Before Survivorship: The Moment of Recovery in Twentieth-century American Cancer Campaigns

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Summary. This paper concerns what I call “the moment of recovery,” the time when, in the 1950s, American cancer campaigns abandoned an earlier tendency to downplay post-operative recovery in their public education programs. This change was signalled by the emergence of new patients groups such as Reach to Recovery (founded 1953), and by a new interest in cancer rehabilitation among physicians, nurses, and manufacturers and sellers of equipment and clothing for patients. My focus is on breast cancer and the nurse-patient-industrial complex that drove the new interest in rehabilitation and recovery, but I also argue that the “moment of recovery” in breast cancer was part of a larger “moment” in cancer more generally. Finally, I seek to distinguish the “moment of recovery” of the 1950s from the discourses around the survivor that have emerged since the 1970s and 1980s, what might be called the “moment of survivorship.”

Keywords: cancer; rehabilitation; survivorship; Reach to Recovery; Terese Lasser; cancer nursing; corsetieres; prostheses; self-presentation; emotional management

Until the 1950s American cancer campaigns paid very little attention to the process of post-operative recovery in their public education programmes. The term ‘recovery’ was often used, but it tended to refer to an outcome or goal of treatment rather than the route by which people got to that outcome or goal. Indeed, a focus on this route was seen as a threat to programmes of cancer control. So great was the public’s fear of cancer therapy, cancer experts claimed, that any public discussion of the twisting, painful and uncertain road ahead of them would dissuade people from seeking help until after the best opportunities for successful treatment had gone.

In the late 1940s, these concerns began to break down. The change was signalled by the creation of new patient organizations such as Reach to Recovery, founded in 1953.1

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1 There is little agreement among historians on the date Reach to Recovery was founded. Maren Klawiter, The Biopolitics of Breast Cancer: Changing Cultures of Disease and Activism (Minneapolis: University of Minnesota Press, 2008), 118, and James S. Olson, Bathsheba’s Breast: Women, Cancer & History (Baltimore: Johns Hopkins University Press, 2002), 124, claim it was founded 1952, but this may confuse the date of Terese Lasser’s operation with the date she founded the organisation. Lasser herself—Terese Lasser and William Kendall Clarke, Reach to Recovery (New York: Simon and Schuster, 1972), 46—suggests it was founded in 1953, Barron H. Lerner, The Breast Cancer Wars: Fear, Hope and the Pursuit of a Cure in Twentieth-Century America (New York: Oxford University Press, 2003), 143) suggests it was established ‘by 1954’ and Kirsten
Sometimes labelled, ‘mutual aid’, Reach to Recovery and similar bodies were generally established by (former) patients to help other cancer patients deal with the consequences of therapy. Occasionally they encountered resistance from physicians, but these organizations were also established with medical encouragement. They were, in fact, part of an emergent network or complex of patients, nurses, social workers, physicians and commercial groups concerned with post-operative recovery that also included voluntary organizations such as the American Cancer Society (ACS) and the federal government’s National Cancer Institute (NCI). This new focus on the route to recovery is what I call the ‘moment of recovery’. This paper is concerned with the origins of the ‘moment’. It asks why cancer agencies tended to avoid the process of recovery in their public education campaigns until the 1950s, and why this process came to be a subject of public discussion during that decade.

The focus of this paper is breast cancer, but the moment of recovery in breast cancer was part of a broader moment in cancer more generally. Similar moments emerged at about the same time around cancers of the colon and larynx, comprising sometimes overlapping networks or complexes of physicians, nurses, social workers, patients, commercial groups and voluntary and federal agencies. This paper seeks to explain what was unique about the moment of recovery in breast cancer, why these three cancers formed the focus of the broader moment, and how they related to an emergent interest in rehabilitation during and after the Second World War.

Lester Breslow and his colleagues have described cancer as if it was the abandoned child of war-time interest in rehabilitation medicine; fathered by the war, but ignored by most specialists who went into rehabilitation fields other than cancer. This paper endorses that point, but also links the moment of recovery to post-war concerns about cancer’s impact on the goals of suburban affluence and married family life to which upwardly mobile Americans aspired in the 1950s, and to issues of self-presentation, emotional management, gendered domesticity and lay knowledge and practices regarding cancer.

A final introductory point is that the ‘moment of recovery’ should not be conflated with the history of cancer survivorship. Thus while the term ‘survivor’ was occasionally used...

E. Gardner, *Early Detection, Women, Cancer, and Awareness Campaigns in the Twentieth-Century United States* (Chapel Hill: University of North Carolina Press, 2006), 148 claims it was founded ‘in 1954’. Likely it began informally, like many small volunteer organisations, and later crystallised into a formal institution. I have opted for Lasser’s date of 1953.


before the 1980s, it was not commonly deployed. The now contemporary portrayal of the triumphant, happy, healthy survivor, whose life has been almost elevated by cancer, is almost entirely absent in the 1940s and 1950s, as is the view of survivorship as providing opportunity for physical, emotional and spiritual renewal. Instead of using terms such as survivor, the public education literature of the 1940s and 1950s tended to use what, to twenty-first-century ears, sound like more brutal expressions such as ‘breast amputee’ or ‘mastectomye’, if it used a label at all. Indeed, one of the paradoxes of the 1940s and 1950s is that alongside shocking expressions such as ‘breast amputee’ was a reticence to give a label to women who had had a mastectomy. The moment of recovery was thus characterized by both discretion and descriptive bluntness.

Maren Klawiter’s study of breast cancer politics provides a valuable comparison between the moments of ‘recovery’ and ‘survivorship’. She argues that while Reach to Recovery set the stage for the emergence of the ‘survivor’, it actually embodied a very different philosophy in that it discouraged women from articulating a political identity defined by their common experience of breast cancer and its treatment. It did this by limiting the contact between volunteer former patients and more recent mastectomees. The volunteers were only to provide assistance during the brief period that their clients were in recovery. After this, they were to leave them to their own devices, and Reach to Recovery discouraged further contact between volunteers and their clients. In such ways, the organization undermined the possibility of a broader movement around women’s experiences of cancer. Breast cancer, in its view, was a temporary aberration and recovery a return to ‘normality’, after which women were to go back to their lives in the home, largely isolated from other mastectomees except as volunteers who helped others.

Klawiter is surely right in portraying Reach to Recovery’s adjustment and recovery approach to breast cancer in the 1950s as very different from that of today. Yet she does not explain why cancer agencies avoided the process of recovery before the 1940s, nor does she fully elucidate what changed in the 1940s and 1950s. This paper explores what changed by focusing on the emergent network or complex of groups and individuals involved in cancer rehabilitation in the 1940s and 1950s, and how and why each part of that complex contributed to the ‘moment’. The terms complex or network are significant.


8 In contrast to literature about ‘masteecomies’ pamphlets targeted at such women tended to avoid the label. Terese Lasser, Reach to Recovery (New York: Reach to Recovery, 1953); Helen B. Radier, A Handbook for Your Recovery, rev. edn (New York: Women’s Society for Memorial Center, 1954).

Until now the tendency within the historical literature has been to stress the role of Reach to Recovery. Yet, Reach to Recovery was only a part of a broader network of groups and individuals involved in the moment, and certainly not the first. This article seeks to re-evaluate its role by focusing on its place within this network, and on how the various groups and individuals involved in this network sought to promote particular views of recovery that served their interests.

