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EDUCATIONAL RESPONSES TO THE CANCER INDUSTRIAL COMPLEX PINK WAR MACHINE: THEORIZING GENDER INSUBORDINATION FROM AUTOBIOGRAPHIES OF BREAST AND GYNECOLOGICAL CANCERS

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EDUCATIONAL RESPONSES TO THE CANCER INDUSTRIAL COMPLEX PINK WAR MACHINE: THEORIZING GENDER INSUBORDINATION FROM AUTOBIOGRAPHIES OF BREAST AND GYNECOLOGICAL CANCERS

A DISSERTATION APPROVED FOR THE
DEPARTMENT OF EDUCATIONAL LEADERSHIP AND POLICY STUDIES

BY

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Dedication

"Illness affects the body,
Yet remains apart.
It cannot reach the spirit
Or touch the human heart.
Love Heals!"

–Robert E. Kogan, "January 6," *Love Heals:
31 Days of Loving You and Other Poems*

To Robert Earl Kogan, poet and dreamer,
and
Linda Beth Kogan, who kept him grounded.

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ABSTRACT

Premised upon John Dewey's contention that dualist notions of minds isolated and elevated from bodies are an "evil" perpetuated in education (1916), this study applies Jane Roland Martin's theories of education as encounter (2011), education as a lifelong series of culture crossings (2006), and education as the transmission of both cultural liabilities and assets (2002) to curriculum theorizing from women's cancer narratives as educational autobiographies (Couser, 1997; Lorber and Moore, 2002; Frank, 2013; Dewey, 1916; Pinar, 1975; Franzosa, 1992; Martin, 2011; Laird 2017, 2018). Informed also by analyses of modes of body discipline and conditions affecting the well-being of bodies in communities (Foucault 1982; Friedman, 1989; Bartky, 1990; Young, 1994; Butler 2006; Shusterman 2008; Warren 2011), this textual study focuses upon the U.S. "cancer-industrial complex" (Ehrenreich, 2001), the conglomeration of medical and research institutions, government and nonprofit agencies, and commercial corporations that shape patient and public health education for women with breast and gynecological cancers (BGC) as a "pink war machine" that fosters cisgender heteronormativity and gender subordination (GS). Education for GS includes three practices—"pink commerce," medical authoritarianism, and "pink narratives"—which compel BGC patients' conformity to gender norms, violate their bodies, suppress their voices, and limit and distort their learning.

This textual study theorizes "Gender Insubordination" (GI) from close reading of eight autobiographical narratives (Campion, 1972; Kushner, 1975; Rollin, 1976; Lorde, 1980; Lucas, 2004; Ho, 2006; Steingraber, 2010; Gubar, 2012) that voice women's critical responses to gender-subordinating, pink war training. This study's thesis is that GI is a self-educating practice, and collectively, that GI narratives can serve as counter-curriculum for revealing, resisting, and redressing pink-war-machine miseducation. Women's diverse narratives express GI educational thought of three kinds: emergent, instigative/informer, and restorative/reformer.

In all cases, four GI actions respond directly to gender-subordinating patient education: Refusing to comply with gender-normed behaviors, developing practices to listen to and sustain bodies, educating others to recognize pink war miseducation, and claiming voice for self-advocacy. Commending Dewey’s insight that education may enhance or harm health (1916), this study closes with a plea to broaden educational studies to apply its disciplines of interpretive, critical, and normative inquiry to health care as a site of vital teaching and learning.

Introduction: "To Learn Something I can Share for Use"[1]

It was during an interrupted weekend cabin trip that the focus of this dissertation came clear to me. I was walking along the shore of Lake Murray, Oklahoma with my daughter, looking for fossils among pieces of driftwood and rocks when my cell phone rang. It was my mother. When I answered, she told me not to panic, but she was "hemorrhaging a little*.*" She immediately followed with "I don't want to bother you on your vacation, but I thought you should know." Feeling the fear hit my stomach, I asked, "Mom-- what do you mean, you're *HEMORRAHAGING*?" "Oh, I'm bleeding like a stuck pig! I called 9-11. I hope my carpet' s not stained, blood is so hard to get out-" Her voice was sounding softer, and I was stricken with terror, calculating how fast I could make the two-hour drive from Lake Murray to Norman. I asked, "Where are you bleeding from, mom?" There was a scary silence on the line. "Mom? Mom!" Finally, she answered, "I have a little spot, and I must have rubbed it too hard in the bath because it started bleeding." "What spot? Where?" I asked, my mind reeling at what she could possibly mean by a hemorrhaging "spot." She tsked annoyance at my question. When nothing more was forthcoming, I shouted, "MOM?!" Finally, she responded, "It's just a little spot of cancer. On my bosom. I didn't want to bother you about it. I just thought you should know. There's no need to cut your trip short. I'm holding a towel to it and waiting for the ambulance. Oh! Here they are. I have to go change shoes. The black ones clash with my pants." . . . Before she hung up, I shouted into the phone, "Mom, I'll meet you at the hospital!" During the rushed packing and driving back to Norman, my thoughts raced in panicked circles—*"A LITTLE hemorrhage? A LITTLE cancer? Mom has breast cancer. ... And she knew. And she didn't tell me."*

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[1] Lorde, *The Cancer Journals*, Kindle Location 674.

Through research, I later learned that my mother's decision to keep her breast cancer a secret, a decision she made five years prior when she found a lump "the size of a walnut" in her right breast, is not so uncommon. In qualitative healthcare research, this kind of behavior is called "healthcare avoidance." From interview data with women who made the decision to avoid breast cancer treatment like my mother, Betina Lund-Neilson, et. al. (2011) pose that a reason some women may decide to indefinitely put off seeking medical care for breast cancer is because they experience an overwhelming sense of "caregiver burden" and believe they do not have the time to seek medical attention or that their own needs are a lower priority than tending to others, such as a sick or elderly family member.[2] Other studies find that religious beliefs, fatalism, medical expenses, a distrust of doctors, prior perceptions of discrimination in medical treatment, and a fear of losing breasts are all factors that can contribute to a woman's decision to avoid seeking treatment.[3] These findings suggest that not seeking medical care can be a way to maintain a semblance of control over one's body and health. When I asked my mother why she literally "put a Band-Aid over it" and ignored her cancer for so long, she said, unapologetically quoting Frank Sinatra and looking at me with an almost defiant stare, "Because I did it my way." With my scholarship focused on feminism and a project of reclaiming the body and health as central to education, could I fully argue that my mother's desire to maintain autonomy and exercise choice in her healthcare was wrongheaded simply because I could not agree with her choice? If I declared her actions irresponsible, irrational, and self-destructive would I in effect be claiming her knowledge and feelings were less valid than my own?

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[2] See, Betina Lund-Neilson, et. al. "An Avalanche of Ignoring, A Qualitative Study on Healthcare Avoidance in Women with Malignant Breast Cancer Wounds" *Cancer Nursing 34* No. 4 (2011): 283.

[3] See, Noreen C. Facione, et. al., "The Self-Reported Likelihood of Patient Delay in Breast Cancer: New Thoughts for Early Detection," *Preventative Medicine 34* No. 4 (2002): 395-405.
See also, Mohammed I.E., et. al, "Understanding Locally Advanced Breast Cancer: What Influences A Woman's Decision to Delay Treatment?" *Preventative Medicine 41* No. 2 (2005): 397-407.

Before this phone call, I knew I wanted to focus my research on women's autobiographical illness narratives as educating texts and to explore how gender values are taught and learned in formal and informal patient education. I also wanted to explore illness autobiographies as both testimonies of gendered learning and as curricular sources advancing or hindering gender messages in healthcare settings. Adult-education and curriculum theorists value the autobiographical genre as a self-educating practice[4] because autobiographical authors gain beneficial insights into pivotal moments in their lives. With the reflection that this writing fosters, even traumatic moments can lead to learning something about one's self and society. For preservice teachers, a regular practice of self-reflective writing is widely endorsed as a way to assess one's strengths and weakness as an effective teacher.[5]

Biography is also a topic understood as germane to education research, especially history of education, but there seems to be a clear theoretical dividing line between the applications of *auto*- and *bio*-graphy in education research that, to some extent, replicates social science skepticism toward the autobiographical genre and its forms. While biographies are often included as curricular sources in classroom teaching and are research sources, the emphasis on the autobiographical *act* of writing as self-educating says nothing about the value of these text as educating texts for others. However, in my reading of first-person testimonies of illnesses, I find educational significance for both readers and writers, with some writers citing earlier *autopathographies* (illness narratives) as guidebooks for how to cope with a life-disrupting

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[4] See, Irene Karpiak, "More Than Artistry: The Integral Aspect of Autobiography," *Canadian Journal of University Continuing Education 31* No. 1 (2005): 87-107.
See also, Robert J. Graham *Reading and Writing the Self: Autobiography and the Curriculum* (New York: Techer's College Press, 1991).

[5] Lynn Alvine, "Shaping the Teaching Self Through Autobiographical Narrative," *The High School Journal 84* No. 3 (2001): 5-12.
See also, Rick Marlatt and Lilian Cibils, "Poets with a Purpose: Using Autobiographical Writing to Engage Preservice Teachers," *International Journal of Teaching and Learning in Higher Education 30* No. 3 (2017): 571-577.

illness.[6] William Pinar's concept of *currere,*[7] the reframing of the "curriculum" as creative, autobiographical action and as a "knowledge-producing method of inquiry appropriate for the study of educational experience"[8]—highlights the potential twofold gain in reading/writing autobiography.

Through the reflective writing experience of *currere*, the author gains a deepened awareness and understanding of her experiences, her responses, and how those experiences and responses are shaped in her community and the wider world. Through the autobiographical act, the writer stands to gain not only self-knowledge but enhanced cultural knowledge. However, I also saw in illness narratives a didactic purpose, whether overtly stated or implied, as if the author is saying, in effect, "my story is not yours, but maybe there are points of connection between us, some insights from my experience, my learning, that you can make use of." If there are other motivations for publishing an autobiography—hopes of writing a runaway bestseller—a didactic purpose and its underlying, empathetic impulse are not nullified.

Breast and Gynecological Cancer: Cultural Significance and Medical History

Boobies, Tatas, Jugs, or Honkers. Titties, Fun Bags, Melons, Zonkers. A Rack, Bazokas, Kahunas, Gazongas. Puppies, Hooters, Chichis, Mambas. . . . This is by no means a complete list of bosom buzzwords. Our fascination in western culture with breasts is not new. It manifests deep-seated associations with sexuality, reproduction, and species survival through the female body. From Paleolithic "Venus" figurines to goddess cults of classical Greek and Roman

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[6] For example, breast cancer memoirist Sarah Horton finds not just inspiration, but awareness of gender issues in cancer treatment and ethical orientations reading the earlier memoirs of Audre Lorde and others. See, Sarah Horton, *Being Sarah: A True Story About Choice, Control, and Breast Cancer* (Liverpool, England: Wordscapes, 2010).

[7] William Pinar, *Curriculum Theorizing: The Reconceptualists*, (United States: McCutchan Publishing Corporation, 1975). 402.

[8] Graham, *Reading and Writing the Self: Autobiography and the Curriculum,* 121.

antiquity, figures of breasted females have been prominent cultural icons.[9] Breasts are symbols of motherhood, the birth of nations, and moral triumph.[10]

In 1758, Swedish naturalist Carolus Linnaeus, credited as the "father" of taxonomic systems for classifying plant and animal life, introduced the term "*Mammalia*" in his revised edition of *Systema Naturea* to describe the group of animals with the common characteristics of three middle ear bones, hair or fur on the body, a four-chambered heart, and mammary glands. In "Why Mammals are Called Mammals: Gender Politics in Eighteenth-Century Natural History," historian of science Londa Schiebinger points out that of all Linnaeus' classes of animals, *Mammalia* "was the only one of his major zoological divisions to focus on reproductive organs and the only term to highlight a characteristic associated primarily with the female."[11] Schiebinger argues that Linnaeus' choice to emphasize mammary glands was at least in part politically motivated. Six years prior to adding the term "mammalia" to his extensive classification system, Linneaus, a practicing physician and father of seven children, published a tract condemning the rapidly growing practice of middle- and upper-class European women giving their infants to professional wet-nurses.[12] Schiebinger notes that Linneaus was "highly moralistic" and committed to "returning women to their rightful place as loving and caring mothers."[13]

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[9] See, J.M. Adovasio, Olga Soffer, and Jake Page, *The Invisible Sex: Uncovering the True Roles of Women in Prehistory* (New York: Routledge, 2009); 119-120; 186-190.
See also, Sarah Milledge Nelson, *Gender in Archeology: Analyzing Power and Prestige* (Lanham, MD: Alta Mira Press, 2004).

[10] The symbol for the city-state of Rome is a she-wolf suckling its mythic twin founders, Romulus and Remus. In Enlightenment Europe, bared breasts were featured in female personifications of liberty and justice. In Revolutionary France, the symbol of freedom is the goddess Marianne, often depicted with one or both breasts bared as she leads the charge to battle.

[11] Londa Schiebinger, "Why Mammals are Called Mammals: Gender Politics in Eighteenth-Century Natural History," *The American Historical Review* 98, no.2 (1993): 384.

[12] Ibid., 405.

[13] Ibid., 408.
See also, Florence Williams, *Breasts: A Natural and Unnatural History* (New York: W. W. Norton, 2012), 25.

In *Emile or On Education* (1762)*,* philosopher of education Jean-Jacques Rousseau claims panacean effects from mothers breastfeeding their children. [14] The maternal breasts are the font of domestic happiness, love, and moral citizen development and education:

> [Only] when mothers deign to nurse their own children, then will be a reform in morals; natural feeling will revive in every heart; there will be no lack of citizens for the state; this first step by itself will restore mutual affection. The charms of home are the best antidote to vice. The noisy play of children, which we thought so trying, becomes a delight; mother and father rely more on each other and grow dearer to one another; the marriage tie is strengthened. In the cheerful home life the mother finds her sweetest duties and the father his pleasantest recreation. Thus the cure of this one evil would work a wide-spread reformation; nature would regain her rights. When women become good mothers, men will be good husbands and fathers.[15]

Mystical and metaphoric meanings attributed to the lactating mother figure span millennia. Sofia, the Greek goddess of wisdom, was said to impart knowledge from her breast milk,[16] and Artemis of Ephesus (Diana of Ephesus), depicted with multiple breasts, often dozens or more, is the Earth mother whose milk nourishes all life.[17] From the Middle Ages to the Baroque period, *Maria Lactans* images featuring Mary nursing baby Jesus were a popular theme.[18] Whether venerated as sacred symbols of a great mother, evidence of a woman's natural and divinely assigned role as mother, or as anatomical proof of female inferiority, the breast and uterus-womb are recognized as holding the power to develop and nurture life.[19] Sin and

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[14] Jean-Jacques Rousseau, *Emile or On Education*. United States: Basic Books, 1979. Book I, Kindle.
[15] Ibid., 250-255.
[16] Londa Sheinberger, "Taxonomy for Human Beings," *The Gendered Cyborg: A Reader,* Gill Kirkup, Linda James, Kathryn Woodward, and Fiona Hovenden, Eds. (New York: Routledge, 2000), 17-19.
[17] While there has been an ongoing debate in archeology, cultural anthropology, art history, and theology as to the nature of the rows of chest appendages on the depictions of Artemis (or Diana) of Ephesus, James D. Reitveld (2006) presents an extensive review of the literature and concludes that she was, at least at some point in her long history of veneration, a polymastic Earth-goddess figure.
For more, see James D. Reitveld, "Universal Goddess on the Via Sacra: The Evolving Image of Artemis Ephesia," Ph.D. diss., Claremont Graduate University, 2006, 38-53.
[18] See Celia M. Dorger, "Studies in the Image of the *Madonna Lactans* in the Late Medieval and Renaissance Italy," Ph.D. diss, University of Louisville, 2012.
[19] Artistole, *On the Generation of Animals* (Australia: eBooks@Adelaide, 2015). Accessed 9 March 2019. https://ebooks.adelaide.edu.au/a/aristotle/generation/book4.htmlhttps://ebooks.adelaide.edu.au/a/aristotle/generation/book4.html.
See also, Carolyn Merchant, "The Violence of Impediments: Francis Bacon and the Origins of Experimentation," *Isis 99* (2008): 731-760.

salvation, life and death, youth and old age, health and sickness, and transcendent knowledge and earthly carnality are all anthropomorphized in the female body.

Given the cultural weight of breasts, breast cancer can elicit a special kind of dread. As James S. Olson (2002) notes, breast cancer "transcends race, class, time, and space, [it is] a horror known to every culture in every age," but "[a]mong ancients, breast cancer *was* cancer."[20] Understanding cancer as primarily a disease of the breast may have had more to do with breast cancer's outward manifestations than metaphors. Its tendency to be recognized as a noticeable mass beneath the skin, as an open wound, or as a spreading rash across the surface (inflammatory breast cancer) enables breast cancer to be seen and felt as an evident wound in a way it is not in other, internal organs of the body.

Besides religious responses such as petitioning gods and saints with votive offerings and prayers for healing (Saint Agatha is the patron saint of breast cancer), medically prescribed breast cancer treatments up through the 19th century included eating crab or crayfish meat (with the understanding that if you consume the representation of the ailment that is consuming you, you can be cured); bloodletting, a variety of poultices and plasters made from warm animal blood, milk, ground seeds and herbs, goats' dung, vinegar, human urine, boiled frogs, arsenic, mercury, lead, and other known poisons, tar (to control the smell of putrefying breast wounds); the application of electric eels and artificial electric currents; imbibing arsenic, hemlock, and belladonna (deadly nightshade) in prescribed (hopefully non-deadly) doses, purgatives, drinking the warm blood of a goose or duck and ass' milk to "cleanse" the tumor; restricted diets; starvation, laxatives, cauterization of the wound with hot sticks, metal blades, and chemical

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[20] James S. Olson, *Bathsheba's Breast: Women, Cancer & History* (United States: The John Hopkins University Press, 2002), 9, emphasis in original.

compounds such as sulfuric acid; and, over the course of thousands of years, the performance of mastectomies and lumpectomies.[21]

While surgery for breast cancer was first practiced in the ancient world,[22] De Muelin notes from the Enlightenment onward, it became routine treatment for breast cancer, although the method and the extent of the surgery varied greatly.[23] In 1811, English novelist Francis Burney underwent a mastectomy without anesthesia which she later describes to her sister Esther in wrenching, vivid detail. In her letter, Burney describes the "torture" of the surgeon's knife plunging into her breast, cutting "against the grain," and "rackling against the breast bone—scraping it."[24] From the end of the nineteenth century onward, radical mastectomy with adjuvant radiation treatments, chemotherapy[25], and/or immunotherapy treatments—the "slash, burn, and poison," medical management of breast cancer--became standard. For now, these interventions remain the best approaches medicine has to offer. In terms of causation, we understand breast cancer to be a complex interplay of biological and environmental factors, but what specifically causes cell mutations in one person and not another and at what age is still not fully understood.

The many causes ascribed to breast cancer throughout history include cancer as a test from God, a curse, divine punishment, an imbalance of humors in the body,[26] poor diet, depression and grief, a contagion, a congenital disease, breastfeeding, not breastfeeding,

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[21] See, Daniel de Moulin, *A Short History of Breast Cancer* (Dordrecht, Germany: Springer, 1983), 42-44.
See also, James S. Olson, *Bathsheba's Breast: Women, Cancer, and History* (Baltimore: Johns Hopkins, 2002), 14.
See also, Ritu Lakhtakia, "A Brief History of Breast Cancer," *Sultan Qaboos University Medical Journal 14* No. 2 (2014): e166-169.

[22] "Evolution of Cancer Treatment: Surgery," *American Cancer Society*, last modified June 12, 2014. Accessed 10 December 2018 https://www.cancer.org/cancer/cancer-basics/history-of-cancer/cancer-treatment-surgery.html.

[23] de Meulin 2-30.
See also Zenon Rayter and Janine Mansi, Eds., *Medical Therapy of Breast Cancer* (New York: Cambridge University Press, 2008), 2.

[24] Francis Burney, *Journals and Letters* (New York: Penguin, 2001), 442.

[25] Sarah Hazell, "Mustard gas – from the Great War to Frontline Chemotherapy" *Cancer Research UK.* last modified August 27, 2014. Accessed 7 April 2018. http://scienceblog.cancerresearchuk.org/2014/08/27/mustard-gas-from-the-great-war-to-frontline-chemotherapy.

[26] See, Steven I. Hajdu, "Greco-Roman Thought about Cancer," *Cancer* 100, no.10 (May 2004). Accessed 7 April 2019. https://onlinelibrary.wiley.com/doi/full/10.1002/cncr.20198 .

childbirth, having no children, menopause, injury to the breast, and corset stays.[27] In *Breast Cancer in the Eighteenth Century*[28] (2013), Marjo Kaartinen adds gender biases to the list of historical causations cancer. She notes that in 1815, physician John Rodman speculated it was women's minds that were "always prone to hysteric that caused breast cancer. Their heads were in any case weaker in every sense."[29]

In "Carcinoma Uteri and 'Sexual Debauchery,'" Karen Nolte (2008) also looks at unbridled female desire as a known cause for breast and uterine cancer in the nineteenth century.[30] She describes the far-reaching influence of German physician Adam Elias Von Seibold, who asserted that over-exerting the female mind and body through physical (e.g. sexual intercourse, masturbation, too much dancing or exercise of any sort) or intellectual stimulation (e.g., too much thinking brought on by philosophical or political conversation or reading) resulted in breast and gynecological cancer.[31] Practical medical advice to avoid breast and gynecological cancers was to ensure a woman's mind and body were occupied with what they were designed to do, reproduce and nurture the species. While this paternalistic counsel was intended to save women's lives from the threat of cancer, it endorsed exposing women to the more common risk of death from childbirth.[32]

Learning from Facing Fear

With my mother's health crisis, my research interest in women's cancer narratives became immediate and personal. This research became a lifeline, a way to focus the fear so that

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[27] Ornella Moscucci, *Gender and Cancer in England 1860-1948* (London, UK: Palgrave Macmillian, 2016), 22.

[28] Marjo Kaartinen, *Breast Cancer in the Eighteenth Century* (London, UK: Pickering & Chatto, 2013), Kindle.

[29] Ibid., Kindle Location 515-517.

[30] Karen Nolte, "Carcinoma Uteri and 'Sexual Debauchery': Morality, Cancer and Gender in the Nineteenth Century," *Social History of Medicine* 21, no.1 (April 2008).

[31] See also, Ellen Leopold, "'My Soul is Among Lions': Katherine Lee Bates's Account of the Illness and Death of Katharine Coman," *Legacy* 23, no. 1 (2006): 62.

[32] In James Copeland's *Dictionary of Practical Medicine* (1847), the author advises the surest cure for breast tumors is for a woman to have children and for the female breast to do what nature designed it for, to lactate.
See, James Copeland, *A Dictionary of Practical Medicine Comprising General Pathology,* vol.5*,* Charles A. Lee, Ed. (New York: Harper and Brothers, 1847), 935.

it did not overwhelm me. Cancer again. Both of my grandmothers had breast cancer. I witnessed my grandmother Ida's transformation from a statuesque woman to a skeletal shell covered in bedsores with pain-wracked eyes. The last time I saw her, I was 18, she was in her early 60s, dying from inflammatory breast cancer in a nursing home. I brushed her hair back gently from her forehead with my hand, and she hoarsely admonished, "For God's sake, don't touch me! I don't want you to catch it! How can you even look at me? I'm hideous." Her eyes filled with tears as she looked away. That is my last memory of her.

Grandma Dorothy had invasive ductal carcinoma. In her platinum blonde, curly wigs, psychedelic-polyester caftans that drew the eye away from her chest, and her signature bright-orange lipstick, she was unsinkable, outrageous. Once when we were alone, she placed a gnarled-fingered hand on top of my mine and, waving casually in the direction of her chest with the other hand said, "If this happens to you, don't let your looks go or ever lose your sense of humor about it. Men love women who take care of themselves and have spunk, not weeping willows." My grandmother's sister, great aunt Lily, also died of breast cancer. I do not know of any close relatives with gynecological cancers, but, given my Ashkenazi Jewish ancestry, it would not surprise me to learn that women in my family tree had gynecological cancers linked to breast cancer through the BCRA1 and BCRA2 genes.[33] Non-Hodgkin's Lymphoma ended my father's life at age 62. Cancer was a looming threat, a shadow monster that terrified me when I was younger, the unspeakable disease that cuts short the lives of the people I love. Now I worry for my health, my children, and my children's children. But it is not genetics alone that worries me. It is the risk of living in the world—the air, food, and water we take into our bodies and the

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[33] I took the genetic tests and am negative for BCRA1 and BCRA2. However, since my mother and both grandmothers were diagnosed with breast cancer, my lifetime risk of breast cancer is one out of four instead of one out of eight women, the risk level in the general population.

toxins accumulating and stored in our tissues, the effects of these toxins upon our genes and what that combination triggers—these now are also my fears.

As Audre Lorde notes in her MLA conference speech, "The Transformation of Silence Into Language and Action," written after her first breast biopsy, "In the cause of silence, each one of us draws the face of her own fear."[34] Mine is cancer. But, she reminds me, "Those threats we dare not speak are no less powerful for our silences. … My silences had not protected me. Yours will not protect you."[35] On the night after my mother's mastectomy, I was unpacking a suitcase of books in her hospital room, setting up a spot in the corner of the room where I could work while I watched her sleep through the night. A floor nurse came in to check on mom and asked me what all the books were for. I told her about my focus on women's illness narratives as educating texts and now, with my mother's cancer, I wanted to focus on autobiographical narratives of women's breast and gynecological cancers. Her body stiffened, nostrils flared, and her head tilted up in obvious offense. She slanted her eyes over to my sleeping mother and admonished, "There's nothing *educational* about what your mother's been through. Breast cancer is a horrible disease. What do you think your mamma's going to learn? She's in pain, and she's got a lot more days and nights of pain ahead. Is making her your research subject helping her or helping you?"

I stared at her slack-mouthed, incensed and abashed. Surely, she didn't think I was suggesting that my mother's suffering or any woman's suffering with cancer was a good thing? *Was* this research topic self-serving, exploitative? The nurse left without another word to me. Confused, hurt, and angry, I turned back to *The Cancer Journals* and Lorde's MLA speech and considered her words: "It is necessary to teach by living and speaking those truths which we

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[34] Lorde, *The Cancer Journals*.
[35] Ibid., 180-190.

believe and know beyond understanding."[36] Then I flipped back a few more dog-eared pages to a passage where Lorde writes about trying to make sense of breast cancer, how it affected her life, what she learned, and why she wrote and published a memoir about it:

> If I said this all didn't matter I would be lying. I see this as a serious break in my work/living, but also as a serious chance to learn something I can share for use. And I mourn the women who limit their loss to the physical loss alone. …I am writing this now in a new year, recalling and trying to piece together that chunk of my recent past, so that I, or anyone else in the need or desire, can dip into it at will if necessary and find the ingredients for which to build a wider construct. That is an important function of the telling experience. I am also writing to sort out for myself who I was and was becoming throughout that time.[37]

Watching my mother sleep hooked up to intravenous bags of blood, saline solution, and a morphine drip, I thought about Lorde's observations. I thought too, about the surgeon who met with my mother the day before her mastectomy and kept glancing down at his Rolex watch as he spoke to her. When she asked him about reconstructive surgery options, he told her that she was too old to be a candidate, that Medicare would not pay for it, and that there was just "no need" for her to go through extra operations. He assured her that in three weeks, she would be "good as new." I kept thinking about his statements after he left the hospital room. I searched online and learned the Women's Health and Cancer Rights Act of 1998 requires that all U.S. group health insurance plans cover reconstruction following mastectomy.[38] I also read the information on the Medicare website and learned that Medicare will pay for either an external (bra fitted) prosthesis following mastectomy for breast cancer or surgical implants. There is no age limit. Perhaps the surgeon was expressing his medical opinion regarding my mother's age-related risk. Perhaps he was also not aware of the Women's Health and Cancer Rights Act requiring coverage for

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[36] Lorde, *The Cancer Journals*, Kindle location 210.

[37] Ibid., 674-682.

[38] "Women's Health and Cancer Rights Act of 1998", *Centers for Medicare & Medicaid Services*, (n.d.), Accessed 17 May 2018 https://www.cms.gov/cciio/programs-and-initiatives/other-insurance-protections/whcra_factsheet.html .

reconstruction. But, even if this were the case, his brusque response that there was "no need" for her to have reconstruction smacked of ageism and sexism.

No, I decided I could not agree with this nurse whom I had unintentionally offended. Not only can a cancer diagnosis and its treatment occasion learning, but it can also occasion miseducating experiences, both in explicit patient-education messages and through an implicit, or hidden curriculum.[39] I thought about Jane Roland Martin's (1998) avowal that the school is only one "agency" and site of education. She writes:

> Church, neighborhood, museums, libraries, zoos, symphony orchestras, banks, businesses, the stock market, newspapers, magazines, book clubs, record companies, publishing houses, sports organizations, billboards, government agencies, TV, the Internet and the media in all its multitudinous forms: These and all the other institutions of society educate young and old alike.[40]

I concluded that not only is there teaching, learning, and curriculum in cancer diagnosis and treatment, but the education that cancer occasions can transmit values that reinforce inequalities based on gender, sexuality, race, class, disability, etc. As Lorde argues, silence serves only as tacit legitimation of the status quo.

Cancer in the Anthropocene: A Human Health Education Crisis

Breast cancer is the most common cancer among all American women. It is the leading cause of death from cancer in Latina women, and the second cause of death from cancer in white, black, Asian and Pacific Islander, and Native American and Alaskan women following lung cancer (colorectal cancer is the third leading cause of death by cancer).[41] Heart disease remains the number one cause of death for American males and females, which means that breast

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[39] Jane Roland Martin, *Education Reconfigured: Culture, Encounter, and Change* (New York: Routledge, 2011), 99-100.

[40] Jane Roland Martin, "The Wealth of Cultures and the Problems of Generations," *Philosophy of Education,* Steve Tozier, Ed., (1998): 28. Accessed 17 May 2017 *Philosophy of Education Archive, https://ojs.education.illinois.edu/index.php/pes/issue/view/20* .

[41] "United States Cancer Statistics: Data Visualizations," *Centers for Disease Control and Prevention*, last modified June 2018. Accessed 10 November 2018 https://gis.cdc.gov/cancer/USCS/DataViz.html.

cancer is the third leading cause of death for all American women—heart disease, lung cancer, breast cancer—the big three.[42] According to data compiled by the World Health Organization (WHO), the number of fatalities among U.S. women from these diseases mirrors global patterns with heart disease being the number one killer[43] and breast cancer as the second leading cause of death worldwide.[44] In the U.S., endometrial cancer is the most common gynecological cancer, but ovarian cancer is the leading cause of gynecological cancer deaths and ranks fifth in terms of causes of women's deaths from cancer overall.[45]

While there are some new developments in breast cancer treatment such as hormone inhibitors to slow cell division and tumor growth and targeted immunotherapy in conjunction with chemotherapy, treatment protocols have changed little in the last thirty years.[46] Women with cancer in the present are being given the same chemotherapy drugs that their mothers were given in 1980.[47] As the Breast Cancer Action Organization points out, the biggest difference between women and breast cancer now and thirty years ago is that thirty years ago 1 in 10 women statistically would get breast cancer over their lifetimes; today the chance is 1 in 8.[48] Comparing public responses to cancer to the AIDS ACT-UP movement of the 1990s, biologist

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[42] Hannah Nichols, "The top 10 leading causes of death in the United States", *Medical News Today*, last modified February 23, 2017. Accessed 10 November 2018. https://www.medicalnewstoday.com/articles/282929.php.

[43] "The top 10 causes of death," *World Health Organization*, last modified May 24, 2018. Accessed 10 November 2018. http://www.who.int/mediacentre/factsheets/fs310/en/.

[44] "10 Must-Know 2015 Global Cancer Facts," *American Cancer Society*, last modified February 4, 2015. Accessed 10 November 2018. (https://www.cancer.org/latest-news/10-must-know-2015-global-cancer-facts.html)

[45] "Statistics: Gynecological Health at a Glance," *John Hopkins Medicine*. (n.d.). Accessed December 31, 2018. https://www.hopkinsmedicine.org/healthlibrary/conditions/gynecological_health/statistics_gynecological_health_at_a_glance_85,P00587 .

[46] Virginia G. Kaklamani, "Developments in Breast Cancer 2017-2018: New Drugs, New Drug Classes – and the Prospect of More to Come," *Cancer Network*, last modified December 15, 2017. Accessed 31 December 2018. http://www.cancernetwork.com/breast-cancer/developments-breast-cancer-20172018-new-drugs-new-drug-classesand-prospect-more-come .

[47] Samantha King, *Pink Ribbons, Inc.: Breast Cancer and the Politics of Philanthropy* (Minneapolis: University of Minnesota Press, 2006) [Kindle Edition] Kindle Location 2479.

[48] "Think Before You Pink® Toolkit," *Breast Cancer Action* [PDF], (2012), 6. Accessed 10 November 2018. https://ojs.education.illinois.edu/index.php/pes/issue/view/20 .

and environmental activist Sandra Steingraber makes the point that cancer provokes public "sadness but not outrage" and "private suspicions but not political action."[49]

Things have changed since the late twentieth century and they have stayed the same. Cancer, especially breast cancer, is a very public cause for nonprofit and corporate activism. However, this is not the kind of "radical" political momentum that Steingraber envisioned. Research funding, treatment protocols, coverage by medical and pharmaceutical insurance policies, and public education campaigns are highly politicized and support profit-driven agendas. Steingraber also points out that cancer education agents like the American Cancer Society (ASC) "minimize the causalities" of cancer and obscure possible links between environmental pollutants and cancer.[50]

In 1991, Steingraber notes that according to the National Cancer Institute (NCI) the "Overall cancer mortality among those over 55 has risen steeply and steadily over the past two

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[49] Sandra Steingraber, "Lifestyles Don't Kill. Carcinogens in Air, Food, and Water Do.: Imagining Political Responses to Cancer," *Cancer as a Woman's Issue: Scratching the Surface,* Midge Stocker, Ed., (Chicago: Third Side Press, 1991), 92.

[50] Ibid., 94.

The question of a link between breast cancer and environmental pollutants been a source of political contention since the end of the twentieth century. 1n 1996, the U.S. National Institute of Health and National Institute of Environmental Health Sciences co-sponsored the Long Island Breast Cancer Study, a longitudinal study to explore possible connections between environmental contaminants produced in manufacturing and high electromagnetic fields. The study, now inactive, found no evidence of a direct correlation between environmental pollutants and breast cancer, and these findings were quickly framed by corporate and government to as definitive proof that no connection exists. However, data from the Long Island Study continues to be used, and recent and ongoing studies are finding links between air pollution and cancers, a fact that the American Cancer Society admits to while simultaneously directing readers to attention to "lifestyle choice" causes, such as obesity, nutrition, consumption of alcohol, and smoking.

For more, see National Cancer Institute, "Long Island Breast Cancer Study Project (Past Initiative)," *National Institute of Health,* 4 June 2018. Accessed 21 Dec. 2018. https://epi.grants.cancer.gov/past-initiatives/LIBCSP/.

See also, Marlie D. Gammon, et. al., "The Long Island Breast Cancer Study Project: Description of a Multi-Institutional Collaboration to Identify Risk Factors for Breast Cancer," *Breast Cancer Research Treatment, 74,* (2002): 235-254.

See also, April Zubko, "High Long Island Breast Cancer Rates: Fact or Fiction?" *Maurer Foundation Breast Health Education.* 1 November 2012. Accessed 21 December 2018. https://www.maurerfoundation.org/high-long-island-breast-cancer-rates-fact-or-fiction/.

See also, Elisabete Weiderpass, "Air Pollution as a Major Risk Factor for Cancer," *World Health Organization International Agency for Research on Cancer.* 11 November 2018. Accessed 21 December 2018. https://www.who.int/airpollution/events/conference/CAPH1_Parallel_sessions_III.3_3_AP_major_risk_factor_for_cancer_Weiderpass.pdf .

decades," and "childhood cancer has risen 22 percent since 1950."[51] By 2017, the findings were even more grim in terms of a global cancer burden. NCI summarized a WHO report on cancer worldwide:

> Cancer is among the leading causes of death worldwide. In 2012, there were 14 million new cases and 8.2 million cancer-related deaths worldwide. The number of new cancer cases will rise to 22 million within the next two decades. More than 60% of the world's new cancer cases occur in Africa, Asia, and Central and South America. 70% of the worlds cancer deaths also occur in these regions."[52]

Steingraber, diagnosed with bladder cancer in her early 20s, evokes the memory of biologist Rachel Carson. Carson died of breast cancer shortly after publication of *Silent Spring*[53] (1962). Steingraber's work carries forward Carson's mission to warn against the short-sighted, profit-driven manufacturing, sale, and use of chemical pollutants. She sees cancer research and medical considerations of risk factors as wrong-headedly avoiding the pollution-cancer connection. Steingraber writes:

> To assess our cancer risk, doctors routinely ask us if our mother or sisters have had cancer. They do not ask us if we grew up near a toxic waste dump or a garbage incinerator. . . . Do we find it more comfortable to blame our mothers than to find out what pesticides are in the food supply? Perhaps. Most women who have been diagnosed with breast cancer, for example, have no family history of the disease at all.[54]

She suggests that while the levels of environmental pollution are so high that it may be impossible for humans to ever be totally free of manmade chemicals in their bodies, we do not have to keep adding to the environmental burden of known or suspected toxins.[55] Philosopher of education Susan Laird (2018) finds the term "Anthropocene," coined by Paul J. Krutzen, as a "rhetorically powerful neologism that signifies the current Earth epoch marked by human

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[51] Sandra Steingraber, "Lifestyles Don't Kill," 94.

[52] "Cancer Statistics," *National Cancer Institute*, last modified April 27, 2018. Accessed 17 June 2018. https://www.cancer.gov/about-cancer/understanding/statistics.

[53] Rachel Carson, *Silent Spring*. (New York, USA: Houghton Mifflin Company, 1962).

[54] Steingraber, "Lifestyles Don't Kill," 100-101.

[55] Steingraber, *Living Downstream,* 9.

activities' dominating influence not only on global climate, but also on planetary health."[56] Laird sees "chemically fertilized soils saturat[ed] with nitrogen and phosphorus" and "massive extinctions of flora and fauna, increased concentrations of CO_2 in Earth's atmosphere, [and] vast amounts of plastic littering oceans and waterways" of the Anthropocene all bearing toxic fruit in "heavily polluted, under resourced, racialized communities whose children are subject to severe environmental health hazards."[57]

The ACS has a "Stay Healthy" page that invites readers to take quizzes to assess their knowledge of cancer risk factors. This page implores readers to lower cancer risks by "making healthy *choices*" such as "eating right, staying active, and not smoking."[58] This seems like straightforward advice, but how do we learn to choose to "eat right" in a fast food nation,[59] and what does eating right assume about foodways, income, and equal access to non-processed foods? When cigarette companies appeal to women living in poverty through gender-marketed discount coupons and advertisements, does advice to not smoke serve as a smokescreen for big tobacco's responsibility? Where is recognition of the exploitative, miseducative messages directed at women living in the bullseye of the tobacco target?[60] Finally, what are the challenges to teaching children to "stay active" in a smartphone-addicted society?

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[56] Susan Laird, "School Lunch Matters: Encountering the New Jim Crow and the Anthropocene," *Educational Studies* 54, no.1 (2018), 22.

[57] Ibid., 22-23.

[58] "Stay Healthy," *American Cancer Society*, (n.d.). Accessed April 2018. https://www.cancer.org/healthy.html. (emphasis mine).

[59] Eric Schlosser, *Fast Food Nation: The Dark Side of the All-American Meal.* (New York: Houghton Mifflin, 2001).

[60] "Cigarette Smoking and Tobacco Use Among People of Low Socioeconomic Status," Centers for Disease Control and Prevention, last modified August 21, 2018. Accessed 10 November 2018. https://www.cdc.gov/tobacco/disparities/low-ses/index.htm.
See also: "Associations Between Smoking Behaviors and Financial Stress Among Low-Income Smokers," US National Library of Medicine – *National Institutes of Health*, last modified October 29, 2015. Accessed 15 Jan. 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4721304/ .

The ACS recommendations for lowering cancer risk are misleadingly simple. Various and intersecting social and biological differences affect cancer rates and prognosis, including gender, sexuality, race, ethnicity, income/social class, disability and age. In the U.S., African American women have a 40 percent higher chance of dying from breast cancer than white American women, and Latina women in the U.S. have a 20 percent higher risk of death than white women.[61] Also, while persons identified within the broad racial category of "Asian American" have lower rates of breast cancer diagnosis and fatalities than white, Latina, or African American women, Hawaiian and Samoan women have the highest mortality rates of any group in the U.S.[62] As Breast Cancer Action Education and Mobilization coordinator, Sarhu Keiser, writes:

> The elephant in the room is the reality that inequities in breast cancer incidence, mortality and survival stem from a complex interplay of social and economic factors, including power dynamics, race/ethnicity, and discrimination. Yet to read the news, or mainstream breast cancer websites, you'd think there's a magical eat-right-exercise-maintain-a-healthy-weight silver bullet to resolve the grossly unequal health outcomes between white and non-white, poor and rich.[63]

Considering the rising rates of cancer worldwide,[64] rising rates of cancer in children and younger adults in the U.S.,[65] food deserts, high rates of childhood obesity and malnourishment,

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[61] Andrea K. McDaniels, "Hispanic Women More Likely to Die After Breast Cancer Diagnosis," *The Baltimore Sun*, last modified February 8, 2018. Accessed 13 March 2018. https://www.baltimoresun.com/health/bs-hs-hispanic-breast-cancer-20180123-story.html.

[62] "Disparities in Breast Cancer: Through the Breast Cancer-Care Continuum," *Breast Cancer Action*, last modified November, 2013. Accessed 13 March 2018. https://bcaction.org/site-content/uploads/2013/11/Disparities-and-Breast-Cancer-Fact-Sheet.pdf.

[63] Sarhu Keiser, "Making Room in the Breast Cancer Narrative: Social Injustices and Health Outcomes," *Breast Cancer Action*, last modified April 5, 2013. Accessed 13 March 2018. https://bcaction.org/2013/04/05/making-room-in-the-breast-cancer-narrative-social-injustices-and-health-outcomes/.

[64] See, Freddie Bray, et. al., "Global Cancer Statistics 2018: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries," *CA: Cancer Journal for Clinicians 68* (2018): 394-424. Accessed 5 June 2018. https://onlinelibrary.wiley.com/doi/epdf/10.3322/caac.21492 .
See also, World Health Organization, "Cancer," *World Health Organization* (n.d.) Accessed 5 June 2018. https://www.who.int/cancer/resources/keyfacts/en/.

[65] Neil Osterweil, "Pediatric Cancers Are On the Rise," *NHL Hub,* 17 May 2018. Accessed 5 June 2018. https://www.mdedge.com/hematologynews/nhlhub/article/165982/pediatrics/pediatric-cancers-are-rise.
See also, American Cancer Society, "Key Statistics for Childhood Cancers," *American Cancer Society,* 10 September 2018. Accessed 20 November 2018. https://www.cancer.org/cancer/cancer-in-children/key-statistics.html.

poverty, structural racism, manufactured toxins in air, water, food sources, and bodies, if cancer-prevention guidance is to "stay healthy" to avoid getting sick, the advice may be impossible to follow (not to mention circular reasoning). It also is disconnected from the socioeconomic realities and challenges of most Americans' daily lives. As Steingraber points out, women and children bear an unequal share of the burden in cancer's link to manmade environmental pollution. These chemicals accumulate in women's breast tissues, are passed on to children in breast milk, and "every year more children are diagnosed with cancer than the year before."[66] Given this reality, we may ask, as some autopathographers do, what does it mean to make healthy choices to reduce the risk of cancer?

Arguing that teaching and learning practices for human health in schools are not only germane to but necessary for democratic education, Laird (2018) focuses on school lunch period, cafeteria spaces, and food offerings as conveying messages about health and social value tied to race, gender, sex, disability, and class biases in education and society. Identifying what she terms education's two "wicked problems"—a "New Jim Crow," or "colorblind" racism and Anthropocene environmental exploitation and destruction, Laird argues that school lunch is neither non-educational nor extracurricular; it is a time and space where teaching and learning happen, intended or not. Laird also observes that considerations for health are "anomalous within the field of educational studies."[67] Whereas there is ongoing, vital recognition of the *embodied* experiences of persons who are racialized, sexualized, classed, "disabled" and

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See also, Hyuna Sung, Rebecca L. Siegel, Phillip S. Rosenberg, and Ahmedin Jemal, "Emerging Cancer Trends Among Young Adults in the U.S.A.: Analysis of a Population-Based Cancer Registry," *The Lancet,* 3 February 2019. Accessed 6 February 2019. https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(18)30267-6/fulltext.

[66] Sandra Steingraber, *Living Downstream: An Ecologist's Personal Investigation of Cancer and the Environment,"* (Cambridge, MA: Da Capo Press, 2010), 45.
; See also: Andy Miller and Brenda Goodman. "Why are childhood cancer rates rising?" *Georgia Health News*, last modified October 24, 2016. Accessed 13 March 2018. http://www.georgiahealthnews.com/2016/10/childhood-cancer-rates-rising-why/.

[67] Laird, "School Lunch Matters," 24.

otherwise marginalized, little attention is given to bodies' states of health as being educationally relevant.

Given the high mortality rates of breast and gynecological cancers (BGCs) worldwide and that their diagnoses, survival statistics, and treatment practices are linked to gendered, racial, economic, and other social inequities, what is taught and learned in BGC patient education[68] is properly a concern of educators across disciplinary areas—philosophy, sociology, and history of education, anthropology of education, aesthetics educators, curriculum theorists and educational psychologists.

A denial of the educational significance of states of health and illness in human bodies obscures the connection between the welfare of individual human beings and the quality of life in a society. As John Dewey reflects, "a proper human environment" is one that is "sound and healthy," but a society's health also depends on the health and well-being of its individual members.[69] If we are to move beyond the legacy of mind-body dualistic notions that Martin (2011) identifies as the foundational premise of education,[70] then various and widespread conditions and social practices that threaten health must be recognized as educationally relevant. Martin points out several examples of these "cultural liabilities," including "violence, hatred, poverty, and greed.;"[71] "rape, murder, racism, dishonesty,"[72] and "sexism, classism [and]

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[68] Educating agents and media for patient education include but are not limited to encounters with medical professionals, insurance and pharmaceutical companies, cancer awareness nonprofits, state and national policies regulating breast and reproductive cancer screenings and treatment, government-funded research and medical centers, the commercial marketplace of goods and services for breast and reproductive cancer patients, corporate-sponsored awareness campaigns, patient activism efforts, visual, performing and literary arts (such as this study's focus on published autobiographical narratives, but also biography, fiction, poetry, drama, and music), printed pamphlets, guides, and lay resource texts, other cancer patients, and the wider community of family and friends and their responses to cancer.

[69] Dewey, "The Unity of the Human Being," Jo Ann Boydston, Ed., *John Dewey: The Later Works 1925-1953 Vol. 13*, (Carbondale, Il: Southern Illinois University Press, 2008), 336.

[70] Martin, *Education Reconfigured*, 27.

[71] Ibid., 10.

[72] Ibid., 116.

homophobia"[73] These are some of the conditions she calls "stains on democracy."[74] While surely many other diverse forms of biases are likewise cultural liabilities, to focus on the immediacy of the body, I want to add malnutrition, childhood obesity, environmental toxins and commercially marketed products with known or suspected toxic ingredients, illicit drug use, underage and excessive alcohol use, and other health-harming practices as urgent issues in education.

We must also learn to recognize the various environmental conditions that make living in the Anthropocene itself a health risk factor, and, where we can and when we can, do what we can to affect change. Philosopher and gender theorist Judith Butler (1989) asks, if we claim that what we call philosophical "theory" is never "disengaged contemplation" then "why not simply call this operation *politics*?"[75] The philosophy of education advanced by Dewey, Montessori, Martin, and Laird not only poses questions about the human condition but is pragmatic, ethical, unapologetically normative in its orientations toward democratic life, and community-action oriented for individual human health and flourishing. Philosophy of education in this tradition is *praxis* based on the proposition that health is neither divisible from nor ancillary to other vital foci in education research. It is from this tradition that this study takes its inspiration.

A way to focus on the effects of gendered educational practices and messages in women's breast and gynecological cancer patient education is to undertake what Martin (2002) calls a "cultural bookkeeping" project to sort "assets" from "liabilities" in some particular portion of cultural stock.[76] This involves identifying and distinguishing among values, ideas, practices, and other artifacts/products of culture we deem important to transmit to the next generation from those we deem outmoded or harmful. But, just as there is an immense amount

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[73] Ibid., 195.
[74] Ibid.
[75] Judith Butler, "Imitation and Gender Subordination," *The Lesbian and Gay Studies Reader,* Henry Ablelove, Michèle Aina Barale, and David M. Halperin, Eds. (New York: Routledge, 1993), 308.
[76] Jane Roland Martin, *Cultural Miseducation: In Search of a Democratic Solution* (New York, USA: Teachers College Press, 2012), 89.

of human development in the thousands of years' worth of accrued stock, there are widely diverse opinions about which portions are necessary to preserve and pass on. Since the work of sorting what we consider a "living legacy" from what deem "dead relics" in cultural stock is a staggering task, especially since new stock is continuously accruing, Martin calls this work the "educational problem of generations."[77] Across social settings, educating agents make decisions about what to leave in and leave out, what to emphasize and what to subordinate in curriculum on a daily basis.

For example, the ACS webpage titled "Stay Healthy" includes a link to another page "Learn About Carcinogens: Explore the Environmental Causes of Cancer."[78] The graphic for this link is a photograph of automobiles and automotive exhaust. However, this image and link is not visible unless a reader scrolls down the page and finds the subheading "More Topics In Stay Healthy." Following this link takes the reader to a choice of four more links, all of which open to lengthy web pages. Given the graphic, I would expect to find some information pertaining to environmental pollution, automobiles, and cancer risks, and, sure enough, "diesel engine exhaust" is included in a long, alphabetical list of many other chemical compounds and substances like "glass wool fibers (inhaled)," drugs, and viral infections that are known carcinogens.[79] But what about non-diesel engine fumes? Doing an Internet search for "chemicals in automobile exhaust," I find that benzene and polycyclic aromatic hydrocarbons (PAHs), both found in trace amounts in non-diesel automotive exhausts, are buried in the ACS's list of known carcinogens but are not identified in any way as chemical components of

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[77] Jane Roland Martin, "The Wealth of Cultures and the Problems of Generations," *Philosophy of Education* (1998), 34.

[78] "Stay Healthy," *American Cancer Society*, (n.d.). Accessed 10 April 2018. https://www.cancer.org/healthy.html .

[79] "General Information about Carcinogens," *American Cancer Society*. (n.d.). Accessed 10 April 2018. https://www.cancer.org/cancer/cancer-causes/general-info.html.

automobile exhaust. Additionally, I am left feeling like this detective work may be a wasted effort after reading the ACS' subtly paternalistic advice:

> Sometimes it's hard to know what to be worried about. People are often more likely to be concerned about factors over which they feel they have less control, such as pollution, even though these things may not pose as much of a risk to us as some other things over which we do have some control.[80]

This advice seems to suggest I should not worry about what is beyond my immediate realm to act in and focus instead on what is presumably, immediately modifiable, such as making better decisions about nutrition and alcohol and tobacco use. But is it coincidental that ACS corporate partners include automobile, airline, and gasoline companies?[81] What curricular messages are implied in the form and content of the ACS public education pages accessed from the "Stay Healthy" page? In the context of taking cancer as having educative significance, Martin's argument that we must broaden our definition of where and when "education" takes place is particularly helpful, especially given the faulty premise that who and what we recognize as educating cannot simultaneously be miseducating.[82]

A cancer diagnosis can initiate a person's non-voluntary membership in an exclusive "cancer club" or, to use the widely-associated metaphor of cancer as war,[83] a cancer diagnosis serves as a draft notice. There is medical knowledge and jargon as specialized as in any secret society or the Department of Defense. There are print and online media that are generally only accessed by persons with immediate (and often fear-driven) interests in the content, mostly other "draftees," and serve as patient-education curriculum. For example, there are pamphlets and

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[80] "Does This Cause Cancer," *American Cancer Society*. May 11, 2017. Accessed 10 April 2018. https://www.cancer.org/cancer/cancer-causes/general-info/does-this-cause-cancer.html.

[81] "Partners Against Cancer," *American Cancer Society*. (n.d.). Accessed 10 April 2018. https://www.cancer.org/our-partners/partners-against-cancer.html.

[82] Martin, "Wealth of Cultures," 35.

[83] Susan Sontag, *Illness as Metaphor* and *AIDS and Its Metaphors.* (New York: Penguin Classics, 2002), 65-66.

magazines produced by drug companies and patient-education media corporations that most people will only see if they spend time in oncology waiting and clinical rooms. In addition to the autobiographical narratives this study focuses on, there are hundreds of self-help guidebooks, everything from *Dr. Susan Love's Breast Book*[84] to *Breast Cancer for Dummies.*[85] Teaching and learning also takes place in online government-sponsored patient education sites like the National Cancer Institute, privative, nonprofit websites like the ACS, online forums, blogs, YouTube videos, editorials, commercial sales websites, and online and in person cancer-patient support group meetings.

Cancer nonprofit- and corporate-sponsored events like ACS Relay for Life and the Susan G. Komen Foundation's Race for the Cure are settings of teaching and learning, but so are radiology, diagnostic imaging, and surgical centers, clinical outpatient rooms, hospitals, chemotherapy rooms, and even patient waiting rooms. National Breast Cancer Awareness Month, Look Good, Feel Better makeover parties, "Save the Boobies" bracelets and tee-shirts, and Rethink Breast Cancer's "Your Man Reminder" videos and telephone apps featuring "hot guys" are also all parts of the "multiplicity of educational agency"[86] transmitting messages about women's breast and reproductive cancers. Finally, cancer education occurs in the larger community—at churches, in neighborhoods, in grocery stores, schools, and post offices. Even and perhaps especially if a person living post-diagnosis does not appear sick and can "pass" as "normal," social values and messages about bodies, illness, and gender are taught, learned, and reinforced.

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[84] Susan M. Love, *Dr. Susan Love's Breast Book, 6th Ed.* (Philadelphia: Da Cappo Press, 2015).

[85] Marshalee George and Kinlin Tan Ashing, *Detecting and Living with Breast Cancer for Dummies* (Hoboken, NJ: John Wiley & Sons, 2017).
See also, Ronit Elk and Monica Morrow, *Breast Cancer for Dummies* (Hoboken, NJ: Wiley Publishing, Inc., 2003).

[86] Martin, *Cultural Miseducation*, 37.

Martin (2011) develops a theory of education not as the one-way transmission and passive reception of knowledge, but as a dynamic "encounter" in which a person comes in contact with another person, idea, concept, object, or another being and the person comes away from that encounter with her or his "capacities" (intellectual, physical, emotional, spiritual) changed or if not, change was the intended consequence.[87] Martin describes this as "yoking" of "capacities" and "culture." If the encounter results in a yoking, education occurs.[88] So, at a doctor's appointment, an ACS Relay Rally, through wigs and prosthetic breast fittings, and

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[87] Martin, *Education Reconfigured.*

[88] Ibid., 16-17. In *Education Reconfigured,* Martin brings together her prior conceptual work to lay out a comprehensive theory of what education and miseducation are and what they do. Martin explains that both the terms "education" and "miseducation" convey normative value notions and are thus somewhat subjective. However, there are some values and practices that a majority of people would agree are liabilities in culture leading to literal and metaphoric conditions of social "illness" and conversely, values and practices that advance human health and flourishing (Martin, *Education Reconfigured,* 115). Martin's point is that how a widely-agreed upon cultural liability is presented in an educational encounter and to what ends—whether it perpetuates ideas and practices as "living legac[ies]" or frames them as what is or should be "dead relic[s]"—marks a distinction between education and miseducation (Martin, *Education Reconfigured*, 128). Both, she argues, are best understood as *encounters* between an individual and some idea or thing in culture. Since the entire world shapes human culture and is affected by it, she follows Rousseau to include the "natural" world, including nonhuman species, as potential interactions that can lead to educational encounters (Martin, *Education Reconfigured,* 16; Rousseau, *Emile,* Kindle Location 78). An encounter may be random, or routine, long or short, and happen anywhere at any time because, in our daily lives, we "encounter" innumerable objects, ideas, people, and nonhuman living beings. However, Martin is not proposing that every encounter results in learning. Rather, for education or miseducation to occur, "the capacities of an individual and [some portion of] the stock of a culture [must] become *yoked* together *by some educational agent* (Martin, *Education Reconfigured,* 64, emphasis mine). By "yoking" Martin means something from the encounter "sticks" with the learner and that in some way, great or small, perhaps not immediately or outwardly manifest, it affects a change. Depending on what kind of cultural stock is transmitted in the encounter and to what effect on the learner, the encounter can be retrospectively judged as educating or miseducating, the change wrought for good or ill (Martin, *Education Reconfigured,* 115). By "educational agent" she means a person, media, institution, object—anything in the world that can transmit information, beliefs, and values, and practices. Educational encounters are cultural transmissions between a person and some "agent" of culture (person(s)or objects that convey information, ideas, values, beliefs, and cognitive, affective, and physical or psychomotor skills). Transmissions are not just one way though; the one who has the encounter also transmits ideas, values, skills, etc. in a creative, interpretive, and inspirational circulation of educational "gifts" in culture (Martin, *Education Reconfigured,* 200). This exchange is not centralized in sites of formal schooling but occurs across "multiple educational agency," including public and private spaces such as families, schools, (including colleges, universities, and professional training sites such as medical, law, and seminary schools), religious institutions, athletic programs, shopping malls, workplaces, and hospitals (Martin, *Education Reconfigured,* 63). Various types and genres of cultural and social media also transmitting educational content. However, while Martin reprises her democratic interpretation of gift exchange as education from her prior work, she also clarifies that education is *not* everything and anything. For the encounter to be considered educational or miseducational, it must result in a "change state" from the individual's process of learning (Martin, *Education Reconfigured,* 19). Additionally, she also notes that change can also occur through un-yolkings of culture and individual capacities, which may or may not result in a net cultural or individual loss (18-19). Martin argues that "whether we like it or not, in our daily lives, we [are all] full-fledged members of the educational realm [and] are all curriculum workers" (Martin, *Education Reconfigured,* 114).

through patient education print and online media, education can occur if a woman's capacities in responding to cancer change as a result of that encounter. However, just as it is important to recognize women's breast and reproductive cancers as occasioning educational encounters, it is important to make distinctions between what is educating and miseducating.

In the service of advancing cultural wealth and limiting liabilities, Martin calls cultural bookkeeping a "wildly ambitious," interdisciplinary, collaborative, and ongoing project, inside and outside of schools.[89] In her 1998 article "The Wealth of Cultures and the Problem of Generations," She suggests bookkeeping is the work of "educational agents" who, as knowledge experts, are "guardians and transmitters of our cultural stock," held "accountable" for their decisions.[90] However, in *The Schoolhome: Rethinking Schools for Changing Families* (2002), she revises her definition of who can and should be a cultural bookkeeper.[91] Arguing that children learn more about the importance of participating in community life by doing rather than as passive listeners and observers in classrooms, Martin contends that through active decision-making, children can learn to act on behalf of "health care, protecting the environment, and preparing nutritional meals."[92] Taking such action is a way to clarify and make immediate the distinction between knowledge assets such as what promotes human health from cultural liabilities such as "drug dealing and gang warfare, polluting our air and rivers, abusing young children and battering their mothers, denying jobs and housing to people of color and persecuting them and other minorities."[93]

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[89] Martin, "Wealth of Cultures," 36.
[90] Ibid., 35.
[91] Jane Roland Martin, *The Schoolhome: Rethinking Schools for Changing Families.* (Cambridge, MA: Harvard University Press, 1992).
[92] Ibid., 1081.
[93] Martin, *The Schoolhome,* Kindle Location 1081-1083.

Similarly, Laird points out that involving students in school lunch program decision making is a way to teach them that the act of making an informed choice has educational significance both for individual and for larger society. This type of choosing requires "knowledge of [the] options and substantial information about them" and "developing self-knowledge and cultural sensitivity."[94] Laird invites us to consider how such a pedagogical shift might affect lines of power and school administrators' and teachers' roles as policing agents in a school-to-prison pipeline for minority students.[95] Involving students in school lunch is educating action.[96] Involving students in the civic, democratic, participatory work of deciding what the content and character of school lunch should be is learning through reflective decision. This kind of educational encounter has the potential to shape students' capacities to act as moral, self-educating agents. It recognizes the validity of experiential and subjective knowledge by placing students in the role of cultural bookkeepers or at least as apprentice bookkeepers. Given that both students and patients occupy the subordinate positions in respective teacher-student and doctor-patient hierarchies of authority and power,[97] we can extend Laird's argument to patients, teaching and learning bookkeeping skill in their own medical treatment.

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[94] Laird, "School Lunch Matters," 25-26.

[95] Ibid., 28.

[96] Could a curriculum for making school lunch choices informed by perspectives in philosophy, sociology, history, and the arts and focused on environmentalism, race, power, precarity, nutrition and health affect desirable school lunch change? A similar question is the premise that underlies the Medical Humanities movement to educate preservice doctors to gain and demonstrate a greater capacity for empathetic doctor-patient interactions through reading patient autobiographical narratives. It seems to come down to questions of social power and the ability of those in dominant or super-ordinate positions in power hierarchies to collaborate with and mentor those in subordinated positions. For this to happen, teachers and school administrators would have to really give power to students to affect change in school lunch and doctors and hospital administrators would have to encourage the same kind of collaborative partnership with patients.

[97] Martin Buber, *I and Thou.* trans. Ronald Gregor Smith, (New York: Charles Scribner's Sons, 1986).

Study Thesis and Rationale

I am working from the premise that cancer treatment and social responses to cancer educate whether we recognize it or not.[98] And, as both Martin and my mother's incensed nurse point out, judging something to be outside the realm of education precludes any consideration of what it teaches[99] or if it results in education or miseducation.[100] I want to consider women's learning as cancer patients and living with cancer and ask if women can, through the self-educating act of writing autobiographical cancer narratives, learn to identify and sort assets from liabilities in their care and if so, what this action accomplishes. Working from a framework of feminist philosophy of education, my analysis focuses on messages in authors' testimonies, explicit and implied, about the female body and a woman's health being tied to gender-normative ideas about "feminine" bodies and behaviors. These messages may arise in medical and social settings, through patient-education media, in popular culture, or in an author's self-critical, self-questioning beliefs about her body, human worth, and how others feel about her.

Taking the publication of these narratives to be, as Lorde states, a means of breaking self-oppressive silences about cancer on others' behalf, I want to consider what they may contribute to patient education as curricular sources. I am especially interested in first-person accounts that demonstrate an author's recognition and critical evaluation of gender-oppressive practices in women's cancer diagnosis, treatment and social responses to these cancers. I argue these critical narratives can be understood as cultural bookkeeping reports benefitting those with cancer, the

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[98] I do not mean that a cancer diagnosis by itself always results in what Martin (2011) terms an "educational encounter;" it is possible that no change in the "capacities" of the person diagnosed change in the cancer experience. However, generally there are educational consequences from medical and social responses to cancer that need to be recognized. For more, see Jane Roland Martin, *Education Reconfigured: Culture, Encounter, and Change* (New York: Routledge, 2011), 64.

[99] This could include considerations of the type of knowledge taught and learned, how this educational context reveals teaching and learning, its curricular medium/media, pedagogical foundations, implicit or overt normative values, a critical analysis of its function and effects, understanding how it operates within and as part of a larger, educational-cultural-social surround.

[100] Martin, "Wealth of Cultures," 35.

medical professionals who treat them, and the wider community. In line with Dewey's, Martin's, and Laird's focus on human health in education, I see this work as contributing a focus on the body and health that largely has gone missing from educational studies.[101]

In addition to these mentor-educator figures, this project owes a large debt to a critical feminist literature on the politics and culture of breast cancer and breast cancer narratives. Monographs, essay collections, journal articles, and dissertations present clarifying historical, literary, and cultural analyses that helped to guide my attention to gender-biased practices in breast and reproductive cancer treatment and are cited throughout this study. However, a philosophical analysis of breast and gynecological cancer narratives as educating texts has not as yet been undertaken. This study is a preliminary attempt to fill this gap. What I hope to add to the body of scholarship on breast and gynecological cancer narratives is a consideration of how ideas about these cancers in society and medical approaches to them occasion an *educational problem* as much as a social and gender justice problem. I am arguing that sex and gender values are "written onto" bodies and are taught and learned in culture. Awareness of these scripts and the ways they shape how we think about illness and health is necessary for individual and communal well-being. However, beyond identifying the problem, I am interested in intervening strategies for resisting miseducation and advancing the agential capacities of people even and especially when they are sick and vulnerable. To do so, I want to reconsider breast cancer narratives through the lens of feminist philosophy of education and focus on exemplary cases of narratives that show awareness of and testify to miseducation in their treatment. I

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[101] This study seeks to expand existing work in the Philosophy of Education in regard to gender, health, and the body. The body was a primary object of concern of early western philosophy, as Michel Foucault documents, and it was often cast as an impediment to be "borne," medically managed, or transcended. Even the word "embodied" suggests we are minds encased in flesh rather than unified body-mind sentient beings. The development of environments and habits for human health were a concern for John Dewey, and late twentieth and twenty-first century feminist philosophers also focus attention on the body. Working with Dewey's rejection of mind/body dualisms, Richard Schusterman (2008) conceives of the body as a site and means of *somaesthetic* practices.

consider these cases as self-educating encounters through the autobiographical act and as curricular texts when these autobiographies are published.

