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# Rethinking Gender and Epistemic Injustice: A Comparative Study of Male and Female Breast Cancer Memoirs

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**Abstract:** Breast cancer patients' experiences of epistemic injustice in healthcare is a well-established fact. However, the significant role that gender plays in deciding the nature of epistemic injustice encountered by male and female breast cancer patients is still underexplored. Through a comparative analysis of Alan F. Herbert's *The Pink Unicorns of Male Breast Cancer* (2016) and Nina Riggs' *The Bright Hour: A Memoir of Living and Dying* (2017), we explore how male and female breast cancer patients distinctly experience vitiated testimonial dynamics and hermeneutical marginalisation. Breast cancer patients can negotiate credibility deficit, identity crisis, and existential crisis caused by epistemic injustice through narrating. Taking from Fricker's epistemic injustice, later contextualised in formal healthcare by Kidd and Carel, this study considers both the male and the female points of view to identify subtle instances of injustice and ways to overcome it. This article also articulates the need to overcome the stigma of considering breast cancer 'a woman's disease' so that male breast cancer patients' testimonies are equally prioritised along with female breast cancer patients. This comparative study highlights the ignorance inside institutional healthcare by foregrounding insensitivity toward all breast cancer patients and especially a lack of awareness of male breast cancer. Therefore, reading and writing such memoirs might secure future epistemic justice to all breast cancer patients irrespective of their gender.

**Keywords:** epistemic injustice; gender; marginalisation; breast cancer; woman's disease; insensitivity; pink unicorns; testimonies; healthcare

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## 1. Introduction

Informed by the theories on epistemic injustice and the need for a more holistic approach to healthcare, this article attempts a close reading of Nina Riggs' memoir *The Bright Hour* (2017) and Alan F. Herbert's memoir *The Pink Unicorns of Male Breast Cancer* (2016). Riggs' *The Bright Hour* chronicles her experiences of living with terminal breast cancer while reflecting on life, death, and the small, everyday moments that spell a new significance. Herbert's *The Pink Unicorns of Male Breast Cancer* charts a candid account of his experiences with male breast cancer, a rare and often overlooked condition. In his memoir, Herbert sheds light on the challenges he faced, not just from the physical aspects of the disease, but also from the societal and psychological hurdles that come with being a man diagnosed with what is typically perceived as a "woman's disease". The comparison of female and male breast cancer memoirs broadens the gendered understanding of breast cancer while simultaneously establishing the importance of valuing patients' physiological, psychological, and existential concerns in healthcare ecosystems that mostly exhibit a ubiquitous disregard for patients' narratives.

Further, this article examines the problematic nature of healthcare providers' privileging "their third-personal, 'objective' knowledge" over "the patients' first-personal, subjective, embodied knowledge" leading to epistemic injustice (Freeman and Stewart 2019, p. 124). It also seeks to establish how both male and female patients experience testimonial injustice in the healthcare system due to lack of time, and the communication gap between them and the professionals, and how male patients are hermeneutically more marginalised especially due to lack of awareness about male breast cancer within and beyond the clinical sphere. A great-great-great-granddaughter of Ralph Waldo Emerson, Riggs was an American professor and writer belonging to an established family (Riggs 2017). Still, she was subjected to epistemic microaggressions as a patient because her doctors often intentionally or unintentionally dismissed, ignored, ridiculed, or failed to acknowledge her epistemic capacities (Riggs 2017). On the other hand, Herbert, who is a London-born white male belonging to a middle-class family, also became a victim of epistemic injustice as he was twice marginalised, firstly as a patient of breast cancer, and secondly as a man afflicted with 'a woman's disease' (Herbert 2016). Herbert records that male breast cancer patients often feel more isolated and vulnerable when narrating their subjective feelings and creating testimonies because the available information and possible treatments are designed for women. He had to face hermeneutical injustice comparatively more than Riggs because of a lack of awareness and previous knowledge about male breast cancer (Herbert 2016). This article uses a theoretical framework based on the concept of epistemic injustice (Fricker 2007; Carel and Kidd 2014; Kidd and Carel 2017), to analyse the two memoirs and address the following three questions: (a) What are the ways testimonial injustice happens to these male and female breast cancer memoirists? (b) How is Alan Herbert, as a male breast cancer patient, more vulnerable to hermeneutical injustice than female breast cancer patients like Nina Riggs? (c) What is the importance of such studies based on breast cancer memoirs to improve breast cancer experiences in healthcare? Simultaneously, this article underscores the importance of including more testimonies of male breast cancer experiences alongside those of female patients to address epistemic marginalisation. By expanding the narrative corpus to encompass diverse perspectives, we can promote epistemic justice and ensure that the nuanced experiences of all breast cancer patients are better understood and applied in practice.

