The British Fight against Cancer: Publicity and Education, 1900–1948

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Summary. This article explores the early history of cancer education in Britain, focusing on the period between 1900, when discussions about a public ‘crusade’ against cancer began in Britain, and the foundation of the National Health Service (NHS) in 1948. Arising from debates around the development of invasive operations for cervical cancer, the campaign had a cautious start because of important uncertainties about the efficacy of available therapies, worries about the undesirable effects of partial knowledge, and anxieties about creating demands that could not be fulfilled. Against this background, anti-cancer activists attempted to produce a discourse which would not undermine people’s faith in medical science, and which would encourage people to consult their doctors without putting excessive pressure on health services funded by public money. A ‘regime’ of hope came to the fore that served to draw patients, philanthropists, practitioners and researchers together into a joint market agenda.

Keywords: cancer education; cancer control; cervical cancer; cancerphobia; cancer research; health education; sociology of expectations

Since James Patterson’s ground-breaking study The Dread Disease: Cancer and Modern American Culture was published in 1987, knowledge of the development of cancer control programmes in early twentieth-century Europe and North America has accumulated at a rapid rate.1 The work of Patrice Pinell on France, Robert Proctor on Germany, Charles Hayter on Canada, and Robert Aronowitz, Barron Lerner, Kirsten Gardner and Leslie Reagan on the United States has given us a better understanding of the process of social recognition of, and response to cancer in different national contexts.

This article explores the early history of cancer education in Britain. Elements of this history have already been analysed by Elizabeth Toon, but on the whole the subject of education of the lay public about cancer in the UK has failed to attract historical attention.2 In this article, I focus on the period between 1900, when discussions about a public ‘crusade’ against cancer began in Britain, and the foundation of its National Health Service (NHS) in 1948. I examine printed, archival and audio-visual sources in order to provide a broad picture of its dynamics and evolution at a time of mounting concern about cancer mortality, increasing therapeutic experimentation and growing state involvement in service provision.

The British fight against cancer resembled campaigns elsewhere, both in its focus on the ‘accessible’ cancers (breast, uterine and, to a lesser extent, skin cancer), and in its

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1Patterson 1987; Reagan 1997; Proctor 1999; Pinell 2002; Lerner 2003; Hayter 2005; Gardner 2006; Aronowitz 2007.

2Toon 2007. See also Patterson 1991.
emphasis on early diagnosis and treatment. But it also differed in significant ways from
the approach adopted in other countries, particularly the United States. British prac-
titioners agreed that health professionals should be instructed in the recognition of
cancer, but they were generally reluctant to spread the educational message to the lay
public. Most thought that public education would undermine the control effort itself,
either by inducing excessive fears of the disease, or by encouraging unrealistic expec-
tations of cure. The result was that, throughout the period under consideration, cancer
education remained a low-key affair, despite evidence that women, who were its
primary audience, were eager for information about the signs and symptoms of the
disease. This is not to say that American campaigners were immune from such anxieties.
As both Cantor and Patterson have shown, American cancer agencies did worry that the
educational message might promote undue fears or hopes in the public, thus leading
audiences to ignore the lessons they were supposed to learn. 3 But in Britain, the tensions
between the realities of cancer and society’s hopes for a cure, between what was achiev-
able in the present and what might be possible in an imagined future, between truth and
hope, were exaggerated.

Looking at the development of cancer education programmes in Britain from the point
of view of the history of health education, it is apparent that official approaches to cancer
control shared certain features with policies developed in other areas of public health
concern. Writing about the post-First World War propaganda campaign for the elimi-
nation of venereal disease, Bridget Towers observes that health education policy has occu-
pied a singularly marginal position in the development of British health policy. Before the
Second World War, health officials recognised that mass education might lead to better
health, but publicity was not regarded as a responsibility of central government. The gov-
ernment’s preferred approach was to leave health education to a variety of competing
agencies, or to delegate the work to local government. 4 In the field of venereal
disease, official concerns about the cost-efficiency of campaigns and about the politically
sensitive nature of the issue enabled a voluntary organisation, the National Council for
Combating Venereal Disease (NCCVD), to take on a leading role in the educational
arena, despite widespread doubts about the efficacy of the moralistic approach cham-
pioned by the society. An analysis of cancer education and prevention in pre- and inter-
war Britain can make a contribution to the history of health education policy in this period
by exploring the way in which the political and administrative organisation of health care
shaped the style and tone of campaigns.

My account highlights anxieties about the demand and supply sides of services in the
context of an emerging health care system based on local authorities. Health officials appreci-
ated that a national cancer campaign would stimulate demand for diagnostic and treatment
facilities, and that not all local authorities could sustain effective cancer services. They also
recognised that any attempt to extend municipal influence in the cancer field posed a chal-
lenge to other professionals already involved in the care of sufferers: private practitioners and

3Cantor 2007; Patterson 1987, especially pp. 75–6.
4Towers 1980, p. 70. Berridge has argued that it was not until the Royal College of Physicians 1962 report
on the link between smoking and cancer that a ‘state-funded activism’ began to develop in Britain. See
Berridge 2007.
consultants working in voluntary hospitals. The scope of anti-cancer initiatives was thus constrained by the resources made available for the problem at a local level; by the cooperativeness of local medical communities and, last but not least, by the enthusiasm and personal commitment of individual Medical Officers of Health (MOHs).