Before the Moment

Until the 1950s, the American Society for the Control of Cancer (ASCC—the forerunner to the ACS) tended to use the terms ‘cure’ and ‘recovery’ interchangeably. Both could refer to an outcome of treatment, or to the path by which people came to this outcome. But, in public cancer education campaigns the former tended to predominate. Recovery was a state of being, a goal to be achieved or the possibility of that goal. The route by which people arrived at this state or goal was hardly mentioned, except to acknowledge that it involved surgery or radiation: for example, a series of advertisements in the early 1930s announced that the probability was that surgery, X-rays and radium could ‘effect complete recovery’ if the tumour was discovered early. But until the 1940s and 1950s public education programmes provided few details if any of what happened during or after surgery or radiotherapy.

This tendency to downplay the route to recovery was tied to efforts to reform public attitudes and behaviours towards cancer. From its creation in 1913, the ASCC argued that if anti-cancer programmes were to work, people had to be persuaded to seek qualified medical assistance at the first sign of what might be cancer, and from the late 1910s to go for a regular medical check-up even if they felt well. The goal was to get to a physician ideally before the onset of disease proper, or very early in its development, and to undergo treatment the moment the disease or its possibility was identified. Thus, the ASCC developed public education programmes to teach individuals to identify the early signs of the

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10Breslow et al., History of Cancer Control Vol. 1, ch. 8. Kirsten Gardner, James Olson and Barron Lerner argue that Reach to Recovery was central to transforming surgeon–patient relations, women’s involvement in (breast) cancer campaigns and to the emergence of patient support groups in the 1950s. See especially Gardner, Early Detection, 147–51; Olson, Bathsheba’s Breast, 120; Lerner, The Breast Cancer Wars, 143–4.
disease, to go for a regular health check-up, and to seek early treatment from a recognized physician if cancer or a pre-cancerous condition was detected.

The trouble for the ASCC was that patients often arrived in the doctor’s office long after the best opportunities for successful treatment were gone.\(^\text{14}\) In its view, the reason for this problem was that people were overly fearful of the disease and its treatment, and that ‘quacks’, purveyors of patent medicines, ill-educated physicians and the advice of family and friends tended to direct people away from qualified physicians. One of the consequences of this was that its educational programmes tended to pay very little attention to what happened between treatment and cure. In the view of the ASCC, such an emphasis could dissuade people from seeking early detection and treatment by emphasizing the pain, disablement and mutilation caused by surgery and radiotherapy (the two main forms of treatment), and the uncertain route to recovery that followed, if recovery was possible at all. In its view, discussion of these issues was best dealt with in the privacy of the doctor–patient relationship, where physicians could most easily deal with patients’ fears and anxieties about cancer and its treatment. Mass public education campaigns were particularly blunt instruments for dealing with these fears and anxieties.\(^\text{15}\)

If the ASCC tended to avoid discussion of the routes to recovery, it had quite a different attitude towards recovery as a state of being after treatment or a goal to be achieved. For the cancer organization, ‘cured’ or ‘recovered’ patients came to be crucial to the success of cancer education, important means of encouraging others to achieve this end. As one physician put it in 1940, ‘An intelligent patient who has been entirely cured, often has more beneficial influence on cancer education in the community than the physician himself.’\(^\text{16}\) The ASCC had used ‘intelligent’ men and especially women as recruiters to cancer control programmes since its creation in 1913, and it was institutionalized in 1937 with the creation of the Women’s Field Army. In the view of the ASCC, one of the roles of the many women involved in the Field Army was to enlist other women, and channel them into emergent cancer services organized by recognized physicians. The mark of their intelligence was their willingness to follow ASCC prescriptions for cancer control, and women who had been successfully treated for cancer were viewed as particularly valuable. In 1939, one commentator described one such woman as an ‘animate document in evidence that the most dreaded of all diseases is conquerable with early diagnosis and proper treatment’.\(^\text{17}\) The key word here is ‘proper’. Animate documents in evidence served as warnings of the dangers of quackery, and of the value of surgery and radiotherapy—when carried out by a recognized physician—as ‘cures’ for this group of diseases.

This is not, however, to say that they were unproblematic documents. There was no guarantee that the ‘animate documents’ would tell the story that the ASCC wished them to tell, and the Society routinely informed people that the only real experts were physicians, and that non-physicians could only be trusted in so far as they reinforced the ASCC’s message. Nor was it clear that the bodies of these ‘documents’ would support the ASCC’s message. Bodies could betray aspects of surgery that the ASCC was not anxious

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\(^\text{14}\) Aronowitz, Unnatural History; Lerner, The Breast Cancer Wars; Cantor, ‘Cancer Control and Prevention’.

\(^\text{15}\) Cantor, ‘Uncertain Enthusiasm’.


to discuss outside the doctor–patient relationship—pain, disability, or the absence of a body part. For such reasons, educational programmes rarely portrayed mutilation, surgery or pain. On the contrary, patients seemed physically no different after the operation than before, except that perhaps they were lighter-of-foot and wider-of-smile in their relief at having escaped the dread disease.\(^{18}\)

**Cured Cancer Club**

Efforts to promote the view of cancer as a curable disease intensified in the late 1920s and early 1930s, as cancer services expanded throughout the country.\(^{19}\) A 1932 symposium ‘Cancer is Curable’ organized by the American College of Surgeons sought to highlight the growing number of people cured as a result of early diagnosis and treatment.\(^{20}\) According to reports, some 8,840 Americans had survived with no recurrence for five years. *Time* noted that the most ‘dramatic witness’ was Dr. Edward Loughborough Keyes, Cornell Medical School urologist. ‘I am an example of the cure of cancer,’ he explained, ‘Three cancers have been removed from my face by radium or actual cautery.’\(^{21}\)

In March 1938, the ASCC’s efforts to use ‘cured’ people to promote programmes of early detection and treatment crystallized into the Cured Cancer Club under its president, Dr Anna C. Palmer.\(^{22}\) Palmer had had a breast tumour excised in the early 1920s, and saw cancer in much the same way as the ASCC—as a disease that if caught early might be cured. The Cured Cancer Club was to ‘show the world that cancer can be cured’, and to help people overcome the fear of the disease.\(^{23}\) *Time* reported that the slogan of the club was: ‘We will drive away the fear that keeps so many people from going to a physician in time to be saved.’\(^{24}\) The organization claimed to have 29,000 members.\(^{25}\)

The educational materials that accompanied this growing use of the word ‘cured’ to promote programmes of early detection of treatment generally did not discuss convalescence after treatment. There were occasional criticisms of this neglect, but, such criticisms seem to have had little impact on the ASCC or the ACS. Throughout the 1940s, the ASCC/ACS’s public education programmes downplayed what happened after the operation.\(^{26}\) As in previous decades, it continued to hold the view that an emphasis on

\(^{18}\)See discussion of *Choose to Live* in Cantor, ‘Uncertain Enthusiasm’; Cantor, ‘Choosing to Live’.


\(^{21}\)‘Caner is Curable’, *Time*, 31 October 1932, 20, 32–3, 32. This quotation is not in the published version of his paper, Edward L. Keyes, ‘Five-Year Cures of Cancer of the Testis, Prostate, and Bladder’, *Surgery, Gynecology and Obstetrics*, 1933, 56, 462–3.


\(^{25}\)29,000 in *Cured Cancer Club*, *The Health Officer*, 1939, 4, 186.

\(^{26}\)See, for example, the review of *Choose to Live* in, MSC 277, Box 4, Folder ‘Cancer 1948’, Adolf Nichtenhauser
convalescence and recovery in such programmes could undermine efforts to persuade people to seek early detection and treatment. The appropriate place to discuss this was not the public forum of the mass media, but the face-to-face encounter between doctor and patient, where the physician could address the specific concerns of the patient in a manner tailored to the needs of that particular patient.