## 2. Breast Cancer Memoirs and Epistemic Injustice

As a distinct subgenre of life writing, illness memoirs, or autopathographies, have been significantly shaped by two seminal works: Arthur Frank's *The Wounded Storyteller: Bodies, Illness, and Ethics* (1995) and G. Thomas Couser's *Recovering Bodies: Illness, Disability, and Life-Writing* (Couser 1997). Subsequently, Arthur Frank (1995) and Rita Charon (2006), the founder of Narrative Medicine, have emphasised the importance of understanding patients' personal stories and experiences of illness, and have also advocated for a healthcare practice that goes beyond the clinical and diagnostic aspects to engage with the narrative dimension of patient care. Extending the scholarship on experiential dimensions, Gayle A. Sulik's *Pink Ribbon Blues. How Breast Cancer Undermines Women's Health* (Sulik 2011) and Emelia Nielsen's *Disrupting Breast Cancer: Stories of Rage and Repair* (Nielsen 2019) examine female breast cancer narratives that challenge the happy stories and the narrative scripts of hope and courage surrounding the Pink Ribbon culture, to lay bare the prevalence of an epistemic injustice inside breast cancer discourses. To further substantiate the superficiality of the Pink Ribbon culture and the problem of epistemic injustice within breast cancer discourses, the present article analyses Nina Riggs' *The Bright Hour* (2017), a female breast cancer memoir and Alan F. Herbert's *The Pink Unicorns of Male Breast Cancer* (2016), a male breast cancer memoir, to explore how these works advocate for more inclusive spaces where patients, especially those who are marginalised, can share their experiences and insights, ultimately leading to a more holistic and honest representation of breast cancer that values all voices. Within the subgenre of the cancer memoir, Riggs' *The Bright Hour* (2017) charts the undercurrent of an epistemic injustice characteristic of the dominant cheerfulness of Pink Ribbon culture that downplays the non-survivors' voices. By contrast, Herbert's *The Pink Unicorns of Male Breast Cancer* (2016) not only records the narrator's personal experiences of breast cancer and epistemic injustice but also includes observations from many other male patients' lived experiences, both before and after the diagnosis of breast cancer.

Despite a growing awareness of patients' experiences of illness, attitudinal and systemic biases still persist in healthcare practices, thus creating a condition that Miranda Fricker (2007) refers to as "epistemic injustice". In recent years, there has been a significant growth in scholarly explorations of epistemic injustice to develop an understanding of the negative social experiences of ill persons within or beyond the clinical world (Kidd and Carel 2017; 2019, p. 152; Blease et al. 2017; Carel and Kidd 2014; Carel and Györffy 2014). In conventional healthcare settings, professionals often downplay patients' testimonies, subjective feelings, experiences, and existential crises because of the strict professionalisation of interaction and lack of time (Kidd and Carel 2017), thus creating a condition for epistemic injustice for patients.

Epistemic injustice is generally defined as "a wrong done to someone specifically in their capacity as a knower" to mark negative stereotyping and prejudice against certain racial and sexual groups (Fricker 2007, p. 1). Within the healthcare system, such experiences of injustice cause deep harm to the patients' epistemic capacities which are integral to their "rationality, identity, agency, and dignity" (Kidd and Carel 2017, p. 175). Epistemic injustice, broadly categorised as testimonial injustice and hermeneutical injustice, can manifest socially and culturally in different ways (Fricker 2013, p. 1317). Testimonial injustice refers to the injustice "when prejudice causes a hearer to give a deflated level of credibility to a speaker's word" (Fricker 2007, p. 1). Generally, it is a negative stereotype that causes a "credibility deficit" in which a person's capacity as a testifier or "a reliable giver of information" is questioned, or in extreme conditions destroyed (Kidd and Carel 2017, p. 177). As a result of "identity prejudice as a label for prejudices against people qua social type", people from certain social groups always suffer an identity-prejudicial credibility deficit (Fricker 2007, p. 4). Further, listeners implicitly or explicitly devalue the testimonies of marginalised groups while enjoying the central position of authority (Fricker 2007, p. 4). Inside formal healthcare, patients' testimonies are undervalued because doctors' testimonies are "overly esteemed" which often leads to "credibility excess" (Fricker 2007, p. 20). Therefore, credibility is "unevenly distributed among different speakers" and the primary characterisation of testimonial injustice is "a matter of credibility deficit and not credibility excess" (McKinnon 2016, p. 438; Fricker 2007, p. 21). Moreover, epistemic microaggressions that occur against patients in clinical systems are of three kinds: "microinsults, microassaults, and microinvalidations" (Freeman and Stewart 2019, p. 122). These microaggressions cause short-term and long-term epistemic harm to the patients through doubting or destroying their capacity as knowers.

