Coercive Biomedical Body Politics: Redefining Breast Cancer as a Gender-Marked Experience in the Case Study of Linda Park-Fuller's '*A Clean Breast of It*.'

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Abstract: The present paper is mainly concerned with exploring the historical stigma, implicit truths, and chaotic dynamics informing women's breast cancer as the most traumatic, disfiguring, and life-threatening illness. For this purpose, the study investigates Linda Park–Fuller's auto-performance, "*A Clean Breast of It*" – a pre-millennial, Anglo-American, and gender-conscious case study with the aim of delving into the plights of fractured female bodies living with breast cancer and harassed by bio-power. Scrutinizing their fragmented state of consciousness, the study considers the ways these female bodies are discursively shaped, regulated, categorized, and manipulated by the authority of the (mostly male) medical gaze and the body-focused, seemingly empowering pink ribbon culture. Administering a Foucauldian-inspired Feminist Post-structural approach, the study reaches the conclusion that the dramatized plight and subjective experience in the case study of Park-Fuller's auto-performance is a gendered journey of reconstructing the self. Moreover, her active questioning of hegemonic discourses and health-related practices of the sexist bio-power serves in demonstrating the ways gender and power relations are constituted within disease regimes, the means by which the sick female bodies are developed within relationships of power, and the potentialities of their (the sick female bodies') radical transformation.

Keywords: breast cancer narratives, female body, feminist post-structuralism, Foucault's biomedical paradigm, Linda Park-Fuller, pink ribbon culture.

1. Introduction

The female body has long been a patriarchal target of power and a prolonged site for male intervention. Discursively shaped, regulated, labeled, manipulated, and subordinated to the authority of the (mostly male) medical gaze and pink ribbon culture, the fractured female bodies living with breast cancer, specifically their plights and subjective experiences, are at the center of this study. Thus,the present paper works toward exploring the historical stigma, implicit truths, and chaotic dynamics informing women's breast cancer as a traumatic, disfiguring, and life-threatening experience. Apart from the side effects of its treatment, women diagnosed with breast cancer often feel assaulted in their identities, trapped in sick roles and powerless positions, subjected to a series of brutal, extensive, experimental, and invasive procedures of constant surveillance while also being exposed to social expectations of behaviors to which they are not ready to adapt. Instigated by the biomedical conception of the body as "a sum of parts that can be

treated, fixed, or discarded independently (Fernandez 2012:97) ", dramatist, performer, and Professor Linda Park-Fuller explores the relationship between the Foucauldian-inspired Post-structural Feminism and theatrical praxis in her auto-biographical performance, *"A Clean Breast of it",* with certain key objectives in mind. Among these objectives, the performance challenges the audience to look at and beyond her specific breast cancer experience; question the larger socio-cultural context highly pervaded by discriminatory cultural and sexist medical paradigms; demonstrate bio-power's inability to address the human side of breast cancer or even to recognize the ways that might stimulate healing; reconsider Park-Fuller's identity as a woman and as a human being; and promote equality in all areas of experience. The main research questions that guide this study include:

First, how is the female body socially constructed by male power? Or more precisely speaking, why is it viewed as problematic?

Second, does the medical establishment – with its knowledge and specialist practices – offer supportive and empowering contexts where women can accept, experience, and effectively manage breast cancer? Or does this establishment instead limit a patient's options for agency?

Third, in what ways is the Foucauldian-inspired Feminist Post-structural approach strongly implicated in the play under consideration? i.e., how women with breast cancer are positioned, and how do they position themselves in the light of prevailing discourses and practices?

Finally, is the case study of Linda Park-Fuller's *"A Clean Breast of It"* a gendered journey of reconstructing the self, or is it demonstrative of how women are implicated in the creation of their docile, conforming, and disempowered female bodies.

Built upon Foucault's Biomedical Paradigm and situated within a Feminist Post-structural context, the present paper conducts a methodology based on a close reading and in-depth critical analysis of Linda Park-Fuller's *"A Clean Breast of It."* This approach also illuminates bodily aspects of women's oppression within medical settings and highlights how the life-threatening experience of breast cancer (with its psychological stress and emotional burden) is no longer just a medical emergency (not purely physiological/bodily experience). Instead, it is a chronic social condition that interferes with the individual ability to achieve personal goals or function in social contexts, partly due to historical biases and power inequalities.

It is worth mentioning that the rationale for this study stems from the researcher's personal loss of a dear family member and the urge to facilitate better understanding of the collective suffering of women with breast cancer. Apart from striving to shift public perceptions and challenge taken-for-granted 'truths' about this illness, the researcher seeks to allow other discourses, subjectivities, and discursive practices to be recognized, explored and brought into play. Thus, this paper, hopefully, seeks to turn scholarly attention to gender-conscious auto-performances and to their significance and implications for broader debates about women's subjectivities.

2. Research problem

2.1. The female body as a life-long territory of male intervention

The female body has long been a territory of male intervention and an ever-persisting space of patriarchal hegemony. This age-old and complicated history of male dominance has permeated every dimension of human activity from religion, history, and philosophy across popular culture, critical disciplines, artistic representations, and scientific knowledge. Situating men in the leadership position and constructing them as the universal referents, the patriarchy positions women as subordinate and relegates them to the position of the 'Other'. They have thus constructed the female bodies, dispossessed them of their agency, subjected their minds to male maneuvering, and converted them into passive objects who interiorize the socio-cultural male values.

