family in the Southwest during her final weeks of life. They bought Christmas toys for the children of a third woman with cancer. They paid for a therapist for a fourth woman who was trying to come to terms with her imminent death. And they helped pay the burial expenses of another. Each woman's story is narrated with respect and compassion.

These are stories of desperation, complications, hardship, loss, and death. The subjects of these stories do not speak for themselves: they are spoken of by another. But they are spoken of, and discursively constituted, as women with complex lives, commitments, and responsibilities; these are women with their own needs, histories, priorities, and desires. They are individuals, but individuals embedded within particular cultures, classes, and communities. These women are not passive and they are not irresponsible—even if they are struggling with and dying from cancer. The speaker makes clear that their lives are lived in a vortex of multiple institutionalized inequalities and that cancer is just one of many obstacles they have faced. Perhaps some of these women will become long-term survivors, but this is not where the logic of the narrative leads. This is not a discourse of individual choice and responsibility. This is not a story of hope, survival, and triumph over adversity. This is a discourse of harsh realities, poverty, and medical marginalization.

Although the Women & Cancer Walk focuses on services, advocacy, and treatment activism for women with cancer, during the last three years the event has begun to emphasize the importance of the environment as a cause of deteriorating health and rising rates of cancer. The keynote address

is delivered by an Italian woman, a cancer and environmental activist who tells a series of stories about real people in faraway places, weaving together the global connections between rising cancer rates, profit-driven industries, and environmental racism. She connects struggles against environmental pollution in the Bay Area to the struggles of communities in Mexico, Italy, and elsewhere. She constructs a hopeful story about a global struggle against the cancer industry. And she identifies herself as an activist with the Toxic Links Coalition.

THE TOXIC TOUR OF THE CANCER INDUSTRY

Just before noon on a crisp October day in downtown San Francisco, a boisterous crowd has gathered on Market Street in front of Chevron's corporate headquarters.⁴⁵ Metal barriers and uniformed police line the sidewalk and street, separating the courtyard and sidewalk traffic from the approximately 150 protesters who are assembling on the other side to kick off the third annual Toxic Tour of the Cancer Industry. As at the Race and the Walk, about three-quarters of the participants are women and three-quarters are white. But a majority of the speakers will be people of color and, in contrast to the Race and the Walk, men are equally positioned as speaking subjects at this event. A large banner identifies the organizers of the Toxic Tour. It reads: "Toxic Links Coalition. United for Health and Environmental Justice." Although neither the name of the coalition nor the slogan on this banner refers explicitly to cancer, the majority of the visual signs and signifiers do. The main theme of the tour—"Stop Cancer Where It Starts! Stop Corporate Pollution!"—is written across a large banner that occupies center stage.

As the Tour proceeds, each and every speaker along the way will create discursive linkages between the rising rates of cancer and the targets of the Toxic Tour—Chevron, the American Cancer Society, Pacific Gas & Electric, United States Senator Dianne Feinstein, Burson Marsteller (a public relations firm), and Bechtel (a builder of nuclear power plants). But these targets are just convenient symbols of what the Tour's organizers characterize as "the cancer industry": they are local outposts of a much larger and interlocking system. During the next hour, these activists will make repeated references to breast cancer, some of them self-referential, but they will consistently connect breast cancer to cancer in general, and to other environmentally related health problems. Within this discourse, breast cancer is positioned as the canary in the coal mine. It is one among many escalating health problems. These health problems will be redefined by the Toxic Links Coalition as human rights abuses rather than individual medical disorders, and they will be discursively linked to the cancer industry. Through the delivery of speeches, the display of signs, and the movement from site to site, the cancer industry as an entity will be physically mapped and concep-

tually constructed—brought to life and materialized through the performance of the Toxic Tour.

The Toxic Tour kicks off at Chevron and begins by ceremoniously replacing National Breast Cancer Awareness Month (NBCAM) with a different public relations campaign: Cancer Industry Awareness Month. NBCAM is exposed as a public relations campaign started in 1985 by Zeneca, a pharmaceutical and chemical corporation that manufactures the pesticides that contribute to the breast cancer epidemic, produces the breast cancer drugs that treat it, and owns the cancer centers that distribute drug prescriptions. All of the speakers shift the focus from the biomedical geography of individual women's bodies that is promoted by NBCAM to the political geography of the cancer industry.⁴⁶

Nancy Evans, a white woman who speaks on behalf of Breast Cancer Action, the Toxic Links Coalition, and the National Coalition for Health and Environmental Justice, delivers the first short speech:

We're here because America has lost the war on cancer. Despite twenty-five years and more than thirty billion dollars, cancer incidence is up 18 percent, mortality is up 8 percent. Breast cancer is only a symptom of this larger epidemic, but every day in the Bay Area twelve women are newly diagnosed with breast cancer, and three women die of breast cancer, and every one of those is one too many. Cancer kills half a million people every year in this country. It kills somebody every minute, and by the year 2000 it's gonna be the leading cause of death. So we're here today to tell the truth about cancer—that cancer starts in the boardrooms of corporate America and in the boardrooms of PR [public relations] agencies who are paid to cover up the crimes of corporate America. If I shoot somebody and kill them, I go to jail. But if a corporation poisons a whole community, they go on doing business as usual. Cancer is a multi-billion dollar industry, and many of the same corporations who are making pesticides and herbicides and other cancer-causing chemicals are also making drugs to treat cancer. . . . It's time to take back our communities. . . . Stop the poisoning!