Patients under institutional care often feel powerless because of testimonial silencing, credibility deficits, and epistemic microaggressions. It can also be harmful and problematic for professionals "to privilege their third-personal, 'objective' knowledge of what a patient is experiencing and feeling over, to the exclusion of the patients' first-personal, subjective, embodied knowledge and resulting testimony" (Freeman and Stewart 2019, p. 124). Hermeneutical injustice occurs at a prior stage to testimonial injustice "when a gap in collective interpretive resources puts someone at an unfair disadvantage when it comes to making sense of their social experiences" (Fricker 2007, p. 1). The sufferers of chronic illness are often vulnerable because of hermeneutical injustices because "the kinds of experiences illness afford are often difficult to make sense of and communicate" (Carel and Kidd 2014, p. 530). For instance, if there is no discourse available for sexual harassment in a culture, then it would be difficult to interpret the experiences of the female victims of sexual harassment (Fricker 2007, pp. 150–51). The lack of previous knowledge and conceptual resources can arise in the following three ways: (a) "a global lack of resources" or non-existence of resources in the social world, (b) "the marginalized group has the resources" but is unrecognised by the dominant social group, and (c) "the marginalized group has no knowledge of or cannot access any available resources due to a politically repressive culture" (Younas 2020, p. 453). No matter what causes the hermeneutical injustice among the above three reasons, it always leads to hermeneutical marginalisation, "a form of powerlessness, whether structural or one-off" (Fricker 2007, p. 153).

As health professionals often enjoy credibility excess due to their professional training, grasp of medical jargon, and expertise in their fields, "patients' testimonies are often dismissed as irrelevant, confused, too emotional, unhelpful, or time-consuming" (Carel and Kidd 2014, p. 530). However, the biopsychosocial model acknowledges the influence of psychosocial factors on health and disease that are still unknown to many medical professionals (Havelka et al. 2009, p. 309). The biomedical model mostly focuses on disease rather than the patient, but the biopsychosocial model (greatly indebted to Georg Engel) focuses on the holistic understanding of the patient instead of studying the "organ or body part" in which the disease is located (Havelka et al. 2009, p. 304). Like other chronically ill patients, breast cancer patients are also subjected to pathocentric epistemic injustice because of a lack of holistic understanding due to the predominance of the biomedical model within healthcare (Kidd and Carel 2019, p. 158; Younas et al. 2019; Younas 2020). The discourses concerning epistemic injustice in breast cancer have also largely ignored the existence of a gendered perspective, which has influenced various aspects of breast cancer including research and practice. Since the understanding of breast cancer has historically been gendered, focuses on women, and is predominantly perceived as a woman's disease, the needs, subjective feelings, and testimonies of male and transgender breast cancer patients often lack serious scholarly attention (Mondal 2023; Younas et al. 2019; Sime 2012; France et al. 2000; Hartley et al. 2018; Stone et al. 2018). Even though breast cancer patients' stories are not given adequate attention in formal healthcare, female breast cancer patients have still discovered an alternative channel to voice their experiences through memoirs, photographic narratives, graphic novels, and social media blogs, all referred to as "mammographies" or "written and visual mappings of the breast cancer experience" (DeShazer 2013, p. 2). The pathographers, healthcare activists, and researchers document and describe the lived experiences of illness to emphasise mostly female patients' dignity, needs, requests, and testimonies that are otherwise ignored or silenced (DeShazer 2013, pp. 42, 165). Owing to the gendered understanding of breast cancer as 'a woman's disease,' there is a rise in female breast cancer patients' memoirs along with the awareness spread by the dominant discourses of breast cancer. On the other hand, male breast cancer patients' memoirs are comparatively more marginalised due to the uncommonness of male breast cancer, the lack of adequate awareness among professionals, and its limited representation in clinical and sociocultural discourses, making it susceptible to an acute form of epistemic injustice (Mondal 2023; Younas et al. 2019; Giordano 2005).

## 3. A Comparative Understanding of Female Breast Cancer and Male Breast Cancer

Breast cancer is more commonly diagnosed in women than in men and it is often referred to as a 'woman's disease' (Mondal 2023; Younas et al. 2019; Broom 2001; France et al. 2000). The physical, mental, and emotional well-being of female breast cancer patients are widely studied, and their coping strategies to improve their quality of life are also addressed by many scholars (Türk and Yılmaz 2018; Trusson et al. 2016; Liamputtong and Suwankhong 2015). An increased association of breast cancer with women is attributed to the cultural notion that "breasts are the symbols of femininity and men have chests" (Younas 2020, p. 452). The experiences of male breast cancer throughout the illness are different and unique from women's. This includes the initial reaction to diagnosis, psychological stress, coping strategies, and access to resources in healthcare settings (Younas et al. 2019, pp. 150–51). Additionally, morbidity and mortality rates are quite high in male breast cancer because of the negligence, unawareness, and lack of prior knowledge among healthcare professionals (Ravandi-Kashani and Hayes 1998, p. 1341; Mondal 2023, p. 1). The physical symptoms of male breast cancer are distinguished by "a higher incidence of oestrogen receptor positivity and more aggressive clinical behaviour", resulting in a comparatively more critical situation in men due to late diagnosis or lack of proper treatment (Ravandi-Kashani and Hayes 1998, p. 1341; Petrocca et al. 2005, p. 365). As the physiological symptoms and natural history of male breast cancer are different from female breast cancer, chemotherapy and other treatment strategies need to be carefully devised by doctors (Ravandi-Kashani and Hayes 1998, p. 1344; Petrocca et al. 2005, pp. 365–66). However, the "treatment strategies in men have been largely guided by the experience in women" by prescribing the commonly used female breast cancer drugs like Tamoxifen, due to limited knowledge of male breast cancer among healthcare practitioners (Ravandi-Kashani and Hayes 1998, p. 1341; France et al. 2000, pp. 345–46; Agrawal et al. 2007, p. 18). Furthermore, men's needs for social groups and emotional support are often considered insignificant (Quincey 2017, pp. 145–46). Research has addressed men's embarrassment in disclosure of breast cancer leading to a crisis of masculinity due to stigma, as it is generally perceived as 'a woman's disease', along with other body image issues (Mondal 2023, p. 1; Trindade et al. 2018; France et al. 2000, p. 345). Even after the recent improvements in clinical research on male breast cancer, the psycho-social impacts of male breast cancer need to be addressed even more as an enormous amount of literature already exists on the psychological impact of breast cancer on female patients. Both male and female breast cancer patients suffer from different levels of psychological problems, not only because of the disrupting effect of disease, but also because of the epistemic injustice present within the healthcare system.

