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BEYOND NESCIENCE

*the intersectional insights of
health humanities*

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ABSTRACT Through a comparison of two graphic novels concerned with the experience of cancer diagnosis and treatment, Brian Fies's *Mom's Cancer* (2006) and Harvey Pekar and Joyce Brabner's *Our Cancer Year* (1994), this essay suggests some of the strengths and limitations of the medical humanities in responding to the experience of illness. It demonstrates how the graphic medium enables us to generate a new set of reading strategies and thus to articulate a more complex and powerful analysis of illness, disability, medicine, and health. Finally, the essay considers the question raised by the comparison of the graphic novels: whether the term "health humanities" might not be preferable to its predecessor, "medical humanities."

THE DAY I BEGAN pulling my thoughts together for this essay, I turned on my computer to be greeted by the "Word of the Day"—*nescience*: lack of knowledge or awareness; ignorance. That "Word of the Day" was right on target: I was sitting down to write about a lack of awareness or ignorance in medicine that can be remedied by the medical humanities. An epistemological narrowing characterizes biomedical thinking, I would argue, that impedes our ability to heal. In what follows, I want to explore how the medical humanities combat that narrowing, replacing medical nescience with healing knowledge.

Though the word *nescience* was new to me, the background to the nescience

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I'm discussing will be familiar to all of us: *biomedicalization*, or the process by which all of life has come to be under the governance of biomedical technologies (Clarke and Olesen 1999; Clarke et al. 2003). Resulting from the introduction of new medical and biological technologies, with their accompanying innovative practices and institutions, biomedicalization goes in tandem with a number of major changes in the ways we live, producing major political and economic reorganization. Among them are an increased focus on health and risk and surveillance biomedicines; the techno-scientization of medical care; transformations of the production, distribution, and consumption of biomedical knowledges; and the transformations of bodies and identities (Clarke et al. 2003). Biomedicalization occurs at all life scales, from the microscopic to the macro-institutional, from the individual to the population. We can see it in operation in practices as different as in vitro fertilization, transplant surgery, psychopharmacology, and regenerative medicine. Although unevenly distributed, biomedicalization has played a crucial force in shifting the task of Western medicine from the control over disease and illness to the transformation of human life (Squier 2004). While the accomplishments of biomedicine are undeniable, they are shadowed by its failures. In its increasing focus on positivist measures, biomedicine has not been fully able to grapple with those aspects of experience that can't be expressed in scientific or quantitative terms. In short, the crucial ambiguities of life have often escaped it.

Given the scale of its ambitions, perhaps it is understandable that biomedicine often seems to lose sight of the individual—not only the patient, but also the health care worker. This is where the medical humanities have played a crucial role. By introducing into the curriculum of medical schools the kinds of knowledge that cannot be reduced to scientific or quantitative terms, they have reclaimed the personal, even spiritual, aspects of illness. By reading stories, plays, and poems about medicine, medical students, physicians, and other health workers can learn new and productive perspectives on medicine. They can engage in ethical explorations of trust, responsibility, and choice; psychological explorations of the relationship between the physician or nurse and the patient or patient's family; and rhetorical analyses of the case history or patient chart revealing how important facts are obscured in the process of marking others. These new perspectives redefine what constitutes medically significant knowledge, adding to evidence-based medicine and bringing welcome attention to the personal, anecdotal, and spiritual of illness and medicine.

Yet even these new perspectives are narrower than they need be, as an excerpt from the Lit-Med ListServ will illustrate. An obstetrician-gynecologist, preparing a talk about fertility preservation in cancer patients, posted a request for literary works about living with cancer. The physician wanted to include some poetry about a patient's feelings of hopes and about life after cancer treatment, or poetry from a physician's or nurse's point of view. This mimetic approach uses literature merely to illustrate a preselected point. While an encounter with a rep-

resentation of the feelings associated with a cancer diagnosis can be enriching, such an approach is but a small part of the productive work literary texts can do in medical education and medical practice.

For example, a more expansive use of literature in medical humanities asks physicians to learn the skills of expert readers of classic texts in order to explore the “great human questions” raised by illness. Physician and literary scholar Rita Charon, a central figure in the field of narrative medicine, has articulated the methodology, as well as the merits, of this form of medical humanities work. Charon’s lead article in *Teaching Literature and Medicine* (2000) exemplifies this approach to medical humanities. Introducing the literary concepts of frame, time, plot, and desire, the article asserts that there is value in training medical professionals to read both literary and medical texts. As a pedagogical resource, Charon provides a sample syllabus for a medical humanities course that combines works by Hemingway, O’Connor, Woolf, James, Lawrence, and other distinguished writers with four medical texts: an attending rounds presentation, a transcription of a routine medical interview, an interview with a patient in a clinic, and the discharge summary for a patient who has died in the hospital.