Study Approach and Design

I conceive of this study as a cultural bookkeeping project to begin to take stock of teaching and learning in and with breast and gynecological cancer (BGC) narratives.[102] Following Laird's work with fictional and nonfictional works written by women to develop a concept of Maternal Teaching (1988)[103] and her work with philosopher Mary Wollstonecraft's biographies and autobiographical works as well as Wollstonecraft's practical manuals and philosophical treatises to theorize Monarchist Miseducation and Republican Co-Education (2008),[104] this work is a philosophical-conceptual differentiation analysis. From my encounters with BGC autobiographical texts, I theorize a concept of "gender insubordination" as a self-educating and teaching practice in BGC cancer diagnosis and treatment. Engaging with the narratives, I distinguish among counter cases (what I call "conventional" narratives), borderline cases (what I call "emergent/conflicted"), unambiguous (what I call "instigative/informative"), and strong cases (what I call "restorative"). Briefly, gender insubordination is an author's demonstrated awareness of and responses to resist diverse, miseducating messages and practices in cancer treatment settings and in wider society. This study does not use coding techniques employed in qualitative, narrative analysis. Rather, the concept of gender insubordination is developed from my interpretive analyses while encountering cancer narratives.[105]

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[102] These may include memoirs, autobiographical essays, autobiographies, and other, hybrid forms of personal cancer narratives.

[103] Susan Laird, "Maternal Teaching and Maternal Teachings: Philosophic and Literary Case Studies of Educating" (doctoral dissertation, Cornell University, 1988).

[104] Susan Laird, *Mary Wollstonecraft: Philosophical Mother of Coeducation.* (New York: Continuum International Publishing Group, 2008).

[105] This approach resembles thematic analysis in that I read autobiographical cancer narratives for repeating themes, but I do so in order to define and differentiate the nuanced developments in authors' gender-insubordinate thought. A brief caveat about this study's limitations: I am not making any claims for what gender insubordination can or should mean outside the context of BGC narratives and the medical and social settings' underlying ideologies as

Paul Smeyers and Piet Verhesschen (2001) argue the necessity for work in philosophy of education to "bridge the gap" between qualitative research and conceptual work.[106] Drawing from the work of Jerome Bruner[107] and Donald Polkinghorn,[108] Smeyers and Verhesschen make a distinction between the approaches of "*narrative analysis*," in which "the researcher arranges events and actions by showing how they contribute to the evolution of a plot" and the "*paradigmatic analysis of narratives,*" in which the researcher looks "not only [to] discover and describe categories, but also to describe the relationship between categories."[109] Smeyers and Verhesschen add that "where in 'analysis of narratives' the narratives are the source of knowledge," in narrative analysis the 'narrative' is what the researchers create.[110] As they see educational research, its purpose is to "understand particular situations and problems instead of aiming first of all at generalizability."[111]

For curriculum theorizing in the educational context of BGCs, the work here may be considered an "analysis of narratives" undertaken to shed light on beliefs, values, and practices taught and learned in cancer that tie gender to health. I consider ways gendered expectations shape women's identities in cancer narratives and may represent oppressive cultural liabilities in cultural stock. However, the point of this analysis of narratives is not to assert any normative conclusions about gender as a concept and component of identity. The value of gender generally

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detailed in these accounts. Further, conceiving of this study as a preliminary attempt to take stock of the pink war machine by reading some autobiographical narratives of women written within it is not an attempt by me to make a universal claim for all women with BGCs, or judge which stories count, including the experiences of males with breast or reproductive cancers, to ignore intersecting social identity constructions that complicate and confound gender and sex, or to make any categorical claims about who "women" with BGCs are. I want to also acknowledge here recognition of my own situated and limiting biases as a middle class, middle aged white woman of Ashkenazi Jewish ancestry with many female relatives afflicted with BGCs.

[106] Paul Smeyers and Peit Verhesschen, "Narrative Analysis as Philosophical Research: Bridging the Gap Between the Empirical and the Conceptual," *International Journal of Qualitative Studies in Education* 14, no.71 (2001), 72.

[107] Jerome Bruner, *Actual Minds, Possible Worlds*. (Cambridge, MA: Harvard University Press, 1986).

[108] Donald Polkinghorne, "Narrative Configuration in Qualitative Analysis," *International Journal of Qualitative Studies in Education, 8*, (1995): 5–23.

[109] Ibid., 76.

[110] Ibid.

[111] Ibid., 84.

as an item of cultural stock is not a consideration of this study nor is it a question considered in my conception of gender insubordination.

However, I argue that the majority of breast and reproductive cancer narratives (what I call "conventional" cancer narratives) reveal an author's internalization of and stated encouragement for others to conform to dominant gender values. Even if a heterosexual, cisgender author suggests gender does not figure into her experience with cancer, there may be implicit messages supporting adherence to a gender-normative status quo for health and recovery. This is not to judge any narrative of a woman's personal experiences in cancer a miseducating "liability" that others should not read. Rather, this study looks at BGC treatment as occasioning gendered, educating encounters[112] between a patient and the physicians, surgeons, medical technicians, nurses, volunteer aids, cancer nonprofits, commercial cancer awareness campaigns, and other educating agents in the wider community.

Study Overview

This study is divided into two parts. Part One, consisting of the introduction and chapters one and two, lays out a consideration of the educational problem in how we treat and respond to BGCs and introduces the major concepts of the cancer-industrial complex (CIC), the pink war machine, gender subordination, and gender insubordination. Chapter one, "The Making of a Pink War Machine," establishes the setting and context for women's cancer autobiographies. I explore how a diagnosis of cancer occasions a culture crossing[113] and a breast cancer diagnosis leads the crosser into a culture of "pink war." This culture is taught [114] through the practices and

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[112] Martin, *Education Reconfigured: Culture, Encounter, and Change,* (New York, Routledge, 2011), 19-22.

[113] Jane Roland Martin, *Educational Metamorphoses: Philosophical Reflections on Identity and Culture* (Lanham, MD: Rowman and Littlefield Publishers Inc., 2007).

[114] The teaching and curriculum conveyed through these approaches may be formal or informal, hidden or overt, deliberate or unplanned.

mechanisms of medical consumerism,[115] medical authoritarianism, and normative "pink war machine" narratives. I look at these three practices as creating conditions of gender-subordination and conveying a curriculum for pink war training that consists of compelling body-mind conformity, violating bodies, censoring voices, and limiting and distorting critical learning. I argue this is the "basic training" curriculum for gender subordination inside the pink war machine.

Chapter two, "The Breaking of a Pink War Machine," presents a philosophical-conceptual analysis of gender insubordination (GI) and GI cancer narratives as addressing and refuting gender-subordinating, pink war machine training. I briefly consider the etymological significance of insubordination and differentiate between insubordination as it is commonly understood to be action serving self-interested, often destructive ends, and historical precedents for insubordinate action grounded in overriding, ethical concerns for communal well being. Working with Judith Butler's[116] (1993) coinage of the term "gender insubordination" (GI), I apply the term to women's cancer narratives that counter mainstream, gender-subordinating narratives. I analyze what I take to be a borderline, a clear, and a strong case of GI narratives to explore the possibility of a range of GI responses in breast and gynecological cancer autobiographies.[117]

Part Two consists of three chapters that present an in-depth philosophical-conceptual analysis of gender insubordination through engaging with BGC narratives. In Chapter Three, "Emergent-Conflicted GI: A Response to Pink War Commerce," I focus on what may be

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[115] See, Gayle Sulik, *Pink Ribbon Blues: How Breast Cancer Culture Undermines Women's Health.* (New York: Oxford University Press, 2011).
See also, Samantha King, *Pink Ribbons, Inc.: Breast Cancer and the Politics of Philanthropy* (Minneapolis: University of Minnesota Press, 2006).

[116] Judith Butler, *Bodies that Matter: On the Discursive Limits of "Sex."* (New York: Routledge, 1993).

[117] Susan Franzosa, "Authoring the Educated Self: Educational Autobiography and Resistance." *Educational Theory* 42, no. 4 (1992).

considered newly developing and inconsistent/ambivalent instances of GI thought in breast and gynecological cancer narratives. I call this variety of GI "emergent-conflicted" and look at three exemplary texts revealing emergent GI perspectives: Betty Rollin's *First, You Cry* (1976)*,*[118] Geralyn Lucas' *Why I Wore Lipstick to My Mastectomy* (2004),[119] and Anita Ho's "The Cancer Diaries" (2006).[120] I argue that while these emergent narratives are largely self-focused on the author's learning encounters in the pink war machine and may even reveal conflicting gender-subordinating perspectives or class, race, and heterosexual biases, they also testify to and demonstrate self-educating, GI practices.

In Chapter Four, "Instigative-Informer GI: A Response to Medical Authoritarianism," I explore GI in women's cancer narratives that reveal a more comprehensive pink war machine critique. I consider how instigative GI authors take up the position of participant researchers in chronicling experiences in their own cancer care. In this kind of GI, the writer deliberately aims to educate readers regarding gendered, miseducating messages and practices in cancer treatment. I consider how these narratives compare with feminist autoethnographies, and, as an act of historical recovery, I focus my analysis on Rose Kushner's *Breast Cancer: A Personal and Investigative Report* (1975)[121] as an exemplary case of instigative GI. Putting Kushner in dialog with Martin (2000)[122] and Laird (2008),[123] I consider how Kushner's observations regarding the enduring nature of male-authorized, hierarchal doctor-patient relations both reflects and reinforces gender subordination in the deep structure of western educational thought.

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[118] Betty, Rollin, *First, You Cry.* (New York: Harper Collins, 1993).
[119] Geralyn Lucas, *Why I Wore Lipstick to My Mastectomy*. (United States: St. Martin's Press, 2004).
[120] Anita Ho, "The Cancer Diaries," in *Breasts and Medicine: The Conceptual History of Breast Cancer and its Implication for Medical Practice*, eds. Mary Rawlinson and Shannon Lundeen (United States: Springer, 2006).
[121] Rose Kushner, *Breast Cancer: A Personal History & an Investigative Report.* (New York: Harcourt Brace Jovanovich, 1975).
[122] Jane Roland Martin, *Coming of Age in Academe: Rekindling Women's Hopes and Reforming the Academy*. (New York: Routledge, 2000).
[123] Susan Laird, *Mary Wollstonecraft: Philosophical Mother of Coeducation.* (New York: Continuum International Publishing Group, 2008).

In Chapter Five, “Restorative/Reformer GI: A Response to Pink War Normative Narratives,” I focus on what I am calling “Restorative GI,” which extends an author’s scope of concern beyond exposing gender-subordinating conditions in the CIC to women taking communal action to redress and end harmful practices both inside and outside the CIC. Authors revealing restorative GI take a moral stance on behalf of the community at large, extending community beyond the bounds of the CIC and healthcare, beyond the local to the global, and beyond human life to life on Earth. I focus the discussion of restorative GI on two exemplary texts. First, working with philosopher Marilyn Friedman’s (1989)[124] distinction between communities of place and communities of choice, I focus my analysis on Audre Lorde’s *The Cancer Journals* (1980) as a strong case of restorative GI. I argue that while Lorde recognizes differences in women’s identities and lived experience that divide them, cancer intersects across all such divisions. She imagines women with breast cancer creating a community of choice to resist heterosexist, sexist, and racial discrimination and marginalization.

Next, I turn to Sandra Steingraber’s *Living Downstream* (1997/2010) and consider how Steingraber extends notions of community beyond human community and species. Focusing on cancer prevention through grassroots organizing to educate communities about cancer-causing environmental pollutants, Steingraber shifts the focus from cancer treatment to prevention. Working with Laird’s (2017) consideration of Steingraber’s maternal thought for sustainable, healthy community life in the Anthropocene,[125] Martin’s contention that education urgently needs to focus on the “3C’s” of care, concern, and connection,[126] and Dewey’s concern that

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[124] Marilyn Friedman, “Feminism and Modern Friendship: Dislocating the Community,” *Ethics 99* No. 2 (1989), 275-290.

[125] Susan Laird, “Learning to Live in the Anthropocene: Our Children, Ourselves,” *Studies in Philosophy of Education 36* (2017): 265-282.

[126] The concept of the “3C’s” of care, concern, and connection as missing or undervalued in notions of what education should be and what it should accomplish is developed throughout the body of Martin’s work. For example, see Jane Roland Martin, *Changing the Educational Landscape: Philosophy, Women, and Curriculum* (New York: Routledge 1994), 113-116.

education advance moral, democratic society,[127] I consider how Steingraber promotes a "preventive education" for communal health and the well-being of its individual members. The conclusion of this study offers some directions this project opens for future educational research with the goal of claiming a space in educational thought and scholarship for a sustained focus on human health and human beings as body-minds. I see this project as seeding future work at the intersections of cancer, health, gender, and education.

See also, Jane Roland Martin, *Education Reconfigured: Culture, Encounter, and Change* (New York: Routledge, 2011), 41-50. Kindle Edition.

[127] See, John Dewey, *Democracy and Education* (New York: Simon and Brown, 1916/2012).

PART I: Crossing into CIC Pink War Machine Culture:

Mis/Educating Metamorphoses

> "Once the renegade flesh was gone
> fall air lay against my face sharp and blue as a needle
> but the rain fell through October
> and death lay a condemnation within my blood."
> --Audre Lorde, "Never to Dream of Spiders,"
> *The Collected Poems of Audre Lorde*[1]

A diagnosis of cancer can mark the start of a profound change in a person's life. It can be understood as culture crossing[2] resulting in what Jane Roland Martin (2007) calls an "educational metamorphosis," or the process of acquiring knowledge, skills, values, and beliefs that change the one who makes a culture crossing in discernable ways.[3] While Martin calls birth and death the "bookend" points between which all culture crossings and "educational changes that comprise a human life" occur,[4] three decades earlier in *Illness as Metaphor*, Susan Sontag (1977), describes birth as the issuing point of two passports to countries in which "everyone who is born holds dual citizenship, the "kingdom of the well," and the "kingdom of the sick."[5] This second passport is one that no one wants to have or to use, but eventually, we all do. When Judith Hooper is diagnosed with breast cancer, she makes this unwanted crossing. In "Beauty Tips for the Dead" (1994), Hooper echoes Sontag by noting her awareness of "two castes" of people in hospitals and other medical spaces, "the diseased ones" like her and "those without," or the medical commuters to the kingdom of the sick who "treat the patients with mild contempt reserved for those on the other side of the glass."[6]

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[1] Audre Lorde, *The Collected Poems of Audre Lorde* (New York: W. W. Norton, 2000), 414.
[2] Jane Roland Martin, *Educational Metamorphoses: Philosophical Reflections on Identity and Culture* (Lanham, MD: Rowman and Littlefield Publishers Inc., 2007), 74-77.
[3] Ibid., 11-13.
[4] Ibid., 77
[5] Sontag, *Illiness as Metaphor*, 3.
[6] Judith Hooper, "Beauty Tips for the Dead," in *Minding the Body: Women Writers on Body and Soul* (New York: Doubleday, 1994), 113.

Disassociating illness, dying, and death from health and daily life, marginalizing those who are sick, and keeping sickness largely invisible are practices that mark an epistemic, experiential divide between the "sick" and the "well" that cancer patients know to be false.[7] Like other cultural constructs, the border separating the kingdoms of the well and the sick is individually and collectively a lot less solid than we may wish. However, unlike race, ethnicity, and other categorical markers of "otherness," the "other" we encounter when crossing into a serious illness or disease is the specter of our own mortality. Anthropologist S. Lochlann Jain (2013) describes receiving news of her breast cancer diagnosis as akin to entering a "silty, crocodile-filled gorge with no paddle in sight.[8] Jain's metaphoric description captures the sense of danger and feelings of dread that those immigrating into the kingdom of the sick[9] may feel upon making this unwanted culture crossing. However, for that those who are able to cross back to the kingdom of the well, Jain's description may call to mind a romanticized "Indiana Jones" style adventure hero and a story of courage and survival against the odds. The framing of breast and gynecological cancer (BGC) narratives as stories of courageous "sheroes" facing dangerous health threats and living to tell their stories is curricular canon in the kingdom of the sick.

Women[10] who immigrate into the kingdom of the sick through the gate of the "cancer-industrial complex" (CIC) with a BGC diagnosis both learn and teach other "recruits" to become

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[7] Hooper, "Beauty Tips for the Dead," 113.

[8] S. Lochlann Jain, *Malignant: How Cancer Becomes Us*. (United States: University of California Press, 2013), 3-4. Jain goes on to observe the "bone-cold testing rooms and the "teeth-grittingly jovial efforts to smear makeup and wigs over the whole messy problem of bodies spiraling into pain and decay" (4-5). She argues there is a "power dynamic resulting from the separation and institutionalization of knowledge . . . [that] devalues the knowledge . . . people with cancer derive from undergoing treatment" (18). The body-minds of persons who make this crossing are treated as deficient, damaged objects in need of medical management.

[9] Sontag, *Illiness as Metaphor*, 3.

[10] My work in this project focuses on autobiographical cancer narratives of cisgender persons assigned the sex of "female" at birth. However, this is not to claim any universal, experiential category of "woman," or to obscure the myriad ways both subtle and patent that race, ethnicity, sexuality, differences in physical and mental appearances and ways of being, social class, and other complexly intersecting markers of social identity shape the concepts of gender and sex. I also recognize my own limitations and biases writing as a cisgender, heterosexual, white, middle-age, middle-class woman of Eastern-European Jewish descent, and I acknowledge how my own religious life as a member of the Baha'i Faith, as a college-educated person with politically "liberal" feminist educator-activist

soldiers in a “war” against an enemy invader in one’s own body. As Martin (2011) reminds us, “since the institutions to which we all belong are [also] educational agents, this means that all of us are educators, many times over.”[11] To flip perspectives, we are also all learners within the cultures of various social structures and institutions we live and work within. Our dual roles of teacher and learner extend into the kingdom of the sick. Chapters One and Two, comprising Part One of this study, consider BGC diagnoses framed as gendered warfare, with gender-subordinating values taught and learned on both sides of the well-sick border. Chapter one looks at various ways the CIC reinforces these messages and values, and what crossers learn and teach other immigrants and those who consider themselves safely “on the other side of the glass.” This chapter theorizes “gender subordination” (GS) as taught and learned through a martial framing of cancer that situates women as soldiers and victims in a “pink war.” In this context, I consider GS as an educational problem. In Chapter Two, I introduce a concept of “gender insubordination” (GI) to respond to and redress GS. In the context of the BGC autobiographical narratives, gender insubordination is manifest as a strategy to end “the war” through self-educating, body-mind practices.

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perspectives, and as the primary caregiver of my mother who is living with metastatic breast cancer shapes and defines this study’s questions and approach.

[11] Martin, *Education Reconfigured*, 114.

Chapter One: Gender Subordination in the CIC:

The Making of a Pink War Machine

> "[W]hen she talks of liberation
> she means freedom from that pain
> she knows what you know can hurt
> but what you do not know can kill."
> --Audre Lorde, "But What Can You Teach
> My Daughter?" *The Collected Poems of
> Audre Lorde*[1]

In *Illness as Metaphor* (1977), Sontag describes a long tradition in western medical education of visualizing cancer as an enemy within and medicine mobilizing military responses to it. She cites medical textbooks from the late 19th century describing tumors as "invading" cells "colonizing" areas of healthy cells and overrunning the body's "defenses." Radiation is used to "bombard" this enemy invader, and chemotherapy is literally chemical warfare, derived from mustard gas used in World War I.[2] While relating cancer's pathology and its treatment to war may have been routine for doctors before the twentieth century, in the public imagination cancer was not so dramatically denoted. In fact, until the late twentieth century the word "cancer" was scarcely spoken in public, and cancer was considered an offensive topic.[3] To understand how a notion of cancer-as-war became entrenched in the public imagination and discourse, why it is so powerful, and how it advances gendered learning in women's cancer treatment, it is helpful to turn to the historic context for this war metaphor.

A Brief History of Pink War

In his 1961 farewell address to the American public, President Dwight D. Eisenhower warned the nation of a developing "military-industrial complex." He urged citizens to guard

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[1] Lorde, *The Collected Poems of Audre Lorde,* 309.

[2] Sontag, *Illness as Metaphor*, 64. Sontag argues the use of military metaphors in cancer reaffirm body/mind divisions and justify the use of medical interventions that are often "worse than the disease."

[3] Ellen Leopold, *A Darker Ribbon: A Twentieth Century Story of Breast Cancer, Women, and Their Doctors* (Boston, MA: Beacon Press, 2000): 26.

"liberties and democratic processes" through vigilance and taking action to prevent unrestrained growth of the "huge industrial and military machinery of defense." Eisenhower saw the growth of this "machine" as linked to technological advances and the "prospect of domination of the nation's scholars by Federal employment, project allocations, and the power of money."[4] A decade later (1971), health policy activists John and Barbara Ehrenreich co-authored *The American Health Empire: Power, Profits, and Politics*, and, reframing Eisenhower's warning, they describe a rapidly rising U.S. "medical-industrial complex."[5] They inform readers that in 1969, "the nation spent over $62 billion on medical care,"[6] and that American healthcare is becoming a "big business, [a] profitable business, and [a] booming business."[7]

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[4] In his final speech to the nation and just days before John F. Kennedy took office, U.S. president, Dwight D. Eisenhower, warned the nation that constant vigilance to prepare for threats from aggressor nations meant that America must have a ready and well-armed military force. However, in the aftermath of World War II and the Korean War, we faced another, insidious threat from within, the rise of a "military-industrial complex." He told the American Public, "This conjunction of an immense military establishment and a large arms industry is new in the American experience. The total influence--economic, political, even spiritual--is felt in every city, every State house, every office of the Federal government. We recognize the imperative need for this development. Yet we must not fail to comprehend its grave implications. . . . In the councils of government, we must guard against the acquisition of unwarranted influence, whether sought or unsought, by the military-industrial complex. The potential for the disastrous rise of misplaced power exists and will persist. We must never let the weight of this combination endanger our liberties or democratic processes. We should take nothing for granted."
See the full transcript of Eisenhower's farewell address at http://avalon.law.yale.edu/20th_century/eisenhower001.asp.

[5] See, Barbara Ehrenreich and John Ehrenreich, *The American Health Empire: Power, Profits, and Politics, A Health-Pac Book* (New York: Vintage, 1971), 95.

[6] Ehrenreich and Ehrenreich, 95.

[7] Ibid.
Ehrenreich and Ehrenreich note that "It has become fashionable to look at the profit-motivated health industrial forces to lead the way out of the health services crisis" (123-124). Healthcare remains a big business and enormous expense in the U.S.
Additionally, although there is no universal healthcare program in the U.S. and America lags behind other developed nations in many health outcome markers, the U.S. continues to spend more on public health that all other nations. See, Bradley Sawyer and Cynthia Cox, "How does Health Care Spending in the U.S. Compare to Other Countries?" *Peterson-Kaiser Health Tracker System*, last modified December 7, 2018. Accessed 22 December 2018. https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-average-wealthy-countries-spend-half-much-per-person-health-u-s-spends.
See also, The Commonwealth Fund, "U.S. Spends More on Healthcare than Other High-Income Nations But Has Lower Life Expectancy, Worse Health. *The Commonwealth Fund.* 8 October 2015. Accessed 7 December 2018. http://www.commonwealthfund.org/publications/press-releases/2015/oct/us-spends-more-on-health-care-than-other-nations.
See also, Kapitall, "All the Countries That Have Universal Healthcare," *Nasdaq.* 7 March 2017. Accessed 7 December 2018. https://www.nasdaq.com/article/all-the-countries-that-have-universal-healthcare-cm757323.

Like Eisenhower, they warn that if the public does not become aware of and involved in civic action to pressure government to intervene, the medical-industrial complex will grow unchecked, the mounting cost of healthcare will continue to escalate, and the growing disparity of health between America's wealthiest and poorest will expand.[8] In the later 20th century, investors in the construction of state-of-the-art medical treatment centers, pharmaceuticals, and diagnostic and treatment technologies realized they could generate lucrative profits from charging insurance companies exponentially increasing rates.[9] Rising costs made it nearly impossible for most Americans to pay for quality care without insurance, and insurance companies, in turn excluded more diagnostic procedures and preexisting conditions from coverage and charged more for patient premiums and deductibles.[10] As Ehrenreich and Ehrenreich observed, the machinery of a medical-industrial complex was rapidly increasing its size and the scope of its effects on Americans' economic and physical health.

In October of 1971, the same year *The American Empire* was published, President Richard M. Nixon, in a bid to get out ahead of Senator Ted Kennedy's healthcare reform platform and secure the win of a second term in office, announced that he was declaring "war"

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[8] Eisenhower's and Ehrenreich's predictions have born true. According to the Henry J. Kaiser Family Foundation, national spending on healthcare rose sharply from 1970-2000 and has continued to rise steadily since then. In 2016, the national expenditure for healthcare was $3.3 trillion, or 17.9% of the GDP. A statistical study on poverty and health in 2017 shows not only that "poverty is positively correlated" with diseases and illness, but also that it is "the strongest indicator" of negative health outcomes.
See, "How Much Does the U.S. Spend on Health, and How Has It Changed?" *Health Care Costs: A Primer. Kaiser Family Foundation.* 1 May 2012. Accessed 3 March 2018. https://www.kff.org/report-section/health-care-costs-a-primer-2012-report/.
See also, "National Center for Health Statistics, Health Expenditures," *Centers for Disease Control and Prevention.* 3 May 2017. Accessed 3 March 2018. https://www.cdc.gov/nchs/fastats/health-expenditures.htm.

[9] See, Elizabeth Rosenthal, *An American Sickness: How Healthcare Became Big Business and How You Can Take It Back* (New York: Penguin, 2017) 13-21.

[10] This state of affairs largely remains the same, and while the Patient Protection and Affordable Care Act of 2010 was designed to curtail the worst exploitative practices in healthcare and bolster Medicare and Medicaid, healthcare costs in the US remain higher than in other "high income countries." See, https://jamanetwork.com/journals/jama/article-abstract/2674671.

on cancer.[11] After decades of military conflicts in World War II, Korea, and ongoing losses in Vietnam, Americans had become disenchanted with foreign wars. Nixon's declaration of a "war" against cancer, a deadly enemy not overseas, but on the home front, proved a stroke of political genius. Widely supported by the public and congress, millions of dollars of new federal funding were allocated to support the cancer war.[12] These developments served to further fuel the rapid expansion of the for-profit medical system Ehrenreich and Ehrenreich were already warning of. Almost fifty years later, war metaphors continue to dominate the discourse and shape our thinking about cancer,[13] and cancer remains a leading cause of death in the U.S. and worldwide.

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[11] James S. Olson, *Bathsheba's Breast: Women, Cancer, and History* (Baltimore, MD: The Johns Hopkins University Press, 2002), 125.

[12] Nixon's framing of cancer as a "war effort" tapped into nationalism and a sense of a shared threat the country was willing to put money and resources toward (Olson 125). Months later, Senator Birch Bayh announced that he would not be making a run for the presidency because his wife, Marvela, was recovering from breast cancer surgery. This announcement, followed soon by news of Shirley Temple Black's mastectomy, brought breast cancer into the American public spotlight (Olson 126). With congressional support of 100 million dollars in new funding for the National Cancer Institute (NCI), Nixon converted an army biological warfare base, Fort Derrick in Maryland, to a cancer research center, and in December 1971, he signed the National Cancer Act, making higher levels of NCI funding a top priority. With this legislation and the symbolic appropriation of a biological warfare facility for cancer research, the U.S. "war on cancer" was officially underway.

For more, see, Surveillance, Epidemiology and End Results (SEER), "Cancer Facts & the War on Cancer," *National Cancer Institute,* Accessed 12 April 2018. http://training.seer.cancer.gov/disease/war/.

[13] While Nixon can be credited with the rise of a cancer-industrial complex with his direct conflation of military metaphors and funding and military property assets to cancer treatment, he did not "invent" the war metaphor in cancer. As Baron Lerner's (2001) research details, the American Society for Control of Cancer (ASCC), which eventually became the ACS, launched a "campaign" in 1936 to raise breast cancer awareness at a time the disease was unspeakable. The "Women's Field Army" (WFA) was comprised of female volunteer members, who, for at least a $1 annual donation, could "enlist" in the army, complete with uniforms, insignia and rank for members. The women of the WFA, volunteers numbering up to 700,000 members by 1943, hosted community cancer education events and passed out pamphlets in public places to educate "civilian" about the importance of early cancer detection. This early iteration of a cancer war/public education campaign was unlike modern breast cancer activism and patient education organizations in that it was not tied to commercial interests. Operational funds were raised by local members. The success of the WFA is attributed the organizational and fundraising efforts of Margorie Bullock Illig, a radiologist and early member of the ASCCs According to Richard Carter (1992), as the Women's Field Army grew in numbers and influence, soon becoming the most powerful lay public health lobbying group, the mainstream (and male controlled) medical community began to feel threatened by women seeming to act and claim knowledge in their sphere with the money and the power to affect national healthcare policy and practices in cancer patient education. Under rising pressure from within the ASCC, the WFA was eventually discontinued during its reorganization to the modern ACS.

For more, see Baron Lerner, *The Breast Cancer Wars: Fear and the Pursuit of a Cure in Twentieth-Century America* (New York: Oxford University Press, 2001), [Kindle Edition], Kindle Location 567-574.

See also, William B. Anderson, "'We Can Do It': A Study of the Women's Field Army Public Relations Efforts," *Public Relations Review 30* (2004): 187-196.

In 2001, after experiencing her own crossing into the kingdom of the sick[14] with a breast cancer diagnosis, Barbra Ehrenreich refines her earlier critique of the medical-industrial complex to name the "cancer-industrial complex" (CIC), she finds herself within. The label cancer-industrial complex aptly emphasizes not only the status of cancer as a leading health threat, but also as a driver of healthcare politics and policies, rapidly increasing individual and national healthcare and pharmaceutical costs, and commercial gains in a for-profit medical system. For those like Ehrenreich who cross into the kingdom of the sick via the CIC, there is no single point of entry, but rather an assembly of interconnected social institutions and agents; the "parts" of the "machine" that crossers' experiences are directly or indirectly influenced by. Government agencies like the National Cancer Institute, the health insurance industry, cancer nonprofits like the American Cancer Society, public and private hospitals, cancer research centers, medical schools, pharmaceutical companies, special patient education media and publishing companies, and medical technologies for detecting and treating cancers—these and more affect what cancer patients are taught and what they learn in their educational encounters within the CIC.

For women with a BGC diagnoses, they may find there is a distinct focus on the feminine or a "pink tinge" to their encounters not evident in the rest of the CIC. Ehrenreich notes her awareness of this, describing a "breast cancer culture" centered around a "cult of pink kitsch" and cheery breast-cancer soldier-survivors.[15] A femininity-first focus advances a notion that a woman's demonstration of feminine-coded, gendered behaviors during and after cancer treatment is vital to her recovery. In the BGC sector of the CIC, the enduring cancer war

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See also, Richard Carter, *The Gentle Legions: National Voluntary Health Organizations in America* (New Brunswick, NJ: Transaction Publisher, 1992) 152-162.
See also, Sharon Batt, *Patient No More: The Politics of Breast Cancer* (Charlottetown, Canada: Gynergy Books, 1994), 216.

[14] Sontag, *Illiness as Metaphor*, 3.

[15] Barbara Ehrenreich, "Welcome to Cancerland: A Mammogram Leads to a Cult of Pink Kitsch," *Harper's Magazine* (2001): 47-48.

metaphor is given a revised, gendered interpretation that both appeals to and reauthorizes heteronormative femininity in cancer. Even when she is sick, a woman with cancer may be reminded of her womanly identity and informed of its vital tie to her physical and mental health. Gender values messages in BGC formal and informal patient education are not happenstance. Rather, they are a consequence of what Martin (2011) calls the "deep structure of educational thought," her term for the longstanding, guiding premise in education of a divided notion of a body/mind that reaches back to Platonic philosophy.[16] This dualist notion of life is reinforced through various educating agents (homes, religious institutions, schools, hospitals) and extrapolated to justify other hierarchal binaries, including man/woman.[17] The resulting gender biases may be subtly or overtly enacted in patient interactions with physicians, nurses, and other healthcare workers, communicated via social codes of behavior, and in the physical environment and its objects, including medical technologies. Additionally, there are strong economic and political incentives for re-affirming gender as significant to cancer recovery.

These interests strategically use war metaphors to fuel a "pink war machine" that generates and perpetuates gender-subordinating conditions in BGC treatment and trains women to become soldiers in a pink war. Outside the CIC and on the "well" side of the border, there are hundreds of civilian contractors who keep the war machine running and enjoy the profits that it generates. This includes manufacturers and retailers of BGC cancer awareness-themed merchandise, corporate sponsors of nonprofit awareness campaigns, and commercial industries that manufacture, market, and sell products to the public that contain known or suspected carcinogens. Additionally, sex and gender healthcare policies and workplace, housing, and educational protections from gender discrimination such as Title VII of the Civil Rights Act of

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[16] See, Howard Robinson, "Dualism", *The Stanford Encyclopedia of Philosophy* (Fall 2017 Edition), Edward N. Zalta (ed.), Accessed 21 January 2019. https://plato.stanford.edu/archives/fall2017/entries/dualism/

[17] See, Martin, *Education Reconfigured,* 28.

1964 and Title IX of the Education Amendments Act of 1972 may affect the experiences of both cisgender and transgender persons with breast cancer. Popular entertainment and news media, religious groups, ethnic communities, schools, workplaces, government, businesses, and the family—all these institutions and more shape our understanding of sex and gender and how health and illness are understood as embodied conditions with moral significance. They may all support pink war machine education.

The Pink Ribbon Battle Standard

By 1985, the cancer war campaign Nixon started was still going strong, and, on the rising tide of the medical-industrial boom it helped to promote, the American Academy of Family Physicians, AstraZenica pharmaceuticals, and several cancer nonprofit organizations jointly launched the first "National Breast Cancer Awareness Month" (BCAM) campaign. In 1990, George H. W. Bush was the first president to officially proclaim October as BCAM, a tradition that has been followed by each successive president. Within a twenty-year timespan, BCAM became an international event, endorsed and supported by hundreds of nonprofit organizations, governments, and corporate partnerships. Pink ribbons, first widely used to symbolize breast cancer as a cause in 1992, became the BCAM battle standard. While the phenomena of the pink ribbons is now self-evident, the educative significance of this symbol is best understood by tracing its development.

In the late 1980s and early 1990s, AIDS activists, Mothers Against Drunk Driving, and the National Family Partnership's anti-drug "red ribbon week" campaigns began using red ribbons as symbols for their respective causes.[18] Following from this tradition, Charlotte Haley, a California woman, started producing breast cancer awareness ribbons from her home in 1992.

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[18] Sarah E. H. Moore, *Ribbon Culture: Charity, Compassion, and Public Awareness* (New York: Palgrave Macmillan, 2010," 57-63.
See also, Gayle Sulik, *Pink Ribbon Blues: How Breast Cancer Culture Undermines Women's Health* (New York: Oxford University Press, 2012): 27-45.

Haley, who had lost many relatives to breast cancer and whose daughter was diagnosed at age 41, cut peach-colored ribbons in her home and pinned them to cards that read, "[The] National Cancer Institute annual budget is $1.8 Billion. Only 5% goes for cancer prevention. Help us to wake up our legislators and America by wearing this ribbon."[19] Haley gave the ribbons to women in her local community and sent them to prominent women across the country. A few months later, *Self* magazine published an article about Haley's peach ribbons, and she was inundated with ribbon requests from all over the country. Alexandra Penney, *Self's* editor-in-chief, and Evelyn Lauder, guest editor for an upcoming *Self BCAM* issue and senior vice president of the Estée Lauder corporation, approached Haley to use her ribbon for a cover story in 1992. Haley refused on grounds that she did not want the ribbon to become commercialized. Rebuffed by Haley, Lauder and Penney consulted lawyers and selected a new color for their ribbon, pink.[20]

Lauder's and Penney's choice of pink, already "the quintessential female color" for their new ribbon, proved to be a stroke of marketing genius.[21] The pink ribbon was a symbolic way for women with breast cancer to (re)affirm their femininity and status as soldiers in a home front war fought on the battlefields of their bodies. However, in the early decades of the twentieth century, the color had another association that the ribbon tapped into. The phrase "in the pink" generally meant "in perfect health." Being "pink" also has earlier connotation in English of achieving a pinnacle of some quality, as when Mecurio exclaims that he is "the very pink of

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[19] Samantha King, *Pink Ribbons, Inc.: Breast Cancer and the Politics of Philanthropy* (Minneapolis: University of Minnesota Press, 2006). [Kindle Edition]. Kindle Location 353-365.
See also, Fernandez, Sandy M., "History of the Pink Ribbon: Pretty in Pink," *Think Before You Pink: A Project of Breast Cancer Action* (1998). Accessed 14 January 2018. http://thinkbeforeyoupink.org/resources/history-of-the-pink-ribbon/.

[20] Ibid.

[21] "Think Before You Pink® Toolkit," *Breast Cancer Action* (2012). Accessed 15 January 2018. https://bcaction.org/site-content/uploads/2010/11/2012-Think-Before-You-Pink-Toolkit.pdf.

courtesy" in Act IV of Shakespeare's *Romeo and Juliet* (1597).[22] If "pink" is the epitome of an ideal, the "quintessential" color for femininity, and it is associated with health, then, in a breast cancer context, pink ribbons effectively tie together heteronormative notions of a feminine ideal, wellness, and consumerism.

At a visual level, there is a suggestion that purchasing pink products is a means for women with breast cancer to be healthier and more feminine and to "belong" to a community of others within the breast cancer movement, taking action to advance awareness of breast cancer as an epidemic affecting millions of persons. However, when a hospital breast center displays posters, murals, and even sculptures of pink ribbons, are these symbols equally welcoming and reassuring to persons of all genders and sexualities seeking treatment? For persons who do not desire to identify as "feminine" but still seek treatment, is there a sense in which they are made to feel deviant, not living up to the pink standard? For that matter, for reason of personal ethics, not all cisgender women feel comfortable with the pink ribbon either.

Pink War[23] Boot Camp: Training Pink War Soldiers for Gender Subordination

A cancer diagnosis disrupts careers, social life, parenting and family life, sexual relationships, educational pursuits, and all other areas of life inside and outside the CIC. A cancer patient may face what seems like reams of repetitive insurance and hospital forms to fill out and file, expenses, medications to manage, appointments to keep track of, and a myriad of

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[22] William Shakespeare, *The Tragedy Romeo and Juliet* (1597). [Online] *Open Source Shakespeare,* (n.d.), (2:4, line 1217). Accessed 12 June 2018. https://www.opensourceshakespeare.org/views/plays/play_view.php?WorkID=romeojuliet&Act=2&Scene=4&Scope=scene.

[23] While the in the late twentieth century many ribbon colors were adopted for various cancers—pink for breast cancer and purple generally for all gynecological cancers with teal specifically for ovarian cancer, teal and white for cervical cancer, peach for uterine and endometrial cancer, light blue for vaginal cancer, and light purple for vulvar cancer, I am using "pink" here not only to signal breast cancer's cultural prominence, but also because of dominant cultural associations of pink as a "feminine" color in the twentieth and twenty-first centuries.
See, "Home" page, *The Betty Allen Gynecological Cancer Foundation* (2019). Accessed 15 February 2018. https://www.gyncancerfl.org/.
See also, Catherine Zuckerman, "Pink and Blue: Coloring Inside the Lines of Gender," *National Geographic*, last modified January 2017. Accessed 12 February 2018. https://www.nationalgeographic.com/magazine/2017/01/pink-blue-project-color-gender/.

physical and emotional effects from cancer and its treatment. Online cancer forums are places where the newly diagnosed can pose questions, share their stories, and learn from seasoned cancer war “veterans.” Often these cancer-veterans offering help and advising frightened newcomers are themselves facing dire health threats. Frequently, those who have been living with cancer (and dying from it), identify themselves in their posts with an online name; their cancer “rank” and pharmaceutical protocol (the serial number of the CIC). These are the credentials for forum membership. For example, “Cat-a-Corn” has “Stage 4 Endometrial Stromal Sarcoma/chemotherapy Paraplatin (carboplatin);” “HeartofTexas” is “Stage IIIb cervical cancer/chemotherapy Taxol (paclitaxel);” and “Sistersorrow” is “Stage IV breast cancer with bone marrow metastasis/hormonal therapy Faslodex (fulvestrant).”

Immigrants living in the land of the sick like these women learn a specialized medical discourse that most of those who have not made the culture crossing do not know and never want a reason to learn. Aside from learning the names, stages, symptoms, and treatment protocols for their diseases, people with cancer gain an “insider” knowledge that is largely experiential. A person cannot really know the burning sensation of chemotherapy drugs flowing through her veins until she herself is having an infusion. She cannot know the sensory or emotional experience of being in a chemotherapy treatment room, the air frigid with the sharp, acrid smell of toxic chemicals. She cannot know what it feels like to sit in a cracked, vinyl reclining chair, offered only the comfort of a threadbare and faded hospital blanket. If she needs to use the bathroom, she must carefully make sure the rubber tubes attached to her arm or port are not tangled or dragging. She must wheel her IV pole with her into the bathroom. Other chairs in the room are occupied by other sick and dying people, all isolated from each other, looking down at cell phones, books, and outdated magazines. A cheery hospital volunteer comes around offering crackers for nausea, caps hand-knitted by volunteers, and reading material to help pass the time during the two-hour transfusion. On the top of the aide's basket is book with a sunny, yellow dustjacket--*The Gift of Cancer.*

A new pink war machine recruit or a person without cancer cannot yet know the experience of having her hair begin to fall out around her like a soft, silent rain while she showers, works, eats, or reads her child a bedtime story. She cannot know the pain of mouth sores from chemotherapy, yeast infections on the skin, an abscessed surgical site that refuses to heal, what it is like to empty the red-tinged fluid from breast drain bulbs after surgery or her own excrement from an ostomy bag. She cannot know what it is like to go about daily life with "chemo brain" and "bone tiredness;" nausea, an altered sense of smell and taste, and blurred vision. The outsider does not know what it is like to be targeted by the stares of curious strangers in a grocery store, the awkward, skirting glances and conversational pauses when she runs into acquaintances or even friends who don't know what to say to her. The uninitiated cannot know what living with an invisible countdown timer over one's head is like while the rest of the world is oblivious and inured to anyone's death so long as it is not their own or their closest relatives. Unless doctors, nurses, and other healthcare workers themselves have been on the patient side of the provider/patient divide, they cannot know what these experiences are like either, even if their credentials give them the authorization to recognize or refuse their patients' somatic knowing.

Within the CIC's pink war machine, narratives about cancer in culture, politics, economics, education, and healthcare overlap and blend. These narratives, which in large part shape how we understand and respond to cancer, frame it as an enemy to fight, contain, and destroy. However, cancer is not a contagion that spreads in community. There is no "anticancer vaccine," and cancer is not thought to be a public risk in the large-scale way communicable diseases are (although cancer's rising global rates make it arguably a pandemic). Rather, it is a threat only to the lives of singular individuals in whose bodies the disease manifests and lives as a collection of multiplying, “rogue” cells. As an enemy from within, cancer is understood as the result of individual actions—what one did or did not do—to adversely affect health, or an unlucky genetic lottery ticket. Once cancer is diagnosed in the unfortunate, she becomes a war machine recruit, a soldier drafted in her own cancer battle. What is emphasized in the CIC is the reality of a person living under constant threat, the need for due diligence against that threat, and an uncompromising commitment to do whatever it takes to “win” the war.

Being a CIC soldier means relying on diagnostic imaging and pathology intelligence reports, chemical-pharmaceutical munitions, and following the orders of her medical commanding officers. As the lowest person in the chain of CIC command, being a “good” soldier means being biddable and amicable to the commands of authority. A patient-soldier has only two duties—to comply with medical orders and to yield her body as a battleground for cancer wars. However, between battles, she has “furloughs” that return her to civilian life, and there are many gender-affirming products and services the cancer patient can receive for free or purchase at discounted rates while she rests up for the next round of battle.[24] There are online and physical spaces where she can share war stories and physically and mentally train with other soldiers. There are also hundreds of cancer guidebooks, cookbooks, and memoirs she can read to learn instructions for survival and be inspired to follow. Among agents of the CIC, she learns there is common gender “script” and “scrip” traded back and forth across the well-sick border.

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[24] Nurses and volunteer advocates may direct cancer patients to stores and programs where they can purchase hair and breast prosthetics at discounted prices, buy fashion, jewelry, and cosmetic products appealing to cancer survivor identity, get house cleaning services and others at free or reduced costs.
For example, See Cancer Horizons, “Free Products and Services for Cancer Patients,” *Cancer Horizons* (n.d.). Accessed 19 March 2019. https://www.cancerhorizons.com/free-stuff/.
See also, The Breast Cancer Research Foundation, “Shop Pink, Save Lives,” *BCRF* (n.d.). Accessed 19 March 2019. https://www.bcrf.org/shop-pink.

Gender biases in culture reflect a longstanding hierarchy that privileges the knowledge, skills, and virtues attributed to males or defined as “masculine.” Idealizations for the female/woman/feminine and the male/man/masculine intersect with other culturally constructed social identity markers such as race, ethnicity, class, age, disability, weight, etc. and serve as a basis for conferring or denying social approval and access to resources. As philosopher Marilyn Friedman (2003) points out:

> To the extent that women are subordinated to men in the traditions and practices of a community, a community expresses its collective view that women are incapable of this achievement-or less capable, at any rate, than men. Around the world, women are generally subordinated to men, not only in the political and economic spheres in which women's lesser participation alone might render them less capable on average of directing their own lives, but also in the spheres of sexuality, marriage, reproduction, and family-spheres of life in which women specialize.[25]

Gender subordination is not an original product of the pink war machine. Rather, it is present within its CIC settings as a *preexisting condition,* a cultural import across the fabricated border between the well and the sick. Responses to cancer in the CIC pink war machine and in the wider community reinforce expectations that females submit to male/masculine authority.[26] In the array of CIC settings, gender messages may be transmitted in a variety of ways, for example, the spaces and décor of waiting areas and treatment rooms, the colors and patterns of examination gowns,[27] art and informational posters on walls, patient education pamphlets, or the ways a nurse, doctor, lab, or diagnostic imaging technician interacts with female patients—all may convey subtle or overt messages about gendered expectations as to what patients find reassuring and how patients

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[25] Marilyn Friedman, *Autonomy, Gender, Politics* (New York: Oxford University Press, 2003) [Kindle Edition]. Kindle Location 3261-3266.

[26] For brevity’s sake, when I refer to the CIC from here on, I am focusing on its BGC-pink war machine-driven sector. While gender-subordination is undoubtedly a widespread condition of the CIC, this study focuses on the education of women with breast and gynecological cancers as revealed primarily in autobiographical testimony, narrative studies, and feminist criticism of BGC practices and “cancer culture.” I about women’s or men’s gendered learning in other cancers.

[27] I have seen surgical tape in breast treatment centers decorated with pink ribbons and flowers.

ought to behave.[28] These are just a few examples of ways gendered expectations may be manifest in the CIC. And while these messages might be so subtle as to go unnoticed, as Martin reminds us, education is a "gendered process."[29]

Additionally, just as gender is an "import" from the land of the well to the land of the sick, so too, are other intersecting markers of social identity and discriminatory labels that may enhance both social unity and disruption, egalitarianism and experiences of oppression. Just where gender intersects with sex, race, ethnicity, sexual orientation, social class, age, disability, body weight, etc., marks each culture crosser's individual experiences of CIC treatment and can positively or adversely affect health outcomes. This realization is critical both in the sense of developing critical perspectives on the CIC and in the sense that it is urgently necessary to take stock of the messages transmitted through various patient education sources.

While I am arguing that messages transmitted to CIC cultural crossers with breast and reproductive cancers are in large part gender-subordinating and in need of change, I am not suggesting that miseducation and GS are the only outcomes of CIC-pink war machine learning. For example, while Audre Lorde is generally critical of her encounters post-diagnosis, she also highlights instances of receiving helpful guidance, valuable information, and well-intended encouragement.[30]

Mechanisms of Control

The education of BGC female soldier-survivors takes place across and within numerous CIC-pink war machine settings where women are trained to internalize a soldier-survivor identity

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[28] See, Debra Roter and Judith A. Hall, *Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits* (Westport, CT: Praeger, 2006), 62-63.
See also, Susan Sared and Ephraim Tabory, "You are a Number, Not a Human Being: Israeli Breast Cancer Patients' Experience with the Medical Establishment," *Medical Anthropology Quarterly 13,* No. 2 (1999): 223-252.
See, Trudy E. Darty and Sandra J Potter, "Social Work with Challenged Women: Sexism, Sexuality and the Female Cancer Experience," *Human Sexuality in Medical Social Work,* Larry Lister and David A. Shore, Eds., (New York: Routledge, 2009), 83-100.

[29] Martin, *Education Reconfigured*, 33.

[30] Lorde, *The Cancer Journals.*

through hidden and overt curricula. As Michel Foucault notes in *Discipline and Punish: The Birth of the Prison* (1975/2012), there is a commonality among prisons, hospitals, schools, and the military in their shared focus on the body as "an object and target of power" to be "manipulated, shaped, [and] trained" and directed toward some capacity the state deems good for public welfare.[31] It is not accidental that "discipline," "teach," and "education" are synonyms (OED), that the word "doctor," from the Latin verb *docere,* means "to teach," or that "patient" from the Latin adjective *patientem* means "suffering," "bearing," or "enduring." Above all else, a good soldier, a brave soldier, endures, right up to the point of death. Distinct from a medical mission to save lives and the Hippocratic Oath to do no harm is a reigning pink war machine educational motto, *semper fidelis femin,* to be always faithful to and defined by "feminine virtue," even and especially after a BGC diagnosis.

From my engagement with critical feminist responses to breast cancer, BGC autobiographical narratives, and my own experience, I see three common manifestations of gender-subordinating education that, while linked and overlapping, are helpful to examine individually for clarity's sake: Pink War Commerce, Medical Authoritarianism, and Pink War Normative Narratives. In the following section, I consider how each of these three educating practices leads to four, recurring effects of gender-subordinating, body-mind discipline inside the pink war machine: Compelling conformity, violating women's bodies, suppressing and killing women's voices, and limiting and distorting women's learning.

Pink Commerce

Every year there are hundreds, if not thousands, of pink war cause-marketing campaigns. One example is the Ford Motor Company and Susan G. Komen partnership's "Warriors in Pink" program," which, among the tee-shirts, caps, and other pink-patterned products, included an

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[31] Michel Foucault, *Discipline and Punish: The Birth of the Person*, trans. Alan Sheridan (New York: Vintage Books, 1977), 136.

apron in the 2017 campaign sold under the label "Courage in the Kitchen." This $34.00 apron ($14.55 of each purchase earmarked for cancer research), harkened back to 1950s-era sitcoms in its gendered, domestic connotations. It seems the intended message was that if a woman is tired and sick after a chemotherapy treatment, she can take consolation in knowing she is courageously soldiering on, cooking family meals and performing other domestic chores.[32] Ford is only one of thousands of global corporate sponsors for BCAM yearly. For example, our kitchen soldier can prepare meals with a bright pink, Kitchen Aid "Cook for the Cure" mixer (retail price $300), also supporting Susan G. Komen,[33] and again, while she "cleans for the cure" with a pink mop or vacuum.[34] If she wants to complete her domestic warrior ensemble, she can don a "fight like a girl," t-shirt,[35] a rhinestone-encrusted, pink-ribbon survivor cap, and a pair of pink ribbon clogs, running shoes, or, for more formal occasions, stilettos.[36] If she is handy

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[32] See, Beverly Brigman, "Discover Ideas About Kitchen Aprons," *Pintrest.* (n.d.). Accessed 21 January 2018. https://www.pinterest.com/pin/427912402068476491/?lp=true .
The idea of an apron for awareness and courage in the kitchen is reminiscent of the 1938 Kellogg's "Pep" cereal print ad that shows a photographed image of man dressed in a suit embracing a woman who wears an apron, a smile, and holds a feather duster. The caption, presumably what the man thinks or says aloud is, "So the harder a wife works, the cuter she looks!"
See also, "Odd Ads: Kellogg's PEP Cereal, 1930s," *History by Zim: Beyond the Textbooks* (blog), July 27, 2013. Accessed 21 January 2018. http://www.historybyzim.com/2013/07/odd-ads-of-the-past-pep-vitamins/.

[33] See, Kitchenaid "'Cook for The Cure' Pink Kitchenware Products – Support Breast Cancer Research Foundation," *I Shop Pink Blog: Pink Products and Reviews.* (n.d.). Accessed 21 January 2018. http://www.ishoppink.com/blog/kitchenaid-cook-for-the-cure-pink-kitchenware-products-support-breast-cancer-research-foundation/.

[34] "American Cleaning Supply, Inc.," *Susan G. Komen Breast Cancer Foundation, Inc*. Accessed 12 December 2018. https://ww5.komen.org/American-Cleaning-Supply-Inc/ .

[35] "Fight Like a Girl 'Knockout' Ladies' V-Neck T-Shirt – Black w/Pink," *Fight Like a Girl: Official Gear*. Accessed 12 December 2018. https://www.fightlikeagirlclub.com/official-gear/fight-like-a-girl-knockout-ladies-v-neck-t-shirt-black-w-pink.

[36] "Cape Clogs Pink Ribbon (Women's), *Shoes.com*. Accessed 12 December 2018. https://www.shoes.com/cape-clogs-pink-ribbon/198145 .
See also, "ASICS Women's GT-10004 Pink Ribbon Running Shoes," *Amazon.* Accessed 21 December 2018. https://www.amazon.com/ASICS-Womens-GT-1000-Ribbon-Running/dp/B00Q4V29ZI.
See also, Glitter Me Badd, "Breast Cancer SURVIVOR Heels," *Etsy*. Accessed 21 December 2018. https://www.etsy.com/listing/181827438/breast-cancer-survivor-heels?ga_order=most_relevant&ga_search_type=all&ga_view_type=gallery&ga_search_query=breast%20cancer%20shoes&ref=sr_gallery-1-9 .
See also, "Ellie Shoes 6 High Heels Sandals Breast Cancer Awareness Beige Dorsay Platform Pumps," *Amazon*. Accessed 21 December 2018. https://www.amazon.com/Ellie-Shoes-Sandals-Awareness-Platform/dp/B0099RLZCM/ref=sr_1_9?ie=UTF8&qid=1537135946&sr=8-9&keywords=breast+cancer+shoes .

around the house, she can do home repairs and improvements with a pink toolkit,[37] or install a pink toilet or jacuzzi.[38] For those who want to wield more than a pink paring knife, screwdriver, or garden sheers, there is a pink crossbow for $450.99 with $10 in proceeds donated to breast cancer charities[39] and "Shoot for the Cure," body silhouette target practice sheets.[40]

Compelling conformity and violating bodies through pink purchasing. There is a sense in which the purchasing of pink kitchenware, tools, clothing, etc. is like displaying the flag on Veterans and Memorial Day. It conveys to others and affirms for oneself a patriotic identity and pays tribute to pink war active-duty soldiers and war veterans alive and fallen. The sale of pink ribbon products, especially during BCAM, is ubiquitous. Products are sold in retail clothing stores, grocery stores, pet stores, the post office, and in online stores. There is a constant, subtle (and not-so-subtle) pressure to buy, and, as feminist critics have pointed out, an effect of all this pink ribbon "branding" is distracting consumers from considering the manufacture and use of products with known or suspected links to increased cancer risk.

For example, Estee Lauder's Advanced Night Repair Synchronized Recovery Complex II, a facial serum marketed to women to "significantly reduces the look of key signs of aging,"[41] is sold during BCAM in a special edition pink bottle (retail cost $98). This campaign and many

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[37] "Apollo Tools 69 Piece Women Essential Took Kit," *Amazon*. Accessed 18 January 2019. https://www.amazon.com/Apollo-Precision-Tools-DT0423P-Household/dp/B003XU7VL0/ref=sr_1_1_sspa?ie=UTF8&qid=1537909791&sr=8-1-spons&keywords=breast+cancer+tool+kit&psc=1.

[38] "Breast Cancer Awareness Month – Let's Help Fund a Cure," *Rubenstein Supply Company.* Accessed 13 November 2018. http://www.rubensteinsupply.com/breast-cancer-awareness-month-lets-help-fund-cure/. See also, "Spas for a Cause – Support National Breast Cancer Foundation with a Pink Spa!" *Freeflow Spas*. Accessed 13 November 2018. https://freeflowspas.com/spasforacause/.

[39] GrabAGun, "Excalibur 6810 Vixen II Fiberoptic," *GrabAGun.com.* Accessed 19 March 2019. https://grabagun.com/excalibur-6810-vixen-ii-fiber-optic.html.

[40] Ibid., "Law Enforcement Targets B-27E-NPT B-27E-NPT Shoot For The Cure Pink Silhouette," *GrabAGun.com.* Accessed 19 March 2019. https://grabagun.com/b-27e-npt-shoot-for-the-cure-pink-silhouette.html.

[41] See, "Advanced Night Repair," *Estee Lauder*. Accessed October 25, 2018. https://www.esteelauder.com/product/681/26959/product-catalog/skincare/advanced-night-repair/synchronized-recovery-complex-ii?gclid=Cj0KCQiAxZPgBRCmARIsAOrTHSajWObN_DTPnorjaY9eoLDUpAg3SNx2-74A3-riGDzzNqPCMP_gzVQaAtRjEALw_wcB&gclsrc=aw.ds#

others like it, appeal to women's learning and internalization of gendered values and vulnerabilities. Targeting an older demographic, the appeal preys on women's fears of losing their appeal as they age. Ageist biases adversely affect women's social status and career potential disproportionately to men. As authors of 2017 working paper from the National Bureau of Economic Research concludes there is "much stronger and more robust evidence of age discrimination against older women than against older men." [42] Women over 50 are also at a higher risk for breast cancer,[43] and the marketing of anti-aging beauty products to women in the CIC spotlights youthfulness and beauty as tied to health and supporting the breast cancer "cause." While Lauder has donated millions of dollars to breast cancer research and education efforts,[44] as numerous critics point out, profits are amassed by corporate sponsors who, in many cases, donate only small percentage of sales to cancer nonprofits and research organizations while keeping consumers' attention, including women with cancer, diverted in fog of pink purchasing.[45]

Lauder's facial serum contains ethylhexyl methoxycinnamate, an endocrine-disruptor that increases the growth of estrogen-receptive cells, which are a known cause of some breast cancers.[46] Lauder is not the only cosmetic company whose products contain known or suspected carcinogens, and it is not the only such company to market beauty products for breast cancer awareness. In effect, while profiting from and reinforcing gender values, supporting breast

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[42] David Neumark, Ian Burn, Patrick Button, "Is It Harder for Older Women to Find Jobs? New and Improved Evidence from a Field Experiment [Working Paper], *National Bureau of Economic Research.* November 2017. Accessed 17 December 2018. https://www.nber.org/papers/w21669.pdf

[43] "Breast Cancer: What are the Risk Factors?" *Centers for Disease Control.* 18 September 2018. Accessed 15 January 2019. https://www.cdc.gov/cancer/breast/basic_info/risk_factors.htm

[44] "Estee Lauder Companies: Breast Cancer Campaign," *Estee Lauder*. (n.d.). Accessed 20 October 2018. https://www.elcompanies.com/our-commitments/the-breast-cancer-campaign

[45] See, Sulik, *Pink Ribbon Blues*, 60.
See also, King, *Pink Ribbons, Inc.,* Kindle Location 785-791.
See also, Barbara Brenner, *So Much to Be Done: The Writings of Breast Cancer Activist Barbara Brenner* (Minnespaolis: Univerisity of Minnesota Press, 2016), 209-210.

[46] "Octinoxate," *Campaign for Safe Cosmetics* (2019) Date Accessed 20 October 2018. http://www.safecosmetics.org/get-the-facts/chemicals-of-concern/octinoxate/.

cancer research, and manufacturing and selling products with ingredients that are unregulated and may be unsafe, companies that profit from the gender self-disciplining of women's bodies may perpetuate mentally and physically harmful preoccupations with conformity to heteronormative notions of feminine beauty and sexual desirability to males, even at the cost of health.

Pink commerce as suppressing voices and limiting learning. Mainstream breast cancer activism has created a global platform for cause marketing, and, for thousands of women worldwide, participation in mainstream, pink ribbon culture is perceived as a vital lifeline and means of gaining a positive focus after a life-altering health crisis. For example, by participating in events like a Komen "Race for the Cure," a person may feel she gains emotional support and that her value is affirmed rather than exploited in receiving corporate-sponsor's gifts. She may feel encouraged to take care of herself by exercising and gain a new focus on nutrition and health along with a sense of belonging to a community of like-minded survivors.[47] Given that thousands of women participate in these events worldwide, claim a survivor identity, and engage in pink "retail therapy,"[48] can we in full assuredness say they are oppressed and just do not know it? This position seems both hubristic and an overgeneralization. A more likely answer is that educational encounters, whatever form they take and wherever they take place, are beneficial to some persons in some ways and harmful and marginalizing to others in some ways. For many women, the benefits of belonging to a community and not feeling alone in the kingdom of the sick may be an important part of recovery. However, as Ehrenreich notes, there is little room for dissenting voices or for acknowledging the voices of women whose lives will not be saved, no

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[47] I make no claim that corporate-sponsored awareness events like the Komen Race for the Cure are solely exploitative or exploitative and gender-oppressive to all women.

[48] See, Liz McNeil, "How Gina de Givenchy's Breast Cancer Led to 'Retail Therapy for Women When They Need It the Most'", *People*, last modified October 16, 2018. See, https://people.com/health/how-gina-de-givenchys-breast-cancer-led-to-retail-therapy-for-women-when-they-need-it-the-most/

matter how hard they train, how many races they run, or how they may be memorialized as "fallen soldiers."[49] Canadian breast cancer memoirist Sharon Batt makes this point even more starkly. She sees cancer charities as "holding up the Rosy [pink-tinted] Filter to breast cancer," and offering "optimistic platitudes disguised as 'education.'"[50] She continues:

> [T]he reassuring slogans encourage us to trust in the system, rather than to ask questions that might reveal weaknesses. When our experience runs counter to the reassurances, we doubt our senses. Women need to know that mammography frequently fails to detect a cancer, that early-detected cancers can be lethal, that women die from breast cancer despite all the proscribed treatments, that five years of survival do not mean you are "home free."[51]

Profit-driven campaigns promoting cancer awareness may also (intentionally or not) promote middle to upper class biases in a variety of patient-education media, such as nonprofit websites featuring online "stores" and links encouraging women to purchase merchandise from partnering sponsors.[52] Encouraging consumerism as a therapy for cancer is also a regular theme in conventional narratives. For example, in her autobiographical breast cancer guide, *A Breast Cancer Alphabet* (2014) Madhulika Sikka gives two thumbs up to "retail therapy," stating, "I can vouch for the therapeutic benefits of shopping for particular items that will make you feel better about yourself."[53] She describes purchasing a new mattress and pillows, and in the chapter, "F is for Fashion Accessories," she argues that purchasing a variety of scarves and earrings is a way to help others respond to a woman's changed appearance from chemo baldness: "Big, bold, interesting earrings. . . . You have license to go a little wild, and you are helping the people around you, giving them something to comment on beyond your naked head. . . . You will feel a

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[49] Ehrenreich, "Welcome to Cancerland," 48.

[50] Batt, *Patient No More,* 233-234.

[51] Ibid., 234-235.

[52] For example, the Susan G. Komen online shop, *ShopKomen.com* sells apparel and other pink-ribbon themed merchandise--shirts, water bottles, backpacks, lanyards, etc. See https://shopkomen.merchorders.com/ Accessed 2 December 2018.

[53] Madhulika Sikka, *A Breast Cancer Alphabet* (New York: Crown Publishing Group, 2014), [Kindle Version], Kindle Location 935-937.

whole lot better."[54] In addition to the message of self-care through purchasing, this message places the onus of social awkwardness on the sick rather than the well who are made uncomfortable. It also seems to not consider the realities of women in the working class who may not have enough money to make a weekly grocery budget work, let alone purchase new earrings or get a manicure. We need to consider whose voices are not heard if pink commerce creates a gendered and class-privileged sense of healthy responses to cancer. What do those who cannot afford to treat themselves learn from pink commerce?

(Pink War) Medical Authoritarianism

In a study of medical students' interactions with patients, Joseph Merrill et. al. (1995) uses the term "medical authoritarianism" to describe medical students demonstrating a set of behaviors including a skeptical, dismissive attitude toward patient complaints, impatience in answering questions and "small talk," and an intolerance for uncertainty and a high need for control.[55] Additionally, these students more than others revealed personal biases affecting their interactions and medical decision-making.[56] While this study did not look specifically at patient gender as a factor in doctors' authoritarian responses, "race and ethnicity are triggers" as are "obesity, substance abuse, chronic pain, psychosomatic disorders, and just old age."[57] Whether a doctor is male or female, attitudes of medical authoritarianism reveal an internalized belief of one's superior status, knowledge, and skills as justifying authority over others. Several CIC fields comprising the "brass" or commanding officers inside the Pink War Machine attract a higher number of students who demonstrate higher levels of authoritarian-tendencies—surgery, pathology, gynecology, anesthesiology, oncology and radiology all attract students who score

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[54] Ibid., 410-413.