Epistemic injustice concerning knowledge creation and acceptance of voices offered by breast cancer patients of both genders occurs due to the gaps in doctor–patient communication (Kidd and Carel 2017, p. 173). As a result, patients are expected to behave "according to the normative expectations of the sick role" (Buchman et al. 2017; Blease et al. 2017; Frank 1997, p. 131). Patients of both genders commonly suffer from testimonial injustice because their subjective feelings and pain are considered 'irrelevant' and 'irrational' as they do not use medical jargon like professionals, and thus inappropriate for 'open discussion' or 'clinical decision making' (Carel and Kidd 2014, p. 530; Younas 2020, p. 4). Due to the scarcity of male breast cancer cases and less awareness about it, male patients' symptoms and feelings are mostly unexpressed, leading to poor prognosis, aggressive therapies, or even the death of patients (Fentiman 2018, p. 1123; Lautrup et al. 2018, p. 618). The male patients' initial denial as a negative defence mechanism not only prevents them from asking for emotional support but also causes "long-term psychological morbidity" (Agrawal et al. 2007, p. 21; France et al. 2000, p. 347). Therefore, men experience stigmatisation and marginalisation, as choices in treatment, care modalities, health promotion, and support groups, are designated for female breast cancer patients and not for male breast cancer patients (Sime 2012, pp. 23–26). Due to stigmatisation and existential crises, they often fail to establish good interpersonal relationships with professionals and receive inadequate care (Midding et al. 2018; Younas et al. 2019). Therefore, men with breast cancer are more victimised due to epistemic injustice, as healthcare often dismisses men's concerns by offering more help and support to women. The representation of male voices in terms of breast cancer narratives is scarce in number compared to memoirs by female breast cancer patients. Since the 1970s, female breast cancer has received generous literary representations which were "widely believed to be the product of the feminist movement" (Kasthuri and Venkatesan 2017, p. 25). Female breast cancer patients often seek to narrate their stories through memoirs, discussions with support groups, and even through online blogs dedicated to breast cancer.

Male breast cancer narratives are even rarer than male breast cancer patients because of the prevalence of a hermeneutical insufficiency (Rudd et al. 2023, p. 291). Due to a lack of representation, they confront difficulty in creating meaning for their social experiences of injustices and, as a result, they prefer to maintain silence instead of articulating their experiences. Online social media websites and breast cancer blogs have become widely popular among women with breast cancer to share their subjective feelings by narrating their lived experiences in terms of a changing body, self, and resources (DeShazer 2013, pp. 205–6; Coll-Planas and Visa 2016, p. 884; Bury 1982, p. 167). However, male breast cancer patients cannot relate their physiological and psychological problems by reading blogs by women or meeting support groups who specialise in handling female breast cancer patients (France et al. 2000, p. 346; Abboah-Offei et al. 2024, pp. 40–46). Therefore, many studies based on the first-hand experience of male breast cancer have established the need for formal counselling and support groups distinctly for men to protect them in post-diagnosis shock, as "the entire treatment continuum and aftercare" of the disease resulting in gender discrimination and marginalisation (France et al. 2000, p. 347; Abboah-Offei et al. 2024, p. 1). Occasionally, healthcare professionals knowingly or unknowingly discriminate among patients' epistemic knowledge, assuming that their "credibility assignment can be faulty" (Carel and Kidd 2014, p. 532). Further, even those people who otherwise hold socially dominant positions in other contexts can experience "epistemic microaggressions" as patients because their positions are diminished in terms of "power, authority, or status" in healthcare settings (Freeman and Stewart 2018, p. 411; 2019, p. 122).