The Moment of Recovery

The ACS’s tendency to downplay the process of recovery in its breast cancer public education programmes began to break down in the 1950s. In 1957 it published a pamphlet, Help Yourself to Recovery, for breast cancer patients, and in 1958 it released the film After Mastectomy (ACS, Oregon Branch), an instructional movie for women who had undergone the operation.27 The movie traced the story of the fictional Kay Elliot, who has recently had a mastectomy, and of how she recovers after the operation. It is the first public education film to show the scar of operation: the script notes ‘CLOSE [shot] on wound with dressing removed. Catheter is visible. Doctor’s hands palpate.’28

The roots of this transformation are commonly traced to a former cancer patient, Terese Lasser—the wife of tax expert J. K. Lasser, author of the bestselling Your Income Tax.29 The story goes that in 1952 her physician found a small lump in her breast, and sent her to Memorial Sloan Kettering for a biopsy. Lasser, like many women diagnosed with the disease, had not fully appreciated what would happen, and was shocked and dismayed at the results. ‘Your hand touches your side. For the first time you are aware of the bandage’ she wrote some twenty years later, describing the experience of waking up after the operation.30 ‘Bandage? From midriff to neck, tight-wrapped as a mummy, you are bound in surgical gauze. Somewhere deep inside you a switch is thrown and your mind goes blank. You do not know what to think, you do not want to guess, you do not want to know.’ Lasser had gone into hospital for a biopsy, and come out without a breast.

The shock of the operation was compounded by the manner in which she was cared for. A sophisticated and energetic woman, the matriarch of a wealthy and well-connected family, Lasser was not used to being patronized. Yet she found herself entirely in the hands of her physicians—referred by her physician for a biopsy, and then rushed to

Papers, Archives and Modern Manuscripts Program, History of Medicine Division, National Library of Medicine. See also Adolf Nichtenhauser to Louis J. Neff, (Executive Secretary, ASCC), 22 March 1944, MSC 277, Box 4, Folder ‘Cancer 1948’, Nichtenhauser papers. For a discussion of this movie see Cantor, ‘Uncertain Enthusiasm’, 51–4.


28 I am grateful to Bill Stine at the ACS for providing me with a copy of After Mastectomy. All references to this film refer to the ACS copy. I am also grateful to David Wexler for providing me with a copy of the shooting script of the movie from the Wexler Film archives. ‘A Film on Readjustment of the Patient After Mastectomy’, Second Draft, Shooting Script, Churchill-Wexler Film Prod, Inc., 801 North Seward Hollywood, California, no date (hereafter After Mastectomy script.). A note in the Wexler archives finding aid records that the film was honoured with a Blue Ribbon Award from the American Film Festival. At the time of writing, the Wexler Film archives were are held at Hollywood Vaults Inc., 742 North Seward Street Hollywood CA 90038, <www.hollywoodvaults.com>, accessed 27 November 2013. There are discussions to transfer the archive to the National Library of Medicine. The scar is shown at 5 minutes, 44 seconds. The description in the script is on p. 7.

29 For discussions of Lasser see Olson, Bathsheba’s Breast, 120; Gardner, Early Detection, 148–151; Lerner, The Breast Cancer Wars, 142–3; Lasser and Clarke, Reach to Recovery.

30 Lasser and Clarke, Reach to Recovery, 19.
radical mastectomy. Hers was a one-step operation common in the 1950s, whereby surgeons sent the biopsy to the pathologist while the woman lay on the operating table, and operated immediately if positive results were returned, before the patient regained consciousness. In most of her publications Lasser praised the technical skills of her physicians, but found them unable or unwilling to provide advice on rehabilitation exercises, what to tell her children, how to resume sexual relations with her husband or how to go about getting a prosthetic device. One day she went to the department store where she had purchased brassieres before the operation, only to find that the saleswoman fled when she discovered her missing breast.

According to the traditional story, these experiences prompted Lasser to start visiting other women who had undergone a mastectomy. She would secretly slip into their hospital rooms to bring them starter ‘falsies’—simulated breasts—to pin on the inside of their nightgowns; a ball, string, and instructions (which she demonstrated) for painful exercises designed to restore arm function; and a Letter to Husbands about sex. Surgeons and hospital staff did not welcome her visits, and she was routinely escorted out of the hospital when discovered, sometimes by the police. Lasser published a booklet Reach to Recovery in 1953, and founded the mutual support organization Reach to Recovery, also in 1953. The women who joined the organization—themselves mastectomees—followed her example by visiting other women in hospital. Like Lasser, they also found themselves escorted out of the hospital on the instructions of surgeons who opposed their visitations. The story goes that Lasser tried to interest the ACS in the organization, but that it rejected her overtures until 1969, when it took over Reach to Recovery.

In fact, the story is more complicated than that. Indeed, the paradox of Lasser’s story about inadequate advice at Memorial is that the year that she underwent her operation—1952—the hospital itself had published a short 16-page advice booklet for women who had undergone mastectomy written by Helen B. Radler—also known as Mrs Leon Radler—a volunteer social worker at Memorial who, like Lasser, had had a mastectomy. A Handbook for Your Recovery with Exercises anticipated some of the themes that would later appear in Lasser’s more famous book.

Thus the story of the antagonism between Lasser and the cancer establishment may have to be revised. While there is no reason to doubt that some surgeons were very hostile to her and her organization—the ACS admitted as much in later publications—cancer experts were far from uniform in their attitude towards her. With more and

31 Radler’s other publications for Memorial included: Helen B. Radler, Inside the Hospital (New York: Society of Memorial Center, 1955); Helen B. Radler, All About an Operation (New York: Society of Memorial Center, 1956).

32 It included rehabilitation exercises for patients recovering from a breast operation, and, like Lasser’s book, it may also have included recommendations for prosthetic devices and fashion tips and sex. I use the word ‘may’ at this point for there are two editions of the booklet, one in 1952 and one in 1954, and I only found copies of the 1954 edition. However descriptions of the booklet—it is not clear whether they are descriptions of the 1952 or 1954 editions—note that it included an insert on fashion suggestions from leading Pattern Companies and an additional supplement, Man to Man, for husbands of women recovering from mastectomy—an echo or anticipation of Lasser’s Letter to Husbands. There is a copy of Man to Man in the 1954 edition of Radler’s book. It is unknown whether it was also included in the 1952 edition. Helen B. Radler, A Handbook for Your Recovery with Exercises (New York: Society of Memorial Center, 1952); Radler, A Handbook for Your Recovery, 1954 edition.

33 On the ACS’s admission of surgeons’ hostility to Lasser and her organization, see Preface to Lasser and Clarke, Reach to Recovery.
more women undergoing mastectomy, the ACS faced growing demand for more information on what happened after the operation. Its preference might have been for such discussion to take place in the privacy of the doctor–patient encounter. But, the ASCC/ACS had long complained that physicians were ignorant of the disease and its treatment, and, by extension, it also feared they were ignorant of post-operative recovery and provided poor advice to their patients, and that public silence of the issue might damage ACS credibility. Thus, the ACS’s resistance to public discussion of the post-operative consequences of cancer began to breakdown. The organization—or at least some individuals within it—began to look for ways to provide patients with information on this issue, and Lasser’s initiative provided one way of doing this. Lasser herself was encouraged to publish and organize by her surgeon at Memorial, Frank Adair—the man who Lasser criticized for providing her with inadequate advice.