[55] Joseph M. Merrill, Lila F. Laux, Ronald Lorimor, John I Thornby, and Carlos Vallbona, "Authoritarianism's role in medicine," *American Journal of the Medical Sciences ,310* No. 3 (1995): 87–90.

[56] Ibid., 89.

[57] Ibid. 90.

high as having authoritarian tendencies. This is not to say that all or even most doctors in these fields demonstrate medical authoritarianism or that it is a demonstrated behavior in only these areas of expertise. However, a perception of medical authoritarianism and medical bullying is attested to in many BGC narratives and qualitative studies.

Compelling conformity and violating bodies. CIC experiences of medical authoritarianism can lead to a patient feeling intimidated, patronized, medically objectified, and even physically abused. The provider can be a doctor, surgeon, nurse, lab tech, or other direct medical or support staff. Patients may tolerate this variety of GS because they do not feel the bullying is a serious enough problem in their care to go to the time, expense, and trouble to seek new medical treatment, or they may be so accustomed to oppression as not to recognize it as a problem. Even if a patient thinks she is receiving poor or abusive care, she may reason that the benefits of necessary medical treatment outweigh the drawbacks.

For example, Katherine Russell Rich (1999) recounts a series of abusive medical encounters in her treatment including a patronizing internist who dismissed her concerns because she is too young to have breast cancer but jokingly offers to "feel her breasts anytime."[58] She also describes a female oncologist who drops Rich from her practice after Rich complains to her that she needs better communication with her doctor,[59] a sadistic CAT scan technician who causes her pain when he brusquely positions her on the imaging table and then leaves her in the machine an extra 30 minutes while he takes a personal phone call, ignoring her cries for help,[60] and a gynecologist who fat shames her before a bone marrow transplant, pointing to Rich's stomach and asking, "What is that? . . . It wasn't there last time."[61] When Rich tells her the weight gain is caused

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[58] Katherine Russell Rich, *The Red Devil: To Hell With Cancer—And Back* (New York: Crown Publishers, 1999), 17

[59] Ibid., 157.

[60] Ibid., 140.

[61] Ibid., 202.

by medications to suppress her hormones and slow the spread of her cancer, the doctor replies, "[Y]ou may want to start watching your calories."[62] Rich reflects, "I'm facing a procedure that kills 10 percent and leaves 80 percent dead in five years, and she's suggesting I work on my abs."[63]

In her memoir of ovarian cancer *In the Body of the World: A Memoir of Cancer and Connection* (2013), Feminist activist, performance artist, educator, playwright and author Eve Ensler likens her treatment of a post-surgical infected abscess in her abdomen to rape. She writes:

> Over the next three weeks, the Sloan-Kettering team will insert tubes on three different occasions into the center of my abscess to drain the pus. Before I know it, the doctor is driving a thick needle attached to a catheter tube through my surgical wound and I yell and tell him it really hurts, but he doesn't stop or drug me properly or even seem to hear me. I scream more and he just keeps going. Afterward I meet with my oncology team, who seem utterly distracted. They tell me they can only begin chemo when the infection is gone and that they have been waiting for me. I feel as if *I have failed.* They send me to another distracted, testy, arrogant doctor dude who makes me feel that my questions are childish and wasting his time.[64]

Given Rich's and Ensler's affluence, education, and access to a variety of medical resources (both are in New York City), one wonders if this is the kind of medical treatment someone who can afford the best gets, what is the worst? If Rich's and Ensler's experiences were outliers, perhaps they could be dismissed as isolated, unfortunate encounters with insensitive doctors and medical technicians. However, as subsequent chapters of this study explore, other breast and reproductive cancer autobiographers recount similar stories of medical bullying.

If a woman internalizes a narrative of self-blame for her disease, reasoning a cancer developed or has not responded successfully to treatment because she "failed" to take care of her health in some way, to fight hard enough, look good enough, or be cheerful enough, such self-miseducating messages can be reinforced through medical bullying encounters. For women who have not yet been diagnosed but suspect cancer and for those who are in treatment for breast or

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[62] Ibid., 203.

[63] Ibid., 203

[64] Eve Ensler, *In the Body of the World: A Memoir of Cancer and Connection* (United States: McMillian, 2013), 614-625. Emphasis mine.

reproductive cancer, feeling medically shamed, blamed, threatened, dismissed as a neurotic hypochondriac, neglected, or otherwise psychologically or physically harmed in treatment can increase feelings of helplessness, anxiety, isolation, etc. As Rich explains, she has a sense of living in "two time zones at once . . . cancer's time and real-world time."[65]

Granted, the majority of breast and reproductive cancer autobiographical narratives (what I have been calling "conventional narratives" in the sense of reflecting mainstream CIC values) do not describe commercial exploitation, compelled conformity, or medical bullying as part of the writer's experience. However, if we recognize that a BGC diagnosis occasions a cultural crossing and new encounters in which patient education and miseducation may take place, then even if accounts of GS seem to be outliers, they should not be dismissed as isolated, subjective, unverifiable, and therefore suspect recollections.[66] For every BGC autobiographical narrative, especially those that do not follow the pattern of the heroic, cheerful, grateful shero and testify to oppression in BGC patient education, how many other's stories go untold? Further, these patient perspectives offer supporting evidence of a recognized male/masculine-normed competitive ethic internalized by medical school students[67] that fosters a culture of hierarchal bullying, a dynamic

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[65] Rich, *The Red Devil*, 37

[66] Here I am thinking of the current political climate, and some responses to the #MeToo movement, the Brett Kavenaugh hearings, and in Trump-era politics, backlash against reproductive rights gains for women, sexual discrimination and harassment protections, and social equity protections for minority groups such as African Americans, Latinos, and LGBTQ folk.

[67] This is the public world, male ethic that Woolf identifies in *Three Guineas* as the value of competing and being competetive for social recognition and resources, including both military and academic hierarchal positions. Consider what Woolf states happens to men in the professional, money-driven world: " [Their] [h]umanity goes. Money making becomes so important that they must work by night as well as by day. Health goes. And so competitive do they become that they will not share their work with others though they have more than they can do themselves. What then remains of a human being who has lost sight, sound, and sense of proportion? (72). Despite the mission of "care" in healthcare, medical schools are not immune from the competitive ethic. Studies find that medical school students have higher rates of depression and suicide than the general population and that women in medical schools have higher rates of depression and burnout than men. See, M. Dahlin N. Joneborg, and B. Runeson "Stress and Depression Among Medical Students: A Cross-sectional Study," *Medical Education Vol. 39*, (2005): 594–604.
Dr. Pauline Chen, M.D. reflects on her negative experiences in medical school as the most "miserable" period of her life: "I knew that I wanted to become a doctor to help people, but I had given little thought to the process. I was poorly prepared for many things: the pressure to excel in ways that seemed so far from caring for people; rapidly

that has been noted across human interactions in medical environments, including doctor-doctor, doctor-nurse, nurse-nurse, and doctor-patient bullying[68] and teacher-student and student-student bullying in medical schools.[69] Bullying in medical education and occupations is often manifest along sex-gender lines, with women experiencing bullying, sexual harassment, and discrimination more frequently than men. Martin's observation that schools are foundational sites of moral learning shaping students' social values and interactions inside and outside schools, even when this education is not part of the formal curriculum, is applicable to adult learners as well.[70]

Doctors act both as gatekeepers and providers of patient medical care. In an immediate and literal sense, a patient may feel a physician or surgeon has control over her life, which helps explain the common phenomena of feelings of parental transference to doctors. Of course, if a patient feels she is not receiving good care, she can seek a second opinion or find another doctor.

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mounting debts I signed off on every semester; a roller coaster existence from chronic lack of sleep; hazing from the more experienced students and residents; and the realities of patient suffering despite my best efforts."
See, Pauline W. Chen, "Medical Student Burnout and the Challenge to Patient Care," *New York Times* 30 October 2008. Accessed 12 October 2018. https://www.nytimes.com/2008/10/31/health/chen10-30.html

[68] See, Whitney Wright and Naresh Khatri, "Bulling Among Nursing Staff: Relationship with Psychological/Behavioral Responses of Nurses and Medical Errors," *Health Care Management Review* 40, no.2 (April/June 2015), 139-147 See, https://journals.lww.com/hcmrjournal/Abstract/2015/04000/Bullying_among_nursing_staff__Relationship_with.6.aspx
See also, Isolde Daiski, "Changing Nurses' Dis-Empowering Relationship Patterns," *Journal of Advanced Nursing*, 48, no.1 (2004), 43-50.

[69] See, Lauren Vogel, "Doctors Dissect Medicine's Bullying Problem," [Online Journal] *Canadian Medical Association Journal (CMAJ) 189* No. 36 (2017): e1161-1162. 11 September 2017. Accessed 20 May 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5595564/.
See also, Ajay Major, "The Problem of Mistreatment in Medical Education," *AMA Journal of Ethics 16* No. 3 (2014): 153-254.

[70] In *The Schoolhome,* Martin argues, "Since all education is moral education, no teacher can safely hide beneath the cloak of subject matter expertise. …one is teaching patterns of conduct. One is also teaching citizenship. See Jane Roland Martin, *The Schoolhhome: Rethinking Schools for Changing Families* (Cambridge MA: Harvard University Press, 1992) [Kindle Edition], Kindle Location 1972.
Even though it is arguably true that children are more impressionable and therefore more vulnerable to internalizing lessons of moral (mis)behavior, it is also true that adult learning prepares students for success in professional settings and cultures. Overt and formally expressed or subtle and understood, social behaviors and values are transmitted in educational settings alongside and sometimes within subject matter. In *Education Reconfigured* (2011) Martin calls sexism and bullying in higher education "'micro-inequalities" of the chilly coeducational classroom." (165).

However, medical costs, which may not be covered by all insurance providers, the time required to schedule a new appointment, distance to alternative providers, the ability to sort through providers, etc. may make a person feel overwhelmed and make seeking an alternative physician an unrealistic option.

Studies of gender-role dynamics in medical interactions suggest that generally, female physicians display more of what Martin calls the moral capacities of the 3C's of care, concern, and connection in patient encounters.[71] Research by Judith Hall, et al. (1994) finds that both female and male patients are given more time and focused attention in clinical settings with female physicians than with males and that "female physicians are more nurturant [*sic*] and expressive and have stronger interpersonal orientations than male physicians."[72] Further, female patients were "more successful in telling their story when with a female physician," as female physicians gave more encouraging verbal and nonverbal cues than males that they were interested in their patients' experiences, concerns, and questions.[73]

However, Harbinder Sandu et al. (2009) found that while female-to-female physician-patient pairings consistently have the longest length of clinical encounters, female doctors epistemically distance themselves from their female patients, distinguishing their superior status by using "more technical bio-medical language" than they do with male patients. Sandu et al. comment that "when dealing with their own sex, female doctors behave more like stereotypical male professionals'; a phenomenon which has been identified amongst females in leadership roles over female employees in other environments."[74] Evidence also suggests a male-normed

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[71] Martin, *The Schoolhome*, Kindle Location 1885-1889.
[72] Judith Hall, et. al. "Gender in Medical Encounters: An Analysis of Physician and Patient Communication in a Primary Care Setting," *Health Psychology, 13*, No. 5, (1994): 390.
[73] Ibid.
[74] Sandhu Harbinder, et. al., "The Impact of Gender Dyads on Doctor–Patient Communication: A Systematic Review," *Patient Education and Counseling 76*, no. No. 3 (2009): 352.
See also, Jane Roland Martin, *Coming of Age in Academe: Rekindling Women's Hopes and Reforming the Academy* [Kindle Edition] (New York: Taylor and Francis, 2000) Kindle.).

bias in widespread dismissive physician responses to women's reporting of pain and other somatic symptoms of illness, a phenomenon which can lead to increased time to diagnosis, misdiagnosis, and less effective treatment, regardless of the sex of medical professionals interacting with female patients.[75]

Distorting women's voices and limiting learning. Some of breast cancer's historic attributions, such as Galen's idea of it being caused by *melancholia* (an imbalance in black bile leading to a depressive personality) or the seventeenth-century surgeon Claude Chapuys de Saint-Amour's assertion that "sadness, boredom, anger, and wrath" cause cancer,[76] have persisted up to the present as the basis for the notion of a "cancer personality,"[77] a designation largely attributed to women who develop cancer. In *Illness as Metaphor,* Susan Sontag (1991) traces the notion of cancer as a corporeal manifestation of repressed anger, a sign and self-

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Martin's consideration of jargon as means of maintaining "aerial distance," or emotional distancing so as to maintain objective rationality. Martin critiques feminist academics adopting this perspective because it distances women from feminist-activist roots (KL 652) and "[i]t can also render us callous toward the victims of such 'cancerous vices' as poverty and disease, domestic violence and sexual abuse, racism and sexism, global war and environmental destruction (KL 648-49).

[75] See Maya Dusenbery, *Doing Harm: The Truth About How Bad Medicine and Lazy Science Leave Women Dismissed, Misdiagnosed, and Sick* (New York: Harper, 2018).

See also, Laura Kiesel, "Women and Pain: Disparities in Experience and Treatment," *Harvard Health Publishing.* 9 October 2017. Accessed 21 June 2018. https://www.health.harvard.edu/blog/women-and-pain-disparities-in-experience-and-treatment-2017100912562.

See also, Ioanna Gouni-Berthold, Heiner K. Berthold, Christos S. Maztzoros, Michael Bohm, and Wilhelm Krone, "Sex Disparities in the Treatment and Control of Cardiovascular Risk Factors, in Type 2 Diabetes," *Epidemiology/Health Services Research* 31, no.7 (2008): 1389-1391. See also, http://care.diabetesjournals.org/content/31/7/1389.short

See also, Joe Fassler, "How Doctors Take Women's Pain Less Seriously," *The Atlantic*, last modified October 15, 2015. Accessed 15 July 2018. https://www.theatlantic.com/health/archive/2015/10/emergency-room-wait-times-sexism/410515/.

[76] Mariana Karamanu, et al., "Melancholy as a Risk Factor for Cancer: A Historical Review," *JBUON 21* No. 3 (2016): 756.

[77] In the late twentieth century, medical researchers proposed the idea that people who are chronically depressed and get angry often are cancer prone. For example, a 1994 study by psychologist *Hans* Jürgen *Eysenck* finds that a "Type C" or "cancer personality" is someone who "present[s] a bland surface," to hide poor coping skills, an extreme amount of anger, and depression. A Type C person "succumbs more readily" and "dies more quickly" from cancer. Eysenck concludes that "[t]here appears little doubt that psychosocial determinants constitute an important risk factor for cancer." See, H.J. Eysenck, "Cancer, Personality, and Stress: Prediction and Prevention," *Advances in Behavior Research and Therapy 16* No. 3 (1994): 167.

See also, M. Blatný and Z. Adam, "Type C Personality (Cancer Personality) Current View and Implications for Future Research," *Vnitr Lek 54* No. 6 (2008): 638-645.

inflicted wound of the unhealthy mind.[78] In different guises, medical science has continued to re-authorize the idea of a feminine cancer personality for hundreds of years, either blaming women for cancer or dismissing their health concerns. For example, a recent study (2016) finds that women with cancer demonstrate "significantly higher neuroticism"[79] than men with cancer, and that gender predicts a patient's report of the cancer-related pain.[80] Krok-Schoen and Baker likewise contend that "being neurotic is more socially acceptable and expected among women,"[81] and that expressing higher degrees of pain correlates to dependency, neuroticism, and other behavior traits such as hysteria and hypochondria, which are also culturally associated with the female mind.[82]

Attributing women's testimony of pain to manifestations neuroticism both reinforces and reflects attitudes of medical authoritarianism and sexism. If gender biases and stereotypes suggest women tend toward neurotic behavior and these biases are transmitted in medical students' education, then they serve to delegitimize women's health concerns. For example,

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[78] Susan Sontag, *Illness as Metaphor*, and *AIDS and Its Metaphors,* (New York: Penguin Books, 1991), 22, 87.

[79] An online article clarifies the difference between neurosis and neuroticism, stating that, whereas "neurosis" is an outdated term for a psychological diagnosis of severe obsessive disorders, "neuroticism" is not a diagnosis but a personality trait, characterized by a "tendency to be in a negative or anxious emotional state. People with neuroticism tend to have more depressed moods and suffer from feelings of guilt, envy, anger, and anxiety more frequently and more severely than other individuals. . . . An individual with neuroticism may be self-conscious and shy. They may tend to internalize phobias and other neurotic traits, such as anxiety, panic, aggression, negativity, and depression." For more, see Adam Felman, "Neuroses and Neuroticism: What's the Difference?" *Medical News Today* 9 January 2018. Accessed 28 April 2018. https://www.medicalnewstoday.com/articles/246608.php

[80] Jessica Krok-Schoen and Tamara A. Baker, "The Influence of Personality on Reported Pain and Self-Efficacy for Pain Management in Older Cancer Patients," *Journal of Health Psychology* 19, no.10 (2013), 514.

[81] Ibid., 514.

[82] Elizabeth B. Pathak, Sarah E. Wieten, and Christopher W. Weldon, "Stoic Belief and Health: Development and Preliminary Validation of the Pathak-Wieten Stoicism Ideology Scale," *BMJ Open 7* No. 11 (2017): e015137. (Online Jornal of the *British Medical Journal*). 14 November 2017. Accessed 10 March 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5695468/
See also, Julie Schmittdiel, Kevin Grumbach, Joe V. Selby, and Charles P. Quesenberry Jr., "Effect of Physician and Patient Gender Concordance on Patient Satisfaction and Preventative Care Practices," *Journal of General Internal Medicine 15* No. 11 (2000): 761-769.
See also, Susan Rabady, *The European Journal of General Practice 9* No. 3 (2003): 101-102. "Influence of Gender on the Provision of Palliative Care"
See also, Valerie Carrard and Marianne Schmid Mast, "The Impact of Gender Stereotypes in Patient-Physician Interactions," in *Gender and Social Hierarchies: Perspectives from Social Psychology*, eKlea Faniko, Fabio Lorenzi-Cioldi, Oriane Sarrasin, and Eric Mayor Eds. (New York: Routledge, 2015).

studies and personal testimonies cite evidence that women's reporting of pain and early cancer symptoms may be discounted by doctors more often than men's.[83] In 1792, philosopher Mary Wollstonecraft suggested that what is now called female "neuroticism," may in some part be a social product and effect of women's gendered learning. She asks:

> Fragile in every sense of the word, they are obliged to look up to man for every comfort. In the most trifling dangers they cling to their support, with parasitical tenacity, piteously demanding succor [sic]; and their natural protector extends his arm, or lifts up his voice, to guard the lovely trembler- what can save such beings from contempt; even though they be soft and fair?[84]

A woman with cancer may indeed be caught in a "neurotic"-feminine double bind. If she has been socialized to be dependent upon or defer to males as authority figures and to believe she needs to make herself physically appealing to men, then cancer diagnosis may be especially frightening. Not only is she confronting the knowledge that she has a disease which may shorten

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[83] See, Diane E. Hoffmann's and Anita J. Tarzian's influential study, "The Girl Who Cried Pain: A Bias Against Women in the Treatment of Pain," *Journal of Law, Medicine, and Ethics 29* (2001): 13-27.
Below I cite several recent accounts of the medical dismissal of women's complaints. I do not list these (and there are many more which could be included) to be repetitive, but to proactively address responses that any accounts of medical professionals dismissing women's concerns are isolated and do not reflect 21st century medical culture writ large. While medical schools commonly include treatment simulation components and preservice doctors are scored on, among other things, their abilities to be empathetic listeners, the dismissal of women's medical concerns remains a commonplace problem. For BGC's, any medical response that downplays a woman's concerns may prove disastrous. Advice that suggests women "push" doctors to work with them and not dismiss their symptoms suggests the urgency of gender-insubordinate patient education.
For more, see:
Claire Martin, "Women Should Know the Symptoms of Ovarian Cancer, Doctor Says," *The Denver Post.* 28 January 2015. Date Accessed 10 October 2018. https://www.denverpost.com/2015/01/28/women-should-know-the-symptoms-of-ovarian-cancer-doctor-says/.
See also, Camille Noe Pagan, "When Doctors Downplay Women's Health Concerns," *The New York Times.* 3 May 2018. Accessed 21 June 2018. https://www.nytimes.com/2018/05/03/well/live/when-doctors-downplay-womens-health-concerns.html.
See also, Fay Schopen, "The Healthcare Gender Bias: Do Men Get Better Medical Treatment," *The Guardian.* 20 November 2017. Accessed 21 June 2018. https://www.theguardian.com/lifeandstyle/2017/nov/20/healthcare-gender-bias-women-pain.
See also, Laura Kiesel, "Women and Pain: Disparities in Experience and Treatment," *Harvard Health Publishing.* 9 October 2017. Accessed 21 June 2018. https://www.health.harvard.edu/blog/women-and-pain-disparities-in-experience-and-treatment-2017100912562.
See also, Veloshnee Govender and Loveday Penn-Kekana, "Gender Biases and Discrimination: A Review of Healthcare Interpersonal Interactions," *Global Public Health: An International Journal for Research, Public Policy, and Practice 3* (2008): 90-103.Accessed 21 June 2018. https://www.tandfonline.com/doi/abs/10.1080/17441690801892208.

[84] Mary Wollstonecraft, *A Vindication of the Rights of Woman*, (Oxfordshire, England: Acheron Press, 1792), 136-138.

her life, but also the knowledge that the treatment for it affects her feminine identity as tied to her abilities to perform caring and domestic labors and threatens to reduce her physical, sexual appeal. When the label "neuroticism" is used to describe women's testimony of pain in psychosocial research, it may be an inadvertent acknowledgement of female education for subordination and dependency.[85]

In a nineteenth-century lay guide to women's health that sold over 150,000 copies in its first edition, American gynecologist George Henry Naphey admonishes female readers that "to acquire, to preserve, and to embellish beauty, is a duty which woman, whether married or single, should never neglect."[86] He later explains that beauty is a matter of very high importance, worth money and time and trouble," because, from a medical standpoint, "beauty is ever synonymous with health."[87] And, in *Some Ideals in the Education of Women* (1900), American educator (and the fifth president of Wellesley College) Caroline Hazard avers "The lesson of greatest importance which our ideal woman must learn, is the lesson of obedience;"[88] she must learn to submit her will to the command of others for obedience is "the foundation of all progress" for

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[85] A variety of neurotic behavior is the 19th-century notion of the female "hysteric," a diagnosis of psychological disorder that Tosca et. al. (2012) traces back some 4,000 years to Hippocrates' idea that the uterus moves throughout the female body. See: Cecilia Tasca, Mariangela Rapetti, Mauro Giovanni Carta, and Biance Fadda, "Women and Hysteria in the History of Mental Health," *Clinical Practice & Epidemiology in Mental Health* 8, (2012): 110-119.See https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3480686/
See also, Lana Thompson, *The Wandering Womb: A Cultural History of Outrageous Beliefs About Women* (Amherst, NY: Prometheus Books, 1999), 21-29.
An early feminist critical description of a diagnosis and treatment of a hysteric is given in Charlotte Perkins Gllman's short story, "The Yellow Wallpaper" (1892). When the unnamed narrator displays anger to her husband after childbirth, she is crossing a social taboo and acting hysterical. He tells her she needs to quit indulging in these negative emotions and act as if she is happy if she wants to get better. When she fails to display convincing cheer, he exercises his masculine authority as both a medical doctor and husband, keeping her sedated and in almost continuous solitary confinement in a room with yellow wallpaper. The wallpaper is as stained and peeling as her own "wallpapered" cheer. After weeks of staring at the walls, she imagines a metaphoric image of herself in a hallucination of a woman trapped behind the garish wallpaper, "and she is all the time trying to climb through. But nobody could climb through that pattern—it strangles so." See Charlotte Perkins Gilman, *The Yellow Wallpaper and Other Stories.* (New York: Dover Publications, 1997), 2, 12.
[86] George Henry Naphey, *The Physical Life of Woman: Advice to the Maiden, Wife and Mother* (Philadelphia, US: David McKay, 1889), 92.
[87] Ibid., 249.
[88] Caroline Hazard, *Some Ideals in the Education of Women* (New York: Thomas R. Crowell and Co., 1990), 11.

her[89] and to avoid the "terrible fate" of female "rebels," a woman must "voluntarily put herself under the reign of [male] law."[90]

These two fundamental, feminine virtues, beauty and obedience, are touted in conventional BGC narratives as a path to health and recovery following diagnosis; they are also key components in a long history of women's gendered education in the west. Typifying the notion of a sex-gender divide in education is Rousseau, who states in *Emile,* that "[m]en and women are made for each other, but . . . he could do without her better than she can do without him."[91] To find a male protector, "[a] woman's education must therefore be planned in relation to man. To be pleasing in his sight. . .. to make his life pleasant and happy, these are the duties of woman for all time."[92] To be "pleasing in his site" is both a dictum to feminine hygiene and appearance and also to feminine virtue—to be gentle, demure, patient, good-natured, and selflessly nurturing to her husband and children. Rousseau's philosophy of education is not based solely on his subjective thought but rather on his evaluation of seemingly "natural" notions about social values, gender, and education; what he notes as "the duties of women for all time."[93]

Authoritarian medical humanities. In medical sociologist Arthur Frank's influential *The Wounded Storyteller: Body, Illness, and Ethics* (1995),[94] he thematically classifies autopathographies (illness autobiographies) to consider their educational significance. Frank's work is foundational to the medical humanities movement, a movement to bring patient voices to preservice doctor education to advance more empathetic, doctor-patient communications. However, the empathetic emphasis in doctor-patient care that these programs

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[89] Ibid., 14

[90] Ibid., 10.

[91] Rousseau, *Emile*, 7015-7029

[92] Ibid.

[93] Ibid.

[94] Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics, 2nd Ed.,* (Chicago: University of Chicago Press, 2013).

promote will not by themselves result in large-scale changes, either in provider-patient relations or in medical school social surrounds.[95] Given Frank's argument of the necessity of recognizing body-mind knowing in illness experiences and treating whole human beings rather than diseased parts, his assertion that gender is "remarkably unrelated" to the experience of illness is bewildering,[96] especially given the prominence of gender as topic in BGC narratives. For example, in one of the earliest modern breast cancer memoirs, *A Breast for Life* (1974)*,* Betty Isaac recounts initially refusing to undergo a mastectomy because she cannot face the possibility of living without her breasts. Isaac spirals into a cycle of depression and painkiller addiction that leads to her institutionalization and months of electric shock therapy.[97] Isaac's reaction to losing her breast may seem extreme and antiquated, but consider Sarah McLean's response to her post-mastectomy body in *Pink is the New Black* (2015):

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[95] Medical humanities is a recent field in medical school programs that has grown in influence since the beginning of the twenty first century. Its interdisciplinary focus draws on sociology, religion, anthropology, history, psychology, and cultural geography as well as areas of study in the humanities such as philosophy, art, autobiography, fiction, poetry, cultural studies, and disability studies. All of these fields are brought together to create a rich context for viewing appropriate treatment for a patient. Specialized areas of study in the medical humanities include bioethics, clinical ethics, and literature and medicine.
For more see, Brian Dolan, Ed., *Humanitas: Readings in the Development of the Medical Humanities.* (San Francisco: University of California Medical Humanities Press, 2015), 1-26.
See also, Charlotte Blease, "Can a Shot of Humanities Make Doctors More Humane?" *The Guardian.* 4 November 2013. Accessed 20 March 2018. https://www.theguardian.com/science/blog/2013/nov/04/medical-humanities-doctors-humane
See also, See Allyson Herbst, "Female Med School Students Deal with Horrific Sexism," *Houston Chronicle* 4 October 2016. Accessed 20 Oct. 2016. http://www.chron.com/news/medical/article/Female-med-school-students-deal-with-horrific-9682244.php
See Also, Reshma Jagsi, Kent A. Griffith, Rochelle Jones, Chithra R. Persumalswami, Peter Ubel, and Abigail Stewart, "Sexual Harassment and Discrimination Experiences of Academic Medical Faculty," (Research Letter) *Journal of America Medicine Association.* 17 May 2016. Accessed 20 October 2016. http://jamanetwork.com/journals/jama/fullarticle/2521958.
See Also, Dijkstra, AF, Verdonk P, Largo-Jansen AL. "Gender Bias in Medical Textbooks: Examples from Coronary Heart Disease, Depression, Alcohol Abuse and Pharmacology," *Medical Education 42* No. 10 (2008): 1021-1028.
See Also, Turbes, S; Krebs, E; Axtell, S. (2002). "The Hidden Curriculum in Multicultural Medical Education: The Role of Case Examples," *Academic Medicine 77* No. 3 (2002): 209-216.
See Also, Barbara A. McAneny, "Challenging Gender Biases in the House of Medicine," *American Medical Association.* 27 September 2018. Accessed 15 November 2018. https://www.ama-assn.org/practice-management/physician-diversity/challenging-gender-bias-house-medicine .

[96] Frank, *The Wounded Storyteller*, 130.

[97] Betty Isaac, *A Breast for Life,* (Hicksville, NY: Exposition-Banner Press, 1974).

> I hung my head, shamed. . . . I felt like a monster. I hated what I saw. I looked like a little boy. Even though I knew the surgery had been necessary to save my life, I began doubting myself. . .. You're repulsive. How can your husband love you now? You're not a woman anymore. You're so ugly. You look deformed. How will you ever feel feminine again? You'll never again be beautiful. What have I done?[98]

Frank's foundational work takes illness narratives seriously as cultural texts, but my analysis diverges from his in that I focus on autobiographical testimonies of gender values in patient education as affecting women's lives and recovery post-treatment. Additionally, a denial of gender's effects as a power-laden concept may lead to a dismissal of other intersecting forms of discrimination, such as class, race, age, and ethnicity in BGC treatment, patient education, and prognosis. As feminist philosopher Iris Marion Young (2005) notes, gender is one of many inter-related social identity categories creating relations of "power and subordination" among persons as they occupy "structural positions . . . privileged or disadvantaged in relation to one another" following "institutional rules and norms."[99]

Masculine-authorized medical research. Medical research is not largely authored by women, a condition resulting from and perpetuating in gender biases in the medical curriculum. Looking at over 1.5 million medical journal articles published between 2008-2015, a 2017 study finds that research teams lacking a first and last female author (indicative of project leaders and research program supervisors), did not take into account sex and gender differences in disease manifestation and treatment. The majority of the papers published during this time frame lacked the names of female authors listed in the first and last position, a finding that is especially significant to how we think about illnesses like heart diseases and cancers because it suggests

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[98] Sara McLean, *Pink is the New Black: Healing the Hidden Scars of Breast Cancer—A Journey from Grief to Grace* (Oklahoma City, OK: Self published, 2015) Kindle Edition. Kindle Location 440-446.

[99] Iris Marion Young, *On Female Body Experience: "Throwing Like a Girl" and Other Essays* (New York: Oxford, 2005), Kindle Location 275-276.

male/masculine bias in medical research and medical training.[100] Male-normed biases in physiology and medicine, wherein the female body has a long history of being described as incomplete, defective, "mutilated," and even "monstrous," have roots in Platonic and Aristotelian thought and biblical exegesis.[101] Long-venerated texts in western philosophy and theology attest to the inferiority of the female body-mind. Feminist philosopher Luce Irigaray argues women's "sexual difference" as defined in patriarchal thought makes them not only subordinate to men, but negates them epistemically, linguistically, and ontologically. The perceived physical differences of women and the belief that they embody cognitive, emotional, and moral differences are taken as indicators not of a different sex, but as cases of deficient males:[102]

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[100] Mathias Wullum Nielsen, Jens Peter Andersen, Londa Schiebringer, and Jesper W. Schneider, "One and a Half Million Medical Papers Reveal a Link between Author Gender and Attention to Gender and Sex Analysis," *Nature Human Behavior* 1, (2017): 791-796. https://www.nature.com/articles/s41562-017-0235-x
Another consideration worth exploring is whether scientific citation systems that use only the first initial of an author's first name contribute to sex and gender disparities in medical practice and research. Does this citation system contribute to an ontological, patriarchal bias in medical research and the sciences at large? Are women qua women "disappeared" from the research terrain in this system? If so, *should* they be accounted for as females? If so, can such a determination be made without making gender biased assumptions about first names or serving to segregate female authors by according them significance as females?

[101] In Plato's *Timaeus* (360 BC)*,* the philosopher Timaeus of Locri explains to Socrates that God made humans, the naturally "superior kind" of human would be called "male." If a male failed to master their emotions and passions and lived unjustly, he would be punished by being reborn a woman, and if then was still unjust, reborn a third time as a wild animal. See Plato, *Timaeus,* Donald J. Zeyl,Trans., (Indianapolis, IN: Hackett Publishing, 2000), 29-30. Likewise, in Book II of the *Generation of Animals* (ca. 450-500 B.C.)*,* Aristotle calls females "deformed" males. See *Aristotle, Generation of Animals,* Arthur Leslie Peck, Trans., (Cambridge, MA: Harvard University Press, 1943), 174. A digitized, searchable, and downloadable version of this book is available from the *Internet Archive*, 22 October 2008. Accessed 17 April 2018. https://archive.org/details/generationofanim00arisuoft/page/176. See also, Thomas Aquinas, *Questiones Disputatae de Veritate* (1256-1259 A.D.)
(*Disputed Questions on Truth*)*,* Robert W. Mulligan, Trans. (Chicago: Henry Regnery Co., 1952).
In Article Nine of Question Five, "Providence," Aquinas addresses the question "Does providence dispose bodies here below by means of the celestial bodies?" In answer 9 to this question, he contends that "[A] male offspring … is more perfect than the female," and that "it follows that conception of female offspring is something of an accident in the order of nature." The text of the entire three-volume set of presented online by the Priory of the Immaculate Conception at the Dominican House of Studies at https://dhspriory.org/thomas/QDdeVer.htm.
In *Summa Theologica* (1265-1274), Aquinas puts the idea of woman being "nature's mistake" even more plainly when he cites Aristotle as his source for calling her "defective and misbegotten." He later explains that "the image of God is found in man, and not in woman." Woman is both a derivative of man and subordinate to him. See, Thomas Aquinas, *Summa Theologica,* Fathers of the English Dominican Province, Trans., (Claremont, CA: Coyote Canon Press, 2010). [Kindle Edition]. Kindle Location 17429, 17629.

[102] Luce Irigaray, *The Sex Which is Not One*, trans. Catherine Porter and Carolyn Burke. (Ithaca: NY: Cornell University Press, 1977), 157.

> "[T]hese systems have produced many other differences that appear articulated to compensate for a sexual indifference. For one sex and its lack [the female], its atrophy, its negative, still does not add up to two. In other words, the feminine has never been defined except as the inverse, indeed as the underside, of the masculine."[103]

According to Martin (2011), a legacy of female subordination and negation is an educational landscape in which the intellectual and moral capacities of women are largely missing. She notes that through the twentieth century, "[t]he textbooks and anthologies in the field [of philosophy of education] almost totally ignored philosophical works about education written by women and also the very topic of the education of girls and women."[104] Where women have been included, it is more as an afterthought as "a chapter on a woman's educational philosophy can be added to a text" without affecting the underlying premises in androcentric educational thought.[105] While Martin "rejects any a priori assumption of the uniformity of women" she contends "the practice of adding without integrating women" is not sufficient to address gender inequities.[106]

When women's experiences and knowledge are deemed inconsequential, or, in a very literal sense, rendered meaning*less* as female sex and gender-assigned attributes are wholly dependent upon what is male/masculine for meaning, the effects in medical research and practice, and women's health can be profound. In *Women's Health: Missing from U.S. Medicine* (1994), Sue V. Rosser argues that consequences of an androcentric, profit-motivated political economy in clinical research include omitting or limiting women's participation in drug trials and neglecting gender, sexual orientation, ethnicity, and age as factors in cancer etiology and determining effectiveness and safety of drug therapies.[107] Since women past child-bearing years

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[103] Ibid.
[104] Martin, *Education Reconfigured,* 47-48.
[105] Ibid.
[106] Ibid., 52.
[107] Sue V. Rosser, *Women's Health: Missing from U.S. Medicine* (United States: Indiana University Press, 1994), 73-76.

are also excluded, Rosser argues this medical research standard practice “reflects sexism and ageism.”[108]

For example, in the case of ovarian cancer, it was only when female activists began to insist that this so-called “silent killer” did, in fact, present symptoms, that researchers and physicians began to reconsider the long held assumption that ovarian cancer was largely asymptomatic and only struck post-menopausal women.[109] Currently, there is no routine screening method for ovarian cancer, and for endometrial cancer, the only existing diagnostic test is painful and expensive to administer, so it is not routinely done.[110] Feminist literary theorist Susan Gubar, also diagnosed with ovarian cancer, points out that it is not only medical professionals who are miseducated to dismiss the early symptoms of ovarian cancer, which is the fifth leading cause of death by cancer in women, but also patients themselves.

Even women who are aware of ovarian cancer’s warning signs, may be reluctant to sound an alarm over their own vague symptoms to undergo time-consuming, expensive, painful, and perhaps unnecessary tests and to be labeled a “hysteric,” neurotic, or hypochondriac if there is no cancer. In *Memoir of a Debulked Woman: Enduring Ovarian Cancer* (2012), she reflects:

> Between 2005 and 2008, how many times had I overlooked or trivialized bouts of constipation and then diarrhea that sent me rushing into restaurant bathrooms or stopping at gas station restrooms? I had work to do, miles to go before I slept, responsibilities to shoulder that ought to take precedence over such banal and disagreeable matters. I thought at the time, who wants to be a wimp or a whiner? Just deal with it, I told myself. . ..[111]

In the online article “Ovarian Cancer: 4 Things To Know,” an MD Anderson Cancer Center senior communications specialist advises that “the most important thing to do if you

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[108] Ibid., 78.

[109] Maya Dusenbery, *Doing Harm: The Truth about how Bad Medicine and Lazy Science Leaves Women Dismissed, Misdiagnosed, and Sick* (New York: Harper One, 2018),) 308-309.

[110] Rosser, *Women’s Health*, 76.

[111] Susan Gubar, *Memoir of a Debulked Woman: Enduring Ovarian Cancer* (New York: W.W. Norton & Co., 2012), 55-56.

suspect you might have ovarian cancer is to persist. Find a doctor who takes your concerns seriously and keep pushing for answers until your questions are satisfied."[112] However, when bodies are routinely dismissed as sources of information and greater value is accorded to the mind in educational thought, can persons learn to take their bodies seriously, especially if medical education, research, and practice routinely do not? Further, when women take their symptoms to a doctor but are dismissed, told to lose weight (ovarian cancer is commonly overlooked in heavier women)[113], they are shamed for their body image and may feel judged and embarrassment for being a hypochondriac, a condition that, in psychiatric literature, is described as three to four times more likely to occur in females.[114] When the best advice to women from a world-renowned cancer treatment and research center is for women to start over with another doctor if they feel dismissed, should we understand this message to be educatively gender insubordinate on behalf of women or abnegating of institutional responsibility for gender-subordinating, medical gender biases and harms?

Pink War Machine Normative Narratives: Breast Cancer Activism and Beyond

Within the pink war machine and advancing its interests, Ehrenreich argues there is a "breast cancer cult" and "cancer culture" transmitting exploitative and gender-subordinating messages by "normalizing cancer, prettying it up, even presenting it, perversely, as positive and

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[112] Cynthia Demarco, "Ovarian Cancer Symptoms: 4 Things to Know," University of Texas: MD Anderson Cancer Center, last modified April 13, 2017, https://www.mdanderson.org/publications/cancerwise/2017/04/ovarian-cancer-symptoms--4-things-to-know.html https://www.mdanderson.org/publications/cancerwise/2017/04/ovarian-cancer-symptoms--4-things-to-know.html

[113] See, Chioma O. Erondu, et. al., "The Association Between Body Mass Index and Presenting Symptoms in African American Women with Ovarian Cancer," *Journal of Women's Health* 25, no.6 (2016): 571-578, See, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4900212/

See also, Maya Dusenbery, "Doctors Told Her She Was Just Fat. She Actually Had Cancer," *Cosmopolitan*, last modified April 17, 2018See also, https://www.cosmopolitan.com/health-fitness/a19608429/medical-fatshaming/

[114] Suzanne B. Feinstein and Brian A. Fallon, "Don't Be Fooled by Hypochondria" *Current Psychiatry* 2, no.9 (September 2003): 27-39, https://www.mdedge.com/psychiatry/article/59754/anxiety-disorders/dont-be-fooled-hypochondria#bib3

enviable."[115] In describing breast cancer as being presented to women as an "enviable" diagnosis, Ehrenreich argues health and illness, like beauty, are culturally determined norms. As Carolyn A. Day (2017) notes in *Consumptive Chic: A History of Beauty, Fashion, and Disease,* "illness is not only a subjective experience but also one defined by its cultural location, both geographically and historically."[116] " For example, in Victorian society, "tuberculosis was rationalized as a positive affliction for women, one to be emulated in beauty ideals and fashion."[117] In the normative narratives of the pink war machine, a cancer diagnosis is, if not a cause of celebration, at least an occasion to "woman up" and fight cancer by embracing a feminine soldier-survivor identity.

Throughout our lives, human beings are bombarded with messages shaping our gender identities as "male" or "female,"[118] along with the promises of benefits that accompany compliance with such messages. As Ehrenreich notes, for women with breast cancer, many breast cancer educational nonprofits advance gender-normative, heterosexist, cisgender

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[115] Ehrenreich, "Welcome to Cancerland." 53.

[116] Carolyn A. Day, *Consumptive Chic: A History of Beauty, Fashion, and Disease* (London, UK: Bloomsbury Academic: 2017), 3.

[117] Ibid., 305.

[118] In the second decade of the 21st century there is a cultural shift toward greater awareness and sensitivity to transgender and gender-fluid identities as the rise of gender-neutral public bathrooms in public spaces reflects. However, American society is not "post gender" or past the idea of binary gender. A 2007 Gallop pole indicates that, "two in three younger adults and most women under 50" want to know the sex of their child before birth. Additionally, current popular themes for boys' nurseries include male superheroes, sports, modes of transport and travel (cars, trucks, airplanes, ships), dinosaurs and hunting/safari/jungle themes. Popular girls' nursery themes include images of small non-predatory, baby animals (e.g., rabbits, lambs, kittens), floral patterns, birds and bird cages, bows, and crystal chandeliers. The symbolism suggests that whereas parents, especially expectant mothers, of boys may want to surround their child with images of being active, assertive, even predacious and "going places," in the public world, parents of girls select serene, dependent, immobile images, and decorative objects of the domestic sphere. According to a website with advice for expectant parents decorating girls' nurseries, pink remains the color of "charm, serenity and womanhood, making it definitely best for a baby girl's room."
See Joseph Carroll, "Do Americans Want to be Surprised by the Sex of their Baby?" *Gallop.* 20 July 2007. Accessed 27 February 2018. http://news.gallup.com/poll/28180/americans-want-surprised-sex-their-baby.aspx
See also, Claudia Foster, "33 Most Adorable Nursery Ideas for Your Baby Girl," *Don Pedro Décor, Home Improvement, and Interior Design* (n.d). Accessed 12 February 2017. https://donpedrobrooklyn.com/baby-girl-room-ideas/
See also, Beth Williams, "Baby Boy Nursery Themes," *Project Nursery + Junior.* 27 February 2014. Accessed 12 February 2018. https://projectnursery.com/2014/02/baby-boy-nursery-themes/

narratives for cancer recovery. These same organizations are vital sources of public information about cancer's symptoms, diagnosis, staging, treatments, and access to free or reduced cost services. They provide in-person and online opportunities for social support and community building among women with cancer, and they act as agents of public education, bringing cancer more fully into the realm of public awareness and lessening its social stigmas by making what was once an unspeakable disease a highly publicized and commercialized causes.

Since the 1970s, breast cancer has gained far greater visibility, is represented by more organizations, and has received more government grants and private donations than any other type of cancer, all including gynecological cancers.[119] Many leading national and international organizations, like Susan G. Komen for the Cure, The Breast Cancer Research Foundation, The American Cancer Society's Look Good/Feel Better Program, and Rethink Breast Cancer fundraise for breast cancer research, patient education, early disease detection programs, and political advocacy. This nonprofit-corporate activism has brought women's health to front and center in social consciousness. In doing so, such activism signals women gaining social and political power.

However, the high levels of government and corporate funding these organizations depend upon speaks to their "insider" status in the pink war machine. In the wake of the phenomenal success of mainstream breast cancer activism, less "sexy" gynecological cancers, such as cervical, ovarian, and uterine cancers have been overshadowed. As Ehrenerich wryly notes, breast-cancer has become "the darling of corporate America" because it "provides a way of doing something for women without being feminist" and without challenging the production

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[119] See American Cancer Society, "Current Grants by Cancer Type," 1 August 2016. Accessed 25 January 2017 https://www.cancer.org/research/currently-funded-cancer-research/grants-by-cancer-type.html
See also, Ashley JR Carter and Cecine N. Nguyen, "A Comparison of Cancer Burden and Research Spending Reveals Discrepancies in the Distribution of Research Funding," *BMC Public Health 12* (2012):526. 17 July 2012. Accessed 25 January 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3411479/

and marketing of chemical agents that may contribute to cancer's rising rates. If breast cancer activism was environmentally focused and took aim at corporate polluters, its high levels of corporate and government support would likely plummet.

Additionally, just as the dogma of a "wall of separation" in America between church and state is not comprehensively practiced and enforced in politics, cancer education and activism serve to advance underlying religious ideologies that can engender gender-subordinating political stances. In so doing, cancer activism may become a source of miseducation in women's reproductive healthcare rights.[120] To be clear, I am not arguing that participation in mainstream activist organizations, even ones strongly reaffirming gender messages, are necessarily wholly gender-subordinating or that these organizations transmit only cultural liabilities.[121] And, again, as the Look Good, Feel Better program's high level of success attests to, reaffirming "normal" gender and body identity provides solace and a sense of empowerment for many women undergoing or in the aftermath of surgical and chemical treatments that poison and maim the body. Finally, there are some outliers to mainstream cancer activism organizations where one can find resistance to gender-subordinating educational messages, but these are few and operate without the widespread public recognition and high levels of corporate and government sponsorship that mainstream organizations receive. Education and activist organizations such as the Breast Cancer Action Network and the National LGBT Cancer Project are creating online and physical spaces for challenging cancer culture's gender-subordinating narratives and creating new ones.

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[120] From the 1950s through 1990s a link between abortion, either induced or spontaneous (miscarriage) and breast cancer was studied extensively, with inconclusive results. However, it was widely suggested that abortion might increase breast cancer risk. With more recent studies, this finding has been reversed. However, media outlets for pro-life policy and pro-life education groups continue to promote abortion as a risk factor for breast cancer. See Susan Berry, "Pediatricians Warn of Abortion-Breast Cancer Link," *Breitbart,* 17April 2015. Accessed 27 January 2017. http://www.breitbart.com/big-government/2015/04/17/pediatricians-warn-of-abortion-breast-cancer-link/

[121] See, Martin, *Cultural Miseducation*, 15.

Pink narratives compelling conformity: the beauty=health myth. In Naomi Wolf's historical-anthropological study of femininity, fashion, and cosmetics *The Beauty Myth: How Images of Beauty Are Used Against Women,* (1992/2002), she describes how ideals of beauty around the world are linked to notions of what is "healthy" for women. Wolf argues the beauty myth and its attendant associations with female health is "not about women at all" but "men's institutions and institutional power."[122] While Wolf links phantasmagorical notions of beauty with female health, she does not consider the role of beauty in shaping the illness experience. However, Hooper (1994) considers this connection in her critique of the American Cancer Society's "Look Good, Feel Better" Program (LGFB).[123]

During her own cancer treatment, Hooper describes seeing signs for LGFB hanging on hospital walls "above the emaciated, wheelchair-bound patients with breathing tubes."[124] Launched in 1989 in partnership with The Cosmetic, Toiletry and Fragrance Association, the LGFB program's stated educational mission is "teach[ing] beauty techniques to people with cancer to help them manage the appearance-related side effects of cancer treatment," and helping people regain a sense of "normal."[125] Considering the cultural narratives the LGFB mission advances, Hooper asks, "Does the American Cancer Society imagine that a woman with a deadly disease will really feel a whole lot better once she gets some expert cosmetological advice?"[126]

LGFB suggests that if a woman has made the crossing into the kingdom of the sick,[127] she can at least hide or mitigate the physical evidence of her immigrant status though

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[122] Naomi Wolf, *The Beauty Myth: How Images of Beauty Are Used Against Women* (United States: HarperCollins, 2002), 13.
[123] Hooper, "Beauty Tips for the Dead," 109.
[124] Ibid., 110.
[125] Look Good, Feel Better, "About the Program," http://lookgoodfeelbetter.org/about/about-the-program/ .
[126] Hooper, "Beauty Tips for the Dead," 111.
[127] Sontag, *Illiness as Metaphor*, 3.

somaesthetic technologies.[128] While LGFB recently created programs for men and teens too, the primary appeal is to cisgender women, as is made clear in the announcement on the program's website that LGFB participation is "open to all *women* with cancer,"[129] not all *persons* (emphasis mine). It seems that for many women LGFB's focus on restoring beauty positively affects confidence and may, in fact, restore at least a semblance of "normalcy." According to an article on the website *OncologyNurseAdvisor,* LGFB gives women with cancer an "arsenal of tools" to restore "normalcy," and since its inception, this program has "helped nearly one million women in the United States" alone.[130] Given the complex, and as yet not fully understood physiological connection between mental and physical states of health,[131] and mental health and a positive gender identity,[132] there may be emotional and physical benefits to self-care practices that reaffirm and restore women's gender identity in BGC's, especially as "[s]ociety [still] regards the breast as the symbol of femininity, charm, and sexuality, so any damage to [the] breast can lead to worries and distress and harm women's [*sic*] whole life."[133]

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[128] Philosopher Richard Schusteman introduced the term "somaethetics" to "highlight and explore the *soma*—the living, sentient, purposive body—as the indispensable medium for all perception" and to take a consideration for aesthetics "back to the core issues of perception, consciousness, and feeling" (3, emphasis mine). Shusterman argues that human somaesthetic experience is indivisible from our moral values and belief systems (30-31) and examines the ways gender subordination and other forms of oppression are "written" onto bodies. He avers, "Entire ideologies of domination can be covertly materialized and preserved by encoding them in somatic norms that, as bodily habits, are typically taken for granted and so escape critical consciousness" (32). Cosmetics are a "representational," somaesthetics practice for creating an image of the self to project to others. He notes that cosmetics, dieting, fashion, and plastic surgery "serve largely to maximize corporate profits" (6).
See. Richard Shusterman, *Body Consciousness: A Philosophy of Mindfulness and Somaesthetics* (New York: Cambridge University Press, 2008.

[129] Look Good, Feel Better, "About the Program," http://lookgoodfeelbetter.org/about/about-the-program/

[130] Bette Weinstein Kaplan, "Program Focuses on How to 'Look Good, Feel Better' During Cancer Treatment," *OncologyNurseAdvisor.* 12 June 2017. Accessed 3 October 2018. https://www.oncologynurseadvisor.com/side-effect-management/program-helps-patients-address-image-issues-associated-with-treatment/article/667801/)

[131] Canadian Mental Health Association, "Connection Between Mental and Physical Health," *Canadian Health Association* (n.d.). Accessed 3 October 2018. https://ontario.cmha.ca/documents/connection-between-mental-and-physical-health/.

[132] World Health Organization, "Gender and Women's Mental Health," *World Health Organization* (n.d.) Accessed 3 October 2018. https://www.who.int/mental_health/prevention/genderwomen/en/ .

[133] Maedeh Rezaei, et. al., "Factors Influencing Body Image in Women with Breast Cancer: A Comprehensive Literature Review," *Iran Red Crescent Medical Journal* [Online Journal] *18* No. 10 (2016): e39465. 10 August 2016. Accessed 12 November 2018.
https://pdfs.semanticscholar.org/2a27/ac0787f162b787a8b00f202253617b2dc404.pdf

When we consider humankind's collective, cross-cultural, cross-historical adoration of female breasts, we need to keep in mind Wolf's point that the value and determinants of beauty are a reflection of male power over women and women's need to please the men they are subordinated to.[134] When a woman "fails" to meet the standard for being "beautiful" with cancer, by whose standards is she a failure? In her 2018 interview on the Apple radio podcast *Body Politics,* Shay Sharpe, first diagnosed with breast cancer at age 26, describes undergoing two unsuccessful breast implant surgeries after a double mastectomy. When her body rejects the implants for a second time, Sharpe opts for reconstructive surgery using tissue from her abdomen, but when her cancer returns, she faces a fourth reconstructive surgery to retain the appearance of breasts. As Sharpe wonders how much more scarring and pain she can endure, her partner at the time tells her he is not comfortable being in a relationship with a woman without breasts. Despite recognizing her partner is pressuring her to undergo surgery, Sharpe states that "I almost really can't be 100 percent mad at him because he's doing to me what I had done to

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In my research, I found that 21st century U.S. scholarship in medical sociology and anthropology does not commonly explore gender issues in breast cancer, especially the significance of gender identity and normative femininity in BGCs. In my informal survey, the effects of BGC treatment on feminine identity was a topic of interest at the end of the twentieth century. However, more recent U.S.-published studies tend to use the term "gender" to designate biological sex and explore issues related to disease etiology, pathology, and prognosis rather than the psychosocial effects of gender identity in cancer. However, as my encounters with 21st century BGC autobiographical narratives reveal, gender, especially concerns with the "femininity," is still very much a factor in how we understand and respond to BGC's. However, the dearth of scholarship on gender issues and patient perceptions of gender biases in BGC treatment would suggest that American society as a whole and oncology is "post-gender;" that any consideration of gender as a category of social identity is suspect, essentializing, outdated, and irrelevant to women's current educational experiences in BGCs. Given the ongoing domination of pink-war symbols and metaphors, At the risk of branding myself a reactionary feminist sounding a patriarchal conspiracy alarm, I am left to wonder if the lack of scholarship is indicative of an effective deployment of a strategy of the pink war machine to normalize and obscure gender subordination so that it remains largely unquestioned. International scholarship on this topic provides an enriching and helpful sense of social environment that I am arguing is applicable to the experiences of U.S. women as well. American society has not advanced beyond gender-based disparities and oppression. The lack of 21st century scholarship on the significance of heteronormative feminine identity issues in BGC's, for whatever epistemically and politically charged reasons, is worth exploring. As Martin reminds us, where there are gaps in educational literature, we just may discover a hidden curriculum at work. See, Jane Roland Martin, *Education Reconfigured: Culture, Encounter, and Change.* (New York: Routledge, 2011) 41-44.

[134] Woolf, *The Beauty Myth,* 59.

myself [for] all those years."[135]" Sharpe's testimony supports findings in a 2017 qualitative study of body image and sexual drive in women with metastatic breast cancer:

> [I]t is possible to hear how women described their own failures, not because they were dying, but because they felt fat, because they felt unattractive, and because they did not feel sufficiently sexual. These failures not only punish them as women but additionally push them outside the category of 'good' cancer survivors who prioritize looking and feeling good and feeling sexy.[136]

Over two hundred years ago Wollstonecraft called beauty "woman's scepter," the sign and the means of her feminine power in system where women were dependent upon male protectors for their social, economic, and physical security.[137] In *The Second Sex* (1949), written almost two centuries after Wollstonecraft's observation, Simone de Beauvoir compares a man's love for a woman to an owner's love for a beautiful possession. She concluded that the twin female virtues of beauty and health determine a woman's love object value:

> First of all, she has to have youth and health, for man cannot be enraptured in his embrace of a living thing unless he forgets that all life is inhabited by death. And he desires still more: that his beloved be beautiful.[138]

She further argues that women are expected and educated to be subordinate to men, and that longstanding, institutional patriarchy has had the effect of indoctrinating women, making them passively compliant with and even at times defenders of a sex-gender hierarchy:

> The fact is that men encounter more complicity in their woman companions than the oppressor usually finds in the oppressed; and in bad faith they use it as a pretext to declare that woman wanted the destiny they imposed on her. We have seen that in reality her whole education conspires to bar her from paths of revolt and adventure.[139]

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[135] Emily MacKenzie, "After a Double Mastectomy: How Breast Cancer can Reshape Gender Identity," *WHYY*, last modified December 7, 2018. Accessed 28 December 2018. https://whyy.org/segments/after-a-double-mastectomy-how-breast-cancer-can-reshape-gender-identity/

[136] Sara I. McClelland, "Gender and Sexual Labor Near the End of Life: Advanced Breast Cancer and Femininity Norms," *Women's Reproductive Health* 4, no.1 (2017): 42.

[137] Mary Wollstonecraft, *A Vindication of the Rights of Men* And *A Vindication of the Rights of Woman* And *Hints,* Sylvana Tomaselli, Ed. (New York: Cambridge University Press, 2009), 116.

[138] Simone De Beauvoir, *The Second Sex.* Constance Borde and Sheila Malovany-Chevallie, Trans., (New York: Vintage Books, 2011), 176

[139] Ibid., 752.

Over sixty years after the publication of *The Second Sex* Ehrenreich notes that breast cancer is often framed in informal media, including conventional cancer patient narratives, as an opportunity for a beauty makeover and a chance for a woman to educate herself about skincare, hair styling, and fashion to "improve" her appearance. Ehrenreich suggests this cisgender-positive narrative in breast cancer culture is part of a concerted effort within the pink war machine by cosmetic surgeons, private corporations, mainstream breast cancer organizations, healthcare providers, and other individual "cancer club members." A heteronormative focus on feeling and looking "beautiful" is a common theme in conventional breast cancer memoirs and self-help guidebooks, which constitute a large part of the informal curriculum for breast cancer patient education.

Consider Caitlin M. Kirnan in *Pretty Sick: The Beauty Guide for Women with Cancer* (2017):

> I talked with Khloé Kardashian and Lamar Odom, and neither seemed to notice that I was in the middle of a major health crisis. Khloé complimented my lipstick and my Jimmy Choo heels. . . . Melissa Gorga and Cindy Barshop, two of Bravo's Real Housewives, grabbed me for an impromptu picture in the photo booth that was rented for the event. . . . Melissa commented on my glowing skin and asked who my facialist was. . . . It was in that moment that I realized that nobody at the party—minus a few of my colleagues—knew I had cancer. I was standing among Hollywood's elite makeup artists, hairstylists, fashion stylists, talent scouts, agents, and celebrities—people who are known for their looks or whose jobs it is to create a flawless aesthetic—and not one of them had a clue I was sick. . . . The fact of the matter is beauty treatments are an adjunct therapy to cancer treatments. . . . They say there are more important things in life than beauty and fashion but I'm here to tell you that they are just as important—if not more so—when you are sick. And why should anyone have to choose between their health or their beauty? They shouldn't—and don't—have to. The two are not mutually exclusive.[140]

Kirnan's notion that beauty and health "are not mutually exclusive" suggests that women can, in fact should, look good to feel better. However, in suggesting the existence of a loss-of-beauty-

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[140] Caitlin M. Kirnan, *Pretty Sick: The Beauty Guide for Women with Cancer* (New York: Hachette Book Group, 2017), 9-12.

for-health Faustian bargain she ignores an inverse question, what are the educational implications of tying beauty to health?

Pink narratives violating women's bodies. Kirnan suggests that beauty and health are not only "not mutually exclusive," but that health is advanced through beauty regimes. Countering this notion Ehrenreich argues a hyper focus on beauty in breast cancer culture is a tactic to distract women from questioning possible environmental causes of cancer that violate human bodies. She sees beauty advice and "infantilizing" practices (e.g., gifting women in treatment with breast-cancer teddy bears), as encouraging a passive, "childlike dependency" on healthcare providers.[141] The assigning of gender roles in culture and beliefs that these reflect "natural" masculine and feminine behavioral inclinations for males and females elides that fact that these behaviors are learned in culture. Ehrenreich suggests that encouraging women's dependence on medical providers and rewarding them for obedience with praise and gifts trains them to accept and endure physical violations and being existentially reduced to an object of medical control.

Heteronormative notions of women's "duties," including looking good to "feel better," whether one ultimately views them as educative and empowering or miseducative and oppressing, teach and reaffirm messages in medical care and wider society conveying how

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[141] Ehrenreich "Welcome to Cancerland," 46.
Authors of a recent study of gender in doctor-patient clinical encounters in oncology contend that even in the 21st century, an expectation among medical practitioners is that female cancer patients to behave as "submissive daughter[s]" to the doctor's "all-knowing father figure."
See, Trudy E. Darty and Sandra J Potter, "Social Work with Challenged Women: Sexism, Sexuality and the Female Cancer Experience," *Human Sexuality in Medical Social Work,* Larry Lister and David A Shore, Eds., (New York: Routledge, 2009), 84.
Additionally, expressions of medical-provider empathy may differently gendered for male and female cancer patients. Although it is incidental and may also express regional (American South Central Plains) idiomatic communication, I have witnessed nurses, doctors, aids, and pharmacists speak to my mother in "baby talk," to placate or cajole her, speaking in singsong cadences (which I have noticed immediately disappears when speaking either to male patients or other providers), calling her "sweetie," and "honey," and "shug," and "rewarding" her after chemo sessions with happy face stickers. I suspect such expressions of empathetic care reveals both gender and age biases.

women with BGC's should respond to their illness. Underlying these messages is the specter of the desexualized, "deformed," and deathly female body. To be clear, such ideas do not arise in the pink war machine by itself but are taught and learned over the course of a lifetime. Well before the rise of the pink ribbon, Lorde writes:

> Women have been programmed to view our bodies only in terms of how they look and feel to others . . . We are surrounded by media images portraying women as essentially decorative machines of consumer function, constantly doing battle with rampant decay … we fight this depersonalization every day, this pressure toward the conversion of one's own self-image into a media expectation of what might satisfy male demand.[142]

However, as feminist philosopher Iris Marion Young (1994) points out, shorthand generalizations such as "us women" fail to shed conceptual clarity or to aid in cultural and philosophical analyses.[143] Further, the commercial success of industries like beauty, fashion, hygiene, cosmetic surgery, and pharmacology speaks to the fact that as a society we give into more than resist depersonalization. Certainly, being able to accept one's altered body after cancer treatment may advance physical and emotional well being. Lorde encourages each woman who has suffered a mastectomy to learn the contours of her "new" body and learn to love it.[144] However, when notions of femininity and beauty are prescriptively linked to health in breast and gynecological cancers, they can be miseducatively oppressive for women who, in a society with racist, heterosexist, ageist, sizeist, and classist standards of beauty, do not "measure up.".

Margorie O'Loughlin (2006) sees notions of health explicitly (and implicitly, of illness), framed as largely an individual's responsibility in western society. A person is either praiseworthy or blameworthy as "the health of the individual body" is "an object of scrutiny" and health curriculum emphasizes "healthy lifestyle habits, advice on individual sexual behavior,

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[142] Lorde, *The Cancer Journals*, 845-849.
[143] Iris Marion Young, *On Female Body Experience: "Throwing Like a Girl" and Other Essays* (New York: Oxford, 2005), Kindle*,* 718.
[144] Lorde, *The Cancer Journals*, 539.

establishing patterns of regular exercise, much advice on diet and so on."[145] Human bodies are in themselves curricular resources, teaching others through their appearance and comportment how to distinguish between socially acceptable and unacceptable behaviors. In conventional women's cancer narratives, what is emphasized and presented as praiseworthy are bodies that reproduce accepted ideals of feminine beauty.

Pink narratives distorting voices and pushing pink cheer. In the pink war machine, women are socially rewarded for demonstrating the "right" behaviors for a woman with cancer. These desirable behaviors include not challenging medical authority, displaying courage, the use of cosmetics, fashion, and prosthetics to "look good" and to "feel better," being militantly bright-sided in response to illness, and in putting this cheerful, fighting spirit on display. In *The Red Devil: To Hell with Cancer—and Back* (1999)*,* memoirist and magazine editor Katherine Russel Rich describes how exhibiting these desired behaviors leads to her gaining the romantic interest of a male colleague. When she tells him she has "put herself under orders to be happy," he smiles his approval.[146] Even though her metastatic breast cancer has spread into her bones, she makes this announcement in part because "I had already figured out people liked it when cancer patients talked like this."[147] He tells her that her courage is a real "turn on" and, combined with her enhanced attention to fashion and use of cosmetics to hide her sickness, he thinks she "looks really good" becomes romantically interested.[148]

If conforming to pink war machine gender scripts leads to Rich feeling happier in her life, more optimistic and hopeful about her health, and gaining approval and even love of others, can we say that following these gender scripts is harmful to her? There is no simple answer to this

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[145] Margorie O'Loughlin, *Embodiment and Education: Exploring Creatural Existence* (The Netherlands: Springer, 2006), 17.
[146] Katherine Russell Rich, *The Red Devil: To Hell with Cancer—And Back* (United States: Crown Publishers, 1999), 143.
[147] Ibid.
[148] Ibid., 162.

question. While Rich seems to suggest she has figured out the “pros” of adhering to the script, putting on a “gender show” requires time, energy, and a performance of selfless courage and cheer during a protracted low tide in energy and health. A better question is, “are the potential gains worth the costs for “buying into” this narrative?”