## 4. Testimonial Injustice and Credibility Deficit

The biomedical approaches predominantly followed in healthcare institutions mostly focus on the biological instead of "existential aspects of illness" and the "subjective experiences of being ill", causing testimonial injustice against patients (Kidd and Carel 2017, p. 176). Learning of the malignancy of her tumour for the first time, Riggs felt as if she was blamed by her doctor for her mastectomy: "The new tumor is malignant, and surgeons love to blame the patient" (Riggs 2017, p. 20). Riggs repeatedly expressed her psychological trauma about her "*Cancer in the breast*" by sharing it with her father, mother, best friend Tita, and husband John (Riggs 2017, p. 7). She also created her testimonies by noting the tormenting experience after the doctor declared "one small spot" from the biopsy report (Riggs 2017, p. 7). While Riggs felt able to reveal the news of her breast cancer to all her family members, Herbert experienced a real challenge when sharing the news with his family: "It was breast cancer, and I was a man . . . That had been my hardest task, having to tell my grandchildren I had cancer" (Herbert 2016, p. 39). However, Herbert considered himself fortunate as his doctor sent him for a mammogram, even after being certain that it could not be breast cancer. Gradually, after this randomly suggested mammogram, his breast cancer was diagnosed. Even though it spread to other body parts, he survived and, therefore, decided to write a memoir entitled *The Pink Unicorns of Male Breast Cancer*. Herbert's memoir serves as both a voice for other "poor unicorns" who were "fathers and many also grandfathers", as well as a response to the testimonial injustice that was committed against him (Herbert 2016, p. 40).

There are many cases of avoidable death because of the late diagnosis or misdiagnosis of male breast cancer. For instance, Herbert recorded the credibility deficit experienced by an unlucky male breast cancer patient whose doctor never took the symptoms of breast cancer seriously: "He had been sent home being told there was nothing wrong by various American doctors for eight years" (Herbert 2016, p. 40). Another similar breast cancer story that Herbert brought to light raises questions about the patient's integrity: "He had been told on multiple occasions that his discharging nipple was just a cyst" (Herbert 2016, p. 40). Herbert also referred to many other similar stories of testimonial injustice against male breast cancer patients from both U.K. and The Netherlands and also remarked: "It is vital time wasted and lives needlessly lost" (Herbert 2016, p. 40). Even if breast cancer is detected in males, the treatment procedure mainly follows the same as female breast cancer, which Herbert felt suspicious of. Being an ex-nurse by profession, he gathered information from his research on the side effects of Tamoxifen, the commonly used drug in female breast cancer, on the male body: "Tamoxifen is an oestrogen suppressant. I am a normal man. I produce very little oestrogen. To delay it for a week or two while my immune system recovers slightly wasn't quitting. The risk from the action I considered to be minimal" (Herbert 2016, p. 56). Within the healthcare system, male patients often doubt the treatment they receive, as the whole treatment system for breast cancer is designed for women. However, Herbert negotiated with his doctor to delay the injection of Tamoxifen inside his body. Through this experience, he stood up for himself, and consequently became a spokesperson for other marginalised breast cancer patients. Herbert also appreciated his open discussion with his radio oncologist about his treatment and radiotherapy: "She warned me that there was a chance the treatment could trigger lymphoedema, a chronic buildup of lymph in the affected arm making it swell up like a balloon" (Herbert 2016, p. 57). Therefore, he emphasised the need for discussion on the side effects of treatment with one's doctor because it prepares the patient for the possible consequences. Generally, male breast cancer patients, like other ill people, are considered "cognitively unreliable, emotionally compromised, or existentially unstable" which renders their testimonies invalid or suspect (Carel and Kidd 2014, p. 531). Herbert, however, sometimes found himself listened to. When he revealed to his radiologist that he is an ex-nurse and ex-radiation worker, his testimonies were taken seriously, whereas this does not happen with all patients.