Interestingly enough, although Evans identifies herself with three organizations, she does not foreground her own history with breast cancer or identify herself, in this instance, as a "breast cancer survivor." Instead, like many other speakers throughout the day, she shifts attention away from her individual story in order to foreground a narrative about the cancer industry. Throughout the Tour, when speakers refer to their individual cancer histories, they do so with outrage and anger, rather than with pride and the sense of accomplishment. Instead of calling herself a survivor, for example, Essie Mormen, an African-American activist, begins her speech by explaining that it is difficult for her to step up to the speaker's platform because "it's hard to move these days since getting this disease and being tired all the time." She then continues with a narrative quite different from the Race's

narrative of survival: "I'm very suspicious of pesticides because my mother died from breast cancer, I just lost my brother, . . . and I'm probably dying from it too! So let's act! . . . We ain't gonna take this anymore!" Other speakers refer to themselves as "cancer victims" and women "living with cancer," thus constructing cancer as an ongoing struggle rather than a story of triumph.

The Toxic Tour is choreographed so that each stop along the way constitutes a link in the chain of the cancer industry. Because good public images are highly valued commodities, the Toxic Tour uses the only weapon it has at its disposal: the Tour attempts to generate negative publicity and sully corporate images. This is a smear campaign, a strategy of public shaming, an attack on corporate images. At each stop along the way, a culprit is identified and its name is bellowed out over a bullhorn. Henry Clark, an African-American activist with the Richmond, California-based West County Toxics Coalition, stands in front of Chevron and condemns them for "profiting at our expense!" He explains that Chevron's incinerators spew dioxins and other toxins into his community, poisoning them, causing cancer, and destroying their health. The goal of the Tour—which is chanted over and over again—is to "Make the Link!" and Clark's narrative is representative of those that will follow. The Toxic Tour makes no attempt to engage in conversation or compromise. There are clear lines separating "us" from "them." And if there is any doubt, these lines are reinforced by the uniformed police escort and barricades. This is ritualized confrontation and condemnation. It is street theater that creates the opportunity for the mobilization and expression of oppositional identities. And it is a far cry from the rituals of corporate caring and cooperation that are enacted at the Race.

There are no freebies distributed at this event—none of the beauty products, pink ribbons, or breast health brochures that abound at the Race. There are no corporate sponsors. Although Chevron and the American Cancer Society are present at both the Race and the Tour, they are participants and sponsors of the Race, whereas they are targets of the Tour. At the American Cancer Society, for example, Judy Brady—a breast cancer activist and self-described "cancer victim"—delivers a series of withering charges which she substantiates by handing out bootleg copies of an ACS brochure and a recent internal ACS memo marked "Confidential." The memo instructs all ACS offices to suppress the distribution of an unauthorized brochure produced by a maverick ACS office. The brochure in question is entitled "Warning: The use of pesticides may be hazardous to your health!" This brochure describes the health hazards of pesticides and suggests non-toxic alternatives. Brady charges the ACS with miseducating the public, ignoring cancer prevention, refusing to take a stand against industrial pollution and agricultural poisoning, and colluding with the corporate stakeholders to hide evidence of corporate carcinogens.

The demonstrators carry signs aloft and loudly chant: "Stop Cancer Where it Starts! Stop Corporate Pollution!"—"Toxins Outside! Cancer Inside! Industry Profits! People Suffer!"—"Stop Environmental Racism!"—"Reduce it! Don't Produce it!"—and "Environmental Justice NOW!" Last year the sixty or so protesters carried handmade signs painted with slogans, miniature coffins, and gravestones emblazoned with a handwritten name, a life span, and the letters "R.I.P." This year, the coffins and gravestones are nowhere to be seen but there are other images of death and destruction. There is a show-stealing twenty-foot papier-mâché puppet representing a woman with blue skin and a mastectomy scar dripping blood where her second breast should be. In each of her gigantic moveable hands she holds a container of toxic substances, painted with a skull and crossbones. One woman holds high an exhibit of photographs of women's nude torsos. The photographs include startling images of disfigured women with double mastectomies—some of them with the concave chests characteristic of the Halsted radical mastectomy, a surgical procedure performed by American surgeons on women diagnosed with breast cancer from the 1880s until the 1980s. It is just these sorts of images that Race for the Cure seeks to banish from the fabric of the collective consciousness. But here they are, resurrected and pasted onto the sandwich boards donned by angry women who are marching through downtown San Francisco.