For many women, gender conformity is more than the use of make-up and prosthetics, and it’s more than self-censoring and cultivating cheer. In the context of breast cancer, reaffirming gender also means undergoing a series of involved, painful reconstructive surgeries, which again, many women view as necessary for feeling “normal” and regaining self-esteem. As one contributor in the collection of photographic/autobiographic vignettes *Looking Good to Feel Good: Stories of Breast Cancer, Breast Reconstruction, Bravery, and Happiness* (2013), remarks, “It took nine surgeries/procedures to reconstruct my breast(s) to their current state. No woman should feel less than a woman because of breast cancer.”[149]

As part of pink-ribbon, breast cancer culture, Ehrenreich sees a “cult of cheerfulness” also reinforcing longstanding gender messages in western education. While De Beauvoir suggests that women may be raised to learn that their social value is tied to their appearance and feminine behaviors, Ehrenreich points out that social conditioning in the CIC’s pink war machine occurs in messages in breast cancer patient-education media and from other women, pressuring new recruits to conform to feminine behaviors in illness. Women who get with the cheery/being “pretty” program are praised for their courage while those who do not are labeled psychologically deviant.[150] Again, there are gender-specific associations for women with demonstrating femininity, especially in being bright-sided, and being “in the pink” of health.

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[149] *Looking Good to Feel Good: Stories of Breast Cancer, Breast Reconstruction, Bravery, and Happiness*, 19

[150] Ehrenreich, “Welcome to Cancerland, 50,”
See also, Samantha King, *Pink Ribbons, Inc.,* Kindle Location 2205-2211. King notes a shifting emphasis in culture having the “right” mental attitude to prevent cancer (a sunny personality, not harboring anger or a neurotic) to optimism and a fighting spirit as survivorship virtues in the twenty-first century

In many conventional BGC narratives, both autobiographical and self-help guides (these genres often overlap), there is implicit or explicit advice to double down on and reaffirm a feminine gender-identity and a cheerful disposition. An extreme example of this is Jami Buchannan Mcnees' *Beautiful Cancer* (2017) in which Mcnees frames her disease and its devastating effects on her body as axiologically "beautiful":

> I had a radical 9-hour surgery to remove the bladder, 20 lymph nodes, my ovaries, my uterus, my cervix and most of my vagina. . . . I have a stoma (hole) in my abdomen that provides access to the new reservoir using an 18-inch catheter multiple times a day to remove urine from my body. . . . I will pee through a tube for the rest of my life and that the lady pleasure palace (vagina) is closed for business permanently. . . .[M]y cancer experience was awesome, wonderful and beautiful. But if you have been diagnosed with cancer and can only see it from a place of doom and gloom, keep reading. Hopefully you find ways to see it from a new perspective.[151]

In breast and gynecological cancer, the gender-coded messages a woman receives from childhood about behavioral expectations for her sex are reframed as helpful advice for emotional welfare and physical recovery in informal patient education messages, both subtle and overt, including advice to other women offered in personal cancer narratives. This advice may include being reliant upon and obedient to male authorities, praying to God, not asking too many questions or independently seeking information about diagnosis and a treatment plan that will only confuse the patient and waste time (e.g., reading medical texts about her diagnosis and usual treatments, finding out about clinical trials, alternative treatment approaches, medically unsanctioned adjutant therapies, getting an outside second opinion, etc.), being cheerful, taking care of feminine appearance through cosmetics, prosthetics, dress, and jewelry, and internalizing the idea that feeling beautiful and making oneself attractive to others, especially men, is vital to happiness and recovery.

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[151] Jami Buchannan Mcnees, *Beautiful Cancer* (2017), Kindle, 96-110

For example, in *A Breast Cancer Alphabet* Madhulika Sikka critically reflects over the pink-tinted, feminized breast cancer culture under her chapter “I is for Indignities”:

> If you are aware of the breast cancer culture that has built up in our society over the last two decades, you might think that you are entering a world of fuzzy pink gauze, soft teddy bears, and garlands of ribbons. Generally [it is] a land of sparkling brightness personified by women who are happy and smiling while they are “battling” this disease.[152]

While Sikka is critical of breast cancer culture, she expresses looking forward to reconstruction when a friend tells her, “[y]ou are going to get the rack of a twenty-four-year-old; it will be fabulous,”[153] and explains, “you find yourself thinking: Why am I so worried about my looks right now? . . . Well, because you are a woman, and it matters more for women.[154]

In the chapter “G is for Guilt,” she admits to feelings of guilt resulting from her inability to maintain her caregiving and domestic labors even though she works as an NPR producer:

> The embodiment of your femininity, the breast, is the treacherous villain in this drama, and you are the one who feels guilty. . .. [because] your life at home (which you might have been holding together with duct tape and chewing gum, if truth be told) is going to be severely disrupted by the fact that you have this disease. Your family has to adjust to a new you, a sometimes needy you . . . You feel guilty about how this might disrupt things for people around you outside your family. For me it was the strain put on my colleagues who were picking up my slack. . .. You also feel guilty when you hear someone else’s story that is worse than yours and so maybe you shouldn’t be feeling so bad about what you are going through.[155]

The range of conflicting responses Sikka reveals—a feminist-informed, critical eye toward breast cancer culture, guilt for becoming the one needing care instead of giving it, and a belief that appearance “matters more for women” reflect gender values in cultural narratives that are reinforced and passed on in the pink war machine.

Pink narratives limiting learning. From an educational standpoint, we need to look more closely at the ideas and values that are taught and learned in breast cancer awareness

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[152] Sikka, *A Breast Cancer Alphabet,* 496-500.
[153] Ibid., 272.
[154] Ibid., 599-602.
[155] Ibid., 423-438.

campaigns and the marketing of pink-toned and pink-ribbon-embossed merchandise. British sociologist Sarah E. H. Moore takes a cynical view of ribbon donning. Troubling for Moore is the concept of "awareness" that ribbon campaigns promote. She argues that "[a]warenss consists of neither knowledge nor the experience of a cause" because "[i]t does not require any concerted action, nor any relationship with a sufferer."[156] Moore's point is that ribbon wearing does not in itself promote learning but rather, a level of cognitive and moral engagement that is superficial and transient. To put her critique of cause ribbons in terms of educative value, Martin argues that encounters with objects and ideas in the world happen continuously and over our lifetimes. However, these encounters are only are educational if they spark a learning-based "change process" through which an individual's "capacities and cultural stock become yoked together."[157] Moore sees ribbon "awareness" campaigns as largely circumventing or discouraging the kind of deeper engagement that leads to individual and social change.

Similarly concerned with awareness as a general health education goal, Robert Trevethan (2017) points out that the terms "awareness" and "knowledge" are often used interchangeably in public health research and literature. He suggests a continuum in conducting health research to assess levels of patient and general public knowledge of issues. On the left side of this continuum is "awareness," indicating a more "generalized or diffuse" cognizance of a health topic, and on the right is "knowledge," which is much more comprehensive, detailed, and grounded in sustained learning practices and personal experience.[158] A focus on awareness in

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[156] Sarah E. H. Moore, *Ribbon Culture: Charity, Compassion, and Public Awareness* (New York: Palgrave Macmillan, 2010, 2-3.

[157] Ibid., 19.

[158] For example, if a public health-education campaign targets obesity, there is a difference between promoting generalized awareness that obesity negatively affects health or even that it is factor predictive of/comorbid with heart disease, high blood pressure, diabetes, cancer, etc. and specified knowledge of one's personal nutritional needs for healthy weight maintenance, genetic predispositions, psychological and socioeconomic factors, and other individual factors affecting health.

See, Robert Trevethan, "Deconstructing and Assessing Knowledge and Awareness in Public Health Research," *Frontiers in Public Health 6,* Article 194 (online, open access journal) (2017): par. 2. Accessed 21 August 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5545880/.

pink ribbons campaigns as an educational goal is less demanding in terms of the sustained commitments to teaching and learning.

This observation is not intended to discount entirely the possible positive learning effects from patient education curriculum developed and transmitted through various media from cancer nonprofits and government agencies that also use the pink ribbon symbol. However, if education is the goal, does the hype around the ribbon and awareness campaigns limit or distort a mission to educate cancer patients and the wider community about known risk factors, causes, screening, diagnostics, and treatment? Pink ribbons may even do more (mis)educational work than Moore credits in that they transmit and reinforce longstanding gender and color-coded messages about human behavior and health in a breast cancer context. Additionally, as Moore points out, the ribbon works as visual euphemism, presenting a way to "talk" about cancer that safely distances the wearer and viewers from painful, frightening, aesthetically deviant and socio-sexual taboos of bodies living and dying with cancer.

However, if a focus on awareness does not necessarily advance patient and public education about breast cancer as both a disease and social issue, the success of its pink ribbon "brand" marketing remains indisputable. While government funding for cancer research and corporate funding to breast cancer nonprofit organizations increased rapidly over the last 30 years, other cancers genetically linked to breast cancer or resulting from breast cancer drugs and radiation (e.g., ovarian, stomach, colon, thyroid, pancreatic, and even prostate cancers as secondary cancers to male breast cancer) remain eclipsed by breast cancer in terms of funding and public awareness campaigns.[159] Given this, how far should our "awareness" extend? How

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[159] "Breast Cancer Genes Linked to Other Cancers," *WebMD*. November 16, 2004. Accessed 10 August 2018. https://www.webmd.com/breast-cancer/news/20041116/breast-cancer-genes-linked-to-other-cancers.
See also, "Second Cancers After Breast Cancer," *American Cancer Society*. August 21, 2017. Accessed 10 August 2018.
https://www.cancer.org/cancer/breast-cancer/living-as-a-breast-cancer-survivor/second-cancers-after-breast-cancer.html.

much responsibility should one be asked to take for being a self-educating, health-conscious, and ethically conscious member of society? What falls under the purview of collective and of individual responsibilities, and what should public and patient education for breast cancer and other diseases be if it should be something beyond awareness? Should it extend to asking consumers to consider human rights and human health issues prior to purchasing? For example, for BCAM 2018, the ACS asked businesses to support their "Denim Days" campaign, days in October when employees can wear jeans to work for a $5 contribution to the ACS.[160] However, given that global manufacturing and dying of denim produces environmentally hazardous byproducts and exposes workers to cancer-causing toxins, does a "denim days" campaign raise awareness of breast cancer in a meaningful way, or does it obfuscate and misdirect participant attention?

Finally, a difference between Charlotte Haley's definition of breast cancer awareness and Evelyn Lauder's can be understood as commitments toward pedagogical movements of social change or of social preservation. Haley's peach ribbon aimed to educate women to take stock of breast cancer as a health issue writ-large in the U.S. and to organize demonstrations in public spaces for political action. From its outset, the pink ribbon tied together corporate marketing and gendered consumerism to advance breast cancer awareness that courted rather than demanded social and political action for women's health. Haley encouraged women to be self-educating actors, to learn about breast cancer's rising rates, its known causes, and the reasons why, in terms of congressional funding, it received such a low priority in the U.S. Enabled with a shared base of knowledge, women could organize, teach others, and demand change at the local, state, and national level.

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[160] "Join Us to Save Lives from Breast Cancer," *American Cancer Society*. (n.d.). Accessed 2 November 2018. https://www.crowdrise.com/ACSDenimDays#.

The Lauder-*Self* partnership's pink ribbon campaign focused on promoting women's individual responsibility for her breast health. Subsequent corporate cause marketing campaigns and partnerships with growing mainstream breast cancer nonprofit groups continue to promote breast cancer awareness by drawing on gendered behaviors learned over a lifetime. This focus may encourage a woman's capacities as an actor (including her identity and values) to become yoked to gender codes and consumer behaviors in a cancer care context. In fact, it may teach women to internalize a gender-subordinated identity as a rank and file pink soldier.

Concluding Notes

This chapter traces the rise of what I am calling a "pink war machine" in the CIC. As Sontag, Jain, and others observe, a breast or gynecological cancer diagnosis represents a cultural crossing from the "kingdom of the well" into the "kingdom of the sick."[161] This crossing occasions an educational metamorphosis when encounters with educating agents and media in the CIC's pink war machine result in pink war machine values becoming "yoked" to the capacities of the culture crosser.[162] An educational metamorphosis happens as a person internalizes the identity of "cancer patient" and "soldier-survivor."[163] A pedagogy for patient-soldier-survivor education, both implicit and explicit and both formal and informal, conditions minds and bodies to comply with CIC values and practices. For women with BGC diagnosis entering the CIC through the pink war machine gate, an unstated pedagogic goal is compelling patient conformity to values and practices of a consumer culture, entrenched medical authoritarianism, and gendered ("pink") narratives of individual and communal identity.

In this chapter I have considered how these practices and values reaffirm exploitative and gender-subordinating conditions, both inside and outside the CIC and its pink war machine. This

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[161] Sontag, *Illiness as Metaphor*, 3.
[162] Martin, *Educational Metamorphoses* and *Education Reconfigured*.
[163] Ibid.

chapter highlights how institutional gender subordination in the CIC reflects wider conditions of structural gender subordination that are, as reflected in the values of the deep structure of educational thought,[164] inherent to western culture. Patient education continues to present BGCs as individual women's crises in need of masculine-authorized, medical management.[165] At the same time, both formal and hidden pink-war-machine curricula present normative, gender-subordinating values as necessary for regaining health. These messages benefit commercial-industrial interests and reaffirm the legitimacy of a gendered, social power hierarchy in breast and gynecological cancers; conditions I argue are educational problems.[166] The next chapter explores how these messages may be revealed as miseducating and refused as part of a gender-insubordinate educational intervention.

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[164] Martin, *Education Reconfigured,* 28.

[165] Notwithstanding significant a growing recognition of the false binary concepts of sex and gender, challenges to sex/gender biases occurring from the late 20th century up to the present, and females entering the medical professions in numbers on parity with males, authoritarian behaviors in medical practice are resistant to change as they are still taught and learned in medical schools. These behaviors reflect male/masculine epistemic biases in wider culutre.

[166] I call these outcomes educational "problems" rather than miseducational because pink war machine's educating agents and institutions aim to reaffirm of normative gender values in BGC patient education; this effect is an expected outcome.

Chapter Two: The Breaking of a Pink War Machine

Body-Mind Practices for Gender Insubordinate Education

> "I know beyond fear and history
> that our teaching means keeping trust
> with less and less correctness
> only with ourselves"
> --Audre Lorde, "Dear Toni …"
> *The Collected Poems of Audre Lorde*[1]

In the last chapter, I considered various ways commerce, medical authoritarianism, and normative narratives of the pink war machine transmit a curriculum for gender-subordinating values within and outside the CIC. This chapter considers the educational significance of cancer narratives that challenge the pink war machine's gender values, collectively creating a pink war "narrative underground." I look at three cases of nonconventional texts and consider each author's thinking and behaviors that reveal "gender insubordination" (GI) as a response to pink war. To begin theorizing a concept of gender insubordination, a guiding premise of this project rejects the notion of superior, transcendent, and rational "minds" divided from their inferior, decaying, and animalistic bodies.[2] I work from Jane Roland Martin's theory that a divided mind-body epistemic paradigm extends down to the roots or "deep structure of educational thought" to consider the way this deep structure guides teaching and learning in the pink war machine.[3]

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[1] Lorde, *The Collected Poems of Audre Lorde,* "Dear Toni Instead of a Letter of Congratulation upon Your Book and Your Daughter Who You Say You Are Raising To Be a Correct Little Sister," 94.

[2] See, John Dewey, *Democracy and Education* (New York: Start Publishing, 2012), 152-155. Dewey avers, (152). He lists some of the "evil" effects in education of this dualism, including framing the body as an "intruder" in learning processes (152). When the body and mind are deliberately separated and "recognition of meaning" is reduced to demonstration of mechanistic steps in a procedure, creativity is stunted. This influences not just learning in the arts, but also in math and science. (153). Most relevant to this study is Dewey's observation that this dualism encourages a parts-focused knowledge based in "inventorying and enumerating" the "isolated qualities" of something rather than the connections among the parts that make up the whole and the way the whole object interacts in series of connected relations with other objects and the environment (155). This legacy is strongly evidenced in modern medicine with its parts-focus approach that can blinder healthcare providers to the well being of the whole person in her or his environment. A parts-focused approach dominates western breast cancer treatment and culture as breasts are, in themselves, iconic body parts.

[3] See, Jane Roland Martin, *Education Reconfigured: Culture, Encounter, and Change.* (New York: Routledge, 2011), 29-30. Martin notes that "[T]he line of demarcation" between the labors and knowledge of the public and

After the educational thought of John Dewey, I use his term “body-mind” to refer to an alternate, unified conception of human physical, emotional, moral, and intellectual life and development.[4] There are two guiding questions in this chapter, “What can GI mean in the context of the pink war machine narratives?” and, “As a strategy for revealing and redressing GS, how can GI be enacted?” To address the first question, I begin with an etymological-philosophical sketch of the concept of insubordination as a problem of rebellion in hierarchal frameworks and, alternatively, as a just response to intolerable rule. From here, I consider Judith Butler’s (1993) concept of “gender insubordination” as a response to heterosexual hegemony and build upon her theorizing to extend the significance of gender insubordination to cancer care.

To turn to the second question, how can GI be enacted, I consider ways that dissenting BGC patient voices express dissatisfaction with pink war education and present critical, alternative perspectives through a self-educating, autobiographical practice. I propose that three kinds of GI are evident in BGC narratives, emergent-conflicted, instigative/informer, and restorative/reformer, and I present a brief, exemplary case of each. I consider how GI narratives

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private spheres of human social life “also represents a gender divide.” She observes, Historically, women have, for the most part, performed the activities and processes of the world of the private home and men have, for the most part, performed those belonging to the world of work, politics, and the professions,” with the former labor devalued and labeled “feminine” and the later admired, financially remunerated, and labeled “masculine” (30). This deep-structure, divided-world, sub-narrative is diffused in various contexts and to various ends throughout western social structures and institutions. Additionally, other dualisms can be extrapolated from the divided mind/body premise and framed as “natural,” self-evident justifications for domination along either/or axes of socially constructed difference such as male/female, white/nonwhite, abled/disabled, culture/nature, etc. Given Martin’s central point that education happens when and where a person and some portion of cultural stock are brought together with an end result of a net change for both the learner and culture, the effects of the deep-structure’s potency in education cannot be underestimated.

[4] In *Experience and Nature* (1925) John Dewey refers to the “body-mind” as descriptor of what he contends “actually takes place when a living body is implicated in situations of discourse, communication and participation.” See, John Dewey, *Experience and Nature* Dover, 1925/2000, 350. After Dewey, I am using the phrase “body-mind” instead of “embodied” to place deliberate emphasis on the idea that all human experience, including the experience of thinking, comes through bodies that are indivisible from minds. Whereas being “embodied” suggests the body as a casing for a non-body object (the “embodied” mind), body-mind suggests unification. “Body-mind” also inverts and collapses the Cartesian dualism of mind/body, signifying the unification and indivisibility of the body and mind but deliberately putting the body first. However, with an ever-increasing understanding of the microbiome living on and within the body and the role microbiota play in health, cognition, emotion, and even individual personality traits, body-mind may also be the most accurate description for physiological processes creating sentience.

of each kind reveal self-educating responses to pink commerce, medical authoritarianism, and pink war normative narratives and how these autobiographical works may serve as curricular resources for educating others. In my encounters with BGC narratives,[5] I argue that pink war normative narratives and GI narratives are educational autobiographies. Whereas the first details a writer's awareness of internalizing pink war messages that shape the body-mind, the second refuses some or all of pink war education.

A Lack of Discipline in the Ranks: A Brief History of Insubordination

Across the world and millennia, insubordination has been widely understood as a state of rebelliousness or disobedience to authority. It is a breach of contract, a breaking of conventions, a willful disregard for the socially necessary and the "good." Even in linguistic theory, where the concept denotes a subordinate or dependent clause acting as a main clause, the construction is considered "improper," a breaking of the rules of formal language and grammar. Generally, the human species takes a dim view of any insubordinate behavior, deeming it extremely undesirable, even dangerous to a group's functioning and survival.[6] However, an irony of vilifying insubordination in cultures claiming a shared Abrahamic history is that insubordination is central to the plotline of many stories of human[7] and cultural origin. It is our foremother's—

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[5] I use the term "encountering" here rather than "reading" after Martin's notion of education as encounter to highlight my commitment to reading not as a passive activity and interpretation not as a fixed response but as a dynamic process of learning through encountering. See, Jane Roland Martin, *Education Reconfigured: Culture, Encounter, and Change.* (New York: Routledge, 2011), 19.

[6] *Merriam-Webster's Collegiate Dictionary*, 11th ed., 2009, KL 608894. See also *The Chambers Dictionary*, 12th ed., 2011, p. 790.

[7] According to Jewish mythology and Talmudic commentary, after God created Adam he created the first woman, Lilith of the same clay to be his companion. However, Adam complained to God that Lilith would not listen to him. She was too willful, insubordinate to his commands. Lilith abandoned Adam and left Eden, so God created Eve, a woman formed from the body of Adam, to replace her. By design, Eve was supposed to remain loyal and subservient to Adam. However, Eve, the weaker being and tempted by the serpent/Satan, was the first to taste the forbidden fruit and then convinced Adam, to try some too. From this mythic tradition, we can understand that from the outset of human life and the expulsion from Eden, insubordination was a problem of female disobedience to male authority.
See Siegmund Hurwitz, *Lilith, the First Eve: Historical and Psychological Aspects of the Dark Feminine* [Kindle Edition] (Einsiedeln, Switzerland: Daimon Verlag, 1999), Kindle Location 2321-2326.

Eve's— "original sin" of disobedience, and, like it or not, insubordination underpins society and culture and religious and secular law.

The root of subordination is *ordinis* (Lat.)*,* meaning rank, sequence, or order, and relating to authority and hierarchal placement.[8] However, the critical difference between the subordinate, the ordinate, and the *in*subordinate is that the latter is a claim jumper. As the Latin prefix denotes, the action of insubordination negates the one intended, *ordination,* which originally meant to be placed in proper order.[9] Just as the "ineffective" does not achieve its aims; the "insincere" cannot be believed, and the "incomplete" is never whole or finished, the insubordinate is "out of order." And, like a washing machine in a laundromat with an "out of order," sign, the insubordinate put extra strain on the others that are in working order or working "as ordered." The insubordinate poses a threat to the entire working order, the social system of a community.

According to St. Augustine, as a result of humanity's shared roots in Edenic insubordination, we each bear the burden of having "insubordinate" bodies. He complains, "Our flesh, which was subjected to us, now [also] torments us by insubordination," namely by its sexuality and desires.[10] Augustine's notion of an inferior body not "obeying" the dictates of the mind, which occupies a "superior" position, is an example of just how deep in western culture the deep structure of educational thought extends.[11] However, insubordination is more than a problem of hormonal and physiological "rebellion" in one's body. Individuals who lack the will

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[8] See *Chambers Etymology Dictionary*, 1999. This is conveyed in such words as "ordain" (to appoint orders upon), "accord" (to comply with), "orderly" (one who carries orders), "ordinance" (an authoritative command), and "ordinary" (a civil or religious officer with the power to make laws).

[9] See, "ordination, n.". OED Online. December 2018. Oxford University Press. Accessed 18 December 2018. http://www.oed.com.ezproxy.lib.ou.edu/view/Entry/132365?redirectedFrom=ordination .

[10] Augustine of Hippo, *City of God,* Marcus Dods, Trans., (Peabody, MA: Hendrickson Publishers, 2009), bk. 14, chap. 15, p. 418.
In the original Latin, "insubordination" is *non seruiendo,* which can also be translated as disobedient.

[11] Martin traces the roots of the notion of a divided world of human culture/nature, thinking mind/feeling body and male/female to ancient Greek thought See *Education Reconfigured,* 28.

to follow social ordering and orders pose a threat to the wellbeing of the entire group. In *Strong's Greek and Hebrew Dictionary of the Bible,* "insubordinate" (in Greek *ἀνυπότακτος*, transliterated *anupotaktos*) is defined as "not subject to rule; unruly," and *Strong's* lists references insubordination as occurring three times in the New Testament.[12] These passages show a biblical precedent for perceiving insubordination as a dangerous threat to a community's welfare that needs to be squelched. Insubordinate behavior merits severe punitive consequences, but why is it so very egregious? To return to the context of BGCs, how does insubordination pose a threat to the pink war machine?

Insubordination as a Threat to Masculine Power

In *Three Guineas* (1938), Virginia Woolf offers an observation for understanding insubordination as a consequence of a masculine system of competition for dominance in hierarchies and the process of males being sorted out for "ordination" within a social system. She draws a connection between clothing and titles designating rank in the military and the university and "a disposition towards war,"[13] concluding both military uniforms and academic robes are designed to "impress the beholder with the majesty"[14] of the wearer's position as a leader in "the professional system with its possessiveness, its jealousy, its pugnacity, [and] its greed."[15] Woolf's critique of what male vestments symbolize to other males and their function

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[12] These references to insubordination occur in Timothy 1:9, Titus 1:6, and Titus 1:10 See also James Strong, *Strong's Greek and Hebrew Dictionary of the Bible,* Kindle Edition. (Miklal Software Solutions, 2011), entries 506 (Kindle Location 39195), 813 (Kindle Location 39929). For example, see these passages in Young's Literal Translation of the Bible (YLT). In other English versions such as the King James Version, the translation is often rendered as "disobedient" or "unruly"; synonyms for insubordinate. In 1 Timothy 1:9, the insubordinate person is placed in a category of social deviants with the "lawless," the "ungodly and sinners," "the unholy and profane," and "murderers." In Titus 1:6, an elder capable of creating civil order or a person in a position of authority, must not have children who are "insubordinate," or accused of "riotous living," suggesting they must not incite anarchy and violence. And in Titus 1:10, insubordinate people are grouped with the "vain talkers" and "deceivers" as those "whose mouth[s] it behoveth [others] to stop."

[13] Virginia Woolf., *Three Guineas* (New York: Harcourt Inc., 1966), 21.

[14] Ibid.

[15] Ibid., 74.

in the public world echoes Hobbes' rationale for the necessity of hierarchal power relations in a social contract where life outside of a sovereign-controlled commonwealth is "solitary, poor, nasty, brutish, and short."[16] However, Woolf argues that masculinized culture, not innate human character, gives rise to social violence and destruction.

As a threat to social order, insubordination arises within the ranks of a group. It is a challenge to authority that comes from within and beneath the superior(s) rather than originating outside the community or from one in a position of greater power. As a threat from within and below, the insubordinate cannot simply leave. This actor has a need or strong desire to stay in the community that supersedes any dissatisfaction with it, however expressed. Woolf's analysis suggests that the social institutions in which insubordination arises—the military, universities, the world of commerce and politics, etc., are public institutions governed by masculine authority. However, the "private house," or domestic sphere, is also a part of what Woolf calls the "patriarchal system" of social order.[17] Across all contexts and settings, insubordination is a rooted in masculine competition for domination—male power over others, power over property, power over the bodies and minds of women and children. In the sense that insubordination arises from "jealousy, pugnacity and greed,"[18] it is commonly understood as a willful disobedience to authority or what can be called a self-interested insubordination. While actions of self-interested insubordination are taken to address an actor's unmet need or desire for something (e.g., higher pay, revenge, etc.) or to right a perceived wrong, the results of the action may be detrimental to others. However, if they do benefit others, that benefit is coincidental to the actor's own.

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[16] Thomas Hobbes, *Leviathan, or the Matter, Forme, & Power of a Common-wealth, Ecclesiastical and Civill,* (1651, Project Gutenberg, 2013), Chapter XIII, par. 8. Accessed 29 January 2017. https://www.gutenberg.org/files/3207/3207-h/3207-h.htm#link2HCH0013.

[17] Ibid., 64.

[18] Woolf, *Three Guineas.*

Insubordination as Conscientious Objection to Tyranny, Violence, and War

There is an alternative conception of insubordination that has long been understood as a response to gross disparities and oppression, one that takes the needs of others as much or more into account as the needs of the actor. I am calling insubordination in this "ethically reasoned." This variety of insubordination is motivated by a desire to address an injustice beyond an immediate concern for one's own interest or grievance.[19] Precedents for an ethically-reasoned notion of insubordination are found in the ancient Greek practice of *parrhesia*, a public act of speaking truth to power to advance a social good.[20] Ethically-reasoned insubordination also has

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[19] In Critical Legal Studies, the principal of *anti-subordination* also provides a helpful precedent for thinking about how claiming the position of "not inferior" may be theorized and to what ends it may be enacted. Anti-subordination holds that "society is a racial patriarchy" and "people at the bottom, e.g., women and blacks, do not have sufficient power to control or value their own lives. . . . The anti-subordination principle is a group-based perspective grounded in an understanding of the way certain groups have historically been treated unequally" (Colker 64-65). This position of the anti-subordination legal actor or argument is that widespread conditions of subordination and marginalization based on race and gender are not address in colorblind or genderblind interpretations of law. Jack Balkin and Reva Siegal argue that the significance of a legal principle of anti-subordination is no less than a "struggle over cultural memory, over the narrative that defined what Americans as a nation had accomplished" (31). Although anti-subordination is seen as a radical perspective in legal studies, its contribution to advancing social justice in law is vital:

> "Equality . . . is not just about the Aristotelian insistence that like cases be treated alike. It is about the struggle against subordination in societies with entrenched social hierarchies. It is about the lived experience of people on the bottom who strive for dignity and respect. And it is about the structures and strategies, institutions and practices that continually deny them this prize all the while professing to bestow it." (31)

Anti-subordination's guiding principle is that differences in experience and intersections of identity matter for advancing social equity.

[20] See, Michel Foucault, *Fearless Speech,* Joseph Pearson, Ed., (Los Angeles: Semiotext(e), 2001), 16-19; 108. Foucault traces the definitional genealogy of politically and philosophically motivated forms of *parrhesia* from his reading of Greek texts (2001), and he argues that the *parrhesiastes* (the one who engages in "fearless speech") shows courage by telling what he perceives as ethical truth from "a position of inferiority with respect to the interlocutor," such as when "a philosopher criticizes a tyrant, when a citizen criticizes the majority, [and] when "a pupil criticizes his teacher." They do this based on a perceived duty to others and on behalf of communal welfare. According to Foucault, in its earliest form, not everyone could be a *parrhesiastes;* to exercise *parrhesia* or to possibly risk one's life in a truth-telling "game" was a right to engage in public politics granted only to male citizens (16-18). In Euripides's *Hippolytus* (428 BC)*,* Foucault finds further evidence that the *parrhesiates* is a high-born male citizen and well-respected member of the community as a social and moral leader (31). However, he also cites an example from Euripides's *Electra* (ca. 410 BC) in the dialog between Electra and her mother, Clytmnestra (34), so it seems that while *parrhesia* was generally reserved for men, on occasion, a high-born woman could exercise this right too but never a slave (30).

Further evidence of a woman as a *parrhesiates* is found in Sophocles' *Antigone* (ca. 441 BC) when Antigone, sentenced by Creon to be entombed alive, speaks to Creon and his senators as she is being led away: "The Fathers of my race! . . . Behold me, lords, . . . what doom is mine, And at whose hands, and for what cause—that I duly performed the dues of piety!" For more, see, Sophocles, *Antigone,* George Young, Trans. [Kindle Edition]. (New York: Dover Thrift, 1993), Kindle location 542. Quoting from *Antigone* in *Rhetoric,* Aristotle draws a distinction roots in Greek thought about ethics in state rule or human law clashing with natural rights, which is the idea that “a human being is a person” with “rights [that] are inalienable and imprescriptible . . . [all of which may] consecrate the idea of the dignity of the human person.”[21] However, there is no guarantee that ethically-reasoned insubordination is always enacted to wholly “good” and selfless ends or that self-interested insubordination is always based solely in selfish motivations. Rarely are such clear-cut distinctions accurate.[22]

Nicholas Evans and Honoré Watanabe (2016) point out that almost universally, a speaker’s use of subordinate clauses as major clauses, (linguistic insubordination) is taken as a sign of the speaker’s low social status and lack of education. However, they argue that these “messy structures” reveal real time, dynamic processes of linguistic evolution. Acting as insider-rebels, native speakers who use insubordinate clauses pose a threat to syntax conventions but also challenge their languages to remain vital expressions of culture.[23] Similarly, Foucault sees the potential of ethically reasoned insubordination to change social order by both advancing democratic aims and destructive ends. He argues that “it would not be possible for power relations to exist without points of insubordination, which, by definition, are means of escape. … In effect, between a relationship of power and a strategy of struggle there is a reciprocal appeal, a perpetual linking and a perpetual reversal.”[24] Foucault’s analysis of human cultural history

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between natural law (the moral law Antigone claims as a defense for her disobedience to Creon) and written law and pointedly remarks that “one cannot alter justice either by fraud or compulsion, for it is based upon nature, whereas contracts may be entered into under both conditions.” For more, see, Aristotle, *Rhetoric* [Kindle Edition]. (Oxfordshire, England: Acheron Press, 2012), Kindle location 924-972.

[21] Paul Foriers and Chaim Perelman, “Natural Law and Natural Rights,” *The Dictionary of the History of Ideas, Vol. 3: Studies of Selected Pivotal Ideas* (New York: Macmillan, 1980), 14.

[22] Conspicuous examples such as the American Revolution and French Revolution show that ethically reasoned motives for insubordination, even when addressing gross social injustices, can lead to violence and war. These are conditions that Woolf saw as rooted in a destructive masculine ethic, an ethic, as I argued earlier, that both inspires insubordination and casts insubordination as a dangerous threat.

[23] Nicholas Evans and Honoré Watanabe, “The Dynamincs of Insubordination: An Overview,” in *Insubordination: Typological Studies in Language*, eds. Nicholas Evans and Honoré Watanabe, (Philadelphia: John Benjamins Publishing Company, 2016), 2.

[24] Michel Foucault, “The Subject and Power,” *Critical Inquiry 8* No. 4 (1982):794.

raises the question of power's meaning, even our ability to recognize "power" as the exercise of authority over others and the institutions and laws that legitimate authority without a co-reliant concept of insubordination.

In the late modern era, the ideas of civil disobedience and conscientious objection are widely recognized as legitimate strategies for social change and the shaping of history. Henry David Thoreau's insubordinate thought influenced Mahatma Gandhi's nonviolent protests, Martin Luther King's civil rights campaigns,[25] and political philosopher John Rawls' defense of civil disobedience.[26] In this tradition and in consideration of "insubordination" being defined as an absence of subordination and claiming a "not inferior" stance,[27] civil disobedience can be

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The idea that natural law justifies insubordination as a "means of escape" under conditions of tyranny underlies the thinking of Locke's social contract theory. This initiative was put into action during the American Revolution and was later the basis of Thoreau's 1849 conscientious objection to American slavery and colonialism during the Mexican-American War in his polemic "On the Duty of Civil Disobedience." Thoreau writes: "[W]hen a sixth of the population of a nation which has undertaken to be the refuge of liberty are slaves, and a whole country is unjustly overrun and conquered by a foreign army, and subjected to military law, I think that it is not too soon for honest men to rebel and revolutionize. What makes this duty the more urgent is that fact that the country so overrun is not our own, but ours is the invading army." For more, see, Henry David Thoreau, "On Civil Disobedience," 4.

[25] See, Gandhi Sevagram Ashram, *Gandhi Literature: Collected Works of Mahatma Gandhi Vol 1-98*. Vol. 7., 187-201. (2015). Accessed 2 April 2017. http://www.gandhiashramsevagram.org/gandhi-literature/collected-works-of-mahatma-gandhi-volume-1-to-98.php .
See also, *Autobiography of Martin Luther King Jr.,* Clayborn Carson, Ed. (New York: Warner Books, 2001), 54.

[26] John Rawls (1971) defines civil disobedience as "a public, nonviolent, conscientious yet political act contrary to law usually done with the aim of bring about a change in the law of policies of a government" (*A Theory of Justice* 1999, 320). This assumes that the society is not a totalitarian regime and the ideals of the laws suggest a potential for a more equitable distributing resources, including the political power to have a voice in reforming laws. Rawls argues there are three prerequisite conditions for enacting civil disobedience when it involves expressly illegal acts (unlike, for example, permitted, restricted, and monitored protesting): first, that the injustice is not minor or fleeting, but lasting and inflicts widespread, oppressive conditions that are ethical violations of the law; second, that other legal strategies of intervention and reform have been attempted and have failed; and third, that not too many diverse factions with competing complaints engage in civil disobedience at the same time (326-329).

[27] The second definition listed in the *Oxford English Dictionary* for "insubordination" is "[t]he absence of subordination or submission." Further, the adjective "insubordinate," can mean "not inferior." This meaning is cited in a passage from an 1868 text referring to buildings adjacent to St. Paul's Cathedral as soaring to an "insubordinate height." Finally, a synonym for "inferior" is "subordinate." From these meanings, it follows that a designation of "insubordinate" may connote the condition of an object, idea, or person being "not inferior" in comparison to others. See, "Insubordination, n.". OED Online. December 2017. Oxford University Press. Accessed 26 January 2018. http://www.oed.com.ezproxy.lib.ou.edu/view/Entry/97185?redirectedFrom=insubordination.
See also, "Insubordinate, adj. and n.". OED Online. December 2017. Oxford University Press. Accessed 26 January 2018. http://www.oed.com.ezproxy.lib.ou.edu/view/Entry/97184?redirectedFrom=insubordinate .
See also, "Inferior, adj. and n.". OED Online. December 2017. Oxford University Press. Accessed 26 January 2018. http://www.oed.com.ezproxy.lib.ou.edu/view/Entry/95313?redirectedFrom=inferior.

understood as a form of ethically-reasoned insubordination. The aim of ethically-reasoned insubordination is not the widespread destruction of social order but, as Rawls argues is his defense of civil disobedience, to act in ways perceived necessary to end prevailing conditions of oppression.[28] In a word, ethically-reasoned insubordination is action taken to *conserve*--to restore and protect community.[29]

Insubordination as a Challenge to Heteronormativity: Judith Butler's Gender Insubordination

Categories connoting identity like "gender" always assign social power. Judith Butler argues that the use of these labels to claim power, even with strategies intended to challenge what is oppressive, can lead to repeating patterns of domination and subordination. In *Imitation and Gender Subordination* (1993), she argues that gender and other categories like race and class are "instruments of regulatory regimes whether as the normalizing categories of oppressive structures or as the rallying points for a liberatory contestation of that very oppression."[30] This is not to say that power exerted to resist oppression always leads to more oppression; only that it can. As Foucault contends, "there are no relations of power without resistances; the latter are all the more real and effective because they are formed right at the point where relations of power are exercised."[31]

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[28] John Rawls, *A Theory of Justice,* Revised ed. (Cambridge, MA: Belknap Press, 1999), 320-321.

[29] For this reason, conceiving of ethically-reasoned insubordination foremost as wholesale rebellion, revolution, or anarchy limits its effectiveness. In fact, imagining oneself continuously embattled is not in the spirit of this option and is emotionally draining, especially if the adversarial force or power is both pervasive and pernicious. This strategy also risks blocking possibilities of cooperative action with those in positions of power who may be allies. For example, in a study of insubordination in school principals who defy repressive district policies to support their staff and student needs, researchers found that these principals often work in partnerships with district supervisors to pursue strategies of "creative insubordination" when doing so is possible. Finally, imagining insubordination in a romantic vein as requiring revolution may justify the use of any means to achieve goals, such as perpetuating conditions of war and violence, but it is not accurate in regard to the uses of this option. The choice of means for achieving goals in ethically-reasoned insubordination always needs prudential consideration to ensure that actions and results do get overly-simplified and reduced to an overly-small range of options.

[30] Judith Butler, "Imitation and Gender Subordination," *The Lesbian and Gay Studies Reader,* Henry Ablelove, Michèle Aina Barale, and David M. Halperin, Eds. (New York: Routledge, 1993), 308.

[31] Michele Foucault, "The Eye of Power," *Power/Knowledge: Selected Interviews and Other Writings 1972-1977,* C. Gordon, Ed., (Hempstead: Harvester, 1980), 142.

As a means to move beyond an endlessly repeating power-struggle paradigm, Butler seeks to negate the category of gender as a medium of power once and for all. This is a seemingly impossible task as gender shapes us from birth and is socially assigned. As Butler contends, "Gender is the repeated stylization of the body, a set of repeated acts within a highly rigid regulatory frame that congeal over time to produce the appearance of substance, of a natural sort of being"[32] She coins the term "gender insubordination" as a broad designation for what can be understood as an anti-gender political stance and also as actions taken for "undoing" gender. Her intention is to refute gender's legitimacy, originality, and its established meaning as a social concept and category of human identity.

In *Bodies that Matter: On the Discursive Limits of Sex* (1993/2011), Butler further explains her project of undoing gender to challenge the notion that unequal and opposite binaries such as male/female and masculine/feminine are natural or fixed. She argues that gender, sex, sexuality, and even bodies can only be understood as discursive reproductions or *performances.* Her position is not strictly immaterialism; she grants that material objects like bodies do exist. However, that physical existence has no meaningful significance outside of what it is assigned in language and culture. She contends, "we might suggest that bodies only appear, only endure, only live with the productive constraints of certain highly gendered regulatory schemas."[33] She argues that the language by which we define and describe bodies is never value neutral. Discourses norm what they name.[34] For this reason, she is troubled by claims of any material, "natural" essence, especially in regard to bodies, sex, and gender. Butler sees such nature-based claims as political strategies creating and supporting oppressive hierarchal power relations.[35]

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[32] Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (New York: Routledge, 1990/2006), 45.

[33] Judith Butler, *Bodies that Matter: On the Discursive Limits of Sex* (United States: Routledge, 2011), Kindle, 142-150.

[34] Ibid., 385.

[35] Ibid., 385-390.

The discursive/material binary that her approach suggests also may serve to re-inscribe the same type of hierarchy she aims to dismantle and, digging down farther, to re-inscribe the mind/body dualisms that Dewey called an "evil" in education when the body is seen as an "intruder," or nuisance to the mind.[36]

Raised as we are with the "deep structure of educational thought"[37] shaping our perceptions, even women with feminist commitments to challenge and undo sex-gender based systems of oppression may become annoyed when the rhythms of intellectual life are disrupted by the material body. In her autobiographical essay "White Glasses" (1999), epistemologist and queer theorist Eve Kosofsky Sedgwick brings together her work with her breast cancer diagnosis, remarking, "It's as though there were transformative political work to be done just by being able to be identified with the very grain of one's illness (which is to say, the grain of one's own intellectual, emotional, bodily self as refracted through illness and as resistant to it)."[38] Similarly, in her 2010 TED talk, "Suddenly, My Body," Eve Ensler confesses that although her career as a feminist playwright and activist focuses on women's bodies, especially vaginas, she felt herself to be a detached head and her body to be a "machine," a thing that she (the head) could use, direct, exploit, and neglect for the higher purpose of her important intellectual labor. She tells the audience that with her ovarian cancer diagnosis, "suddenly I had a body," and that "cancer exploded the wall of my disconnection" between mind and body.[39]

Butler's perspective that bodies "exist" for us through discursive constructions does not diminish bodies' physical and social significance in quotidian existence. Social constructions

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[36] Dewey, *Democracy and Education*, 152.
[37] Martin, *Education Reconfigured.*
[38] Eve Kosofsky Sedgwick, "White Glasses," *Living on the Margins: Women Writers on Breast Cancer* (New York: Persea Books, 1999), 68.
[39] Even Ensler, "Suddenly, My Body," filmed December 2010, TEDWomen Video, length 12:49, https://www.ted.com/talks/eve_ensler#t-356270 See especially 5:28-6:05.

like gender, race, class, and disability can be challenged as bases of subordination and disparities in cancer treatment while acknowledging that these concepts convey meaning and value as "items of cultural stock" and, therefore, urgently need attention in the educational realm.[40] The "democratic promise" Butler entrusts to gender insubordination to "permanently trouble" how we think about gender as a social construct asserting power over bodies extends its potential beyond negating gender altogether. Such a reframing of gender insubordination pragmatically advances GI in social, immediate contexts, such as in shaping how we experience health and illness.

Theorizing Educating Action for GI in the Pink War Machine: The Narrative "Underground"

As Butler argues, "gender is a kind of imitation for which there is no original,"[41] but the significance we assign to gender and its effects in BGC patient treatment and education are very real. Gender's intersections with other social constructions such as race, sexual orientation, and social class[42] have direct bearing on experiences of BGC diagnosis and treatment and cancer's mortality rates. The reasons for some of these differences are complexly varied in and between groups and not yet fully understood.[43] For example, while some medical research findings argue genetic expression is the cause of higher breast cancer mortality rates and differential pathogeneses for African American women compared to other minority groups and white women, other studies contest conclusions that a biological basis in race determines risk.[44] In

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[40] Martin, *Education Reconfigured*, 53.

[41] Butler, "Imitation and Gender Insubordination," 313.

[42] For a discussion on the concept of intersecting oppressions and the importance of how claim these distinctions and take them into account in affecting social disparities, including in healthcare, see, Nira Yuval-Davis, "Intersectionality and Feminist Politics," *European Journal of Women's Studies 13* No. 3 (2006): 198-209.

[43] For example, see Vickie L. Shavers and Martin L. Brown, "Racial and Ethnic Disparities in the Receipt of Cancer Treatment," *Journal of the National Cancer Institute 94* No. 5 (2002): 334-357. Accessed 16 December. https://academic.oup.com/jnci/article/94/5/334/2520084/Racial-and-Ethnic-Disparities-in-the-Receipt-of.

[44] For example, medical research still does not fully understand why Black women have a higher risk of developing a type of breast cancer called triple negative, which does not respond to many traditional treatments for controlling hormone-receptor positive breast cancers. However, while African-American women have a slightly lower risk of

addition, qualitative studies reveal patient perceptions of racial discrimination and profiling[45] and ongoing gender and race biases in medical research, such as the underrepresentation of women of color in drug trials.[46] Other examples of gender combined with other factors in shaping diagnosis and treatment experiences include a lack of access for women with disabilities to diagnostic screenings like mammograms,[47] and commonly reported perceptions of doctors spending less time with disabled women.[48] Obesity and mental illness are also reported as factors in the lower quality of patient care and patients receiving less education about their treatment and diagnosis from healthcare providers.[49] Social class[50] and sexuality[51] are also bases upon which

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developing breast cancer than Caucasian-Americans, they have a much higher risk of dying from it. This and other factors and their genetic-racial and cultural-lifestyle bases remain a contested topic in medical research.
For example, see Humberto Parada Jr., et. al., "Race Associated Biological Differences Among Luminal A and Basal-Like Breast Cancers in the Carolina Breast Cancer Study," *Breast Cancer Research* [Open Access Online Journal] 19:131 (2017). 7 November 2017. Date Accessed 21 January 2018. https://breast-cancer-research.biomedcentral.com/articles/10.1186/s13058-017-0914-6.
See also, Ryan A. Denu, "Reported Biologic Difference in Breast Cancer by Race Are Due to Disparities in Screening," *JAMA Oncology 1* No. 4 (2018): 883.

[45] Thu Quach, et. Al. "Experiences and Perception sof Medical Discrimination Among a Multiethnic Sample of Breast Cancer Patients in the Greater San Francisco Bay Area, California," *American Journal of Public Health 102* No. 5 (2012): 1027-1034.

[46] See also, Laurén A. Doamekpor and Diana Zuckerman, "Lack of African Americans in Breast Cancer Studies Results in Less Effective Treatment and Higher Death Rate," *Cancer Prevention and Treatment Fund.* 2017. Accessed 20 May 2017. http://www.stopcancerfund.org/in-the-news/lack-of-diversity-in-cancer-drug-clinical-trials-may-exacerbate-racial-disparities-in-mortality-rates/.

[47] Jordyn Taylor, "Women with Disabilities are More Likely to Die of Breast Cancer – Here's Why," *Mic Network Inc.*, last modified February 17, 2016. https://mic.com/articles/134979/women-with-disabilities-are-more-likely-to-die-of-breast-cancer-here-s-why#.UnU6zNoGO

[48] Marissa Weiss, "Study Finds Discrimination Against Disabled Patients," *ABC News*. November 6, 2006. Accessed 4 August 2018. http://abcnews.go.com/Health/story?id=2633167&page=1.

[49] Beth Fand Incollingo, "Weight Bias in Healthcare Endangers Obese Women with Breast Cancer," *Oncology Nursing News*. April 27, 2015. Accessed 4 August 2018. https://www.oncnursingnews.com/conference-coverage/ons-2015/Weight-Bias-in-Healthcare-Endangers-Obese-Women-with-Breast-Cancer.

[50] See Christine Bouchardy, Helena M. Verkooijen and Gérald Fioretta, "Social Class is an Important and Independent Prognostic Factor of Breast Cancer Mortality," *International Journal of Cancer 119* (2006): 1145-1151. Accessed 16 December 2016. https://www.researchgate.net/profile/Christine_Bouchardy/publication/7220896_Bouchardy_C_Verkooijen_H_Fioretta_GSocial_class_is_an_important_and_independent_prognostic_factor_of_breast_cancer_mortality_Int_J_Cancer_1191_145-151/links/54c25f690cf2911c7a473a2d.pdf.

[51] See Gwendolyn P. Quinn, et. al., "Cancer and Lesbian, Gay, Bisexual, Transgender/Transsexual, and Queer/Questioning Populations (LGBTQ)," *CA: A Cancer Journal for Clinicians 65* No. 5 (2015): 384-400. Accessed 12 December 2016. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4609168/.
See also, American Osteopathic Association. "Unconscious Bias Among Physicians Results in Low Quality Care for LGBT, Disabled Patients: Invisible Barrier May Be Responsible for Poorer Overall Health Among Special Patient Populations." *ScienceDaily*. 5 October 2015. Accessed 25 January 2018. www.sciencedaily.com/releases/2015/10/151005132723.htm .

breast cancer patients report experiences of discrimination. Given women's experiences of gender subordination in the pink war machine and that women may be diversely and multiply marginalized in cancer treatment, by what means can women individually and collectively demand change?

In *Coming of Age in Academe: Rekindling Women's Hopes and Reforming the Academy,* Martin (1999) provides some guidance. She imagines scenarios in which university students, faculty, and staff resist gender subordination and sexual harassment. Rather than continuing to bear oppressive conditions silently or filing grievances with the campus Title IX coordinator[52] and waiting for conditions to change, the female faculty and students of Martin's imaginary campus are inspired by the metaphoric example of the women in the Greek play *Lysistrata* to "act outrageously," exposing, remonstrating, and refusing gender subordination where and when it occurs. Defiant speech acts, walk outs, and other forms of group action are strategies for resistance that Martin imagines. While she does not list the skills and knowledge female students need to organize resistance to gender subordination on campus, she suggests that collectively, women can democratically teach each other how to recognize oppression and demand change. For example, faculty women may organize regular meetings, inviting female faculty, staff, and students across campus to participate in "feminist *fikas,*" or informal gatherings.[53]

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[52] Jane Roland Martin, *Coming of Age in Academe: Rekindling Women's Hopes and Reforming the Academy* (New York: Routledge, 2000). 167.
Although it is possible that Martin's imaginary students also filed grievances, a rational choice for a first means of recourse, she does not include an account of taking these actions in her described scenario. Rather, she explains that "there is no need to rehearse here the bureaucratic responses that the women faculty at this *fika* would encounter were they to usher a case like this through official channels. I do not say they should not try." Martin's aside here suggests she is skeptical that faculty women helping students to formally filing a grievance against this male professor will result in any change. Rather, in Marin's scenario, to end oppression, the faculty women advise the students to take direct action themselves.

[53] Ibid., 163-165.

Gender biases inherent in the deep structure of Western educational thought and its gender-subordinating effects in BGC's are not natural or self-evident to the human condition but are taught and learned. Martin's scenario of women acting up in response to sexual harassment is a particularly helpful illustration of Michel Foucault's contention that power is spread diffusely throughout the social body, and it is "exercised from innumerable points" and "comes from below" as well as from above with those in positions of authority. [54] Given that those subordinated positions also have power, change can be affected through the exercise of individual and collective activism to resist gender-subordinating conditions. Philosophers of education John Dewey, Paulo Freire, and Jane Roland Martin each argue that a culture's fluidity and dynamic potential for change is a resource to draw from. In Martin's consideration of the deep structure of educational thought and its culture-mind/nature-body split, she avers, "structural change is possible, and . . . [this] change is of the greatest urgency. . .. [T]he fundamental beliefs of education's deep structure systematically narrow down our thinking about education and ruthlessly cut off our options."[55] As she also reminds us, "it is a mistake to assume" that the sex-gender equity gains made since the late twentieth century mean that we have achieved a fully sex-gender egalitarian society. For example, the existence of coeducational spaces does not guarantee sex-gender equity because notions of gender neutrality or gender blindness come with implicit and explicit biases that default to male-masculine norms (54).

While Martin's vision of widespread, grassroots, movements on college campuses remains largely theoretical, the #Me Too online movement is an example of women creating narrative spaces to testify to the prevalence of sexual harassment and oppression and inspiring

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[54] Michele Foucault, *The History of Sexuality: An Introduction Volume 1,* (New York: Vintage Books, 1978/1990) 94.

[55] Jane Roland Martin, *Education Reconfigured*: *Culture, Encounter, and Change* (Routledge, New York, 2011) 28.

other women to do so. For women with BGC's, writing, reading, and responding to autobiographical texts may be a means for creating cross-temporal, intertextual, reader-writer-educating spaces in the spirit of Martin's vision of feminist fikas. Taken collectively, women's GI cancer autobiographies may function as an educational "narrative underground," a space for testifying to diverse experiences of subordination and discrimination and strategizing change within the pink war machine.

However, while insubordinate narratives may help to promote a GI consciousness in writers and readers, examining gender's significance to health- and gender-based oppressive practices in cancer treatment does not mean that GI is a project of "undoing" gender entirely or universally refuting its value as a social construction and item of cultural stock. Martin (2011) explains that while her theory of education as encounter[56] rejects "stereotypical thinking about race, gender, class, disabilities, or any other category" of difference and "also rejects the hierarchies that the stereotypes entail," it does so without "rejecting the concepts of gender, race, class, disabilities" completely.[57] Likewise, I am asserting GI as a set of strategic actions to challenge and change gender subordinating practices without rejecting gender's personal and social significance whole-cloth.

Understood in this way, GI is actions taken by an author on her own behalf and on behalf of others to reject sexism, exploitation, and gender-based, oppressive practices in women's cancer treatment without necessarily renouncing gender entirely. While pink war normative narratives reflect and transmit gender compliance, gender-insubordinate narratives respond to

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[56] Martin, *Education Reconfigured*.

[57] Ibid., 53. Martin gives two reasons for rejecting the effects of these identity constructions without rejecting them wholesale as concepts: "In the first place, as items of cultural stock, these concepts belong in the educational realm. In addition, so long as the culture employs them, it is foolhardy to eschew them" (53).

educating encounters in the pink war machine through autobiographical and auto-ethnographic critiques of gender-subordinating messages and practices.[58]

A universal definition for GI and the conditions it aims to change in BGC treatment cannot be deduced from any single narrative since, as discussed above, gender-subordination may be experienced in different ways or not at all. Time-limited and context determined, GI is not a worldview, a large-scale national or global social movement, a comprehensive educational theory, or synonymous with "feminism." As Butler's example of drag makes clear, gender insubordination is not necessarily focused on specifically "feminist" aims. Rather, as I have conceptualized it in the context of BGC's, GI claims an ethically-reasoned stance asserting the position of "not inferior" by reason of gender and social categories indivisible from gender in a person's identity. As philosopher Iris Marion Young (1994) reminds us, there is no distinct "woman part" or "gender part" that can be isolated from the whole of a person's experiences and sense of self.[59]

Conduct Unbecoming A Pink War Soldier: Gender Insubordination in Cancer Narratives

From my engagement with BGC narratives demonstrating what I am calling gender-insubordinate responses to cancer framed as pink war, I am theorizing three kinds of GI revealing differing authorial perspectives and educational goals. I will consider each of these

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[58] Another possibility is a neutral response to the CIC and cancer culture where gender norms are seemingly not a factor in a woman's account of experience of cancer treatment or her identity during and after treatment. However, as in my earlier response to Frank's assertion that gender is not a factor in identity in illness narratives, I am suggesting that when gender appears to not be a factor because the author makes no direct mention of, gender is diffuse in the cultural air we breathe. It remains entrenched in our thinking and linguistic expression, as Martin notes, it is part of our cultural stock. Further, I would argue when a narrative seems to be gender-neutral, the author's underlying assumptions, her identity and her worldview may still reflect heteronormative, gendered, class, and race biases.

[59] Young, *On Female Body Experience*, Kindle Location 714.

kinds in brief below and in greater detail in Part II.[60] The first kind is *Emergent-Conflicted GI*,[61] wherein GI is manifest in an author's awareness of gender-subordinating practices in her cancer treatment and her questioning of how pink commerce, medical authoritarianism, and normative narratives affect her gender identity and wellbeing post diagnosis. However, there may be limited or inconsistent awareness of the way gender and other categories of identity intersect to create divergent experiences for others.

The second kind of GI narratives, *Insider Informer/Instigative*, reveal a wider social critique and fuller awareness of various gender-subordinating practices that are oppressive and exploitative with the pink war machine. The educational aim of instigative/informer GI is to raise others' awareness of harmful practices that have gone unnoticed and unchecked in BGC treatment. In the third kind of GI, *Reformer-Restorative GI*, the author extends the scope of her critical reflection to consider the consequences of BGCs locally and globally. Here the notion of community is focused beyond one's immediate life, family, and friends, and beyond the medical culture of CIC to the wider world. While the author's personal experience with cancer diagnosis and treatment occasion her awareness of gender-subordinating conditions, reformer-restorative

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[60] Again, these designations are not intended to suggest rigidly categories, but as a way to think about gender-insubordinate responses and actions as evidenced in women's cancer memoirs that do not necessarily reject the sex-gender social structure in total even while calling attention to its harms in cancer treatment.

[61] I am using the term "emergent" throughout this study as an adjective describing the quality of being in an early state of formation or the state of arising, as in a bean sprout emerging from the soil or as in a person's emerging awareness of gender-subordinating effects of medical and social responses to BGCs. However, in varying contexts and in the vernaculars of natural science, physics, social science, and philosophy, the term "emergent" connotes the phenomenon of objects or events being more than the sum of their individual parts. For example, emergent norm theory in the social sciences can be used to describe the ways social groups develop and change. The formation of an angry mob is an example because there is no mob until group sentiment coheres and disseminates among enough individuals to create a mob, which is a different pattern of social grouping than previously existed.
For more, see, "emergent, adj. and n.". OED Online. March 2019. Oxford University Press. Accessed 05 May 2019. http://www.oed.com.ezproxy.lib.ou.edu/view/Entry/61131?redirectedFrom=emergent.
See also, Mitchell M. Waldrop, Mitchell M. *Complexity: The Emerging Science at the Edge of Order and Chaos*. New York: Simon & Schuster, 1992).
See also, R. Keith Sawyer. *Social Emergence: Societies as Complex Systems.* (Cambridge, MA: Cambridge University Press, 2005).

GI authors focus their attention on the means to both resist harmful practices and re-vision community. These narratives testify and critically respond to gender-subordinating practices and messages in the pink war machine.

Where pink war commercialism, medical authoritarianism, and normative narratives compel conformity, these autobiographical narratives refuse compliance. Where pink war violates bodies, GI authors find ways to safeguard their body-mind self-sovereignty. Where pink war censors and kills women's voices, GI narratives are a creative means to claim identity and voice. And, where pink war limits and distorts learning, GI narratives evince a self-educating practice and educative aim in their publication for the well-being of body-minds, both those of the authors and their readers.

Emergent-Conflicted GI and the Case of Rosamond Campion: Disrespecting Superior Officers

Babette Rosmond's *The Invisible Worm* (1972), written under the pseudonym Rosamond Campion, is one of the earliest published breast cancer memoirs.[62] The narrative focuses around Campion's (Rosamond's) refusal to sign papers giving consent to her doctor to perform a radical mastectomy during a surgical biopsy if cancer is detected. A single-step biopsy and mastectomy was the standard operating procedure even for early-stage breast cancers through the mid-1970s and was still practiced up through the mid 1980s.[63] Campions's refusal was shocking at the time, tantamount to insulting the knowledge and expertise of her surgeon and challenging his

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[62] As discussed in chapter one, there are few mentions of breast cancer mentioned in texts before the 20th century. One of the earliest personal narratives of breast cancer is the journal-style letter Frances Burney wrote to her sister Esther in 1812 graphically describing her mastectomy without anesthesia. The 1935 autobiography of Charlotte Perkins Gilman briefly mentions her discovery of breast cancer and ends with her decision to commit suicide rather than die from it. See, *The Living of Charlotte Perkins Gilman, An Autobiography* (Madison: University of Wisconsin Press, 1935/1990), 329-331. Terese Lasser's *Reach to Recovery,* the memoir of the founder of the Reach to Recovery Program, and Babette Rosamond's *The Invisible Worm* are both published in 1972, followed by Betty Isaac's *A Breast for Life* (1974), Rose Kushner's *Breast Cancer: A Personal History & An Investigative Report* (1975), Betty Rollin's *First You Cry* (1978), Marvella Bayh's *Marvella: A Personal Journey* (1979) and Lorde's *The Cancer Journals* (1980). It is shortly after this that the illness "memoir boom" begins and breast cancer memoirs become commonplace.

[63] See George H. Sakorafas, "The Origins of Radical Mastectomy," *Acorn Journal 88* No. 4 (2008): 605-606.

authority. When Campion awakens from the biopsy, her surgeon informs her she has breast cancer, that she "asks too many questions," and that she has put herself in a position to needlessly endure a second surgery, a mastectomy, which she needs right away.[64] As her doctor, nurses, a hospital chaplain, friends, and neighbors learn that she plans to seek a second opinion before scheduling the surgery, they are stunned and warn her she is being a "silly," and "dumb" woman.[65]

Refusing to comply: Standing up to medical bullying and paternalism. Campion refuses to acquiesce to pressure to have a mastectomy, even when her regular doctor tells her, "There are times when a woman is better off not knowing too much. She must put her faith and trust in her surgeon. *He knows best*."[66] In 1971, lumpectomy for early-stage cancer was an experimental alternative that many doctors were not aware of and most who did know of it were skeptical of its efficacy. As an affluent, college-educated magazine editor and novelist (she published nine novels and many short stories), Campion had access to information and economic resources that, almost 50 years later, many women facing a BGC diagnosis do not. When a professional colleague gives her an advanced copy of an upcoming magazine issue featuring a story about a doctor who is performing breast-sparing surgeries, Campion decides to refuse to sign the standard release form. This form, is "*given to every woman entering every hospital,* whether or not she is fully informed of the consequences and their meaning in her life, [and] permit[s] radical surgery if the biopsy reveals a malignancy."[67]

A few weeks later, when the news of her diagnosis and refusal to have a mastectomy spreads among her social circle, a friend who has undergone a mastectomy suggests that

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[64] Rosamond Campion, *The Invisible Worm* (New York: The Macmillan Company, 1972), 33.
[65] Ibid.,33-38.
[66] Ibid., 41, emphasis in original.
[67] Ibid.,28, emphasis in original.

Campion would benefit from talking to a psychiatrist. Intending to reassure her, Campion's friend writes, "'Now don't worry about the operation. It's not bad at all and the physical part works out fine.'"[68] Campion is not convinced or comforted by her friend's advice. Rather, she experiences a surge of gender-insubordinate anger "I felt resentful. . . . why should she or anyone else assume that I was going to be a good, docile sheep and follow the others to the butcher's block?"[69] Whether the pressure to comply with standard medical dictates comes from doctors, nurses, or well-intended friends, Campion refuses to submit to medical bullying.

Sustaining the body-mind: Going to drastic lengths to safeguard sovereignty. Campion views the radical mastectomy and the pressure put upon women to sign away any discussion of treatment after a surgical biopsy as a gross body-mind violation. She refuses to sign the surgical release form for a breast biopsy that allows a surgeon control of a woman's body, performing whatever operation he and any of her male relatives deem necessary. She is so horrified at the thought of waking up to discover her breast had been removed without her knowledge that she hides enough sleeping pills in her hospital suitcase to commit suicide just in case, pledging, "I alone [am] in charge of my body and my life."[70]

This act of defiance, Campion's final safeguard in case her surgeon tries to pressure her husband into signing the form to allow the mastectomy while she is unconscious, is shocking. It even raises questions about Campion's mental stability as it also reveals her GI thought in nascent form, a refusal to accept a violation of her body in the most extreme of self-negating ways. However, Campion's admission of this plan, its deliberate inclusion in memoir, is a clear gender insubordinate act. She effectively tells both female and male readers that she is willing to go any length to maintain body-mind self-sovereignty. Reading this, it is no wonder that

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[68] Ibid., 45-46.
[69] Ibid., 46.
[70] Ibid., 88-89.

surgeons responding to her memoir considered her foolish and a dangerous influence to other women. When she learns her diagnosis after waking from surgery (with both of her breasts intact), she seeks a second opinion with Dr. George Crile Jr. of the Cleveland Clinic, an early pioneer of lumpectomies featured in the magazine article. Campion is determined not to undergo a radical mastectomy unless she alone is convinced it is the best option for her. Crile tells her because her cancer is small and localized, she is a good candidate for a "segmental mastectomy" (now known as lumpectomy), and together they weigh the benefits of adjuvant radiation. Campion, not Crile, makes the final decision to forgo any chemical or radiological treatments.