Among the multiple physical and social androcentric contexts that negatively affect women's psychology and manipulatively trigger their self-objectification is the artistic representation of women in the film industry. These oppressive practices of representation have situated the female body as the consumable vessel, desirable object, and sexual prop for the pleasure of the male viewer. Thus, these practices do not represent female characters as principal and empowering, but they are instead framed from a masculine, heterosexual perspective as visual supports for the male characters, passive subjects of observation, and bodies "in ostentatious display of breasts, legs, and buttocks (Neroni 2005:41)." This androcentric scenario has governed and still determines other social constructs like advertisements, magazine covers, pin-up images, and social media. One can easily discern how the bodies of female celebrities are typically shown and provocatively framed as attractive and sexy to feed the sexual interest or agenda of the male viewers. Showing lots of skin; wearing bikinis, heels, and tight dresses; having faces in full make up; and dancing in a sexualized manner are but instances of the process of habitual female body monitoring. In daily interpersonal experiences and interactions as well, women – obsessed with looking their best for the male gaze – struggle to shape their deficiently deemed bodies to fit the contours of androcentric ideals of female beauty. Many such women turn to risking their health by dieting, binging, purging, and having multiple cosmetic surgeries, such as tummy tucks, gastric sleeves, and re-routing stomach path – all for the sake of meeting men's sexual needs (Morgan 2008:25-53).

Suffering from the objectifying male perspective of women only as desirable objects, women must bear the burden as well of feeling unsafe and insecure. For even walking on the streets without fear is a privilege often reserved only for men. For many women, street sexual harassment is almost expected and often accepted with silence. Feeling that their bodies are objectified, many women would prefer to be invisible rather than being harassed by unwanted sexual looks, comments, or lewd gestures, or by actual or attempted rape and sexual assault (Weitz 2003:3-11).

Reinforcing stereotyped notions of female sexuality and gender inequality, patriarchal society tends to perpetuate the role of toxic masculinity within the medical sphere. Despite the obligations of the states to respect, protect, and fulfill rights related to women's sexual and reproductive health, health care professionals'

violations of these rights are frequent and diverse. Comprising all procedures that "involve partial or total removal of the external female genitalia… for non-medical reasons (WHO 2016)," genital mutilation is a form of violence against female bodies that has been around for more than a thousand years. Painful, humiliating, and traumatic, this practice has no scientific merit or clinical basis. It is instead a grave violation of human rights, medical ethics, and women's "privacy, physical integrity, and further disempower(s) them (WHO 2018:3)." The social pressure upon females to conform as well as their fear of being rejected by the community are strong motivations to perpetuate this practice.

Evidence has shown the range and extent of mistreatment to which female bodies are subjected during pregnancy and childbirth. Among the forms of obstetric objectification that systematically disempower women and impede their ability to decide freely about their bodies and sexuality are physical and verbal abuse; experiences of discrimination, abandonment and neglect; denials of privacy and confidentiality; and non-consented procedures and non-supportive clinical care (Brand, Peg & Granger 2011:215-236). In addition, the act of forcefully ending a woman's reproductive capacity through either contraception or forced sterilization is an objectifying practice considered normal in society. Despite the objections of the WHO that considers these practices as 'torture and cruel, inhuman, and degrading' such procedures still occur in many settings and contexts. Continuing the vicious cycle of oppression, the burden of contraception, which often involves unhealthy chemicals that do great harm, falls disproportionally on women. The contraceptive experience is therefore 'stratified' since the female body is the one who often has to take the risk (Danish Institute for Human Rights 2014).

The view of women's bodies as inherently defective and in need of external regulation is not confined to just reproduction. This male view extends to the authority of the medical institutions (hospitals and clinics) and their (mostly male) health care practitioners providing this care to breast cancer female patients.

2.2. Breast cancer as a life-threatening illness and traumatic experience

Widely considered as the defining plague of our generation and the second leading cause of death among women, breast cancer has long been known as a serious, chronic, formless, timeless, life-long illness and pervasive adversary. The emperor of all maladies and the king of terrors (Khorana 2010:994), breast cancer abruptly alters the balance and social life of women, reconfigures their entities, and activates processes of revision of the meanings of life, suffering, illness, and death (Aydin, Gulluoglu & Kuscu 2012:6-9). Developing if the immune system is not working properly and/or number of cells produced is too great for the immune system to eliminate (Khuwaja & Abu-Rezq 2004:235-242), diagnosed breast cancer requires the surgeon to determine the most effective treatment, such as radiation therapy, chemotherapy, hormonal therapy and, more recently, nanotechnology and gene therapy. However, the treatment of breast cancer and its side effects can often be harsh and unforgiving (Breast Cancer.Org 2021). But the side effects of the treatment of this illness are not the only burden metastatic breast cancer (MBC) female patients must bear.

Most women diagnosed with breast cancer, if not all, tend to adopt strategies to cope, redefine themselves and their lives accordingly, partly to manage the associated worries affecting their personal, physical, psychological, social, and family lives (American Cancer Society 2009). Among the worries experienced are: The threat of the disease spread or recurrence; end of life considerations; the side effects of chemotherapy (the changes in appearance, the loss of feminine physical characteristics, and the consequent negative body image and low self-esteem); the hectic practices for long-term wellness; the frightening possibility of their offspring inheriting the disease; the reluctance to disclose information; the reaction of family members; the threat of marital discord; and the possibility of being 'outed' by the community (Stephan 2007). A women diagnosed with breast cancer – and overwhelmed with the idea of her own mortality – reports:The word death always rings in my ear...the fear of recurrence affects my life...I worry about my future in terms of my marriage life and my work...the word cancer is, especially, a big word (Al-Azri, Al-Awisi…and Al-Moundhri 2014:17).