The Toxic Tour draws heavily upon, and seeks to promote, the public's heightened awareness of cancer and its growing sensitivity and exposure to discourses of risk. The bright orange flyers distributed along the way announce that one-third of United States women and half of United States men will be diagnosed with cancer in their lifetimes. The flyer states that the lifetime risk for breast cancer is one in eight and rising, that the Bay Area has the highest rates of breast cancer in the world, and that African-American women living in Bayview-Hunters Point (a predominantly African-American and low-income neighborhood in San Francisco) have rates of breast cancer double those of the rest of San Francisco. The orange flyer also states that "we are all exposed in increasing doses to industrial chemicals and radioactive waste *known* to cause cancer, reproductive, and developmental disorders" and that "big profits are made from the continued production of cancer-causing chemicals." It is this growing sense that cancer is everywhere and affects all of us that the Toxic Tour seeks to mobilize and redirect into demands for cancer prevention and industry regulations.

At the Toxic Tour, there is no call for more research to uncover the mysteries of tumor biology or discern the patterns of epidemiology. There are no demands for more or better science, or for more or better medical services. There is no call for women to be vigilant, to practice breast self-exam and get mammograms. Mammography is invoked—but as an example of false promises and corporate profit-mongering. These activists do not pro-

mote the ideology of early detection. Instead, they map the sickness and disease of the collective body onto the corporate corpus. Prevention, it is clear, requires a different kind of cartography.

PROJECTING THE LOCAL ONTO THE GLOBAL

Twenty years ago, Susan Sontag dreamed of a world in which people diagnosed with cancer would no longer be forced into exile and haunted by the lurid metaphors created by fearful and ignorant outsiders. Although she was an artist and a visionary, Sontag nonetheless considered farfetched the possibility of redeeming the stigmatized social identities of people with cancer, and she viewed as impossible the task of aestheticizing a disease so thoroughly "overlaid with mystification" and so firmly shackled to "the fantasy of inescapable fatality."⁴⁷ Impossible, that is, but for the forces of biomedicine. In Sontag's biomedical dreamscape—a dreamscape shared and institutionalized by the state, by the pharmaceutical industry, and by the scientific research and medical establishments—faith and fantasy joined hands and together mapped a future in which the stigmatizing metaphors of cancer would become obsolete as the steady march of biomedicine demystified disease and disconnected it from macabre visions of death. Drawing an example from the history of tuberculosis, Sontag reasoned that advances in the science of cancer would likewise remove it from the realm of metaphor, place it squarely in the realm of science, and then sweep it into the dustbin of history. In short, stigma would be replaced by science, meaning by medicine, and cancer by cure.

In the twenty years that have elapsed since the publication of *Illness as Metaphor*, the socially organized stigmatization of women diagnosed with breast cancer has indeed diminished. At first glance, then, it might appear that Sontag was prophetic in tying the social fortunes of people with cancer to advances in biomedicine. But closer examination reveals that the necessary conditions for this process of destigmatization were *not* produced as a result of the medical and scientific *conquest* of this disease but rather as a result of its medical and scientific *colonization*. It was, in other words, the vast expansion of breast cancer screening, treatment, and patient support practices, more than any significant progress in preventing, treating, or curing the disease, that reorganized the structure of stigma and hence created the preconditions for its resignification by breast cancer movements. In fact, what changed most dramatically in the last twenty years was not the *effectiveness* of breast cancer medicine, but its expansion.

Treatment regimens multiplied, support groups proliferated, and screening expanded into asymptomatic populations. This three-dimensional transformation in the management of breast cancer resulted in the formation of new social spaces, social networks, solidarities, and sensibilities among

women with and without the disease. It resulted, in other words, in the production of new subjects and new socio-spatial relations of disease, and it was these subjects and socio-spatial relations that constituted the facilitating conditions of the social movements that ensued. In turn, the movements around breast cancer reshaped the social contexts in which breast cancer was experienced and encountered, and resignified the stigmas attached to it.

As this chapter demonstrates, the politicization and resignification of breast cancer in the Bay Area occurred in at least three different ways and according to three different logics. All three strands of the local field of activism challenged the stigma of breast cancer by building upon, strategically mobilizing, and reshaping these new subjectivities, solidarities, and sensibilities. And each strand of the breast cancer movement drew upon the material and discursive resources of pre-existing fields in order to do so. Race for the Cure drew upon the medical-industrial complex, corporate cultures, and the beauty, fitness, and fashion industries. The Women & Cancer Walk drew upon the women's health movement and AIDS activism. And the Toxic Tour drew upon feminist cancer activism and joined it with the environmental justice movement. What distinguished each strand of the local breast cancer movement was the way in which it mobilized these resources and shaped new discourses of disease and new forms of breast cancer activism.