Educating the body-mind to claim agency. Campions's aim in writing an article about her breast cancer experience for *McCalls* magazine in 1972, expanding it into *The Invisible Worm*, and later appearing on television with Dr. Crile, is to argue that women should demand the right to be made aware of options other than radical mastectomy and refuse the standard release forms. She presents a threat to the pink war machine when she points out that "tiny schoolchildren are told all about the supreme scientific achievements" of society, while women are told nothing about their bodies, their health, their medical treatments, and "possible perils" of the "vast sphere of ignorance" women are kept in. She avers that since "doctors do not know which method of treatment is best" with any full certitude, "the surgeon should not be the only one to make the final decision. . . . the patient is entitled to be brought in as an informed participant."[71] At the end of the memoir, Campion makes her GI, educative aim clear, writing, "Even in the thrall of a dread disease [a woman] is unique and must be paid by her doctor the compliment of being allowed partnership, within the proper framework of her illness, in deciding what is the best solution for her own special or even eccentric needs."[72] Rosamond demands that women are owed what philosopher of education Martin Buber calls an "*Ich-und-Du"* or *I-*

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[71] Ibid., 58.
[72] Ibid., 96.

and-Thou relational ethic of respect and empathy. This relation is based on recognition of patients' and doctors' shared humanity, even while a doctor or surgeon maintains some situational power in the relationship as the one with context-specific knowledge and skills.[73]

Claiming Voice: Responding to censoring silences. Through her published memoir and an earlier *McCall's* magazine article version of it,[74] Campion is an early voice that helps to launch the modern breast cancer movement.[75] Her work for patients' rights has come to be associated with 1970s women's movement,[76] even while she remained openly critical of contemporary (white) feminists whom she saw as obliviously complicit in gender subordination in BGCs. For instance, she takes issue with feminists who "storm all-male bars," arguing that instead they should "question [medical] authority" and consider "why have breast cancer patients

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[73] See, Martin Buber, *I and Thou,* Ronald Gregor Smith, trans. [Kindle Edition]. (Amazon Digital Services, 2011). Buber does not see *I-Thou* relations as possible and desirable only with other humans. Rather, he extends the possibility of recognized mutuality so that the "I" speaker/thinker/seer acknowledges the presence of God in the other, whether that other is another person, an animal, or even a tree (Kindle location 1591). Buber argues for the necessity of educating for *I-Thou* reciprocal, sacred-spiritual encounters rather than one-way, subject-object, *I-It* teacher-student interactions in classrooms. His notion of education occurring through genuinely open instances of encountering the other as an equal participant is the cornerstone to his moral philosophy of education. Through his own encounters with Buber's works, philosopher Maurice Freedman (1993) observes, "The teacher is able to educate the pupils whom he finds before him only if he is able to build real mutuality between himself and them. This mutuality can come into existence only if the [student] trusts the teacher and knows that he is really there for him." See, Maurice Freidman, *Encounter on the Narrow Ridge: A Life of Martin Buber* (New York: Paragon House, 1993), 186.
Buber's conviction of the moral necessity of *I-Thou* relations in teaching has points of connection with Martin's (201) theory of education as encounter, although Martin's theory is not centered on creating moral, sacred encounters as Buber's is, nor does she reference his educational thought. I am extending this dynamic of mutuality to the physician-patient relationship, which Buber also notes creates a special circumstance of necessary hierarchal power interactions (See *Ich und Du,* R. G. Smith trans., Kindle Location 1695). However, I am arguing that from the perspective of GI autobiographers in the pink war machine, it cannot remain up to the one in power to "build real mutuality," rather the GI actor must claim a right to participate in this action as well, which is precisely what Campion does in her patient-surgeon relationship with Crile.

[74] On the frontispiece of *The Invisible Worm* the following publisher's statement is included: "This book is based upon an article, 'The Right to Choose,' by Rosamond Campion that originally appeared in the February 1972 issue of *McCall's* magazine."

[75] See Jo Cavallo, "Author Babette Rosamond Helped Propel the Adoption of Patients' Rights To Choose Their Cancer Treatment," *The ASCO Post, American Society of Clinical Oncology.* 1 November 2012. Accessed 26 January 2017. http://www.ascopost.com/issues/november-1-2012/feminist-author-babette-rosmond-helped-propel-the-adoption-of-patients-rights-to-choose-their-cancer-treatment/.
See also, Barron H. Lerner, *The Breast Cancer Wars: Hope, Fear, and the Pursuit of a Cure in Twentieth-Century America* (New York: Oxford University Press, 2001), Kindle Location 1875.

[76] Ibid.

meekly accepted for more than fifty years a surgical procedure performed almost perfunctorily?"[77]

Problematic pronouncements in Campion's emergent GI. In places, Campion seems unaware of her privileged status, such as when she describes an African-American live-in-domestic worker as "our maid (an impressive name for a combination friend-cook-chauffer-doctor-handywoman and part-time drunk)."[78] She recounts scenes from her daily life before and after her lumpectomy that strike racist and classist notes,[79] such as when she remarks that "it is unfashionable to admit that all blacks aren't beautiful,"[80] and when she reproduces the broken English of an immigrant grocery store owner to create a comic effect.[81] Later, in another aside, she expresses her disgust for a homosexual love scene in a movie and remarks, "in a society that is still basically heterosexual there is bound to be something offensive in having to watch two males together in bed," and she argues that "art" devolves into depravity "if we don't resurrect taste."[82] But, perhaps the most problematic passage in her memoir occurs when she compares her ability to choose what kind of treatment she will have for breast cancer with a male black child's "choice" to "use the intelligence and charm and wonderful self-assurance that he is blessed with as keys to the doors that are still closed" to him and "other children of displaced blacks."[83]

Despite classist, racial, and sexual biases revealed in Campion's memoir that merit critique, I am arguing it has educational value as an early case of pink war machine GI. The inclusion of her candid, "unfashionable" perspectives supports the idea that gender-insubordinate

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[77] Ibid., 95.
[78] Ibid., 61.
[79] Ibid., 60-62.
[80] Ibid., 62.
[81] Ibid., 49-51.
[82] Ibid., 90-91.
[83] Ibid., 62.

stances and acts evidenced in BGC personal narratives are not reducible or united in terms of authors' worldviews or the aims their works advance. GI BGC narratives do not fit neatly umbrella terms like "feminism" or "social justice activism" although they may certainly align with these aims. Further, deeming a BGC autobiographical narrative as outmoded and therefore irrelevant to the development of GI thought risks advancing a chronocentric bias.

In *Beyond Slash, Burn, and Poison: Transforming Breast Cancer Stories into Action* (2004), Marcy Jane Knopf-Newman is critical of Campion's decision to publish her memoir under a pseudonym. She argues Babette Rosamond's decision to publish her memoir under the name of Rosamond Campion "perpetuate[s] the legacy of breast cancer as a silent [unspeakable] subject."[84] Knopf-Newman goes so far as to suggest that "if Campion's work had been less obscured by metaphorical images and a veiled identity, perhaps the debate would have attracted a larger and more sustained following, and the first lady's [Betty Ford's] surgeon might have advised her that she could choose a less mutilating surgery."[85] However, this suggestion is both speculative, unfair, and seems unsympathetic to Campions's challenge to maintain a personal and professional life while navigating her way within the kingdom of the sick.

When Campion decided to publish an article in *McCalls* magazine about her decision to have a lumpectomy rather than mastectomy in 1972 and later that year expanded her story to a memoir, she was working as a magazine editor and freelance fiction writer. She was writing and speaking out against established breast cancer experts' advice, and she was admitting she had a disease that was widely considered a private, unseemly subject, possibly making herself vulnerable to social and professional biases. In the memoir she describes receiving both encouraging words of support and angry, even threatening responses to her *McCalls* article:

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[84] Marcy Jane Knopf-Newman, *Beyond Slash, Burn, and Poison: Transforming Breast Cancer Stories into Action* (New Brunswick, NJ: Rutgers, 2004), 59.

[85] Marcy Knopf-Newman. Beyond Slash, Burn, and Poison: Transforming Breast Cancer Stories into Action (New Brunswick, NJ: Rutgers, 2004). [Kindle Edition]. (Kindle Locations 318-319).

"'You haven't any right to go around shooting off your mouth about this. What do you know? You'll be dead before you can say such stupid things again.' I was struck by the determination of women who'd undergone mastectomies to boast about it, to accuse me of frivolousness and flippancy."[86]

I would argue that while some readers in the present (including myself) may find some of Campion's views unsupportable, we cannot condemn her for failing to live up to twenty-first century values, especially without full consideration of the social surround that she is educated within and responding to. Campion's narrative reveals actions of GI to resist pink war machine values and practice. However, it also reveals heterosexist, classist, and racist biases. Her assertion that black children can choose to make better futures for themselves if they do as she has done and simply choose to take charge of their futures suggests an underlying logic of domination in her thinking.[87] If an author in the past or present reveals awareness of gender-subordinating oppression in her cancer treatment but also reveals internalized, oppressive values and biases, do we classify the narrative, as gender subordinate, insubordinate, or both? If we choose gender-subordinating, do we cast it in with conventional narratives of soldier-survivors? And, if so, do we also declare all these narratives cultural liabilities? I am taking the position that *every* woman's cancer narrative has educational worth as a self-authored account of living with illness. I take this position not only for the ethical importance of recognizing the value of every person's voice but also for the practical reasons that these books can be helpful resources,

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[86] Campion, 93.

[87] See, Karen J. Warren, *Ecofeminist Philosophy: A Western Perspective on What It Is and Why It Matters* [Kindle Edition] (Lanham, MD: Rowman and Littlefield, 2000).
A "logic of domination" is Warren's term for a perspective that justifies oppressive hierarchal relations. As Warren explains, "[A] logic of domination assumes that superiority justifies subordination. A logic of domination is offered as the moral stamp of approval for subordination, since, if accepted, it provides a justification for keeping Downs down. Typically this justification takes the form that the Up has some characteristic (e.g., in the Western philosophical tradition, the favored trait is "mind," reason, or rationality) that the Down lacks and by virtue of which the subordination of the Down by the Up is justified" (Kindle location 803-805). By this logic, if a black child does not succeed, they are making a choice not to put forth the necessary effort, and therefore, any subordination they experience is logically justified.

even when they convey an author's biases. Further, as a group and as individual cases, BGC personal narratives illustrate how gender-subordinating beliefs and practices in culture are taught and learned in medical and social responses to these diseases. If we can recognize both their value, e.g., Campion's call for women to not passively submit to medical authority figures and the ways in which they may reflect and re-inscribe gender values and biases, their educative significance is brought forward.[88] In the context of pink war BGC memoirs and other forms of published autobiographical narratives,[89] I see Campion's early stand against paternalistic and physically maiming practices in breast cancer as a valuable case of an emergent-conflicted GI narrative, which I will discuss in greater detail in the next chapter.

Instigative/Informer GI and the Case of Susan Gubar: Inciting Discontent in the Ranks

While conventional BGC narratives affirm the solider-survivor motif and a gendered curriculum for basic training in optimism and obedience, Susan Gubar's *Memoir of a Debulked Woman: Enduring Ovarian Cancer* (2012) starkly presents body-mind repercussions of cancer treatment, which she finds worse than the symptoms of cancer. Comparing the debulking operation and subsequent chemotherapy to torture,[90] Gubar's memoir exemplifies instigative-

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[88] Jane Roland Martin, *Education Reconfigured: Culture, Encounter, and Change* (New York: Routledge, 2011), 127-130.

[89] While some gender-insubordinate autobiographical narratives would qualify as "memoir' in the traditional sense of an autobiographical focus on a specific period and defining event in an author's life, there are also hybrid forms of GI narratives. For example, Lorde's *The Cancer Journals* includes the text of a speech she gave at an MLA conference, dated brief diary entries, and longer journal reflections in essay form that include citations from newspaper articles and medical journals. Other hybrid forms include poetry, personal letters, and other forms of literary and visual art, such as Miriam Engelberg's *Cancer Has Made Me a Shallower Person: A Memoir in Comics* (2006), and even in short passages presented in qualitative research. A GI personal narrative may also be a shorter document, such as Barbra Ehrenreich's essay "Welcome to Cancerland" published in Harper's Magazine (2001) or Eve Kosofsky Sedgwick's "White Glasses" first presented as a conference speech and subsequently published in her published essay collection, *Tendencies* (1994). Recognizing a necessity for clear genre and sub-genre distinctions in autobiographical studies in order to be attendant to the textual style and content of a text, in this study I focus on autobiographical narratives as educational autobiographies that "speak" to women's learning in BGC experiences. With gender-insubordinate, educational content as my primary focus, I will refer to *The Cancer Journals* (although it includes different forms of writing brought together as a "journal") and other works that present a focused and developed narrative of a person's life as affected by cancer as "memoirs." Otherwise, I will use the broad and admittedly vague designation of "BGC narratives."

[90] Susan Gubar, *Memoir of a Debulked Woman: Enduring Ovarian Cancer* (New York: W.W. Norton, 2012). 74, 98.

informer GI. It is part autoethnograpy, an ovarian cancer patient's first-person account of women's absorption inside the "medical machine" and how the machine operates,[91] and part autopathography, an account of personal pain, fear, and humiliation as she submits to the machine rather than being "eaten alive" by an "'internal alien.'"[92]

While the literary marketplace for breast cancer narratives has enjoyed a "boom" since the rise of the pink war machine along with a heightened public interest in memoirs in general at the close of the 20th century,[93] the number of gynecological cancer autopathographies remains much lower. Further, these cancers are eclipsed by breast cancer in public recognition and resources, and comparatively, there are a limited number of patient resource guides/self-help books, educational nonprofit online sites, and representations of these cancers in other genres.

Outside the 20th-century political history of framing cancer-as-war in the U.S., Gubar concedes that war metaphors in cancer make sense to us in that "[w]ar, which can be defended on ethical grounds, resembles chemotherapy because both set out to wreak massive injury" (100). Likewise chemotherapy compares to torture because "both chemotherapy and torture damage people; they produce an injurious effect on the human subject. Like chemotherapy, torture does not kill an individual outright but rather mimes or truncates murderous assaults that wear down and tear down the human being" (98). With these reflections, Gubar provides insight to the enduring psychic draw of the soldier-survivor motif in BGC autobiographical narratives. Like a P.O.W. who has survived both conditions of war and living under torture, a woman who survives cancer and its treatments is afforded heroic status. The ability to endure body-mind mutilations inflicted by others or survive under conditions of extreme duress and mortal danger is praiseworthy because survival speaks to individual and human collective fortitude. Those who exemplify survivor ability are inspirations to others because ability to survive is something collectively valued. This notion of virtue traces down to the gender-divided roots of the deep structure of western educational thought and an ethic of competition for resources and recognition that is culturally gendered as male/masculine behavior. As Martin notes in *Education Reconfigured* (2011), schools and other educating agents yoke "the efficacy of violence" and war to "children's capacities." (40). In the pink war machine, longstanding and readily available cultural tropes of heteronormative, masculine heroicism in war and stoically enduring torture are transposed on female body-minds in BGC treatment. Medical mutilations to treat mastectomy or hysterectomy or debulking (and for some women, both) are accorded a similar moral laudation to P.O.W.-survivor status. However, the "she-roe" is expected to adhere to behaviors accorded the value of "feminine" in BCG. She may not need to be stoically silent during her treatments, but she is supposed to be a cheerful, smiling, grateful, obedient, selfless paragon of ill female virtue and do it while looking good. GI BGC narratives question what interests may be served and to what ends in a celebratory focus on "survivor" stories of cancer she-roes. What are the body-mind realities of living post-diagnosis that are glossed over? Are the lives of those living with and dying sooner from cancer (terminal, metastatic disease) obscured by this focus? How are gender and other social identity constructions present in these narratives, and how do these identities affect BBC diagnosis, treatment, and prognosis?
See also, Jane Roland Martin, *Education Reconfigured: Culture, Encounter, Change* (New York: Routledge, 2011), 40-50.

[91] Susan Gubar, *Memoir of a Debulked Woman: Enduring Ovarian Cancer* (New York: W.W. Norton, 2012). 213.

[92] Ibid., 65.

[93] Ben Yagoda, *Memoir: A History* (New York: Riverhead Books, 2009), 237-241.

Ovarian cancer has not received a level of political attention, been afforded government resources, or attracted corporate sponsorship close to that of breast cancer. Gubar suggest this is due "not only because [ovarian cancer] is difficult to narrate progress within a cheerful recovery framework but also because such stories would inevitably address still stigmatized (and thus hidden) [body parts and] bodily afflictions."[94] While breast cancer has gained social acceptance and prominence as a cause over the decades since the U.S. government's war on cancer, ovarian cancer remains shadowed.

Gubar contends that ovarian cancer remains breast cancer's "'poor neglected cousin'" because ovaries do not carry the same iconic weight that female breasts do.[95] She describes the medical consequences of a cultural breast bias, noting that breast cancer "has its own patron saint, St. Agatha, who offers her sliced-off breasts on a platter," and that "most people could not name the color of [ovarian cancer's] ribbon (teal). . . . The state of medical responses to ovarian cancer corresponds to the state of medical responses to breast cancer half a century ago."[96] Gubar argues that for this to change, there must be a public demand for ovarian cancer to receive more attention as a health crisis and to raise awareness of the body-mind traumas experienced by women afflicted, including social isolation, depression, fear, and disruption of gender identity.[97]

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[94] Gubar, 23.

[95] Ibid., 22. While female breasts have historically been the outward sign of the feminine and venerated a sign of reproduction and life-giving font, Gubar's chapter "Ovariana" traces medical and sociocultural understandings of the female reproductive system and how androcentric biases have affected knowledge and medical interventions in "managing" the "unruly" and unhealthy female reproductive system (e.g., a woman's reproductive organs are an inverted, interiorized and inferior version of a man's; the vagina is an enervated penis and the ovaries are shriveled testes).

[96] Ibid., 23.

[97] For younger women with advanced ovarian cancer requiring a debulking surgery like Gubar's, the loss of reproductive organs and the premature onset of menopause can adversely affect female identity and sexuality. For women of any age who are ostomates (persons who have had an ileostomy), the ostomy bag can elicit a sense of body shame affecting intimacy and sexuality.
See, Dena Schulman-Green, et. al., "Quality of Life Among Women After Surgery for Ovarian Cancer," *Pallative Support Care 6* No. 3 (2008): 239-247.
See also, Karin C H M Bisseling, et. al., "Depression, Anxiety and Body Image After Treatment for Invasive Stage One Epithelial Ovarian Cancer," *The Australian & New Zealand Journal of Obstetrics & Gynaecology. 49* (2009): 660-6.

She explains that, “ovarian cancer . . . establishes a series of issues quite distinct from those of breast cancer. No visible, external body part gets sliced off the ovarian cancer patient in surgery. . .. Except for a vertical line of stitches down the belly and easily covered by panties, the wounds remain inward, invisible.”[98] In *Debulked,* Gubar makes those private wounds public.

Refusing to comply: Rejecting didactic optimism. In *Outshine: An Ovarian Cancer Memoir* (2012), Karen Ingalls recounts that when asked her how she manages to stay positive given her dire prognosis she replies, “I have great faith in God, [and] my doctor.”[99] Gubar, however, makes it clear that she has no such great faith in medicine, and refuses to unquestioningly submit her body to medical authorities. She is not pessimistic but accepts the survival statistics for advanced stage ovarian cancer—less than a fifty-percent chance of living beyond five years—with equanimity. Still, she is not resigned to dying, and, eleven years postdiagnosis, she is alive and continuing to write for a feature *New York Times* blog, “Living with Cancer.”

Gubar is aware that “[t]hose who credit their survival of ovarian cancer to ‘positive thinking, trust, and hope’”[100] may believe her lack of optimism makes her “complicit in [her] illness.”[101] She is also aware that other published BGC narratives present “many urgent instructions from brave people.”[102] By comparison, Gubar’s story offers no such inspiring wisdom, and is “not comforting.”[103] Reading another conventional ovarian cancer memoir, she admits that the author’s “cheerful view butts up against my determination not to prolong false hopes . . . that rob me of my self.[104]

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[98] Gubar., 22.
[99] Karen Ingalls, “*Outshine: An Ovarian Cancer Memoir* (Edina, MN: Beavers Pond Press, 2012) [Kindle Edition], Kindle Location 830.
[100] Gubar, 24.
[101] Ibid., 24.
[102] Ibid., 25.
[103] Ibid., Kindle Location 46.
[104] Ibid., 191

To be clear, Gubar does not disparage any other person's optimism or religious faith in helping them through cancer treatment, but when these attitudes and beliefs are presented as normative values in patient education, she finds reason to object, especially when optimism and a "fighting spirit" are presented as necessary for survival and, by tacit extension, those who acknowledge death as an imminent reality are blameworthy if they do not survive. She writes:

> The two doctors who published *100 Questions & Answers about Ovarian Cancer* conclude the 2006 edition of their book by counseling patients to combat the disease: "Anyone diagnosed with ovarian cancer must want to fight it and must trust that treatments are available and successful and can give you back your life."

Gubar asks, "Do such admonitions spawn the guilty suspicion that the anxious or distrustful patient is responsible for her own decline or demise?"[105] In conventional ovarian cancer patient-education literature, there is the suggestion that "hope for a cure provides a cure, or at least the proper environment for the return of health,"[106] and this idea is extended to the point where patient education from various sources—medical pamphlets, medical self-help reference books, and autobiographical narratives "sometimes seems to collude in the idea that death [itself] can be cured."[107] To resist a pedagogy for didactic optimism from formal and informal education media and agents, Gubar cultivates a practice of aesthetic awareness in her quotidian, secular life that does not require her to feel heroically brave or hopeful:

> Despite the constant pain of the drain, I want the quiet concentration of each everyday task to fill me with an active love of living and a passive acceptance of dying . . . [t]o make the moment of being stand still—that's how Virginia Woolf frequently thought about her quests in consciousness. What I seek is "a willingness instead of willfulness, an ability to take life on life's terms as opposed to putting up a big fight," as Lauren Slater expresses it in *Lying*, her astonishing memoir about the impossibility of telling the whole truth and nothing but the truth.[108]

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[105] Ibid., 28

[106] Ibid., 221.

[107] Ibid.

[108] Ibid., 141-142.

Gubar's desire to be *willing* instead of *willful* is a rejection of pink-war didactic optimism that, in addition to suggesting that death can be "beaten" if only a woman has the right, fighting spirit, may also compel her to disavow body-mind awareness that gives her the peace that may come from knowing that for the remainder of her life, however shortened, she is "taking life on life's terms." She is an active, responsible agent, but not a failure to herself or others for "failing" in a fight against a disease that outstrips the limits of medical knowledge or a fight against death itself.

Sustaining the body mind: Exposing the body as battleground and its war wounds. At length and in graphic detail, Gubar writes about her wounded and ill body-mind, the symptoms of ovarian cancer, the debulking surgery to save her life from cancer, the subsequent surgeries to save her life from the effects of debulking, and, finally, chemotherapy. Gubar provides a testimony of suffering that reveals how her wounded body overwhelms her, becomes her looming focus. First, she explains:

> A woman about to be debulked will be informed that she is undergoing a hysterectomy—removal of the ovaries, uterus, fallopian tubes—accompanied by the possible removal of the omentum (a membrane lining organs in the abdominal cavity), parts of the involved bowel (which may require a bowel resection), and cytoreductive surgery which excises as much as possible of the visible cancerous tissue in the area.[109]

She tells readers to "[t]hink of debulking as evisceration or vivisection or disemboweling but performed on a live human being."[110] Next, she details successive hospitalizations and procedures to deal with the complications only a war machine "insider" would know:

> The conveyor belt of the medical machine cranks into overdrive . . . . . . while I careen from fevers to hospitalizations, various stents—invisible, unlike the drains of the interventional radiologists—are positioned in various parts of my anatomy . . . In addition to the ongoing doses of carboplatin, daily and sometimes twice-daily infusions of powerful antibiotics must be administered so a PICC is installed and maintained again.[111]

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[109] Ibid., 61

[110] Ibid., 59-60

[111] Ibid., 250.

Shattering any comforting cognitive distance gained in reading the body through medical jargon, Gubar describes the agony of two drain tubes inserted into her buttocks to fight an abscess on her coccyx and later, the intimate details of her body-mind adjustment to life as an ostomate. She traces a long cultural and literary history linking women's bodies to filth and excrement across cultures and the revulsion she feels toward her own body with an extra "mouth," the stoma:

> The rust-red stoma on my belly sticks out, a protrusion less than an inch long, less than an inch wide. . .. There is a tiny hole at the stoma's center from which liquefied crap drops intermittently. . . . It is a foul mouth with pursed lips, lips that press out to emit crap and then withdraw back in reticence. Since the word "stoma" means mouth and since the puckering protrusion involuntarily spews filth, an ileostomy might be considered the physical analogue of Tourette's syndrome. At erratic moments, this mini-Vesuvius spurts or burps out drops of brown fluid that descend down into the plastic bag in which it remains encased. . .. A normally invisible internal organ resides vulnerable and visible outside the body. What should be hidden has been outed like Judas's foul intestines after his bowels explode. Additionally, a once discrete and volitional act has become uncontrollable and continuous. I can feel belches of liquid when they emerge from the stoma and every trip to the toilet involves emptying the bag which, I hope, might become routine. Each time, though, I think that vets would not do this to a dog. No need to consult Julia Kristeva on the psychic power of my horror, but the truth of Freud's insight—"dirt is matter in the wrong place"—comes home to me. I am perpetually dirty, defecating incessantly from my belly. [112]

Gubar does not include these intimate, scatological body-mind details to illicit disgust or pity. Rather, she makes a gender-insubordinate choice to make her wounds visible to readers so as to let her body "speak" to the realities of cancer treatment that devastate body-minds as much as mastectomy but remain hidden and unspeakable. She admits that in daily life she hides her ostomy bag in public to "pass" as a "physically normal person,"[113] and she describes emotional responses of self-loathing in dealing with her body's new needs as an ostomate. She details the time it takes to accomplish even simple, daily tasks and shares with readers what her stoma and

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[112] Ibid., 151-153.

[113] Ibid., 230.

ostomy bag represent to her, a "grotesque abrogation of bodily containment or integrity."[114] She explains her motive for writing about "foul matters" is "to tell the truth about the body."[115] Making her body the subject of a pink war exposé, Gubar's aim is to go public with the suffering that optimistic narratives hide as evidence in a case to demand that more public attention, funds, and research efforts be directed at this devastating disease.

Educating the body-mind: Reading and writing as rebellion in the trenches. Gubar's aim is for readers encountering her narrative to come away with the conviction that it is not enough to accept what is common knowledge—that existing protocols for ovarian cancer diagnosis and treatment are ineffectual at best and devastating at worst. While ovarian cancer is not as frequently diagnosed in the general population as breast cancer, it is currently the fifth leading cause of death by cancer for women in the U.S,[116] and less than half those diagnosed are expected to live beyond five years.[117] This is in large part due to the fact that there are no early screening methods, and symptoms are not noticed or taken seriously until the cancer is in advanced stage.[118] As she observes,

> Over the past few decades, there has been little substantial progress in medical approaches to ovarian cancer. Advocates seeking to increase research for ovarian cancer should not compete against but instead join forces with breast cancer activists because, as Susan Love has put it about government funding, "We don't want a bigger piece of the pie—we want a bigger pie." [119]

While she explains that "my central motive [in writing] consists of a fierce belief that something must be done to rectify the miserable inadequacies of current medical responses to ovarian cancer,"[120] writing her memoir also serves a more personal, immediate need. Reading others'

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[114] Ibid., 156.

[115] Ibid., 155.

[116] "Statistics," *Ovarian Cancer Research Alliance.* (n.d.), Accessed 12 Jan. 2019. https://ocrahope.org/patients/about-ovarian-cancer/statistics/ .

[117] Ibid.

[118] Robert J. Kurman and le-Ming Shih, "Ovarian Cancer. Silent and Deadly," *Atlas of Science.* 21 May 2016. Accessed 12 2019. https://atlasofscience.org/ovarian-cancer-silent-and-deadly/ .

[119] Gubar, 259.

[120] Ibid., 65.

narratives and writing her own becomes Gubar's self-educating lifeline, a way to keep her from drowning in the immediate, inescapable sufferings of her body-mind. She explains:

> The personal narratives I found and then quoted, the memoirs and essays I consulted, bonded me to other individuals who have struggled with illness and buoyed me up in the conviction that this sort of witnessing supports numerous volunteers organizing for progress against dread diseases. Reading and writing about cancer cast a lifeline between me and people whose honesty about mortal encounters mitigated my fearful loneliness and thereby steadied me.[121]

Gubar's memoir contains no entry dates to signal where one day's testimonial reflections end and another begins. The chapters follow chronological order from diagnosis to treatment, treatment to remission, and remission to recurrence, but there is a sense of presentness to her writing, a sense that while she is reporting from the trenches to create a record for others later, she is also writing without the distance of time to consider her body-mind reactions beyond physical sensations of pain and emotional responses of anger, fear, disgust, and grief in the moment she experiences them. Fully realizing the implications of her diagnosis and the life-threatening infections resulting from treatment on her prognosis, Gubar acknowledges that she lives with the imminence of death so as to come to terms with it.

While refusing the identity of militantly optimistic pink war soldier-survivor, she is not resigned to death either and time and again makes informed choices to attempt the means, however excruciating to endure and unlikely to succeed, to extend her life. Reflecting on a family history riddled with suicides, Gubar avers as much for herself and for readers that "the person who wills herself dead fails to acknowledge responsibility for others."[122] She writes not to "fight" death with blind optimism or to mournfully allow it to abrogate the remainder of her

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[121] Ibid., 262.
[122] Ibid., 221.

life, but to find a middle road, a means to desegregate death's potentiality from daily life by simultaneously bearing witness and testifying to living with death "at closer proximity."[123]

A feminist professor of literature by profession, Gubar does not write her cancer memoir "as a retrospective educator, autobiographer, or critic;"[124] whatever readers encounter on the pages are her responses written "while in the midst of living this process." Explaining her commitment to approach her body-mind experiences in cancer as an educating encounter, Gubar maintains that "intimacy with the mortal body educates us. Cancer and its treatments teach us, or have taught me after two years of coping with bizarre consequences, that life without the finitude of death—the inconceivable finality of one's own death—would be intolerable."[125] However, it is not a self-eulogistic impulse that compels her. As the title of her memoir suggests, Gubar wants her body-mind testimony of *enduring* ovarian cancer, living with it, and the results of its medical interventions to be part of her teaching practice, an insightful and GI-inciting testimony of body-mind harm for the purpose of demanding change. However, the introductory chapter contains a statement of her educative goal that could be a eulogistic wish:

> Let this record redound not against my personal fate but against an undetectable and then unfixable condition that continues to threaten the health and welfare of future generations. . .. We must save our successors from a diagnosis synonymous with death and from current medical responses that are debilitating as well as ineffectual: gutting, draining, bagging, and the poisoning many patients with other forms of cancer also receive as chemotherapy. . . . [These] standard protocols undertaken not to eradicate but to retard metastases or to help the ailing body function—damage the lives of many ovarian cancer patients. [126]

Claiming Voice by Listing Grievances. The title of the final chapter of Gubar's memoir, "Loconocology,"[127] is her neologism to signify medical harms wrought in ovarian

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[123] Ibid., 30.
[124] Ibid., 28.
[125] Ibid., 30.
[126] Ibid., 32-33.
[127] Ibid., 235.

cancer treatment. *Loconocology*, crazy or frenzied oncology,[128] is distinct from iatrogenic effects (ensuing from medical care) in that the latter medical harms arise from unforeseen and unintended results, complications, and medical errors. In ovarian cancer, some harms, such as the multiple infections Gubar suffers after her debulking, fall under the category of iatrogenic. However, Gubar makes a categorical distinction between iatrogenic medical consequences and *loconogenic* debulking to ensure readers understand the devastating effects of this routine treatment of ovarian cancer are known and accepted ahead of time—*not* by patients, but by their doctors who "fully realize that standard treatments trigger destructive effects, but there is no alternative available to them."[129]

The removal of many or all female reproductive organs and possibly parts of the colon, small intestine, bladder, stomach, gall bladder, liver, and pancreas (depending on the cancer's spread) that debulking entails creates life-threatening complications that are so commonplace as to be expected. She notes that "50 to 70 percent of debulking operations are suboptimal, leaving visible evidence of cancer that increases the risks of a recurrence," and that "[d]ebulking, which rarely eradicates cancer, often damages the [remaining] organs surgeons try to repair."[130] For Gubar and most other debulked women, the results are suboptimal. Gubar's digestive system is irrevocably damaged in surgery, reducing the time and scope of her life, and after this devastating surgery, she learns that a "shelf of cancer" remains "lodged" inside her which surgeons cannot remove.[131]

Even after enduring debulking, the toxic treatments of chemotherapy, and the subsequent surgeries to fix the holes in her intestine leaking inside her—iatrogenic effects of the

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[128] Gubar does not define her term, but, given the context, this is what I presume she means, combining *loco* for a crazed or frenzied state with "con," meaning "with" and oncology.
[129] Ibid., 240
[130] Ibid., 257.
[131] Ibid., 86.

debulking—Gubar is still facing a recurrence of her cancer's spread. The best she can hope for living the rest of her life as an ostomate (the ileostomy proves irreversible) is that pharmaceutical interventions can keep the cancer "load" down. In ovarian cancer, a "remission" is any period of not having a high rise in the level of the cancer in the body, sometimes for only months at a time. When the drugs fail to stop the spread of Gubar's cancer one year later, her life depends upon finding another drug that can more effectively battle back against the "enemy's" advance. But, as she explains:

> [A]t some point the chemotherapy stops working: tumors metastasize in the liver or breast, bowel or brain, lung or bone. . . . In later stages of ovarian cancer, carcinomatosis (the proliferation of tumors throughout the body) frequently causes ascites (fluid obstructing the diaphragm), bowel obstruction (requiring a PEG or percutaneous endoscopic gastrostomy tube to provide continuous drainage), abdominal blockage (requiring an NG or nastrogastric tube), lymphedema (fluid retention in the lymphatic system), kidney obstruction (requiring nephrostomy tubes or stents), fistulas (abscesses), dyspnea (difficulty in breathing), and malnutrition—all convincing oncology nurses that care after unsuccessful chemo should become palliative, though proactive doctors may resist such judgments.[132]

Facing the fact that if cancer doesn't kill her, the treatments for it will, Gubar uses her voice through writing to instigate for change, informing readers of the "deficient and debasing" and "dehumanizing" effects of the pink war machine's medical management of ovarian cancer to instigate for change.[133] While she does not pose answers as to how to respond to these harms, she does direct her readers' attention to the conditions and practices she finds most intolerable. She lists GI grievances on behalf of "the 200,000 women annually diagnosed worldwide"[134] living with and dying from ovarian cancer.

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[132] Ibid., 103.
[133] Ibid., 24-25.
[134] Ibid., 256.

Restorative/Reformer GI and the Case of Audre Lorde: Mutiny in the Pink War Machine

Audre Lorde, who frequently referred to herself as a "black lesbian feminist poet," is considered a "pioneer in articulating the female experience of breast cancer."[135] When Lorde was diagnosed with breast cancer in 1979, she was already an internationally-known poet, college educator, and academic activist.[136] With the publication of *The Cancer Journals* and *A Burst of Light* (1988), a collection of autobiographical essays, Lorde made the decision to publicly announce her cancer, making it a part of her professional identity as a feminist educator-activist. She died from breast cancer in 1992, ironically the same year that Estée Lauder and *Self Magazine* launched the first pink ribbon campaign.[137]

Making her culture crossing into the kingdom of the sick before the rise of the pink ribbon culture, Lorde's *The Cancer Journals* (1980), nevertheless calls attention to the gender-subordinating teaching approaches and mechanisms of CIC's pink war machine already in place—medical consumerism, medical authoritarianism, and normative narratives—and their miseducating effects. She also reflects on her experiences of racism and heterosexism and considers links between profiteering and pollution and aesthetic technologies as means for

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[135] Caterina Riba, "Dealing with Breast Cancer: The Journals of Audre Lorde," *Journal of US-China Public Administration 11* No 6 (2011): 550.

[136] In 1968, Lorde was appointed poet in residence at Taugaloo College, and in the 1970s through 1980s she taught in the CUNY system at John Jay College of Criminal Justice where she helped establish a Black Studies program and at her alma-mater, Hunter College. At Hunter College, she held the position of Distinguished Thomas Hunter Chair, created and ran a poetry workshop, and taught American literature and poetry courses. In 1983, she also taught writing for a semester at the Free University of Berlin. See Beverly Threatt Kulii, Ann E. Reuman, and Ann Trapasso, "Audre Lorde's Life and Career," *Modern American Poetry.* Accessed 14 January 2017. http://www.english.illinois.edu/maps/poets/g_l/lorde/life.htm
See Hunter College, Women and Gender Studies Department, "Livestream of Celebration of Audre Lorde, Biography," 2017. Accessed 14 March 2017. http://www.hunter.cuny.edu/wgs/repository/images/Audre%20Lorde.jpg/view?searchterm=
See also, Alexis De Veaux, *Warrior Poet: A Biography of Audre Lorde* (New York: W.W. Norton, 2004), 291-292.; 296-342.
See also, *Audre Lorde: The Berlin Years: 1984-1992.* Film. Directed by Dagmar Shcultz, Distributed by DGRA Design, Oakland, CA: 2012.

[137] The pink ribbon quickly became the most iconic sign for breast cancer public awareness and commercial philanthropy. See Sandy M. Fernandez, "History of the Pink Ribbon," *Think Before You Pink.org, A Project of Breast Cancer Action.* Accessed 10 January 2017. http://thinkbeforeyoupink.org/resources/history-of-the-pink-ribbon/

controlling women's bodies. Lorde's message in *The Cancer Journals* differs from messages in conventional breast cancer narratives and patient-education programs such as "Look Good, Feel Better." As detailed in chapter one, a frequent leitmotif in conventional BGC narratives is the ability of a woman to regain health by focusing on beauty, normative notions of femininity (looking like a "normal," healthy woman)[138] and demonstrating "womanly" graciousness,[139] trusting compliance with doctors, and cheer in illness—these are the hallmarks of the pink war soldier-survivor theme. However, a driving concern for Lorde and reason for publishing her memoir is to reveal and put an end what she sees as discriminatory, oppressive, and exploitative messages and practices in CIC patient education. Unlike Campion's emerging-conflicted GI response, Lorde is well aware of how constructions of class, race, and sexuality shape social and medical responses to cancer and inequities in patient treatment. Like Gubar's instigative GI, Lorde calls attention to what she sees as oppressively subordinating practices inside the CIC's the pink war machine. However, her restorative GI focus expands to call attention to social and medical responses framing breast cancer as foremost a problem of gender maintenance while neglecting to confront cancer's possible links to environmental negligence and corporate greed.

Refusing to Comply: The GI warrior versus the pink war soldier. For straight, lesbian, bisexual, or asexual persons; for cisgender, transgender, or other gendered persons, Lorde's *Journals* offers a message of assurance that differs from conventional cancer narratives. She offers no advice for regaining "normal" femininity after cancer or for viewing cancer as a spiritual journey that can lead to becoming a better, more enlightened person. Rather, the hope

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[138] These ideas are culturally determined and are tied to gender, sexuality, race, and other markers of identity.

[139] I understand the notion of "grace" in cancer as tied to gendered notions of pink soldier-survivor courage, specifically, a woman's ability to demonstrate good humor and optimism to make others feel better, her obeisance to medical authority, and stoic endurance during physically and emotionally painful medical interventions. This is not to suggest that all frequently recommended cancer resources for patient education, including personal narratives, convey only gender-subordinating messages, and I am not arguing against the value of messages of hope and optimism in cancer treatment. The have their place for all of us. However, when such narratives link ideals of heteronormative femininity to health and recovery, they may work as curricula for women to internalize gender-subordinating messages and behaviors affecting their identity in cancer treatment and living post diagnosis.

she offers comes from not feeling entirely powerless and without choice, even in a health crisis. She resists becoming entirely dependent upon medical professionals and unquestioningly following their orders. For example, when she is instructed by hospital nurses and Reach to Recovery volunteers to wear a breast prosthesis as soon as possible after surgery to hide her amputation, Lorde refuses. Possibly aware of the Nixon administration's declaration of war on cancer a few years earlier, she declares herself a cancer "warrior," but, for Lorde, going to war does not mean being at war with her body as a betrayer or cancer as the "invader" within it. Unlike the pink-war soldier-survivor who is heroically feminine in maintaining a heteronormative appearance and amenable disposition, Lorde declares herself at war with cancer's manmade risk factors and society's gendered responses to it. She writes:

> I have been to war, and still am. So has every woman who had had one or both breasts amputated because of the cancer that is becoming the primary physical scourge of our time. For me, my scars are an honorable reminder that I may be a casualty in the cosmic war against radiation, animal fat, air pollution, McDonald's hamburgers and Red Dye No. 2, but the fight is still going on, and I am still a part of it. I refuse to have my scars hidden or trivialized behind lambswool or silicone gel. I refuse to be reduced in my own eyes or in the eyes of others from warrior to mere victim, simply because it might render me a fraction more acceptable or less dangerous to the still complacent, those who believe if you cover up a problem it ceases to exist. I refuse to hide my body simply because it might make a woman-phobic world more comfortable.[140]

On September 29, 1979, one year after her mastectomy, Lorde spoke at the Second Sex Conference on the importance of acknowledging differences among people whose bodies mark them as outsiders to "the master's house." The phrase "the master's house" is an allusion to antebellum plantation mansions, which are symbolic of hierarchal, socioeconomic relations and the tools and strategies by which power holds on to power. She offers the critical observation that even women identifying as feminists can reveal inculcated values of "the master's house" when they unreflectively use ideological tools of a racist heteropatriarchy. She writes:

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[140] Audre Lorde, *The Cancer Journals* (San Francisco: Aunt Lute Books, 1980). [Kindle Edition]. Kindle Location 782-788.

> Those of us who stand outside the circle of this society's definition of acceptable women; those of us who have been forged in the crucibles of difference — those of us who are poor, who are lesbians, who are Black, who are older — know that survival is not an academic skill. It is learning how to stand alone, unpopular and sometimes reviled, and how to make common cause with those others identified as outside the structures in order to define and seek a world in which we can all flourish. It is learning how to take our differences and make them strengths. For the master's tools will never dismantle the master's house.[141] (112).

Sustaining the body-mind: A practice of self-love. Although Lorde does not include mention of "those of us whose bodies and lives are shaped by illness" in her Second Sex Conference speech, breast cancer and mastectomy are also "crucibles of difference" marking women's bodies as outsiders. Lorde's body-mind knowledge and ethical directives as a black, feminist, lesbian inform her responses to the CIC and breast cancer, and, in turn, her educational encounters in the CIC reaffirm her body-mind practices as a black lesbian feminist activist, writer, and teacher. While she agrees to a mastectomy, she refuses to have her body-mind worth be determined by heteronormative social pressures within and outside of the CIC, writing that women's body-minds are more than "decorative machines of consumer function" that exist to "satisfy male demand."[142] Lorde argues that what matters is how a woman feels about her own body and the recognition that any somaesthetic practices for the body-mind should be the woman's choice alone.

In her identity as a black lesbian feminist, Lorde is deeply committed to developing awareness of and claiming her body as both an act of self love and as a political stance on behalf of other women, regardless of race or gender identity. She states that "growing up Fat Black Female and almost blind in america [sic] requires so much surviving that you have to learn from it or die."[143] But even as acutely aware of being marked by difference as she was throughout her

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[141] Ibid., 112.

[142] Ibid., Kindle Location 849.

[143] Audre Lorde, *The Cancer Journals,* Kindle Location 475-478.

life, breast cancer and mastectomy present new challenges for Lorde to re-claim her body-mind as worthy of joy and love. She comments that she stands at an emotional crossroads of choice: “either I would love my body one-breasted now or remain forever alien to myself.”[144]

Educating the body-mind: Emotions as knowledge for “self-conscious” living. *The Cancer Journals* is Lorde’s record of her reflections over her mastectomy and her experiences and observations of gender subordination in breast cancer. She writes during a time when her life was disrupted and health threatened, explaining:

> I am learning to live beyond fear by living through it, and in the process learning to turn fury at my own limitations into some more creative energy. I realize that if I wait until I am no longer afraid to act, write, speak, be, I’ll be sending messages on a Ouija board, cryptic complaints from the other side. When 1 dare to be powerful, to use my strength in the service of my vision, then it becomes less important whether or not I am unafraid.”[145]

In *The Cancer Journals* and other works, Lorde’s includes accounts of her physiological and emotional response to cancer; the pain, fear, sadness, anger she experiences and her critical engagement with these body-mind states. Rather than burying or turning away from these inner experiences, Lorde explores their educative significance. She values her emotional learning, even the learning gained from “negative” emotions, as a clarion call for change. For example, in her autobiographical essay “A Burst of Light: Living with Cancer” (1988), written after breast cancer had returned and metastasized in her liver, Lorde closes with an affirmation that political activism is a right to claim her body as home and to claim joy from it, even while her body is sick and dying: “I work, I love, I rest, I see and learn. And I report. These are my givens. . . . whether or not living them with joy prolongs my life, it certainly enables me to pursue the objectives of that life with a deeper and more effective clarity.”[146]

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[144] Ibid., Kindle Location 543.

[145] Ibid., Kindle Location 118-122.

[146] Audre Lorde, “A Burst of Life: Living with Cancer,” *A Burst of Light: Essays by Audre Lorde* (Ithaca, NY: Firebrand Books, 1988), 134.

Lorde writes *The Journals* as part of what she calls "self-conscious"[147] living. For Lorde, this means autobiographical writing is a reciprocal and dynamic learning-teaching practice. Through encountering and engaging with her memories of her body-mind experiences post-mastectomy and responses to breast cancer, writing *The Journals* is a self-educating practice. For example, aware that her life may end sooner than she had expected before cancer, Lorde conducts an audit of her life's aspirations to maximize her chances of achieving what she decides is most important.

To this end, she identifies lingering "ghost[s] of dreams that [need] to go in favor of those which I [have] some chance of effecting."[148] She wryly notes that while "I will never learn ballet, nor become a great actress," but she is, in the present and remaining moments of her life, becoming "who the world and I have never seen before."[149] However, it is not the achievement of any "final product" or end state that Lorde wants to direct her energies toward, but the engagement in continuous acts of cultivating moral, intellectual body-mind learning. She sees cancer as causing a "serious break"[150] in her professional life as a feminist writer, teacher, and poet until she reframes it as part of her professional identity and educating practice.[151] Although

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[147] Ibid., Kindle Location 33.
What Lorde calls "self-conscious living," has connections to Pinar's concept of *currere,* the idea of curriculum-as-verb to signify learning through self-dialog which occurs and is given form in autobiography. In *Democracy in Education* (1916) John Dewey similarly considers a process of "reflection in experience;" the deliberate, directed application of "thinking" faculties "to discover connections between something which we do and the consequences which result, so that that two become continuous." Dewey understands reflection in experience as "an explicit rendering of the intelligent element in our experience." While Dewey does not specify autobiography as a way to render thinking through experience specifically, he states that he considers reflection in experience a means "to act with an end in view," and to move education beyond replication of culture to education for human progress. For Dewey, reflection in experience is as an aesthetic, creative act. I am bringing together reflection in experience with *currere* to highlight and clarify Lorde's evinced commitment to "self-conscious living" in her autobiography as education for human progress.
For more, see William Pinar, *Curriculum Theorizing: The Reconceptualists*, (United States: McCutchan Publishing Corporation, 1975), 405-409.
See also, John Dewey, *Democracy and Education* (New York: Start Publishing, 1916/2012), 157.

[148] Audre Lorde, *The Cancer Journals,* Kindle Location 590.

[149] Ibid., Kindle Location 593-596.

[150] Ibid., Kindle Location 670.

[151] Ibid,. Kindle Location 242-249.

writing about breast cancer is not a direction she planned to go in her work, she decides to think of her experiences "as a serious chance to learn something I can share for use."[152] To this end, she writes:

> I am learning to speak my pieces, to inject into the living world my convictions of what is necessary and what I think is important without concern (of the enervating kind) for whether or not it is understood, tolerated, correct or heard before. Although of course being incorrect is always the hardest, but even that is becoming less important. The world will not stop if I make a mistake.[153]

Lorde's stated aim in publishing her memoir is to share what she has learned, so that a reader may "come to terms with her living and dying"[154] and to teach women to recognize that:

> [A]s we open ourselves up more and more to the genuine conditions of our lives, women become less and less willing to tolerate those conditions unaltered or to passively accept external and destructive controls over our lives and our identities. Any short-circuiting of this quest for self-definition and power, however well-meaning and under what guise, must be seen as damaging, for it keeps the post-mastectomy woman in a position of perpetual and secret insufficiency, infantilized, and dependent for her identity upon an external definition by appearance. In this way, women are kept from expressing the power of our knowledge and experience, and through that expression, developing strengths that challenge the structures within our lives that support the Cancer Establishment.[155]

While perhaps it is true that fully engaging one's capacities in a self-reflective, autobiographical writing act is a learning experience and any published autobiographical narrative is an artifact of cultural stock and can be understood as a curricular text to some educating end, Lorde shows a rare metacognition in her awareness that as she writes, as she plans to publish her writing, she is never doing so for her own benefit alone, but to find and mine some insights that she can "share for use" with others.

While only eight years earlier Babette Rosamond felt the necessity of keeping her identity as a cancer patient separate from her professional identity and published *The Invisible Worm* under the pseudonym Rosamond Campion, Lorde decides to incorporate "breast cancer warrior" into her professional identity as a "black lesbian feminist mother lover poet all I am."

[152] Ibid., Kindle Location 673-674.

[153] Ibid., Kindle Location 598-601.

[154] Audre Lorde, *The Cancer Journals,* Kindle Location 931.

[155] Ibid., Kindle Location 745.

Claiming voice: How to be a pink war saboteur. As Lorde learns to "speaks her pieces"[156] by writing and publishing *The Journals,* her autobiographical reflections become a part of her GI teaching practice as she uncannily predicts and critically comments on the rapid rise of industry partnerships with cancer activist organizations, government, and privately-funded research and treatment institutions. She contends that these partnerships are based on an incentive to maximize profits by medically and pharmaceutically managing cancer, referring to this medical business model as "Cancer Inc."[157] and "the Cancer Establishment."[158] Almost a decade before Ehrenreich (2001) describes the "Cancer Industrial Complex,"[159] Lorde points out that "there is no profit in the prevention of cancer; there is only profit in the treatment of cancer."[160] In her MLA Conference speech, "The Transformation of Silence into Language and Action," included in its entirety as the second chapter of *The Journals,* Lorde warns readers that silence can amount to compliancy in violations that both harm health and oppress and marginalize body-minds when those silences allow the perpetuation of harm to continue. She urges women to take gender-insubordinate action and claim their voices:

> Death . . . is the final silence. And that might be coming quickly, now, without regard for whether I had ever spoken what needed to be said, or had only betrayed myself into small silences, while I planned someday to speak, or waited for someone else's words. And I began to recognize a source of power within myself that comes from the knowledge that while it is most desirable not to be afraid, learning to put fear into a perspective gave me great strength. I was going to die, if not sooner then later, whether or not I had ever spoken myself. My silences had not protected me. Your silence will not protect you.[161]

In places, Lorde poses questions to herself in *The Journals,* all focused on how to use her voice to help others. However, this is not framing cancer as a "gift" in any way, but rather, an

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[156] Ibid., Kindle Location 601.
[157] Ibid., Kindle Location 818.
[158] Ibid., Kindle Location 749.
[159] Ehrenreich, "Welcome to Cancerland," 52.
[160] Audre Lorde, *The Cancer Journals: Special Editions* [Kindle Edition] (San Fransisco: Aunt Lute Books, 1980/1997), Kindle Location 958.
[161] Ibid., Kindle Location 176-180.

occasion where her voice, and she would argue all women's voices, are urgently needed. She asks: "How do I provide myself with the best physical and psychic nourishment to repair past, and minimize future damage to my body? How do I give voice to my quests so that other women can take what they need from my experiences?"[162] Given the rapid rise in commercial publication and sales of illness narratives in the 1990s and their ever-growing numbers,[163] Lorde's work remains unique in its clear, critical examination of both the inner-workings of the pink war machine and her physical and emotional responses to cancer as body-mind learning and a focus for teaching. It remains an exemplary, strong case of GI that aims to amend and restore a sense of community in responding to BGCs, and it is as relevant now as it was in 1980.

Excursus: GI Educational Autobiographies in the Pink War Machine

Philosopher of education Susan Douglas Franzosa (1992) looks at autobiographical narratives of early schooling as a type of self-writing. She coins the term "educational autobiography" to describe these narratives and what she identifies as their evident themes of "accommodation and resistance" in response to racism, sexism, and other experiences of discrimination in schooling.[164] The resistance revealed by the adult author reconstructing an account of prior, oppressive educational experiences may be "tacit," meaning the resistance is demonstrated in such a way that those holding power over the author at the time and place of the narrative's setting did not recognize it as defiance, or the action is "overt," meaning that it did draw the attention of authority figures in the narrative, and there were consequences.[165]

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[162] Ibid., Kindle Location 139-143.

[163] See Tanja Reiffenrath, *Memoirs of Well-Being: Rewriting Discourses of Illness and Disability* (Bielefeld, Germany: Transcript-Verlag, 2016), 11.

[164] Susan Douglas Franzosa, "Authoring the Educated Self,": Educational Autobiography and Resistance," *Educational Theory 42* No. 4 (1992): 396.

[165] Ibid., 411.

"Accommodation" in educational autobiographies is a form of tacit resistance when an author appears to be complying with those regulating her behavior, but the outward compliance is a "strategy[y] for survival" of a "well concealed, authentic self."[166] Accommodation can also be manifest as submission to imposed standards in a reconstructed moment that the author later rejects in her reflection. The autobiographical act "allows a writer to describe and a reader to understand both the relations of power experienced at the school and what the autobiographer has discovered as significant in his or her own development as an educated person"[167] Franzosa contends writing and publishing educational autobiographies is a means for authors to "reclaim the authority to create their own identities,"[168] overwriting the power of schools to do so. In this context, educational autobiographies are works of self-formation that tell us "about an individual's inquiry into what it means to become an educated self."[169]

Stephen J. Ball's reading of Foucault's concept of self-care aligns with Franzosa's argument that educational autobiographies are a way for a writer to reclaim authority and create identity. In *Foucault as Educator* (2017), Ball argues that for Foucault, the meaning of "self-care" is the continuous practice of constituting one's ethical self, and that "the technique of *self-writing*" is the means by which the ethical self is constituted and reconstituted to resist "governmentality."[170] Ball explains that Foucault "came to understand his own writings as

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[166] Ibid.
[167] Ibid.
[168] Ibid., 395.
[169] Ibid., 412.
[170] Stephen J. Ball, *Foucault as Educator* (London, UK: Springer, 2017), 69-70. According to Ball, self-formation for Foucault is an "active and engaged process, based on learning from the immediate and quotidian . . . over and against or redeploying the techniques of *governmentality*" (70).
"Governmentality" is Foucault's term for the actions a government takes to intervene in the lives of citizens with the aim of advancing public welfare. Tania Murray Li observes further that Governments exert control by "educating desires and configuring habits, aspirations, and beliefs" of citizens.
Foucault also argues that government's power is never total. Power is only in operation when "the other [the one over whom power is exercised] is thoroughly recognized and maintained to the very end as a person who acts." See Tania Murray Li, "Governmentality," *Anthropoligica 49* No. 2 (2007): 275.
See also, Michel Foucault, "The Subject and Power," *Critical Inquiry 8* No. 4 (1982): 789.

'experiences' which changed him as he worked on them and which were 'offered as open invitations to the public to have their own experience while reading them.'"[171] Ball makes this point to position self-writing as a pedagogical practice. Agreeing with Ball, I see GI breast and reproductive cancer narratives as responding to "governmentality" and martiality in the CIC's pink war machine. Further, I understand these narratives as ethical acts of self-formation.

Following Franzosa, I am framing educational autobiography as an account of making strategic assessments and taking actions to redress injustice; to resist "the process of normalization" where it is oppressive.[172] While Franzosa focuses on personal narratives of formal schooling as educational autobiographies, I am expanding this idea to BGC narratives. I take Lorde's *Journals* as a foundational example of strong GI and consider it along with other personal narratives about accommodation and resistance to gender subordination in the CIC.

But what of conventional BGC narratives not evidencing GI? Arguably, as these personal narratives recount writers' experiential learning in cancer diagnosis, treatment, and living post-diagnosis, they attest to educational encounters also. However, Franzosa emphasizes the transgressive character of educational autobiographies, that is, the evaluative-analytical reflections that, in hindsight, allow the writer to recognize experiences in her education that in some way were oppressively normative. Such perspectives are missing from women's conventional cancer narratives. Further, Townsend and Weiner (2011) clarify that the types of narratives that Franzosa refers to are "*critical* educational autobiographies" that speak to circumstances in the past and present with the intent to change the future both for the writer and readers.[173] Townsend and Weiner describe critical autobiography as a personal narrative with a

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[171] Ibid, 71.
[172] Ibid., 395.
[173] Lucy Forsyth Townsend and Gaby Weiner, *Deconstructing and Reconstructing Lives: Auto/Biography in Educational Settings* (Ontario, Canada: The Althouse Press, 2011), 189, emphasis mine.

political agenda, one that reveals "*gender, race, and class* as explicit factors in the analysis"[174] of how "voice, identity, and individual agency" are formed in and through educational settings.[175]

In this sense, women's GI cancer narratives may be more properly considered critical educational autobiographies, although the form of a particular text may or may not properly be considered autobiography. Additionally, there are means to act insubordinately beyond critique. For example, practices such as "going flat" (refusing breast reconstruction and prosthetics) and not wearing wigs or head scarves might be body-mind GI somaesthetics;[176] so might the use of humor as in Miriam Engelberg's graphic memoir *Cancer Made Me a Shallower Person* (2006),[177] or the poignant and powerful collection of artist Hollis Sigler's paintings in her *Breast Cancer Journal* (1999), where the artist pairs her painting with known facts about breast cancer's causes, statistics, quotes from memoirists such as Audre Lorde, and her own reflections to give aesthetic form to her sense of isolation and physical and emotional desolation.[178] It might be asked, "If a critical educational autobiography transgresses normative, (mis)educating authorities and tells a personal story with a political agenda, what can a concept of GI add?" My answer is that gender-insubordination in the context of pink war is educating action for guarding and

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[174] Ibid., 189. Ibid., emphasis in original.

[175] Ibid., 190.

[176] See, Roni Caryn Rabin, "'Going Flat" After Breast Cancer," *The New York Times,* 31 October 2016. Accessed 20 December 2018. https://www.nytimes.com/2016/11/01/well/live/going-flat-after-breast-cancer.html
See also, David Jay, *The Scar Project, Vol. 1* (The Scar Project, 2011).
See also, Richard Shusterman's discussion of Judith Butler and "somatic performativity" in *Body Consciousness: A Philosophy of Mindfulness and Somaesthetics* (New York: Cambridge, 2008) [Kindle Edition], Kindle Location 2026.

[177] See Miriam Engelberg, *Cancer Made Me a Shallower Person: A Memoir in Comics* (New York: Harper, 2006). For example, in the satiric comic strip "F.O.L. Gene" Engelberg responds to clichés and the bombardment of messages in cancer culture that cheerfulness and a vivacious personality is a healthy response to cancer. In one frame, she depicts a comic of herself addressing readers like a reporter, saying, "Yes, scientists have now proven that 90% of all cancer deaths are linked to the F.O.L. (full of life) personality type. In the next frame, under the heading "You'll Never Hear These Comments at a Funeral," two mourners stand beside a casket. The first remarks, "I still can't believe it, she was so blasé about life." The second mourner responds, "I never met a more lackluster person!" In the next frame, Engelberg's comic avatar proclaims, "That's why a simple modification in lifestyle can make the difference between life and death!" In final frame, Engelberg depicts herself once more, this time as a channel-surfing couch potato, turning down a friend's invitations to go to a concert, take a walk on the beach, or go out to dinner.

[178] See, Hollis Sigler, *Hollis Sigler's Breast Cancer Journal: With Texts by Susan Love, M.D., and James Yood* (New York: Hudson Hills Press, 1999).

restoring the well-being of women's body-minds. While gender and sex are socially defined designations (even if society decides they are shifting), these labels are applied to human beings. Recognizing that our understandings of what bodies are, including states of health, disease, disability, and even death, are shaped in language and culture, I am concerned with the body-mind's material, finite existence. Cancer threatens that existence and cuts it short. Cancer treatments disrupt lives and cancer treatments traumatize body-minds. When cancer treatment includes normative gender messages in formal and informal patient education, which is often the case in breast and gynecological cancers, these messages can constrain a person's ability to make informed choices as well as negatively affecting her identity and self-image. This can be the case even if her medical care increases her chances of survival. I am arguing that when normative gender values are equated with health, the wellbeing of individuals and of society-at-large may be harmed. I see gender-insubordinate cancer narratives as vital, educating sources for recognizing and countering harm caused by deeply rooted notions of binary divisions along gendered lines in the deep structure of educational thought.[179]

However, to be clear, I am arguing that both GI narratives and conventional narratives of breast and reproductive cancer are articles of cultural stock belonging to education's sphere of action and its domain of study.[180] While all women's cancer narratives may offer testimony as to "what it means to become an educated self" within the CIC, GI personal narratives may be especially important sources to motivate new types of cancer activism when other means of recourse to end gender-subordinating practices are not wholly effective. Finally, if changing culture and practices is the goal, it simply is not effective to depend on or wait for medical education programs and conventional breast cancer organizations to change the culture of the

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[179] Jane Roland Martin, *Education Reconfigured: Culture, Encounter, and Change* (New York: Routledge, 2011), 28.

[180] See, Jane Roland Martin, *Cultural Miseducation,: In Search of a Democratic Solution* (New York: Teacher's College Press, 2002), 64.

CIC, even when they are well intentioned. In the next three chapters, I will explore and clarify the stances and actions of GI cancer narratives within the pink war machine through my sustained encounters with emergent-conflicted, instigative/informer, and restorative/reformer GI narratives.

Part II: Challenge and Change Inside the Pink War Machine:

The GI Narrative Underground

> "I have survived the gifts still puzzling me . . .
> teaching me how to die insisting death is not a disease."
> --Audre Lorde, "Mawu," *The Collected Poems of Audre Lorde*[1]

Feminist epistemologist Miranda Fricker (2007) contends that "[w]henever there is an operation of power that depends … [on] shared imaginative conceptions of social identity, then *identity power* is at work."[2] Whether viewed as producing good or ill effects or a mixture of both, the pink war machine is an identity-power generator for soldier-survivorship. Its mechanisms of control examined in chapter one—commercial exploitation, medical authoritarianism, and normative narratives—all shape how women adjust to life post-diagnosis and promote a prevailing pink war soldier-survivor ethos. As also noted in chapter one, gendered knowledge claims and values in the deep structure of educational thought[3] create gender-subordinating conditions that are not unique to or originating within the CIC. However, these social phenomena are amplified and exerted on the "ground" of the ill female body. In BGC's—diseases tied to female sex and feminine gender—a woman's response to cancer may be shaped through gender values internalized over her lifetime and as she encounters them anew in multiple educational agency[4] of the pink war machine. Even when camouflaged or presented as "neutral," normative gender narratives shape encounters in BGC treatment and patient education.

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[1] Audre Lorde, *The Collected Poems of Audre Lorde* (New York: W. W. Norton & Co., 2000), 378.

[2] Miranda Fricker, *Epistemic Injustice: Power and the Ethics of Knowing* (New York: Oxford University Press, 2007), [Kindle Edition], Kindle Location, 220, italics in original.

[3] Jane Roland Martin, *Education Reconfigured: Culture, Encounter, and Change* (New York: Routledge, 2011), 28.

[4] Jane Roland Martin, *Cultural Miseducation: In Search of a Democratic Solution* (New York, USA: Teachers College Press, 2012), 273.

As creations and creators of culture, such narratives have identity power. In medical understandings of states of health and illness and in approaches to diseases like cancer, normative narratives are running background tapes, again, whether we "hear" them or not. As Martin (2011) observes:

> Take physical health. From time immemorial, this has been considered a praiseworthy individual attribute. That what counts as physical health is an item of cultural stock is evidenced by the fact that different cultures define bodily health differently and that, even within a given culture, the norms of good physical health change over time.[5]

Stories of who "we" are suffuse both practitioners' and patients' teaching and learning, guide doctors' actions and medical research, and delimit the questions we ask in our efforts to understand cancer's causes and deciding which studies to fund. Cancer narratives, especially personal narratives, have a strongly dramatic appeal, and for someone diagnosed with cancer, these stories can be overtly or implicitly didactic, even if an author's personal story diverges radically from a reader's.

Individually and collectively, BGC narratives are cultural artifacts. For every breast and reproductive cancer story written, how many millions have gone untold? Published BGC narratives are curricular sources for patient education, both for the writer who, in the reflective-creative act of *currere,*[6] "re-members" her past to glean information and for readers, including others with cancer. They also are educational resources for caregivers, medical professionals, and the general public. A case can be made that autobiographical accounts convey more practical information than other forms of cancer patient-education print and online media, including glossy, commercial publications filled with pharmaceutical ads and images of the

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[5] Jane Roland Martin, *Education Reconfigured*, (New York, USA: Routledge, 2011), 92.

[6] William Pinar, *Curriculum Theorizing: The Reconceptualists*, (United States: McCutchan Publishing Corporation, 1975), 405-409.

smiling sick,[7] and the ever-present, rudimentary, and nondescript “Cancer-and-You” sort of pamphlet found in plastic display racks in patient waiting rooms. While many conventional guidebooks offer fashion and cosmetic advice to female cancer patients to look “normal” and feel “feminine,”[8] in the tradition of the feminist reproductive health guidebook *Our Bodies, Ourselves*, there are breast and gynecological cancer guides such as *Dr. Susan Love's Breast Book* (2015), now in its sixth edition,[9] that provide clear information about cancer diagnosis, staging, and pathology, practical advice on best-practices in seeking treatment, and encouraging women to be self-advocating in the CIC.

