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Cancerisation

The historian of the experienced body faces the contemporary phenomenon of cancer prevention

Contribution to the international conference of the German Society for Cancer.
Conference:" LIVES of women and cancer: possibilities of prevention"
Frankfurt 29/30 October 1997

Translated by Nasha Abadian

Corrected by Mother Jerome

Printed: 23.06.00
Filename and date: CANCTL2.DOC
Old filename and date: cancer1.doc, verkrebs.doc (deutsch)

STATUS:

1. Distribution
- friends only

2. *Copyright*
- Translation by Nasha Abadian. The German manuscript is not published yet.

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Cancerisation

The historian of the experienced body faces the contemporary phenomenon of cancer prevention.

When the official program actually lay in front of me, I couldn't help asking myself: how did you come up with the idea to invite an historian to hold the first lecture? What the German Cancer Society wants to discuss today is much too young for my field of work. And the treachery of my subject, namely history, is that it excludes the researcher from the present. For the study of history leads one to deal with forms of existence that have nothing in common with forms that we today take for granted. The context of "cancer" has become the big risk for the women of today. The historian, however, knows that both concepts - "cancer" and "risk"- are alien to the past. And now I am asked to talk to an assembly which is concerned with injecting a new "consciousness of risk" and therefore "oncophobia" into not only German, but also all other European women.

There are privileges which appear to be embarrassing, and my historical distance to this problem which you are committed to was an embarrassing privilege during the preparation for this lecture. In order to be able to articulate myself at all about this problem from an historian's perspective, it is necessary to define what the problem actually is : it is neither the context of cancer as a scientific fact, nor the context of cancer as a word for the pain of the illness, treatment and self-stigmatization of the people concerned,[1] it is the context of cancer as the process of social disembodiment in a society of risk.

When I talk about cancerisation, I am talking primarily about this form of control and not about the suffering or the stigma involved. My first step will be to show you how cancerisation is almost incomprehensible seen from an historical perspective; secondly I shall prove the absence of cancerisation in medical history. My third step will be to show the gender-specific consequences of cancerisation: the loss of a sense of time particular to women.

[1] Susan Sontag in: Illness and Metaphor. New York: Farrar, Strauss and Giroux, 1978, described the difference between the suffering of being ill under treatment and the suffering about the metaphorical interpretation of its diagnosis, from her own experience twenty years ago. " I want to describe, not what it is really like to emigrate to the kingdom of the ill and live there, but the positive or sentimental fantasies concocted about that situation". She brilliantly differentiates between suffering of illness and the suffering produced by the medical diagnosis.

1. The conscious incompetence of the historian throws a special light on the cancerisation of women.

A. Oncophobia is not a natural phenomenon

If I stay within my professional limits, i.e. commenting as an historian about something which was as alien to epochs I have researched as the pill or TV were, then I have to start by denying any competence. I am marked, because I know that my predecessors lived without the risk of cancer. They lived without what I call "cancerisation", intense onco-logy[2],cancer as a fact that forms society. It did not exist. Consumption, syphilis, malaria were the public enemies. I know very well that the cultivation of oncophobia provides income for hundreds of thousands of people, scares millions more and makes hundreds of millions of profit for hospital architects, suppliers of machines and chemicals and insurance business men. But this does not tell me anything about how the different kinds of cancer are related to one another. I cannot say whether this biological confusion called "cancer" refers to a similarity in physical changes, or whether a melting-pot concept was made so that therapeutic attempts could deal with different incurable illnesses.[3]

B. Similar tumors may have existed in the past, but definitely not "cancerisation".

I know that archeological cytology can diagnose cancer. I know that archeologists and oncologists cooperated in order to find a description in the Eber papyrus of Ancient Egypt of an illness that would have been called "cancer" today.[4] But this does not contribute to the discussion of whether or not cancer itself can be seen as a modern phenomenon,[5] or whether a larger or smaller number of phenomena in former epochs would be diagnosed as "cancer" today, and- much more importantly - would be feared to be cancer today.[6]

[2] Oncos, Greek for "mass or tumor"; from the reduplication of the indogermanic root *enk to *enenkein, which stands for "burden".

[3] F. Luthi "Le cancer est-il une maladie nouvelle? A propos du diagnostic des maladies tumorales dans le De Medicina de Celse". Gesnerus. 53(3-4): 175-82, 1996. "it is possible that both the changed medical conceptualization and the real increase in prevalence are responsible for the actual importance of cancer".

[4] W.M.Pahl. Tumors of bone and soft tissue in ancient Egypt and Nubia: a synopsis of the detected cases. International Journal of Anthropology 1,3, 1986. A further example for Onco-Archeology: Trevor Anderson, Jennifer Wakely, Adrian Carte. "Medieval examples of metastatic carcinoma: a dry bone, radiological, and SEM study. "In: American Journal of Physical Anthropology of Physical Anthropology 89,3, 1992, pp. 309-32.