The political logic of each strand of Bay Area activism—biomedical research and early detection; patient support and health care activism; and cancer prevention—was mirrored at the global level, although imperfectly, in the three main themes of the World Conference on Breast Cancer—diagnostics and treatment, caring for the whole woman, and breast cancer and the environment. But this apparent mirroring of activist agendas and organizing trajectories occluded what was actually quite extraordinary about both sites of activism. What distinguished both Bay Area activism and the Kingston conference was the incorporation of environmental justice issues into the center of breast cancer activism. Indeed, both the Bay Area field of activism and the Kingston gathering were exceptional, rather than representative, for having created a potent synthesis between the feminist health and environmental justice movements.

But this synthesis was neither automatic nor easy. Indeed, a quick glance in another direction demonstrates that a different trajectory of global organizing was simultaneously gathering momentum. This trajectory was spearheaded by the National Breast Cancer Coalition (NBCC), a feminist, Washington, D.C.-based breast cancer activist and lobbying organization that was formed in 1991 in order to raise awareness of breast cancer, increase the federal budget for breast cancer research, and expand the influence of breast cancer advocates in research and public policy arenas. In

March of 1997, the NBCC sought to expand the breast cancer movement and extend its assistance to breast cancer activists in other parts of the world by organizing a global gathering quite similar to the Kingston affair. The NBCC-organized event, the "First World Conference on Breast Cancer Advocacy—Influencing Change," was held in Brussels, Belgium, in March of 1997 and attended by approximately two hundred fifty breast cancer activists, health professionals, health educators, and industry representatives from forty-three countries.⁴⁸

Although the Brussels and Kingston conferences shared a number of qualities, they differed along one key dimension.⁴⁹ Whereas in Kingston breast cancer was linked to issues of environmental justice and the post-World War Two chemicalization of the planet, in Brussels breast cancer was conceptualized strictly within a biomedical paradigm. The presentations and workshops on cancer and the environment that were so numerous in Kingston were noticeably absent from the Brussels agenda and its roster of speakers.⁵⁰ In their place, the chemical-pharmaceutical industry was well-represented—materially, as the underwriters of the conference, and discursively, as potential allies of the movement.⁵¹ Whereas the Kingston conference moved the environment to the center of the agenda, the Brussels conference pushed it off into the silence of the margins. In fact, because the Brussels conference embraced an individualizing, biomedical model of disease, when the discourse of prevention actually appeared, it did so in the guise of individual risk-reduction "lifestyle" practices and pharmaceutical risk-reduction "treatments." The most obvious difference, then, was that the third prong of activism—cancer prevention—did not penetrate this global geography of action.⁵²

The distinctiveness of the world conferences on breast cancer in Kingston and Brussels indicates that the nascent globalization of breast cancer activism is moving in two different directions. One trajectory, represented by the National Breast Cancer Coalition's (NBCC's) globalizing vision of breast cancer advocacy, has aligned itself with Sontag's dream of salvationist science and curative medicine. Its "lifestyles" approach to public health is symbolized by individually oriented practices of risk-reduction and early detection, and by a growing alliance with the pharmaceutical industry. A second trajectory, spearheaded by the Women's Environment and Development Organization (WEDO) and a diverse array of predominantly grassroots, North American, feminist, cancer activist organizations, has developed a global vision of public health that is oriented toward forms of cancer prevention that are neither individual nor pharmaceutical in origin. Here, the precautionary principle and the reduction of environmental carcinogens has replaced individual-level models of risk assessment; and here, an alliance with the global environmental justice movement has replaced alliances with the global pharmaceutical industry.

Despite their distinct trajectories, however, the global assemblies share something quite significant in common. Both global gatherings, despite the participation of activists, experts, and allies from around the world, are clearly the projects of local, specifically North American, contexts and conditions. Both global assemblies, in other words, are the projects and projections of very specific and privileged sites of activism. For activists and organizations from the San Francisco Bay Area, for example, the transition from the Bay Area to Kingston, and the translation from local to global sites of activism, was relatively effortless because the global site of activism mirrored, albeit imperfectly, the discursive constellations with which they were already engaged and familiar. But, although in some ways the Bay Area field of activism can be seen as the prototype of the Kingston conference, it must be remembered that it is a prototype that excludes most of the world. For those coming from elsewhere, the transitions to Kingston were bumpier, and the translations from the global to the local, and vice versa, were more partial and incomplete. It remains an open question whether either trajectory of breast cancer activism will be able to achieve relevance and resonance within local sites and struggles around health in other parts of the world.