Another female breast cancer patient declares: "I could not sit or sleep alone; I was always calling my children to be beside me, scared of dying alone, without seeing them (17)."

In addition to being a fear and anxiety-inducing illness, breast cancer has hitherto – and until recently – been a hush-hush, 'whispered about' topic (Brody 2001:6). Many women are less likely to disclose cancer to neighbors or associates for fear of being socially judged, rejected, isolated and stigmatized. Stereotyped as being less productive in the workplace, women with a history of breast cancer often find it difficult to return to work after an illness-related absence, or to try to secure new employment. Furthermore, breast cancer is constructed through several religious discourses as related to personal sin, and thus may be seen as a form of punishment. Even medical discourses have positioned breast cancer as caused by cancer-prone personalities (Sontag1977, 2001). Dr. Hayes Agnew believes that anxiety and worry, both feminine attributes often problematically ascribed to women, predispose women to breast cancer (Goodbody1994:32-51). Breast cancer has also been framed as a disease that women could prevent and control if they assumed full personal responsibility in taking preventive measures. In other words, women often feel that "they are to blame for not detecting the disease earlier or having failed to pursue the most aggressive treatment (Wong 2008: 579-594)." Finally, the belief in the impossibility of recovery, that nothing can be done to prevent cancer, and that cancer is always fatal, are all part of the dangerous social attitudes toward cancer (Wilson & Luker 2006).

2.3. The Pink ribbon culture as (a seemingly) ultra-positive women's health initiative

In contrast to the previously negative, distancing, minimizing, and unsupportive breast cancer-related beliefs and myths, an ultra-positive women's health and cause marketing initiative, known as pink ribbon culture, has emerged. Actively

advocating more hope, awareness, funds, empowerment, and individual responsibility to produce a reliable, permanent cure, this pink-themed initiative constructed and celebrated three intersected discourses and imperatives: the discourse of optimism, the imperative of individual responsibility, and the all-important feminine/beauty ideal.

The discourse of optimism entails that any woman diagnosed with breast cancer who demonstrates acceptance of the illness, or the possibility of death, is positioned as 'giving up' on herself and 'letting down' all women. On the other hand, any woman who confronts and overcomes her illness is viewed as appreciating life more, inspirational to others, and as a model of treating breast cancer as an opportunity for self-growth (Herndl 2006:221-245). These women are thus positioned as an empowered heroine and an idealized, assertive, self-reliant, strong, and courageous patient. Constructing optimism as a moral imperative, the pink-themed initiative also honors the imperative of individual responsibility, which locates the management of illness as individual responsibility. Thus, it marginalizes women who are not vigilant or pro-active in detecting, preventing, or recovering from breast cancer. Likewise, this pink ribbon culture emphasizes the imperative of patriarchal female beauty ideals. Hence, many associated programs are launched to encourage restoring women's looks, feminine identity, and sense of wholeness and self-worth. Offering advice on how to feel attractive during and after breast cancer treatment and stressing the beauty remedy of 'look good; feel good,' this pink-themed culture encourages women to "wear their survivorship with pride, elegance, sensuality, and the perfect blend of cosmetic enhancements (Sulik 2010)."

3. Michael Foucault's conceptual framework and the Feminist Post-structural theoretical perspective

Michael Foucault's conceptual framework and the Feminist Post-structural theoretical perspective are two current substantial lines of thought that highlight the interplay between power, knowledge, discourses, and reality in constructing gender hierarchies and manipulating, training, and marking female bodies as gendered subjects. Foucault's conception of modern power contrasts existing models that regard power as domination – a centralized and repressive force, a physical coercion, or a suppression of desire and truth – exerted by one group over another. The novelty of Foucault's model thus stems from conceiving power as omnipresent, "not because it embraces everything, but because it comes from everywhere (1977: 86)", as it is dispersed throughout society, inherent in social relationships, and embedded in a network of practices, institutions, and technologies. Maintaining further that power operates by producing 'knowledge and desire', Foucault demonstrates that the type of knowledge produced – not neutral or objective – is inseparable from power. It is the knowledge that represents perspectives, norms, conventions, and motivations. It is the knowledge that influences the behaviors of individuals and has a controlling effect on their bodies. Power, according to Foucault, operates as well by producing desire, i.e., making the norms appear moral or right. It operates further by marking those who fall outside these norms as

deviants who should be targeted with disciplinary strategies and regimes designed to neutralize their deviance.

> Power would be a fragile thing if its only function were to repress, if it worked only through the mode of censorship, exclusion, blockage, and repression... If, on the contrary, power is strong, this is because, as we are beginning to realize, it produces effects at the level of desire … and at the level of knowledge. Far from preventing knowledge, power produces it (1980 b:59).

The manipulation of knowledge and desire, as Foucault maintains, proves that power is strongest and most successful when it can mask itself and hide its mechanisms. Apart from making that which is repressing and constraining appear positive and desirable, power can also be disguised as resistance or empowerment. Finding new ways of manifesting itself or re-asserting itself in a new guise, power – Foucault (1980 a:139) maintains – subtly links free will to will power and empowerment to self-discipline. Concealment thus allows the normalization and legitimization of these discursive practices and makes possible hegemonic power structures.