[5] Vilhjalmur Stefansson. Cancer: Disease of civilization? An anthropological and historical study. Introduced by Rene Dubos.

[6] Several new studies are interested in how the borders between normality and pathology are manipulated in the field of oncology, even nowadays. An example of this is cell morphology, which Papanikolau standardized at the time of the First World war.

C. Epistemological reasons for profound fear

But I do know one thing: the acute and often paralyzing fear of women's cancer and the fear of cancer spreading amongst our children is very new. This fear is not only new, it was, until recently, also very expensive. Onco-Phobia was therefore dependent worldwide on people's income; it was dependent on a middle-class life-style. Conferences like these feed media, they thus cheapen the education in oncophobia. They want to mobilize women, motivated by fear, either rich or poor, to take prescribed precautions and therefore prepare them for a timely medical intervention.
Information about cancer has a peculiar potential for creating fear. Panic, not reasonable caution. Why? Certainly because tumors suggest a form horror easy to visualize, that grabs You. More deeply, however, because of something else: the information with which the so-called prevention of cancer is propagated and legitimized presupposes a statistical way of thinking that appears in the media as a disquieting phantom.
Parallel to the statement:
"Zero Point Two Percent probability in the next thirty years" a visiotype is produced, a curve on the graph and your profile is projected on to a point on this curve. If you see yourself there, you put yourself in the world of risk. And this reduction to a point on the visiotype causes fear and panic.[7]
Rates of cancer are more responsible for this than accident rates because they evoke a fear of something which is not in the outside world, on the road, but inside, something which you are afraid of inside yourself.
Both of these phenomena, cars and cancer, are a part of the drama and tragedy of the modern human condition.[8] They are a part of my world. Both cancer, as well as accidents, belong to the dangers that I fear. But I would never let myself be threatened by an anonymous danger. I feel threatened only by someone in particular.

I am afraid of drivers after they have drunk in bars, I am afraid of doctors after having been visited by the medical pharmaceutical representative, of the guy hanging around my office at night.
Concrete fear is different from anxiety. Fear is, as I said, concrete, healthy , clear and keeps me alert. Anxiety is the result of feeling trapped, it is hurting and dark, it makes me nervous and keeps me from sleeping. Anxiety is the only result of cancer consultation. Oncophobia is the consequence of reducing your self-definition to being a "case".
I don't see myself as a "case". I do not perceive myself as being a profile of probabilities. I refuse to speak of my pregnant colleague as a risky case. Cancer-rates do not concern me because I do not let my actions and wishes be influenced by probabilities. The use of statistics removes me from my own reality, it makes it literally un-graspable, un-sensual, pointless. Statistics are physically even more pointless when I understand their function in everyday life. Statistics are used to create

[7] From a general point of view, one can say that a list of "Icons" replaces the statement; a suggestive sequence in an argumentative statement. Uwe Pörksen in: The World market of Images: A Philosophy of the Visiotype. Stuttgart 1997 characterized these suggestive images as "visiotypes" and discussed its strange and new utilization as a way to create psychological pressure and fear.

[8] Nelson S. Hartunian, The incidence and economic costs of major health impairments. A comparative analysis of cancer, motor vehicle injuries, coronary heart disease, and stroke. Lexington, Mass., Lexington Books 1981. (An Insurance Institute for Highway Safety book.)

disembodiment. As soon as you try to see yourself as being part of a population, part of a statistical group, you let yourself be influenced by probabilities that you think you are influencing. And I do not know any other more intense conditioning for this kind of disembodied self-organization , at least for women today, for this helplessness-in-need-of help, than the consciousness of risk in the context of cancer and children.[9]
It is for this reason that I think that the propaganda for chance and risk, probability and fact leads unavoidably to confusion by educating the public about something which essentially cannot be understood: it has the consequence of the heterogenesis of the self, which results in a new form of profound and irrational anxiety.

D. Effectiveness, efficiency and equity.

I have studied the cyclical succession of scaremongering discoveries and encouraging promises, for they belong to the essence of the cancerisation enterprise and their evaluation is mainly monopolized the enterprise itself. The historian can only be astounded by oncological self-criticism: by the studies of effectivity, efficiency and of the epidemiology of the business. The studies about effectivity fit into the tradition of miracula, i.e. the books of miracles that display of long tradition of what has already been believed; the studies about costs and utilization evoke the mythology of Croesus, for every so-called "progress" in the field of oncology is immediately turned golden and the epidemiology of the treatment series reminds one of a "Count Bobby" joke that I shall tell you in a minute.