What, then, can the history of breast cancer activism in the Bay Area teach us about global formations? If it can teach us anything, it is that the development of breast cancer movements is nurtured not only by shared visions of salvationist science, miraculous medicine, and environmental justice, but requires the prior restructuring of silence, isolation, and invisibility, and the creation of new subjects, solidarities, and sensibilities. Without the challenges to stigma that are made possible by these restructurings and recreations, private dreams can never be transformed into publicly enacted global visions.

NOTES

I thank the individuals and organizations, both named and unnamed, who participated in the events and movements written about here. Their visions and commitment inspired my analysis, and I hope they will see themselves reflected in this text. Thanks also to Barrie Thorne, Jennifer Pierce, Leslie Salzinger, Charles Kurzman, Ruth Horowitz, Judith Stacey, and Barron H. Lerner for their helpful comments. I also thank the Doreen B. Townsend Center for the Humanities; the University of California, Berkeley, Department of Sociology; and Sociologists for Women in Society for their generous support of this research. A different version of this paper received the 1999 Sally Hacker Graduate Student Paper Award from the Sex and Gender Section of the American Sociological Association.

1. Susan Sontag, *Illness as Metaphor*, p. 8.
2. Erving Goffman, *Stigma: Notes on the Management of Spoiled Identity*, p. 1.
3. Michel Foucault, *Discipline and Punish*, p. 183.

4. Sandra Steingraber, "We All Live Downwind," p. 43.
5. Nancy Scheper-Hughes and Margaret M. Lock, "The Message in the Bottle," p. 414.
6. Ibid.
7. James Patterson, *The Dread Disease*, p. 231.
8. For analyses of the "War on Cancer," see Robert N. Proctor, *Cancer Wars*; National Cancer Advisory Board-Subcommittee to Evaluate the National Cancer Program, *Cancer at a Crossroads*; Patterson, *The Dread Disease*; Walter S. Ross, *Crusade*; Paul Starr, *The Social Transformation of American Medicine*; Richard A. Rettig, *Cancer Crusade*.
9. In fact, organized cancer research had existed on an international level since the turn of the century—in England, there was the Imperial Cancer Research Fund; in Germany, the Institute for Cancer Research; and in Denmark, Sweden, and Switzerland there were other centers of research. The American Association for Cancer Research was founded in 1907, and the American Society for the Control of Cancer (ASCC), which later became the American Cancer Society, was founded in 1913. See Daniel de Moulin, *A Short History of Breast Cancer*.
10. Michael P. Coleman, Jacques Estève, Philippe Damiécki, Annie Arslan, and Hélène Renard, *Trends in Cancer Incidence and Mortality*.
11. Ralph W. Moss, *Questioning Chemotherapy*.
12. The patterns of breast cancer incidence and mortality that I am presenting here represent the dominant discourse at the World Conference on Breast Cancer in Kingston, Canada. This discourse is not out of the mainstream, however, and is based on figures gathered by the International Agency for Research on Cancer (IARC) and reproduced in many textbooks and reference books on cancer epidemiology. See David Schottenfeld and Joseph Fraumeni, Jr., *Cancer Epidemiology and Prevention*, for a widely accepted presentation of epidemiological patterns and data. The authors of this text state that: "The incidence of breast cancer is increasing slowly in most countries, the rate of increase tending to be greatest where rates were the lowest, e.g., 3.2 percent per annum for Singapore Chinese who have experienced an increase most noticeable in the under 50 age-group. Mortality rates have also been increasing in, for example, Japan and Hong Kong, but have had a tendency to remain stationary in Western countries. In the United States mortality in white women less than 65 years of age has fallen, but among older white women and black women of all ages mortality has been increasing." Schottenfeld and Fraumeni, *Cancer Epidemiology*, p. 156.
13. This assessment and those that follow are based on *SEER Cancer Statistics Review, 1973-1994*.
14. In 1994, the Northern California Cancer Center published data from the SEER cancer statistics and the International Agency of Research on Cancer showing that "white women in the San Francisco/Oakland Area have the highest rate in the world" and that Bay Area black women have the fourth highest rate of breast cancer in the world. See Northern California Cancer Center, *Greater Bay Area Cancer Registry Report*.
15. The Women's Cancer Resource Center (WCRC), a feminist organization that provides free, direct services to women with cancer, was the first of its kind in the country and was founded in 1986 in Berkeley, California. Over the years, it has functioned as a key site for the development of social, cultural, and political projects

around cancer. Also in 1986, the Cancer Support Community was established across the bay, in San Francisco. Out of the Cancer Support Community, the first breast cancer treatment activist organization in the country—Breast Cancer Action (BCA)—was organized in 1990. BCA has been a key activist organization in the breast cancer movement, both locally and nationally. At about the same time that WCRC and CSC were founded, one of the first chapters of the Susan G. Komen Breast Cancer Foundation was established in San Francisco. In 1991, the San Francisco chapter of the Komen Foundation began organizing annual “Race for the Cure” events and funding local early detection campaigns for medically underserved women. In 1992, Charlotte Maxwell Complementary Clinic, the only clinic in the country that provides free complementary therapies to low-income women with cancer, was founded in Oakland. And in 1992, The Breast Cancer Fund, an increasingly influential activist foundation, was established in San Francisco. The Toxic Links Coalition was founded in 1994, and in 1995 Marin Breast Cancer Watch was established.

