In *Manmade Breast Cancer* Zillah Eisenstein offers not only a feminist manifesto but also a genealogical narrative of her family’s illness history: “I want to go deeply into my body’s story, which is entwined with my mother’s and sisters’ bodies. . . . If there is such a thing as genetically inherited breast cancer, I most probably have it” (1–4). Her mother, Fannie Price Eisenstein, contracted breast cancer during the 1960s at age forty-five but, after a radical mastectomy, survived into her eighties. Eisenstein’s older sister, Sarah, and her younger sister, Giah, were less fortunate; both were diagnosed in their mid-twenties, underwent mastectomies followed by chemotherapy, lived free of cancer for several years, then learned that the disease had returned. Sarah’s breast cancer metastasized in her lungs and finally spread to her brain, while Giah contracted cancer in her second breast and had another mastectomy, only to be diagnosed several years later with stage-four ovarian cancer. Despite extensive medical treatment, both sisters died in their thirties. At her doctors’ urging, Eisenstein had a prophylactic oophorectomy shortly after Giah was diagnosed; following her sisters’ deaths she contracted stage-one breast cancer, underwent a mastectomy followed by chemotherapy, and ultimately had a preventive mastectomy on her remaining breast. “Giah’s second breast cancer weighed heavily in this decision,” Eisenstein explains. “My cancer was lobular, which often means it will occur bilaterally. I did not want to risk another round of chemo down the road” (30). As of 2000, Eisenstein had remained cancer free for twelve years and had elected not to be genetically tested, despite the fact that Giah had tested positive for the BRCA1 mutation. Although Eisenstein acknowledges genetics as a factor in her disease, she finds disturbing the reigning medical assumption that the cause of breast cancer in the 5–10 percent of women who are BRCA-positive is their genetic makeup. “Knowing Giah had the BRCA1 mutation makes everything seem more fixed than it is,” she argues. “The gene is a predisposition but not for all
women who carry it. I think you never know if it is the gene or the trig-
gers to the gene that are the culprit” (37).

Eisenstein’s is one of a growing number of autobiographical narra-
tives that chronicle women’s experiences with inherited breast cancer
and their decisions to undergo prophylactic mastectomies; in some cases
the illness saga also includes ovarian cancer and preventive oophorecto-
 mies.1 Many memoirists reveal less skepticism than Eisenstein, however,
regarding the necessity of genetic testing and the role that genes play in
the cancers that plague their family members.2 Indeed, they view genetic
 predisposition as both the reason for these familial cancers and a threat
to themselves, and they consider prophylactic surgery a reasonable or
an essential form of protection, even if they have not been diagnosed
with breast cancer.3 What has happened in recent decades, scientifically,
medically, and culturally, to lead women with breast cancer in their fami-
lies to seek genetic testing, to have their breasts removed upon testing
positive for a genetic mutation, and, in certain cases, to document their
family histories and their own surgical experiences in multigenerational
memoirs?

Mammographies that foreground prophylactic mastectomies are
largely a postmillennial phenomenon, since the research that made
genetic diagnoses possible is only two decades old. In 1990 geneticist
Mary-Claire King discovered a gene connected to hereditary breast can-
cer, located on the long arm (q) of chromosome 17, thus confirming on-
cologists’ long-held beliefs that certain cancers clustered in families. By
1994 Mark Skolnick and his colleagues at Myriad Genetics, a biotech-
 nology company in Utah, had determined the precise DNA sequence of
BRCA1, the name given to the gene that King had identified; a second
gene, BRCA2, was located in 1995.4 Mutations in these tumor suppressor
genes sometimes produce defective proteins and a lack of control over
cell division, which can lead to breast and/or ovarian cancer. Because
they are “autosomal dominant,” genetic mutations in BRCA1 and BRCA2
can be passed down to offspring by only one parent, and each child of
that carrier has a 50 percent chance of inheriting what journalists have
widely (though mistakenly) termed the “breast cancer gene” (Lerner,
276–79). As memoirist Janet Reibstein explains, “It is sometimes said
that ‘breast cancer genes’ have been found. This is not only inaccurate
but misleading. . . . Every gene contains a complex set of instructions
which normally guide our bodies to work but also can be faulty, giving
the wrong information and possibly causing defects and disease. This is
what happens in the two ‘breast cancer genes’ marked so far” (243–44). During the 1990s genetic testing was possible in the United States only through trial studies conducted primarily at academic medical centers, but near the end of the twentieth century it became available commercially through Myriad Genetics. While testing is free in the United Kingdom and Canada through the National Health Service, in the United States it has decreased in cost from as much as $3000 in 2003, depending on whether the test was designed to identify a founder mutation, a single-site mutation, or a full genetic sequencing, to $200 to $300 in 2012. However, as of 2012 genetic testing in the United States was still inconsistently covered by insurance providers (Lerner, 278–79; 23andme.com).

Genetic testing has sometimes been controversial for ethical reasons. Inherited cancers have been found to be especially prevalent among Ashkenazi Jews—studies estimate that one in forty women of this ethnicity carries a BRCA mutation—a fact that has raised the specter of ethnic stereotyping (Lerner, 281–82). In addition, fears of medical and insurance discrimination against people who test positive for genetically triggered diseases abound, although these have been somewhat alleviated by the 2008 passage in the United States of the Genetic Information Nondiscrimination Act (www.facingourrisk.org). While there has been no rush to genetic testing on the part of high-risk women, its commercial availability, along with the suffering that occurs in families who watch loved ones die of breast or ovarian cancer, has led more women than ever before to be tested for BRCA mutations and, if positive, to choose preventive mastectomy. According to the National Cancer Institute, testing has become more widespread in the United States since 2000, and a 2008 study reported in the *Journal of Clinical Oncology* indicates overall satisfaction on the part of women who have undergone prophylactic mastectomy (www.cancer.gov.search/geneticservices; Brandberg, 3943–49). This satisfaction is especially keen among women who had already been diagnosed with cancer in one breast. An October 2007 study in the *Journal of Clinical Oncology* found that the rate of bilateral mastectomies among U.S. women with nonmetastatic breast cancer doubled between 1998 and 2003, from 1.8 to 4.8 percent (Tuttle 5203); of the 78,000 U.S. women who undergo mastectomies each year, researchers estimate that between 8,000 and 10,000 elect prophylactic intervention (Rabin). Since roughly 40,000 U.S. women die each year from breast cancer, these mastectomies are motivated in part by fear; as one woman explained, “You
either do it and get on with your life, or you don’t, and you risk the possibility of dying” (Springen, 1).