Any history of cancer education in Britain must also take into account the influence of voluntary organisations like the Imperial Cancer Research Fund (ICRF) and the British Empire Cancer Campaign (BECC), which were more focused on research than their American counterpart, the American Society for the Control of Cancer (ASCC). The metropolitan physicians and surgeons who controlled the ICRF and the BECC considered education to be an unnecessary diversion from the main objectives of their organisations. Furthermore, they worried that popular education would undermine public support for cancer research, either by creating excessive fears of the disease, or expectations of cure that medicine could not fulfil in the present.

In an article on disclosure practices in American oncology, Good has described how the ‘politics of hope’ link in research institutions, patterns of availability and promotion of particular anti-cancer therapies, the search of treatment and cures by patients, and norms of disclosure.5 There is now a growing literature on the ‘sociology of expectations’, an emergent field which explores how the rhetoric surrounding new technologies affects their construction, as well as their clinical and commercial usefulness.6 Within this context, Moreira and Palladino have discussed the tensions in modern biomedicine between a ‘regime of hope’ characterised by the view that new and better treatments are always about to come, and a ‘regime of truth’ characterised by the view that most medical therapies are, as often as not, less effective than claimed.7 This paper makes a contribution to this field by exploring how the aspirational discourse of hope came to play a key role in popular cancer education as a means of managing public expectations, enrol support for the anti-cancer effort, and justify further work at a time of profound uncertainty about the curability of this ‘dread’ disease.

The Problem of Cervical Cancer and the First British Anti-Cancer Campaign

In 1899, the Practitioner drew attention to the growing threat posed by cancer. Rising mortality rates and the mystery that still surrounded its causes had endowed the disease with the ‘gruesome fascination of a ghost story’.8 No one seemed to know how cancer started in the body, and every attempt to cure the disease had ended in failure. The introduction of invasive operative procedures in the latter part of the nineteenth century had raised hopes that the disease could be cured by early and complete operation, but by 1900 the optimism of the early days had given way to disillusionment. The limited information surgeons had gathered about the long-term results of operation showed that the hoped-for cure of cancer was still a long way off. Recurrences were common after surgery, and most patients eventually died from the disease.

5 Good et al. 1990. See also Good et al. in Conrad and Gallagher (eds) 1993.
6 Brown and Michael 2003; Brown 2006.
7 Moreira and Palladino 2005.
8 Anon. 1899, p. 362.
Uncertainty over the efficacy of surgery was compounded by anxieties about the increasingly extensive nature of operations for malignant disease. Still in the realm of experimental surgery, these procedures raised disturbing questions about the ethics of intervention. While surgeons like Kocher, Czerny and Halsted boldly ventured forth into territory hitherto taboo, more conservative surgeons in Britain, France and America argued that it was pointless to submit cancer patients to dangerous operations in the hope of adding at most a few months to the life of sufferers. A particular focus of this debate was the surgical management of cervical cancer, the leading cause of female cancer death in most of the countries for which statistics were available. The first attempts to treat the disease by amputation and vaginal hysterectomy had been made in the early 1800s, but the surgery rarely eradicated the malignancy, and the frequently fatal haemorrhages that complicated the treatment had served to discourage further attempts. Surgery was back on the agenda by the mid-1870s, thanks to the work of German surgeons. Practitioners initially tried to remove the uterus by the abdominal route, but the results were so disastrous that gynaecologists from Paris to Berlin revolted against the practice. Further attempts to extirpate the uterus through the vagina were more successful. By the late 1890s, advances in operative techniques and proper selection of cases had helped lower the operative mortality to approximately ten per cent, leading to the establishment of vaginal hysterectomy as the treatment of choice for cancer of the cervix.

On the whole, fewer women died from surgery at the turn of the nineteenth century than did at its beginning, but most cases still ended in death as the disease tended to recur, sometimes many years after a successful operation. How these results should be interpreted was the subject of intense debate. In 1897 William Halsted, the American pioneer of the radical mastectomy operation, argued that breast cancer should be considered ‘radically’ or ‘permanently’ cured if three years had passed without evidence of local recurrence. According to the German gynaecologist Georg Winter, any patient who was free from recurrence for a period of one year should be regarded as ‘cured’. English anti-cancer activist Charles Childe, on the other hand, used the term ‘cure’ to mean ‘lasting relief’, with patients eventually dying from some other disease. By this definition, very few patients were ever cured of cancer. Thus, the French gynaecologist Samuel Pozzi argued in 1895 that even in the more favourable cases one could only speak of ‘prolonged survivals’. In the same vein, the Belgian gynaecologist M. Kufferath commented in 1904 that he had never had a case of ‘cure’, either by abdominal or by vaginal hysterectomy.