16. This argument is developed in greater theoretical and historical detail in my dissertation, “Reshaping the Contours of Breast Cancer: From Private Stigma to Public Actions.” There I conceptualize the breast cancer apparatus in terms of two regimes of practices and show how the second regime, “the regime of biosociety,” altered the social terrain of breast cancer, reconstituted the subjects produced within it, and created the facilitating conditions of breast cancer movements. I argue that social movements theory within sociology is stuck in a modernist moment that fails to comprehend the growing significance of biopower, biopractices, and bio-institutions for the emergence of postmodern social movements.

17. Theresa Montini, “Resist and Redirect”; Theresa Montini, “Women’s Activism for Breast Cancer Informed Consent Laws.”

18. Although this legislation did not abolish or criminalize the one-step procedure, it did require surgeons to inform their patients of their treatment options and to inform them, prior to undergoing a surgical biopsy, that they had the right to have this diagnostic procedure separated from any ensuing surgical treatment. Failure to inform patients of their rights to a two-step procedure was categorized as “unprofessional conduct.” Theresa Montini, “Gender and Emotion.”

19. The term “docile bodies” is taken from Michel Foucault, *Discipline and Punish*; “gaz[ing] back” is a reference to the concept of the “clinical gaze” in Foucault, *The Birth of the Clinic*.

20. See Theresa Montini and Sheryl Ruzek, “Overturning Orthodoxy,” for pioneering work on the belated demise of the Halsted radical mastectomy and the resistance of American surgeons to less radical surgeries. The expansion of surgical repertoires occurred not only as a result of the development of new techniques and the clinical trials that proved their effectiveness, but also, and importantly, as a result of patient demands that grew out of the patients’ rights and women’s health movements. Also see Barron H. Lerner, “Inventing a Curable Disease.”

21. Breast-conserving surgeries—a term which many assume refers simply to lumpectomy—include partial or segmental mastectomy, quadrantectomy, tylectomy, wedge resection, nipple resection, lumpectomy, and excisional biopsy, with or without dissection of axillary lymph nodes. Cyllene R. Morris and William E. Wright, *Breast Cancer in California*.

22. Ralph W. Moss, *Questioning Chemotherapy*.

23. Michael W. DeGregorio and Valerie J. Wiebe, *Tamoxifen & Breast Cancer*.

24. In 1986, two cancer support communities were founded by women with breast cancer who were frustrated by the lack of support groups in the Bay Area. In Berkeley, a group of women led by Jackie Winnow founded the feminist and lesbian-friendly Women’s Cancer Resource Center and, in San Francisco, Victoria Wells and Treya Killam Wilber founded the Cancer Support Community. During the nineties, as these grassroots, alternative organizations expanded their outreach to communities of color, support groups for women with breast cancer became institutionalized within the Bay Area health care system.

25. The incorporation of support groups into the health care delivery system was given a boost when David Spiegel, a highly respected scientist-physician at Stanford University Medical Center, published the results of a follow-up to a case-control study. His results showed that women with metastatic breast cancer who had participated in a short-term support group ten years earlier had lived an average of eighteen months longer than those who had not. Spiegel had conducted the follow-up study to disprove what he considered to be exaggerated claims about the survival benefits of support groups. Much to his surprise, however, his findings reinforced this set of claims and propelled forward the institutionalization of support groups in the medical care system. David Spiegel, J. R. Bloom, and H. C. Kraemer, “Effects of Psychosocial Treatment on Survival of Patients with Metastatic Breast Cancer.”

26. The first program, Reach to Recovery, was developed by an ex-breast cancer patient in 1952 and became an ACS-administered program in 1969 (Ross, *Crusade*). The second program, Look Good/Feel Better, reflected changes in patient needs and medical practices and was oriented toward women undergoing radiation and/or chemotherapy. It was incorporated into the ACS rehabilitative arsenal in 1988 (Sharon Batt, *Patient No More*).

27. Batt, *Patient No More*; Ross, *Crusade*; Lester Breslow, *A History of Cancer Control in the United States, 1946–1971*; Audre Lorde, *The Cancer Journals*; Rose Kushner, *Breast Cancer*.