Such resistance was also weakened by changing ACS attitudes towards the problem of delay. Whereas in the 1930s, the ACS had feared that public discussion of the nature of the treatment for cancer would undermine public willingness to seek early detection and treatment, by the late 1940s and 1950s this began to break down with the takeover of the organization by Mary Lasker who brought in business people and advertisers, and transformed the organization, including its public education programmes. Increasingly, subjects which had been off-limits in such programmes began to be included, albeit somewhat cautiously. Operative scenes were included in educational films which had earlier been excluded, as were live-action images of tumours. These new scenes highlight a growing belief within the organization that the public was not as vulnerable as previously thought to fears of cancer or its treatment, and might not delay as a result of seeing images previously of concern. Such changes set the stage for including the process of recovery in public education programmes, albeit targeted at those who had had the operation rather than the broader general public.

Against this backdrop, the ACS began to work with Lasser to promote her efforts. An early suggestion of an association is an ACS advertisement—Give to Conquer Cancer—embedded in Lasser’s first public account in 1954 of her experience of mastectomy. Three years later, in 1957, Lasser joined with Radler and Ella Bernhardt (the founder of Identical Form Inc., which produced bust forms for breast amputees) to co-author the ACS’s 1957 booklet, Help Yourself to Recovery, which figured prominently in the 1958 ACS movie, After Mastectomy. By the end of the decade, both Radler’s and Lasser’s booklets were regularly cited in medical and nursing texts on cancer rehabilitation.

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34 See Aronowitz, Unnatural History; Lerner, The Breast Cancer Wars.
35 Cantor, ‘Uncertain Enthusiasm’; Cantor, ‘Choosing to Live’.
37 Bernhardt, Lasser and Radler, Help Yourself to Recovery. After Mastectomy, 5 minutes, 59 seconds. After Mastectomy script, 8.
Practices of Recovery

Historical accounts of Lasser’s educational efforts often credit her with inventing the techniques that she employed—exercises for physical rehabilitation, advice on prosthetic devices, relationships and on how to deal emotionally with the mastectomy. Such stories have roots in Lasser’s own account of the impetus behind her efforts to develop these exercises—the inadequate advice she received from her physician and nurse. ‘Exercise of any kind,’ she recalled her nurse as saying in answer to a question about what sort of exercises she, Lasser, should do, ‘just so that you move your arm.’ And that was it: no supervision, no real guidance, which meant that she was forced to rely on her own resources. Lasser was a golf enthusiast, so she tried a golf swing as an exercise, and a rubber ball she had used in the past to strengthen her golf grip, adapting these through trial and error to her new condition. The rubber ball—but not the golf swing—later figured in her 1953 self-help booklet, Reach to Recovery, joined by a variety of other exercises: wall climbing, clothes line, hair brushing, window, jump rope, posture and household exercises (see Figure 1). But these rehabilitation exercises were not the simple invention of Lasser. Both she (and Radler, who used similar techniques in her earlier publication [Figure 1]) adapted techniques from the emergent literature on cancer nursing and rehabilitation in the 1940s and 1950s. In Radler’s case, a nurse—Marian Ellingwood, RN—provided the exercises for her 1952 booklet.

This nursing literature was the product of a small group of nurses, who were beginning to promote cancer nursing as a specialty in the 1940s and 1950s. In their view, cancer nursing was a complex field that covered all aspects of cancer care. Nurses were expected to persuade women to seek early detection and treatment, prepare patients for surgery and promote cancer nursing as a specialty in the 1940s and 1950s.43 In their view, cancer nursing was a complex field that covered all aspects of cancer care. Nurses were expected to persuade women to seek early detection and treatment, prepare patients for surgery and promote cancer nursing as a specialty in the 1940s and 1950s. 

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39Lasser and Clarke, Reach to Recovery, 22–7.
40Ibid., 22.
41See, for example, the wall-climbing exercise in Cancer Nursing: A Manual for Public Health Nurses (a joint project of the National Cancer Institute, Public Health Service, Federal Security Agency and the New York State Department of Health, January 1950), 48. See also Genevieve Waples Smith, ‘When a Breast Must Be Removed’, American Journal of Nursing, 1950, 50, 335–9, 337.
42Marian Ellingwood RN joined the University of Nebraska School of Nursing, Omaha, as director of student health and instructor in public health in 1948. ‘Marian Ellingwood R.N.’, The Modern Hospital, December 1947, 69, 164.
radiotherapy, assist physicians during the operation, help with the rehabilitation of patients, manage their pain and care for them as they died, among many other activities. As regards rehabilitation, one of the key tasks of the nurse was to encourage breast amputees to begin rehabilitation exercises and to continue them when they went home.

But this was not easy. Recent mastectomies were often depressed and in pain, shocked at their loss, reluctant to begin the exercises, or to continue through the ups-and-downs of recovery. As the narrator in the 1958 movie *After Mastectomy* noted, ‘physical rehabilitation takes hard, sustained work, frequently more than it seems to the patient that she is able to give.’

Even the most motivated found these exercises difficult, and they had a host of questions for the nurse: Which exercises were most appropriate for them? Would the stitches on the scar tear? How much exercise should one do? What did it mean if pain accompanied the exercises? How long would it take to recover? How did one deal with the host of physical problems that accompanied recovery, such as lymphedema (a swelling that often occurred in mastectomy patients caused by a build-up of fluid in soft body tissues when the lymph system was damaged or blocked perhaps by cancer or by the mastectomy itself)? How did one face a lifetime of publically concealing the absence of a breast? What did ‘recovery’ mean?

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44 *After Mastectomy*, 12 minutes 58 seconds. *After Mastectomy* script, 15.
Nurses constantly had to deal with these questions for which there were often no easy answers. Yet, like Radler and Lasser, they found a dearth of published advice for women who had undergone mastectomy. Some turned for help to the small number of physicians who in the 1940s and 1950s began to focus on post-operative rehabilitation, including the psychology of post-mastectomy depression. But, while these physicians could provide explanations for the ways in which mastectomy patients responded to the disease and the operation, and advice on the process of recovery, they had little in the way of literature to give to patients. In such contexts nurses were keen for anything they could give to patients to help them begin and continue the exercises, and the new patients’ literature was a boon. Thus when a Committee for the Care of Mastectomy Patients was established at New York Hospital in the 1950s, it produced its own patients’ literature, and reviewed Lasser’s and Radler’s booklets with a view to evaluating which should be distributed to patients. The techniques of recovery had come full circle. If Radler and Lasser had adapted rehabilitation exercises from the nursing literature for their booklets, by the end of the 1950s nurses routinely handed out these booklets to cancer patients.

**Networks of Recovery**

It should be clear by now that the moment of recovery in breast cancer was prompted not only by patients such as Lasser and Radler concerned about the lack of help for mastectomy patients, but also by nurses in the emergent field of cancer nursing. Other groups also contributed to the moment even before Lasser and Radler got involved, including the small number of physicians interested in cancer rehabilitation. Lester Breslow and his colleagues argue that until the 1940s and 1950s cancer rehabilitation was neglected by existing cancer organizations such as the ACS and the NCI; that many cancer specialists were ignorant of the subject; and that most medical and paramedical specialists entering rehabilitation medicine after the Second World War concentrated on spinal injuries, diabetes and stroke rather than cancer. In Breslow’s view, it was mutual aid organizations such as Reach to Recovery that were crucial to turning the situation around. But this may overstate the case. While Reach to Recovery helped to promote the work of specialists in cancer rehabilitation, these specialists also promoted Reach to Recovery, and help set the stage for its emergence. For example, in May 1950 a Rehabilitation Service was established at Memorial to promote a new focus on the ‘whole patient’, and to counter growing concerns about the impact of radical surgery on patients.