However, only BGC autobiographers have the ability to assess what it means to become an educated self in the context of the CIC and from inside the pink war machine. Offering critical, interpretive, and normative perspectives on gender issues in cancer treatment, these autobiographies foster empathetic writer-reader educating encounters as readers meet fellow nonvoluntary migrants into the kingdom of the sick[10] who have made the crossing. In some cases, like the ones I explore here, BGC autobiographers act as underground guides, taking

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[7] For example, the commercial patient education media company, Health Monitor, publishes print magazines for medical offices to purchase and place in waiting and treatment rooms. These magazines feature pharmaceutical advertisements and a series of upbeat, informative, short articles with images of smiling people, mostly women. A recent chemotherapy issue includes article titles such as “Get back to the life you love,” “Conquering chemo anxiety,” and “Chemo is my lifeline!” Health Monitor makes it clear in their client outreach that business profits are the primary benefit of purchasing these magazines for waiting rooms—patient education is the *last* of the listed benefits. For more, see, “Print Products,” Health Monitor, accessed at https://www.healthmonitornetwork.com/print.html

[8] Often cancer beauty guides are a hybrid genre, part conventional personal narrative and part guide for “managing” somaesthetics to hide all evidence of illness and conform to cisgendered female norms.
See, Lori Ovitz, *Facing the Mirror with Cancer: A Guide to Using Makeup to Make a Difference* (Chicago, Bell Press, 2004).
See also, Victoria Tillotson and Lana Koifman, *Surviving Beautifully: Your Comprehensive Guide to Aesthetic Issues During Cancer Treatment* (CreateSpace Independent Publishing, 2015).
See also, Caitlin M. Kiernan, *Pretty Sick: The Beauty Guide for Women with Cancer* (New York: Hatchett Books, 2017).
See also, Marybeth Maida and Debbie Kiederer, *Beauty Pearls for Chemo Girls* (New York: Citadel Press, 2009).
See also Aury Caltagirone and Tania Doney, *Feeling Beautiful: How to Look Your Best During and After Cancer Treatment* (Herve Conan, 2013)

[9] Susan M. Love, *Dr. Susan Love's Breast Book, 6th Ed.* (Philadelphia: Da Cappo Press, 2015).
See also, Kristi Funk, *Breasts: The Owner's Manual: Every Woman's Guide to Reducing Cancer Risk, Making Treatment Choices, and Optimizing Outcomes* (Nashville, TN: Thomas Nelson Press, 2018).

[10] Sontag, *Illiness as Metaphor*, 3.

readers through the backstreets of the kingdom of the sick and inside the pink war machine to teach them to recognize gender-subordinating identity power messages and exploitative agents.

To meet these guides, this second section of the study consists of three chapters that present an expanded conceptual analysis of GI evident in narratives that respond to, resist, and revision/restore BGC teaching, learning, curriculum, and policy, both inside and outside the pink war machine. Chapter Three, “Emergent-Conflicted GI,” focuses on the most common kind of GI. Here I engage first with a late 20th-century breast cancer memoir, Betty Rollin’s *First, You Cry* (1976) and two twenty-first century narratives, Geralyn Lucas’s *Why I Wore Lipstick to My Mastectomy* (2004/2014), and Antia Ho’s autobiographical essay, “The Breast Cancer Diaries” (2006). I consider these three narratives, spanning over 30 years, to focus on how each voices emergent-conflicted GI.

Chapter Four, “Instigative/Informer GI,” is a focused engagement with another early published breast cancer narrative, Rose Kushner’s *Breast Cancer: A Personal History and Investigative Report* (1975). The designation of “Instigative/Informer GI” acknowledges Kushner’s ethnographic and journalistic impulse to document what she finds within the pink war machine. Chapter Five, “Restorative/Reformer GI,” returns to an in-depth look at Audre Lorde’s *The Cancer Journals* (1980) not only as one of the earliest BGC narratives, but also as one that continues to have lasting influence. Finally, I consider Sandra Steingraber’s *Living Downstream* to consider how her ecofeminist perspective broadens the field of operations, both for understanding the effects of pink war and GI responses to it locally, globally, and beyond the anthropocentric. This study ends with some preliminary conclusions, personal reflections, and directions for future research.

Chapter Three: Emergent-Conflicted GI: A Response to Pink Commerce

> "[Y]ou are Teaching Yourself to learn
> again."
> --Aurdre Lorde, "Martha," *The Collected Poems of Audre Lorde*[1]

Emergent-conflicted narratives reveal an author's ambivalence toward the psychological trappings of pink war as she demonstrates GI awareness while adhering to deeply engrained beliefs about her worth being tied to normative ideals of female beauty. While emergent-conflicted BGC narratives address the overlapping pink war approaches and mechanisms of commerce, medical authoritarianism, and normative narratives, they focus most directly on pink war commerce as these authors' struggle against pink war gender-identity trappings. Due to the author's internal conflict between their held GS values and gender-insubordinate responses, the emergent-conflicted BGC autobiographical narrative reveals contradictory impulses. On the one hand, the author is showing awareness of gender-subordinating, exploitative messages in her patient education stressing women should "invest in themselves" through cosmetics, prosthetics, and reconstructive surgeries to look "normal" and regain health and happiness after diagnosis. On the other hand, these authors give an honest account of not being able to resist the pull of these ideas as they tap into deep-seated and often unexamined fears brought to the surface in the body-mind crisis of a BGC diagnosis and treatment. These writers need what pink war commerce offers because they no longer feel secure in their sex-gender identities and come to doubt their own worth.

As British BGC memoirist Sarah Horton explains, cancer entails a myriad of losses: "[L"oss of dignity as a cancer patient, loss of control of what happened to my life, loss of status in the world . . . loss of confidence. Loss of people around me who I thought were my friends.

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[1] Audre Lorde, *The Collected Poems of Audre Lorde,* 39.

Loss of ovaries. Loss of energy. Loss of trust in myself."[2] Inspired by Ehrenreich and Lorde, whom she calls her "angry sisters"[3] and feminist critic Samantha King's detailed critique of the profit agenda in breast cancer,[4] Horton is aware that "breast cancer is guided by commercial interests,"[5] and is "repelled" by the industry of prosthetic breasts and the pressure from medical providers she is put under to wear one.[6] However, she later decides to undergo multiple surgeries to reconstruct her breast, purchases a custom-made, prosthetic nipple, and sexy lingerie and bras to regain a sense of feminine confidence.[7]

The conflicted responses Horton admits to, both her feelings of dismay, anger, and a refusal to being reduced to a body-object and also her need to regain a sense of feminine gender identity to feel "normal", is common in emergent-conflicted GI narratives. What makes these narratives gender-insubordinate rather than conventional is evidence of the author's evaluation of her internalized beliefs and actions, a sense of coming into critical consciousness. As Freire (1968) notes, "coming into awareness" of oppression can be frightening, especially if it raises questions about a person's entire value system. In such cases, a person may "see ghosts" and "take refuge" in what is familiar "to achieve security which he or she prefers to the risks of liberty."[8]

In her evaluation of autobiographical texts testifying to sexual abuse, Wendy Hesford (1999) notes that "survivors report that speaking out is an important and often transformative

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[2] Sarah Horton, *Being Sarah*. (United States: Wordscapes, 2010), 169.

[3] Ibid., 248-249.

[4] Ibid.,
See also, Samantha King, *Pink Ribbons, Inc.: Breast Cancer and the Politics of Philanthropy* (Minneapolis: University of Minnesota Press, 2006)

[5] Ibid., 249.

[6] Ibid., 84.

[7] Ibid., 230.

[8] Paulo Freire, *Pedagogy of the Oppressed*, trans. Myra Bergman Ramos (New York: Bloomsbury: 2000), Kindle, 200.

step from being a passive victim to an active survivor,"[9] even if in the act of speaking out there are some conflicted responses. As a testimony of an individual's body-mind trauma, every cancer narrative deserves respectful reader engagement.[10] However, in the context of trying to recognize where and how gender insubordination manifests within the CIC's pink war machine, some narratives will be more germane than others.

As Hesford also notes, "we must realize that trauma and survival narratives can function in ways that both counter the invisibility of violence against women and reinscribe existing subject-object relations."[11] Feminists, further must "challenge the facile equivalence of self-disclosure and opposition" to conditions of oppression and violence.[12] While all BGC cancer autobiographies break silences about what was once considered a woman's private ordeal, and collectively challenge cultural taboos by making the ill body visible through writing, they do not each always reveal critical perspectives on learning and gender in cancer diagnosis and treatment. For the aim of considering how gender-insubordinate narratives may intervene in and counter gender-subordinating education in the pink war machine, Hesford's observations

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[9] See, Wendy S. Hesford, *Framing Identities: Autobiography and the Politics of Pedagogy* (Minneapolis: University of Minnesota Press, 1999) [Kindle Edition], Kindle Locaton 2066.
Hesford explores the image of a clothesline as a metaphor for autobiographical works that put the private, painful experiences of sexual violence "under constant view" to reclaim the author's or artist's power (Kindle Location 2125). Incest, rape, and other acts of sexual abuse are traumas distinct from a cancer diagnosis and treatment, and the comparison I am drawing is not to suggest that "victim" is an apt term for someone with cancer. My sense is the use of identity labels like "victim" or "survivor" should be at the discretion of individual persons. However, both these terms have been controversial in cancer as "victim" in illness discourses may connote a person without agency and reinforce the notion of cancer as a state of being at war with one's own body. Similarly, "survivor" may connote an inaccurate sense of cure and an identity label that does not include people whose cancer is advanced and terminal.

[10] To engage with and "listen" to a woman's cancer narrative as a testimony of gender-subordinating, miseducative practices in cancer treatment, and to "hear" testimony equitably, I am taking to heart Lorraine Code's (1991) admonition that readers never engage purely with a text; there is no direct transfer of information, not here or in any other form of communication. As individual body-minds, we are always acting as interpreters, and when we read, we are always "implicated in the process" and "accountable" for how [we] … interpret the written testimony of others and to what ends it is used.
See, Lorraine Code, *What Can She Know? Feminist Theory and the Construction of Knowledge.* (Ithaca, NY: Cornell University Press, 1991), 258.

[11] Hesford, *Framing Identities*, 2065-2072.

[12] Ibid., 3257.

highlight the need to distinguish gender-insubordinate cancer autobiographical writings from the larger, ever-growing body of women's cancer autobiographies.

However, some narratives blur the lines between endorsing conventional, gender-value messages and a gender-insubordinate stance. The emergent-conflicted narratives explored in this chapter—the most common kind of GI in BGC narratives—reveal the complexity, pervasiveness, and identity-conflicting effects of gender normativity that shape human lives. The narrative focus in emergent-conflicted GI is the writer as the experiencing subject during and after cancer diagnosis and treatment. This *auto* focus is not egoistic narcissism but an author's claiming of her situated, subjective, body-mind knowledge. In so doing, the author asserts her authority as one who knows, acting as what Miranda Fricker (2007) calls an "epistemic agent" rather than merely or only being an object of information for others' use.[13]

Betty Rollin: Trapped in Pink War and Hoping to "Pass"

Four years after the appearance of Campion's *The Invisible Worm* and four years before Lorde's *The Cancer Journals,* Betty Rollin wrote *First, You Cry* (1976). An NBC News correspondent, Rollin was a national figure prior to her cancer diagnosis. She opens *First, You Cry* with the recollection of an NBC story she reported on two years earlier focusing on Betty Ford's mastectomy. Reporting from the clinic where Ford received treatment in 1974, Rollin tells her audience, "The terror women feel about breast cancer is not unreasonable. What is unreasonable is that women still turn their terror inward. They think if they avoid investigating the possibility that they have the disease, they'll avoid the disease."[14]

Her admonishment to her viewing audience is ironic because in her memoir she admits that at the time of filming she knew that there was a lump in her breast "the size of a yellow

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[13] Fricker, *Epistemic Injustice*, 132.
[14] Betty, Rollin, *First, You Cry.* (New York: Harper Collins, 1993), 1.

grape" for at least a year.[15] A member of New York City's affluent social society, at the time of her diagnosis, Rollin is rising in her career as a television journalist. She admits that she also considers herself to be "pretty," "smart," and a "Jewish [American] Princess,"[16] too full of life to be sick. In her own assessment of her motives for putting off a visit to the doctor, she admits that the idea of "deprivation, injustice, [and] disease" were bad things that happened to other people but were as "remote as Bangladesh" in her affluent world.[17]

Rollin describes herself as a career-focused feminist,[18] but she also reveals an identity deeply tied to traditional constructions of heterosexual, feminine gender and white privilege. She spends money to calm her nerves facing cancer, getting her hair styled the day before her mastectomy because "if there was about to be a tragic occurrence I wanted to look nice."[19] Before the biopsy appointment, she shops at Bloomingdales and buys "an expensive pair of silver earrings" and "an expensive pair of shoes" to bolster her confidence.[20] Like the character Jennifer North, the socialite diagnosed with breast cancer in Jaqueline Susann's novel *Valley of the Dolls* (1966), Rollin takes Valium to cope with depression and fear that the thought of losing her breast causes.[21]

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[15] Ibid., 3. Rollin, who is only 39 when her breast cancer is diagnosed, admits that one of the reasons she did not see a doctor when she first discovered the lump was a sense of youthful invincibility. She describes herself up to this point as leading a "golden life."

[16] Ibid., 23-24.

[17] Ibid., 25. Due in part to Rollin's public recognition as a television journalist, *First, You Cry* became a bestseller and was made into a television movie starring Mary Tyler Moore in 1978.

[18] Ibid., 15, 24.

[19] Ibid., 44.

[20] Ibid., 45.

[21] Rollin's inclusion of her concern to "look nice" for her biopsy, her shopping spree at Bloomingdales, an iconic luxury department store in New York, and taking Valium to cope with depression suggest an identification with the stereotype of the "Jewish [American] Princess." In American popular culture of the 1970s and 1980s this ethnic joke featured Jewish American women as being materialistic, sexually deviant (either not interested in sex or highly sexualized) and "overly concerned with appearance." See Josepha Sherman, *A Sampler of Jewish American Folklore* (Little Rock, AR: August House, 1992), 5-6.
Rollin does not mention *Valley of the Dolls* in *First You Cry,* but incidentally, when she was an editor for *Look* magazine she produced a photo spread of the actresses who starred in the movie version released in 1967, so she was aware of this novel and the character of Jennifer North. See Betty Rollin, "The Dames in *The Valley of the Dolls,"* *Look* (1967): 53-56, 58 and cover.

Refusing to Comply: Refusing the "sheroic" virtues of indefatigable resilience and cheer

According to Baron H. Lerner (2001), it was Rollin's admission that the loss of her breast was a psychological trauma that made her book a bestseller. He states, "what most resonated with her readers . . . was her contention that women approaching and recovering from breast cancer surgery should be allowed to think about issues of appearance."[22] In 1976, same year that *First, You Cry* was published, Margaretta "Happy" Rockefeller's essay, "If It Should Happen to You," was published in the May issue of *Reader's Digest.* Rockefeller offers "appropriate" etiquette for women after breast cancer. She barely acknowledges the physical and emotional trauma of a double mastectomy, saying only, "I've had my ups and downs,"[23] but "I have never felt better physically and I am happier than I have ever been" because "like thousands of other women who have had this surgical experience, I've *learned* to accept what happened to me."[24]

Rockefeller's educational message is that there is hope for a happy life after breast cancer if a woman can learn to not complain and "buck up." By contrast, Rollin does not gloss over the trauma of breast cancer she experiences as a cisgender, heterosexual, "feminine" woman. Rather, she refuses to comply with the cultural expectation that Rockefeller exemplifies for a woman post-mastectomy; a paragon of female virtue rising above feminine "vanity." Rollin's memoir addresses the fact that a woman's concern for appearance after breast cancer reflects deeply engrained beliefs and someaesthetic practices learned over a woman's lifetime. Rollin brings to light the feminine double bind of an oppressive, gender-subordinating social

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An important point is that Rollin does not learn these gendered responses in cancer treatment; rather, they are part of her persona as a tragic "Jewish Princess," figure, a role that she constructs for her breast cancer treatment. Rollin's frequent references to needing to take Valium and her desire to be seen as "sweet" and "fragile" in nightgowns trimmed with lace and rosebuds while in the hospital recovering from her mastectomy suggest she is performing an illness role that she thinks will bring her both sympathy and praise. She wants people to see her as "looking like Ophelia," and "fragility, I thought, would complement my stoicism" (73).

[22] Barron H. Lerner, *The Breast Cancer Wars: Fear, Hope, and the Pursuit of a Cure in Twentieth-Century America* (New York: Oxford University Press, 2001) [Kindle Edition]. Kindle Location 2237-2243.

[23] Margaretta Rockefeller, "If It Should Happen to You," *Reader's Digest 108* No. 649, (May 1976), 133.

[24] Ibid., emphasis mine

framework. Women are "damned if they do" care too much about their appearance as shallow and vain, and "damned if they don't" as unfeminine and reduced in social value.

Sustaining the body-mind: confessing fears of being "unwomaned" and needing to "pass."

Days after her mastectomy, Rollin is determined to resume her life and place in the New York social scene but continuously fears that she will shame herself if she doesn't look "normal." She attends a cocktail party with her husband and worries about "passing" throughout the affair, wearing a bra stuffed with stockings:

> I was drunk, but not so drunk that I didn't know that I was passing. I *was* passing. Incredible. Nobody knew. Nobody could tell. They thought I looked wonderful. Thin. "Lovely," someone else said. Each time someone complimented me, I ducked into Joanna's bathroom and, standing on my toes, checked myself out in the medicine-cabinet mirror. Front and side. Then I repowdered my face and went back into the living room for another go.[25]

She describes herself as feeling like "the prettiest freak of all."[26] Even when going to the grocery store, she feels like she must maintain a charade of feminine "normality": "I couldn't face the possibility of shocking and repulsing my fellow shoppers. In America, bodies are whole, teeth are straight, and the sight of a deformed person—that's you, kid—is a turnoff."[27]

Rollin challenges feminist critiques such as Betty Freidan's (1963) argument that a woman who judges her fulfillment chiefly in terms of her "status as a desirable sex object"[28] and by adhering to gender-proscribed role as wife, homemaker, and mother is buying into the "feminine mystique."[29] Rollin expresses skepticism that any feminist identity liberated completely from traditional femininity is possible or even desirable. She asks, "What was this perverse terror of *not* being a sex object? Was I, am I not, above that? Answer: No. I am not,

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[25] Ibid., 109.
[26] Ibid., 122.
[27] Ibid., 153.
[28] Betty Freidan, *The Feminine Mystique* (New York: W.W. Norton, 2013), 306.
[29] Ibid., 316.

have never been, and probably will never be above that. Nor are most women I know, most of whom are ardent, authentic, card-carrying feminists."[30]

Educating body-minds: Nascent GI awareness and the body as a war zone

Rollin's memoir reveals an emerging awareness that she has internalized prior, gender-specific teachings equating her perceived sexual attractiveness with her ability to have physical and emotional intimacy with others and her social value.[31] At one point, she references a longstanding rape fear, problematically conflating sexual violence and sexual intimacy to express her negative body image: "I was no longer afraid of being raped because, I thought, 'who'd want me now?'"[32] Including these uncensored responses, Rollin demonstrates a self-educating impulse and awareness that she is both conscious of and working through conflicted, gender-subordinating and feminist ideologies. At another point, Rollin wryly asks, "who needs a breast, anyway, you can't *do* anything with a breast, you can't type with it or type with it or walk on it or play 'Melancholy Baby' with it?"[33] Reflecting on her reasons for wanting to go to the

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[30] Rollin, *First, You Cry*, 110, emphasis in original.

[31] In *The Human Condition* (1958), philosopher Hannah Arendt makes the compelling argument that culture is the first and most powerful teacher. From the moment we are born, we experience "natality" in that we arrive late into a pre-existing world. Natasha Levinson (2001), commenting on Arendt's assertion, notes the "simple and yet disconcerting fact that the world does not simply precede us but effectively constitutes us as particular kinds of people," including as males and females. The "world" Levinson refers to is the world of human culture, and arriving "late" means that for a period of time our involvement in culture consists primarily of learning its language, customs, values, and other constituting features. As Martin (2011) argues, beliefs and values associated with notions of sex and gender-based divisions are not "natural," inevitable, or culturally fixed. They are, however, deeply engrained, pervasive, and persistent. Gender learning occurs over the course of human lifetime, but Ardent sees the inherent, inescapable condition of natality as inspiring the countering impulses to act to preserve and to re-shape culture. In this way, natality generates all "political thought."[31] Arendt's and Martin's insights about culture suggest that while identity depends largely on an individual's unique cognitive and emotional qualities and responses to culture, identity is also a product of acquiring culture, that is, of education in Martin's broad sense. In Rollin's memoir, we can see her wrestling with the competing impulses of natality, to preserve what she has learned and also to challenge it as her gender-insubordinate thinking clarifies through self-educating, self-reflective thought. See Arendt, *The Human Condition* (Chicago: University of Chicago Press, 1958), 6-8.
See also, Natasha Levinson, "The Paradox of Natality: Teaching in the Midst of Belatedness," *Hannah Arendt and Education: Renewing Our Common World,* Mordecai Gordon, Ed. (Boulder, CO: Westveiw Press, 2001), 13
See also, Jane Roland Martin, *Education Reconfigured*, (New York, USA: Routledge, 2011), 27.

[32] Rollin, *First, You Cry*, 145.

[33] Ibid., 70., emphasis in original.

cocktail party, she admits to wanting to be admired as a model of feminine pluck while at the same time testing her ability to hide the loss of her breast:

> I wanted to see if I could camouflage the war zone, if I could still get myself up to look nice. . .. Everyone at the party thought I was still pretty. I passed, all right. But transvestites pass, too. It's nice to fool everyone. It's nice to get a prize for your costume. But it doesn't stop you from knowing, yourself, what's underneath. I got a little drunker.[34]

Rollin's concern with "passing" reveal her awareness of the performative aspects of gender—both she and transvestites can "pass." As Butler (1993) states, drag emphasizes gender's construction and "implies that all gendering is a kind of impersonation and approximation."[35] Throughout her life, Rollin is told that she is "pretty,"[36] and, as an adult, being pretty becomes integral to her identity. In his analysis of Nathan Jean Toomer's mixed racial identity and passing for white, Henry Lois Gates Jr. remarks that when a sense of social acceptance and security comes at the cost of hiding or denying what is integral to one's identity, an "ironic double sense of 'passing' and [simultaneously] 'dying,'" can occur.[37] Gates is noting a sense of identity loss and other negative psychological and physical effects. Despite Rollin's earlier assertion that breasts are body objects that serve no practical purpose, at the cocktail party her social confidence is deeply tied to breasts.

As Rollin explores her conflicting responses and shares thoughts and actions that might present her as shallow or narcissistic, her self-focus takes a critically reflective turn. Martin (2011) makes the point that "the uncoupling of cultural stock from an individual's capacities

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[34] Rollin, *First, You Cry*, 107-112.

[35] Judith Butler, "Imitation and Gender Subordination," *The Lesbian and Gay Studies Reader,* Henry Ablelove, Michèle Aina Barale, and David M. Halperin, Eds. (New York: Routledge, 1993), 313.

[36] Rollin, *First, You Cry*, 22.

[37] Henry Louis Gates, *Figures in Black: Words, Signs, and the 'Racial' Self* (New York: Oxford University Press, 1989), 202.

[does not] necessarily entail" loss.[38] Rather if a "cultural liability becomes uncoupled from an individual's capacities, the loss can be judged a definite gain to both the individual and the culture."[39] While the notion of gender is not inherently a cultural liability, when gender and sex are used as justifications for a logic of domination[40] they become connected in support of socially-destructive practices such as misogyny and racism.[41] When Rollin begins to suspect that her concern with being "pretty" and "passing" is self-objectifying, this insight, even if she continues to have an identity investment in "passing," represents a potential "loss" or at least devaluation of gender-subordinating cultural stock in her life.

Claiming voice: The mourning after mastectomy

Feminist philosopher Sandra Lee Bartky (1990) argues that messages in culture teach women that "[n]ot only must we continue to produce ourselves as beautiful bodies, but the bodies we have to work with are deficient to begin with"[42] and must be shaped through various technologies to meet cultural standards for beauty and approval. Given Bartky's points, Rollin's presentation of mastectomy as body-mind trauma raises a complex issue for feminist-oriented, educational goals in women's cancer care. If a feminist response to women's concerns for appearance completely invalidates their body-mind lifelong learning, then the knowledge, emotions, and agency of women with breast cancer who hold these concerns may be devalued. Dismissing the lived traumas of breast cancer, mastectomy, and reconstructive surgery as simply shallow or as sign of women internalizing patriarchal values and practicing self-objectification may reinforce a culture of silence about cancer's physical and psychological effects.

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[38] Martin, *Education Reconfigured.*

[39] Ibid., 17.

[40] See, Karen J. Warren, *Ecofeminist Philosophy: A Western Perspective on What it is and Why it Matters.* (New York: Rowman and Littlefield, 2000) [Kindle Version]. Kindle Location 802.

[41] Martin, *Education Reconfigured*, 11.

[42] Bartky, *Femininity and Domination: Studies in the Phenomenology of Oppression* (New York: Routledge, 1990), 108-109.

While the loss of a breast does not present the same challenges as a loss of a hand or foot (as Rollin puts it, "you can't type" with a breast or "walk on it"), a mastectomy is still a bodily loss. As Sikka Madhulika (2014) observes, it is an amputation:

> Something that was there is now gone, something that protruded from my body is now "lopped" off. The words amputate or amputation never came up when I was diagnosed with breast cancer. They still don't. . .. Mastectomy is a word that tens of thousands of women hear every year, and it is a course of action they take. It is a brutal, violent thing to have happen to you.[43]

Over forty years after *First, You Cry,* U.S. qualitative studies continue to report negative effects of breast cancer on women's bodily image, psychological health, and sexuality.[44] "Slash, burn, and poison"[45] cancer treatments are physical and psychological traumas, and, Like Rollin, twenty-first century BGC memoirist describe anxiety, self-loathing, shame, and other negative emotional responses to their bodies and gender identity after surgical treatments. Despite critical contributions of feminist perspectives on the body and gender and public attention garnered by breast cancer activism, the internalized sense of being deformed and "unwomaned" that Rollin gives frank testimony to remains common, even if not commonly expressed or glossed over in conventional soldier-survivor narratives. Rollin's self-educating, critical reflection does what Lorde calls for women to do, to break culturally imposed silences that obscure the "the pain of amputation" and serve to divide women from each other.[46]

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[43] Madhulika Sikka, *A Breast Cancer Alphabet* (New York: Crown Publishing Group, 2014), Kindle, 640-647.

[44] See, S.H. Varzi and F. Lofti Kashani, "Sexuality After Breast Cancer: Need for Guidelines," *Iranian Journal of Cancer Prevention 5* No 1 (2012): 10-15. Accessed 15 May 2017. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4352520/.

[45] This slang emphasizes perceived harms done to bodies in western medical practices of breast cancer diagnosis and treatment, specifically the iatrogenic effects of lumpectomy/mastectomy, radiation, and chemotherapy. I could not find an origin for this phrase, although feminist breast cancer activists commonly reference it. Donald Gowronski attributes this phrase as a more generalized critique leveled against mainstream allopathic medicine by alternative medicine advocates. See Gayle Sulik, *Pink Ribbon Blues: How Breast Cancer Culture Undermines Women's Health* [Kindle Edition]. (New York: Oxford University Press, 2001) Kindle Location 259. See also, Donald V. Gowronski, *Medical Choices* (Lincoln, NE: Author's Choice Press, 2002), 52.

[46] Lorde, *The Cancer Journals,* Kindle Location 35.

Geralyn Lucas: Trapped in Pink War and Hoping to Stand Out

Refusing to Comply and Sustaining the Body Mind: Lipstick as GI Self Care

Geralyn Lucas's *Why I Wore Lipstick to My Mastectomy* (2004/2014; film version 2010) is a clear example of twenty-first century BGC narrative. On the surface, Lucas' story mirrors Rollin's in several ways. She is also a young, white, affluent New Yorker and a television journalist at the time of her diagnosis. And, like Rollin, Lucas embraces the use of representational somaesthetics,[47] specifically cosmetics, as a response to breast cancer. But, unlike Rollin who is more concerned with "passing," Lucas wants not only to hide her illness but to use cosmetics and fashion as a demand for attention, to claim individuality and personhood in treatment. For Lucas, red lipstick is emblematic of feminine courage and bold identity claiming.[48] When she decides to put it on in the hospital before her mastectomy, she does so not for vanity's sake, but to refuse the position the CIC assigns to her as a passive, surgical object. Lucas decides to let that splash of red color on her lips "speak" for her when she is anesthetized so the people in the surgical room with her will remember she is a person. She writes:

> [S]omehow I need to be myself in this sterile room, during this surgery that has been forced on me. I need to remind everyone that I am not just another mastectomy, right side, on the OR table. I need to leave a trace that I was here. . . maybe I will leave a little smear of lipstick in the operating room today just to let them know I was there?[49]

Lucas, who is only twenty seven at the time of her diagnosis, struggles with her impending sense of loss of feminine identity and value, what Barkty describes as a fear of becoming gender "de-skilled."[50] After several male surgeons advise her to have a lumpectomy, and one says aloud what she knows the others are thinking— "'It would be so unfortunate to lose

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[47] Richard Shusterman, *Body Consciousness: A Philosophy of Mindfulness and Somaesthetics* (New York: Cambridge University Press, 2008.) [Kindle Edition]. Kindle Location 638.

[48] Ibid., Kindle Location 41-62.

[49] Ibid., Kindle Location 633-639.

[50] Bartky, *Femininity and Domination,* 77.

your breast. You're such an attractive young woman,'"[51] Lucas goes to a strip bar, a "mammary Mecca" to observe the way men respond to breasts. She visits the bar to help her decide if she will have a mastectomy as advised by all of the female surgeons she has consulted or if she will follow the male surgeons' advice and have a lumpectomy to spare her breast.[52] She is aware the male surgeons' "breast conservation" argument places a concern for her appearance and her psychosexual welfare above a concern for her life, which is her female doctors' primary concern. However, she cannot escape what her male doctors have suggested, that she will no longer be "wholly female" without her breast. Sitting in the strip bar, she observes that "[a]ll the men in this room are reminding me of the power I stand to lose. They are here to worship boobs."[53] Placing her life and health above her looks, Lucas decides to have a mastectomy, defying the masculine authority of the six male surgeons who are more interested in preserving her youthful beauty and of all men whom she observes "worshipping boobs."

However, this decision is not made without the costs that worried her male surgeons. She mourns the loss of her sexual power after her mastectomy: "I never realized how often men used to look at me on the street until they stop. I would give anything for a once-over. It's as if I don't exist. I just walk by as an invisible woman. . .. I remember when I counted. When men would smile and even catcall."[54] While not as extreme as Rollin's problematically self-pitying response that not even a rapist would want her after mastectomy, Lucas longs for masculine appreciation from strangers; her husband's reassurances are not enough that she retains her feminine "power" and personhood. To reclaim her identity, Lucas "dresses for success" for her chemo treatments. She wears fashionable, feminine clothes, high heels, and heavy makeup

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[51] Lucas, *Why I Work Lipstick,* Kindle Location 123.
[52] Ibid., Kindle Location 322-329.
[53] Ibid., Kindle Location 70-83.
[54] Ibid., Kindle Location 938.

because "hearing the click of my patent leather strappy shoes against the sanitary white floors gives me so much hope."[55] Walking in her heels down the quiet hospital hallways, the sound and sight of her own color is a practice to sustain herself and defiantly to remind others that she has an identity, a personality outside of the mass of near-invisible people in the kingdom of the sick.

However, even lipstick cannot protect her from being reduced to a diseased part with her doctors and nurses in post-operative appointments: "They all keep looking at me in the same way. No eye contact. I make jokes, I wear beautiful suits with lots of perfume and lipstick to catch their attention. . . . I want them to look at *me* and realize I am not the cancer. . . . But something has happened: *I* don't exist anymore. I've become a lab report."[56]

Educating the body-mind and claiming voice: A way out of/back into pink war

Being attractive to men assures Lucas that she retains her familiar identity and social power even in the face of extreme physical and psychological trauma. Wollstonecraft's observation over 200 years ago that women learn from childhood that their social worth is tied to heteronormative ideas of feminine beauty, the "scepter" of female power, remains undeniably relevant in breast and reproductive cancer care. Watching her young daughter play with a Barbie doll, Lucas reflects that that female breasts are a symbol of gender power and status in the competition for males. She observes, "This is a breast-obsessed society. It starts when little girls are only three! And it just gets worse. It doesn't matter that I have two Ivy League degrees—I have only one boob."[57]

Noting that the creator of the Barbie Doll, Ruth Handler, also had breast cancer, Lucas wonders why there is no "Breast Cancer Barbie:"

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[55] Ibid., Kindle Location 1104-1110.
[56] Ibid., Kindle Location 283-290.
[57] Lucas, *Why I Wore Lipstick*, Kindl Location 2115-2216.

> [T]hey have a Doctor Barbie, Astronaut Barbie, and even a Barbie that does math. If one in eight women get breast cancer, a Breast Cancer Barbie feels more relevant than an astronaut one. I cannot get the image of Breast Cancer Barbie out of my head. Could Breast Cancer Barbie still somehow be beautiful with a large red bolt across her chest? Maybe if there were a Breast Cancer Barbie, a Hooter Girl, a one-boobed pin-up girl in Playboy, a one-boobed stripper, I would know there is a template somehow for that kind of beauty."[58]

Lucas's sense even young girls (and boys) could learn about a disease that affects mothers, grandmothers, sister, aunts, teachers, friends, and others through a "breast cancer Barbie" doll[59] suggests a GI educating impulse, possibly a way for parents and children to talk about the effects of cancer on the body in a way that fosters empathetic awareness and reduces body stigmas. However, her fantasy of featuring women with mastectomy scars in the sex industries as a "template" for female beauty problematically conflates a notion of teaching girls and women that their worth is not dependent upon their number of breasts with the notion that it *is* still dependent upon their ability to be objects of sexual commodity value to men. Lucas's focus here is not about making breast cancer visible as a social health issue, an aim which was achieved through 1990s conventional-corporate activism, but to normalize it, make it *beautiful,* perhaps, even aspirational. This is an idea which affirms rather than denies pink war machine's gender-subordinating values and elides the fact that cancer, no matter how you try to sexualize or normalize it, kills.

Anita Ho: Trapped in Pink War and Knowing Better

Rollin and Lucas suggest their experiences of breast cancer as a crisis of gender identity are in part attributable to gender values learned and internalized over a lifetime. However, Anita

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[58] Ibid., Kindle Locatoin 2119-2125.

[59] A collector's Breast Cancer Awareness Barbie Doll was manufactured in 2006-2007. This doll is sold wearing a flowing evening gown with a pink ribbon emblem. Mattel donates $2.50 to Susan G. Komen for the sale of each doll. The dolls do not have mastectomy scars.
See, "Barbie Collector Pink Ribbon Barbie Doll," *Amazon.* Accessed 14 November 2018. https://www.amazon.com/Barbie-Collector-Pink-Ribbon-Doll/dp/B000ERVLV6/ref=sr_1_3?ie=UTF8&qid=1549054969&sr=8-3&keywords=breast+cancer+barbie.

Ho's "The Breast Cancer Diaries" (2006) attests to her internalizing normative gender values only later, as a grown woman inside the pink war machine. A professor of feminist bioethics teaching at a woman's college at the time of her diagnosis, Ho describes herself getting "trapped in breast culture"[60] even though as a feminist educator one might think she would "know better." Ho's narrative straddles and blurs a theoretical distinction between emergent-conflicted and instigative-informative GI. Like a cultural anthropologist who has become deeply involved a community that she is researching, Ho's voice alternates between personal-emotional patient and detached-critical observer of pink war's gender-subordinating effects.

Refusing to comply and sustaining the body-mind: testifying to coerced compliance

As a bioethicist, Ho has been trained to recognize ethical issues in the legislation of human health. However, when she finds herself on the receiving end of an implicit curriculum of patient training to become a docile body,[61] a dehumanized object of medical scrutiny, she expresses consternation and anger. Much like Lucas, she realizes that the doctors have "received the license to stare, judge, and probe because the breast is seen as a disjointed part of me—a diseased and dissected part."[62] Like Lucas too, she describes feeling invisible during routine medical procedures, but she does not rely on lipstick to gain her doctors' attention. Instead, she notes that doctors, nurses, and medical technicians "focus intensely on my breast . . . talk to each other in codes and medical jargon. . .. Hearing them talk to each other as if I was not there makes

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[60] Anita Ho, "The Breast Cancer Diaries," *The Voice of Breast Cancer in Medicine and Bioethics,* Mary C. Rawlinson and Shannon Lundeen, Eds. (Dordrecht, The Netherlands: Springer, 2006), 88.

[61] In his historical-conceptual study of the way power operates to control bodies in prisons, the military, schools, and hospitals, French philosopher Michele Foucault describes a "docile body" as a resource for the interests of power to shape as docile bodies are "manipulable" and may be "subjected, used, transformed, and improved."
See, Michele Foucault, *Discipline and Punish: The Birth of the Prison* (New York: Vintage, 1999), 165.

[62] Anita Ho, "The Cancer Diaries," in *Breasts and Medicine: The Conceptual History of Breast Cancer and its Implication for Medical Practice*, eds. Mary Rawlinson and Shannon Lundeen (United States: Springer, 2006), 86-87.

me feel like a mannequin with movable body parts."[63] In an entry dated September 8, 2003, she expresses frustration in being left out of discussions and decisions about her health:

> Why do I keep feeling like I don't know what they are doing to/with me? Why do I have to keep looking up medical journals and Internet sites to get information about my condition? . . . when obtaining consent, my doctors seem to care *only* about protecting themselves from liability; ensuring I have a good understanding of what is going on doesn't seem to be a priority for them. . .. I have received almost no information regarding my treatment progress.[64]

Ho enters the CIC with prior awareness of the myriad ways medical authority is gendered in hierarchal relations and how cultural expectations for "care" in healthcare can obscure the profit agenda in modern medicine. However, this foreknowledge does not protect her from feeling objectified, dismissed, and coerced into signing medical release forms she is given only minutes before surgery that state she understands the risks of the procedure and is willing to sign away her rights should anything go wrong.[65]

Diagnosed with high-grade ductal carcinoma in sutu (DCIS), Ho has a lumpectomy followed by radiation to ensure that the cancer is eradicated.[66] After surgery, she is referred to an oncologist who will oversee her follow up care, but his response communicates to her that "he does not care about me,"[67] and she feels her personhood being relegated to just another set of

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[63] Ibid., 82.

[64] Ho, "The Cancer Diaries," 84.

[65] Ibid., 77, 84.
Ho shows the double bind women may find themselves in when confronted with medical authoritarianism, even if they perceive they are being oppressively subordinated in treatment. In Ho's case, the choices she makes during cancer treatment to refrain from asking the doctors questions, to not complain when she feels medically objectified, and to sign consent forms presented to her minutes before surgery are made because she does see any good outcomes in noncompliance. Arguably, she could cancel the surgery and seek treatment elsewhere. However, even if she is able to think of this option in the midst of a body-mind trauma and coming under medical pressure to comply, making a prudent choice to do so assumes there are alternative medical facilities she could reasonably get to, that the doctors there would be covered by her insurance, and that her surgery could be rescheduled quickly so her cancer does not have time to spread. It also assumes that at some other treatment facility her new doctors would treat her differently. Without knowing if these conditions are all feasible, and facing an aggressive form of cancer that spreads rapidly, Ho's compliance is arguably given under duress.

[66] DCIS cases like Ho's account for approximately 1 out of every 5 newly diagnosed breast cancers. DCIS is a cancer too small to detect with a physical exam and contained in the milk ducts. In Ho's case, finding DCIS due to a suspicious but ultimately benign breast lump was fortuitous because her cancer is form that spreads rapidly.

[67] Ho, "The Cancer Diaries," 79.

medical charts and a defective body. She observes that her healthcare is "fragmented" among providers who do not communicate with each other.[68] When she meets the oncologist, he bluntly states a poor prognosis for her long-term health. He tells her that despite her surgeon's reassurances that the DCIS was removed, malignant cells could still remain, and her young age (26 years), makes it more likely that her cancer will return, requiring a future mastectomy. After delivering this "brutally honest" news, he leaves her crying to process both this dire news and the way she has been treated. It is only after he leaves the room that she realizes he has given her no information about follow-up care and that she has forgotten to ask. Rather than feeling like equal participant in her decision-making process, part of a team, Ho feels information has been dumped on her without any empathetic support. She writes, "Instead of feeling empowered to make an informed decision by his truth-telling, I feel isolated and overwhelmed."[69]

As a bioethicist, she is aware of a power imbalance manifested in this doctor-patient encounter and of multiple studies finding that "physicians' poor communication skills can make patients feel less hopeful."[70] Depressed and afraid, she is uncertain about what actions she

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[68] Ibid., 80.

[69] Ibid., 81.

[70] Ibid.

A 2010 article reviewing doctor-patient communication research cites studies finding that communication skills "tend to decline as medical students progress through their medical education." The rigors of medical training "suppress empathy, substitutes techniques and procedures for talk, and may even result in derision of patients." See, Jennifer Fong Ha, Dip Surg Anat, and Nancy Longnecker, "Doctor-Patient Communication: A Review," *The Ochsner Journal 10* No. 1 (2010): 39.

Even if a doctor is empathetic and a good communicator, there are interconnected time and policy constraints limiting doctor-patient interactions in corporate medicine.[70] For example, doctors come under pressure to meet daily patient quotas. They also have to document each patient visit and prescribed treatment in detail, which is arguably a beneficial practice. However, given that doctors have limited time and this documentation is time-sensitive and time consuming, it puts pressure on doctors to document in the midst of treatment rather than waiting for the patient to leave. Clinical treatment rooms with computer screens have become standard, and the physical separation of the doctor sitting behind the monitor and the patients on the table can create a heightened sense of the power divide. This practice has also tended to reduce the number of minutes doctors and patients spend in direct physical contact and making eye contact during conversation.

For more see, Roni Caryn Rabin, "You're on the Clock: Doctors Rush Patients out the Door," *USA Today*, last modified April 20, 2014, https://www.usatoday.com/story/news/nation/2014/04/20/doctor-visits-time-crunch-health-care/7822161/

See also, Pauline W. Chen, "For New Doctors, 8 Minutes Per Patient," *New York Times*, last modified May 30, 2013, https://well.blogs.nytimes.com/2013/05/30/for-new-doctors-8-minutes-per-patient/

should take next. She admits in her diary entries to remaining silent and obedient because she is afraid her questions could be taken as a challenge to medical authority, and this could compromise the quality of her care.[71] She also sees the expectation for patient compliance enforced through patterns of nonverbal intimidation in doctor-patient hierarchal interactions. As the subordinate in this relationship, if she asks too many questions, her doctor may signal impatience, which she sees as a threat to the level of care she receives.

However, when her radiation treatment plan suddenly changes without explanation, she breaks her self-imposed silence to confront her radiologist, demanding to know why the change is being made. The doctor is evasive, telling Ho, "it's kind of complicated."[72] This response

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See also, Erin Spain, "Do Doctors Spend Too Much Time Looking at Computer Screen?" *Northwestern Now*, last modified January 23, 2014, https://news.northwestern.edu/stories/2014/01/do-doctors-spend-too-much-time-looking-at-computer-screen/

See also, Christine Sinsky, Lacey Colligan, Mirela Prgomet, Sam Reynolds, Linsey Goeders, Johanna Westbrook, Michael, and George Blike, "Allocation of Physician Time in Ambulatory Practice: A Time and Motion Study in 4 Specialties," *Annals of Internal Medicine*165, no.11 (2016): 753-760, accessed at http://annals.org/aim/article/2546704/allocation-physician-time-ambulatory-practice-time-motion-study-4-specialties?utm_source=MMGSeAlert&utm_campaign=AdministrativeBurdenofEHRsOpensDoorstoMedicalScribes&utm_content=4-26-2017

[71] Ho, "The Breast Cancer Diaries," 86.

A pair of qualitative studies in 2017 suggest that there is a basis for Ho's concern, finding that "disruptive" patients' are given lower "likability" scores by doctors than "neutral" or non-disruptive patients. The study showed, further, that the misdiagnosis rate rises when patients are perceived as troublesome

In both studies, clinical vignettes of doctor-patient interactions were given to doctors and residents to read. For every vignette, the doctors were instructed to diagnose the fictive patient's condition and rate the patients presented on a Likert likeability scale. In both studies, researchers created eight types of "disruptive" patients: 1) a "frequent demander," 2) an aggressive patient, 3) a patient who questions the competency of their doctors, 4) a patient who "ignores doctor's advice," 5) a patient that has "low expectations of support," 6) a patient who "presents herself as utterly helpless," 7) a patient who "threatens the doctor", and 8) "a patient who accuses the doctor of discrimination" (15). The study does not look at distinctions among disruptive and neutral patients by sex, sexuality, gender identity, race, or other social categories, but being "utterly helpless" is presented in the research with a feminine pronoun.

See, Sílvia Mamede, et. al., "Why Patients' Disruptive Behaviors Impair Diagnostic Reasoning: A Randomized Experiment," *BMJ Quality and Safety 26* (2017): 13-18.

See also, H. G. Schmidt, et. al., "Do Patients' Disruptive Behaviors Influence the Accuracy of a Doctor's Diagnosis: A Randomized Experiment," *BMJ Quality and Safety 26* (2107): 19-23.

According to findings in Mamede et. al., difficult or disruptive patients interfere with a doctor's reasoning abilities (16), and an unstated conclusion is that patients are, at least in part, responsible for diagnostic errors. However, definitions for the eight disruptive categories are unclear. For instance, what behaviors and what frequency of the behaviors make for a "demanding" patient? Is asking questions being "demanding," and if so, how many questions does it take to be labeled demanding? What behaviors make a patient "neutral" and more "likeable?" Perhaps a question to consider and to look at in light of gender and other categories of social difference is "what conditions or experiences in medical treatment might contribute to patient disruptive behaviors?"

[72] Ibid., 85.

suggests that it is really better if Ho just lies back on the radiation table and trust the experts to make decisions about what is best for her. Reflecting on this exchange, Ho asks, "[I]s it not the doctor's job to explain complicated matters in an understandable way to patients? It seems that [this] is a challenge to which the doctor must rise."[73] Ho leaves this encounter feeling ambivalent, at once guilty for pressing her radiologist for answers and also angry at being patronized.[74]

In *Pedagogy of the Oppressed* (1970), Freire considers the practice of someone holding specialized knowledge (a teacher, or, in Ho's case, a doctor) "projecting an absolute ignorance onto others" as "a characteristic of the ideology of oppression" that "negates education and knowledge as processes of inquiry."[75] Freire calls this one-way flow and strict control of knowledge the "banking" model of education.[76] The radiologist's answer of "it's complicated," suggests "it's *too* complicated for *you*," and punctuates a difference in status between doctor and patient. As the one who does not have medical expertise, what is expected from Ho is, like the student in the banking model, near unquestioning compliance.

As Foucault (1982) reminds us, power circulates throughout culture, and in all but extreme cases, even those who seem powerless exercise some measure of power. Insubordination is a threat because it is an ever-present potential of the subordinated to use their power to resist.[77] Similarly, in "Oppression by Choice" Ann E. Cudd (1994) makes the point

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[73] Ibid.
[74] Ibid.
[75] Freire, *Pedagogy of the Oppressed*, 993.
[76] In Freire's "banking" model of education grounded in oppressive ideologies, the one who has the knowledge has the power to bestow or withhold it as she or he sees fit, and, when knowledge is shared, it is done so for the sake of replication. Students are not encouraged or taught to think for themselves and teachers do not learn from students. Rather, knowledge is controlled, static, and one-way. See Paulo Friere, *Pedagogy of the Oppressed, 30th Anniversary Edition,* Myra Bergman Ramos, Trans., [Kindle Edition] (New York: Bloomsbury, 2014), Kindle Location 993-1006.
[77] Foucault, "The Subject and Power," *Critical Inquiry 8* No 4 (1982): 794.

that "to be coerced to act is still to act,"[78] but she explores to what extent the action is voluntary. Cudd contends that the coerced is compelled to comply with those coercing her because her choices are limited, perhaps by constraints of geography, economy, religious beliefs, family ties, or out of a necessity to preserve physical safety and health. I agree with Cudd that "we need a moral theory that can recognize injustice in social institutions,"[79] including injustices that occur in medical institutions. Although Ho is making "rational choices" to comply with gender-subordinating agents and practices of the CIC, her freedom is compromised by her need for expedient medical treatment.

Educating body-minds and claiming voice: Addressing body shame as pink war learning

Detailing the medical practices that she finds harmful, Ho's memoir breaks the self-imposed, coerced silences she keeps during her treatment to expose what she sees as widespread gender-subordinating, oppressive medical practices. However, this GI action does not mitigate the gender-identity trauma she suffers. Like Rollin and Lucas, Ho comes to equate her sense of confidence and sexual attractiveness with normative femininity and breasts, something she did not pay attention to or value before entering the pink war machine. She explains, "As a feminist who teaches at a woman's college, I have an ethical responsibility to reject patriarchal standards of what it means to be a woman . . . [but] being situated in a culture that continues to hold to various gender and sexual norms . . . I suddenly find myself trying to prove my womanhood."[80] Ho reads breast cancer patient-education books and pamphlets made available through the hospital and notes these sources "teach women how to keep a feisty attitude" and provide information about nutrition, exercise, and reconstructive surgeries, but nothing to help her deal

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[78] Cudd, Ann E. "Oppression by Choice," *Journal of Social Philosophy* 25th Anniversary Special Issue (1994), 27.
[79] Ibid., 32.
[80] Ho, "The Cancer Diaries," 87-88.

with her new body image insecurities. The patient education sources she finds are "relatively quiet regarding body and sexual image."[81]

She puzzles over this seeming silence, suggesting, "perhaps this is something people find too difficult or awkward to discuss."[82] She begins to wonder if "others may measure my worth and desirability by my breasts" and internalizes medicalized messages that her breast is a diseased object and her body is fragmented and "damaged."[83] Like Rollin and Lucas, Ho seeks masculine validation that she remains sexually desirable, but she refuses to let her spouse see or touch her scarred and radiation-burned breast, although he reassures her that he still finds her desirable.[84] Ho recognizes that her insecurities and body disgust were not part of her identity before breast cancer. These responses do not necessarily follow from a cancer diagnosis or treatment either, but rather social and medical responses to a woman's changed body after cancer. Ho's reactions are products of her educational encounters in the pink war machine.

Her observation that women's sexual health and gender issues are not openly addressed in formal patient curriculum highlights the difference between explicit gender-normative messages in the pink war machine and informal, implicit ones that suggest adhering to gender norms in breast cancer can restore a woman's health and happiness, including her sexual health. Ho's admission that she sees her breast as damaged and no longer sexual reveals an awareness of her own gender-subordinating learning. However, she does not fully explore her new focus on her breasts and body as an educational consequence of pink war, nor does she seem aware that the advice on female "feistiness" (a pink war soldier-survivor "sheroic" characteristic) and patient information pamphlets on breast reconstruction convey both implicit and explicit

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[81] Ibid., 87.
[82] Ibid.
[83] Ibid., 87.
[84] Ibid., 86-88.

messages about cisgender, heterosexual women's sexual health. Given her observations, one is left to wonder if she came across titles such as *Cancer Vixen,*[85] *Surviving in Stilettos,*[86] *No Less a Woman,*[87] or Lucas's *Why I Wore Lipstick to My Mastectomy* in the patient education media she was offered. Each of these sources offer tips and encouragement for a woman to see herself as a powerful, feminine, soldier-survivor and sexual being. She also makes no mention of Lorde's *The Cancer Journals,* which candidly confronts gender learning and sexuality after breast cancer.

Pinar (2011) notes that "education requires subjectivity in order for it to speak, for it to become concrete, to become actual. Without the agency of subjectivity education evaporates, replaced by the conformity compelled by scripted curricula."[88] Emergent-conflicted critiques like Rollin's, Lucas's, and Ho's assert subjective agency and, in different ways, resist conformity to gendered-subordinating narratives. Ho confronts contradictions between her theoretical, feminist knowing that sexual objectification and medical authoritarianism harm body-minds and her experiential body-mind knowing that breast cancer has rendered her vulnerable to gender-subordinating messages. However, she does not try to resolve her epistemic disconnect.[89] Rather, she closes with the recognition that, just like everyone else, she has become "trapped in the breast culture"[90] that shapes how we view bodies and health.

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[85] Marisa Acocella Marchetto, *Cancer Vixen: A True Story* (New York: Pantheon, 2014).

[86] Deetria Cannon, *Surviving in Stilettos: Inspiration to the Divas Who are Young, Fabulous, and Dealing With the Effects of Breast Cancer* (Twenty-Two Publications, 2014)

[87] Deborah Hobler Kahane, *No Less A Woman: Femininity, Sexuality, and Breast Cancer* (Alamada, CA: Hunter House Publishers, 1995).

[88] William Pinar, *What is Curriculum Theory?* (New York: Routledge, 2011), 43.

[89] Anita Ho, "The Breast Cancer Diaries," *The Voice of Breast Cancer in Medicine and Bioethics,* Mary C. Rawlinson and Shannon Lundeen, Eds. (Dordrecht, The Netherlands: Springer, 2006), 88.

[90] Ibid.

Chapter Four: Instigative/Informer GI: A Response to Medical Authoritarianism

"But something in my body teaches
patience is no virtue
every month
renews its own destruction"
--Audre Lorde, "To Marie, in Flight,"
The Collected Poems of Audre Lorde[1]

In what I am calling instigative/informer gender insubordination, BGC autobiographers focus most directly on medical authoritarianism as a mechanism of pink-war control over women's body-minds in cancer treatment. Whereas emergent-conflicted narratives focus on the authors' developing awareness of gender-subordinating messages in cancer treatment, in instigative/informer narratives, the authors' focus turns to sustained critiques of the pink war medical surround as a site of gendered teaching and learning. Authors of instigative/informer GI autobiographical narratives speak in the voice of participant-researchers, reporting back to the "well side" from the kingdom of the sick.[2] While autobiographical testimony of the author's body-mind experiences frames the narrative, these experiences are not the sole or even necessarily primary focus. Rather, they are proffered as supporting evidence for a wider critique of medical authoritarianism's gender-subordinating harms locally and globally. Demonstrating much more clearly defined and consistent theoretical and political stances than emergent-conflicted GI, instigative/informer narratives explore how medical responses to breast and gynecological cancers reflect and reinforce gender biases in wider society.

These writers often reveal a background of advanced formal education and feminist orientations, sharing what they have learned. They argue that women can best protect their interests if they are more involved in medical decision making. They implicitly suggest or explicitly argue that women should learn to recognize the various interests that may be

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[1] Lorde, *The Collected Poems of Audre Lorde,* 145.
[2] Sontag, *Illiness as Metaphor*, 3.

advancing their own agendas in BGC research and care. These writers advance an ethical imperative for gender-insubordinate action, urging others to examine the social implications of how we respond to cancer and to situate one's own illness within a larger social and cultural framework. While usually not medical experts, they understand key medical issues and discuss the progression of their disease and the recommended and available treatments.

Instigative/informer GI shares some characteristic with the genre of feminist autoethnography. As Elizabeth Ettore (2017) contends, autoethnography "helps to raise oppositional consciousness by exposing precarity,"[3] and feminist-oriented autoethnographers merge "emotions, intellect, bodily sensations, and sensibilities" in literary art and "feminist science."[4] They do this to examine the ways in which social constructions of gender affect "how bodies are situated in space and time" and challenge western, epistemic assumptions that support oppressive hierarchies. For both the authors who write such narratives and their readers, feminist-informed illness autoethnographies are a way to interrogate "what illness is and does as well as what making meaning of illness involves."[5]

While instigative/informer GI shares an ethical orientation with feminist autoethnography and some gender-insubordinate cancer narratives are autoethnographic, they may not all reveal the "diverse interdisciplinary praxes"[6] of autoethnography or always demonstrate the personal vulnerability that Ruth Behar (1997) and Dwayne Custer (2014) identity as central to autoethnographic method.[7] However, like autoethnography, instigative/informer GI narratives

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[3] Elizabeth Ettore, *Autoethnography as Feminist Method: Sensitizing the Feminist "I"* (New York: Routledge, 2017), 4.
[4] Ibid., 14-15.
[5] Ibid., 44.
[6] Tami Spry, "Performing Autoethnography: An Embodied Methodological Praxis," *Qualitative Inquiry 7* No. 6 (2001): 710.
[7] Ruth Behar, *The Vulnerable Observer: Anthropology that Breaks Your Heart* (Boston: Beacon Press, 1996), 13-14.
See also, Dwayne Custer, "Autoethnography as a Transformative Research Method," *The Qualitative Report 19* (2014): 4.

explore how social institutions and mechanisms shape meaning in human experience; in this case, how the pink war machine shapes social responses to breast and gynecological cancers.

In *Gender and the Social Construction of Illness* (2002), Judith Lorber and Lisa Jean Moore contend that people must refuse to be treated as "passive receptacles" for health information. Rather, they must demand to become "participants in the creation of healthcare"[8] and act as agents for "resistance and transformation."[9] Lorber and Moore call for gender-insubordinate action in the social contexts of health, illness, and gender. Instigative/informer GI autobiographers like Barbara Ehrenreich,[10] Susan Gubar,[11] Sharon Batt,[12] and, Rose Kushner, the writer whose narrative is the focus of this chapter, take up this call. These authors blend the autoethnograhic impulse to discover what "meaning making" in the pink war machine involves with a social activist stance to change those meanings when they are oppressive, cultural liabilities.[13]

Rose Kushner: Embedded Pink War Journalist

Now largely eclipsed by the sheer volume of subsequent cancer narratives, Rose Kushner's *Breast Cancer: A Personal History & Investigative Report* (1975) is one of the earliest examples of a gender-insubordinate, instigative/informer breast cancer narrative.[14]

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[8] Lorber, Judith and Lisa Jean Moore. *Gender and the Social Construction of Illness,* 2nd ed., (Plymouth, UK: AltaMira Press, 2002), 149.

[9] Ibid.

[10] Barbara Ehrenreich, "Welcome to Cancerland: A Mammogram Leads to a Cult of Pink Kitsch," *Harper's Magazine* (2001).
See also, Barbara Ehrenreich, *Bright-Sided: How the Relentless Promotion of Positive Thinking has Undermined America* (New York: Henry Holt and Company, 2009)

[11] Susan Gubar, *Memoir of a Debulked Woman: Enduring Ovarian Cancer* (New York: W.W. Norton, 2012).

[12] Sharon Batt, *Patient No More: The Politics of Breast Cancer* (Charlottetown, Canada: Gynergy Books, 1994).

[13] Elizabeth Ettore, *Autoethnography as Feminist Method: Sensitizing the Feminist "I"* (New York: Routledge, 2017), 100

[14] Rosamond Campion's *The Invisible Worm* is published in 1972, three years before Kushner's *Breast Cancer.* Campion's memoir focuses on her refusal to sign release papers allowing her surgeon to immediately perform a radical mastectomy (Halsted mastectomy) while she was still unconscious if cancer was found during a surgical biopsy. This one-step biopsy and mastectomy procedure was routine up through the 1970s and was considered to be in the patient's best interest. Campion's was the first published memoir to call for a woman's right to a two-step procedure and right to choose less extreme surgical treatments such as simple mastectomy and lumpectomy.

Kushner, who died in 1990 from a metastatic recurrence of breast cancer, was widely recognized as America's first national breast cancer activist and as a driving force behind the decision to end the long-held practice of a one-step biopsy and mastectomy procedure.[15] Like Lorde, Kushner died before the rise of the CIC and pink war commerce that tied breast cancer nonprofits, corporations, and government agencies like the National Cancer Institute together in a pink-ribboned, multimillion-dollar industry. However, Kushner was critical of "our free-enterprise 'fee-for-service' medical system" and incentivizing surgical and chemical disease management over cancer research.[16] Three months after a modified mastectomy, the *Washington Post* published her autobiographical newspaper article "Breast Cancer Surgery: The Breast-Cancer Controversy," and it was nationally syndicated.[17]

Kushner's BGC narrative and activist work defines instigative/informer GI narratives. The 1960s and 1970s was a period of widespread social change as the African American Civil Rights Movement inspired the youth counterculture movement, and the women's rights movements. These disparate social movements each took on the "white male establishment" in their own ways and toward their own ends. In 1971, the first edition of the Boston Women's Health Book Collective's *Our Bodies, Ourselves*[18] was published and widely distributed,

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Kushner narrative carries Campion's call forward for patient rights forward and presents more detailed information about breast cancer's causes and a critique of paternalistic, gender-subordinating practices in breast cancer. At age forty five, Kushner discovers a lump in her breast, and employs her knowledge and skills as a journalist and trained medical researcher to actively participate in medical treatment decisions. Like Campion three years earlier, Kushner refuses a one-step biopsy and mastectomy surgery.

[15] See, Amanda M. Olson, *The Narrative Construction of Breast Cancer: A Comparative Case Study of the Susan G. Komen Foundation and National Breast Cancer Coalitions' Campaign Strategies, Messages, and Effects* [PhD Dissertation]. (Ohio University, 2005) 39.
See also, Gayle Sulik, *Pink Ribbon Blues: How Breast Cancer Culture Undermines Women's Health* (New York: Oxford University Press, 2012), 32.

[16] Rose Kushner, *Breast Cancer: A Personal History & an Investigative Report.* (New York: Harcourt Brace Jovanovich, 1975), 348.

[17] Baron H. Lerner, *The Breast Cancer Wars: Hope, Fear, and the Pursuit of a Cure in Twentieth-Century America,* [Kindle Edition]. (New York: Oxford University Press, 2001), Kindle Location 2141. See also,

[18] In its second edition in 1979, *OBO* included expanded information about breast cancer from the first edition and cited Kushner's work. See The Boston Women's Health Book Collective, *Our Bodies, Ourselves, 2nd ed. Completely Revised and Expanded* (New York: Touchstone, 1979), 131.

presenting a feminist claiming of women's rights and voices in female reproductive health. However, even within a milieu of widespread social change, the topic of cancer remained largely taboo. By boldly raising questions about how women should be treated for cancer and proposing that women should be involved in their own cancer treatment decisions, Kushner was undermining the medical status quo, challenging the expertise and judgment of male doctors and surgeons.

Compared to the significant emphasis that emergent-conflicted writers give to expressing the body-mind trauma of cancer, Kushner's personal responses to cancer are sparse. At one point, she describes "cuddling my left breast as if to say a last goodbye,"[19] but she does not frame the loss of her breast as a psychological trauma affecting her perception of her social worth or gender identity. She shares little of her own psychosexual responses, saying only, "He [her husband Harvey] probably misses my left breast just as I sometimes miss his once thick head of curly hair . . . neither of us is the same as we were twenty-four years ago."[20] As a middle-aged (45-year-old), married woman with three children, Kushner explains that she does not experience mastectomy as a younger, single woman or woman without children might. She frames her experience as a regrettable loss, but not the trauma to her sense of gender identity emergent-conflicted GI writers describe.[21]

However, as Sidonie Smith (2001) notes, "omissions, gaps, and silences" in autobiographical texts are important to pay attention to. She reminds readers to avoid the impulse to see any narrative as a coherent truth or a complete, chronological accounting of a

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See also, Sandra Morgen, *Into Our Own Hands: The Women's Health Movement in the United States 1969-1990* (New Brunswick, NJ: Rutgers, 2002), 143.

[19] Kushner, *Breast Cancer,* 238.

[20] Ibid., 252.

[21] Ehrenreich later criticizes responses like this (but not Kushner directly) for suggesting cancer is a "rite of passage" and a "normal marker in the life cycle" rather than "an injustice or a tragedy to rail against." See, Barbara Ehrenreich, *Bright-Sided: How the Relentless Promotion of Positive Thinking has Undermined America* (New York: Henry Holt and Company, 2009), 28-29.

portion of a life.[22] Similarly, Richard J. Gerrig (2010) notes a distinction in literary studies "between *story*—what is being told—and *discourse*—the manner in which it is being told,[23] and Townsend and Weiner (2011) note that autobiographers "may unconsciously draw from the conventions of a variety of discursive traditions . . . demonstrating the internalization of the demands of policing."[24] These are all important reminders given that Kushner's narrative is something of a hybrid, interweaving qualitative and narrative research with personal narrative vignettes to advance a curriculum for gender-insubordinate breast cancer patient education. Leopold (1999) describes *Breast Cancer* as "a memoir, a comprehensive handbook, and a manifesto all rolled into one"[25] As such, her narrative marks an important contribution to the women's health movement of the 1970s and 80s and is a forerunner of late twentieth-century and twenty-first century feminist breast cancer critiques and guidebooks like *Dr. Susan Love's Breast Book*. Kushner emphasizes journalistic objectivity, "authorizing" her contribution to patient education. Taking up the position of an embedded journalist-researcher, no one can say she is reporting "fake news" to advance a biased agenda. Rather, Kushner's autobiographical-subjective, body-mind knowing serves to create a personal context for her "investigative report" from the pink war front line.

Refusing to Comply: Mr. President, women are not docile bodies

With *Breast Cancer*, Kushner aimed to end paternalistic practices in medicine that prevented women from having choices in their breast cancer treatment. While the successive revelations of Ford's and Rockefeller's cancers in 1974 along with Marvella Bayh's in 1971 and

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[22] Sidone Smith, *Reading Autobiography: A Guide for Interpreting Life Narratives* (Minneapolis: University of Minnesota Press, 2010), 78.
[23] Richard J. Gerrig, "Reader's Experiences of Narrative Gaps," *Storyworlds: A Journal of Narrative Studies* 2 (2010): 19.
[24] Lucy Forsyth Townsend and Gaby Weiner, *Deconstructing and Reconstructing Lives: Auto/Biography in Educational Settings*, (University of Western Ontario: Althouse Press, 2011), 296.
[25] Leopold, *A Darker Ribbon*, 234.