Providing a new way of understanding power, Foucault (1975:206) maintains further that the previously mentioned norms of discipline, regulation, and subordination enforced in the governmental setting are extended as well to the medical institutions and the regime of bio-power. At the level of ideology, the transferring of control to the authoritative clinical establishment and its 'scientific knowledge' results in the creation of two discourses: The learned clinical discourse to which individuals desire to conform, and the discourse of risk that considers any deviation from it as dangerous and unethical risk-taking. Meanwhile, at the level of practice, the dissemination of the medical discourse leads to the clinical establishment's tighter control over patients' bodies and even conduct through a set of medical procedures and disciplinary practices, such as "scans, punctures, x-rays, analyses, blood pressure control, experimentation with drugs, … etc. (Foucault 1974:45)." Working in concert with the physicians' coercive treatment of patients' bodies as things is another mode of clinical manipulation and subjugation that systematically categorizes, classifies, and distributes subjects as sick or healthy. Patients thus become tied to docile identities by conforming to the routines and procedures of hospital staff unquestioningly.

Rooted in the work of French philosopher Michael Foucault and built on his conceptual framework, Feminist Post-structuralism [FPS] emerges as a comprehensive and complex theoretical perspective equally conscious of how ideas and, by extension, discourses work to construct the world – especially gender hierarchies and hegemonic masculinity. Illustrating how Foucault's meditations on power, discipline, and subjectivity are particularly pertinent to feminist analysis and discussions of fractured female bodies trapped in sick roles, FPS thus makes other power relations "visible, analyzable, and revisable" (Davies and Gannon 2010:312). Including other potentially oppressive binaries such as health care providers and care recipients, FPS renders clear these binaries that grant normality, rationality, and naturalness to the dominant term and mark the subordinated term

as the 'other'. FPS thus makes visible the constitutive force of language and dismantles its apparent inevitability and significance. For it is only through construction in language that "'things' – objects, subjects, states, living beings, and material structures – are given meaning, socially constructed and endowed with an identity (Shapiro 1981:218)."

Claiming that language does not carry meaning in and of itself, but only as it occurs within particular cultural narratives and through the discursive and interactive processes of everyday life (Davies 2000a), FPS analysis then works toward revealing how discourse can position experience in particular ways, can produce versions of reality that appear inappropriate, and can make us think, act and create fictions that are comfortable for us or that we wish to live in (Gough 1991:31-42). Equally important is FPS's respective analysis of the notion of subjectivity. From an FPS perspective, subjects cannot claim to be authors of their ideologies (Weedon2004) as they are "'subjects of' cultural narratives or storylines. They have no fundamental or essential selves nor have an independent consciousness or core." Instead, "they speak and act from within an existing discourse and they produce others' social and psychological realities (Davies 2000a:55)." Hence, it is ideology that constructs the understanding of oneself and of what is both possible and permissible.

Among the articulations and assumptions of FPS is the notion of category. The FPS subject is thus constantly (re)inscribed as a subject within a category and asserts – through self-disciplinary acts – what acceptable membership (i.e., behaviors, dress...etc.) in the category looks like (Davies 2000a). Hence, to belong successfully to the category and be an acceptable subject, the FPS subject must speak and act appropriately in ways that are regulated by discourses. Failure to be constructed in accordance with the category is to risk condemnation.

FPS theorizing reflects also on positioning. It maintains that in the context of medical setting, the health practitioners – whose subjectivities have been produced by discourses of 'science as truth' – are positioned as the legitimate all-knowing leaders in the field, whereas the patients are positioned as the illegitimate others. Meanwhile, the female subjects agree to assume these "multiple positioning and desire to correctly constitute themselves within the discourses available even if they may be contradictory and/or oppressive and no one would ever rationally choose (Davies2000a:74)." In doing so, these female subjects place themselves within the hegemonic discourse of science and reinforce it as legitimate or as one having authority (Davies 1990).

The final central focus of FPS is agency. No longer the concept of the female standing outside or against social structures and processes – opposing, resisting, subverting, and decomposing the discourses through which she is constituted – FPS's agency becomes instead a recognition of the power of discourse, i.e., the love of, immersion in, and debt to that discourse. FPS's agency also considers the capacity to multiply possibilities, to boost ways of thinking about 'male' and 'female', and to generate new subjectivities capable of disrupting or eclipsing gender discourses and regulatory practices. It is the possibility of moving beyond

what is already known and understood (the male/female binary) to other not-yet-known lines of flight (Davies et al. 2010:319).

4. Linda Park Fuller's auto-performance *'A Clean Breast of It'*

Working towards chronicling cultural, social, and political tendencies around breast cancer, the present paper thus approaches Linda Park-Fuller's autobiographical solo-performance, *'A Clean Breast of It'* (1993), as a notable anglophone, women-centered one-act show that incorporates therapeutic gender perspectives. A straight-forward personal narrative, the play is composed four years after dramatist, performer, and Professor Park-Fuller had gone through her experience of breast cancer. Apart from interpreting her own life story and arduous battle with breast cancer, '*A Clean Breast of It'* seeks as well to reconstitute the world in less oppressive ways and "unmask layers of power unrecognized in institutional establishments (Davies et al. 2006:12)."