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46Some such as Arthur M. Sutherland, the head of the newly created Rehabilitation Service at Memorial came to rely on Lasser’s and Radler’s literature themselves.

47Cornell University—New York Hospital. Exercises for Persons Who Have Had a Mastectomy. (Tentative Draft By Nursing Committee, 30 June 1955), Folder 14, Virginia Dericks Papers, Center for Nursing Historical Inquiry, Claude Moore Health Sciences Library, Historical Collections, University of Virginia. See also Smith, ‘When a Breast Must Be Removed’, 337; ‘Minutes of the Committee meeting for Care of Mastectomy Patients’, Folder 13, Virginia Dericks Papers.

48The 1959 edition of Surgical Nursing included a new section on patient teaching aids and information in it on surgery of the breast, and Radler’s and Lasser’s booklets were included in the bibliography. This section had not being in the previous 1950 edition. Eliason, Ferguson and Sholtis, Surgical Nursing, 1950 edition, 407; Ferguson and Sholtis, Eliason’s Surgical Nursing, 1959 edition, 524.

efforts to promote early detection and treatment, and that such operations exacerbated post-operative depression. The Service may have benefited from the creation of the mutual aid group two years later, but Reach to Recovery also benefited from the Service.50

In addition to nurses and rehabilitation experts, there were two other groups that were interested in mastectomies: manufacturers (of breast prostheses, and surgical bras and corsets) and corsetieres (the women who fitted bras and corsets). Both saw the 50,000 women who underwent a mastectomy each year as a new and growing market, with perhaps half a million women in total living with the operation.51 Yet it was a tricky market to develop, and manufacturers and corsetieres sought to recruit nurses and patients’ groups to promote their products and services.

The growing commercial interest in breast cancer is illustrated by trade magazines such as the Corset and Underwear Review (which during the 1950s came to include regular articles on breast cancer awareness), and by the growing tendency of retailers to provide breast cancer education in their lingerie departments.52 In general these educational efforts aimed to encourage women to seek early detection and treatment, and to identify what might be the early signs of cancer.53 But, manufacturers and retailers also focused increasing interest on mastectomies. Thus, during the 1950s the existing trade in simulated breast forms and bras aimed at mastectomy patients expanded substantially, while retailers—even before Lasser’s encounter with the saleswoman who fled—began to train their staff to work with mastectomy patients.54

As corsetieres and manufacturers turned to the mastectomee market, the process of fitting a breast amputee with a bra became a sort of rehabilitative encounter that aimed not only to obscure the missing breast, but also to heal the client’s psychological wounds and help her gain confidence to face the public. ‘When you fit a customer who has suffered a breast amputation,’ Mercy Dobell, a sales training director (and later editor of the Corset and Underwear Review) informed her readers, ‘you must fit not only her scarred physical tissues but also a heart that is heavy, a spirit that has been crushed and a frightened mind that feels that she and she alone is maimed and abnormal for the rest of her life. Along with the bust form, you must sell her a new confidence in herself and the feeling that the rest of the world need never know about her loss.’55

The portrayal of bra fitting as a transformative, rehabilitative encounter meant that corsetieres who fitted amputees had to be specially trained. They had to understand both the anatomy and the psychology of the mastectomee. An understanding of anatomy was important to ensuring a comfortable fit, and the appearance of a normal bust (Figure 2);
an understanding of psychology was necessary to manage the emotional consequences of the operation. Corsetieres were advised never to joke with their clients about their operation; to offer kindness, but not pity. In the view of Mercy Dobell, women who had had a mastectomy needed to be managed sensitively, and the corsetiere could show kindness by seeming not to notice her condition. She was to avoid a show of over-sympathy, and to guard against developing a hard, brittle attitude. Dobell advised corsetieres to use their most feminine room for fitting the bra (Figure 3).

If anatomy and psychology were important to the rehabilitative aspect of bra fitting, they were also important to its commercial aspect. A badly fitting bra would not encourage a woman to return, and could damage the reputation of the store that sold the bra and the manufacturer that made it. An insensitive seller could also discourage sales by failing to take account of her client’s fragile state, or by letting her give way to an impulse to buy. ‘If you let her go on a wild buying spree,’ Mercy Dobell counselled corsetieres regarding breast amputees, ‘she will hold it against you and will avoid you for ever more.’ In her view, the corsetiere should restrain her customers. She should get them to return for adjustments to ensure a good fit for the bra, and only after her final adjustment should she

Fig. 2  ‘Measure normal side from spine to center front’, Mercy Dobell, ‘Fitting Facts. On How to Sell to Amputees’, Corset and Underwear Review, May 1951, 82–4, 83.
encourage the customer to begin to build up her wardrobe. A central part of the ritual of ensuring customer loyalty, to Dobell, was the moment the saleswomen offered her her card.\footnote{Ibid., 84.}

But, corsetieres worried that clients had little incentive to stay with a trained saleswoman. Part of the issue was that whereas in the past retailers had offered complex style lines and size configurations, they were increasingly selling brassieres with standardized chest measurements and lettered cup sizes. Such changes deskilled the work of brassiere saleswomen, weakened their power to negotiate increased wages, and allowed retailers to sell pre-packaged brassieres in department store ‘bra bars’ where customers could select merchandise without the assistance of a corsetiere.\footnote{Jill Fields, \textit{An Intimate Affair: Women, Lingerie, and Sexuality} (Berkeley: University of California Press, 2007), 102.} The consequence was that women increasingly bought what these saleswomen regarded as cheaper throwaway competition that did not involve the adjustments and readjustments that the corsetiere offered. The real cost, corsetieres argued, was that women had to fit into anonymous, standardized ‘figure types’. The problem was not restricted to women who had undergone mastectomy: the cheaper standardized competition, corsetieres argued, tended to reduce all women to these types. But it
was particularly significant in the market for surgical bras and corsets. Women who had had an operation, or who were obese, or who needed a surgical bra for some other medical reason required individualised attention. The mass produced bra or corset often did not work on such women. They needed someone, corsetieres argued, to ensure that the bra or corset fitted well, and to address what the fitters regarded as their fragile psychological state. The surgical business was thus a key area where corsetieres defended their special expertise against the threat of the mass market.60

Corsetieres’ claims to have special expertise gained support from nurses and the authors of advice literature. Lasser urged mastectomees to go to a good corsetiere.61 Radler directed women to department stores and specialty shops.62 And the narrator in After Mastectomy noted that ‘Many reliable stores have specially trained saleswomen to help with the selection.’63 At the New York Hospital, the Committee for the Care of Mastectomy Patients sought to evaluate various breast forms, worked with manufacturers to improve them, and compiled a list of shops where prosthetics might be obtained and assessed whether they had staff trained to deal with breast amputees.64 A budding nurse-volunteer-commercial complex began to emerge with patients groups and nurses working with manufacturers and corsetieres in educational efforts directed at mastectomees.65 For instance, Ella Bernhardt the founder of Identical Form Inc., and a former X-ray technician at a New York hospital, published articles about the rehabilitation of mastectomy patients for nurses, before joining with Lasser and Radler to publish the ACS’s 1957 booklet for patients, Help Yourself to Recovery.66

Nurses and patients’ groups not only worked closely with corsetieres and manufacturers, they also echoed the industry’s assertions that women’s self-confidence was a product, at least in part, of how they looked to others.67 The point is made clear in After Mastectomy which explores the anxieties of breast amputees about presenting themselves in public. The film opens with Kay Elliot reflecting on a nosy friend or neighbour who has been surreptitiously observing her to determine which breast is missing. Kay’s confidence is boosted when she realizes that the friend or neighbour has failed to figure this problem out, and later in the film we find out how Kay did it. When Kay is about to leave hospital after the

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61 Lasser, Reach to Recovery, 16.