According to Dr. Todd M. Tuttle, chief of surgical oncology at the University of Minnesota Medical Center, several developments are “driving the trend”: “More women are going for genetic testing after a diagnosis of breast cancer, and improvements in both mastectomy and breast-reconstruction techniques have made the option of a double reconstruction less daunting” (quoted in Rabin). In some cases women not diagnosed with breast cancer choose preventive mastectomies because they are BRCA-positive and thus have up to an 87 percent risk of contracting the disease if they live into their seventies (Lerner, 279). BRCA-positive women who are pre-menopausal carry especially high risk, and they often experience virulent forms of advanced breast cancer. Prophylactic mastectomy thus provides a potential antidote, since studies suggest that it can lower women’s risk by up to 90 percent, depending upon the type of procedure and the amount of tissue removed (Lerner, 286).

Although hundreds of women have been quoted in medical and journalistic articles about prophylactic mastectomy, few have written memoirs that present their genetic histories and medical choices. Those published thus far are by women living in the United States and the United Kingdom, where scientific barriers, cultural prohibitions, and the cost of preventive surgeries have fallen. Memoirs of prophylactic mastectomy juggle autobiographical, educational, and memorializing imperatives, as writers recount their struggles to confront their cancer risk and the surgeries that could minimize that risk, inform readers about the BRCA genetic mutations and the genomic advances of recent decades, and pay elegiac tribute to women in their families who died of genetically driven cancers. Some memoirists employ the military rhetoric decried by Susan Sontag in Illness as Metaphor—they wage war against inherited cancers and view prophylactic mastectomies as a means of defeating the enemy—while others describe an existential quest, a wrestling with the fates that would doom them to death by cancer, and posit elective surgery as a way to avoid a “chilly, genetically predestined future” (Queller, 96). Still others approach their cancer legacies pragmatically, accepting available surgical interventions without apparent emotional upheaval.

In this chapter I focus on three compelling postmillennial narratives of prophylactic mastectomy: Janet Reibstein’s Staying Alive: A Family Memoir (2002), Elizabeth Bryan’s Singing the Life: A Family in the Shadow of Cancer (2007), and Jessica Queller’s Pretty Is What Changes:
**Impossible Choices, the Breast Cancer Gene, and How I Defied My Destiny** (2008). Although Reibstein, Bryan, and Queller tested positive for the BRCA1 genetic mutation, none of them had been diagnosed with breast cancer at the time of her mastectomies; each woman was motivated to undergo surgery by her sense of genetic risk and her painful witness of the death of family members from breast or ovarian cancer. These three writers represent a diversity of ages, nationalities, ethnicities, and professions. Reibstein, an Ashkenazi Jew born in New Jersey, lives in England and works as a psychologist; she was in her late forties in 1995, when her bilateral mastectomy took place, and in her early fifties when she wrote *Staying Alive*. Bryan, an Englishwoman and an Anglican, practiced pediatric medicine in the north of England until her death in 2008; in her late forties she had a preventive oophorectomy, at sixty she underwent a prophylactic double mastectomy, and in her early sixties she wrote her cancer narrative. Queller, also an Ashkenazi Jew, was in her mid-thirties and a New York television writer when she decided in 2005 to undergo a contralateral prophylactic mastectomy and write her family history. All three women are heterosexual, an identity relevant to their narratives because Reibstein and Bryan discuss the effects on their marriages of their decision to undergo preventive mastectomies, while Queller foregrounds her desire to marry and bear children and her initial fear that having prophylactic mastectomies could reduce her chances of finding a male partner. Moreover, as their titles suggest, these writers embrace different narrative foci and generational views: Reibstein emphasizes the quest for survival, having watched her aunts and her mother die of breast cancer; Bryan highlights the importance of celebrating daily life regardless of cancer’s shadow; and Queller emphasizes redefined standards of beauty and the urgency of defying destiny.

Despite salient differences, these narratives share three common threads that my analysis seeks to unravel. First, each writer presents an intergenerational account as well as an individual testimony; tales of grandmothers, mothers, aunts, sisters, and cousins figure as prominently as the writer’s own story. Thus all three memoirs are haunted by the presence of the dead, as each writer creates a narrative pastiche by including excerpts from her loved ones’ journals, letters, and/or poems. Second, each memoirist focuses on three pivotal decisions she must make: whether to be genetically tested; whether, if positive, to undergo mastectomy; and, if so, whether to have reconstructive surgery. Probing
the medical, psychological, and sexual considerations that inform these choices constitutes a central imperative in the narratives, and the rhetorical effect is that of a classic bildungsroman, a movement from innocence to experience. Finally, each writer includes a pedagogical postscript in which she probes her post-operative reactions and forges an emotional link to readers by sharing her health-related complications, along with her ethical musings and vision of the future. After analyzing these aspects of the focal narratives I explore briefly the cultural work that they perform, some issues they fail to address, and the competing discourses of self-determination and biological determinism that they feature.

Genealogical Legacies: Cancer as Inheritance

The prologue to Reibstein’s narrative depicts her scrutinizing her breasts before the mirror, a pivotal site of both inspection and introspection for many writers of cancer memoirs, and remembering the pleasure those breasts provided during moments of sexual and maternal activity. After bidding them farewell, she affirms her choice to undergo a bilateral prophylactic mastectomy and laments that this option did not exist for her aunts, Fannie Pomerance and Mary Kaufman, or for her mother, Regina Reibstein, each of whom died of metastasized breast cancer—in 1954, 1968, and 1985, respectively. A historical account of the three sisters’ immigrant childhoods and the harrowing stories of her aunts’ illnesses and demise make up the first third of Reibstein’s memoir, while her mother’s longer story dominates the middle section; only in the final section does the writer turn to her own experience. This genealogical emphasis occurs through a variety of narrative strategies, most notably Reibstein’s graphic depiction of her aunts’ mastectomies, invasive follow-up procedures, and painful deaths; and the inclusion of her mother’s illness-centered poems and journal entries as a means of memorialization. The result is an elegiac narrative collage, a multigenerational work of cancer auto/biography.

Early in her memoir Reibstein establishes a connection to her Aunt Fannie by describing as her most vivid early childhood memory “the smell of hospitals and with it a picture of myself, bored, looking up at the legs of older relatives hovering around her hospital bed” (39). Diagnosed with breast cancer in 1947 at the age of thirty-three, Fannie had no choice
but to undergo a brutal Halsted mastectomy in which “whole chunks of her—a breast and then muscle—were gouged out” (33). In that era, Reibstein reminds readers, this stigmatizing disease was surrounded by silence: “Fannie was one of breast cancer’s lonely victims. Women then didn’t know that others like them were also fighting in isolation. Young women in particular were hidden—to have a breast full of poison was unspeakable. Fannie would not be able to ‘come out’ after leaving the hospital” (34). Reibstein further laments the disruptive hormonal treatments her aunt underwent when cancer occurred in Fannie’s second breast in 1949, massive radiation to shrink her ovaries and prevent estrogen production, followed by androgen therapy that caused early menopause, masculine features, and behavioral changes: “Her moods swung rapidly and deeply, darkening the world around her and her daughters. She tried to control her temper, but the hormones coursing through her were too powerful” (37). Shortly before her excruciating death, Reibstein explains, Fannie attempted to manipulate her sister Regina’s toddler into giving her an overdose of medication; years later, Reibstein’s mother wept bitterly when recounting this episode to her writer-daughter. “I can’t take any more,” Fannie sobbed as Regina confronted her angrily. “He wouldn’t have known what he was doing. Who could I ask?” After that episode Fannie disengaged from life, coped with pain only minimally controlled by morphine, and died at forty from bone and spinal metastases (43).