The evaluation of specific therapies report mostly the success of oncology. What is typically reported to be a success, is, for example, that much fewer of the cohorts of women without a uterus die of metastases in the five years following a hysterectomy than women who were diagnosed but not operated. Whether and how much longer they live is not included in this research. The methodological reasons for this reduction of focus are often described in detail. The undoubtable success consists therefore of the fact that the criteria of a statistical basis are [10]cut to size to fit successful results. Thousands of reports about scientific progress create the impression of a "final victory over cancer". This wishful thinking is credible because the reports apparently come from the mouths of specialists responsible for a particular organ. Not only the media, but also many of the cancer research charity groups are a conveyor belt for these reports of victory, so that the naive reader may well be surprised that people are still dying of a cancer which has apparently been

[9] William Ray Arney, Experts and Expertise in the Age of System: Tickling the Tail of the Dragon. Albuquerque, University of new Mexico, 1995 studies, as a historian of statistics, the context of systematic thought and the reduction of the self to a "case", more precisely, to that which "I" identify myself as a profile of a fixed number of characteristics.

[10] In 1993, the National Cancer Institute took back its recommendation that all women over 40 years of age should start screening for breast cancer. The council of the NCI, who was responsible for proving the uselessness of screening, now tried to prevent these obviously negative results from being officially publicized, in the autumn of 1997.

"overcome".[11] At the same time, political groups ardently encourage the fight for the millions set aside for the research of a particular form of cancer which is feared the most by its members; a fight which supports the credibility of so-called progress.[12] By my knowledge of ethnology I have heard of places of pilgrimage that specialize in one particular disease and I am challenged to believe in miracles. In this case, the opposite is required: I have to believe in the miraculous survival of tumors which have long since been overcome.[13]

The research studies about the financial support of this campaign are just as surprising. The more obvious the failure, the more money there is available. Why do our contempories keep having to pay constantly increasing premiums in order to be pointlessly tormented? Only a joke, which I heard in Vienna, hits the nail on the head:
There was once more a revolution. At the center of town they had built a platform with a scaffold. Bobby climbs up. He sees the executioner with his ax and turns around on the last step to his fellow-sufferer Rudi and says: "Hey, how much do you think they get tipped?"

D. Secondary analyses

The secondary and system analyses[14] show a contrast to the judgment of individual actions by a particular guild. These are mostly statistical investigations aiming to create a relationship between the effect that therapy, diagnosis and prevention have on the mortality rates of particular age-groups. If one summarizes these studies, it becomes clear that most of the statements about the positive effects of cancer therapy turn out to be zero-hypotheses.[15] Many millions of breasts are cut off in pairs in order to come up with these results.

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[11] Editorial in LANCET 341. 6. Feb. 1993, pp. 343 -344. ìBreast Cancer: have we lost our way." : "If one were to believe all the media hype, the triumphalism of the profession in published research and the almost weekly miracle breakthroughs trumpeted by the cancer charities, one might be surprised that women are dying at all from this (breast) cancer".

[12] Robert N. Proctor. Cancer wars: how politics shapes what we know and don't know about cancer. New York, Basic Books, c1995. viii, 356 p. For information about the mutual legitimization of military and oncological research see: United States Congress. House Committees On Armed Services. The uses of military technology and information in the war against breast cancer : hearing before the Research and Technology Subcommittee of the Committee on Armed Services, House of Representatives, One Hundred Third Congress, second session, hearing held October 4, 1994, (Shipping list no.: 95-0162-P. "H.A.S.C. no. 103-59.)

[13] 13. EDITORIAL in LANCET 341, 6. Feb. 1993, pp. 343-344. "Breast cancer: have we lost our way?" "Some readers may be started to learn that the overall mortality rate from carcinoma of the breast remains static."

[14] If one studies the history of secondary analyses, i.e. the analyses of the results of similar research studies already in existence, one has the impression that this sociological method was made especially for scientifical evaluations of medical projects.

[15] The institutional attempt to evaluate the effectivity of cancer diagnosis and therapy already began in 1926: International Symposium on cancer control, 1926, Lake Mohonk, N.Y. "Cancer control, report of an International symposium held under the auspices of the American Society for the Control of Cancer", The Surgical Publishing Company of Chicago, 1927

This echoes the order of the queen "First off with his head and then we can have the verdict" as reported by Alice in Wonderland.[16] I personally find it difficult to swallow the repeated use of procedures that have just as often turned out to be inappropriate torment, as a historical fact It remains unclear to me whether the propagated cancer-related behavior of doctors and patients reduces women's pain and relieves the strain on women, or whether women are worn out by cancerisation so that they are more easily subjugated to a cancer therapy which has become more and more subject to doubt.

E. Illness or suffering?

The results of the secondary analyses create the impression that cancer medicine is an enterprise that aims to introduce everyone to the cancerisation potential of their population group, in order to take control over their cancer. In this case we are dealing with an entity of "illness" which has been made absolute, the origins of which, however, are found by medical historians to be in the late eighteenth century. Up to this point the doctor's aim was to refresh, encourage and yes, even heal the suffering patient. Since this time, the doctor solely diagnoses a patient's "illness", whether the patient is aware of it or not.