In addition to doubts about the curability of clearly operable cases, there were also anxieties about the development of more extensive abdominal operations for otherwise inoperable cervical cancer. These were the cases where the malignancy had spread well

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9 Darmon 1993, p. 216.
10 Halsted 1894–5, p. 8.
11 Grimoud 1904, p. 200.
12 Childe 1906, p. 2.
13 Pozzi, quoted in Anon. 1907a, p. 431.
14 Grimoud 1904, p. 246.
beyond the limits of the uterus, rendering the removal of the cancerous tissue from below virtually impossible. The first attempts to extend the field of operability by the abdominal route were made in the mid-1890s by John G. Clark and Howard Kelly, both surgeons at the Johns Hopkins Hospital in Baltimore, who developed an operation involving the removal of the uterus, ovaries, fallopian tubes, pelvic nodes and part of the vagina. A variation of this procedure was later popularised by Ernst Wertheim, the turn-of-the century Austrian gynaecologist. Wertheim initially targeted the women who, in his own words, were ‘shut out of life’, but he later extended the scope of his operation to all cases of carcinoma of the cervix—including those in which vaginal hysterectomy could have been carried out.

Wertheim's hysterectomy is now synonymous with the term ‘radical hysterectomy’, where ‘radical’ means ‘drastic and extensive’. In the late nineteenth and early twentieth centuries, however, the term ‘radical’ merely referred to the surgical philosophy of ‘rooting out’ cancerous growths by removing a good portion of apparently healthy tissue in addition to the overtly cancerous cells.

Pioneers hailed the extended operation as a breakthrough in cancer care, but the majority of British surgeons and gynaecologists were more sceptical. The appalling operative mortality (30 per cent in Wertheim's first 100 cases) rekindled old debates about mutilating surgery on women, leading to claims that a large portion of extended hysterectomies for cancer were ‘homicidal vivisections’. The general consensus in Britain was that total abdominal hysterectomy for cervical cancer was not a justifiable procedure. As one of Wertheim’s foremost British critics, the Sheffield gynaecologist Frederick McCann, commented in 1907:

unless temporary or permanent benefit can be promised to the patient, it is not justifiable to subject her to a prolonged and dangerous operation which cannot completely remove the disease, more especially as the palliative operations and methods of treatment give considerable relief in the advanced stages of the disease and are less dangerous.

Wertheim’s opponents argued that operability rates should be increased, not by devising bold procedures for late-stage cancer, but by getting women to come forward for treatment as early as possible in the development of the disease. The malignancy could then be removed by vaginal hysterectomy, which had a better safety record than the extended abdominal operation. Critics also observed that patients treated by the vaginal operation had a better prognosis, highlighting cases in which the patient remained well as many as 10 or 20 years after operation. The numbers involved were very small even by contemporary standards, but conservative practitioners seized on the figures in an attempt to boost confidence in the efficacy of surgery. The underlying concern was that cancer sufferers would lose confidence in the profession and stray from the correct path if practitioners themselves had no faith in the treatment. As the leading obstetrician Herbert

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16Anon. 1905a, p. 691.

17Sinclair 1902, p. 324. See also Jessett 1893. For an account of the nineteenth-century debate on gynaecological surgery, see Moscucci 1990, pp. 134–64.

18McCann 1907, p. 89.

19Anon. 1907a, especially pp. 432, 436–7.
Spencer, Professor of Obstetrics at University College Hospital Medical School, argued in 1907:

pessimistic views on the subject... do much harm by inducing in the mind of the public and of the profession an entirely erroneous view that cancer is incurable, and lead to delay in seeking medical advice, which would be of little consequence were it true that cancer is incurable, but which is of the utmost importance with a disease of such rapid progress and such terrible course as cancer.20

The debate served to shift medical attention on to the reasons why women presented late. These were variously identified as ignorance of the symptoms that might suggest cervical cancer; fears about the disease; women’s reluctance to submit to intrusive gynaecological examinations; visits to ‘quacks’; shortcomings in the teaching of gynaecology; and general practitioners’ tendency to temporise with medicinal treatment.21 Practitioners did not consider that ability to pay may have determined whether or not the doctor was consulted. Also absent from these early debates was any discussion of the diagnostic and treatment facilities that would be needed in order to fulfil the promise of the educational message.