63 After Mastectomy, 16 minutes, 56 seconds. After Mastectomy script, 19.

64 Minutes of the Committee meeting for Care of Mastectomy Patients, Folder 13, Virginia Dericks Papers. See also letter from Virginia C. Dericks to Ella Bernhardt, 9 November 1955, Folder 13, Virginia Dericks papers.


67 This theme of reassurance is common in articles written by mastectomees about their experience. For example, Charlotte George noted the reassurance she felt after receiving an artificial breast. ‘I knew then that the only people who need know about my breast-removal are those I choose to tell’, Charlotte George, ‘I’m Glad I had my Breast Removed’, Today’s Health, August 1957, 35, 50–1.
Nurse Burnford brings her a starter falsie; some cotton to fill in for her missing breast. She tells Kay: ‘Let’s see what we can do to fool the public.’

The theme of ‘fooling the public’ is highlighted in the iconography of Lasser’s and Radler’s (1954) booklets, both of which deployed variants of the New Look, a fashion introduced into the USA in 1947 (Figures 1 and 4). In both pamphlets the women who have undergone a mastectomy have an hourglass figure: narrow waists emphasized by spreading skirts/dresses below and busts above. Critics had attacked the heavy corset and padding necessary to achieve the New Look as unduly restrictive after looser war-time styles of dress, but these pamphlets suggested that, in emphasizing the bust, the corset and heavy padding also represented a way for a mastectomee to determine to whom they revealed the results of the operation. In addition, where some critics saw the New Look as a regressive step after the shorter, more revealing dresses available during the war, advocates of its look for mastectomees welcomed the concealment that the long dresses gave. Note for example the black shawl in Figure 4 (left), which could be used to hide the lymphedema, as could the long sleeves and high necklines in most of the images in Radler’s book. For Lasser and Radler the New Look was a way to encourage mastectomees to overcome their fears of social engagement and to stress the possibility of a return to domestic normality.


68 After Mastectomy, 14 minutes, 53 seconds. After Mastectomy script, 17.

The New Look has been portrayed by some feminist historians, and indeed by Christian Dior its creator, as representing a post-war ‘refeminization’ of women and an accompanying return of women to their ostensibly ‘natural’ place within the home after their increased involvement in paid work during the war. From such a perspective the narrow waist symbolized and reinscribed separate social spheres for men and women, and the New Look played a role in efforts to distinguish women from paid workers in the public sphere, and to return them to the roles of wives and mothers in the private sphere of home and family. In practice, there were myriad versions of the New Look, as women adopted and adapted it to their needs and desires, sometimes in ways that contradicted efforts to return them to the private domain of the home.

But such countervailing messages were not deployed in the iconography of Lasser’s and Radler’s booklets. In providing ways of ‘fooling the public’, these women sought to help others present themselves as physically ‘normal’ (at least in public) since the loss of the breast could deprive the female body of its sexual and maternal meanings and functions, and so symbolically threatened the post-war cultural emphasis on the role of the woman as wife and homemaker. For both Lasser and Radler, these rehabilitative exercises were also a route to a return to what in the 1950s would have been regarded as women’s domestic activities, and were represented iconographically in their booklets by women undertaking these tasks while wearing some variant of the New Look. Indeed, these very activities—brushing hair, opening and closing windows, and household work—were a route to recovery. Lasser noted: ‘Making beds, sweeping, vacuuming, ironing, cleaning windows and mirrors, putting small things away on high shelves, cleaning the bathtub and REACHING to its farthest corners—all these homely chores will help to achieve a lovelier you’ (Figure 1). Breast cancer and mastectomy could thus be a positive transformative experience in the 1950s, but to Lasser, Radler and others it was one that fitted well with specific expectations of gender roles.

A final point needs to be made, which is that whereas physicians, nurses, manufacturers and corsetieres tended to emphasize the fragility of the mastectomy patient, the advice literature designed for mastectomees tended to stress the importance of the


73The 1957 leaflet produced by Lasser and Radler for the ACS also treated domestic activities as a route to recovery. Several pages from the booklet are displayed in the movie After Mastectomy which show exercises that include: Hair brushing exercise (6 minutes, 03 seconds), Pulley Motion (6 minutes, 06 seconds), Backscratcher (6 minutes, 11 seconds), Hand wall Climbing (9 minutes, 48 seconds and 11 minutes, 22 seconds) and Rope Turning (11 minutes, 35 seconds). Kay Elliot also read from the book that hanging cloths on the line, washing windows, fixing closet shelves and pruning bushes were equivalent to hand wall climbing (After Mastectomy, 11 minutes, 25 seconds). Nurse Burnford also shows Kay how to do a wall push (After Mastectomy, 13 minutes, 00 seconds). After Mastectomy script, 13–15.
self-management of emotions as a part of the recovery process—an echo, perhaps, of the contemporary interest in the power of positive thinking.74 As Lasser noted: ‘The first step is a determination to face your problem with assurance and courage. Once you accomplish this, the rest of it will be much easier.’75 For both her and for Radler the exercises, and the return to gendered domesticity that they represented, marked a crucial part of this effort to inculcate emotional self-management.

This is not to say that patients could attain such self-management by themselves. They needed the help of physicians, nurses and corsetieres to heal their psychological wounds, and they also needed the help of members of their family. The problem for physicians and nurses was that families could be as much a hindrance as a help. As the narrator in After Mastectomy notes: ‘But the members of the family shouldn’t be overlooked. They can be a great help, or do greater damage.’76 Particular attention focused on the husband, since his response to the amputation was viewed as critical to the recovery of the mastectomee. Radler’s Man to Man and Lasser’s Letter to Husbands make the point, as does After Mastectomy where there is a scene in which the husband is interviewed by the woman’s physician. They avoid explicit discussion of sexual or physical relations, but focus more generally on the husband’s consideration for his wife, and the debilitating impact of pity. ‘A buddy of mine had a leg taken off by a land mine,’ the husband notes, highlighting the parallel with the rehabilitation of the war wounded. ‘After he came out of the hospital, the worst thing you could do was show that you felt sorry for him or try to do things for him.’77 ‘That’s right,’ responds the Doctor, echoing the advice given by Mercy Dobell to corsetieres, and Lasser and Radler in their pamphlets for husbands: ‘We need to be careful not to show pity or help too much. It only makes a person feel worse.’78 And he adds: ‘She’ll need some help and sympathetic understanding at first. But the greatest single thing you can do to help is to let her know that your feelings towards her as a person haven’t changed one bit.’79

**Spaces of Lay Knowledge and Practice**

The moment of recovery not only involved issues of self-presentation, gendered domesticity and emotional (self) management; it also involved creating a space for lay knowledge and practices. In Lasser’s view, recovery involved as much an act of will as an act of exercise. But it was also something that depended on the support of others, especially other mastectomees, at least in the beginning. Mastectomees had a special form of knowledge of cancer, she claimed, both as women and as women without breasts. It was a knowledge quite different to the knowledge a surgeon might have of the disease, something quite different too

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76 After Mastectomy, 8 minutes, 34 seconds. *After Mastectomy* script, 11. The script has ‘great damage’ instead of ‘greater damage’.
77 After Mastectomy, 8 minutes, 40 seconds. *After Mastectomy* script, 11. The quotation in the script is slightly different: ‘A buddy of mine had a leg taken off by a land mine. After he got out of the hospital, the worst thing you could do was show you were sorry for him or try to do things for him.’
78 After Mastectomy, 8 minutes, 51 seconds. *After Mastectomy* script, 12. ‘We need to be careful not to show pity or to help too much. It only makes the person feel worse.’
79 After Mastectomy, 9 minutes, 06 seconds. *After Mastectomy* script, 12. The quotation in the script is the same as in the film except that the doctor says ‘toward’ rather than ‘towards’.
from the knowledge that a man might have. ‘Remember that your surgeon is a busy man and, being a man, he cannot always foresee the many questions which beset a woman,’ Lasser wrote in 1953.80 ‘The women who inspired this booklet have lived through these questions and we want to help you find the answers which we found.’