In oncological algology, i.e. the pain treatment of cancer patients, the indifference of biocracy for the suffering human being world-wide becomes very clear. It is true that pain-killers are given more generously to patients that have undergone cancer therapy and are willing to die under medical control, than for patients of any other illness. Paradoxically however, strong analgesica have been criminalized for all patients who cannot afford a hospital death-bed, under the pressure of the US drug paranoia. The new algology, therefore, de facto serves to secure the further acceptance of aggressive and expensive therapies, even if they are mainly without success. A poor woman in Mexico has to buy her opiates on the black market because she couldn't afford to be operated, and it is only hospital patients who can get hold of doctors who are allowed to prescribe analgesica. Cancer therapy is therefore not concerned with this woman's suffering, it is concerned with the guarantee of her medical treatment.

F. Conclusion

If I observe the present time from the perspective of cancer-economy, I am not able to come to any kind of conclusion, not even to an assumption of a conclusion:

[16] The American National Cancer Institute began to analyze not only the positive effectivity and its financial costs, but also the expensive and damaging side-effects of cancer treatment only since the beginning of this decade: "We must not simply question effectiveness, but ask what harm these diagnoses do, and at what cost. "New England Journal of Medicine 17. April, 1997: "Wither Scientific Deliberation in Health Policy Recommendations? Alice in the Wonderland of Breast-Cancer Screening." In order to put this through, it was necessary to institute an arbitration commission: "The NIH Consensus Development Conference on Breast Cancer Screening for Women Ages 40 to 49". Says Suzanne W. Fletcher, Harvard medical school, the head of this committee: "Until recently, the NCI primarily considered evidence of effectiveness in reducing cancer-related mortality when issuing recommendations; now, evidence on the adverse effects of medical intervention is also considered, but not issues of cost and cost effectiveness."

= if an entity, attributed to biology, called "cancer", was invented as a focal point in order to finance the oncological complex

= if a symbolic enemy, as diffused as communism used to be, offers itself as an ideology for gender-specific discipline,

= or if oncology is the seed of an enterprise which should, after the conclusion of the Human-Genome Project, supply the follow-up projects of the Malthusians and Eugenics.

In this assembly for European cancer prevention I shall not be concerned with the following aspects of oncology: I am not interested in cancer as an object of research and treatment, cancer as financial resource for the oncological market, oncology as a perfect example for influencing human needs and encouraging tolerance of increasingly inappropriate technology. I am also not interested, as I have been on other occasions, in showing from a new perspective, namely that of a historian of the body, how the sensual perception of the woman's body as a "stream" has been replaced by an iatrogenous, i.e. attributed to medicine, internalized physical construction. Today I am primarily concerned with a specific consequence of cancer-prognosis in women's history. I want to show that the cancerisation of society robs women of their own particular temporality.

There are doubters and representatives of heretic perspectives about cancer. However, I am not yet sure if I shall find support for my argument. In my view, cancerisation is, first and foremost, an extreme form of internalization of the society of risk by which the women’s body is detached from lived time. I am asked to talk about women and cancer in the reflection of the past, in the reflection of a time that doesn't exist anymore. For this reason I shall talk today about women and the moon. I shall talk about the woman as a spinner of time, about the woman whose becoming pregnant used to be a sign for an invisible presence and coming reality. And, in this context, I shall talk about the consciousness of cancer as a destroyer of this liveliness rooted in the woman's body, an openness towards something which has "not yet" happened.

In spite of its solely speculative significance, you want, at all costs, to propagate an awareness of risk, to recommend checkups and preventive lifestyles. I am of the opinion that you automatically destroy traditional attitudes to time. What used to be called "Good Hope" in my childhood at Schliersee, now becomes, in the shadow of risk, a source of insecurity, gnawing fear and suffering because of something which has "NOT YET" happened. Prevention causes a woman to be vulnerable to rape by a type of time that doesn't fit her body. Existence which is threatened by this "NOT YET" takes away from the female body the fertility of spinning time.

2. The medical history of cancer requires completion through the history of the body.

There is no Older History of cancer. A critical look at the medical historical literature about this topic shows this. The tumor has almost always been misrepresented in such a way that classical and

early modern observations were homologised as historical variations of the modern oncological object.[17]

At about 400 BC, the doctors of the island KOS, the so-called Hippocratics, differentiated tumors, growths and swellings of the breast, stomach and uterus. [18]Oidemata: soft cysts, mostly hot zysts and hard karkinoi. The Hippocratics advised against therapy. Kos, therefore, is the start of two thousand years of therapeutic nihilism. In the first century AD, Celsus [19] was of the opinion that therapy "irritates tumors". Just about a century later, Galens differentiates more than a dozen tumors in de tumoribus praeter naturam[20]: phlegmone, which are "throbbing, hot and red", the polysarkia "watery boils"; kolpai, which fester, karkinoi, "hard swellings, which first become painful when they break though the skin" and then become festering phagedaina; aneyrysmata, in which blood has builded up; elephas of the lepers, myrmekia or warts, the psydrakes or pimples; the epiknyktides that are produced by insect-bites and then the kirsoi, which correspond to our varicose veins.[21] According to Galens, most of these tumescentai are caused by the blocked-up gall-bladder and he urgently advises that the doctor should abstain from cauterization or operation. Galens' etiology, as well as his warning against medical attempts to cure these diseases remained valid, even obligatory, until the nineteenth century.