British writers on cervical cancer cited the work of their German colleague Georg Winter as an example of what might be done in order to reduce delay. In 1902 Winter, who was Professor of Gynaecology at the University of Königsberg, had taken the lead in promoting early detection by launching, single-handedly, an educational campaign in East Prussia.22 This pioneering initiative, which addressed not only midwives and medical practitioners, but also women themselves, was said to have been highly successful. Figures reported in the Journal of Obstetrics and Gynaecology of the British Empire for 1904 indicated substantial reductions in both diagnosis and treatment delay. The resulting increase in the rate of operable cancers was thought to be particularly encouraging.23

The suggestion that a similar campaign should be launched in Britain did not, however, receive serious consideration until 1905, when leading gynaecologists attending the annual meeting of the British Medical Association heard Wertheim give a memorable address on total abdominal hysterectomy. The paper served to focus the minds of participants on the benefits of early diagnosis, prompting calls for the establishment of an organised cervical cancer awareness scheme in Britain.24 But differences of opinion were immediately evident with regard to the best means of encouraging early diagnosis. Gynaecologists agreed that general practitioners, nurses and midwives should be taught to recognise the early signs of cervical cancer. Few thought, however, that the educational effort should speak to women as well. Thus, when the first national anti-cancer initiative was launched in 1909 under the aegis of the British Medical Association (BMA),

20Anon. 1907a, Herbert Spencer’s opening address, p. 432. See also Snow 1904.
21Anon. 1907a.
22Interestingly, Winter also was an advocate of vaginal hysterectomy. See Grimoud 1904, p. 275.
23Lockyer 1904.
24Limited attempts to publicise the issue had already been made in Liverpool and London by the Committee of the Liverpool Cancer Research Fund, and by the Cancer Hospital on London’s Fulham Road; see Anon. 1907a, Charles Ryall’s intervention, p. 437; Anon. 1904.
no provision was made for the instruction of women. This reluctance to enlist the public to the war on cancer was to remain a prominent feature of British cancer control initiatives during the first half of the twentieth century, in marked contrast to the extensive public education programmes undertaken in the United States.

Cancer and the Public

Lay cancer education did have a vocal champion in Britain. This was Charles Plumley Childe, a surgeon and public health activist in Portsmouth. In the early decades of the twentieth century, Childe gained international renown as the author of the seminal text of the cancer education movement, *The Control of a Scourge, or How Cancer is Curable*. Published in 1906, the book made the strongest possible case in favour of lay education by arguing that the fight against cancer could not be won without the assistance of sufferers. Reiterating the familiar warnings against delay in treatment and quack remedies, Childe claimed that cancer was ‘curable’ if treated by early operation. He also recommended preventive surgery in all those conditions that might lead to cancer, such as warts and obstetric injuries (women who suffered cervical lacerations during birth were widely thought to have an increased risk of developing cancer). In practice, the organised campaign envisaged by Childe only focused on a limited number of cancers: cancer of the skin, mouth, breast, cervix and rectum. The assumption was that these lesions were more ‘accessible’ for diagnosis and treatment and therefore more ‘curable’. Childe took it for granted that women’s cancers would be a primary target of any such campaign, since cancer of the breast and cervix accounted for 80 per cent of all cancer in women, and both were in regions that were accessible to surgery. The question was how best to disseminate the early detection message. Childe believed that press articles were unlikely to make much of an impact, as people tended to forget what they read. A better plan might be to persuade the ICRF, established in 1902 under the aegis of the Royal College of Surgeons and of the Royal College of Physicians, to take the lead by placing all the necessary information in the hands of the ‘intelligent and educated classes’. Nurses, midwives and health visitors would take charge of the ‘uneducated classes’ once they had been equipped with the ‘facts’ of the disease.

Few practitioners, however, shared Childe’s enthusiasm for lay education. Most general practitioners and hospital consultants worried that cancer education could do more harm than good because it had the potential to undermine its own ‘early detection’ message. ‘Half knowledge’ was as bad as no knowledge at all, critics argued, because it might encourage self-diagnosis and excite irrational fears about the disease. The latter was

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25For the full text of the appeal, see Anon. 1909a. The scheme was criticised for failing to address women. See Anon. 1909b.
26Childe 1906.
27The idea of involving an official body like the ICRF may have been motivated by concerns over medical advertising; see Lewers 1902, pp. 621–2.
28Childe 1906, p. 240.
29Childe 1906, p. 233.
30Anon. 1905b, p. 40.
regarded by far as the greatest danger. Practitioners believed that ‘cancerphobia’ was almost inevitable given the supposed propensity of the British public to morbid introspection and hypochondria. As fear and mental depression were widely thought to predispose people to cancer, it was clearly important that the profession should not contribute to the death-rate from cancer by fanning undue fears about the disease. Such considerations played a prominent part in the BMA’s decision to restrict its cervical cancer awareness campaign to medical practitioners and other professionals involved in women’s health care, with one practitioner reportedly claiming that any scheme of public education would give women cancer from fright.31

British practitioners and government officials were especially wary of copying initiatives such as National Cancer Week, an annual programme launched by the ASCC in 1921. During Cancer Week, a deluge of pamphlets and other forms of propaganda spread the ‘Message of Hope’—early detection—and free tumour clinics were set up for the purpose of diagnosis and advice.32 Elite practitioners in Britain rejected the nationally co-ordinated media ‘blitz’ on the grounds that it would cause undue alarm in the population: as the eminent physician Lord Dawson of Penn reportedly commented in 1923, ‘to employ broadcasting and kinemas would mean the concentration of attention on morbid and lurid aspects, which would do more harm than good’.33 Leeds gynaecologist James Young, writing in 1925, argued that ‘other schemes of permeation’ might be more suitable in the UK.34