28. The first study to assess the viability and cost-effectiveness of using mammography as a screening technology was actually conducted between 1963 and 1968 by the Health Insurance Plan of Greater New York (HIP). But it was the Breast Cancer Detection Demonstration Project (BCDDP), a collaborative project of the ACS/NCI that introduced the concept and practice of screening to a wider audience. Ross, *Crusade*, 1987.

29. Ibid.

30. Ibid.; Susan Rennie, “Mammography: X-rated Film.”

31. These controversies include debates over whether there is any benefit to screening, in terms of increased survival, for women under the age of fifty (the standardized marker of pre- and postmenopausal status) and whether there is any safe level of exposure to ionizing radiation (in the form of mammography), especially in premenopausal women. Probably the most infamous controversy—but one that more or less died with the demonstration project itself—involved the discovery that mastectomies had been unnecessarily performed on more than sixty women. For discussions of the controversies and politics surrounding screening mammography, see Rennie, “Mammography: X-Rated Film”; Batt, *Patient No More*; and Roberta Alt-

man, *Waking Up, Fighting Back*. Whereas the controversy over screening mammography during the seventies centered around the questions of safety (whether ionizing irradiation of the breast—mammography—was ever risk-free), effectiveness, and age recommendations, the mammography debates during the nineties have centered around issues of age recommendations and access for the category of women referred to as “medically underserved”—primarily women of color and women without insurance.

32. Barron H. Lerner, “Seeing What Is Not There.”

33. Batt, *Patient No More*; Kate Dempsey, Nechama Katz, Traci Sawyers, Ellen Taggart, “Screening Mammography.”

34. Batt, *Patient No More*; Monte Paulsen, “The Cancer Business.”

35. For critiques of Breast Cancer Awareness Month, see Batt, *Patient No More*; Paulsen, “The Cancer Business”; and Proctor, *Cancer Wars*.

36. Morris and Wright, *Breast Cancer in California*.

37. By 1994, the percentage of women over fifty who had ever received a screening mammogram ranged from a low of 68 percent among “Asian/Other” women, to a high of 90 percent among “Black” women. Rates among “non-Hispanic white” women were measured at 87 percent, and 76 percent of “Hispanic” women had received a screening mammogram. Among women between the ages of forty and forty-nine, the rates were 70 percent for “Asian/Other,” 71 percent for “Black,” 69 percent for “Hispanic,” and 83 percent for “White.” Data are based on the California Behavioral Risk Factor Surveillance System (BRFSS); Morris and Wright, *Breast Cancer in California*.

38. Barron H. Lerner, “Fighting the War on Breast Cancer.”

39. Ibid.; Morris and Wright, *Breast Cancer in California*.

40. In 1991 federal legislation mandating partial reimbursement for the cost of mammographically screening women over the age of fifty with Medicare coverage was approved by Congress (Altman, *Waking Up, Fighting Back*). That same year, federal legislation was enacted that established the Breast Cancer and Cervical Cancer Program (BCCCP), administered through the Centers for Disease Control and Prevention (CDC). California immediately applied for participation and became one of the first test sites for that program. Then, in 1993, California enacted legislation that established a statewide Breast Cancer Early Detection Program (BCEDP) comprised of fourteen regional partnerships (the other arm of the legislation established the California Breast Cancer Research Program). Both the BCCCP and the BCEDP, which eventually merged administratively, were designed to provide free clinical breast exams and screening mammograms to poor and uninsured women, and both were targeted, primarily, to communities of color and older women. For additional administrative history and background information on each program, see BCEDP, “Request for Applications,” and BCCCP, “Request for Applications.”

41. The San Francisco chapter of the Susan G. Komen Breast Cancer Research Foundation held its first Race for the Cure in 1991 and has continued to do so, on an annual basis, ever since. I was a participant-observer at San Francisco's Race for the Cure in 1994, 1995, 1996, and 1997. Race for the Cure is a registered trademark. For the sake of easier reading, I have eliminated the trademark symbol (“®”) in the remainder of the chapter.

42. The Komen Foundation is part of the national steering committee of NBCAM.

43. The first Women & Cancer Walk was held in 1992 as part of a larger, collaborative, fundraising effort. In 1993 the Walk was held as its own affair in Golden Gate Park and it has been held there on an annual basis ever since. I was a participant-observer and helped organize the Women & Cancer Walk in 1995 and 1996.

44. Originally formed in New York City in 1987 in order to spur pharmaceutical companies and the federal government to pay greater attention to the AIDS crisis and the needs of people with AIDS and HIV, ACT UP chapters quickly mushroomed across the country—Boston, Chicago, Los Angeles, New Orleans, Portland, San Francisco, Seattle, and Houston. Known for in-your-face politics and flamboyant street theater, ACT UP was “a magnet for radical, young gay men and women” (Steven Epstein, *Impure Science*, pp. 219–20). For an excellent study of ACT UP, see Joshua Gamson, “Silence, Death, and the Invisible Enemy.”