Aiming to set a dialogue between her and the audience by destroying the fourth wall, and to counter any suggestion that hers is a universal cancer story, Park-Fuller (the narrator/performer) opens the performance walking to the center of the stage and introducing the performance with a heart-felt dedication:

> This performance is for all those who have struggled with breast cancer – those who have survived and those who have not. They all have their own unique stories, and I do not claim to speak for them. But I dedicate this performance to them (2003:222).

Moreover, assuming no knowledge of breast cancer experience among her audience and emphasizing her own ignorance of the disease as well prior to diagnosis, Park-Fuller adopts the strategy of a conversational personal narrative. To contextualize her individual tale, she stimulates the audience's own involvement in the story by directing questions to them. These questions revolve around breast cancer and include essential information about its impact on relationships. Critiquing its treatment and letting the audience recognize that they can be affected as well in significant ways and at any time, Park-Fuller asks: "How many people in the United States will be diagnosed with breast cancer this year?" "(Radical mastectomy?) What is that?" "Doesn't anyone talk to anyone else in this hospital?" and "How do you make love to a woman with one breast? (222, 225, 230). " She then adds the rhetorical question "Is anybody paying attention? (230) " to confront the audience with the fact that they are also responsible to act.

In a minimalist setting, Park-Fuller crosses to a downstage area then back to the audience. She picks up a guitar (something she had always wanted to learn) and then sings – with untrained voice and simple chord changes – an opening song entitled 'It will Come to Me':

> It will come to me just like a song.
> It will make it up as I go along.
> The push and pull, the give and take
> will even out, for goodness' sake.
> The sun might shine, or the wind might blow.
> I cannot say, because I do not know

whatever it is that meant to be (222).

The simplicity of the song reinforces the improvisational nature of life. Moreover, it becomes a clear-cut manifestation of what Park-Fuller has learned about living from her breast cancer experience.

To balance her life after diagnosis and surgery by playing the guitar, Park-Fuller interrupts the performance three more times with her singing:

> I want to learn to love, myself and others, unconditionally.
> I want to learn to forgive. (Singing)
> I have spent so many yesterdays worrying about forever.
> But no amount of worry makes the day go any better.
> And no amount of planning makes the difference worth a time.
> Whatever's goanna happen; it is goanna take its own sweet time.
> And it will come to me just like a song… (226-7).

In a clear and simple language, Park-Fuller then explains carefully what she has learned about how cancer attacks the body with its own cells:

> What fascinates me most is that cancer is all about communication – intercellular communication, and about how the cells communicate (or fail to communicate) with one another. When you think about it, cancer is just one big misunderstanding (228)!

Actively involved in reflecting on and learning more about her life-threatening disease, Park-Fuller then quotes a poem entitled *'Faith':* When you walk to the edge of all the light that you have and take the first step into the darkness of the unknown, You must believe one of two things will happen:

> There will be something solid for you to stand upon or you will be taught how to fly (234).

Throughout the performance Park-Fuller also interrupts her narrative with an electronic timer. Setting the timer near the beginning of the performance and not knowing when it will sound Park-Fuller states:

> Whenever it goes off, the narrative is interrupted. I stop, turn it off, and reset it – allowing time for the significance to set in – and then try to pick up the narrative, but without attempting to precisely resume and skipping entire parts, if necessary (227).

Like the cancer that occurred so unexpectedly, the sounding of the electronic timer interrupts Fuller's (the survivor's) narrative at frequent intervals (every thirteen minutes). It thus painfully illustrates the fact that this illness narrative is a typical disruptive one. Described as a three-fold strategy by Park -Fuller herself, the use of the timer serves

> First, as a social-medical critique, it sharpens our comprehension of how many people die from the disease and how little progress has been made against it. Second, aesthetically, it symbolizes the theme of life's interruptions and improvisation, since I, as performer, cannot predict exactly when the timer will go off. Like the cancer that occurred so unexpectedly, forcing me to stop, reevaluate and revise my life, so the sounding of the timer forces

> me to stop and revise my performance. And third, ethically, the timer evokes awareness of others whose stories do not end so fortunately as mine (218).

Aiming to deconstruct the patriarchal, biomedical body politics, Park-Fuller makes her critical attitude towards the medical establishments obvious from the very beginning and throughout the whole narrative. At one point, for example, Park-Fuller (2003:229) explains that the funniest thing that occurred at lunch one day was when they (the hospital) served her a six-ounce can of diet Shasta Soda Pop. As she was pouring it into the glass, she noticed a printing on the side of the can which said: "Warning: This product contains saccharine which has long been known to cause cancer in laboratory animals (229)." Surprised, Park-Fuller asks and explains:

> Huh! Doesn't anyone talk to anyone else in this hospital? I mean, for what am I here in? … So that is when I realized that if I thought behavioral changes were going to make a difference in preventing recurrence…then I would have to initiate them myself (229-230).

At another point, Park-Fuller introduces a critique to the economy-centric health policy of the U.S., which clearly fosters inequality. She questions the cost of cancer drugs and mentions the unavailability of insurance to many women by asking: “Why is it that in Canada and other countries sixty tablets of the cancer drug, tamoxifen, sell for $12.80, whereas in the United States, those same sixty tablets of the same tamoxifen drug sell for $156.42(232)?” Park-Fuller thus demonstrates bio-power’s inability to address the human side of breast cancer or even to help in recognizing or promoting strategies that might stimulate healing.