Reibstein’s Aunt Mary followed a similar trajectory even though her diagnosis occurred more than a decade later. When she sought treatment in 1967 for a lump in her breast several years after finding it, having decided out of panic to do nothing until it suppurated, Mary endured a Halsted mastectomy followed by massive radiation, an oophorectomy when her ovaries became cancerous, the removal of her pituitary gland to curb estrogen production, and hormonal shifts that changed her appearance and deflated her natural optimism. “In the end Mary became a Fannie,” Reibstein asserts, a broken woman who died in isolation, filled with self-hatred and rage (99). By telling her aunts’ stories in grim detail Reibstein works against forgetting. In commemorating these women who died before any breast cancer movement, the memoirist pays homage to her matrilineal pioneers and contextualizes her mother’s story and her own.

The middle section of Reibstein’s narrative shifts focus to her remarkable mother, a poet and community leader who served as president of
New Jersey’s League of Women Voters in the 1960s and directed New York’s first Commission on the Status of Women in the 1970s. Diagnosed with stage-two breast cancer in 1963 at forty-three, Regina Reibstein also underwent a Halsted mastectomy followed by massive radiation; although she remained healthy for ten years, in 1975 she contracted cancer in her remaining breast and underwent a second mastectomy, further radiation, and chemotherapy, then a new treatment for virulent cancers. Reibstein’s genealogical musings continue throughout her account of her mother’s saga. During recovery from her first mastectomy, Regina was plagued by memories of Fannie’s travails that Reibstein conveys through twin imagery.

During the days in hospital, awaking to the immediate knowledge that her left breast was gone, that she now had a label, “cancer patient,” she’d felt twinned with her dead sister. She ached doubly in her wounds, knowing that Fannie had ached alone. . . . With the realization came guilt. Now, too late, my mother understood the loneliness of Fannie’s struggle. (74–75)

Alongside the survivor’s guilt of her mother, Reibstein features her own regret at having been in conflict with her mother during her initial illness and recovery. As a high school student reveling in her newfound independence, she resented both her mother’s criticism and the inconvenience of her cancer: “I didn’t want her to be sick. I was angry at her for being un-whole, vulnerable. Cancer: it was like moral blackmail; I should have been a good person and always borne it in mind. But I couldn’t” (89). A painful mother-daughter legacy thus emerges, as Reibstein describes their parallel regret at having disappointed a loved one who suffered from cancer.

Reibstein cements her matrilineal legacy by featuring her mother’s writing prominently in her narrative. In 1982, sixty-two years old and in and out of remission from metastatic breast cancer, Regina participated in a University of Chicago-sponsored journal-writing project to document her daily experiences of combating a lethal disease. Reibstein highlights excerpts from her mother’s journals as both daughterly tribute and cancer testimony. An entry entitled “Regeneration” from Regina’s March 1983 journal, for instance, reflects upon the passive stance she formerly took toward her cancer and her resolve to engage life despite her increasing dependency.
I have had cancer, or more precisely, cancers, for almost twenty years. My first cancer operation was entirely successful and there was no metastasis. I was not convinced by medical assurances, however, and for the next ten years I assumed I was on the verge of death, suspicious of the least symptom, waiting for the pronouncement, terminal. . . . I no longer cultivate the notion of death. I don’t speculate on which kind of exit appeals most to me. . . . It would not be so demeaning, I now believe, to accept help and favors. (153–56)

Even as this mother writes philosophically about accepting decline, her stricken daughter chronicles her own state of denial: given her mother’s accomplishments, Reibstein fantasizes, “maybe she’d be the first to outwit advanced breast cancer” (157). The narrative effect of these juxtapositions is a genealogical mirroring: Janet longs futilely for her mother to survive just as Regina had hoped in vain that her sisters would.

The final matrilineal scene, Regina’s farewell visit to Janet just weeks before her death, portrays what Adrienne Rich in *Of Woman Born* terms the “mother–daughter cathexis.”

The cathexis between mother and daughter—essential, distorted, misused—is the great unwritten story. Probably there is nothing in human nature more resonant with charges than the flow of energy between two biologically alike bodies, one of which has lain in amniotic bliss inside the other, one of which has labored to give birth to the other. The materials are here for the deepest mutuality and the most painful estrangement. (226)

Having acknowledged years of estrangement between herself and her mother, Reibstein represents their last encounter as deeply mutual, an affirmation driven by grief and familial legacy. When her mother decides to end her visit early, Reibstein describes her own regression to infancy and Regina’s ultimate act of maternal reassurance.

I felt as if she were literally peeling me off her, like a clinging baby. But I guess she needed to be on her own to say goodbye to that wider world which had always drawn her.

On her last night in Cambridge she lay on her bed and cuddled me as I wept at her leaving. . . . And then out of nowhere she whispered, “I know you think I’ve always preferred the boys,” and she
stroked my hair as if I were small again... “But I haven’t. I have loved you as passionately as I’ve loved them.”... Everything was healed then. (180)

After her mother’s death Reibstein rereads her journals and poems for comfort: “Doing so was a ritual to mutate her into a force inside me, to keep her voice with me. It has worked. I came to feel her as a dispersed presence inside me as I began to build a life in England” (186). What begins as a mourning ritual thus becomes an internalization of her mother’s legacy.

Elizabeth Bryan, in Singing the Life, also highlights the illness of three sisters, but in her case a genealogical history of ovarian cancer dominates that of breast cancer. The writer’s paternal grandmother, her grandfather’s sister, and her younger sister, Bernadette (Bunny) Hingley, all died of ovarian cancer, Bryan explains. Shortly before her death in 1995 at forty-seven Bunny tested positive for the BRCA1 genetic mutation, later found to have been passed on through her father. Bryan notes that genetic researchers deemed unusual her family’s ovarian cancer history with no comparable history of breast cancer, since the latter disease is usually dominant in carriers of the BRCA1 mutation. Nonetheless, breast cancer had not appeared in Bryan’s family until her other sister, Felicity, contracted it in 1999. Bryan incorporates Bunny’s and Felicity’s illness histories, as well as her cancer genealogy and her own medical saga, through narrative techniques similar to those of Reibstein—the use of family members’ journal entries and letters—as well as a second strategy, the inclusion of letters to family members that convey vital medical information.