This terminological collection expands and almost doubles itself during the time of the Renaissance and the tendency with which Galens had begun catches on, i.e. to emphasize what these almost completely diverse symptoms have in common by ending their names with "-oma". The nineteenth century adds papilloma, ardenoma, fibroma, cloroma, lymphoma, among others, to the classical termini such as "sarkoma."

Oncology comes into existence as the doctrine of the "-omata" .[22]

Even less successful were the successive attempts to create a new class by trying to find a common etiology for these "-omata". In 1796, Morgagni began by making mutations of the organs, and not the black gall-bladder, responsible for tumors. Iatrophysicists and iatrochemists accused the lymph. In 1761, John Hill discovered the relationship between regular tabacco-snuffing and the tumor of the

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[17] For more information about the conceptual history of cancer see first of all: L. J. Rather. The Genesis of Cancer. A Study in the History of Ideas. Baltimore 1978. Easy to read: Robert Allan Weinberg, Racing to the beginning of the road : the search for the origin of cancer. New York, Harmony Books, 1996. Also helpful for historical orientation: Shimkin, Michael Boris, Contrary to nature, being an illustrated commentary on some persons and events of historical importance in the development of knowledge concerning cancer. U.S. Dept. of health, Education, and Welfare, Public Health Service, National Institutes of health: Superintendent. of Documents, U.S. Government Printing office, 1997.

[18] Hans Dont. "The Terminology of the Ulcer, the Tumor and the Swelling in the Corpus Hippocraticum" Diss.Phil. University of Vienna, 1968.

[19] F. G. Brunner. Pathology and Therapy of Tumors in the classical medicine of Celsus and Galen. Zürich 1977.

[20] Vigliani R. "Oncologia di Galeno" Pathologica. 87,5, Oct. 1995, pp. 577-90, "Claudius Galenus". Interpretation of "De tumoribus praeter naturam"; the standard version by : K. G. Kuhn ("Opera omnia Claudii Galeni" : Vii, 705-732).

[21] D. G. Lytton und L. M. Resuihr. "Galen on abnormal Swellings." in Journal of the History of medicine and the Allied Sciences 33, 1978, pp. 531-49

[22] Harry Keil. "The Historical Relationship between the Concept of the Tumor and the Ending -Oma". Bulletin for the history of medicine 24, 1950. pp. 352-77.

nasal cavities; 14 years later Parcival Pott discovers the relationship between chimney-sweeping and the tumor of the scrotum; twenty years later Samuel Thomas Sömmerring proved the connection between pipe-sucking and the carcinoma of the lip. The epoch of chemical etiology had begun. In 1847 Virchow founds the archive, named after him, which is still the leading journal of cancer pathology and extends this in 1857 to cover also cellular pathology, his doctrine "of the tumors which could be explained by the mutations of cells"[23]

It was only after the turn of the century that oncology succeeded in becoming a social topic and thereby taking over the role of consumption as the "scourge". Therapeutical experiments come in waves, pile on top of each other and only drop off long after it has been proved how inappropriate or even harmful they are. Christian Albert Billroth gained respect for cancer surgery in Vienna as early as 1867. The dramatic drop in mortality rates during ovariotomy operations from 50 percent to 20 percent during the time-span of only ten years was celebrated as a big success. In 1897, the first patient survives a radical hysterectomy.[24] A "systematic" illness had been created out of a local malignant "tumor", the symptom of which was the tumor itself.[25] George Beatson introduces the hormone treatment around 1900,[26] and, until the end of the Second World War, thousands of women with breast cancer were sterilized. We have the pap-test since 1913. Chemotherapeutical enthusiasm, mostly in connection with x-ray experiments,[27] does not begin until children with leukemia were successfully treated after the Second World War.

The demand for early diagnosis, after ecological factors and especially after preventive changes in life-style had been disposed of, did not begin until the time of the Berlin wall. The use of victim blaming allowed one to interpret the previous disappointment of unsuccessful diagnostical and therapeutical experiments as a lack of ecological and genetic systematic analysis. Then around 1980, a new ruling of medical language wins through: a weakness of the immune system is seen in the light of a program wrongly functioning[28] and the activation of cellular oncogenes as inherited misinformation.[29]

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[23] Dhom G. "The Cancer Cell and the Connective Tissue. A historical review". A short comprehensive report about the use of the microscope in oncology, Virchow's short-lived theory about the origin of cancer in the connective tissue and the criticism of this theory.

[24] John Stallworthy. "Progress in gynecologic oncology: a personal retrospective view." Gynecologic Oncology 8, 1979, pp. 253-264.