> In another context, Park-Fuller targets her critical discourse at the medical professionals treating her. Making all the decisions without consultation and maintaining a narrow perspective that does not include analyses of possible environmental or lifestyle influences, the male surgeon abruptly tells Park-Fuller right after diagnosis: "We'll have to do a modified radical mastectomy (225)." Like the most traditional cancer reasoning described by Susan Sontag (1997: 63), it was a case of physicians (soldiers) against cancer (enemy) in a non-stop battle where the female body becomes the field of chemical and radio therapeutic warfare.Doctors, the medical establishment, were not talking about diet or meditation or exercise. They did not tell me how to help myself. They were going to treat my cancer in just two ways: surgery and drugs (Park-Fuller 2003: 226).

Accordingly, the sick female here is violently erased from the equation, and what is treated is the cancer itself, not Park-Fuller as a subject who needs her various complex and disabling psychological features of living to be considered.

Apart from the politicization of breast cancer itself, Park-Fuller places great emphasis on the importance of the female voice in transcending its traditional space and reaching the public sphere. So, bearing witness, regaining power over language,

giving a central position to sick women's experiences, facing the loses made by cancer, and sharing these all – are crucial strategies employed by Park-Fuller. For she believes that the very act of speaking one's story publicly "is a move toward subjecthood; toward agency, with political implications (Cohen 2006:104)."For this purpose, Park-Fuller makes her agency obvious from the very first line of the autobiographical monologue. Seizing control of the dramatic discourse, Park-Fuller keeps the lead of her story always in her own hands. She inscribes the voices of the unheard females going through the experience of breast cancer in the universal and objective medical history. She breaks away from the initial 'accommodating patient' identity that she has been taught to internalize (109) and exercises agency through the verbalization of anger.

> Park-Fuller insists on the inscription of her voice as the subject of a narrative that forms part of an oppositional discourse promoted by the 1990s breast cancer movement – a discourse that reinterpreted the meaning of being a woman with cancer, challenged existing stereotypes of how they should behave, and demanded recognition of a new paradigm (Fernandez 2012:132).

The need to tell her story in her own words is the motivating force throughout the performance. This agency is made obvious also when Park-Fuller proudly assures that she still feels beautiful, sexy, and powerful. And, most importantly, in the inspirational end of the performance, when Park-Fuller feels lucky for the things that she had once seen unfortunate, she states:

> I was lucky because I found the lump in time, and so many people do not. I was lucky because I had a good medical team and a good insurance, and there are millions of women, even in this country, that do not have that luxury. And I had good support from my husband, my family, and my friends … (Park-Fuller 2003:233).

As a non-conformist woman, Park-Fuller rejects the position of victim or sick/patient who has nothing to do but accept treatment and wait passively to be cured, whatever the physical or psychological price. She manages to escape the dialectical trappings of the medical establishment which turn the sick female body into just a 'patient'– a collaborator in her own oppression and a self-regulating subject in the Foucauldian sense. As a non-conformist woman, she instead takes an active role in shaping her own recovery. She attains this by speaking out about her and other women's physical and psychic losses, needs, demands, sacrifices, rages, and aspirations, and by:

> telling of pain, of medical exploitation and coercion, of fear in the face of powerful medicalizing macro-institutions, and of degradation and violence directed at them by those entrusted with the medical gaze in micro-institutional settings and by those holding a monopoly over healing technologies (Morgan 2008:10).

As a confrontational attitude against these gender-blind, standard medical practices, Park-Fuller puts her text and body on stage. She employs different dramaturgical techniques – 'transgressive discursive strategies' – that serve in

highlighting Foucault's conceptual framework and the ongoing Feminist Post-structural project of consciousness-raising and socio-political transformation. To rewrite the identity of the sick and/or dying women, connect her story to the larger context of breast cancer experiences, and invite the audience to view her as a friend, Park-Fuller eliminates 'the middleman.' Utilizing simple colloquial language, she speaks directly, clearly, and humbly about her journey in a strongly testimonial style. Her language is thus "too intentionally vernacular, as she sprinkles the script with 'you know,' 'oh', 'oh boy', 'oh man', and 'you see' (Edwards 2003:184)."

Similarly, Park-Fuller manages to do a great deal of teaching along the way. Believing in the rich potential of using personal narratives to educate people, Park-Fuller (2003:216) maintains: "Trained as a performing artist …, I did not consider myself a "writer" but an appreciative critic and a "page to stage" translator of writers' words and the worlds they evoked." Moreover, Park-Fuller makes use of a chronological organizational structure. She narrates her experience from the moment of discovering a lump in her breast, through diagnosis, analysis, surveillance, and treatment, and the first few months of re-orienting her life after cancer. Park-Fuller wants to make sure that "the audience understands the emotional and practical impact of breast cancer (Edwards 2006:143)."

In addition to Park-Fuller's educational narrative, the performance includes outrageous humor, which serves as a healing force evoking the audience's astonished laughter. It includes excerpts of song that break up the narrative, reinforcing the theme of improvisation and providing unity to the performance by their repetition throughout. The performance also includes information about breast cancer research and treatment in addition to cancer-related poems borrowed from other writers. Additionally, the whole one-act play is told in the form of a conversation with the audience to bring them into the same performing space and eliminate any walls that separate the audience from performer.