Early in her narrative Bryan explains that she first learned of her family history through a letter from her father’s first cousin, a physician and researcher, who reported “a 50% incidence of ovarian cancer diagnosed in our family on the Hall side in two generations” and urged her female relatives to be vigilant about screening (4). Bryan acknowledges, however, that being thirty-three and healthy she ignored this missive for more than a decade. In 1990, however, unable to have children despite fertility treatments, and past childbearing age, she underwent regular ovarian ultrasound “with a view to having my ovaries removed in the relatively near future” (23). Ironically this decision came just a year before her sister Bunny was diagnosed with lung cancer that had metastasized from the ovaries, a saga that dominates the initial third of Bryan’s mem-
oir. The mother of two young daughters and one of England’s first female Anglican priests, Bunny documented her cancer in journals from which Bryan quotes extensively. One journal entry recounts Bunny’s response to her cancer’s recurrence after two years and the terrible prognosis her oncologist offers: “I asked her how I would die, and she said that people died of a blockage in the bowel caused by cancer growth. I asked the final question: how long did she think I had to live? ‘I hope you will see the year through,’ was the reply” (43). Bryan supplements her sister’s journal entries with the disclosure that at Bunny’s urging both she and Felicity underwent prophylactic oophorectomies, after which they learned that their ovaries had been healthy.

Bryan intersperses her sister’s journal writings with her own account of Bunny’s decline, thus assuming the role of familial witness.

I marveled at how, with the same confidence as she gave her sermons, but now in pain and heavily drugged with painkillers, she dictated fluently the most beautiful and reassuring message to each child. . . . For me this was a strange and precious time. Not only was I with Bunny, but I was also back in the hospital where I had spent my first rewarding and sometimes heart-rending year as a doctor. (59–60)

This passage reminds readers that Bryan narrates her family’s cancer history not only as a grieving sister but also as a physician for whom any hospital setting is inevitably professional. Nonetheless, her primary narrative impetus is genealogical, as witnessed by her inclusion of elegiac poems written by Bunny’s daughter Catherine: “There are too many memories, too many lives, / How will the broken pieces make a whole?” (78).

Bryan’s concern for younger generations that must confront their family’s genetic history distinguishes her narrative from that of Reibstein, who discusses her two sons’ reactions to her cancer but does not highlight next-generation inheritance. Readers meet Bunny’s and Felicity’s daughters, for whose welfare Bryan assumes medical, ethical, and maternal responsibility, determining not to discuss the family’s cancer history until the children reach their twenties. When that time comes Bryan writes them an explanatory letter, included in her narrative, whose tone is straightforward: “As both Felicity and Bunny carried the gene, all four of you have a 50/50 chance of carrying it too. You could all be
negative and therefore in the clear. But equally you could all have the bad luck of carrying it” (260). In her narrative reflections Bryan emphasizes the need to let the young make their own confidential decisions regarding genetic testing and preventive surgeries, acknowledging wryly that “for a family who generally talks openly about personal matters this will require restraint from us” (262).

Breast cancer occupies a less central place in Bryan’s memoir than in Reibstein’s, since Felicity’s 1999 diagnosis was the family’s first encounter with this disease. Although Felicity, like Bunny, tested positive for BRCA1 after contracting breast cancer, she chose lumpectomy in the hope of preserving her breast; however, radiation and tamoxifen failed to prevent cancer from attacking her other breast, at which time she had a bilateral mastectomy, chemotherapy, and further radiation. Bryan’s inclusion of Felicity’s 2002 journal entries reinforces her genealogical commitment and introduces new themes such as the militarism of cancer discourse.

[The surgeon] said that this recurrence showed that my gene was “expressing itself.” She need say no more. Without even looking at Alex I looked down at my bosoms and said I regarded them as time bombs and wanted them both off at her earliest convenience. She said that before that she would like me to have other tests to see if the cancer was elsewhere in my body. . . . I saw her point. (99–100)

While Felicity’s resilience is moving, her inflated rhetoric of cancerous breasts as “time bombs” is unsettling. After several chapters on Felicity’s treatment and recurrence, the narrator foregrounds her own subjectivity: “I felt obliged to think about the future, of the preventive measures I should be considering, and of the next generation” (96).

Jessica Queller focuses in Pretty Is What Changes on the death of her mother from ovarian cancer, her own subsequent medical decisions, and those of her younger sister, Danielle. A vexed mother-daughter dynamic dominates the early narrative, as Queller recounts her lifelong ambivalence toward this fashion designer who sported heavy makeup, false eyelashes, and a voluptuous body. Ironically, Stephanie Queller often reminded her daughters they had inherited “good genes,” a legacy called into question when she contracted stage-two breast cancer in 1996 and stage-three ovarian cancer in 2002. Queller acknowledges that at
the time of her mother’s breast cancer their relationship was strained, but the diagnosis caused tensions to ease: “My mother was sick—all else was moot. That said, my mother, sister, and I did not grasp the gravity of breast cancer. The possibility of death was never considered” (33). Instead, the sisters support their mother during grueling chemotherapy treatments while Stephanie worries about hair loss, which, her daughter notes wryly, “to any woman . . . would be a terrible blow, but to my mother was pure horror” (33). Despite her humorous depiction of her mother’s vanity, Queller admires this woman who “regardless of nausea, vomiting, mouth sores, or lymphedema . . . exercised on the stairmaster every weekday morning, got dressed in her Armani suits and Manolos, caught the subway, and was in her designer showroom by nine” (34). Using victorious rhetoric that Barbara Ehrenreich views as “denigrating the dead,” Queller claims that for years her mother “triumphed over breast cancer” by refusing to see herself as sick (Ehrenreich, 45; Queller, 34–35). She presents her mother’s later confrontation with ovarian cancer as similarly embattled but less certain in its outcome: “At age 52, my mother had beaten stage 2 breast cancer. Would this be a harder fight?” (22).