In a similar vein, Riggs only initially felt comfortable when she attempted to share her subjective experiences with her radiologist. While her radiologist was performing her post-chemo scan, Riggs attempted to express her fears to the radiologist. She narrated a dream she had the previous night, in which her fear was personified in the form of two tigers. After patiently listening to Riggs, the radiologist said with a great amount of disbelief: "Hmmmm—two tigers, huh?" (Riggs 2017, p. 69). Even though she had not seriously considered Riggs' visions about the growth of tumours, she factually explained the exact position and condition of two tumours found after the scan (Riggs 2017, p. 69). This is an example of a subtle way of showing disrespect to a patient's testimony as critics have established that testimonial injustice can "range from the subtle and hard to detect bias to brutal rejection of clear evidence of suffering" (Carel and Kidd 2014, p. 534). Further, Riggs did not feel equally comfortable with all her doctors during her cancer journey: "As Dr. Cavanaugh is talking, I feel like I'm hurtling backward, that I'm that many steps farther away from getting back to normal whatever that is" (Riggs 2017, p. 114). The patients can only comfortably share their testimonies when the doctors are trained to listen attentively to the patients' speech. For instance, Riggs tried to be empathetic with her surgeon by emotionally involving him: "I ask the surgeon if he would recommend a double mastectomy if it were his wife" (Riggs 2017, p. 71). Even after this, the surgeon managed to disregard her question as irrational by saying "We're all different" (Riggs 2017, p. 71). Thus, Riggs' encounters with both her radiologist and surgeon show the downgrading of patients' testimonies, which occur frequently within institutional care. Sometimes, the communication gap between patients and doctors creates testimonial injustice because of "the 'coldness' associated with impersonal diagnostic procedures, doctors' perceived indifference to or ignorance of the concerns of their patients, and a disorientating use of medical jargon" (Kidd and Carel 2017, p. 173). For instance, Herbert felt scared and alienated after his suddenly unannounced biopsy, and the technician's vague reply while conducting the biopsy. He narrated his testimonies about the delay in test results and his anxiety about it: "Again, the wait for results. Until everything was cut and dried, they would not give me any information, not even a pencil line plan, no prognosis" (Herbert 2016, p. 11). Thus, both Riggs and Herbert consider memoirs a medium for expressing their personal feelings while facing testimonial injustice. Instead of being passive listeners, they both attempt to overcome the communication gap with healthcare professionals and pen down their emotions related to being unheard, or not paid serious attention to share with their readers.

## 5. Hermeneutical Marginalisation and Existential Crisis

A difficult epistemic situation emerges between doctors and patients when "neither group can engage in effective testimonial and hermeneutical relations with the other" (Carel and Kidd 2014, p. 173). The social stigma and hermeneutical marginalisation of male breast cancer puts male patients at a disadvantage while trying to make sense of their social experiences. For instance, Herbert mentions that several cancer organisations only use six specific words as information about the disease: "men can also get breast cancer" (Herbert 2016, p. 2). Due to a lack of sufficient knowledge about the disease, patients often feel like pink unicorns which are mythically present but non-existent in the real world: "We are so rare that some doctors don't even consider breast cancer as a male diagnosis" (Herbert 2016, p. 8). When Riggs first found the symptoms of lumps in her breast, she immediately suspected the condition, so she sought help as breast cancer is quite common in women. However, Herbert delayed the process of breast examination after finding the symptoms because of his lack of awareness. Even after feeling the itchiness in the left nipple, "dry flaky skin", and "a small hard lump", Herbert delayed seeking professional help as he considered it a regular "nipple rub or mastitis", which is common for a long-distance runner, but he never suspected breast cancer (Herbert 2016, p. 4). A lack of media representation and awareness about male breast cancer often leads male patients to doubt the possibility of the condition. When a person cannot understand or express an important part of their experiences due to "absences of proper interpretations" or "hermeneutical gaps", it leads to an existential crisis (Fricker 2007, p. 160). For instance, Herbert could not overcome his shock as a patient diagnosed with male breast cancer as he never had a family history of breast cancer or any hormonal issues (Herbert 2016, p. 14). However, to overcome the shock of being diagnosed with "a woman's disease", he gradually developed a sense of humour as a defence mechanism by identifying himself as a special case, the pink unicorn or "the only man they (hospital authority) have on their books" (Herbert 2016, pp. 13, 26).

Riggs' breast cancer case is the opposite to Herbert's, because she is not only a woman, but she also has a long family history of cancer on both her paternal and maternal sides. Therefore, Riggs neither finds the diagnosis unlikely, nor endures an existential crisis, as female breast cancer is the second most common disease among women (Bu et al. 2022, p. 1; Broom 2001, p. 249). Contrarily, Herbert asked various radiographers whether they had ever treated any male breast cancer patients before and the answer was negative. He started desperately searching for information about male breast cancer online but found that all the social media support groups are meant for women. Herbert also narrated the incidence of visiting a lung specialist who called him "Mrs. Herbert" instead of Mr. Herbert (Herbert 2016, p. 66). After that, Herbert tries to correct her but she firmly replies, "But I read breast cancer!" as she was unable to believe that breast cancer could happen to males as well (Herbert 2016, p. 67). While booking an appointment with the surgical department, Herbert experienced the crisis of being a "pink unicorn" in the female world:

> The telephone line went deathly silent at the hospital end. After about forty-five seconds, the receptionist then confirmed what I had said, sounding very flustered indeed. This is the reaction my family and I have become used to. The Pink Unicorn strikes again. (Herbert 2016, p. 27)

Because of the general disbelief from the receptionist, doctor, or even hospital staff, male patients feel marginalised in the breast cancer community.