To demonstrate her desire to connect with the audience, trigger their own involvement in the story, and disrupt the image of the silent and passive patient, Park-Fuller interrupts the narrative with the question-answer frame. Likewise, the movements, positions, and non-stop crossings through the presentation space help Park-Fuller dominate the stage and create connection and intimacy with the audience. Following the school of Feminist Brechtian theatre and working within its traditions, Park-Fuller rejects the realistic convention of mimesis that prevailed in traditional dramatic theatre. She focuses instead on the re-examination of history, the performer-audience relationship, the utilization of limited movements and gestures, as well as the emphasis on words rather than on a character's acting – i.e., the verbal rather than the non-verbal (Ibrahim 2020:22-39).

5. Conclusion

To conclude, finding Foucault's concept of power and his analysis of the clinic useful, expressive, and applicable, and recognizing that the Feminist Post-structural approach coincides with Foucault's original proposals, the present study thus draws on the two frameworks to denounce gender-marked and inequality practices in medical settings. Illuminating bodily aspects of women's oppression – their

treatment as cases, numbers, sets of symptoms, and not as independent persons anymore – the study thus highlights the control of the medical professionals who privilege specialized knowledge over nurturing and care and hamper any meaningful patient-doctor interaction. Rather than offering supportive or empowering contexts where women can accept, experience, and effectively manage breast cancer, these medical professionals eliminate the sick women's identities, suppress their need to express their plights, and limit the consideration of other aspects (like emotional distress) from which they may have needed to recover as well. For the medical professionals solely focus on the healing of the biological female body (its physical scarring), on the continued surveillance for the recurrence of disease, and on the production of docile, conforming, and disempowered women patients.

An investigative case study beyond physical pain, *"A Clean Breast of It"* demonstrates different gender-conscious dramatic strategies for this purpose: The use of simple colloquial language to invite Park-Fuller's audience to view her as a friend who manages to do a great deal of teaching along the way; the placement of the author/performer's body at the center of the stage to make breast cancer and its personal and political effects on women visible; the breaking of the fourth wall, the conversational personal narrative style, and the question-answer frame to render the audience active participants in the production and transform illness from an individual into a collective phenomenon. Also, the songs, poems, information, and statistics quoted are all efforts by Park-Fuller to inform, educate, and raise consciousness about breast cancer as a potentially lethal disorder. The pervasive outrageous humor in the performance is itself a healing force. The movements, positions, gestures, and perpetual crossings of Park-Fuller help her dominate the stage and achieve connection and intimacy with the audience. The use of the electronic timer helps in symbolizing the death rate of breast cancer in the United States and illustrates the fact that this illness narrative is a typically disruptive one. The chronological organizational structure, the re-evaluation of history, the emphasis on the verbal rather than the non-verbal, and the rejection of the realistic convention of mimesis are all at the service of Park Fuller's ends.

To sum up, by daring to name and make explicit on her stage the issue of breast cancer and maintaining her and other women's ill – but surviving – bodies at the center of the discussion, Park-Fuller becomes a key agent in the process of making this illness and its terrible stigmas visible. By rejecting to conform to biomedical and social expectations that imply dependence, passivity, and obedience to the biomedical rules, she makes her mark in resisting the profoundly lacking traditional bio-power(s) and keeping its flaws on the front line. Moreover, by winning her battle against cancer with courage and faith, breaking out of the prescribed, marginalized role of patient-victim, she empowers sick women to take over the authorship of their own lives, make their radical transformation possible, and emphasize their female bodies as sites of power and resistance. Finally, by putting gender-conscious dramatic strategies into play, Park-Fuller reinforces a new paradigm of restructuring identities, reshaping relationships, re-imagining lives, and re-interpreting the meaning of being a woman diagnosed with breast cancer.

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References

Al-Azri, Mohamed, et al. (2014). *Psychological Impact of Breast Cancer Diagnosis among Omani Women*. U.S.A: National Library of Medicine.

American Cancer Society. (2009). 'What is breast cancer?' https://www.cancer.org/docroot/CRI/content/CRI_2_4_1x_what_is_breast_cancer_5.asp (Retrieved on 13 March ,2022).

Aydin, Elvin, Bahadir M. Gulluoglu, and Kamal M. Kuscu . (2012). 'A psychoanalytic qualitative study of subjective life experiences of women with breast cancer'. *Journal of Research Practice*, 8(2), Nov.: 6-9.

Brand, Peg and Paula Granger. (2011). 'The aesthetics of childbirth'. In Sheila Lintott and Maureen Sander-Staudt (eds.), *Philosophical Inquiries into Pregnancy, Childbirth, and Mothering: Maternal Subjects*, 215-236.New York: Routledge.

Breast Cancer. Org. (2021). Stages of Breast Cancer. https://www.breastcancer.org/symptoms/diagnosis/staging.jsp (Retrieved on 19 February ,2022)

Brody, Jane E. (2001). 'Personal health. The deadly whisper of ovarian cancer'. *The New York Times*, Oct. 02: 6.

Cohen-Cruz, Jan. (2006). 'Storytelling redefining the private: From personal storytelling to political act'. In Jan Cohen-Cruz and Mady Schutzman (eds.), *A Boal Companion: Dialogues on Theatre and Cultural Politics*,103-113. London: Routledge.

Danish Institute for Human Rights. (2014). Reproductive Rights Are Human Rights. https://www.sciencedirect.com/topics/social-sciences/reproductive-rights (Retrieved on 19 February,2022)

Davies, Bronwyn. (1990). 'The problem of desire'. *Social Problems*, 37(4): 501-516.