Queller depicts this second cancer as traumatic, for Stephanie loses her hair, her hope, and eventually her life. Still, mother and daughter draw closer during nights Stephanie spends at Jessica’s apartment, suffering from chemo’s grueling side effects and from terror of death. Queller narrates her despair at her inability to alleviate her mother’s suffering, for Stephanie confronts open wounds in her mouth and rectum, a painfully inflamed bowel, and terrible physical disintegration. Like Reibstein, Queller includes in her narrative a deathbed scene in which Stephanie issues delirious commands, whispers to her daughters “I don’t want to die,” and mutters desperate last words: “Help! This is against my will” (87–89). Although Queller’s deathbed narrative offers an anguished immediacy that largely avoids sentimentality, her subsequent reflection on matrilineal inheritance does become sentimental: “As her illness progressed and she became increasingly present as a mother, my judgments against the material things she loved were silenced. Now, every item that belonged to my mom was endowed with emotion. . . . I’d begun wearing her heels to work. As I traipsed up the stairs to join the other writers, I realized I was literally and metaphorically walking in my mother’s shoes” (90–91).

Although Queller does not incorporate her mother’s writing into her narrative, as do Reibstein and Bryan, she includes a letter of tribute from a woman who met Stephanie when the two were receiving post-operative
treatment at the same hospital. Queller uses this letter to enhance readers’ understanding of her mother’s illness experience and to foreground breast cancer sisterhood, even when the women are apolitical. “I had just turned forty and my third son was twelve months old,” the friend, Liza Wherry, explains.

Your mother was fifty. Right away we liked one another and we were the first “breast cancer friends” one another had come into contact with in the days following our surgeries. Also, I am not a “political breast cancer patient.” I don’t go on marches and don’t seek out other women who had had breast cancer. I don’t wear a pink baseball cap and a Susan Komen t-shirt. It just isn’t me. I got the feeling that your mother, too, (as we stood outside Dr. Roses’ office waiting for him to arrive) was a more discreet person and not one to devote her life to being a “survivor” (a word I really don’t like). (163)

In subsequent encounters, the letter continues, Liza and Stephanie shared agitation over chemotherapy, laughed at Liza’s expensive wig in the hospital restroom, and comforted one another. Wherry’s letter confirms Queller’s belief that her ill mother became “more maternal”: “In many of our phone calls your mother indicated how concerned she was about her ‘girls’ . . . she didn’t want you and your sister to worry nor have added stress in your lives” (165). The inclusion of this letter adds emotional heft to Queller’s memoir, while its content affirms a matrilineal bond.

Their genealogical memoirs reveal Reibstein, Bryan, and Queller as haunted by ghostly revenants, the women in their families who died of cancer but inspire the living to survive it. Commemorative, informational, and autobiographical impulses intersect, as each writer carries memories of her aunts, mothers, and/or sisters to the printed page.

Vexed Decisions: Genetic Testing, Preventive Surgery, Breast Reconstruction

According to their memoirs, the decision of whether to be tested for a BRCA genetic mutation was easy for all three of these writers to make, but for different reasons. For Bryan it was pro forma: given her curiosity as a physician, her family history of ovarian cancer, and her sister’s
death, she never doubted that she would seek testing once commercial procedures became available. In 1999 she learned from a Cambridge genetic researcher who had been studying her family’s history through the United Kingdom’s Familial Ovarian Cancer Register that his team had identified a “pathogenic mutation” in the BRCA1 gene, “a deletion of 4 bases designated 3875 del 4,” as the cause of the high incidence of ovarian cancer in her family; he urged Bryan to undergo genetic testing so that her risk could be quantified (92). Having taken the test, Bryan felt “a rather weary acceptance” upon learning that she had inherited the mutation (93). Since she had already undergone a prophylactic oophorectomy, she considered that decision vindicated by the research findings but was not concerned about her breast cancer risk because at that point no family member had ever been stricken. Several months later, however, her sister Felicity learned that she had breast cancer, and shortly afterward Bryan tested positive for BRCA1 (94).

As a woman in her thirties, Queller belongs to a generation that views genetic testing as simply a facet of modern life. She explains in her memoir that she neither remembers a time when this procedure was unavailable nor considers it ethically vexed. Yet taking a genetic test was for her precautionary; never did she imagine that her mother’s cancer might have been genetically triggered.

I wanted to take the test simply for the peace of mind of having a clean bill of health in writing. . . . In spite of the fact that my mother had cancer twice, I did not feel the disease would ever strike me. I had witnessed the horror of cancer up-close. I knew my mother had been shocked each time she’d been seized by cancer. And yet, strangely, I still felt invincible. (92)

When she learned her results in 2004, Queller felt ill-prepared to cope with being BRCA-positive or with the doctor’s claim that she would have an 85–90 percent chance of contracting breast cancer in her lifetime, information that stunned her even as she suspected that it would change her life.

Reibstein reports having initially decided not to be genetically tested because of her confidence that she would test positive, given her family history and her cousin Joyce’s recent contraction of cancer in both breasts. Rather than seek testing she undergoes a bilateral prophylactic mastectomy, yet despite her certainty she is shocked to learn that her
amputated breast tissue contains multiple sites of carcinoma in situ, a precancerous condition whose traces indicate that she likely carries the mutation: “We daughters of breast cancer mothers were thinking: maybe not us. Maybe our mothers’ deaths were a fluke of their Paterson childhood. Maybe the cancers were entirely environmentally caused. Maybe no faulty genes were involved at all” (188). In her narrative Reibstein acknowledges the depths to which denial can extend in women with familial cancer histories.

For each narrator an especially vexed decision was whether to remove her apparently healthy breasts. Bryan records the least angst, although for two years after testing BRCA-positive she underwent frequent screening rather than taking more drastic measures, but motivated by her sister's breast cancer recurrence, she determined at last “to be rid of my potentially deadly appendages” (103). Her concern that “it seemed heartless to be thinking of removing two healthy breasts when she [Felicity] had no option but to suffer the physical and emotional trauma of losing hers to cancer” was mitigated when her sister urged Bryan to undergo prophylactic mastectomies (104). As suggested by her use of the word appendages, Bryan acknowledges that breasts were not important to her body image and that she harbored no nostalgic memories of breastfeeding. Instead she wanted to stay alive—for her pediatric work, for her husband, a cancer survivor himself, and for the next generation. Sexuality was not a factor in her decision: “Even without the setbacks, at 60 and 74 I doubt that our sex life would have been a page-turner. Indeed it probably never had been. Sex had always been a very happy, straightforward, vital and yet unadventurous part of our life” (111). While acknowledging women who fear that removing healthy breasts might compromise their femininity, Bryan explains that she felt differently: “my breasts were not something for which I had a particular affection” (103). Aware that preventive surgery would not be covered under NHS, her primary concern was choosing an experienced private surgeon who would respect her decision and answer her questions fully. Having done so, in November 2002 she underwent a bilateral prophylactic mastectomy.

Reibstein describes her decision as more complicated, in part because her process began in 1990, when taboos were greater and post-operative silence reigned.