This gendered epistemology helped to create a space for a new form of women’s volunteer work. The ASCC/ACS had long used women volunteers to encourage women to seek early detection and treatment, but Lasser took volunteer work in a different direction. In her model—derived apparently from Alcoholics Anonymous—women visitors, themselves mastectomees, would visit women in hospital soon after an operation, provide them with emotional and practical support, and by their cheery, optimistic manner and bodily appearance help them to realise that the disease was survivable, and that it did not mean any change in the way they were perceived by others, except those who already knew about the operation. Crucially, this model of volunteer work depended on their special, personal knowledge of what the loss of a breast meant to a woman, and of how women might come to terms with it. This was a very different model to that provided by the earlier Women’s Field Army, and marked a contrast to the work of other prominent women involved in cancer, especially Mary Lasker. Where Lasker sought to promote research, Lasser sought to promote recovery.

If Lasser’s epistemological rationale helped to create a space for a new form of women’s volunteer work, it also helped to transform the idea of the ‘animate document in evidence’. The women who joined Reach to Recovery continued to be such ‘documents’, but what they documented had changed. They were no longer simply representations of the outcome of early detection and treatment, goals to be achieved for those who faced mastectomy. They also represented the means of achieving these goals. Through their words and actions, these women portrayed cancer and mastectomy as temporary aberrations from which a return to (something like) normality—recovery—was possible. They provided women with the exercises and attitudes they deemed necessary to achieving these goals. And, they highlighted the importance of women’s knowledge and practices to recovery, albeit a knowledge and practice often subservient to male surgical knowledge. Lasser urged her readers to follow the advice of their physicians before attempting her programme of recovery, or any other.81

Lasser’s efforts to create a space for women’s knowledge received tentative endorsement from the ACS in the 1950s, but only tentative endorsement. Despite its recent tendency to introduce the topic of post-operative recovery into its public education programmes, the ACS remained concerned that the topic might undermine its efforts to recruit people into programmes of early detection and treatment by generating fears about cancer treatments, and worried that Lasser’s efforts might make the situation worse. The organisation was under growing criticism that it had gone too far in its post-war use of scare tactics in its public education programmes.82 Critics argued that the organisation was fomenting popular panic, and a growing body of psychological evidence suggested that fear-arousing communications could easily backfire and undermine the educational messages that

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80 Lasser, Reach to Recovery, 6–7.
81 Ibid., 6.
82 On the ACS’s growing use of fear in its advertising see Patterson, Dread Disease, 175–6. For criticism of this from alternative perspective on the ACS and scare advertising see Charles Falkner, ‘Do Cancer Drives Create Fear’, Bernarr MacFadden’s Health Rev., 1950, 94, 30–1, 58–9.
they were supposed to promote. In such circumstances, anything that threatened to exacerbate these concerns and criticisms was a problem, and this included Reach to Recovery. The result was that the ACS was cautious about Lasser’s efforts to create a space for women’s knowledge, despite the help it promised for post-operative patients, and despite Lasser’s efforts to limit and subordinate women’s knowledge to male surgical expertise. It was too easy, the ACS felt, for things to get out of hand, and for these lay women to do harm to patients, to dissuade others from seeking help, and to exacerbate the existing criticism and concern about the ACS’s scare tactics by highlighting the mutilating effects of the operation—often much more mutilating than the scars shown in After Mastectomy. Besides many ACS surgeons still felt uneasy, if not resistant, to women volunteers trespassing on what they regarded as their territory within the hospital. For these reasons, the ACS was cautious about Lasser’s efforts, caught between a desire to encourage women to help each other through recovery, and a fear that it all could go horribly wrong.

A Broader Moment

The focus of this paper has been on breast cancer, but breast cancer was only one part of a broader moment of recovery. Similar moments can also be detected in other cancers, and in particular cancers of the colon and larynx. In all of these three diseases physicians claimed that the five-year survival rates were much higher than in other bodily sites, other than the skin. All were also the subject of an increasing focus on radical surgery, and contemporary commentators highlighted the importance in all three cancers of a substantial need for muscle re-education, and the psychological and social adjustments to living with the results of the surgical intervention for life. There were other cancers in which similar adjustments were discussed. For example, the facial disfigurement that followed a radical removal of cancer of the jaw, mouth, eyes or neck, often required substantial plastic surgery, and efforts to ensure that patients were not scarred emotionally as well as physically. But in


86 On the history of cancer rehabilitation see Breslow et al., A History of Cancer Control, Vol. 1, ch. 8
the 1940s and 1950s it was the breast, colon and larynx that received most attention in terms of rehabilitation and recovery.

If differential survival rates help to explain why cancers of the breast, colon and larynx formed the vanguard of broader moment, so too did the emergence of similar networks or complexes of recovery. In the case of cancers of the colon, the groundwork was laid by the creation of earlier mutual aid organizations for ulcerative colitis. A key figure was Edith Lenneberg, a refugee from Hitler’s Germany who settled in Boston. Diagnosed with ulcerative colitis in the early 1950s, she underwent an ileostomy, and in 1952 helped to found the Ostomy Association of Boston with the encouragement of physicians who hoped it would help them manage their patients by addressing their psychological needs. Like Reach to Recovery, the Ostomy Association began as a women only group, before enlisting men into its ranks. It later expanded to include cancer patients, encouraging—also like Reach to Recovery—former patients to visit new patients and provide emotional support and practical advice, including various information pamphlets.87 There was advice on odour control, irrigation, hygiene and care of the skin, what clothes to wear with the bag, the process by which one regulated oneself, what equipment was needed and where to get it, what to do in emergencies (diarrhoea), whether to use laxatives or cathartics in the case of constipation, and diets such as the ‘low residue diet’. Much of this advice had been developed earlier in the nursing and medical literature, and the Ostomy Association, along with some nurses, adapted it for lay audiences. Nurses and others eagerly sought out these pamphlets to give to their patients, investigated different colostomy devices, and recommended manufacturers and local suppliers of equipment to their patients. For their part, manufacturers and suppliers sought out nurses to promote their wares and services, and a nurse-industry complex emerged, overlapping to some extent with the similar movement around breast cancer.88

In the case of laryngeal cancers, the groundwork was laid by Lost Chord Clubs set up before the Second World War.89 But in the 1940s and 1950s the numbers of such

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organizations took off, many promoted by physicians interested in encouraging patients to learn to speak again, psychosocial rehabilitation and in persuading patients who might be hesitant about an operation that they could speak again. In 1952, the various lay organizations coalesced into the International Association of Laryngectomees, supported by the ACS and the National Cancer Institute, which also provided pamphlets and films for laryngectomees. There was advice on how to speak again, the psychosocial problems of adjusting, the return to work and the problems of cleaning the stoma. The Associations also promoted the Clubs as important to the exchange of ideas about appropriate clothing, the use of stoma covers and other devices to protect the breathing tube, and how the stoma and signs of surgery might be obscured. As with breast and colon cancers, there seem also to have emerged a nurse/medical-industrial complex of sorts, with nurses, speech therapists and physicians researching manufacturers and suppliers to provide information to patients, and manufacturers and suppliers seeking out the former.