Shirley Temple Black's in 1972 helped lessen the public stigma of breast cancer and create a rapid rise in women routinely practicing self-examinations and scheduling mammograms, Kushner was alarmed that both Ford and Rockefeller had one-step biopsy-mastectomy procedures, a decision made by their husbands and doctors once their surgical biopsies revealed cancer.[26] When it was announced in the news that Betty Ford was scheduled for breast cancer surgery in 1974, Kushner called the White House, using her connections as a D.C. insider and journalist to try to speak with the first lady to urge her to have only a biopsy performed first. Kushner was not able to speak with Betty Ford directly. Instead, a speechwriter for President Ford relayed her request to the President. When the speechwriter returned to the phone, he apologetically told her that "the President has [already] made his decision."[27]

According to Lerner (2001), in her private correspondence, Kushner called President Ford's response "male-chauvinist-piggery," and "the all-time [most] sexist declaration of no-woman rights."[28] In response, Kushner writes a nationally syndicated article for *The Washington Post,* "Breast Cancer Surgery: The Breast-Cancer Controversy," In *The Post* article, Kushner argues that women "have the right to choose" the type of breast surgery that they have and to

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[26] Kushner, *Breast Cancer*, 310.
From the 1920s through 1970s, it was standard practice in the U.S. for a surgeon to perform a surgical biopsy and then, while the woman was still under anesthesia and in the operating room, have a frozen biopsy sample rushed to pathology for immediate results. If cancer was found, the surgeon would perform a mastectomy while the patient was unconscious, most often a "Halsted" or radical mastectomy, which involved total removal of all breast tissue, skin, underlying muscles, and surrounding lymph nodes down to the chest wall. In some cases, women might be informed by their doctors that a mastectomy was a possible outcome if cancer was found, but not every woman was made aware of this standard surgical protocol and even fewer were told what a Halsted radical involved. A woman would not know if she had cancer until after she awoke and discovered her bandaged chest and surgical drains. If cancer was also suspected in the other breast, as it was in Rockefeller's case, a second biopsy was performed, also without the patient's knowledge. If there was cancer in the second biopsy sample, a double, radical mastectomy could be performed or the woman might be allowed to recover from her first mastectomy and be told at that time of her husband's and doctor's decision that she would need to have a second mastectomy.
For more, see, Lerner, *The Breast Cancer Wars*, 381.
See Also, Susan M. Love, *Dr. Susan Love's Breast Book, 6th ed.* (Boston: Da Cappo Press, 2015), 564.
See Also, Gayle Sulik, *Pink Ribbon Blues: How Breast Cancer Culture Undermines Women's Health* (New York: Oxford University Press, 2012), 32.

[27] Kushner, *Breast Cancer*, 311.

[28] Lerner, *The Breast Cancer Wars*, 2161-2164.

find surgeons that they trust to perform the surgery competently and respect their wishes, even if the doctor thinks the woman is being “stupid and suicidal” and her choice to have anything less than a radical mastectomy is “idiotic vanity.”[29] Within months, she publishes her own memoir, *Breast Cancer.* Here she frames her attempts to contact Gerald Ford before Betty Ford’s surgery as a lesson for a gender-insubordinate curriculum to resist and end masculine, medical authoritarian practices in breast cancer treatment. She writes:

> Nowhere is male domination more evident than during the short interval in which the decision is made about the mastectomy—because we patients are usually unconscious! . . . [E]ven the president of the United States is not free of a lifetime of conditioning in our masculine society. Just as I hope women will learn from reading this book what they have a right to expect and demand, I hope men will understand that their wives should not be denied a conscious voice in their destinies.[30]

Kushner writes *Breast Cancer* to expand her argument in *The Post* for women’s choice in breast cancer treatment and to address a breast cancer “education and information gap” that she perceives as subordinating women to male control of information about their bodies and health.[31]

Like Ho, Kushner examines profit-driven practices and medical authoritarianism in breast cancer treatment, but she does not stop here. Rather, she calls for women to be self-educating and demand the right to participate in their cancer treatment planning. Kushner’s notion of participating in one’s cancer treatment rejects the behavior of “good” pink-war-soldier-survivor passive compliance with medical authorities. She calls for women to educate themselves about breast cancer, including the specific etiologies and pathologies for each woman’s disease. She also calls for women to be informed about the diagnostic, surgical, pharmaceutical, and cosmetic

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[29] Rose Kushner, “Breast Cancer Surgery: The Breast-Cancer Controversy,” *The Washington Post.* 6 October 1974. Accessed 12 November 2018. https://search-proquest-com.ezproxy.lib.ou.edu/docview/146104053?accountid=12964.

[30] Kushner, *Breast Cancer*, 311-312.

[31] Kushner as quoted in: Ellen Leopold, *A Darker Ribbon: A Twentieth Century Story of Breast Cancer, Women, and Their Doctors* (Boston, MA: Beacon Press, 2000), 223.

technologies for treatment, common physical and psychological effects of breast cancer, and the limits of medicine and surgery to prevent a recurrence, metastasis, and death.

Sustaining the body-mind: Redefining the patient role as employer

Breast Cancer opens with a brief foreword from Dr. Dao, the surgeon who performs Kushner's mastectomy. While disagreeing with her that there is an "economic incentive" in the treatment of breast cancer, he praises her for being "her own woman" and concludes that Kushner's book is a valuable source for women to learn how to be self-educating and self-advocating in breast health: "She exhorts women to protect themselves by regular breast self-examination, education, and critical evaluation of what they are told. Moreover, she does not shrink from confrontation with the medical profession, should such be unavoidable."[32]

Kushner meets Dao after her internist tells her that the lump she found in her breast needs to be biopsied. Right away, she draws on her prior education as a medical researcher and reporter to respond: "'I don't want any ordinary surgeon cutting into a possible cancer,' I insisted. 'It's got to be an oncologist.' He stared at me, amazed that I knew a cancer specialist is called an oncologist."[33] When her internist doesn't know where to send her, she calls the National Institutes of Health (NIH) to schedule an appointment at the breast center for a mammogram. When she learns they will not see her without a referral from her doctor, she writes her own patient referral letter for the internist to sign.[34]

Before the biopsy, she asks the general surgeon to sign a contract she drafts with the help of a lawyer stating that he will only do the biopsy. The surgeon treats the contract as a "huge joke" and scolds her, asking, "ready to be put to sleep now, worrywart?"[35] However when the biopsy reveals cancer, the surgeon is upset she did not let him perform a mastectomy. She

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[32] Rose Kushner, *Breast Cancer*, xii-xiii

[33] Ibid., 7.

[34] Ibid., 8, 11.

[35] Ibid., 24.

recounts, “One of the nurses told me I had hurt his feelings badly. ‘He’s considered one of the best general surgeons around,’ she explained. ‘I know,’ I recall telling her sleepily. ‘But for cancer I want more than a general surgeon.’”[36] Kushner includes this and other vignettes to demonstrate her gender-insubordinate responses to safeguard and sustain her body-mind, even in the midst of an onslaught of medical pressure to submit to local medical authorities, which, as a privileged woman, are some of the best in the country.

Acting more as an employer interviewing potential employees than as a patient, Kushner interviews breast surgeons until she finds Dr. Dao at Roswell Park Memorial Institute who is willing to perform a modified mastectomy rather than a radical one. Emphasizing a need to be resolutely self-advocating and self-educating, she closes the first chapter directly addressing her presumed-female readers, stating, “[T]he point of this book is to show that we women should be free, knowledgeable, and completely conscious when the time comes for a decision, so that we can make it for ourselves. *Our* lives are at stake, not the surgeon’s.” She adds that her story is “one example of what women can do—if they have some information to go on . . . a streak of stubbornness, and a loud voice.”[37] While Kushner suggests she is presenting a template for other women to follow, she concedes some necessary conditions exist. They can do as she has done *if,* like she, they possess knowledge and skills to go about finding a specialist, and *if,* like she is, they are tenacious and assertive.

However there are other, connected, necessary conditions she does not mention-— if they are affluent and highly educated; if they have access through social and professional channels to learn where the “best” care can obtained and have the social and financial resources to gain access to it; and if they have the time in terms of disease progression and work/family life to wait and do research before making provider and treatment choices. These are some fairly large

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[36] Ibid., 25.

[37] Ibid., 30, emphasis in original.

preconditions for the kind of self-advocating action Kushner demonstrates. However, Kushner acknowledges her relative position of educational privilege compared to other women she interviews as part of her research:

> From my 130 interviews, I discovered that my experience was not a typical one, from the beginning. For example, because I have been a medical writer for a long time, I can understand doctor's jargon and can read "the literature" without its being simplified in the popular press. Also, I had the advantage of being ten minutes away from two of the finest medical libraries in the country. . .. Most women do not have either piece of good luck. They must rely on their doctors to explain. The word most of my respondent used to describe their feelings was "helpless." One said she "suddenly became a shivering bit of jello [sic] who followed my surgeon like a toddler following mommy on the first day of nursery school."[38]

Understanding gender subordination is linked to other social identity markers used as a basis for marginalization, we can also say Kushner's self-advocating action is aided also by her being white, cisgender, and heterosexual. We can also see how her educational aim in *Breast Cancer* reveals an assumption that she is addressing heterosexual readers in spousal relationships where males financially support females.[39] She addresses males in their role as compassionate husbands to women with breast cancer, urging them to "[b]e with your wife as much as you can throughout the ordeal, and support her with your presence as well as your checkbook."[40] While such heteronormative, gender, and class assumptions and racial biases in her research date her work for twenty-first-century readers,[41] Kushner goes to great lengths to detail what she learns

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[38] Ibid., 255.

[39] Unlike Rollin, who writes *First, You Cry* only one year later and at least acknowledges the existence of lesbian women, there is no mention of lesbians in Kushner's text.

[40] Kushner, *Breast Cancer*, 309.

[41] While Kusher includes data on breast cancer in European countries, Canada, Japan, Iceland, Russia, and South American countries, she does gives little textual weight to discussing breast cancer in American racial minority populations. She mentions breast cancer incidence in American Indian women once, in African American women once, and makes no mention of Latina, Asian American, Alaskan native, or Pacific Islander populations, making white women, including ethnically Jewish women, the primary group for her study and target audience. However, this may due in part to epidemiology statistics of the 1970s rather than an overt racial bias. She notes that "in the United States, white women have a higher incidence than women of other races, a pattern that seems to prevail all over the world" (82). Data from the CDC for 21st century shows a changing pattern in breast cancer statistics. While white women in the U.S. still have the highest rate of diagnosis, African American women are a close second followed by Latina, Asian and Pacific Islander, and finally American Indian and Alaskan Native. Further, according to the CDC, breast cancer rates have steadily decreased in the U.S. from 1999-2014, but it is still the most diagnosed

and to share it with others. "Armed" with the knowledge she compiles in her report and her examples of how to apply this knowledge to one's own care, readers may, as Dao and Kushner suggest is necessary and possible, become critical, self-advocating evaluators of their own care.

Educating the body-mind: Spotlighting sexism from elementary through medical schools

Similar to Rollin's confessional, conflicted awareness, Kushner is aware that her responses to breast cancer and mastectomy are shaped by her internalization of gender values. Kushner admits to submitting to economic-social realities in conflict with her convictions. Even while she sees a "malevolent influence of a male-dominated medical profession" reinforcing "male chauvinism" and gender-health messages in breast cancer, she suggests that little can be done to change the gendered status quo and that in part this is due to economic realities. With regret and chagrin, she admits that if her two sons and daughter all wanted to go to medical school and she only had funds for two, she would send her male children because they would be family breadwinners.[42] At the time of Kushner's writing of *Breast Cancer,* the Patsy Mink Equal Opportunity in Education Act (Title IX of the Education Amendments), passed in 1972, was only in operation for three years. Kushner mentions recent legislation (presumably Title IX) makes it easier for women to enter medical school than in the past, but the widespread practice of limiting women's entry in the medical professions continued.[43]

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cancer among women of all races in the U.S. and is a leading cause of death for Hispanic women and the second cause of death after heart disease for white and African American women. However, more African American die from breast cancer than for any other group. For more, see "Breast Cancer Rates by Race and Ethnicity," *Centers for Disease Control and Prevention.* 15 June 2016. Accessed 22 June 2017. https://www.cdc.gov/cancer/breast/statistics/race.htm
See also, "Leading Cause of Death by Race/Ethnicity, All Females-United States 2014," *Centers for Disease Control and Prevention.* 11 January 2017. Accessed 22 June 2017. https://www.cdc.gov/women/lcod/2014/race-ethnicity/index.htm
See also, "Breast Cancer Statistics," *Centers for Disease Control and Prevention.* 7 June 2017. Accessed 22 June 2017. https://www.cdc.gov/cancer/breast/statistics/index.htm

[42] Rose Kushner, *Breast Cancer*, 305; 315-316.

[43] Ibid., 304.
Forty-five years later, the Mink Act and feminist activism have helped to change the gendered educational landscape of U.S. medical schools. In 2016, women were represented in medical school in near parity with men. According to the Association of American Medical Colleges, in 2016, the number of women admitted to U.S. medical schools

As Kushner queried in 1975, how might a lack of women surgeons and a male-dominated education for surgeons affect what women learn in breast cancer diagnosis and treatment? How do these disparities reflect and support gendered, hierarchal doctor-patient interactions, decision making in breast cancer research and treatment, and cultural perceptions of health and gender? Asking why breasts are culturally prized object-symbols of womanhood that tie health and cancer recovery to gender identity, Kushner recounts a conversation with a "young man" who blames girls and women for making breasts the primary sex symbol in commercial and entertainment media:

> 'What are you talking about, Rose? The girls do it to us. From the time I was in seventh grade, when only a couple of girls in my class had anything, they were always sticking them out and practically shoving them in our faces. You've got it all wrong,' this budding MCP [male chauvinist pig] insisted. 'It's not the males who do it to the females. It's the girls who make breasts a sex symbol, not the boys.'[44]

As this man's response shows, the gendered hierarchies of nature/culture, mind/body, male/female, reason/emotion, and public/private at the rock bottom of the deep structure of

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was 49.8%, nearly equal to men. Data from the Henry J. Keiser Family Foundation for 2015 shows that the number of women graduating from U.S. medical schools (8,907) was also nearly half the total number of graduates (47.6%). However, gender patterns in medical education begin to show in residency programs. Whereas more women choose to specialize in pediatrics, family medicine, psychiatry, and obstetrics and gynecology, more men specialize in surgery, emergency medicine, anesthesiology, radiology, oncology, and internal medicine. Surgery in particular remains a bastion of male authority. In 2016, women represented only 19% of all practicing general surgeons in the U.S., 22% of surgical teaching faculty, and 1% of department chairs.

For more, see "Number of Female Medical School Enrollees Reaches 10-Year High," *Association of American Medical Colleges.* 1 November 2016. Accessed 22 June 2017. https://news.aamc.org/press-releases/article/applicant-enrollment-2016/

See also, "Distribution of Medical School Graduates by Gender, Timeframe 2105" *The Henry L. Keiser Family Foundation.* (n.d.) Accessed 22 June 2017. http://www.kff.org/other/state-indicator/medical-school-graduates-by-gender/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Male%22,%22sort%22:%22desc%22%7D

See also, Lyndra Vassar, "How Medical Specialties Vary by Gender," *AMA Wire.* 1 February 2015. Accessed 22 June 2017. https://wire.ama-assn.org/education/how-medical-specialties-vary-gender

See also, Andrea Merrill, "Why Are Women So Underrepresented in Surgery Leadership?" [blog post] *HuffPost.* 10 September 2016. Accessed 22 June 2017. http://www.huffingtonpost.com/andrea-merrill/women-surgeons_b_8079896.html

See also, Nicole Martin, "Women Surgeons and the Challenges of 'Having It All," *The Clayman Institute for Gender Research.* 17 November 2015. Accessed 22 June 2017. http://gender.stanford.edu/news/2015/women-surgeons-and-challenges-%E2%80%9Chaving-it-all%E2%80%9D

[44] Kushner, *Breast Cancer*, 302.

educational thought[45] are enduring cultural constructions and evaluations of human bodies' worth and merit. Even in the coeducational society Plato envisions for his *Republic* where women are ostensibly equal to men in education and occupations, they remain subordinated as sexual and reproductive property.[46] Sexist biases and their underlying bases in biological determinism are transmitted as an informal curriculum from a variety of agents in culture, including schools.

It is easy to see the similarities in the responses of Kushner's young male friend in 1975 with the responses Martin (1992) cites when, in 1989, sixth-grade boys are asked what words they would use to describe girls. They answer, "'Pumping ("big tits"). Nasty. Vagina. Dope bodies (big breasts and behinds). Door knob[s] (breasts).'"[47] Behaviors of blaming girls for their objectification, conflating girls with their bodies, and referring to girls' bodies in sexualized, derogatory terms reflect an underlying and widespread cultural ethos of male privilege and misogyny, which also is manifested in sexual bullying and abuse in schools. A 2011 survey by the American Association of University Women (AAUW) over sexual bullying in U.S. middle and high schools reveals student perceptions that the "[g]irls whose bodies are the most developed are the most at risk"[48]

Blaming and shaming girls for their bodies is the flip side of "mammocentric" messages in culture that shape responses to breast cancer. As Kushner argues, the notion that women are responsible for the hyper-sexualization and commodification of breasts denies the reality of women's and men's informal, cultural education: "[L]earning experts know that breast

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[45] Martin, *Education Reconfigured*, 28-32.
[46] Plato, *The Republic of Plato, 2nd ed.* Allen Bloom, Trans. (New York: Basic Books, 1991), 101, 138-139.
[47] Jane Roland Martin, *The Schoolhome: Rethinking Schools for Changing Families.* (Cambridge, MA: Harvard University Press, 1992), Kindle, 72.
[48] Catherine Hill and Holly Kearl, "Crossing the Line: Sexual Harassment at School," *American Association of University Women* (Washington, D.C.: AAUW, 2011), 16.

consciousness is definitely nurture not nature. Either way, our culture certainly considers breast loss a sexual deficiency."[49] In 1792, Mary Wollstonecraft hoped educating boys and girls together in a common curriculum would end some of the worst imbalances in power relations between the sexes and the worst behaviors of each that undermine moral foundations for a civil society. Regrettably, as Martin and Laird point out, Wollstonecraft's vision of coeducation, implemented so far in only a "thin" sense,[50] has not yet realized her goal of ending gender-subordination. As it stands, the effects of the existing "sex-gender system"[51] in education perpetuate gendered, heterosexually normed, hierarchical relations and have undeniable effects on human health. As Kushner observes:

> Male chauvinism plays an important role in all aspects of breast cancer, from the moment a sixth-grader's budding chest . . . make[s] her popular . . . Later, the belief that breasts are vital in getting and keeping a boyfriend and then a husband is reinforced by blatant blandishments of our male-dominated media . . . [and is] perpetuated [by] . . . medical masculinity to the present.[52]

Kushner's observation that a sex-gender education system from elementary schools through medical schools shapes human health remains all-too relevant. For women to claim their right to be actively involved in their healthcare and to resist "medical masculinity," she suggests women need to find a way to level the doctor-patient field of engagement. This does not mean that women must become doctors themselves to end paternalistic, authoritarian behaviors, but rather to be effective participants in decision making, they need understand, ask questions about, and discuss some basic information about their disease, such as risk factors, specific information about the cancer type and grade, available treatments, and best practices for physical and emotional recovery. *Breast Cancer* presents a curriculum for patient self-education that addresses these topics.

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[49] Kushner, *Breast Cancer*, 302.
[50] Laird, *Mary Wollstonecraft*, 62, 64, 188.
[51] Ibid., 188.
[52] Kushner, *Breast Cancer*, 315-316.

Claiming voice: breaking taboos and gender boundaries

Breast Cancer generated controversy for its direct discussion of the topic of breast cancer,[53] for Kushner's criticisms of patriarchal medicine,[54] and for her conclusion that despite nationalistic propaganda to the contrary, America was not the world leader in breast cancer diagnosis or treatment. While the one-step surgical biopsy and Halsted radical remained the orthodox practice in the U.S., by the mid-1970s European countries were performing more outpatient biopsies and less extreme types of mastectomy with the same efficacy in treating cancer as in the U.S.[55] *Breast Cancer* provoked both censure and praise from the medical and lay communities. While Kushner received letters of gratitude from women across the U.S., she also became a target for public denunciation by members of the National Cancer Society and American College of Surgeons. Even some journalists were embarrassed by the topic and thought Kushner was wrong to challenge the knowledge and authority of medical professionals.[56]

In her blunt detailing of her own cancer and the differences in mastectomy surgeries, she also broke social taboos. In the *Post* article, she refers to the location of her tumor, stating "the damned thing was too close to the nipple" to make her a viable candidate for a skin-sparring mastectomy.[57] Inspired by Kushner, Canadian breast-cancer-activist Sharon Batt (1994) notes that too often "optimistic platitudes disguised as 'education'" encourage women to "trust in the

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[53] Lizzie Stark (2014) notes that through the end of the 20th century, printed obituaries used euphemisms to reference deaths from breast and reproductive cancers such as "prolonged illness," or "women's cancer." See Lizzie Stark, *Pandora's DNA: Tracing the Breast Cancer Gene Through History, Science, and One Family Tree* (Chicago, IL: Chicago Review Press, 2014), 148.

[54] Leopold, *A Darker Ribbon*, 236.

[55] Kushner, *Breast Cancer*, 171-184.

[56] Lerner, *The Breast Cancer Wars*, 2175-2182; Leopold, *A Darker Ribbon*, 236.

[57] Kushner, "Breast Cancer Surgery."

system."[58] She calls on women to "stake a claim in the public areas of breast cancer from which we were excluded" and to do so by "insist[ing] that the public share its load of the suffering that has been private."[59]

Breast Cancer became a commercial success, but after the first edition in 1975 Signet, the publisher of the 1977 second edition, changed the title to *Why Me?* in a bold, large font with the subtitle underneath in a smaller font, "What Every Woman Should Know about Breast Cancer to Save Her Life." In 1984, a revised edition of *Breast Cancer/Why Me* was reissued by Warner Brothers under a new, more ambiguous title—*Alternatives*. The subheading, "new developments in the war on breast cancer," is written in a much smaller font still.[60] In a period of increasing public awareness about breast cancer, the decision to make "breast cancer" as inconspicuous as possible on the cover of a book about breast cancer sends a message to women that the topic of breast cancer is, like the bodies of women with breast cancer, something to hide.[61]

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[58] Sharon Batt, *Patient No More: The Politics of Breast Cancer* (Charlottetown, Canada: Gynergy Books, 1994), 234.

[59] Ibid., 304-305.

[60] For the covers of all three editions, see Google Images, Accessed 17 November 2018.
https://www.google.com/search?client=safari&rls=en&biw=992&bih=525&tbm=isch&sa=1&ei=QRJZXLqHA42QsAWfxICwDg&q=Breast+Cancer+a+personal+history+and+investigative+report&oq=Breast+Cancer+a+personal+history+and+investigative+report&gs_l=img.3...502932.512954..513281...0.0..1.92.3645.57......2....1..gws-wiz-img.....0..35i39j0j0i67j0i8i30j0i24.wvS7ScgODc0#imgrc=inzi0ahnyfQIPM:
See Also:
https://www.google.com/search?client=safari&rls=en&biw=992&bih=525&tbm=isch&sa=1&ei=QRJZXLqHA42QsAWfxICwDg&q=why+me+rose+kushner&oq=Why+me&gs_l=img.1.0.35i39j0l9.46454.48362..49906...0.0..1.73.389.6......1....1..gws-wiz-img.....0..0i67.uLuDs5thBtY#imgrc=B-8ypsscCwT0UM:
See Also:
https://www.google.com/search?client=safari&rls=en&biw=992&bih=525&tbm=isch&sa=1&ei=sARZXNfWCKOs5wKU67DwBA&q=Alternatives+Rose+Kushner&oq=Alternatives+Rose+Kushner&gs_l=img.3...3462878.3471775..3472048...0.0..1.75.1662.26......3....1..gws-wiz-img.....0..0j35i39j0i67j0i5i30j0i8i30.HJC230gZmhE#imgrc=RvPt7W5a-Kg87M:

[61] According to Couser (1997), Kushner decided to change the title on the second and third revised editions because she had been told the original title was "off putting."
See, Thomas G. Couser, *Recovering Bodies: Illness, Disability and Life Writing* (Madison: University of Wisconsin Press, 1997), 63.
Whether Kushner made this decision alone or with her publishers, it is also worth noting the change in cultural messages and marketing appeals in each iteration of the title and cover design. The original title, *Breast Cancer: A Personal History and Investigative Report,* directly appeals to logos and is an accurate and concise description of the

In chapter 14 of *Breast Cancer,* "Male Chauvinism, Sex, and Breast Cancer," Kushner calls attention to cultural biases limiting women's participation in medical fields such as surgery[62] when she makes the observation that "[i]t seems as if the United States' entire breast-cancer Establishment is masculine."[63] In the final chapter of *Breast Cancer,* "The Future," she extends her critique of masculine domination in medicine to the entire American education system, linking gender biases justified through the deep structure of educational thought[64] to an

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book's contents. The declaration on the bottom of the cover by Dr. Thomas L. Dao, M.D. that "every woman in the United States should read this book" ironically lends the name of a male medical expert to authorize Kushner's work as a valuable curricular resource for patient education.

The second edition's title appeals to pathos with the question *Why Me*? By the late 1970s, media coverage of the public announcements of Black, Ford, Rockefeller, Rollin, and Minnie Riperton, a 28 year-old African-American singer and songwriter who revealed she had breast cancer and mastectomy on *The Tonight Show* in 1976, effected a sharp increase in the number of women getting checked for breast cancer. With breast cancer becoming commonplace in public discourse, by the late 1970s, the implied promise in the subtitle that the book holds life-saving information is fear-based marketing.

The third edition's title, *Alternatives,* and the cover art, a stylized drawing of a nude female figure from the back with a partial outline of a breast, appeals to 1980s ethos. By 1984, ten years after the first edition of *Breast Cancer,* women's participation and choice in cancer care has increased dramatically, in large part through the activist effort of Kushner. However, there was also increasing social conservativism during the Regan era and, as Susan Fauldi (1991/2006) recounts, a rising cry in the media and from political and religious conservative figures that women's social and economic gains and feminism generally were causing a breakdown in American values, family life, and culture (90-91). Both the title *Alternatives* and the cover image, while clearly representing a nude woman are nondescript. The endorsing quote for this edition—"An immensely supportive, informative, uplifting book for all women just in case it happens to you. Put it on your 'must do' list."— is not from a male doctor, but Ann Landers, a fictional female advice columnist. Landers, a penname created by Ruth Crawley for the *Chicago Sun Times* in 1943, was inherited by Esther Lederer in 1955. Lederer was a supporter of women's reproductive rights but conservative in her opinions regarding LGBTQ rights. She was appointed to a cancer advisory board in 1977 under the Carter administration. The selection of Landers/Lederer for the cover endorsement represents a feminist-conservative compromise with perhaps the added bonus of being issued by a well-known, but fictitious female figure. The subtitle, "new developments in the war on cancer" references the cancer war initiated by President Nixon in 1971 and continued to develop in the aftermath of the Vietnam War. As Baron Lerner notes, "By the early 1980s, roughly 14,000 women were undergoing preventative breast removal every year. It might reasonably be argued that America's war on cancer had reached its pinnacle with the annual removal of thousands of healthy breasts" (KL 2442). These three titles and covers for Kushner's work each reveal distinct educational messages about gender, the body, and cancer in the U.S. over a ten-year period.

See, Baron H. Lerner, *The Breast Cancer Wars: Hope, Fear, and the Pursuit of a Cure in Twentieth-Century America,* [Kindle Edition]. (New York: Oxford University Press, 2001), Kindle Location 140.

See Also, James S. Olson, *Bathsheba's Breast: Women, Cancer & History* (United States: The John Hopkins University Press, 2002), 142.

See Also, "Eppie Lederer," Wikipedia, last modified December 18, 2018, https://en.wikipedia.org/wiki/Eppie_Lederer;

See Also, "Ask Ann Landers," Wikipedia, last modified December 28, 2018, https://en.wikipedia.org/wiki/Ask_Ann_Landers

[62] Ibid., 306.

[63] Kushner, *Breast Cancer*, 307.

[64] Jane Roland Martin, *Education Reconfigured,* 28.

ethic of masculine competition for "wealth and political influence" that Virginia Woolf sees driving universities.[65] Kushner writes:

> We must remember that it our free-enterprise "fee-for-service" medical system that is responsible for the "economic incentive" that pays surgeons "by the inch" . . . Until we change our American way of education from the very beginning…medicine and scientific research will continue to be "businesses" requiring huge investments. First the initial costs must be recovered and then a tidy profit turned.[66]

After writing *Breast Cancer,* Kushner became a breast cancer activist, using her voice to become a "one woman crusade[r]" in breast cancer politics.[67] From the late 1970s up to her death from breast cancer in 1990, Kushner attended medical symposiums as a lay expert and journalist, challenging male surgeons publicly while working to establish rapport with them in private, seeking to secure gender-insubordinate partners from among those in political positions of leadership in breast cancer surgery for changing procedures.[68] She also testified before congress and senate subcommittee hearings and lobbied for insurance programs to cover mammograms and pap smears. In 1977, she was the only woman appointed to an NIH panel and successfully argued for the adoption of the two-step biopsy and mastectomy. Her efforts also helped to spur the change from the Halsted radical mastectomy as standard procedure to modified radical mastectomies, which are easier to recover from and result in fewer complications.

In 1986, President Carter appointed her to the National Cancer Advisory Board, and she served on the American Cancer Society Breast Cancer Task force in 1989, only stopping her work when her declining health would no longer allow her to continue.[69] A primary aim in

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[65]Virginia Woolf., *Three Guineas* (New York: Harcourt Inc., 1966)*,* 113.

[66] Rose Kushner, *Breast Cancer*, 348.

[67] Baron Lerner, *The Breast Cancer Wars: Fear and the Pursuit of a Cure in Twentieth-Century America* (New York: Oxford University Press, 2001), [Kindle Edition], Kindle Location 2059.

[68] Ibid., Kindle Location 2185

[69] Ibid., Kindle Location
See also,

Breast Cancer is to educate women to claim their voices as participatory agents with doctors, exercising choice in making treatment decisions. However, her educational autobiography serves as a curricular text both for patients as change instigators on behalf of other women to end gender-subordinating practices and for medical provider education as well. She weaves qualitative research findings on breast cancer in the U.S. and globally, including her own survey and interview data, within an autobiographical framework both to give personal testimony to gendered learning in breast cancer and to use her voice to address a gap in breast cancer research conducted by males and written for males about females as objects of research. Describing a conference on breast cancer she attends, she observes that "no mention was made of any past, present, or proposed study of what goes on in a woman's heart and mind when she is faced with the disease."[70] In blending "authorized" scientific studies with personal testimony, Kusher claims epistemic "space" for subjective, body-mind experience as knowledge. As feminist epistemologist Lorraine Code (1991) points out, subjective knowledge, in particular women's knowledge claims, have been historically devalued in favor of male-dominated domains of knowledge deemed to be "objective" and "true."[71]

Many of the practices that Kushner advocated as urgently needing changes in breast cancer to redress gross gender-subordinating injustices in patient health women can now take for granted in breast cancer treatment. However, awareness of Kushner's *Breast Cancer* and her accomplishments is in danger of being lost in a still-rising tide of pink war conventional narratives. Further, ingrained gender biases in the deep structure of educational thought[72] continue to dominate BGC treatment. As Martin shows, we are steeped in these biases which are

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[70] Rose Kushner, *Breast Cancer,* 307.

[71] See, *Lorraine Code, What Can She Know? Feminist Theory and the Construction of Knowledge* (Ithaca, NY: Cornell University Press, 1991), 27-28.

[72] Jane Roland Martin, *Education Reconfigured: Culture, Encounter, and Change* (New York: Routledge, 2011), 28.

learned, preserved, and passed on from formal and informal educational agents. Kushner's narrative is worth reclaiming both for its historical value and its gender-insubordinate accomplishments that pave the way for others to begin to dismantle the pink war machine, as we will see in the next chapter on restorative/reformer GI.

Chapter Five: Restorative/Reformer GI: A Response to Pink War Normative Narratives

> "We rise from war
> to walk across the earth
> around our house
> . . . stunned that sun can shine so brightly
> after all our pain"
> --Audre Lorde, "Walking Our Boundaries,"
> *The Collected Poems of Audre Lorde*[1]

Restorative/reformer BGC autobiographical texts respond most fully to gender-subordinating normative narratives; those cultural stories that spring from the deep roots of western educational thought[2] and serve to reify sex and gender idealizations and justify their inequities in private and public life. Within the CIC's pink war machine, normative narratives advance a pink-war, soldier-survivor patient education for feminine-gendered somaesthetic practices and behaviors. Restorative/reformer GI autobiographic texts seek to replace these narratives with ones that foster human health inside and outside the CIC. Whereas writers of emergent-conflicted narratives focus most directly on personal body-mind experiences and writers of instigative/informer focus more on practices in the pink-war medical surround, restorative/reformer writers stress the necessity of conserving and restoring community health inside and outside the CIC.

These writers reveal a conservationist ethic in their commitment to protect women's body-minds from commercial exploitations, environmental harms, and medical mutilations. Of all GI writers, restorative/reformer are concerned with the ways pink war normative narratives serve to distract us from cancer's devastating effects in community and social-environmental[3] links. Comprehending the gender-subordinating mechanisms of pink commerce, medical

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[1] Lorde, *The Collected Poems of Audre Lorde,* 261.
[2] Martin, *Education Reconfigured,* 30-32.
[3] Here I mean both man-made environmental toxins in air, water, and food, and also position that cancer is largely linked to "lifestyle" choices such as drinking, smoking, and obesity without a consideration of the socioeconomic factors linked to these behaviors and the interests of those who promote and profit from these choices.

authoritarianism, and normative narratives as the interlocking gears of a pink war machine, these writers seek to block each and, in turn, shut the machine down. This chapter opens with a return to Lorde's *The Cancer Journals*, presented as an exemplary case of restorative GI in chapter two, to consider her gender-insubordinate, educating action in depth. I close this study with Sandra Steingraber's *Living Downstream: An Ecologists Personal Investigation of Cancer and the Environment* (1997/2007) as a second example of restorative/reformer GI. I consider how Steingraber, inspired by Lorde's call to look at cancer's environmental causes, extends Lorde's educational vision on behalf of community to all human and nonhuman life.

Audre Lorde: An Outsider Inside the Pink War Machine

Refusing to comply: Rejecting pink war indoctrination

In a journal entry dated October 3, 1979, Lorde reflects on her identity, stating "I am defined as other in every group I am a part of, the outsider."[4] Her outsider identity as a black, lesbian feminist shapes her experiences when she crosses into the kingdom of the sick, giving her a different view of the CIC than white, heterosexual women might have. Lorde writes her memoir before the rise of Susan J. Komen and other physical and online breast-cancer organizations, at a time when the only official (medically authorized) group providing patient education and a community for women with breast cancer was the American Cancer Society's Reach to Recovery program. Given Lorde's identity as a black lesbian and her feminist-educator convictions, Reach to Recovery was not a community where she felt welcome or a sense of shared values.

Lorde observes the "kindly" volunteer who visits her in her hospital room "with a very upbeat message" and bearing gifts of "a little prepared packet containing a soft sleep-bra and a wad of lambswool pressed into a pale pink breast-shaped pad."[5] She describes this woman as a

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[4] Ibid., Kindle Location 81.
[5] Ibid., Kindle Location 502.

person who would "uphold and defend to the death those structures of a society that allowed her a little niche to shine in."[6] While Lorde is grateful to learn the arm exercises that the volunteer teaches her to do to regain strength after surgery, she sees this volunteer as an educating agent for values she stands against and outside of. Lorde refuses to wear the pink prosthesis, a gift which, in addition to being the "wrong color" for her skin tone, she sees as tacit pressure to hide her amputation. She writes:

> I . . . stuffed the thing into the wrinkled folds of the right side of my bra where my right breast should have been. It perched on my chest askew, awkwardly inert and lifeless, and having nothing to do with any me I could possibly conceive of. Besides, it was the wrong color, and looked grotesquely pale through the cloth of my bra.[7]

It is at this point that Lorde understands "either I would love my body one-breasted now, or remain forever alien to myself."[8]

At the time, Reach to Recovery was self-admittedly a program for the training of gender-conformity post-mastectomy. As the organizational founder Terese Lasser explains in her breast cancer memoir and story of the Reach to Recovery Program (1972), the program exists only through the authorization of male doctors. To qualify as a volunteer a woman had to obtain a letter from her doctor recommending her as "physically and *emotionally"* fit to counsel other women.[9] If approved, she would be asked to a first interview with a panel of doctors where she should appear wearing a "well fitted" prosthesis to give her a balanced "figure" and posture, have no impaired movements from lymphedema, and be able to "project optimism and self-confidence," as evidence of her successful post-mastectomy "adjustment;" meaning she appeared

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[6] Ibid.

[7] Ibid., Kindle Location 535.

[8] Ibid., Kindle Location 541, punctuation in original.

[9] Terese Lasser and William Kendall Clarke, *Reach to Recovery* (New York: Simon and Schuster, 1972), 136, emphasis in original. Lasser's BGC narrative, one of the two earliest published can be compared to Babette Rosamond's (written under the pseudonym Rosamond Campion) *The Invisible Worm* (1972), highlighted in chapter two as a case of emergent-conflicted GI.

and acted as if the breast cancer had never happened.[10] If a woman passed through this initial evaluation, she was "screened by the local American Cancer Society and *indoctrinated* in our code of ethics."[11]

While Lorde is appreciative of Reach to Recovery's mission to help women who are recovering from a mastectomy feel they are not alone,[12] she also finds messages in their printed curricular materials and peer mentorship programs problematic, especially the idea that breast cancer does not need to change your life and that no one need ever know. She believes this message "encourages [a] false and dangerous nostalgia in the mistaken belief that women are too weak to deal directly and courageously with the realities of our lives."[13] She sees the same conflations of race, sex, and gender norms in society-at-large repeating and reinforced in breast cancer patient education where the implicit expectation is that women's physical and emotional needs are all the same and that women are white and heterosexual.[14]

Lorde sees that from a variety of patient-education sources, including Reach To Recovery, women with breast cancer learn that they should wear prostheses for the sake of being "decent."[15] She refuses to do so because she considers hiding the physical effects of breast cancer as "another way of keeping women with breast cancer silent and separate from each other;" in other words, as a tool of gender subordination.[16] When the volunteer asks Lorde to look at her chest and identify which breast is prosthetic, Lorde agrees that it impossible to tell

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[10] Ibid., 140-141.
[11] Ibid., 141, emphasis mine.
[12] Lorde, *The Cancer Journals*, Kindle Location 502-515.
[13] Ibid., 712-715.
[14] Doing a search on Google Images under the words "breasts" and "breast prostheses" hundreds of images appear that are predominantly light-skin toned with a scattering of images of darker-skin toned women and their breasts. This evidence of visual commercial and popular culture illustrates ongoing normative assumptions about female bodies and race. Although the Google Images search engine is not necessarily evidence of racial biases in culture and breast cancer, it does suggest that, at least widely speaking in culture, "breasts" defaults to "white breasts." Prostheses for darker skin toned are now available through several commercial and nonprofit suppliers.
[15] Ibid., Kindle Location 849.
[16] Ibid., Kindle Location 134.

with her sweater on. However, she takes exception to her volunteer's message that being "bright-sighted" and appearing physically unchanged for others are the keys to recovery.[17] Feeling alienated rather than reassured after this encounter, she yearns for a sense of community, writing, "I ached to talk to women about the experience I had just been through . . . . But I needed to talk with women who shared at least some of my major concerns and beliefs and visions, who shared at least some of my language."[18]

Lorde views her unorthodox reactions and outsider status in breast cancer as another facet of her identity as a lesbian woman in heterosexual, patriarchal culture, as a black feminist perceiving black women's experiences and knowledge to be marginalized by white women, and as a black person living in racist, white-privileged American society.[19] She sees her unique perspective as both a "strength" and a "weakness," but she recognizes that "without community," however imperfect, "there is certainly no liberation, no future," and no possibility of envisioning ways to improve community.[20]

She finds no one at Beth Israel Hospital or even in her community of friends and family to teach her how to navigate the experience of breast cancer and interactions with doctors, nurses, volunteers, or other patients as a black, lesbian feminist.[21] With no teachers available, Lorde creates her own curriculum. She engages in a cultural bookkeeping project[22] of available patient education, sorting out what she sees as gender subordinating and racist from what she finds genuinely helpful for health and recovery. She mines whatever sources she finds for information applicable to her experience and gathers published newspaper and medical journal

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[17] Ibid., 724

[18] Ibid., 502.

[19] These are some of the overarching themes she explores in her essays and brings together in the 1984 published collection *Sister Outsider.*

[20] Lorde, *The Cancer Journals*, 69-82.

[21] Lorde, *The Cancer Journals*, see chapters 3, 43.

[22] Jane Roland Martin, *Cultural Miseducation: In Search of a Democratic Solution* (New York, USA: Teachers College Press, 2012), 89.

articles, seeking knowledge before her biopsy to prepare for what she was facing.[23] She cites Kushner twice and makes an indirect reference to Rollin's *First, You Cry*, but does not find the inspiration, information, or advice she needs in the memoirs of white, heterosexual women or from the nurses, the Reach to Recovery volunteers, or the well-intentioned recommendations of other white, heterosexual breast cancer patients.

While her outsider perspective enables her to see heterosexist, white presumptions and her outsider body-mind is not in compliance with the proper behaviors for adjusting to life after a mastectomy, she also yearns for a wider vision for community, both inside and outside the CIC. In addition to being one of the earliest BGC memoirs, *The Cancer Journals* is the first written by an African American woman who is also a self-identifying lesbian. As a narrative written by a woman who finds no easy, single group to identify with, it establishes an epistemic "space" in breast cancer literature for claiming and sharing subjective knowledge of sexually diverse people.[24] A major aim in *The Cancer Journals* is to foster an encompassing notion of community as a moral and practical necessity for human health. With this aim in mind, Lorde makes it clear she is not against breast prostheses per se or breast reconstruction if a woman freely chooses either for herself, but she does not want women to make this choice unreflectively or as a result of coming under pressure to conform to normative gender idealizations of the female body.[25]

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[23] Ibid., 307.

[24] A growing number of personal cancer narratives by sexually diverse persons have been published since the end of the twentieth century, many of which credit and engage with Lorde directly. Lesbian feminist artist Hollis Sigler's *Breast Cancer Journal* (1999) combines an autobiographical essay, paintings, facts and statistics about breast cancer, and quotes from *The Cancer Journals.* The collection *Coming Out of Cancer: Writings from the Lesbian Cancer Epidemic* (2000) includes poems, short stories, critical essays, and autobiography, including several journal entries from Lorde's second cancer memoir, *A Burst of Light* (1988). In *My One-Night Stand with Cancer* (2005), breast cancer activist, author, and playwright Tania Katan interweaves the story of her dating life as a lesbian and Jewish ethnic identity with her breast cancer diagnoses at age 21 and 31, and in "Cancer Butch" (2007), anthropologist S. Lochlann Jain expands upon and critically reexamines Lorde's arguments.

[25] Ibid., 826. These are longstanding idealizations of women that originate in what Friedman calls communities of place—homes, schools, workplaces, churches, etc.

Sustaining body-minds: Creating community to resist pink war

Thinking back on the days leading up to her mastectomy, Lorde opens *The Cancer Journals* (1980) with a passage describing the care she receives in the hospital as a "corporate effort,"[26] but she does not mean the efforts of the doctors, nurses, and others at Beth Israel Medical Center. She is referring to the care labors of women in her community, her friends and family, and her word choice is deliberate. To call her care a "group effort" would be a more common phrasing, but instead she uses "corporate," an adjective rooted in the Latin *corpus,* or "body." Here "corporate" may refer simultaneously to the physical body-minds of women and to the *communal body*; the group of women who are caring for her and her two young children as she undergoes and recovers from a mastectomy. She writes:

> From the time I woke up to the slow growing warmth of Adrienne's and Bernice's and Deanna's and Michelle's and Frances' coats on the bed, I felt Beth Israel Hospital wrapped in a web of woman love and strong wishes of faith and hope for the whole time I was there, and it made self-healing more possible, knowing I was not alone. Throughout the hospitalization and for some time after, it seemed that no problem was too small or too large to be shared and handled. . . . Adrienne offered to rise early to park the car for Frances so she could be with me before the operation. Blanche and Clare took the children shopping for school clothes . . . My sister Helen made chicken soup with homemade dumplings. Bernice gathered material and names and addresses and testimonials for alternative treatments for breast cancer. And through those three days between the biopsy and the mastectomy, good wishes came pouring in by mail and telephone and the door and the psychic ether. To this day, sometimes I feel like a corporate effort, the love and care and concern of so many women having been invested in me with such open-heartedness. My fears were the fears of us all.[27]

Lorde's sense of "self-healing," enlivened by the "love, care, and concern" she feels from her community, even sharing her fears in community, marks this experience as a significant educational encounter. From this early woman-centered, "corporate" experience, she gains an insight that guides her reflective, autobiographical project: Breast cancer is never just an individual experience. It affects others in one's community. In Lorde's experience, this means

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[26] Ibid., Kindle Location 332.

[27] Ibid., Kindle Location 313-324.

—her partner, children, friends, and family. And, in turn, her community affects her illness experience.[28] During this traumatic period, Lorde acknowledges she is sustained by women who are "black and white, old and young, lesbian, bisexual and heterosexual."[29] She also retains a sense of communal connection to women in her past who were her teachers, conveying "the primary lessons of survival."[30] Lorde sees that the character of a community—its social structures, power dynamics, and the use of its resources—are directly related to human health.

Not knowing any other black women or any other "dykes who had mastectomies,"[31] Lorde asks her friends to help her find people to talk to, and soon she is talking to a lesbian couple and an elderly African American woman who, until hearing of Lorde's cancer, had kept her own breast cancer a secret. A concern for communities is a consistent theme evidenced throughout the body of Lorde's memoir, but to better understand this concern, we first need to be clear about who she is concerned about and why. What constitutes a community for Lorde, and who are its members? Feminist philosopher Marilyn Friedman's (1989) distinction between communities of "place" and "choice" may help clarify questions of scope and substance in Lorde's communal vision.

According to Friedman, communities of place are located in political, economic, and social institutions of collective human activity. They constitute physical places (e.g., neighborhoods, schools, universities, churches, hospitals, cities, states, nations) and also *place* in

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[28] I quote from this passage almost in its entirety with the names of several women who are part of her community—the feminist writer and poet Adrienne Rich, Deanna, Bernice, Michelle, her lover, Frances, and others—to "listen" with full engagement to Lorde's sense of community. In this scene, she creates a vivid microcosm of women, but not just any women. It's these particular women as subjects that Lorde wants us to pay attention to in her naming of them. These women act together to care for Lorde's physical and psychic wellbeing after her biopsy, making sure her children are comforted, fed, and are able to attend to the daily tasks of life. They cover her with their coats when she wakes up shivering after the surgery and the nurses tell her there are no spare blankets (297), and they research breast cancer treatment alternatives for when she is unable to do so for herself.

[29] Lorde, *The Cancer Journals*, Kindle Location 184.

[30] Ibid., Kindle Location 466.

[31] Ibid., 622.

the sense of those specific, roles and identities within these institutions that one cannot or does not easily break ties with (e.g., being a spouse, child, parent, sibling; working as a surgical oncologist or a carpenter; being a member of religious congregation, a homeowner's association, belonging to the working class, etc.).[32] She argues that communities of place are based on male-controlled "hierarchies of domination and subordination" and support an ideal of self-serving, aggressive individualism.[33] Although Friedman does not cite Woolf, she suggests her agreement with Woolf's observation in *Three Guineas* (1938) that "there is something in the conglomeration of people into societies that releases what is most selfish and violent [,] least rational and humane in the individuals themselves."[34] Friedman concedes that while the social institutions comprising communities of place may be necessary for societal functioning,[35] in large part they do not foster responsible social selves, but rather, autonomous, competitive selves.[36]

In contrast are communities of "choice," which are voluntary associations based on similar life experiences and common cause that promote values of social connection and mutual nurturance.[37] For example, the feminist *fikas* for university faculty, staff, and students such as Martin envisions is a community of choice.[38] What Friedman finds most compelling about communities of choice is that the social support that they offer "foster[s] not so much the constitution of subjects but their reconstitution."[39] Social learning can occur in communities of choice that reorient members' interests from being autonomous, competitive selves to becoming

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[32] Marilyn Friedman, "Feminism and Modern Friendship: Dislocating the Community," *Ethics 99* No. 2 (1989): 288-290.
[33] Ibid., 279.
[34] Virginia Woolf., *Three Guineas* (New York: Harcourt Inc., 1966), 104.
[35] Friedman, "Feminism and Modern Friendship," 290.
[36] Ibid., 279.
[37] Ibid., 280.
[38] See, Jane Roland Martin, *Coming of Age in Academe: Rekindling Women's Hopes and Reforming the Academy*. (New York: Routledge, 2000), 163-169.
[39] Friedman., 289.

inter-dependent, collaborative selves. For people who share a marginalized identity, such as lesbian women, and for oppressed groups of people "who are distributed throughout social and ethnic groupings and who do not themselves constitute a traditional community of place,"[40] communities of choice are vital social support systems.[41] Friedman considers women as "a prime example of such a distributed group" since "[w]omen's communities are seldom the original, nonvoluntary found communities [of place] of their members."[42]

Feminist philosopher Iris Marion Young's notion of "Gender as Seriality" (1994) provides further clarification for considering communal relations that is helpful to thinking about communities of choice. Young defines a serial as a collection of people that are "unified passively by the objects around which their actions are oriented."[43] She cites Sartre's example of seriality as people waiting at a bus stop. There is nothing that brings this "collective" of individuals together other than the fact they are all waiting for a bus. There are no common or "essential" characteristics or interests that they all must share.[44] She argues that we should think of women and gender as serials, but they are not "as simple and one-dimensional as bus riders[.]" Rather, "gender, like class, is a vast, multifaceted, layered, complex, and overlapping," created by a "set of [social] structures and [physical] objects."[45]

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[40] Ibid., 290.

[41] Although predating online social media and social networking, Friedman's theory of communities can be applied to the Internet too. Many communities of choice exist as discussion boards, open and closed groups, etc. These online forums create an important community of choice to women with BGCs. However, as the Association for Progressive Communications statement "Feminist Principles of the Internet-Version 2.0" argues, the Internet's structure, webpage design, and navigation features function may continue to function as an extension of the patriarchal power constituted in communities of place.
See, Association for Progressive Communications, "Feminist Principals of the Internet—Version 2.0," *Association for Progressive Communications,* August 2016. Accessed 12 August 2017. https://www.apc.org/en/pubs/feminist-principles-internet-version-20

[42] Friedman, "Feminism and Modern Friendship," 290.

[43] Iris Marion Young, *On Female Body Experience: "Throwing Like a Girl" and Other Essays* (New York: Oxford, 1994/2005), Kindle Location 724.

[44] Ibid., Kindle Location 718.

[45] Ibid., Kindle Location 728.

Young adds that “[a] person can choose to make none of her serial memberships important for her sense of identity. Or she can find that her family, neighborhood, and church network makes the serial facts of race, for example, important for her identity and development of a group solidarity.”[46] Groups can develop from within serials, but they are comprised of people who recognize “a unified relation with one another,” which in the basis for the group’s identity. Over time, people in the group share a sense of purpose and recognize each other’s actions toward a common goal.[47] While “women” are a seriality, feminists are “women grouping as women in order to change the structures that serialize them as women.”[48] Additionally, separate, smaller groups may form within larger ones, such as with lesbian feminists and black lesbian feminists. She is thinking of “women” and gender distinctions as broad, serial categories from which some people may come together to form groups, but women qua women are not a group of people with “natural” affinities toward each other.[49]

Lorde makes distinctions between communities of place/serialities and communities of choice/groups in her thinking about women, gender, race, class, and human health. She sees a potential benefit in imagining and creating new, gender-insubordinate communities of choice for herself and others to become change agents working to end gender-subordinating practices from within the CIC. Her communal thinking encompasses more than the CIC and women with breast cancer; it is “the world I crave for my daughters and my sons. It is thinking for the survival of the species—thinking for life.”[50] As Susan Laird (1988) notes, Lorde’s “TEACHING of love and survival” for both her children “is not TEACHING in the ‘standard sense’ nor is an

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[46] Ibid., 733.
[47] Ibid., 723-724.
[48] Ibid., 736.
[49] The same is true for all gender identities; there is nothing about any gender identity that naturally creates group feeling with others of the same gender.
[50] Lorde, *The Cancer Journals*, 78.

acknowledged form of 'acculturation'" in which humans learn to behave according to norms but do so without a deeper understanding of why those norms exist and what they do,"[51] It is teaching them to recognize that human society is harmed by an underlying logic of domination[52] that exists to justify gendered, racial, and class divisions, reinforce oppressive hierarchies, and promote the interests of those in power.

In "Our Breasts Ourselves: Identity, Community, and Ethics in Cancer Autobiographies" (2006), Diane Price Herndl argues that Lorde is exemplary of breast cancer personal autobiographers who are "'living out loud'" both to reconstruct a "relation of the self to the body" and to create connections to others.[53] Herndl sees Lorde's *Journals* as establishing an "imperative" for women with breast cancer to write their memoirs as a "political act" undertaken more for the benefit of others than the self.[54] To Herndl's point, Lorde situates her own experiences within the larger framework of women's breast cancer, and her hope is that other women, even those who have not had breast cancer, find her experiential knowledge a source to draw on. Seeing herself as responsible to others, Lorde imagines that she is "writing across the gap[s]" of cultures, life experiences, and temporal distance—projecting her voice

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[51] Susan S. Laird, "Maternal Teaching and Maternal Teachings: Philosophic and Literary Case Studies of Educating," (PhD dissertation, Cornell University, 1988): 112-113, capitalization in original.

[52] See, Karen J. Warren, *Ecofeminist Philosophy: A Western Perspective on What it is and Why it Matters.* (New York: Rowman and Littlefield, 2000).

[53] Diane Prince Herndl, "Our Breasts, Our Selves: Identity, Community, and Ethics in Cancer Autobiographies," *Signs: Journal of Women in Culture and Society 32* No. 1 (2006): 225. Herndl states that "the absence of models for dealing with breast cancer that troubled Lorde in the late 1970s is no longer a problem. Today's breast cancer patient has no need to look further than her nearest library or bookstore" (234). However, while there are certainly a plethora of books available, both autobiographies and guidebooks, the great majority explicitly speak to or implicitly assume a commonality of experience with women readers who are heterosexual and cisgender. Further, the majority of these texts speak to and from a race and class experience—what breast cancer is like for white, middle class and affluent women. The kind of guide in the terms of those writing about breast cancer from the social margins of sexuality, gender, race, etc. remain in short supply and are often overwhelmed and lost among the number of what I am calling conventional, pink-war narratives. For this reason, Lorde's gender-insubordinate voice as a self-educating "guide" remains a vital and socially relevant BGC narrative.

[54] Idib., 221.

across her own future death to incorporate the lives and deaths of other women with breast cancer.[55]

However, it is not an optimistic outlook of "sheroic" inspiration she offers, but a gender-insubordinate call to action. She does not want readers to be docile, silent, or to unquestioningly accept oppressive messages and practices in their patient education in breast cancer. Tying together social critiques of racism, sexism, violence, commercialism, and gender-subordinating messages in breast cancer treatment, she defines the contours of the pink-war machine well before the rise of pink ribbon activism:

> [W]hat Woman of Color in america [sic] over the age of 15 does not live with the knowledge that our daily lives are stitched with violence and with hatred, and to naively ignore that reality can mean destruction? We are equally destroyed by false happiness and false breasts, and the passive acceptance of false values which corrupt our lives and distort our experience.[56]

Rather than prescience, what Lorde points out is that the CIC breast cancer war machine was humming along well before mainstream breast cancer activist and corporate-sponsored culture painted it pink. She calls attention to social and medical inequalities that continue to imperil the lives of African-American woman differently than white women.

According to Gayle Sulik (2011), *The Cancer Journals* "continues to serve as a prophetic message for numerous cancer survivors and community-based organizations."[57] In her conference talk given at "Lesbian and Literature" panel of the Modern Language Association in 1977, "The Transformation of Language into Silence and Action," included in its entirety in the first chapter of *The Cancer Journals,* Lorde draws upon the tradition of Kwanza to instruct her audience about the centrality of community health to individual wellbeing and survival.

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[55] Lorde, *The Cancer Journals*, 678.
[56] Ibid., 1018-1020.
[57] Gayle Sulik, *Pink Ribbon Blues: How Breast Cancer Culture Undermines Women's Health.* (New York: Oxford University Press, 2011), 339.

Emphasizing the vital importance in communities of choice for sustaining body-minds inside the body-violating war machine, She writes:

> The first principle is Umoja, which means unity, the decision to strive for and maintain unity in self and community. . . . the second day . . . [is] Kujichagulia— self-determination— the decision to define ourselves, name ourselves, and speak for ourselves, instead of being defined and spoken for by others. [T]he principle for today is Ujima— collective work and responsibility— the decision to build and maintain ourselves and our communities together and to recognize and solve our problems together. . . . [I]t is necessary to teach by living and speaking those truths which we believe and know beyond understanding. Because in this way alone we can survive, by taking part in a process of life that is creative and continuing, that is [shared] growth.[58]

Educating body-minds: Imagining women as warriors to survive pink war

As a poet, Lorde often uses metaphoric language to convey meaning, and, scattered throughout her poetry, essays, and autobiographical writings are evocations of war imagery. For example, in *The Cancer Journals* entry dated January 1, 1980 she writes: "Faith is the last day of Kwanza, and the name of the war against despair, the battle I fight daily. I want to write about the battle, the skirmishes, the losses, the small yet important victories that make the sweetness of my life."[59] In "The Transformation of Silence into Language and Action," Lorde uses "warrior-poet" as one of her self-authored titles,[60] and throughout *The Cancer Journals,* Lorde evokes the image of women warriors, a frequent motif in her poetry and essays, to describe her vision of how women should respond to breast cancer. However, some twenty-first century feminists responding to breast cancer find her use of war metaphors troubling and contradictory to Lorde's own anti-patriarchal stance.

For example, Robina Josephine Khalid (2008) sees Lorde's use of war metaphors as undermining to her feminist project for reframing heath and gender issues. She notes that a call to battle in illness is "a specifically western understanding of disease that is by no means

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[58] Lorde, *The Cancer Journals*, 206-215.
[59] Ibid., 72-88.
[60] Ibid., 189.

universal."[61] Agreeing with Lorde's critique of gender-subordinating practices in breast cancer and the need to reframe cancer as a crisis of human health rather than an individual's problem, Khalid is unable to see Lorde's frequent references to war as anything other than a "stumbling block."[62] She writes, "If I believed that my body was engaged in contact rather than combat, I might be getting a step closer to the nurturance which Lorde promotes."[63]

S. Lochlann Jain (2007) also takes exception to Lorde's fascination with war metaphors, especially when Lorde compares Israeli prime minister Moishe Dayan's missing eye and his eyepatch to changed bodies of mastecomized women. Lorde writes, "[N]obody tells him to go get a glass eye, or that he is bad for the moral of the office. The world sees him as a warrior with an honorable wound . . . . Well, women with breast cancer are warriors, also. I have been to war, and still am. So has every woman who had one or both breasts amputated."[64] Jain finds this passage an especially problematic "moment in the theorizing of breast cancer in need of updating."[65] She asks, "If we are to be warriors, who are we fighting? What is our mode of violence? Who is to be protected? How might breast cancer culture be understood in relation to—and against—singular normative ideals of femininity, but in a way that does not take on a militarized masculinity?"[66]

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[61] See, Robina Josephine Khalid, "Demilitarizing Disease: Ambivalent Warfare and Audre Lorde's *The Cancer Journals," African American Review 43* No. 3-4, (2008): 698. Khalid also recognizes that Lorde is not the originating source for war metaphors in cancer and that war imagery is applied to and "serve[s] a particular function in the modern nation-state in much the same way as do racial and sexual categories which Lorde fundamentally opposed (698).

[62] Ibid., 699.

[63] Ibid., 710. Khalid does not suggest erasure of all metaphoric language is necessary in breast cancer but an updating that gets rid of appeals to violence and destruction. Cities, which Friedman sees as promising environments for fostering communities of choice and connections among women, are also Khalid's metaphor of choice for fostering interconnectedness among persons with cancer and an *intra*-connectedness of a person's body-mind responding to cancer and its treatments. Khalid contends that [I]magining the body as neighborhood and as communities makes available a much more richly varied environment from which to define 'strength.'"
See also, Marilyn Friedman, "Feminism and Modern Friendship," (287-288).

[64] Lorde, *The Cancer Journals*, 774-780.

[65] S. Lochlann Jain, "Cancer Butch," *Cultural Anthropology 22* No 4 (2007): 508.

[66] Ibid., 522.

Khalid and Jain see Lorde's use of war metaphors in *The Cancer Journals* as ironically reauthorizing the same masculine metanarratives that her work seeks to disrupt. However, a case can be made that an alternative, nonwestern conception of the warrior archetype is the source of Lorde's inspiration, one not centered on implicitly celebrating masculine violence. When Lorde identifies herself as a "warrior," there is evidence to suggest she is drawing on African historic, mythic, and spiritual figures of strong, creative women outside of western cultural narratives.

For example, in *The Cancer Journals,* she references the Dahomey Amazons, a historical military regiment of women in the kingdom of Dahomey (ca 1600-1904) in the coastal area of the in the modern Republic of Benin. Known in the local Fon language as the *N'Nonmiton*, or "our mothers," these women were originally a king's bodyguards and developed into an army of several thousand. Known for a Spartan-like military culture, harsh physical discipline, and ruthlessness in battle, the *N'Nonmiton* were called "Amazons" by western visitors.[67] Lorde draws inspiration from imagining Dahomey Amazons as a community of fierce foremothers embodying female strength and self-definition. She accepts the legend that, like the mythic Greek Amazon women, the *N'Nonmiton* women cut off their right breasts to be better archers.[68] While this is historically inaccurate and the *N'Nonmiton* were more renowned for lacking mercy than for mothering, it is not a historical truth that Lorde looks to the *N'Nonmiton* for so much as a "narrative truth," a *story* through which she can reconstruct her embodied identity as a one-

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[67] See, Stanley B. Alpern, *Amazons of Black Sparta: Women Warriors of Dahomey* (New York: New York University Press, 2011), 4-11.

[68] Lorde, *The Cancer Journals*, 398, 701.

breasted woman.[69] With no ready role models for being a black lesbian with breast cancer,[70] Lorde creates her own story of who the *N'Nonmiton* were and who she can become, imaginatively crossing time, cultures, geography, and weaving together historical and fictional narratives to connect with a community of women who can be her teachers, even if only imaginatively.

In several places in the *Journals,* she poses questions about the Amazons' fortitude to both reinforce the story that she is creating and to imagine her own recovery as not involving a prosthetic re-covering of her changed body and distancing her from the disease that threatens her life. The effect of the truth she seeks to create is a means to integrate the knowledge that she has cancer with her life and work as a black feminist lesbian poet, activist, teacher, and mother. She asks, "The Amazon girls were only 15, how did they handle it?"[71] Later she reflects on the anguish she feels after a mastectomy, reflecting, "If I cried for a hundred years[,] I couldn't possibly express the sorrow I feel right now, the sadness and loss. How did the Amazons of Dahomey feel? They were only little girls[,] but they did this willingly, for something they believed in. I suppose I am too, but I can't feel that now."[72] And, at another point in the memoir reflecting on her months of pain and sadness, she asks, "I wonder how long it was before the Dahomean girl Amazons could take their changed landscapes for granted?[73]

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[69] I borrow the term "narrative truth" from Donald P. Spence's theory that people interpret the events of their lives in psychoanalysis through constructing personal narratives of experience. This subjective interpretation differs from any verifiable facts of the experience, although Spence admits that notions of historical veracity and objectivity are always problematic. What is important to Spence is the way subjects interpret and filter information and experiences for insight to assign meaning. He contends that "[i]f a narrative fills a longstanding gap in the story the patient tells about himself which continues to mesh with new pieces of experience, it acquires narrative truth." This notion creating stories to fill experiential gaps in a person's sense of identity and to integrate new experience into that identity fits with the significance of a story of one-breasted African Amazon warriors for Lorde after her mastectomy. See, Donald P. Spence, *Narrative Truth and Historical Truth: Meaning and Interpretation in Psychoanalysis* (New York: W.W. Norton, 1982) 466.

[70] Lorde, *The Cancer Journals,* Kindle Location 716.

[71] Ibid., Kindle Location 288.

[72] Ibid., Kindle Location 397.

[73] Ibid., Kindle Location 552.

Speculating on the Amazons' responses, Lorde begins to create her own "wider construct" from which to respond to breast cancer.[74] Feeling like an interloper and outsider amongst the "white" spaces and white faces of hospitals,[75] Lorde imaginatively creates a new community of choice. From this vantage point, she can distance herself from the gender-subordinating, normative messages that she perceives in her patient education: That women with breast cancer should be cheerful and obedient to medical authority; they should cover their mastectomy scars to be "decent;" and that they should adhere to heteronormative gender codes to regain health.