Contrarily, Riggs finds joining the book club community very fruitful in her cancer journey as she narrated her experience of reading books like Kelly A. Turner's *Radical Remission*, Claudia Emerson's *Late Wife*, Svetlana Alexievich's *Voices from Chernobyl*, and sharing her reflection and self-realisation with other members. As a male breast cancer patient, Herbert had a lack of shared social tools because everything was targeted towards women: "In one folder I was given, it had one page about the disease and treatments and five pages about wigs, prosthesis, special bras, reconstruction, and implants... All the line drawings regarding the post-operative exercises are of a woman" (Herbert 2016, p. 27). He also highlighted the feelings of alienation as reflected through cancer charity organisations, because two thirds of them specified that only women breast cancer patients could receive funding. Therefore, he had address those organisations that ignored the existence of male breast cancer patients: "Breast cancer is not a "woman's" disease. It kills men too" (Herbert 2016, p. 76). In this context, Herbert also recorded the difficulty he had faced in finding sponsorship for his memoir. Contrarily, there are many such communities where sharing knowledge is possible for female breast cancer patients, and Riggs received help from a chemo school, where other patients and nurses discussed survival skills, as well as a book club. Conversely, men often struggle existentially as breast cancer patients because of the hermeneutical injustice against them, while women have gradually overcome the hermeneutical gap through community building. Thus, there is a need for more representation of male voices who are diagnosed with breast cancer to understand and differentiate those male-specific experiences of existential crisis and hermeneutical injustice.

## 6. Significance of Breast Cancer Memoirs and Their Application in Healthcare

As healthcare professionals' work is mostly "task-based rather than patient-focused", they often fail to understand "patients' personal needs and values" leading to epistemic injustice (Kidd and Carel 2017, p. 176). The healthcare professionals can only advise on or prescribe necessary treatments, but it is the patients who fight the actual battle with the body's needs and problems. Riggs compared her subjective feelings of losing herself while going through chemotherapy to a 'deep ocean': "At chemo, I can never find my center anymore. It's like a big, empty ocean" (Riggs 2017, p. 49). However, there are few ideal instances when professionals play the role of "good physicians" through "understanding people" and having good "communication skills, and an ability to interact with people with empathy [and] integrity" (Kidd and Carel 2017, p. 174). For instance, Riggs liked Dr. Cavanaugh, her oncologist, and connected with her as she memorised every minute detail of her case "off the top of her head" (Riggs 2017, p. 19). Riggs also highlighted her oncologist's powerful use of humour who preferred calling chemo combinations "recipes" instead of calling them "cocktail[s]" as the word "cocktail" provoked her desire to drink (Riggs 2017, p. 19). She felt very comfortable in expressing herself to the oncologist because of her attention to the details of the case history and her use of humour. The genetic counsellor whom Riggs consulted also explained every fact in detail along with diagrams. The counsellor revealed that medical science has not completely mapped all the genes involved with breast cancer gene mutation. It is important for patients to know the reality and the limitations of medical science through a proper discussion with healthcare professionals to avoid epistemic injustice. In Herbert's case, he found himself amid utter confusion because many doctors have little information about the possibility, symptoms, and treatment of male breast cancer. Herbert considered himself lucky, as many male patients are misdiagnosed or diagnosed late, resulting in death: "I had a good chance of a cure. Too many granddads are robbed of that, being diagnosed too late. For them, it's just the long goodbye" (Herbert 2016, p. 39). Therefore, Herbert not only sympathetically confessed the reality of male breast cancer but also attempted to create a change by sharing his story through social media, where the female audience admires the "male view" on the same subject (Herbert 2016, p. 31). Breast cancer has a significant impact on the lives of both male and female patients, as they experience the same disease differently.

However, women narrating breast cancer experiences are often vulnerable because the breast bears the symbol of femininity and losing a breast means losing their societal role as women (Bu et al. 2022; Trindade et al. 2018). Being a wife and mother, when Riggs' breast cancer was detected for the first time her whole world changed before her. Herbert himself said while comparing breast cancer in males and females:

> Breast cancer isn't the same traumatic disaster for a man as it is for a woman. My breasts haven't been a major factor in my life since I was about nine or ten years old. They mean nothing to my manliness. (Herbert 2016, p. 12)

Along with the breast, Herbert also mentioned that hair does not carry any significance to his manhood. Contrastingly, Riggs recorded her troubling experience of hair loss which has disrupted her female identity:

> As a bald woman, I noted stricken looks from other moms at PTA meetings and grocery parking lots. I noted our mailman hurrying to avoid me on the stoop. Discomfort from waiters and shop attendants. (Riggs 2017, p. 120)

Both Riggs' and Herbert's narratives reflect women's difficulty in narrating physical changes that question their feminine identity. Herbert found himself repeatedly in an advantageous position as his transformation in outward appearance did not lead to self-crisis. Therefore, he replied to the nurse who inquired about the male point of view on post-chemo baldness: "I am a man! I am already going bald and have been for years. What's the big deal? (Herbert 2016, p. 29). Thus, a comparative study of male and female breast cancer memoirs shows that when men struggle with an existential crisis for their gender, then women struggle with an identity crisis after their diagnosis of breast cancer. The present study also establishes that male breast cancer patients fight against their hermeneutical injustice and credibility deficit. On the other hand, female breast cancer patients suffer from testimonial injustice and identity crisis because of the pre-decided notions of female beauty (Broom 2001, p. 256). Riggs bravely expressed her fear and anxiety related to her breast cancer and the associated physical transformation in her memoir. On the other hand, Herbert also politely educated his lung specialist who disqualifies him as a breast cancer patient by calling him "Mrs. Herbert" (Herbert 2016, p. 75). Therefore, studying such literary narratives helps authors overcome both identity crises and existential crises by articulating experiences of hermeneutical marginalisation, credibility deficit, and testimonial silencing.