Discussions about the dangers of dramatic reporting reflected in part broader concerns about the manipulative potential of the media. Medical commentators were extremely suspicious about the vulnerability of the mass mind to the emotional appeal of popular film and fiction. Little adapted to reasoning, the ‘man in the street’ was also likely to overreact to any educational message that employed sensationalist techniques of persuasion.35

At a different level, a nationwide publicity campaign was problematic because it raised difficult questions about the diagnostic and therapeutic facilities that would be needed in order to make it successful. Concerns over the relationship between propaganda and service provision did not emerge until the early 1920s, when central government began to take a more active interest in the ‘cancer problem’. The memorandum on cancer issued in 1923 by the Departmental Committee on Cancer of the Ministry of Health encouraged local health authorities to take the lead in matters of propaganda, but it also stated that the government was not contemplating the establishment of a state-funded cancer service analogous to the services for tuber-

31 Anon. 1907a, p. 438.
32 Patterson 1987, pp. 91–4. For a contemporary account, see Soper 1928.
33 Anon. 1923a, p. 509. These concerns were not entirely unjustified. In 1937, the American weekly Life provoked a public outcry when it published graphic images of skin cancer in order to illustrate the progress of cancer therapeutics. Lederer 2007, p. 101. The strategy adopted by American cancer agencies was to exclude from the media subjects which, it was feared, might deter sufferers from seeking medical advice—for example, radical surgery. See Cantor 2007.
34 Young 1925.
35 Cantor in Sturdy (ed.) 2002.
culosis or venereal diseases. Public health officers were anxious to take the lead in matters of education, but the Medical Officer of Health, while generally favourable, sounded a note of caution. In 1924, it reprinted an article, originally published in the American Journal of Public Health, which neatly summed up its own position on the matter. The American journal warned that the medical profession was becoming increasingly suspicious of the health officials’ efforts to arrange clinical services of any sort. If the public health officer had attempted to organise a service for cancer, he would no doubt have encountered still more active opposition. At the same time, the journal emphasised that ‘mere propaganda to awaken a need for a special service, in the absence of adequate facilities to supply the service to rich and poor alike, defeats its own ends’.

As anticipated, the establishment of publicly-funded diagnostic clinics proved controversial. On both sides of the Atlantic, private practitioners resisted the establishment of cancer clinics as a threat to their autonomy and income. In Britain, it was the BMA that took up the issue on behalf of the profession. When the Leicester and Greenwich public health departments opened diagnostic clinics in the late 1920s, its Medico-Political Committee expressed concern that the clinics were bypassing the referral system and poaching patients.

For the elite practitioners associated with cancer agencies like the ICRF and the BECC, a charitable organisation founded in 1923 for the purpose of promoting clinical research, the main question was whether cancer control should take priority over research. Perhaps not surprisingly, the feeling amongst the metropolitan physicians who controlled these organisations was that cancer research was more deserving of public support than cancer control. As Cecil Rowntree, pioneering cancer surgeon and BECC trustee, reportedly said at a meeting of the Royal Society of Medicine in 1923, ‘the dissemination of knowledge of these diseases would merely result in mental suffering. What was more needed was proper organisation of cancer research to enable the energies of many workers to be better directed’.

Cancer experts still fretted about cancerphobia after the introduction of the NHS, but the argument by then was that doctors’ surgeries would be inundated with people who imagined they were suffering from cancer. The establishment of a system of health care that was free at the point of use raised concerns that people would take advantage of the facilities on offer and rush to see the doctor at the slightest hint of trouble. Neither the Ministry of Health nor the cancer establishment wished to increase the workload of the general practitioner by suggesting that people should seek medical advice if they suspected cancer. Most commentators therefore, while expressing admiration for the vigorous educational efforts made by the American Cancer Society (the new name of the ASCC after 1945), thought that a US-style campaign was not appropriate to

36 This was Memorandum No. 426. The National Archives (hereafter NA), FD 1/2037.
37 ‘The cancer problem from the public health standpoint’, quoted in Anon. 1924a, p. 90.
38 Contemporary Medical Archives Centre, Wellcome Library, London (hereafter CMAC), SA/BMA/C.178. See also Champneys 1926–7, p. 20. Similar problems arose in the USA; see Aronowitz 2007, pp. 211–16.
39 Anon. 1923b, p. 596.
British conditions. The Secretary of the BECC was absolutely clear on this point when he wrote in 1949:

Laudable as is the object of this campaign, its method clearly shows the different requirements of different countries. It seems to us that the American publicity has an underlying ‘fear’ motif. . . . The British public would not react favourably to such a motif. In our view any approach to the British public must be through hope rather than fear. Our public should be brought to appreciate the vital factor of early diagnosis without creating cancer phobia which will cause many healthy people to seek overhaul too frequently.40