45. The Toxic Links Coalition (TLC) is a synthesis of feminist cancer activism and the environmental justice movement. Formed in the summer of 1994 by activists from the Women's Cancer Resource Center, Breast Cancer Action, Greenpeace, and the West County Toxics Coalition, the TLC expanded within a few months to include more than twenty organizations, most of which were drawn from the environmental movement sector. I began attending monthly meetings and conducting participant observation during the fall of 1994 and was involved in the Toxic Tours of the Cancer Industry in 1995, 1996, and 1997.

46. In 1995 Zeneca bought a 50 percent stake in Salick Health Care, and in 1997 Zeneca's growing vertical integration came full circle when it bought the remaining shares of Salick and took over the management of eleven cancer treatment centers in the United States—including a cancer center just down the road from the Women's Cancer Resource Center, the meeting place of the TLC (Elisabeth Rosenthal, “Maker of Cancer Drugs to Oversee Prescriptions at 11 Cancer Clinics”). NBCAM was listed as the country's second most important censored story in 1998 by Project Censored, a media watchdog project that, for almost twenty-five years, has published an annual list of the top twenty-five stories that were censored or downplayed by the mainstream media. Project Censored is conducted by more than 125 faculty, student researchers, interns, and community experts around the country and is based at Sonoma State University in California. See Jim Doyle, review of *Censored 1999*. See also Gabriel Roth, “Not Fit to Print?”

47. Sontag, *Illness as Metaphor*, p. 84.

48. In fact, although the NBCC's world conference was held *before* the Kingston conference, the NBCC did not begin planning their global gathering until well *after* plans for the Kingston conference were finalized and publicized. And, although Susan Love, one of the founders of the NBCC, delivered a luncheon speech at the Kingston conference, neither she nor the NBCC leadership attended the conference proceedings. The significance of NBCC's absence at this global gathering was noted by many. My analysis of NBCC's First World Conference on Breast Cancer Advocacy is based upon their publication, *A Report on The First World Conference on Breast Cancer Advocacy—Influencing Change*, a one hundred page document that includes coverage of official papers, presentations, and workshops from the conference as well as excerpts from participants' feedback. It is available on the World Wide Web at <http://www.natlbcc.org>.

49. For example, both conferences were feminist in tone and in tools of analysis; both emphasized the importance of building grassroots movements relevant to

their local contexts, countries, and conditions; and both conferences drew upon discourses of "the global" and constructed visions of global movements. NBCC's report on the Brussels conference indicates, for example, that phrases such as "global standards," "influencing global change," "work[ing] together globally," and "the dream that one day we would join hands globally" were sprinkled liberally throughout the first day's plenary sessions.

50. In fact, according to my conversations and correspondence with a participant at the NBCC-sponsored conference in Brussels, those who were interested in networking and organizing around the issues of breast cancer and the environment were forced to meet informally in the hallways because formal meeting space was not made available to them. And obviously, their concerns about the chemical-pharmaceutical were not incorporated into the official conference proceedings.

51. In a plenary presentation entitled "Influencing Industry, Government & Science," Jane Reese-Coulbourn, former Executive Vice President of the NBCC, advised that "Some industries want positive press with their customers. Women are their customers and helping NBCC work on eradicating breast cancer is viewed positively. If you are thoughtful and careful, there can be mutually beneficial relationships with industry without giving up your independence" (NBCC, *A Report*, p. 52). In contrast to this, the Kingston organizers rejected the offer of a major pharmaceutical corporation to sponsor their conference because they viewed the practices of the pharmaceutical-chemical industry as part of the problem and thus believed that allowing this industry to attach its name to the breast cancer movement would create a false impression of the industry's innocence and would be a signal to others that the movement had been co-opted by the pharmaceutical-chemical industry.

52. For example, according to the official conference report, in a plenary speech on cancer causes and cancer prevention delivered by Dr. Susan Love (one of the founding mothers of the NBCC, a breast cancer surgeon, and the author of *Dr. Susan Love's Breast Book*), pesticides were mentioned briefly and only in passing—as substances that are metabolized as estrogens. But any analysis of the broader implications of this link was quickly abandoned as Love redirected her focus to the individual-agent model of biomedicine. Love's overview of approaches to cancer prevention, for example, focused exclusively on individual and "lifestyle" factors such as exercise, diet, prophylactic surgeries, and pharmaceutical forms of risk reduction—namely, tamoxifen. Here, she simply ignored the efforts of environmental movements to prevent cancer by eliminating and better regulating the production and circulation of endocrine-disrupting chemicals and carcinogens. And, although another speaker offered a brief analysis of the rapidly globalizing pharmaceutical industry, he did not link the pharmaceutical industry to its other arm—chemical and pesticide manufacturers—or to the actual production of cancer.

Conclusion