Besides this, memoirs also provide a platform for patients to capture their vicarious feelings or subjective emotions, which are otherwise unheard of by specialists, but considered irrelevant for diagnosis and treatment. For instance, Riggs tried to metaphorically visualise her unique experience while sharing it with her readers: "a lovely space has opened up inside my chest, a little, deep pool in the thickest woods" (Riggs 2017, p. 14). Thus, she imagined her cancerous cells as some deep mysterious place where there is a pool inside the woods. Such testimony can only be created through the personal memoir, as it provides a meeting ground for the speaker with the inner self. Similarly, Herbert also confidently shared his knowledge: "I have suffered a few 'nipple twisters' in my time, but a biopsy is really something else. It's like someone striking a match inside your breast" (Herbert 2016, p. 5). Despite not having professional medical knowledge, the patients discipline themselves to survive the difficult sessions of chemo, and those coping strategies devoid of medical jargon are not included in the discourse of medical sciences: "This is where the self-discipline begins to kick in. You feel sick. You don't want to eat or drink. You have to force yourself" (Herbert 2016, p. 23). Thus, Herbert has not only testified his authority as a knower but has also fulfilled his hermeneutical responsibilities by creating a channel for discussion about other male breast cancer patients who silently suffer, as the breast cancer community only discusses woman-specific problems.

## 7. Conclusions

Nina Riggs' *The Bright Hour* (2017) and Alan F. Herbert's *The Pink Unicorns of Breast Cancer* (2016) are not only memoirs narrating their authors' individual struggles, but also sites for a dialogue about the epistemic injustice that male and female breast cancer patients are subjected to. Breast cancer makes everybody's journey difficult, but it also makes each individual's journey different from that of others. Herbert, while referring to his illness as a massive roller coaster, as it could come with "twenty-two side effects at various severities", has very appropriately pointed out the fact that "each person's ride is different" as the severities vary from person to person (Herbert 2016, pp. 36, 37). The memoirists discussed in the article battle against testimonial injustice, credibility deficit, hermeneutical marginalisation, and existential crisis both on an individual and on a community level. To develop a better understanding of overcoming these challenges, the current study has addressed the need to rethink epistemic injustice in breast cancer from the gendered point of view. As a female breast cancer patient, Riggs remains in an advantageous position to overcome the challenges, as multiple discourses on female breast cancer are available to her. For male breast cancer patients like Herbert, the fight is not only against testimonial injustice in cancer care but also for recognition (Herbert 2016, p. 68). Therefore, the present study emphasises the need for more male breast cancer narratives to articulate the dangers of hermeneutical marginalisation and the perception of breast cancer as 'a woman's disease'.

In his capacity as an individual knower or informant, Herbert considers it his duty to narrate the challenges of other male breast cancer patients within and beyond healthcare, and unassumingly remarks that though many applauded his courage, he personally found nothing courageous about it (Herbert 2016, p. 52). Rather, he considers it his epistemic responsibility to bring awareness and equality for patients of different genders. He asserts, "The word needs to be put out there to stop men from dying needlessly, to make people realise breast cancer isn't just a woman's disease, and to make some doctors think again" (Herbert 2016, p. 52). Just as Herbert educated the lung specialist about male breast cancer, the present study establishes the need for educating people, creating support groups for male breast cancer, and also encouraging both the "pink ribbon and blue ribbon culture" (Younas 2020, p. 8; Quincey 2017). Alongside this, the study also emphasises the need for attentive listening, practising empathy, observing integrity, and open-mindedness by health professionals through practical application within healthcare. As patients build up their stories based on the holistic experiences of body and mind, it fills the gap in doctors' interpretation of the objective knowledge of human anatomy, thereby suggesting that doctors practise 'open mindedness' as an anti-prejudicial virtue, so that patients' stories are not only encouraged to be told, but are also believed (Kwong 2015, p. 340). When the patients themselves create testimonies, readers become more informed about epistemic injustice in healthcare and the subjectivity in illness emphasising how factors like emotions, personal beliefs, cultural background, and social influences shape a person's understanding and experience of their illness. The two gendered breast cancer memoirs analysed in the article offer mutual value by providing a fuller, more inclusive picture of the disease, promoting empathy across genders, encouraging a broader, more nuanced conversation about breast cancer that benefits everyone, and envisaging a more holistic healthcare culture. Thus, healthcare can gradually pave the way for the realisation of the capabilities of patients through a positive nonjudgemental approach by ensuring epistemic justice.

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