The broader moment of recovery can therefore be seen as a sort of Venn diagram, each overlapping circle comprising its own moment and including a complex of patients, nurses, physicians, voluntary, government and commercial groups. It is the existence of these parallel complexes that helps to explain why cancers of the breast, colon and larynx were at the vanguard of the moment. The word complex is key here. Physicians and nurses promoted rehabilitation in many other cancers, but medical or nursing interest by itself did not constitute a moment of recovery. What turned nursing or medical interest in (cancer) rehabilitation into a broader moment was the existence of mutual aid organizations interested in promoting recovery discourses and practices among patients, and industries interested in the sorts of markets that encouraged these discourses and practices. It may be that the higher lethality of other cancers worked against the development of similar movements elsewhere: higher mortality meant a small pool of survivors, smaller opportunities for mutual aid organizations to flourish, and smaller long-term commercial markets for rehabilitation devices. But, mortality figures were only part of the explanation for the emergence of a moment. This emergence depended on a diverse range of contingencies that brought medical, nursing, mutual aid and industry groups together around a particular cancer, and eventually also secured the attention of voluntary organizations like the ACS and the Federal Government. It is the contingencies around breast cancer that have formed the core of this paper.

It is beyond the scope of this essay to fully explore in detail these other moments around cancers of the colon and larynx, but they shared with breast cancer a common focus on treating cancer as a temporary aberration and recovery as a return to a ‘normality’ that involved patients concealing their identities as people who had undergone cancer therapy. What


93 Klawiter, The Biopolitics of Breast Cancer, 120.
constituted normality differed from cancer to cancer in part because, as psychologists argued at the time, the loss of the voice, colon or breast all had very different meanings. In addition, each operation offered different social challenges to patients. All of them had to live with the possibility of discovery, but it was perhaps more difficult for a laryngectomy patient to obscure his or her operation in public than for a mastectomee or colostomy patient. The latter lived with the anxiety that ill-fitting equipment would release tell-tale odours; the former lived with the anxiety that ill-fitting equipment would indicate the missing breast.

Recovery was thus a precarious state, constantly under threat from the disease, the interventions against it, the emotional responses of patients, and the malfunctioning of equipment designed to disguise it. It could be a long process, with no assurance of a return to full functionality, a continuing struggle to fool the public and the ever present fear of recurrence. A core set of assumptions behind the broader moment of recovery was that the anxieties associated with the disease and operation would become manageable, that people would adapt to their new physical conditions and that cancer was curable. But sometimes these assumptions proved false. Instead of liberating people from disease and dependency, interventions against cancer could do quite the opposite.

The problem was further complicated when the effects of cancer on the patient’s family were taken into account. The NCI made the point in evidence to the House Committee on Interstate and Foreign Commerce. In its view, cancer care could be enormously expensive, especially in the terminal stages of the disease, and could overwhelm family budgets when the breadwinner succumbed. And in addition there was the loss of status or self-respect when a family was forced to accept relief which they had never previously needed; the long-term effects on children whose mother assumed a wage earning role because of the father’s illness; or the difficulties faced by a father who had to assume the role of caring for the children when a mother was ill. Men, in particular, faced a bleak employment outlook. ‘Most industries refuse to employ individuals who have had cancer because of the increased risk of compensable illness. New opportunities for creative or productive employment are difficult to find for many cancer patients, particularly males,’ noted the Institute. ‘Thus, there is nearly a total socio-economic loss to the community in the case of male cancer patients, and a substantial one with female patients, even when they have survived their initial course of treatment for the disease.’

The NCI’s account was very different to the return to normality narrative that dominated the moment(s) of recovery. In its view, cancer threatened families with exclusion from the dream of post-war economic affluence. It raised the unwelcome prospect of financial hardship and the stigma of dependency and pauperism, and highlighted the fragility of the post-war nuclear family, isolated from supportive kin in the suburbs.

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94 Cantor, ‘Memorial’s Stress?’
96 Committee on Interstate and Foreign Commerce, Ibid.
97 May, Homeward Bound, 20.
deprive the family of its prime breadwinner (the husband in 1950s domestic ideology), not
only by killing or crippling him, but also by turning him into a liability for employers. In addi-
tion, the NCI's comments suggest that cancer threatened the family in other ways. It dis-
rupted the division of labour within the 1950s family, forcing men into roles that were
gendered female, and women into roles that were gendered male. And it raised the prospect
of such families producing maladjusted children, so feeding into emergent concerns about
the role of the family in producing juvenile delinquency and childhood psychic ills. Against
such concerns, the moment of recovery offered the comforting hope of a better future, and
the promise of knowledge and techniques by which the individual and her family might
achieve it. But, it also opened the door to blaming those same individuals for their failure
to achieve recovery, despite or because of the odds stacked against them.

Passing Moments

From the 1970s and 1980s the moment of recovery began to pass. Increasingly, Reach to
Recovery, the ACS, the NCI and a host of other organizations began to identify people as
cancer ‘survivors’, and the old labels of ‘breast amputee’, ‘mastectomee’, ‘colostomatee’
or ‘laryngectomee’ began to disappear. Unlike these older labels, ‘survivors’ often adopted
the new label themselves, and for life (not simply for the period of recovery), and came to
question the subordination of their own knowledge of the cancer to that of medicine.
This is not to say that the notion of recovery entirely disappeared. The idea of the cancer sur-
vivor made normal persisted, but it served different purposes. Whereas in the 1950s, it pro-
vided a counter-narrative to concerns about exclusion from post-war suburban affluence, in
the 1970s and 1980s it provided a counter-narrative to concerns about the economic prob-
lems, unemployment and spiralling health care costs of those decades (all of which unduly
affected cancer patients), as well as to emergent concerns about the threats posed by occu-
pational and environmental carcinogens. In addition, with more women entering the work-
force and a growing feminist movement, the domestic ideology that had helped shape the
moment in the 1950s was less relevant to the survivor made normal discourse of the 1970s
and 1980s. Commentators also identified a variety of other discourses that existed along-
side, and sometimes challenged, the dominant recovery model, including portrayals of
cancer survival as an accomplishment, a quest or a descent into chaos.

Other changes also undermined the moment of recovery of the 1950s. From the 1980s,
the older complex of commercial, professional and patients’ groups associated with the
moment of recovery was joined and displaced by a new market-driven survivorship industry
in which a variety of new corporations turned their promotion efforts to finding a cure for the
disease. Critics came to worry that this new industry overwhelmed public health prevention
efforts, undermined attempts to explore the social, economic and political causes of cancer,

and turned ‘survivors’ back into ‘animate documents’ that demonstrated the potential of biomedicine to cure cancer and the need for more research. The patient made normal was part of such demonstrations, but embedded in the new series of debates about survivorship. For some the term ‘survivor’ had been hijacked by the ‘survivorship industry’, which turned the experiences of ‘survivors’ (along with the associated identity politics) to their own corporate advantage. Others focused on its multiplicity of meanings as: indicative of a flourishing grass roots movement; a barrier to forging a coherent political movement around identity politics; or a label that failed to capture certain experiences of cancer. The existence of debates and struggles around identity politics and corporate hijacking (both absent from the debates in the 1950s) marked the beginning what might be called the moment of survivorship and the end of the moment of recovery.

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