A small but growing number of women in the U.S. had chosen this operation. However, the sisterhood of prophylactic mastectomy
survivors was secret. People remained revolted and confused by the notion that a woman would willingly undergo mastectomy without a definite diagnosis of breast cancer. Women with breast cancer had come out of the shadows, but what was done to them hadn’t. . . . Albeit no longer “dirty” or the death of a women’s sexuality, [mastectomy] remained horrid and hidden because it might signal death. (203–4)

This passage reminds readers of the cultural shifts during the two past decades in breast cancer awareness and of the isolation experienced by many pioneers of prophylactic mastectomy. Reibstein records the outrage she feels at the reactions of others: “Some friends were terribly shocked, even repelled, by my decision. That was much as I’d expected, but it angered me. For God’s sake, what are a pair of breasts worth compared to survival?” (207). She further explains that over the years she had begun to question the cultural fetishizing of cleavage and eventually “came to dislike breasts in general, and mine in particular” (193). Yet only when her cousin contracted cancer in her second breast did Reibstein decide to act, and only on the gurney did she realize the significance of her decision.

What I was about to do represented the cutting edge (literally) of what women with an inherited tendency towards breast cancer could do to prevent it. Not great, perhaps, and possibly not what would be done ten, twenty, thirty years from now, but so much better than waiting for the probable diagnosis one day. My operation also signified amazing progress for a far larger population than the relatively few of us with a wonky genetic loading. (212)

Queller expresses anguish about prophylactic mastectomy because of her youth and her concerns about sexuality. Following confirmation by phone that she had tested positive for BRCA1, she describes receiving an ominous report by mail.

In the center of the report: POSITIVE FOR A DELETERIOUS MUTATION was printed in bold letters and framed by a rectangular box for emphasis. The paragraph underneath contained the grim statistics the doctor had told me over the phone, but in greater detail: “Deleterious mutations in BRCA1 may confer as
much as an 87% risk of breast cancer and a 44% risk of ovarian cancer by age 70 in women. Mutations in BRCA1 have been reported to confer a 20% risk of a second breast cancer within five years of the first as well as a ten-fold increase in the risk of subsequent ovarian cancer.” (96)

This information underscores the pedagogical imperative of Queller’s narrative, which urges readers to learn about genetic risks. Still, she too acknowledges having engaged in denial for months before seeking genetic counseling, and she admits feeling anger at her counselor’s suggestion that she consider having prophylactic surgery. “Was she out of her mind?” Queller wonders on her drive home, dismayed by the chilling Ca 125 blood test to which she had been subjected, the “claustrophobic, loud and eerie” MRI, and the sonogram that led doctors to palpitate her fibrocystic breasts (102). “Back off,” she instructs her friend Kay, who urges Queller to consider the geneticist’s advice: “There was no way I was going to cut my breasts off” (104).

A professional opportunity causes Queller to reconsider prophylactic mastectomy: an invitation to write an op-ed column for the New York Times about testing positive for the BRCA1 mutation. By her own admission Queller led a privileged life: a highly paid writer for the television series The Gilmore Girls, she jetted weekly between New York and Los Angeles and encountered celebrities daily at her Hollywood studio office. Hoping that a column in the Times would advance her journalistic career, she began the research into breast cancer genetics that would later inform her decision about preventive mastectomy. The publication of her New York Times article provoked a family conflict: the evening before the column appeared, Queller reports, her sister expressed anger at being “outed” as a member of a cancer-prone family: “Your taking the test has cancelled out my choice to remain sheltered from all of this. And your writing about it has taken away my privacy” (155). Stunned and apologetic, Queller realizes that in making her own medical decision she has overlooked her sister’s right to privacy. Although the narrative never probes this issue in depth, Queller, like Bryan, raises in her memoir the important topic of ethical accountability.

As someone whose family history included not only breast and ovarian cancer but also an emphasis on bodily perfection, Queller writes frankly of the psychological struggle her consideration of prophylactic mastectomy evoked. Uncomfortable with her large breasts and with
the cultural sexualization of women, she nonetheless admits, “I had a love-hate relationship with my breasts. I did not want to be valued for them. . . . At the same time I understood that men found my body sexy and I liked that” (124). Concerned that her sex life would suffer if she had surgery, Queller poses a series of questions that reveal the gender-essentialist perspective that dominates her narrative: “Would men no longer find me desirable? Would I feel deformed? Would I ever want to be touched again? Would I no longer feel like a whole woman?” (127). In addition to these fears, she acknowledges wanting a child and, at thirty-five and single, feeling “already up against the biological clock” (128). Despite her worries, Queller describes an epiphany she experienced during an interview with Cokie Roberts on Nightline. “Having watched my mother die a brutal, horrific death,” she tells Roberts, “I would do anything” to avoid dying of cancer (187). On a vacation shortly before her surgery, Queller affirms her decision in a journal entry: “Having surgery is taking care of myself. My true self. My spirit, my character, stuff on the inside. Whatever the cosmetic result of my body, my breasts, is not all that consequential” (221). Thus in September 2005 she underwent a prophylactic mastectomy performed by the same surgeon who had operated on her mother years earlier. Queller’s account of the night before her surgery employs war imagery to presents her journey as bildungsroman: “I felt remarkably calm. I was ready for battle. . . . I thought of what I was about to endure as a rite of passage into adulthood” (228). Like Reibstein, Queller views her post-operative pathology report as vindicating this decision, since it revealed atypical ductal hyperplasia, pre-cancerous tissue, in her right breast. “You did the right thing,” her surgeon assures her (234).

These writers also detail the reasons they choose breast reconstruction. Bryan offers a familial justification: to protect her young nieces, with whom she often shared a room when vacationing, from seeing their aunt’s post-operative chest and learning too early of their genetic legacy. She explains to readers her decision to have silicone implant reconstruction at the time of her mastectomies, with the understanding that nipples would later be tattooed on or rebuilt from skin. Although she never expresses regret, Bryan acknowledges that reconstruction entailed “a higher price to pay in worry, money and discomfort than I had expected” (105). A gruesome saga follows, as she describes her leaky, swollen left breast, infected a week after surgery, its failure to respond to antibiotics, and the subsequent removal of her implant, a procedure
that left her asymmetrical and in pain. She further records her surprise at how “ugly” she found artificial breasts without nipples (“they badly need adornment”), her humorous efforts to recall the tint of her original nipples so that the prosthetic ones could match, and her relief when the reconstructive process was completed: “I felt transformed” (111).