Davies, Bronwyn. (2000). *A Body of Writing*. Oxford: Rowan & Littlefield.

Davies, Bronwyn, et al. (2006). 'Constituting the feminist subject in post-structural discourse'. *Feminism & Psychology*, 16 (1):87-103.

Davies, Bronwyn and Susanne Gannon. (2010). 'Feminist / post structuralism'. In C. Lewin and B. Somekh (eds.), *Research Methods in the Social Sciences*, 312-319.Thousand Oaks, CA: Sage Publications Inc.

Edwards, Paul. (2006). 'Performance and beyond literature'. In Judith A. and D. Soyini Madison (eds.), *Hamera*. *The Sage Handbook of Performance Studies*,143-150.Thousand Oaks, CA: Sage Publications Inc.

Fernandez-Morales, Marta. (2012). 'The new breast cancer (im)patient: Female revolt against biomedical violence in US drama.' In B. Ozieblo et al. (eds.), *Performing Gender Violence*,97-132.New York: Palgrave Macmillan.

Foucault, Michel. (1975). *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. by A.M. Sheridan Smith. New York: Vintage Books.

Foucault, Michel. (1977). *Discipline and Punish: The Birth of the Prison*, trans. by Alan Sheridan. London: Allen Lane.

Foucault, Michel. (1980a). *The History of Sexuality. Volume I: An Introduction*, trans. by Robert Hurley. New York: Vintage.

Foucault, Michel. (1980b). 'Power/Knowledge'. In Colin Gordon (ed.) *Selected Interviews and Other Writings 1972-1977*,55-62. Brighton: Harvester.

Goodbody, Bridget L. (1994). 'The present opprobrium of surgery: 'The Agnew clinic and nineteenth century representations of cancerous female breasts. '*American Art*,8 (1):32-51.

Gough, Noel. (1991). 'Narrative and nature: Unsustainable fictions in environmental education'. *Australian Journal of Environmental Education*, 7:31-42.

Herndl, D. P. (2006). 'Our breasts, our selves: Identities, community, and ethics in cancer autobiographies'. *Signs*, 32(1):221-245.

Ibrahim, Hala. (2020). 'Illness narratives and audience engagement in Linda Park Fuller's A clean breast of it and Susan Miller's My left breast'. Textual *Turnings*, 2 (1):22-39. https://ttaip.journals.ekb.eg/article_133415_96db37653dcb96e6cd1f6168f3ca3fda.pdf (Retrieved on 19 February, 2022)

Khorana, Aloka. (2010). 'The definitive history of the fight to cure cancer'. In Siddhartha Mukherjee (ed.), *The Emperor of All Maladies: A Biography of Cancer*,993-994.New York (NY): Scribner.

Khuwaja, G.A. and A.N. Abu-Rezq. (2004). 'Bimodal breast cancer classification system'. *Pattern Analysis and Application*, 7(1), April:235-242.

Morgan, Holmes. (2008). *Intersex: A Perilous Difference*. Cranbury, NJ: Associated University Press.

Neroni, Hilary. (2005). *The Violent Woman: Femininity, Narrative, and Violence in Contemporary American Cinema*. Albany: State University Press of New York.

Park – Fuller, Linda. (2000). 'Performing absence: The staged personal narrative as testimony'. *Text and Performance Quarterly*, 20 (1):20-42.

Park – Fuller, Linda. (2003). 'A clean breast of it.' In Lynn C. Miller, Jacqueline Taylor and M. Heather Cover (eds.), *Voices Made Flesh. Performing Women's Autobiography*, 215-236. Madison, Wisconsin: The University of Wisconsin Press.

Shapiro, Martin M. (1981). *Language and Political Understanding. The Politics of Discursive Practices*. New Haven: Yale University Press.

Sontag, Susan. (1977, 2001). *Illness as Metaphor and Aids and its Metaphors*. New York: Picador.

Stephan, Punitha. (2007). 'What you need to know about breast cancer symptoms. *About. Com: Breast Cancer*. Dec. 06. http://breastcancer.about.com/od/whatisbreastcancer/a/bc_symptoms.htm. Accessed19Feb.2022 (Retrieved on 19 February,2022)

Sulik, Gayle A. (2010). *Pink Ribbon Blues. How Breast Cancer Culture Undermines Women's Health*. New York, NY: Oxford University Press.

Weedon, Chris. (2004). *Feminist Practice and Post Structural Theory*. Second Edition. Malden, MA: Wiley Blackwell.

Weitz, Rose. (2003). 'A history of women's bodies.' In Rose Weitz (ed.), *The Politics of Women's Bodies: Sexuality, Appearance and Behaviour*, 3-11. Oxford: Oxford University Press.

WHO. (2016**).** *Female Genital Mutilation/Cutting: A Global Concern*. New York: UNICEF.

WHO. (2018). *Eliminating Virginity Testing: An Interagency Statement*. Geneva: World Health Organization.

Wilson, K. and K. A. Luker. (2006). 'At home in hospital? Interaction and stigma in people affected by cancer'. *Social Science and Medicine,* 62 (7):1616-1627.

Wong, Nancy. (2008). 'The cultural construction of risk understandings through illness narratives.' *Journal of Consumer Research*, 34 (5), Feb.:579-594.