[25] Martensen, Robert L. "Cancer: medical history and the framing of a disease." The Journal of the American Medical Association. 271, 24,1994, pp. 1901: "the historical view of cancer as a primarily local disturbance has been replaced in the late 20th century by the idea of a primarily systemic disease that is amenable to medical treatment."

[26] "On the Treatment of Inoperable Cases of Carcinoma of the Mamma: Suggestions for a new method of treatment, with illustrative cases." Glasgow Cancer Hospital 1896.

[27] "Chronology of Radiotherapy. 1900-1960. Selected Chapters from German radiooncological literature". Band 2: 1926-1936.

Special Issue of the magazine ìRadiotherapy and Oncology".

[28] Anne-Marie Moulin. Le dernier langage de la medicine. Histoire de l'immunologie de pasteur au Sida.

From a medical-historical perspective, oncology gives the impression of trying to use the model of Sisyphus to build up a big enterprise.[30]

3. IN ORDER TO SPEAK ABOUT CANCER AND WOMEN FROM A HISTORICAL PERSPECTIVE, I SHALL USE THE HISTORY OF TEMPORALITY. I SHALL DISCUSS HOW THE SELF-ATTRIBUTION OF CANCER RISK OR EVEN CANCER DIAGNOSIS HAS THE EFFECT OF RELINQUISHING THE TIME-VECTOR OF BODY EXPERIENCE.

My abdication of competence and this little tour through the medical curiosity cabinet may have convinced you of three things:

= one could say that cancerisation has no predecessors at all, as seen from a medical historical perspective.

= that oncology may very well soon be seen to be the biggest failure of medical experimentation on people of the twentieth century, in spite of all victory reports by the politicians.[31]

= that the prevention campaign has the effect of making women support a lost cause.

As a historian, I belong to a generation that cannot perceive the past as being analogous to the present. I belong to a generation in which my experience of the present has moved beyond my professional horizon, because, as a woman, my pre-sense is so important to me. In spite of this point of view, I accepted your invitation. Why?

It is not difficult for me to answer: you offer me the opportunity to talk about cancer - not from a biological perspective, not from a epidemiological perspective, and also not from the perspective of

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Paris: PUF, 1991. According to the author, the concept of causality was turned on its head with the first illness that was named after its pathogene, namely AIDS. the patient is interpreted, via the Leibnizian monad, to be a provisory subsystem of her natural surroundings and the society she lives in; as an "immune system". This word appears in 1976 at a congress and. within half a decade, caught on as a key concept which people took for granted. Likewise: "The Immune System: A key Concept for the History of Immunology." Hist. Phil. of the Life Sciences 11, 1989, pp. 221-236.

[29] M. Morange. "The discovery of cellular oncogenes." History and Philosophy of the Life Sciences. 15,1,1993, pp. 45-58 first sketches the experiments that seem to prove the existence of an archaic family of genes between 1975 and 1985, whose functions as regulators of cell-growth becomes malignant because of cell-alien factors. He then sketches the velocity with which this onco-genetic paradigm was taken up in academic books since 1985.

[30] Moss Ralph W. The cancer industry: unraveling the politics. new York; Paragon House, 1989.

[31] As an example for this stubborn optimism I shall quote Donna Shalala, the minister for health and social security. In: new cancer mortality rates. Washington DC. Department of Health and Human services, 1996, - press conference: "We must continue to work for the day, when our children must turn to the history books to learn about a disease called cancer...it will take better research, better treatments, better detection, and most important, it will take better education...from tobacco to poor diet, the lack of reproductive screenings, we must give the American people the information they need to prevent cancer and make the best choices with their lives."

life insurance technicalities. I want to talk about cancer as a sign of the times. Since I have spent a lot of time thinking about the historicity of autoception, I want to call attention to the contribution of cancer to contemporary changes of body history. How does oncology change women's self-perception, how does it mirror and support a breaking away from the self-perception of my mother? There is a lot to say about this subject. I shall restrict myself to the context of time, the loss of a particularly female sense of time,[32] which I shall call, after long thought, the "loss of the moon".[33] With this name I want to refer to the etymological, semantical and mythological motifs that attest the relationship of the woman's body to social life. The mobilization of women in the context of cancer prevention has the effect of connecting a woman's body to a kind of Not Yet, which is crassly opposed to a female temporality as seen from a historical perspective.

The experience of cancer therefore, whose generalization many women here support, is a particularly good example for the gender-specific aspect of modern disembodiment. I do not want to show a cause-and-effect relationship between cancer diagnosis and the loss of time in this epoch of acceleration, of "real time" and of appointment calendars. I only want to show how the woman's body becomes ill during the process of cancer prevention.

I see this as being a consequence of how the anticipation of the future suppresses rhythmic experience. I accepted your invitation because your work in urgently advising people to educate themselves in prevention and precaution permits me to talk about one of the most forgotten of aspects of misogyny in our epoch: the loss of a physical time experience. In this context, "riskî is, in my opinion, a symbol of women's fate.