Lurking just below the surface of the debate were also physicians’ own doubts and anxieties about cancer. When Childe’s book appeared in 1906, an anonymous reviewer questioned the basis for such ‘youthful optimism’. Though well-intentioned, Childe’s attempts to publicise the benefits of early surgery rested on a claim that most practitioners considered to be misleading: the view that cancer was curable simply did not reflect the realities on the ground.41 It was a perspective echoed half a century later by another critic of cancer education, the radiologist James Brailsford. In answer to those who blamed delay in treatment on public ignorance of cancer symptoms, Brailsford argued that delay was a rational response to what people already knew about the disease. He added:

From my experience, doctors . . . are probably less ready to come forward for investigation than members of the general public, for they know the serious limitations and possibilities of treatment. . . . Find a cure for cancer and there will be no need for propaganda—our people will seek it at once.42

Public Rhetorics

Managing the fears and hopes of the British public was important not only because people’s attitudes towards cancer affected service provision, but also because they had a bearing on the fund-raising activities of cancer research organisations. In the early decades of the twentieth century, it was not uncommon for cancer agencies to dress up their fund-raising efforts as education. Anxious to demonstrate the necessity for public support, their leaders frequently adopted a style of propaganda that dramatised the horrors of cancer. This worried contemporary observers, some of whom felt that scare tactics were more likely to shock the public into hiding than into action. People did not want to read about unpleasant matters such as cancer, critics argued, so they would simply ignore any charitable appeal that emphasised the gruesome aspects of the disease. Thus in 1922, the Lancet unfavourably compared a handbook for the lay public published in aid of the Cancer Research Fund of Ireland with a publication issued by the League of the Red Cross Societies. The League’s brochure gave the patient a ‘sound conspectus’ of what was known about the disease, and what was

40CMAC, SA/CRC/Q.1/6: Tours to Mrs Hutton, 21 September 1949.
41Anon. 1907b, p. 657.
42Brailsford 1951, p. 1154.
hoped for from its treatment. The same could not be said of the Cancer Research Fund publication:

Here we have an association of general health propaganda with the advertisement of a special fund, and the blend is perilous. With detailed information as to the pathology and prognosis of special forms of cancer there are included fuller descriptions of symptoms than can be considered necessary for lay reading, accompanied by illustrations of advanced cases which are not nice to look at. It is doubtful whether it is kind or wise to excite more horror than already exists, and whether such provocation will lead to the desired result—financial support for the Cancer Research Fund of Ireland.⁴³

Avoiding what may be termed ‘charity fatigue’ was the BECC’s main reason for eschewing shock tactics. As the agency’s Secretary explained in 1949, the organisation could raise a very large sum of money by launching a ‘fear’ campaign:

but these funds would give no guarantee that the problem would be solved, and within a few years they would therefore dry up, as the public would grow tired of listening to the Campaign’s cry of wolf. We therefore feel it better not to attempt to raise funds by such spectacular methods, but to continue to preach a gospel of hope which enables the work of this Campaign to go forward steadily and unsensationally.⁴⁴

After the war, these anxieties prompted the BECC to separate its appeal and educational literature. The material intended for public education was then rewritten to express a more optimistic outlook, with an emphasis on early diagnosis and curability.⁴⁵ But the Campaign was also careful to downplay the ‘fear’ element in its appeals for public support, as can be seen from a poster commissioned in 1947 from Abram Games, the famous graphic designer. Here the ghostly profile of a woman is shown rising from a grey sea. The woman’s eyes are semi-closed, her lips tightly sealed. She is looking up towards the sky, which is coloured in an uplifting shade of yellow to signify hope for the future. Juxtaposed to the profile is the image of a hand releasing a bird, again symbolising Britain’s hopes of defeating cancer. Underneath, the caption reads: ‘Please help give us hope’. While the menacing sea and ethereal profile serve to remind the viewer of the grim toll of death and suffering exacted by cancer, the poster subordinates the fear-inspiring elements to the ‘message of hope’, which appears in a number of different guises.

Hope could nonetheless become a problem if it generated unrealistic expectations about the possibility of a cure. Anti-cancer propagandists routinely accused ‘quacks’ and unscrupulous practitioners of making false claims about particular therapies, but they were themselves frequently taken to task for misrepresenting the benefits of

⁴²Anon. 1922b, p. 236.
⁴³CMAC, SA/CRC/Q.1/6: Tours to Mrs Hutton, 21 September 1949.
⁴⁴CMAC, SA/CRC/31/1: BEEC Cancer Education Committee Minutes, 10 March 1950. Discussions to the same effect had taken place before the war: see CMAC, SA/CRC/A.22/1: BECC Propaganda Committee Minutes, 28 March 1935.
cancer control policies. In 1922, for example, the *Lancet* criticised educationists’ tendency to portray early detection as a form of prevention.\(^{46}\) It was irresponsible to suggest that ‘early’ diagnosis could reduce the incidence of cancer, the journal argued, since no one knew when cancer began, and detection was only possible when the disease was already well established. Thus, ‘we should not raise false hopes among the public by suggesting that such an effort is in any way likely to control or even to combat cancer’.\(^{47}\) In the same vein, Professor W. R. Lazarus-Barlow, of the Middlesex Hospital in London, gave a warning against misleading statements made in public with regard to cancer research and the success of the anti-cancer campaign. Speaking at the Royal Sanitary Institute annual congress in 1924, Lazarus-Barlow urged medical men to be careful of the words they used: the public had a right to know the truth, but it must not be ‘garbled truth’.\(^{48}\) Puffing up the achievements of the anti-cancer campaign was bad practice, not only because it blurred the distinction between ‘quack’ and orthodox practitioners, but also because it threatened to expose the limitations of medical knowledge. The danger was that people would quickly become disillusioned and plunge into a downward spiral of pessimism about cancer, thus defeating the stated aims of educational and control programmes.