Both Reibstein and Queller decide upon reconstructive surgery only after viewing the post-operative breasts of other women. Reibstein notes in her narrative that she experienced these encounters as traumatic. “It took me two years to talk to the two survivors. To do so represented a major step towards my decision. If I talked to them I was facing it. I knew I wouldn’t retreat from what they’d tell me, and I knew that what they’d tell me was that they did not regret their surgery” (193). When she finally views an acquaintance’s reconstructed breasts, the narrator describes both appreciation and shock at the scars, surgical nipples, and unconvincing breasts she confronted: “I went white when she showed me hers; I hadn’t really registered that I would indeed look different from the way I’d always looked—how could I when there were no pictures? I’d even nurtured a fantasy my breasts would be improved—the sag lifted, the size perfect” (206). Although she hid her negative reaction, Reibstein admits that she later “had vivid dreams about ugly and distended bodies, bodies mutilated” and that only in retrospect did she appreciate the value of knowing what her new breasts might look like (207). Queller, in contrast, is inspired by her encounter with a friend who underwent prophylactic mastectomies and reconstruction; she views this woman’s reconstructed breasts as “rather beautiful” and “astonishingly real” (150).

Surgical reconstruction becomes problematic for Reibstein but is largely positive for Queller, as each explains in her memoir. Throughout 1994, Reibstein discussed reconstructive options with her surgeon and finally selected a subcutaneous mastectomy that would preserve her nipple, allow soy implants to be inserted, but remove only 90 percent of her breast tissue, thus leaving a potential site for further exposure to cancer. She rues this decision when her surgeon finds carcinoma in situ in both breasts and recommends another surgery to remove the remaining tissue. Reibstein details the infections, medical complications, and additional surgeries that led ultimately to the removal of her soy implants and the implantation of silicone alternatives. In contrast, Queller recounts a largely successful reconstructive process. Although fluid accumulation and leakage require antibiotics and extensive drainage, she is ultimately pleased with the feel of her silicone implants, the natural appearance of
her nipples, and the size she chooses for her new breasts: 32B rather than the 32D’s toward which she had long felt ambivalent. Her decision to reduce her breast size signifies a rejection of cultural sexualization and a fulfillment of her desire for agency in constructing her own hybrid body.

In their narrative accounts of genetic testing, preventive mastectomy, and breast reconstruction, these memoirists grapple with questions of sexuality, identity, and medical efficacy: What effects does a prophylactic mastectomy have on the patient’s sexuality? How does it affect her sense of self, of wholeness? What medical risks accompany such surgeries, how effective are they in preventing breast cancer, and which types of procedure retain valuable chest muscle and tissue while minimizing risk of cancer occurring there? Ultimately each writer expresses confidence in her decision to be genetically tested, choose preventive mastectomy, and undergo breast reconstruction.

Postscripts / Cautionary Tales / Future Visions

In Reibstein’s final chapter readers find her sunbathing in 1999 on a Mediterranean beach, wearing an old red bathing suit and pondering her new body: “I like my shape. These breasts are neither beautiful nor grotesque. They are neither me nor not me” (238). She further recognizes, as she surveys the topless women around her, that breasts no longer serve as markers of beauty or desirability—that she is “beyond breasts” (239). This realization comes, however, after major complications from multiple reconstructive surgeries, from life-threatening infections to implant removal to disfiguring scars, which she recounts in her postscript. Reibstein further reflects upon the phenomenon of many Western women now living with advanced breast cancer rather than dying from it. While she has prevented cancer by choosing prophylactic surgery, she describes many friends with chronic breast cancer who “lead comfortable lives, their periods of medical treatment relatively short and compassionate, despite inevitable suffering and discomfort, in comparison to what Regina, Mary, and Fannie endured twenty, thirty, and fifty years ago” (243). Pleased that “knowledge of the genetics of breast cancer has exploded,” she explains how a family genogram finally confirmed that she carries the BRCA1 mutation, probably passed down from her mother’s father (243–45). Reibstein’s conclusion exudes optimism: genetic consultations are readily available in the twenty-first century; prophylactic mastecto-
mies for BRCA-positive women save lives; and she is thrilled to consider herself cured. Her final paragraph returns to the genealogical reflection with which her narrative began, but with a triumphant tone previously absent.

I went one better than my mother. Because of her I fought. Because of her I was vigilant. Because I live when I do, I stopped it, caught it quickly, and survived. . . . I know she would be proud of me. I have imagined her loving me through this very strongly. I can almost see her crowing down from an imaginary Heaven, shouting “That’s my girl!” It would be great if the next generation could go on to be free of the shadow, free, too, of the knife. Now that my mother, and her sisters, would have loved. (248)

Despite her problematic use of triumphalist rhetoric, Reibstein’s conclusion remains compelling because it envisions increasing numbers of women free of cancer’s shadow.8

As a physician Bryan makes an overt pedagogical commitment to readers by including appendices that describe the BRCA1 mutation in lay language, assess the ethical and medical questions raised by genetic testing and elective surgeries, and define key terms used in the narrative. Especially informative is a concluding chapter, “BRCA1 Today and Our Family,” which notes that in 2006 the Human Fertilization and Embryology Authority in the United Kingdom endorsed pre-implantation genetic diagnosis, or PGD for the BRCA1 and BRCA2 gene mutations, and explains that PGD enables carriers who wish to have children to engage in an in vitro fertilization procedure that tests the cells of embryos, to implant a BRCA-negative embryo, and thereby to avoid passing on the mutation to their fetus. She probes the ethical implications of this procedure by presenting differing views of medical practitioners and her own family members and by acknowledging relief that she did not have to make such a vexing decision.

Bryan’s narrative conclusion jolts readers by revealing her diagnosis at sixty-three of advanced pancreatic cancer, after which she undergoes surgery and chemotherapy. Given this cancer’s virulence, she experiences a recurrence one year after her original diagnosis and acknowledges in her memoir that she is dying as she writes; her narrative thus shifts from autopathography to autothanatography. Nonetheless, she continues to chronicle her disease dispassionately, explaining that while breast cancer
represents 23 percent of all cancers in women, pancreatic cancer represents only 3 percent; that the lifetime risk of contracting breast cancer is 1 in 9 for women in England, while the risk of pancreatic cancer is 1 in 95; that only 13 percent of patients with pancreatic cancer survive more than a year after diagnosis and 2–3 percent more than five years; and that while she hopes to be one of the survivors, she does not expect to be (160–61). Curiosity leads her to investigate whether her BRCA1 status might have been a factor in causing her pancreatic cancer, a determination she ultimately deems impossible to make, and she describes her excitement at being one of the two first pancreatic cancer patients to enter a trial study to assess potential links to BRCA1 and her later disappointment that the trial medications worsen her cancer and necessitate her withdrawal from the study. Through all of this Bryan remains philosophical: while she acknowledges that prophylactic surgery might have led her BRCA mutation to manifest in the pancreas because less deadly locations were no longer available, she refuses to dwell on that possibility, admitting merely that she feels “a bit miffed” to have undergone prophylactic mastectomies only to contract a more virulent cancer (293). In the final pages readers witness Bryan’s physical decline and preparation for death, as she shares farewell emails sent to family and friends, and describes her participation in a gathering of music and tributes that she considers a prelude to her own funeral. In “A Husband’s Afterword” readers learn that Bryan died peacefully at home in February 2008; her final words were “wonderful, wonderful” (294). Bryan’s narrative violates readers’ expectations by ending not with the recovery of the narrator but with her untimely death. Singing the Life thus serves as authorial self-commemoration as well as a narrative of intergenerational genetic cancers.