In order to prepare myself for this meeting, I have spent the last few months watching out for media representations of cancer, reading texts from women's initiatives that had been sent to me in the last couple of years, paying more attention to conversations about cancer amongst women and visiting the women's book shop, where there is a whole pile of books about cancer. During this time, I realized how often and with what emphasis "cancer" was connected to words that didn't appear so often until recently: contraception, precaution, suspicion, early identification, a normal case, advice, operation, screening, control, "management", informed consent, and, above all, risk.

I am shocked, for these are exactly the same termini that have infiltrated themselves in conversations about pregnancy. Cancer and pregnancy have become similar states, to a large extent, in the context of obligatory prevention, the compulsion to act, the need for advice and control, and above all in the context of the disembodiment of time. I understand this as a challenge to the history of time in a double sense: the history of our time, and the time experienced in history.

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[32] Jacob von Uexküll (1922) posed a theory that a particular subjectivity creates a particular form of time in its surroundings and called this time "Eigenzeit". The idea, but not the name, goes back to the discoverer of the ovum humanum, Karl E. von Baer (+1876). Since Uexküll, the empirical research of biorhythms has been developed broadly. However, the temporality that I am referring to, should not be related to this tradition.(??)

[33] Emile Benveniste refers to the close etymological relationship between measure, moon, medicine and femininity in: "Med- et la notion de mesure." In: Le vocabulaire des institutions indo-europeénnes. Paris: Minuit, 1969, Bd 2 pp. 123-132

The fact that consciousness of time, experience of time and temporality have their own history has been an important point of discussion for historians of the last two generations.[34]
How time-pressure discriminates women already became a topic of national economy since the beginning of the century.[35] History of time, however, does not usually concern itself with the experience of temporality. It does not make the point of the loss of time in connection with the "moon", that I would like to express. I am concerned with the rootedness of socially experienced temporality in the bodies of women living in past epochs, which made women beings who weave time.

This temporality, the loss of which seems so significant to me, does not have anything to do with days or hours, it has to do with processes; bios, the curriculum, i.e. the flux of life, it has to do with pregnancy as the presence of a child that is not yet there, the future, which is already growing inside a woman. It has to do with the humoral body, i.e. the perception of existence as a stream with influences from different sources whose harmonious reciprocity evokes a feeling of well-being. And this temporality finds its clearest expression in the identification of flux with being alive. In the English language, the word "quickening" is still used to describe the first movement of the unborn.
For years I have attempted to understand how women of the eighteenth century experienced their bodies as shown in diaries, letters and ways of speech. Only step by step did I understand that descriptions of health and sickness had mainly to do with blood; the directions and the strength, the periodicity and the way out of the flux which women experienced themselves as being.
The farmers and court-ladies did not go to the doctor because they were ill; they went because they felt blocked-up inside. What they were motivated by, was the fear and worry about blockages. And that was also what women were afraid of at the time of Hippocrates: congestion, non-movement, non-flowing in their own insides.[36] These women looked for help from doctors because something had become too solid inside. Women's complaints emphasized the fearsome loss of flux, i.e. they feared the loss of what I understand to be their embodied temporality.[37]

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[34] Toulmin, Stephen. Forsight and Understanding. NY: Harper and Row 1961. Leach, E: R: "Two essays concerning the Symbolic Representation of Time". In: Rethinking Anthropology, London, 1961, the researchers directed their attention to the history of time itself and not just its measurement. Kern, Stephen. The culture of time and space 1880-1918. Cambridge, Mass. Harvard University Press, 1983 is a standard work from the school of Jung-orientated phenomenologists of corporeality. Glasser. Richard. "The concept of Time in the Renaissance. In: Time in French Life and Thought. Manchester University Press, 1972 refers to a freedom hardly comprehensible to us today, with which past epochs were not separated from the present by "time-spaces". Maiello, Francesco. Storia del calendario. La misurazione del tempo 450-1800. Mailand, Enaudi, 1996 shows convincingly how much time it took and how difficult it was for the idea of calendar-organized "Tomorrows" of uniformly successive days to catch on, which we, today, take for granted.(??)

[35] Bidlingmaier, Maria. The farmer-woman in two communities of Württemberg. 2.Issue. Kirchheim/Teck: Jürgen Schweier, 1990.

[36] Padel, Ruth. In and Out of the Mind: Greek images of the Tragic Self. Princeton, Princeton Univ.Press, has a comprehensive chapter on the flux of feeling. As a classical philologist, she tries to delve into a deeper layer of the experienced flesh in Ancient Greece. She opens up a way by which we can intuit what went on inside people and how inseparably physis and feeling, matter and emotions were entangled.

[37] Verdier, Yvonne. Three Women. Life in the Village. Stuttgart, Klett-Cotta, 1982. She shows how, in a village in Burgundy, the rhythmic processes between menstruation and the moon still exist.