**Educational Strategies**

British anxieties about nationally co-ordinated campaigns and media ‘blitzes’ did not, however, translate into an attitude of general apathy towards lay cancer education. At a local level, public education was vigorously pursued by medical practitioners and public health officials anxious to make a contribution to the British anti-cancer crusade. The first publicity campaigns were undertaken in the period immediately before and after the First World War. Portsmouth led the way in 1914; Leicester, Bradford and Birmingham followed suit after the war.\(^{49}\) The public education work of local health authorities received a boost in 1923 when the Ministry of Health established a Departmental Committee on Cancer. Guidance for local authorities on dealing with the disease came in the first of a series of memoranda on cancer, published by the Committee in 1923.\(^{50}\) Local Cancer Committees were soon formed in Birmingham, Manchester and Plymouth, with responsibility for public education, data collection and research into the social aspects of the disease.\(^{51}\)

Anti-cancer propagandists used lectures, leaflets and articles in the press in order to spread the early detection message. The educational material provided instruction about symptoms and offered advice about prevention, focusing on those malignancies that were more ‘visible’ and ‘accessible’ for diagnosis and treatment: uterine, breast, skin, mouth and rectal cancer.\(^{52}\) The Portsmouth scheme also provided for the

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\(^{46}\)See Adams 1922 for an example.

\(^{47}\)Anon. 1922c.

\(^{48}\)Anon. 1924b.

\(^{49}\)Childe 1914, p. 644; Millard 1928.

\(^{50}\)This was Memorandum No. 426. NA, FD 1/2037.

\(^{51}\)On the work of the public health authorities, see Hall-Edwards 1926; Champneys 1926–7; Clark 1928.

\(^{52}\)Most propaganda contained warnings about the dangers of ‘irritation’ from, for example, broken teeth and clay pipes.
microscopical examination of tissue samples, entirely free of charge. The local model was also in evidence when national cancer agencies like the BECC belatedly entered the educational arena. After Childe’s death in 1924, the gynaecologist and radiotherapy pioneer Malcolm Donaldson took up the leadership mantle of the cancer education movement. A member of the BECC, Donaldson repeatedly tried to persuade the organisation to take a serious interest in lay cancer education. But while the provincial branches of the BECC actively championed the cause through lectures and exhibitions, its London-based executive committee resisted Donaldson’s proposals, which included revolutionary plans for a national screening programme. It was not until 1934 that the BECC, finally giving in to pressure from Donaldson and allied provincial activists, half-heartedly agreed to set up a Propaganda Committee. Under Donaldson’s direction, the Committee approached the general practitioners of three counties in the South of England to see if they would be willing to speak to the lay public. Those who agreed were grouped into local panels and sent a standardised educational lecture. The scheme targeted local organisations in an attempt to reach deep into the community. Reflecting the long-standing concern with breast and uterine cancer, women’s clubs and community associations provided the initial focus. The popularity of the lectures later prompted the Propaganda Committee to extend the scheme to men’s organisations, but to Donaldson’s disappointment, male audiences proved difficult to attract. Arguably, three decades of woman-centred anti-cancer propaganda had persuaded British men that cancer was a female disease.

Oral instruction had long been popular as a means of imparting health instruction to the poorest and most ignorant, who lacked the application and time necessary to get such lessons from reading. The genre continued to find favour with anti-cancer propagandists, partly because lectures could be tailored to suit different audiences, partly because they offered an opportunity to address individual concerns about cancer. The lecture format also served to emphasise the importance of personal communication between doctor and patient, reinforcing the authority of the physician as the source of expertise about cancer. Another strategy pursued in the 1920s was to present the subject within the context of general health advice. Lectures with titles such as ‘The Beginning of Disease, or a Stitch in Time’ served to plant the information within a wide variety of health-related matters, thus helping defuse any fears people might have harboured about cancer.