In what Lorde calls her "biomythography," *Zami* (1982),[76] and in her biography written by Alexis De Veaux,[77] there are details suggesting that Lorde learns about the *N'Nonmiton* in her travels to Africa in 1974 with her partner, Francis, and her children. As a first-generation American and the daughter of African-Caribbean immigrants, she undertakes this journey to search for ancestral roots. Traveling through the region of Dahomey and listening to local narratives in storytelling, song, and dance, she feels a connection to a community that is more mythological than genealogical.[78] In addition to her identification with Dahomey Amazons, Lorde invokes an African goddess in *The Cancer Journals.* In the first journal entry dated January 26, 1979, she writes, "Oh Seboulisa ma. Help me remember what I have paid so much to learn."[79] Lorde does not identify Seboulisa in the *Journals* but does so in her poetry collection *The Black Unicorn* (1978). She petitions Seboulisa in two poems and in the glossary identifies her as "The goddess of Abomey [the capital city of Dahomey]— "The Mother of us all."[80]

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[74] Ibid., Kindle Location 681.
[75] Ibid., Kindle Location 568.
[76] Audre Lorde, *Zami: A New Spelling of My Name* (New York: Crossing Pres, 1982).
[77] Alexis De Veaux, *Warrior Poet: A Biography of Audre Lorde,* (New York: Norton, 2004)
[78] Ibid., 142, 146-147
[79] Lorde, *The Cancer Journals*, 41.
[80] Audre Lorde, *The Black Unicorn*, (New York; Norton, 1978/1995) 121.

While the publication of *The Black Unicorn* predates *The Cancer Journals,* she is writing poems in the period during diagnosis and after her mastectomy in 1978. In the poem "125th St. and Abomey," Lorde sees a vision of Seboulisa walking in the streets of New York and entreats her: "Seboulisa mother goddess with one breast/eaten away by worms of sorrow and loss/See me now/Your severed daughter/Laughing our name into echo/All the world shall remember."[81]

Although military metaphors are scattered throughout *The Cancer Journals* as nouns (e.g., war, army, warriors, enemies, forces) and verbs (e.g., Lorde fights battles, feels assaulted, refers to "enemies destroying" black women and "poisoning" the earth), the textual evidence from Lorde's poetry, autobiography, and biography suggest these references are rooted in her imaginative revisions of African mythic women, not western, male warfare As her biographer, Alexis De Veaux, notes (2004), "*The Cancer Journals* signaled Lorde's self-styled transfiguration as Seboulisa incarnate. She became a living version of the one-breasted warrior goddess, central to her spiritual links to a reimagined, mythic Africa. But it was not simply that Lorde had breast cancer or a mastectomy; it was what she did with those facts."[82] Lorde's petition in *The Cancer Journals* to Seboulisa "to remember what she has paid so much to learn" expresses a commitment to confront her breast cancer as an educating experience and to turn dreams for survival into language, language into ideas, and ideas into action. She does so to deploy the knowledge she gains and to share it with others.[83]

If my reconsideration is correct and she relies on military metaphors on behalf of love and survival, why does she "deploy" war rhetoric to do so, and why does she not explain her intention more clearly? In "Age, Race, Class, and Sex: Women Redefining Difference," Lorde gives a possible answer when she argues, "in order to survive, those of us for whom oppression

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[81] Ibid., 12-13.
[82] Alexis De Veaux, *Warrior Poet,* 271.
[83] Lorde, *The Cancer Journals*, 124.

is as american [sic] as apple pie have . . . to become familiar with the language and manners of the oppressor, even sometimes adopting them."[84] While she sees that "the master's tools will never dismantle the master's house,"[85] she may resort to the master's linguistic tools to convey the ideas that she wants to express to the most people. It may also be that Lorde's use of war metaphors is much like Martin's example of a metaphoric evocation of *Lysistrata* inspiring female students to stand up to sexism.[86] If so, Lorde employs her "narrative truth" of women-at-war to draw attention to the myriad gender-subordinating harms in the CIC, to learn and teach others how to be gender-insubordinate women warriors, not pink war soldier-survivors.

Claiming Voice: The master's tools will never dismantle a pink war machine: GI for communal health

Due largely to the gender-insubordinate educational efforts of Rosamond and Kushner, by 1978, a two-step procedure for biopsy and mastectomy was not something Lorde had to fight for in her care. However, Lorde identifies other, gender-subordinating practices and messages, such as doctors and nurses pressuring women to wear prostheses or to have reconstruction surgeries to appear "normal" within a profit-driven system of disease management.[87] She objects too, to messages that women need to be cheerful to be healthy, which she sees as a way to blame women for their illness while obscuring the possibility that toxins in foodways and the environment cause cancer.[88] She also is aware of and calls attention to heterosexist and racist messages in patient education, including her doctor-patient encounters.[89]

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[84] Audre Lorde, "Age, Race, Class, and Sex: Women Redefining Difference," *Sister Outsider* (Berkeley, CA: Crossing Press, 1984),114.

[85] Audre Lorde,

[86] Jane Roland Martin, *Coming of Age in Academe: Rekindling Women's Hopes and Reforming the Academy* (New York: Routledge, 2000). 167.

[87] Lorde, *The Cancer Journals,* Kindle Location 955.

[88] Lorde, *The Cancer Journals,* Kindle Location 784.

[89] Lorde, "A Burst of Life: Living with Cancer," *A Burst of Light: Essays by Audre Lorde* (Ithaca, NY: Firebrand Books, 1988), 112-113.

Lorde's educational aim in writing the *Journals* is to respond to these myriad harms and for others with cancer to find within its pages "the ingredients with which to build a wider construct"[90] outside of the war machine. In her essay "The Master's Tools Will Never Dismantle The Master's House," she reminds us that "community must not mean a shedding of our differences, nor the pathetic pretense that these differences do not exist," but that we must learn "how to make common cause with those others identified as outside the structures in order to define and seek a world in which we can all flourish."[91]

If we read *The Cancer Journals* as a reorientation of her thesis a year earlier in "The Master's Tools," then the question Lorde's poses—"how do my experiences with cancer fit into the larger tapestry of my work as a Black woman, into the history of all women?"[92] –is both self-reflective inquiry and an invitation for readers to find "common cause" with others aiming to end oppressive gender subordinating practices, both in breast cancer and in every aspect of communal life. After her declaration that women who have had mastectomies are warriors, she asks readers to imagine with her, "What would happen if an army of one-breasted women descended upon Congress and demanded that the use of carcinogenic, fat-stored hormones in beef-feed be outlawed?"[93]

Like Dahomey Amazons with missing breasts visible to each other and the world, Lorde's imagined army of one-breasted women forms to make breast cancer visible to each other and the nation and to demand action on behalf of communal health. While Kushner's *Breast Cancer* was the first GI narrative to raise questions about environmental links to breast cancer and explore its known causes for a general audience, Lorde is the first to sound the alarm that cancer is not only the result of something looming in an unfortunate individual's DNA. As

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[90] Lorde, *The Cancer Journals,* Kindle Location 676.
[91] Lorde, "The Master's Tools," *Sister Outsider* (Berkeley, CA: Crossing Press, 1984), 112.
[92] Lorde, *The Cancer Journals*, 141.
[93] Ibid., 138.

medical reporter navigating the male-biased world of science, Kushner takes a measured stance in her suggestion that "not every chemical that might cause cancer can or should be banned," but "the more dangerous, less essential carcinogens can at least be regulated."[94] Unlike Kushner, Lorde as a feminist activist sounds a blaring alarm, to incite readers to press the government for research to explore environmental links to breast cancer. Lorde finds the American Cancer Society and National Cancer Institute "notoriously indifferent, if not hostile" to considering the possibility that cancer has environmental causes outside the individual body or the individual's control.[95]

Lorde's "army" is comprised of women who are self-advocating, self-educating agents. She argues that "every woman should add to her arsenal of information about breast cancer"[96] and that:

> [E]very woman has a militant responsibility to involve herself actively with her own health. We owe ourselves the protection of all the information we can acquire about the treatment of cancer and its causes as well as about the recent findings concerning immunology, nutrition, environment and stress. And we owe ourselves this information *before* we have a reason to use it.[97]

She considers the normative value of cheerfulness in the war machine as sapping and misdirecting the energies women should spend demanding that society pay attention to environmental factors affecting human health. She observes:

> Like superficial spirituality, looking on the bright side of things is a euphemism used for obscuring certain realities of life, the open consideration of which might prove threatening or dangerous to the status quo[98]. . . . Let us seek 'joy' rather than real food and clean air and a saner future on a livable earth! As if happiness alone can protect us from the results of profit-madness.[99]

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[94] Kushner, *Breast Cancer*, 115.
[95] Lorde, *The Cancer Journals*, 962.
[96] Ibid., 962.
[97] Ibid., 979, emphasis in original.
[98] Ibid., 979.
[99] Ibid., 1000-1002.

Lorde's critique is a moral response on behalf of all life, and she urges others to join her and "spea[k] out against our silent passivity and the cynicism of a mechanized and inhuman civilization that is destroying our earth and those who live upon it."[100] Lorde situates *The Cancer Journals* as a part of her continuing commitment to social justice in learning and teaching. Like her poetry, the *Journals* become a way to "give voice" to her experience, to "share it for use" so that "the pain [of breast cancer should] not be wasted."[101]

John Dewey (1937) argues that conditions that disrupt physical and emotional wellbeing cannot be addressed through knowledge of "chemical, immunological, physiological and anatomical" conditions of isolated bodies alone. He writes that "we cannot understand and employ this knowledge until it is placed integrally in the context of what human beings do to one another in the vast variety of their contacts and associations."[102] What we choose to do together and to each other and how we choose to define community shape human health outcomes.

Lorde and Dewey share the opinion that advancing health is not possible without a focus on preventative approaches to disease and a conservationist focus on health. These twin foci require educating people for communal thinking. As Dewey asks, "is there anything in the whole business of politics, economics, morals, education, indeed, in any profession, save the construction of a proper human environment that will serve by its very existence to produce sound and whole human beings, who will in turn maintain a sound and healthy human environment?"[103] Lorde emphasizes the necessity of creating a "proper human environment" when she argues that we cannot dismiss "cancer . . . [as] just another degenerative and unavoidable disease of the aging process."[104]

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[100] Ibid., 1000.
[101] Ibid., 129.
[102] Dewey, "The Unity of the Human Being," Jo Ann Boydston, Ed., *John Dewey: The Later Works 1925-1953 Vol. 13*, (Carbondale, Il: Southern Illinois University Press, 2008), 331-336.
[103] Ibid.
[104] Lorde, *The Cancer Journals*, 979.

The creation of "proper human environments" for maximizing and sustaining conditions for human health requires focusing on the needs of "whole human beings," or body-minds, in a social environment. According to Warren (2000), ecofeminist communities foster "spiritual healing" to members through "survival and empowerment strategies in the prefeminist, patriarchal present."[105] Warren points out that such communities are anti-militaristic and stand against any rationale for justified violence. I have been arguing that Lorde's communal thinking, while expressed in militaristic language, does so to emphasize women's capacities to act on their own behalf and communal care to name, resist, and end oppressive, gender-subordinating conditions that harm human health. Laird (1988) identifies this emphasis in Lorde's writings as her practice of "TEACHING for love and survival,"[106] This commitment to teaching for love and survival is at the center of her vision of women as breast cancer warriors fighting on behalf of human health, both inside and outside the CIC. As she reminds us, "We must learn to count the living with that same particular attention with which we number the dead."[107]

Sandra Steingraber: Shutting Down the Pink War Machine

In *Living Downstream: An Ecologist's Personal Investigation of Cancer and the Environment* (1997/2010 2nd ed.), Sandra Steingraber carries forward Lorde's call to focus on communal health. Although Steingraber does not directly cite Lorde in *Living Downstream,* in her prose poem "An Apology to Audre Lorde, Never Sent" (1995), she credits Lorde with nurturing her ability to recognize miseducating, gender-subordinating messages in social and medical responses to cancer that women internalize. Steingraber writes:

> Oh, Audre, I've heard you have news of a recent metastasis. I want to tell you about my mother's paper towel breasts, how they felt against my ribs when she embraced me. Paper towels, like she's trying to mop up a little accident. . .. Audre, I want to tell you

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[105] Warren, *Ecofeminist Philosophy*, 3287.
[106] Laird, "Maternal," 112-113.
[107] Lorde, *The Cancer Journals*, 673-689.

> about the catheter tube that stretched between my own two legs, how I still reach for it in my sleep. . .. Your words saved me. I was yoked to terrible things then.[108]

Combining personal narrative, scientific research, autoethnographic exposé, and an environmental manifesto, Steingraber, like Kushner and Lorde, presents an illness narrative that goes beyond the scope of traditional memoir. Although Steingraber is diagnosed with bladder cancer rather than a breast or gynecological cancer, her narrative is directly concerned with BCG's and, in the tradition of Lorde's *Journals, Living Downstream* is a restorative/reformer gender-insubordinate response to normative, pink-war/CIC normative narratives. However, Steingraber focuses her gender-insubordinate critique on the narrative foundation undergirding the CIC—the story of American progress through free, open, and largely unregulated industrial development and that of a global, corporate marketplace. She argues this narrative and the profit ethic it valorizes justify the production of billions of pounds of environmental toxins yearly, even though evidence points to suspected and in some case incontrovertible links between these chemicals in air, water, and foodways and globally rising cancer rates.[109] Steingraber contends that if the industrial-development-for-social progress narrative changed, the CIC and its pink war machine would grind to a halt. To this educating end, she opens *Living Downstream* with a story of her own:

> There was once a village along a river. The people who lived there were very kind. These residents, according to parable, began noticing increasing numbers of drowning people caught in the river's swift current. And so they went to work devising ever more elaborate technologies to resuscitate them. So preoccupied were these heroic villagers with rescue and treatment that they never thought to look upstream to see who was pushing the victims in. This book is a walk up that river.[110]

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[108] Sandra Steingraber, *Post-Diagnosis* (Ithaca, NY: Firebrand Books, 1995, 38).

[109] Sandra Steingraber, *Living Downstream: An Ecologists Personal Investigation of Cancer and the Environment,* 2nd ed. (Cambridge, MA: De Capo Press, 2010), 45, 148.
See also, Freddie Bray, et. al., "Global Cancer Statistics 2018: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries," *CA: Cancer Journal for Clinicians 68* (2018): 394-424. Accessed 5 June 2018. https://onlinelibrary.wiley.com/doi/epdf/10.3322/caac.21492 .
See also, World Health Organization, "Cancer," *World Health Organization* (n.d.) Accessed 5 June 2018. https://www.who.int/cancer/resources/keyfacts/en/.

[110] Ibid, 20.

Steingraber takes readers "upstream" with her to identify who or what is creating a crisis of community and destroying human lives—her answer is industrial polluters. Her GI call to action, first sounded in 1997, echoes in Thomas J. Burns' and Beth Schafer Caniglia's (2017) alarm that we are living in a "world out of balance," affecting not only the natural environment and climate but social stability as well.[111] Globally, the ability to create and sustain conditions for communal health, both at the level of society and at the level of individual body-minds, has become more precarious over the last 70 years than at any other time in human history. These developments pose a troubling question for the 21st century of the Anthropocene[112] epoch:

> Rachel Carson pointed out the disastrous consequences of DDT . . . today, the number of chemicals in use that may be even more harmful than DDT is a thousand fold greater. Air and water pollution, diseases and cancers, and global warming are the most noticeable signs of an environment out of balance and are immediate threats to the health and life of every individual. But what of the effects on societies? What are the social outcomes?[113]

A concern for the answer to these questions drives Steingraber's narrative as she positions her own cancer story as "one data point in the statistical story."[114] Steingraber interweaves her cancer narrative within a larger discussion of environmental toxins in order not

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[111] Thomas J. Burns and Beth Schafer Caniglia, *Environmental Sociology: The Ecology of Late Modernity* (Norman, OK, US: Mercury Academic, 2017), Kindle Edition. Kindle Location 3260.

[112] The term "Anthropocene," a designation indicating the impact of humans in shaping the current geologic period, is now widely accepted (See Burns and Caniglia, 2017; Kindle Location 1670). However, this designation is not official and it is still debated (the scientific term for the current epoch is the "Holocene"). Critics point out that "Anthropocene" may inspire the idea high-tech solutions to problems created by the products and byproducts of technological innovations in the first place. Another criticism is that calling this period Anthropocene suggests that human mass environmental impact is both "natural" and that all humans, instead of just some, are responsible for the ecological damage and that humans are "intrinsically bad." According to Aaron Vansintjan, the Historian James C. Moore proposes the alternative label of "Capitalocene." According to Vansintjan, this "the geological era of capitalism" is the product of governments and social systems that create "innovative property laws backed up by military and police forces, as well as uneven power relations between a small class of capitalists and the working poor, women, indigenous cultures, and other civilizations. It was these institutions, developed and perfected over several hundred years, that allowed for the destruction of cultures and the over-exploitation of earth's natural resources, culminating in our current crisis." For more, see Aaron Vansintjan, "The Anthropocene Debate: Why Is Such a Useful Concept Starting to Fall Apart?" *Resilience* 26 June 2015. Accessed 3 September 2017. http://www.resilience.org/stories/2015-06-26/the-anthropocene-debate-why-is-such-a-useful-concept-starting-to-fall-apart/

[113] Burns and Caniglia, *Environmental Sociology,* Kindle Location 3263-3268.

[114] Steingraber, *Living Downstream*, 90.

to “make too exceptional what is common and ordinary.”[115] Diagnosed with bladder cancer at age 20, a cancer strongly linked to industrial pollutants[116] and a possibility of developing as secondary cancer to ovarian cancer,[117] she calls for people to educate themselves about and vocally oppose the widespread use of organochlorine compounds, coal derivatives, and petrochemicals in agriculture and manufacturing and as ingredients in consumer household products. To this educating end, she includes an annotated bibliography including websites for information about chemical toxins and cancer with the tacit encouragement for readers to not just take her word for it but begin connecting the research dots for themselves and find GI-oriented organizations resisting pink war normative narratives.[118]

Like other crossers into the kingdom of the sick before her, Steingraber experiences her cancer diagnosis as entering “an unfamiliar country where all the rules of human contact are alien.”[119] This “unplanned and unchosen journey”[120] shapes the course of her professional life as she focuses her training as biologist on cancer to become an environmental educator and activist.[121] Written some 30 years post-diagnosis, *Living Downstream* testifies to her miseducating encounters in the CIC and her GI, self-educating program to explore cancer’s environmental links and social effects in communities.[122]

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[115] Ibid., 110.
[116] Ibid., 90.
[117] See, University of New Mexico Comprehensive Cancer Center, “Ovarian Cancer,” 2016. Accessed 3 January 2018. http://cancer.unm.edu/cancer/cancer-info/types-of-cancer/ovarian-cancer/ .
While Steingraber’s cancer is not a breast or gynecological cancer, the female reproductive system and bladder are closely tied and a common site of ovarian cancer spread is into the bladder. Steingraber make
[118] Steingraber direct readers to Breast Cancer Action and Breast Cancer Fund, two organizations that address social disparities in breast cancer diagnosis, treatment, and prognosis, and call for recognition of cancer’s environmental links.
[119] Steingraber, *Living Downstream*., 35.
[120] Ibid., 36.
[121] Ibid., 138.
[122] For example, a 2017 report on cancer statistics in the U.S. from the National Cancer Institute (NCI) projects that worldwide, cancer rates between 2012 and 2030 are expected to rise 50%, from 14 million a year diagnosed to 21 million. In this same time frame, deaths are expected to increase 60%, from 8 million a year to 13 million. In the U.S., there appears to be some good news as cancer death rates from 2004 to 2013 fell by 13%. However, this says nothing about the diagnosis rate. Here is what the NCI has to say about risk factors for cancer: “As the overall

Refusing to Comply: Rejecting Objectivist, Objectifying Science

Although Steingraber relies on data from scientific research to construct an argument that carcinogenic effects of many chemical compounds are routinely downplayed and ignored, she also positions herself strangely from mainstream practices in the science community, bringing forward narratives of individual and communal life to counter both a profit ethic that disregards human health and an objectivist, scientific conceptual framework. For example, when she learns that there are "immortal" or continuously replicating lines of breast cancer cells, Steingraber traces the history of the cells sold for research and development back to the woman who donated them. She discovers that "MCF-7 is among the oldest of breast cancer cell lines . . . the coin of the realm" for breast cancer research. The woman who donated her cells and agreed to undergo biopsies seven times to extract them was Frances Mellon, a Catholic nun from Michigan known as Sister Catherine Frances. Steingraber shares with readers the small bit of information she gleans about Frances:

> Sister Catherine Frances died of her disease in 1970. An old newspaper clipping reports that "she was a slightly built woman of medium height, with auburn hair, gray eyes and hands that were remarkable for their delicate beauty." Before entering Immaculate Heart in 1945, she had worked for twenty-five years as a stenographer at the Mueller Brass Company in Port Huron. Both her mother and sister died of cancer before her. The cancer cells that ultimately begat the MCF-7 line were extracted from fluid trapped in her chest cavity.[123]

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cancer death rate has declined, the number of cancer survivors has increased. These trends show that progress is being made against the disease, but much work remains. Although rates of smoking, a major cause of cancer, have declined, the U.S. population is aging, and cancer rates increase with age. Obesity, another risk factor for cancer, is also increasing" (par. 17). While smoking, aging, and obesity are identified as threats, the article is silent on environmental pollutants. For more, see, "Cancer Statistics," *National Institutes of Health, National Cancer Institute.* 22 March 2017. Accessed 27 August 2017. https://www.cancer.gov/about-cancer/understanding/statistics As Steingraber points out, this projected global increase in cancers cannot be accounted for by aging populations alone. She tells her own family's story of cancer in rural Illinois, a state that, in 2007 ranked 13th in terms of pollution creation and ninth in toxic spills (6). She writes, "There is a lot of cancer in my family. My mother was diagnosed with breast cancer at age 44. I have uncles with colon cancer, prostate cancer, stromal cancer. My aunt died of the same kind of bladder cancer—transitional cell carcinoma—that I had. But here's the punch line to my family story: I am adopted. . . . the chance of an adopted person dying of cancer is more closely related to whether or not her adoptive parents had died of cancer and far less related to whether or not her biological parents had met such a fate" (KL 61-70).

[123] Ibid., 126.

To Steingraber, these details of a long-dead woman's life are part of a project of humanistic recovery to counter scientific detachment that distances what we do from who we are. At a banquet dinner for a breast cancer foundation a colleague mentions to her that he is using the MCF-7 cell line. She asks him, "Did you know she was a nun?" She watches him "grope" with this information, blinking several times and taking several sips from his water glass before asking, "Then MCF is her name, her initials?" Steingraber proceeds to tell him all that she has learned about this woman's life.[124] In this instance, she breaks with social decorum in the breast cancer research community to make a gender-insubordinate claim for this woman's life and death to be remembered by those who use and profit from the cells of her body.[125]

In *Living Downstream* she proposes that MCF-7 be "rechristened": "Let them be called MBFM-7: The immortal breasts of Frances Mallon, attempt number seven. Let them be known as sacrament. *This is my body, which is broken for you. Do this [research] in remembrance of me."*[126] Recovering Mallon's name, her ownership of her breast cancer cells, and her embodied humanity for public memory are actions on behalf of strengthening empathetic education in the medical research community. Re-defining human tissue research as sacrament is also a demand to see beyond a narrow, dehumanizing, parts-focused approach in medicine.

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[124] Ibid., 130.

[125] The objective distancing from Mellon's humanity that Steingraber notes in scientific discourse is evident in a website for the MCF-7 cell line. Here an "Origin of the MCF-7 Cell Line" statement informs readers that the cells were collected in 1970 and that the donor was a "69-year old Caucasian woman." However, it is also states that "[o]f the two mastectomies she received, the first revealed that the removed tissue was benign." Mellon underwent two mastectomies, and the first "tissue," examined—the first breast she lost—turned out to be cancer free. Then, according to this origin narrative, "[f]ive years later, a second operation revealed a malignant adenocarcinoma in a pleural effusion from which tissue was taken that would eventually result in the MCF-7 line." In this factual account, the story of the woman, any evidence of her humanity and suffering is lost. There is a link to purchase frozen cells for $229.00 to $1617.00, depending upon the amount ordered. For more, see "MCF-7 Cell Information," *MCF-7 Cells: Human Breast Adenocarcinoma Cell Line* (n.d.) Accessed 2 Sept. 2017. http://www.mcf7.com/

[126] Steingraber, *Living* Downstream, 2353-2359.

Sustaining body-minds: The precautionary principle as GI for Community Health

To protect human health inside and outside the CIC Steingraber argues for the "precautionary principle,"[127] a standard for protecting human welfare in scientific research, medicine, and industrial development to be applied to US industries and commercial products. The Precautionary Principle was first articulated in a brief statement developed during the 1998 Wingspread Conference in Wisconsin.[128] In 2007, it was adopted as Article 191 of the Treaty on the Functioning of the European Union.[129] This principle puts public health first by advancing a policy that if there is an indication that an action such as releasing a chemical into the environment may be harmful to human health, there is no immediate proof available to the contrary, and "waiting for proof [of no harmful effects] may create irreversible, catastrophic damage," the action should not be taken.[130] This principle is "conservative" in the sense of three necessary criteria: First, an action shall not be taken unless there is a strong indication that it will not cause harm to human health, second, the action not cause harm to the nonhuman ecology and natural resources, and third, the action does not pose an economic risk. To this last point, the reasoning is the potential harm is avoided, then human, economic, and environmental resources are not directed later toward fixing a costly and dangerous problem. Steingraber advocates the principle's three criteria to be met before taking action, and to ensure they are applied, she calls for "open, informed, and democratic" inquiry before allowing any chemical into the environment, the exploration of alternatives to any chemicals that are potentially harmful, and a

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[127] See World Commission on the Ethics of Scientific Knowledge and Technology (COMEST), "The Precautionary Principle," *UNESCO Digital Library* 2005. Accessed 21 January 2019. https://unesdoc.unesco.org/ark:/48223/pf0000139578 .

[128] See, Science and Environmental Health Network, "Wingspread Conference on Precautionary Principle,' *SEHN,* 26 January 1998. Accessed 21 January 2019. http://sehn.org/wingspread-conference-on-the-precautionary-principle/ .

[129] Consolidated Version of Treaty on the Functioning of the European Union (English Version), *Official Journal of the European Union* 26 October 2010. Accessed 21 January 2019. https://eur-lex.europa.eu/legal-content/EN/TXT/PDF/?uri=CELEX:12012E/TXT&from=EN .

[130] Steingraber, *Living Downstream*, Kindle Location 189.

"*principle of reverse onus,*" which shifts the burden of proof to those who want to "produce, import, or use the substance in question" to show that it causes no harm.[131] Not only does Steingraber support the precautionary principle, she advocates for its adoption at the level of local communities for engaged civic participation.

Opponents of the precautionary principle use *reductio ad absurdum* arguments to show that it is an unreasonable position. They call the those who support the principle "romantics" and "quasi-religious," anti-science, anti-progress bigots.[132] Martin Peterson (2007) employs Enlightenment ethical utility to argue against application of the precautionary principle in pharmaceutical research and clinical drug trials. He contends that "the benefits outweigh the risks" of these trials and "tragic accidents should be accepted, depending upon the expected benefit of the new drug."[133]

However, the precautionary principle does not, as Peterson suggests, categorically block all action that might be harmful. The aim is to prevent and minimize harm when reasonably possible to do so. Steingraber's investment in public ecology education aims to cultivate democratic participation in considering the matter of allowing chemical production and release in local communities. For example, she points out that dioxin is "never manufactured on purpose" but is a by-product of industrial production and the incineration of plastics "linked to a variety of

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[131] Steingraber, *Living Downstream,* 282.

[132] See, "Beware the Precautionary Principle," *Social Issues Research Center* (n.d.) Accessed 27 August 2017. http://www.sirc.org/articles/beware.html
See also, "Paralyzing Precautionary Principle: Problems with The Precautionary Principle & Sustainable Development That the Environmentalists Do Not Want You to Know," 2010. Accessed 27 August 2017. http://paralyzingprecautionprinciple.com/problems-with-the-precautionary-principle.html
See also, Martin Peterson, "The Precautionary Principle Should Not be Used as a Basis for Decision Making: Talking Point on the Precautionary Principle," *EMBO Reports 8* No. 4 (2007): 305-308. Accessed 27 August 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1852769/

[133] Martin Peterson, "The Precautionary Principle Should Not be Used as a Basis For Decision Making: Talking Point on the Precautionary Principle," *EMBO Reports 8* No. 4 (2007): 305. Accessed 27 August 2018. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1852769/

cancers and is now believed to inhabit the body tissues of every person living in the United States."[134] She argues:

> High levels of dioxin are found in food and dairy products produced near incinerators. People who live near waste incinerators have higher levels of dioxin in their blood than do members of the general population, with incinerator workers at particularly high risk of exposure. Every day people all over the nation sit down to a meal that originated from the central Illinois countryside. The question of whether or not to construct an incinerator in the midst of all this agriculture seemed to me in 1994 like a national issue—one the whole country should vote on. It still is. Because our main route of exposure to dioxin is in food, all of us have a stake in the question of whether or not generating electricity by lighting garbage on fire is a genuine form of renewable energy—as is now being claimed—or a wolf in sheep's clothing. Instead, decisions on incinerator sitings are too often made by a handful of small-town city councils desperate to shore up their communities' economies. This was true in 1994 and is still true today.[135]

As Kriebel et. al. (2001) similarly argue, the precautionary principle is a measured response to "apparent contradictions in our regulatory process; if the laws governing toxic chemical release are effective, then why are mercury levels in freshwater fish so high that pregnant women should not eat them? How is it possible that human breast milk may not meet U.S. Food and Drug Administration contaminant limits for baby food?"[136]

Educating body-minds: Teaching for Community Health in the Anthropocene

While Steingraber acknowledges that there are other risk factors for cancer including genetic predispositions, she urges readers to consider the role of environmental factors in deterring or increasing susceptibility to disease. She explains that since "each of us is exposed repeatedly to minute amounts of many different carcinogens and to any one carcinogen through

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[134] Steingraber, *Living Downstream,* Kindle Location116.
See also, United States Environmental Protection Agency, "Learn About Dioxin," 28 January 2019. Accessed 3 February 2019. https://www.epa.gov/dioxin/learn-about-dioxin

[135] Steingraber, *Living Downstream* Kindle Location 223-224.
To understand the continuing threat of dioxin being released from incinerated plastics, see Oliver Milman, "'Moment of Reckoning': US Cities Burn Recyclables After China Bans Imports," *The Guardian.* 21 February 2019. Accessed 17 March 2019. https://www.theguardian.com/cities/2019/feb/21/philadelphia-covanta-incinerator-recyclables-china-ban-imports.

[136] David Kriebel, et. al., "The Precautionary Principle in Environmental Science," *Envrionmental Health Perspectives 109* No. 9 (2001): 871-872.

many different routes," it is difficult to show a precise correlation for most environmental toxins and cancer.[137] However, the complexity of the research task of wholly unweaving the tangled web between these toxins, "lifestyle choice" factors such as obesity, smoking, and alcohol use (also advanced in the population by exploitative, commercial practices), and genetics does not discount the evidence that as industrial pollution rises, so too do worldwide cancer rates.[138] Her opposition to widespread chemical manufacturing is not based on vague, subjective biases but rather on her analysis of extensive evidence of harm to human health and human rights violations. As a scientist examining data that link many chemicals to negative health outcomes but are nevertheless largely dismissed as inconclusive studies, she asks that readers adopt a self-educating practice to become educating agents and act locally with a primary concern for community health.

Her goal is that readers recognize "profound" and "inescapable" consequences of a materialist ethic that economically benefits few while others bear great economic and health costs.[139] She points out that "we know that toxic sites are disproportionately located in poor and minority communities."[140] She responds to Jain's (2007) question, "who are we fighting?" in the "war" on cancer,[141] suggesting chemical manufacturing as an appropriate target for this battle:

> [P]eople are not uniformly vulnerable to the effects of environmental carcinogens. Among those who may be affected more profoundly are infants, adolescents, whose bodies are being resculpted by sex hormones; and the elderly, whose detoxifying mechanisms are less efficient. . . .When carcinogens are deliberately or accidentally introduced into the environment, some number of vulnerable persons are consigned to death. . . [None] will die quick, painless deaths. They will be amputated, irradiated, and

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[137] Ibid., 32.

[138] See, Freddie Bray, et. al., "Global Cancer Statistics 2018: GLOBOCAN Estimates of Incidence and Mortality Worldwide for 36 Cancers in 185 Countries," *CA: Cancer Journal for Clinicians 68* (2018): 394-424. Accessed 5 June 2018. https://onlinelibrary.wiley.com/doi/epdf/10.3322/caac.21492 .
See also, World Health Organization, "Cancer," *World Health Organization* (n.d.) Accessed 5 June 2018. https://www.who.int/cancer/resources/keyfacts/en/

[139] Diana Tietjens Meyers, "Agency," *A Companion to Feminist Philosophy,* Alison M. Jaggar and Iris Marion Young, eds. (Malden, MA: Blackwell Publishing, 2000), 377.

[140] Steingraber, *Living Downstream*, 280.

[141] Jain, *Malignant: How Cancer Becomes Us*, 522.

> dosed with chemotherapy. They will expire privately in hospitals and hospices and be buried quietly, at a rate of ninety-two funerals a day. Some of them will be children. Photographs of their dead bodies will not appear in newspapers. . .. Their anonymity, however, does not moderate this violence. In 2007, 834,499,071 pounds of known or suspected carcinogens were released into our air, water, and soil by reporting industries.[142]

Since the reissued publication of *Living Downstream* in 2010*,* the poundage of toxic chemicals in the environment continues to increase. The total reported to the U.S. Environmental Protection agency in 2016 was 3.54 billion pounds, a figure only including U.S. industrial and manufacturing emissions.[143] A 2014 study by the World Health Organization finds that air pollution is linked to seven million premature deaths every year around the world (1 in 8 of every deaths). As Dr. Carlos Dora, WHO coordinator for Public Health and Environmental and Social Determinants of Health, recognizes, "[e]xcessive air pollution is often a by-product of unsustainable policies in sectors such as transport, energy, waste management and industry."[144]

However, despite evidence of likely harm from chemical pollution, U.S. regulatory agencies continue to place a burden of incontrovertible proof on those contesting their use. Steingraber argues that a substance not being proven to cause harm is not good enough to support its pervasive use, and she points out that women are the target consumers for carcinogenic compounds in household pesticides and cleaning products with messages that these products make life "better." They make the home sanitary and safe.[145] Additionally, carcinogenic compounds such as formaldehyde are commonly found many personal hygiene and

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[142] Steingraber, *Living Downstream,* 280-281.

[143] Ode to Clean, "The United States of Toxins," *Ode to Clean* (blog post). 24 October 2017. Accessed 3 January 2019. https://blog.odetoclean.com/the-united-states-of-toxins-1e219e5a701f

[144] "7 Million Premature Deaths Annually Linked to Air Pollution," *World Health Organization, Media Center,* para. 14. 25 March 2014. Accessed 28 August 2017. http://www.who.int/mediacentre/news/releases/2014/air-pollution/en/

[145] Steingraber, *Living Downstream,* 7.

cosmetic products,[146] many of which are marketed for women, and, as Steingraber adds, "we still don't know how many chemicals in commerce cause breast cancer."[147] As of 2018, many chemical compounds linked to cancer remain largely unregulated in their production, use, and disposal.[148] "Amid a flood of information" about the environmental and human health harms, Steingraber sees that there is "an absence of [public] knowledge."[149] A lack of awareness of and public silence surrounding environmental factors harming human health in general and specific ways, such as the sharp rise in breast cancer since the 1950s, is what her project aims to address.

Susan Laird (2017) engages with Steingraber's autobiographical works *Having Faith* (2003) and *Raising Elijah* (2011) and sees *Raising Elijah* as a presentation of "the Anthropocene's health crisis [framed] as a moral crisis."[150] Laird argues that public educators must make of teaching a mission to redress ecological degradation. This goal must be met by a curricular practice as "all of us are collectively responsible for the future of the world."[151] She calls education a vital means "to make the Anthropocene long-lasting, equitable, and worth living."[152] Laird also asks what "learning to live in the Anthropocene" can and should mean as this learning is essential for "human agency consequential to the Earth's habitability."[153] For children to learn how to live in an ecologically and culturally shifting world, there must first be adults who learn the appropriate skills and can transmit this knowledge.[154]

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[146] Ibid., 100.
[147] Ibid., 284.
[148] Amounts for each chemical compound produced by petrochemical "feedstocks" in the U.S. are measured in billions of pounds. These chemicals are used in the production of many compounds and components, such as plastics in manufacturing and agrochemicals (pesticides and herbicides). For more, on the various products made from petrochemicals, see the flowchart, "How Petrochemicals Are Used Today," Accessed 22 August 2018. https://www.icis.com/globalassets/documents/forms/ppf-pdf/icis-petrochemicals-flowchart.pdf
[149] Steingraber, *Living Downstream*.
[150] Susan Laird, "Learning to Live in the Anthropocene: Our Children and Ourselves," *Studies in Philosophy and Education* 36, (2017), 273.
[151] Ibid., 267.
[152] Ibid.
[153] Ibid., 268.
[154] Ibid., 270.

Laird argues that an "ecological gap" exists within the philosophy of education, suggesting that the field has not yet fully focused critical attention toward teaching social and environmental ethics necessary for health and survival. She notes that this gap corresponds with one that Martin[155] identified in the philosophy of education, "the exclusion, marginalization, and devaluation" of women "as both subjects and objects of canonical educational thought."[156] Laird sees a lack of concern for the natural environment and gender issues in education as resulting in a devaluation of love and care. She calls this nexus point "The Big Gap,"[157] and argues that this Big Gap is "ethically significant"[158] and an urgent issue in education and ecology.

To address these conditions in the present and future, Steingraber's gender-insubordinate, ecological narrative of cancer focuses on community education. Woven through her personal narrative is a primer for chemical pollution responsiveness. She aims to ensure that her children do not have to cross, as she did, into cancer culture and learn the lessons of CIC patient education:

> Because there are skill sets I don't want my children to have to learn—how to schedule cancer check-ups in between college exams is one—I am determined to see the Precautionary Principle implemented in the public sphere as a tool of environmental decision making, and not just within my own household. With an emphasis on better safe than sorry, the Precautionary Principle does not tell us what we should do, but it does serve as a starting point for imagining a future where nontoxic alternatives to inherently dangerous practices are embraced as the commonsense solution.[159]

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[155] See Jane Roland Martin, *Education Reconfigured: Culture, Encounter, and Change* (New York: Routledge, 2011), 47-51.

[156] Laird, "Learning to Live in the Anthropocene," 274.

[157] Ibid., 274.

[158] Ibid.

[159] Ibid.

Claiming Voice: Speaking Truth to CIC/Pink War Power

Steingraber is aware that "interlocking economic structures [have] bound the direction of medicine and science to the interests of industry."[160] She looks at sites of elevated cancer risks at local, national, and global levels, from chemical waste Superfund sites across the U.S. (there are well over a thousand) to the "triangle of death" in Naples[161] and to the Arctic circle where "the highest concentration of the most villainous chemicals . . . are inside the bark, blood, and tissues of the organisms living the farthest from the sources of these chemicals.[162] With her master's degree in poetry and a Ph.D. in biology, Steingraber is not a detached scientist studying soil samples. She coveys a somaesthetic, sensuous awareness of the world around her.

Lying in a cornfield at night and listening to the strains of a symphony playing from her car radio, Steingraber reflects on the obscenity of "arguing about exactly how many picograms of dioxin could acceptably contaminate these fields, the bodies of the people who plow them, and the flesh of their hogs, turkeys, and garden vegetables" and the "rapacity of subsidizing incineration over recycling."[163] For Steingraber, the past and present, the personal and communal, and land and culture interweave to form ecological patterns that affect human health. In *The Enigma of Health* (1993) philosopher Hans-Georg Gadamer points out that the word "ecology" comes from the Greek *oikos,* which denotes domesticity, the home. He adds that *oikos* "includes not only the ability to manage [the home] by one's self, but also the ability to manage along with other people."[164] Steingraber's commitment to communal and environmental health support democratic life and the wellbeing of our shared Earth-home. She demonstrates

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[160] Steingraber, *Living Downstream*, 20.
[161] Ibid., 135.
[162] Ibid., 173.
[163] Ibid., 234-235.
[164] Hans-Georg Gadamer, *The Enigma of Health: The Art of Healing in a Scientific Age,* Jason Gaiger and Nikolas Walker, Trans., (Stanford: University of California, 1993), 79.

agreement with Dewey's perspective that democracy is more than a style of governing; it is "the best means so far found for advancing human relationships."[165] According to Dewey, democracy is collective public action for sustaining "social welfare and the full development of human beings as individuals." This depends on the "participation of *every* mature human being" to collectively create "the values that regulate the living of [people] together."[166]

Dewey adds that democratic participation is a means of claiming a capacity to act: "What the argument for democracy implies is that the best way to produce initiative and constructive power is to exercise it."[167] When people cannot or do not actively take part in civic life and exercise their voices in matters of community welfare, whether due to apathy, blind trust of those in authority, competing and immediate self-interests, or because there is no avenue open for participation, there is less social power. Responsiveness and responsibility to community are not inborn. They are habituated or learned behaviors. As Dewey notes, "we are born organic beings associated with others, but we are not born members of a community."[168] Dewey's "good citizen,"[169] the kind of citizens that Steingraber wants us to be, requires we individually recognize our shared interdependence and the necessity to act together for the promotion of public health, education, and welfare.

Further, Dewey's call to promote a "sound and healthy" human environment[170] by focusing on societal and environmental conditions affecting public health[171] cannot be advanced

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[165] John Dewey, "On Democracy," (1937), paragraph 1. Accessed 17 October 2018. https://wolfweb.unr.edu/homepage/lafer/dewey%20dewey.htm .
[166] Ibid., paragraph 1, emphasis mine.
[167] Ibid., paragraph 11.
[168] Ibid., 154.
[169] Dewey, "The Unity of the Human Being," Jo Ann Boydston, Ed., *John Dewey: The Later Works 1925-1953 Vol. 13*, (Carbondale, Il: Southern Illinois University Press, 2008), 332.
[170] Ibid., 336.
[171] A concern for conditions of health and illness is a recurrent strand of thought through many of Dewey's works. For example, in *The Public and Its Problems* (1927), he includes "sanitation and public health" in his list of most pressing social problems (139). He also notes that while medical practices are private "transaction[s]" between a patient and physician, the "exercise of the [medical] professions has consequences so widespread that the

solely through traditional, reactionary, parts-focused medicine, even when, like the villagers along the river in Steingraber's parable, these approaches are well-intended and effective on the individual level. What Lorde, Steingraber, and Dewey call for are preventative approaches to illness advanced through individual and community education. Dewey writes, [T]he work of preventing disease and disorders is not completely done when the physical conditions of sanitation, pure water, and milk supply, sewage disposal, and healthy homes have been attended to."[172] While these are all vital for human health, to ensure these conditions are universal and sustainable, we must address the underlying social conditions and cultural values that shape the meaning of human health and our responses to health threats.

Lorde's and Steingraber's cancer narratives reveal the values of care, concern, and connection; the "Three Cs" that Martin says we need more of in education[173] and are largely missing or directed toward miseducating ends in pink war patient education. Both Lorde and Steingraber present the 3C's as urgently needed for reframing cancer as a communal health crisis and focusing on disease prevention rather than management. These narratives can be understood as a patient education counter-curriculum and, more broadly, as a means for sharing knowledge, fostering the Three Cs, and promoting democratic aims.

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examination and licensing of persons who practice them become a public matter" (66). In his essay "A Sick World" (1923), Dewey argues that the notion of a cure "does not touch the cause" of disease. For a "a truly healthy life" a focus on disease prevention rather than cures is needed. And, in *Democracy and Education* (1916), he agrees with Rousseau that physical health cannot be divided from an educational aim of fostering cognitive growth. He contends that "The aim of natural development says to parents and teachers: Make health an aim; normal development cannot be had without regard to the vigor of the body—an obvious enough fact and yet one whose due recognition in practice would almost automatically revolutionize many of our educational practices" (125).
See, John Dewey, *The Public and Its Problems* (Chicago: Gateway Books, 1946), 66, 139. *Internet Archive.* Accessed 14 March 2018. https://archive.org/details/in.ernet.dli.2015.190550 .
See also, John Dewey, "A Sick World," *The John Dewey and F. Matthias Alexander Homepage* (n.d.). Accessed 13 March 2019. https://www.alexandertechnique.com/articles/dewey/.
See also, John Dewey, *Democracy and Education* [Kindle Edition]. (Start Publishing, 2012), 125.

[172] Ibid., 337.

[173] See also, Jane Roland Martin, *Education Reconfigured: Culture, Encounter, and Change* (New York: Routledge, 2011), 41-50.

Lorde and Steingraber engage in gender-insubordinate critiques along the line of what Michele Foucault (1997) calls “the art of voluntary insubordination,”[174] which is critique as speaking or writing truth to power to draw public attention to abuses of power and dangerous threats to communal welfare. In so doing, the *parrhesiastes* (critical truth speaker) puts herself at some risk for punitive action. According to philosopher of education Stephen J. Ball (2017), *parrhesia* is “a confrontation of the normative with the ethical.”[175] He applies Foucault’s analysis in *Fearless Speech* to case studies of teachers who, through autobiographical online publications, critique teacher evaluation standards and “state-authorised [sic] pedagogy and school management” practices.[176] Ball considers these teachers *parrhesiastes* who are “confronting power in the most immediate sense.”[177] As ethically-motivated action, this kind of critique, understood as an insubordinate art, is not solely self-focused but rather taken on behalf of community. It is “about where you stand and what you do today,” and how to “engage in and develop the arts of misconduct.”[178] Ball declares that “freedom is the capacity and opportunity to participate in one’s self–formation, and ethics is the practice of this capacity in relation to oneself and others.”[179] Both freedom and ethics are necessary for democratic life.

I see all educational autobiographers whose BGC narratives are gender insubordinate as *parrhesiastes,* women exercising their freedom to identify and challenge oppressively subordinating practices in the CIC’s pink war machine construct. Babette Rosamond, Betty Rollin, Geralyn Lucas, Anita Ho, Susan Gubar, Barbara Ehrenreich, Rose Kushner, Audre Lorde, and Sandra Steingraber—each of these writers issues a distinct and focused gender-insubordinate, ethically reasoned critique of pink war. And, while conventional BGC soldier-

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[174] Foucault, *The Politics of Truth* (Los Angeles, CA, US: Semiotext(e), 2007), 47.
[175] Stephen J. Ball, *Foucault as Educator* (London, UK: Springer, 2017), 67.
[176] Ibid., 64, sic.
[177] Ibid., 69.
[178] Ibid.
[179] Ibid.

survivor narratives far outnumber gender-insubordinate BGC personal narratives, the exemplary cases of emergent-conflicted, instigative/informer, and restorative/reformer GI presented here are not the only such educational autobiographies of GI learning in and against pink war.

However, at stake in *The Cancer Journals* and *Living Downstream* is a question of how we define community and think about health and illness generally and women's experiences of cancer specifically. Lorde is concerned with how oppressive practices such as normative social constructions of feminine and masculine gender identities in medical treatment shape responses to cancer while obscuring the realities of cancer's physical, mental, and social costs and the threat it poses to life. Lorde and Steingraber both draw attention to the prevalence of environmental contaminants with known and suspected links to cancer and the routine dismissal of these urgent threats to human health. Steingraber puts her professional credentials on the line to present evidence that environmental abuses justified by a profit ethic is the motor of the pink war machine and source of a global human health crisis. She asks us to consider whether we will continue to hold to our present values and behaviors that situate health and education as private concerns or if we will re-envision our approaches to health and education as a collective undertaking and a shared commitment for democratic life, social welfare, and environmental protection. In the face of widespread environmental destruction, climate change, and numerous and rising health threats, including rising rates of cancers globally, John Dewey's call for sound human environments for sound and healthy human beings[180] is even more pressing today that when he said it. It is a question of no less importance than will we work for our continued existence and coexisting with other nonhuman species in peace or go forward in a state of war.

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[180] Dewey, "The Unity of the Human Being," Jo Ann Boydston, Ed., *John Dewey: The Later Works 1925-1953 Vol. 13*, (Carbondale, Il: Southern Illinois University Press, 2008), 336.

Preliminary Conclusions and Directions Foreword

Personal Reflection

This project began with a phone call from my mother and her admission to the hospital for a mastectomy. While she was in the hospital, I decided to focus my dissertation study on cancer autobiographical narratives, specifically narratives of breast and gynecological cancers. Aside from cancer's renewed proximity in my life (renewed because my father died from non-Hodgkin's lymphoma in 2000), my research interests in philosophy of education, women and gender studies, and women's trauma narratives as educational texts guided my focus specifically to cancers that affect the female reproductive system and that signal body's femaleness[1] and femininity in culture. I was not focused in the disease process as a learning experience with cancer as "teacher," per se, but rather the ways that medical and social responses to cancer shape a curriculum for teaching and learning.

During my mother's hospitalization and ensuing months of follow-up appointments, diagnostic imaging and lab appointments, and chemotherapy sessions, I was a witness to many of her encounters with doctors, nurses, lab technicians, case workers, hospital administrators, pharmacists, prosthetistis, and others. I realized that many of these encounters had an unmistakably pink tinge. Some gender cues in the environment and transmitted through provider-patient interactions were subtle and benign, for example, a candy dish in a hospital breast center lobby offering dainty organza bags of pink-ribbon-stamped white M&Ms; pictures of seascapes and lighthouses on the walls in general waiting room areas, pictures of frolicking kittens, puppies, and flowers the breast clinic rooms; side tables offering patients free copies of breast cancer magazines filled with pictures of smiling women promising to tell readers the secrets for staying optimistic and surviving; a nurse talking to my mother in a lilting, singsong

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[1] Breasts are a sign of females but can be replicated through prosthetics. Other signs of gender are created through somaesthetic technologies, e.g., girdles, padding, styling of hair and wigs, cosmetics, fashion, etc.

tone that was noticeably not present in her voice while she checked in a male patient; a chemotherapy nurse calling her “honey,” and “sugar.”

Other cues were more clearly oppressive—the hospital nurse who refused to call the doctor to write a script for more pain medication because she thought my mother was not in as much pain as she claimed and could wait, the doctor who told her there was little chance she would live more than three years and it was her fault for not coming for help sooner, and the surgeon who repetitively checked his Rolex watch and told my mother she didn’t need to have breast reconstruction and it was not covered by Medicare anyway. Still, I wondered if my feminist perspectives were shading everything through a gendered lens. I had previously read Audre Lorde’s *The Cancer Journals* in a gender values and education graduate class. Reading it again in the hospital while my mother slept and an incensed duty nurse reprimanded me for claiming cancer as an educating experience, Lorde’s voice was an affirming presence. As a witness to gender dynamics and gender messages in my mother’s cancer care, I could dismiss what I saw as being of little significance given that my mother’s life was extended through medical interventions (what mattered most), or I could focus on gender messages in responses to cancer as an educational problem to attempt to clarify for myself and others. Reading *The Journals* again, it seemed that Lorde was speaking directly to me, holding my eyes with her own, holding me accountable to respond. It still does feel that way.

I questioned if the gender-subordinating conditions Lorde testified to in 1980 were still widely evidenced in women’s cancer treatment. I also wanted to verify and clarify my proposition that a cancer diagnosis occasions educating encounters. I asked, in what ways are a person’s values, knowledge, and even identity “yoked” or changed through medical and social responses to cancer from educating agents across diverse contexts and settings? To begin to look for answers, I wanted to read as an active “listener” to women telling their own stories. I decided the best place to start was not primarily in reading studies that translated, interpreted, and excerpted women's experiences through a researcher's lens, but through engaging with the voices of women themselves through their autobiographical accounts of cancer.[2]

Granted, that would make *me* the researcher doing the translating, interpreting, and excerpting. However, I wanted my encounters with autobiographical texts to be as direct as possible while taking into account as fully as I could my responsibility for the interpretation of other's experiences that I put forward as theory. This includes acknowledging my own prior perspectives, biases, situated identity, and privilege as a reader/interpreter.[3] Through this ethically concerned approach and as I engaged with a growing number of BGC autobiographical narratives, I often felt as if I was in intimate dialog with the women who spoke to me across time and who brought with them different life perspectives. As I came to see major themes in narratives that I eventually named broadly "conventional" and "GI," I realized the gendered cues I observed in my mother's encounters were not uncommon. In fact, in one way or another, the autopathographers I encountered (including many not mentioned in this study but whose narratives still inform this theoretical work), speak to significance of gender norms and gender identity in shaping BGC educational experiences.[4] I found this to be true whether an author endorses the value of adhering to norms in surviving cancer, seems unaware of their influence, or expresses developing or strong opposition to them.

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[2] I consulted qualitative studies in sociology of medicine and nursing to compare patterns of experience I found in the autobiographical narratives and to get a broader perspective of issues related to gender, sexuality, and other identity markers in cancer care, both from patients' perceptions and from medical practitioners that were not addressed in some or all of the narratives I engaged with as primary research sources.

[3] Lorraine Code, *What Can She Know? Feminist Theory and the Construction of Knowledge.* (Ithaca, NY: Cornell University Press, 1991), 258.

[4] Even in narratives where there seems to be no evidence of gender-subordination or gender insubordination, gender's absence as a topic does not necessarily mean gender identity is irrelevant to BGC diagnosis and treatment. As Eve Sedgwick and Susan Gubar make clear, they learn there is an immediate indivisibility of the body-mind that in sickness can both disrupt gender identity and give it new significance.

I wanted to better understand what authors of BGC narratives experience when they make a culture crossing into the kingdom of the sick.[5] Specifically, I wanted to know how gender identity is affected by both breast and gynecological cancers and their interventions on both sides of the well/sick border. I also wanted to know how gender shapes social, medical, and governmental, and corporate responses to cancer—what is taught to the culture crossers and by what means. Ehrenreich's term the "cancer-industrial complex,"[6] aptly describes what I came to see as a composite "site" where formal and informal patient learning take place in a disease-management-oriented, for-profit medical system. Susan Laird offered additional clarification by suggesting what I described in both my mother's care and the autobiographical narratives was a distinct area of the CIC's production geared toward women with BGC diagnoses, a "pink war machine."[7]

I undertook this project as an attempt to understand how gender constructions and values affect women's learning and wellbeing in BGC cancer diagnoses, particularly when some capacities of those who make the crossing become yoked (or fail to yoke) to some portion of CIC/pink war stock, specifically, heteronormative gender values as conveyed through gender-subordinating practices of commercialism, medical authoritarianism, and normative narratives. I also wanted to see if health and illness and healthcare settings have a legitimate and relevant place within the domain of educational concerns. Presenting my work at conferences and peer colloquia amidst pressing topics such as racism and sexism in the classroom and the corporatization of public schooling, I would occasionally get puzzled stares as to why I was talking about cancer in education forums. One of my graduate student peers asked me directly, "what does any of this have to do with education?" This study is an attempt to answer that

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[5] Susan Sontag, *Illness as Metaphor* and *AIDS and Its Metaphors.* (New York: Penguin Classics, 2002), 3.
[6] Barbara Ehrenreich, "Welcome to Cancerland: A Mammogram Leads to a Cult of Pink Kitsch," *Harper's Magazine* (2001): 47-48.
[7] Susan Laird, personal communication, 12 December 2018.

question. It argues the case that teaching and learning happen during BGC treatment and living post-diagnosis. To this end, women's BGC autobiographical narratives are analyzed as cases of educational autobiographies testifying to pink war machine education that, in multiple ways, is gender subordinating. My aim in claiming education occurs in BGC experiences is part of a larger project of refocusing on the body-mind and its states of health and illness as urgently needing attention in the realm of educational thought. I mean the body as it is racialized, sexed, and gendered and also conditions affecting human health, including social responses to diseases and even how we think about death.

As I mentioned in the introduction, working on this project has been a lifeline for me through a period of unexpected changes and challenges as I became my mother's primary caregiver for several months after her surgery and during her convalescence, and, later, through a period of unexpected life transitions of my own. This project has given me a way to follow Lorde's advice to confront my fears, to voice them, and in so doing to *encounter* them, to allow them, once unearthed and brought more fully into the open to be my teachers. Again, my hope is that this study contributes to advancing scholarly engagement in education with the interconnected topics of human health and health of individual body-minds. This is no less than what John Dewey called on us to do over a century ago, stating, "Make health an aim; normal development cannot be had without regard to the vigor of the body—an obvious enough fact and yet one whose due recognition in practice would almost automatically revolutionize many of our educational practices."[8]

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[8] John Dewey, *Democracy and Education,* (New York: Start Publishing, 2012), 125.

Caveats, Limitations, and Future Directions

As Martin points out, not every encounter results in education.[9] It is important to acknowledge that a woman may leave the pink war machine no more "pink" than when she entered and without having gained any gender-insubordinate knowledge. It may be that for some women a cancer diagnosis and treatment do not occasion an educating encounter. It may also be true that other educational outcomes exist that do not foster either gender-subordinating or gender-insubordinate thought and action. For example, BGC *autothanatographies* [10] (death and dying personal narratives), are not considered here but deserve sustained attention for what they contribute as BGC curricular resources. The number of death narratives is growing, and metastatic BGC autothanatographies such as Christina Middlebrook's *Seeing the Crab* (1996), Eva Saulitis' *Becoming Earth* (2016), and Nina Riggs' *The Bright Hour* (2017) de-mythologize pink war and speak to the experience of living with body-mind knowledge of the imminence of death.

A focus on questions of care ethics in GI narratives also remains to be addressed as, among other things, GI disrupts parts-focused medicine and may advance an ethic of dialogic relations[11] rather than doctor-directed, patient-centered, or even person-centered care. My son, who graduated medical school in 2019, assures me that empathy training has become standardized in medical education. However, I wonder about the efficacy and effects of imposing objectivist standards for acknowledging shared humanity in doctor-patient medical encounters. Are educative values of care, concern, and connection achieved by meeting

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[9] Jane Roland Martin, *Education Reconfigured: Culture, Encounter, and Change* (New York: Routledge, 2011), 16.

[10] Mary K DeShazer, *Mammographies: The Cultural Narratives of Breast Cancer,* (Ann Arbor: University of Michigan Press, 2013), 175-176.

[11] Martin Buber, *I and Thou.* trans. Ronald Gregor Smith, (New York: Charles Scribner's Sons, 1986). See also, Ronald C. Arnett and François Cooren, *Dialogic Ethics* (Philadelphia: John Benjamin Publishing, 2018).

standardized criterion such as holding a patient's eyes for 5 seconds before looking away? Do simulated and supervised doctor-patient encounters in medical school translate into lived practice? How is the patient role affected in these encounters?

Undoubtedly there are doctors and surgeons who routinely demonstrate respect for their patients, show genuine interest and concern for patients' lives, evidence no discriminatory biases, bullying, or authoritarian attitudes, and include patients in the medical decision-making process without abnegating their responsibility for exercising prudential judgement (placing the patient's well-being first). Susan Gubar (2012) describes her encounters with compassionate doctors and nurses who show her respect and tangibly demonstrate concern for her body-mind welfare.[12] However, Eve Ensler (2013) describes doctors and surgeons dismissing her concerns and recreates a chilling scene of medical violence and bodily violation.[13] In addition to the necessity of promoting dialogic ethics in medical school education, what beliefs, ideas, and actions may advance such a dynamic in patient education? Through what agents and media may women learn to advance dialogic ethics in their cancer care?

Interviews with women in the present is a separate project that may reveal different answers to these questions and raise different issues than an analysis of autobiographic narratives. Additionally, while qualitative, interview-based studies considering the effects of BGC treatment on gender and body image exist and some are citied in this study, interview-based studies focusing on patient perceptions of gender's role in BGC education from various agents and media and among women with diverse, intersecting identities (e.g., race, social class, age, sexual orientation, gender identity) would make valuable contributions to scholarship on gender, health, and education. Additionally, a sustained exploration of BGC patient education in

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[12] Susan Gubar, *Memoir of a Debulked Woman: Enduring Ovarian Cancer* (New York: W.W. Norton & Co., 2012), 239.

[13] Eve Ensler, *In the Body of the World: A Memoir of Cancer and Connection* (United States: McMillian, 2013), Kindle Edition. Kindle Location 613-694.

print and online social media such as pamphlets and magazines in hospitals and clinics, BGC organization websites, online discussion forums, blogs, and other networks of social support, and depictions of these illnesses in fiction, poetry, and art may further contribute to understanding the role of gender and other categories of difference and identity in BGC teaching, learning, and curriculum.

To turn from theoretical research to practical applications of GI in patient education, alongside autobiographical narratives such as *The Gift of Cancer*[14] or *Cancer Vixen*[15] as educational resources in lending libraries or as given to patients as free gifts, narratives such as *The Cancer Journals and Living Downstream* could concurrently be offered and suggested reading. As educational research projects, GS and GI narratives could be featured texts for reading groups and included as curricular resources in high school, undergraduate and graduate courses focusing on gender and health in education, history, sociology, and other fields. To aid these projects and for independent patient education, the development of an open-access, collaborative Wiki site to create an ongoing, annotated bibliography of BGC autobiographical narratives, patient education guidebooks, links to BGC educational nonprofits, and scholarly research books, journal articles, and dissertations would be a helpful curricular resource.

The sheer volume of BGC narratives in commercial circulation speaks to both the growing size of an audience for these narratives and the growing number of women engaging in self-educating, reflective writing practices. To this point, theoretical work focusing on conventional narratives remains to be done. While this study advances the proposition that these

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[14] Linda Ranalli-Mar, *The Gift of Cancer: Miracles Happen When You Change Your Thoughts and Release the Fear!* (Bloomington, IN: Balboa Pess, 2016).
See also, Brenda Micheals, *The Gift of Cancer* (New York: Skyhorse, 2014). There are several books with the title *The Gift of Cancer* or a variation on this title. While Ranalli-Mar's and Micheals' are BGC narratives, others are autopathographies of other cancers. All feature messages of hope and healing through learning to see cancer as conveying spiritual teachings.

[15] Marisa Acocella Marchetto, *Cancer Vixen: A True Story* (New York: Pantheon, 2014).

narratives reveal an overarching, solider-survivor, pink-war theme, like GI narratives, the authors' perspectives also reveal different kinds of perspectives not detailed here. In my preliminary differentiation analysis of conventional, autobiographical texts, I call these "gift of grace," "comedic courage" and "lipstick feminism" narratives. An analysis of narratives mirroring that presented in part II of this study may shed light on values and ideas transmitted in pink war teaching and learning. The point is not to juxtapose "bad" conventional narratives with "good" GI. As I contend in chapter one, all testimonies of illness have intrinsic value as a person's story of a life-disrupting event. All can also be understood as creative projects of self-education.

Closing Thoughts

In consideration of Susan Laird's pressing question for living in the Anthropocene, "Can and should educators adopt, form, transmit, [and] teach ways of living to maintain, if not enhance, Earth's habitability,"[16] a focus on the links between human health, culture, and the environment are needed as part of a gender-inclusive coeducational curriculum. The Young Survival Coalition, a breast cancer organization specifically for women diagnosed under age 40, cites the statistic that "[e]ach year, approximately 70,000 men and women age 15 to 39 are diagnosed with cancer in the US. Breast cancer is the most common cancer for women in this age group."[17]

Directly or indirectly, cancer affects the lives of all persons, not just those diagnosed. Mothers, sisters, grandmothers, girlfriends, spouses, partners, teammates, teachers, colleagues, friends, and neighbors are living with cancer. Many are dying or have died from it. This study brings together a complexly diverse array of parts operating within the pink war machine. When

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[16] Susan Laird, "Learning to Live in the Anthropocene: Our Children, Ourselves," *Studies in Philosophy of Education 36* (2017): 265-282.

[17] Young Survival Coalition, "Breast Cancer in Young Women: Statistics and Disparities,"*Young Survival Coalition* (n.d.). Accessed 21 February 2019. https://www.youngsurvival.org/learn/about-breast-cancer/statistics#2 .

we consider the economic-ecological-epidemiologic connections inside and outside the CIC, it may be that no GI action, either individual or collective, will be enough to fully dismantle the pink war machine. However, this aim may be furthered and gender-subordinating conditions sooner addressed with the aid of education for political action. Nature/culture, male/female mind/body binary biases pervade the deep structure of educational thought[18] and are not going to be easily changed. However, as Martin argues, making the deep structure visible, recognizing it even exists, is a first step.[19] I see GI educational autobiographies recognizing the gender-subordinating, miseducating harms of pink commercialism, medical authoritarianism, and normative narratives as curricular sources for change. To this end, we can count on the pragmatic profit ethic of the pink war machine. If enough people turn a critically questioning eye toward pink war, if we refuse gender subordinating and self-abnegating silences to demand change, and if we work to build a wider construct[20] for how we respond to cancer, the pink war machine may one day become cultural stock we can count as a dead relic rather than a living legacy.[21]

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[18] Jane Roland Martin, *Education Reconfigured: Culture, Encounter, and Change* (New York: Routledge, 2011), 28.

[19] Ibid.

[20] Lorde, *The Cancer Journals,* Kindle location 682.

[21] Jane Roland Martin, *Cultural Miseducation: In Search of a Democratic Solution* (New York, USA: Teachers College Press, 2012), 89.
See also, Martin, *Education Reconfigured,* 128.

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