I am telling you what I know, because the life-long search for "chances of prevention", i.e. living in the awareness of cancer, living in fear of cancer, living in the context of unavoidable risk, threatens this aspect of being a woman that used to be the center of enjoyable attention in the past: a flux spun by every woman beyond "now", i.e. her own temporality. The fixation on an over-average risk of cancer even before the menopause causes young women to fantasize about themselves as being carriers of a statistical threat, disembodying and therefore horrifying and indefinable.
In order to analyze this fixation on risk, I have compared this situation with the wind-screen perspective.[38] Driving a car demands a kind of attention that former epochs did not know or practice. The routine of driving a car influences both self-perception as well as the unconscious course of stereotype reactions when steering or using the breaks. This conditioning of perspective, without which driving a car is impossible, makes it possible to see and discuss certain ideally typical characteristics that can be found in many different kinds of contemporary behavior and situations, especially in the context of cancer precautions. I call this type of perception the "wind-screen perspective" , and now want to explain some of its characteristics.

1. The faster the speed, the more the driver has to concentrate on the distance ahead. The side-view shrinks to a small funnel wherein everything just glides by; individual objects are no longer differentiated.[39] Fear of the risk of cancer reduces the perception of the body with similar power.

2. The pre-technological perspective eyes a cat playing: it follows the movements of the cat and tries to see the cat from different angles. The wind-screen perspective is used to the gliding perspective on an imaginary point, which flies by on the white lines of the road while "not yet" there. The new perspective is adapted to a distance, it doesn't concentrate and play with one object. Details are consciously overlooked, because one's attention is always taken up by an always probable, never foreseeable danger, and only this can trigger the driver's automatic reaction at the steering-wheel or the breaks. Tests and probabilities take up one's attention in a similar way, thus handicapping one's own liveliness.

3. Oneís perspective does not only shrink and glide. It turns into a starr. Our eyes, which normally wander from left to right, up and down in their hunt after the visible, become paralyzed. They do not concentrate on one thing, they become fixated on a distance. Consciousness fixated on risk paralyses the ability to dure, to bare the unforseen; disziplined venture turns into anxious self-control; programs replace openness to surprise

[38] Since about the last 15 years, psychologists, insurance economists, traffic and car engineers and government representatives have been meeting irregularly to talk about the wind-screen perspective, and have published several books of their reports. An unusually good paper on a seminar about the Federal Republican Perspective was produced by Erwin Flohr: "Driving a Car and its Effect on the Human Eye-View." University of Hannover, Institute for Sociology, June 1995.

[39] One often overlooks how tormenting this unfocussed perspective on everything flying by can be. The optical suggestion of a no-exit tunnel- wall flying by with no white stripe to divert the eye is a torture method that has been internationally discriminated because it drives people mad.

4. In order to react on time by using the breaks or steering, in this situation of fixated precaution on a future rushing past, the driver must be, beyond the horizon of his actual present, a participator in traffic, seat-belted in a placeless time-queue which penetrates the countryside.[40]

These characteristics of the wind-screen perspective can be summarized as being a caricature of modern life. The present does not come out of experiencing the flux of the "Not Yet"; the present becomes a function with a calculated risk. Oncophobia, which is advertised for here as "cancer-awareness", influences women much more intimately and specifically than the steering-wheel. Much against my own feeling for language, I felt myself obliged to use a neologism: "cancerisation." How else could I refer to the withdrawal of the flux of the present replaced by an organized life within an abstract space of possibilities?

Whoever surrenders herself to systematic cancerisation, is placed in a non-stop training course for existence in an un-real present: she always has to be somewhere where she has not yet reached - and maybe shall never get to. This new type of colorless present consistently demands to be in the future. And a cancer precaution practiced in this way goes much further than the disembodiment demanded by car-driving. Being in the pre-sent becomes a pre-caution, i.e. a form of action that already takes place in the shadow of calculated risk. The present shrinks into the future.
The motivations for preventive action is not easy to grasp or easy to perceive, because they are based on a construction of probabilities. This goes for pregnancy as well as for cancer. Precaution changes the meaning of illness, as it does with pregnancy: It makes illness a threat, it forces one to suffer about a possibility which might not even happen. In this same way it makes pregnancy into a risk, that only doctors who work with probability rates can prophesy.

I know from my research that women's suffering used to be about "blockage", a woman deaded the loss of flux. The de-temporalizing of experience influences women with its "who-knows" mentality more than men. It is exactly in those parts of the body that were traditionally understood as places of intense life-giving vividness, as places of desire and yearning, that attention is concentrated on the calculated probability of a malignant tumor.

So, here I stand as a historian in front of my hosts, and I remember a line from the "Frogs" of Aristophanes. Allow me to quote:
"I have introduced myself, with a courageous heart and a look of Oregano"
And now I notice, again with Aristophanes:
"how my speech filled your eyes with mustard".

What consoles me is the following: in the Galenic tradition, mustard served to digest heavy meals. I therefore wish you "bon appetit" for the rest of this meeting.

[40] Paul Virilio. The negative horizon; movement, velocity, acceleration. Munich, 1989. pp. 136-139.