Yet another method was by visual display at health exhibitions. Here, again, the idea was that a cancer stall arranged as part of a comprehensive health exhibition was less likely to generate public anxiety than an event entirely devoted to cancer. But despite

53 Childe 1914, p. 644.
54 On the Yorkshire Council of the BECC, see Hillman 1928. On Donaldson’s activities, see CMAC, SA/CRC/ R.1/3; Donaldson 1933.
55 See CMAC, SA/CRC/A.22/1.
56 Donaldson was against the idea of using lay lecturers on the grounds that they might spread cancerphobia. By 1949, he had changed his mind, but other members of the BEEC remained wedded to the view that lay people should only be instructed by qualified medical practitioners; Donaldson 1949.
57 Historian Leslie Reagan has noted a similar trend in the US; Reagan 1997. See also Moscucci 2005.
58 Partridge 2005.
the contemporary anxiety about cancerphobia, it seems that, on occasion, organisers did not hesitate to employ the sensationalist techniques employed by the popular press. At a Health Exhibition held in Hull in the mid-1920s, for example, the cancer stall had a background representing the 50,000 lives lost through the disease every year. The death toll from cancer was represented by a sinking ship, while a few boats pulling away symbolised those saved by early treatment. In order to emphasise the ignorance and mystery that still surrounded cancer, the whole scene was enshrouded in fog; a lighthouse with the light endeavouring to pierce the gloom signified the effort of medical research. The dangers of delay were illustrated by a picture of a lady descending the steps to a cemetery; each step signified one month, and the total number of steps represented the average number of months that elapsed between the noticing of a lump in the breast and the seeking of medical advice. Juxtaposed to this grim picture was the ‘message of hope’—a radiant woman, ‘cured’ by an early operation. Microscopical preparations showing both normal and malignant tongue tissue samples were also provided in an effort to attract public interest.\(^\text{59}\)

As noted earlier, British commentators had strong reservations about the use of the motion picture as a public education tool. In 1928, the BECC did produce a film as part of its publicity campaign, but its subject was the cultivation of living tissue rather than the human interest and action story favoured by American activists at the time.\(^\text{60}\) It was not until the late 1930s that the BECC, again at Donaldson’s suggestion, began to experiment with the melodrama as a means of disseminating the gospel of ‘early detection’. Although still indebted to the oral tradition of the Victorian and Edwardian eras, the BECC’s 1938 film ‘Out of the Shadow’ was innovative by British standards.\(^\text{61}\) Donaldson’s script dramatised the early detection message by wrapping it around a story capable of arousing interest and sympathy in the viewer.\(^\text{62}\)

The film starts off with a lecture by a fictional eminent physician, but its focus quickly shifts on to a series of vignettes that allude to the symptoms of the most common forms of malignancy: uterine, stomach and breast cancer. Its central part develops the early treatment story by focusing on a pretty young bride who, or so we gather from her distressed behaviour, suspects that a lump in her breast might be cancerous. Instead of rushing to the doctor, she frets for days on end, until her husband finally persuades her to reveal the source of her anxiety. He then urges her to consult the physician, who recommends an immediate operation; off-screen, the lump is successfully removed. The tumour is benign but, the doctor warns, if left alone it might have progressed to cancer. The patient is delighted. Now cured of her potential cancer as well as of her fears, she can look to the future with renewed confidence and joy.

\(^{59}\)Daley 1928, pp. 579–80.

\(^{60}\)Filmed by the pathologist R. G. Canti, the movie was the first to use time-lapse photography of cells grown in culture. On Canti and the Strangeways Laboratory, see Squier in Brodwin (ed.) 2000; Wilson 2005; Cantor 1987. On the ASCC’s early enthusiasm for movies, see Cantor 2007.

\(^{61}\)The film was directed by Andrew Buchanan and produced by Gaumont-British. A copy is available from the British Film Institute.

\(^{62}\)CMAC, SA/CRC/R.1/3. On the use of the movie as public health tool, see Pernick 1996; Boon 1999; Fedunkiw 2003.
‘Out of the Shadow’ resonated with gendered assumptions about female patients and
male physicians, asserting not only medical but also male authority over women’s beliefs
about cancer. A proxy for the archetypal ‘public’, women also personified those attitudes
which, according to cancer educationists, impeded progress in the war on cancer: fear,
ignorance and irrationality. These assumptions would be challenged in the 1950s by
the educational ‘experiment’ undertaken by the Manchester Committee on Cancer. As
Toon has described, this study suggested that the problem facing educators was not
public ignorance of cancer symptoms, but the public’s knowledge of the disease’s
all-too-frequent consequences: pain, suffering, dependency and death.63 But during
the first half of the twentieth century, the view underpinning the educational effort
was that the public should be saved from its ignorance and irrational fears, as well as
from cancer itself.

Conclusion
Historians familiar with the American ‘war’ on cancer have drawn attention to the much
more subdued approach adopted by the British cancer establishment before the Second
World War. This article has argued that cancer education was controversial in Britian
because of important uncertainties about the efficacy of available therapies, worries
about the undesirable effects of partial knowledge, and anxieties about creating
demands that could not be fulfilled. Against this background, anti-cancer activists
attempted to produce a discourse which would not undermine people’s faith in
medical science, and which would encourage people to consult their doctors without
putting excessive pressure on health services funded by public money—a complex balan-
cing act. By minimising the truth and avoiding the hype, they sought to negotiate the
uneasy relationship between present realities and imagined futures. A ‘regime’ of hope
came to the fore that served to draw patients, philanthropists, practitioners and research-
ers together into a joint market agenda.

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