In the postscript to Pretty Is What Changes Queller extends her matrilineal emphasis, reveals her experience of post-operative sexuality, and establishes her identity as a cancer activist. She chronicles her sister Danielle’s decision to undergo a prophylactic double mastectomy in 2007, motivated not only by Jessica’s act but also by the discovery of their mother’s breast cancer journal, which she interpreted as a sign: “Our mother was speaking directly to her from beyond the grave . . . telling her to have the operation and have it now” (265). A year earlier, Queller explains, Danielle had tested positive for the BRCA1 mutation; that discovery and her decision to have surgery had strengthened the sisters’ bond. Queller also discusses her embrace of breast cancer activism as a previvor—a term for BRCA-positive women who choose preventive surgery—who has joined
FORCE (Facing Our Risk of Cancer Empowered), a U.S. organization for women at risk for genetically driven cancers. She further reports that she and her sister received the Lynne Cohen Foundation’s 2007 “Courageous Spirit Award” for testifying publicly about their prophylactic mastectomies.

Queller’s narrative concludes with the news that single, thirty-seven, and eager to have a child, she is “heading to the sperm bank” (273). As part of in vitro fertilization she plans to take a PGD test that will allow her to select for uterine implantation an embryo that does not carry the BRCA1 mutation, thus assuring a genetic erasure of her familial cancer history. An important aspect of Queller’s postscript is her ethical reflection on PGD testing.

Had this technology been available in 1969, I would have ended up in the trash can. Can I, in good faith, choose embryos that don't have the mutation and destroy the others? Is taking action to ensure my unborn child will not have to go through the terrors my mother, sister, and I have suffered the responsible choice? Or is it immoral to extinguish a life merely because it carries a gene that I myself live with? (274)

She ponders how far U.S. society will and should go to engineer embryos and what new technological options stem cell research might produce. Moral and pedagogical imperatives converge as Queller expresses her belief in “utilizing biotechnology to promote health,” extols the scientific opportunities now available to save lives, and urges readers to “seize them” (274, 277).

Environmental Myopia and Competing Discourses

What do narratives of prophylactic mastectomy contribute to their readers’ understanding of the breast cancer continuum? What do such narratives offer as postmillennial cultural commentary? For women considering genetic testing or preventive surgery, these narratives provide information and possibly inspiration. For academic and general readers they offer new medical and technological knowledge as well as riveting autobiographical profiles. Any remaining social stigma attached to the choice of prophylactic mastectomy for women who test positive for
BRCA1 or BRCA2 can arguably be lessened by such memoirs; new affiliations can be established between women who have entered the “uncharted waters” of our DNA age and readers who bear witness to their journeys (Queller, 274).

While I applaud these writers for raising awareness about genetically inherited cancers, I share the concern of Eisenstein in *Manmade Breast Cancers* that environmental factors are downplayed in assessments of genetic cancers, and I find such minimizing troubling in the prophylactic mastectomy narratives under consideration.9 Eisenstein argues that breast cancer must be seen as “a social and political/biological problem defined by the food and tobacco industry, the military-industrial complex, and corporate polluters” (78). Indeed, the breast itself requires reimagining, and she offers a template for doing so.

Connect it to the body systematically and to its complex environments cyclically. Define our environments with open yet connected boundaries between air, water, soil, economic and racial hierarchies, and the female body.

Interrogate the cause/effect scientific model for its linear blinders. Supplant this model with an interactive and multistage model of malignant growth that recognizes the interstices between bodies, genes, and environments. (76)

Although such a template might reasonably be viewed as the work of medical researchers rather than memoirists, I wished for more consideration of intersections between genetic and environmental cancer influences in the narratives of Bryan, Reibstein, and Queller.

To be sure, Bryan and Reibstein acknowledge that environmental factors might play a role in determining which BRCA-positive women will contract breast and/or ovarian cancer, but they largely embrace a single-causality approach. Bryan correctly points out that “environmental influences, including diet, can influence the appearance of a cancer even when it is primarily determined by one’s genes” and that it is “not yet understood why some people who carry the BRCA1 cancer gene survive into old age with no sign of cancer while the majority show it much earlier in life” (154). She does not, however, explore the role that environmental toxins play in causing cancer to manifest. Reibstein goes further, noting that “carcinogens are multiplying in the environment, due to industrial processes, vehicle emissions, factory farming, food technology
and packaging” and that “this greater load of carcinogenic pollutants presumably increases the probability of cancer being triggered earlier” (241). Still, she fails to assign to these carcinogens a greater causal significance than diet, longevity, and lifestyle, and she views genetic mutation as the greatest risk factor (241). Queller barely mentions environmental links to BRCA-related cancers, noting merely that her research provided “no medical consensus on what factors caused expression of the gene,” although she mentions diet, reproductive history, and “environmental exposures” as possible factors (119). Overall, environmental carcinogens receive minimal emphasis in genetically centered sagas.

These narratives rely instead on discourses of biological determinism that assume the veracity of the adage “biology is destiny” even as they laud new biotechnologies. Queller’s subtitle, “How I Defied My Destiny,” best exemplifies this discursive tendency, but Bryan exhibits it as well by endorsing the view that her sister has contracted breast cancer because “her gene [was] expressing itself,” despite the fact no other BRCA-positive family members had ever had breast cancer (99). Reibstein comes closest to recognizing Eisenstein’s perspective that genetics is but one potential factor in causing breast cancer, since she acknowledges that in future studies BRCA status might “have more muted roles in cancerous growth than we think,” but she offers no further consideration of breast cancer’s environmental links (244). In addition, discourses of self-determination often compete in these narratives with discourses of genetic absolutism. Reibstein and Queller, in particular, boast of conquering or outwitting breast cancer through canny use of biotechnological advances and will-power: Reibstein claims to have “defeated the thing” her mother merely strove to conquer (248), while Queller describes having “decided to live,” as if Bryan and other women who lost their lives to cancer decided to die (book cover). Although readers can appreciate these narratives of prophylactic mastectomy for their autobiographical, pedagogical, and commemorative power, it is important from a feminist perspective to query their problematic representation of genes as destiny to be defied through an unsettling combination of self-aggrandizing agency and cutting-edge biotechnologies available to many wealthy women of the world, but certainly not to all.