Yet even that more sophisticated, reciprocal deployment of literary and medical texts and practices still leaves certain essential aspects of the medical experience unchallenged, in particular the notion that the patient is white, male, and middle class. And if a reevaluation of the patient attempts to redress bias simply by substituting a new typical or stereotypical “other” for the old norm of white middle-class male, little is gained (see Fadiman 1997 and Stanford 2003 for challenges to these notions). Not only must the category of “patient” be extended to embrace the full range of humanity in terms of race, class, sex, ability, ethnicity, and so on, we must also rethink how different conceptions of the patient will shape and reshape medical practice.

Intersectionality theory is crucial in this reconceptualization, because it challenges any idea that identity is unitary or mutually exclusive. Legal scholar Kimberle Crenshaw, whose landmark 1991 article introduced the theory, argues that claims for social justice grounded in identity politics can have negative effects because “Race, gender, and other identity categories . . . [function] as vestiges of bias or domination—that is, as intrinsically negative frameworks in which social power works to exclude or marginalize those who are different” (p. 1242). In her analysis of the way identity categories shape the social response to violence against women of color, Crenshaw uses intersectionality theory to arrive at an alternative formulation of identity. She maps three different types of intersectionality: structural (arising from the convergence and collision of different identity positions); political (arising from the convergence and conflict of different political positions); and representational (produced by the way cultures construct and represent identities). Although her specific focus in the article is on race and gender, Crenshaw urges that the concept of intersectionality “can and should be expanded by factoring in issues such as class, sexual orientation, age, and color”

(p. 1245). She also urges feminist legal scholars to anticipate in their research, and attempt to account for, the structural, political, and representational convergences and collisions of identities.

Crenshaw's reminder that there are identities other than the dominant one, and that those other identities interact in complex and important ways that must be understood by legal scholars, holds for medicine as well. In the last 30-plus years, the women's health movement and the reparative attention paid (post-Tuskegee) to the role of race in access to and quality of medical care have offered a welcome alternative to the status quo ante. But even this turn from one narrow identity category (now understood as inadequate) to a wider group of other identities (in hopes of being comprehensive) leaves something out. The problem is not only that medicine too often has a narrow conception of the patient's identity, but also that even when new identity categories are added, they are frequently conceived of as unchangeable and sequential, not fluid and overlapping.

This point was made clear in May 2006 at a conference on women's health convened at the Centre for Research in Women's Health at the University of Toronto. The organizers, neurobiologist Gillian Einstein and philosopher Margrit Shildrick, challenged researchers to approach women's health as an intersectional phenomenon, something that simultaneously and complexly involves issues of race, class, ability, and age, as well as sex or gender. Reflecting their own expertise in cross-disciplinary conversation, they took the concept one crucial step further. Rather than assuming that categories such as sex, race, class, ability, and so on have inherent (and stable) meaning, and staying with either/or categories that let so much of life escape, they urged conference participants to examine women's health through the lens of what they call "postconventional" thinking. Their term is intended to capture the insights of postmodern philosophy and the impact of contemporary biomedical technologies. These converging forces challenge what it might mean to practice medicine sensitive to issues of race, sex, class, ability, and age, in this era when the very terms "body" and "mind" are being renegotiated. Influenced by postconventional thought, Shildrick and Einstein ask what we understand human life to be, in an era when the lifespan itself, and every aspect of the human being (from conception and birth through growth to aging and death) are subject to reconceptualization and reconstruction.

Shildrick and Einstein's work is concerned with medical practice, but I want to advocate a similar encounter with the implications of postconventional thought for the medical humanities. If we are turning to literature to combat epistemological narrowing, it makes no sense to engage in the parallel process in literary studies, accepting without question a narrow definition of literature. As Rita Charon (2000) has observed: "On opening a book, the reader first identifies the narrative frame into which he or she is situated by the act of reading and then endorses the contract implied by that frame" (pp. 31–32). Just as medicine has narrowed from a field combining science and philosophy to a scientific realm

governed by evidence-based practice, so too has literary study increasingly defined both the acceptable texts and the acceptable methods for textual study as it has professionalized. In both medicine and literature, we need to reexamine the contract we are endorsing and question the frame that produces it. If the medical humanities only attend to works thematically linked to medicine or those canonized due to their perceived literary merit, we will find our possibilities restricted. To return to the gynecologist's posting to the LitMed Listserv, if we choose to discuss only those poems or short stories that can *illustrate* a medical issue, we are implicitly accepting—and thus endorsing—the medical frame. And if we discuss only canonized texts, we are endorsing another sort of frame, reflecting another sort of cultural contract. The canonical text perpetuates not only the aesthetic values that canonization celebrates, but the institutional and socioeconomic structures and the epistemological assumptions subtending those aesthetic values.

In what follows, I want to demonstrate how the introduction of a more diverse set of literary texts and a new set of reading practices can release us from the contract to which we are bound when we accept the implicit frame of both medicine and literature. I mean the term “literary texts” to include not merely canonical fiction and poetry, but also the full range of written cultural expression, including autobiography, memoir, popular journalism, science fiction, and even graphic fiction—or what used to be called comic books. In what follows, I will turn to two graphic novels to demonstrate how their genre works against the nescience—the unawareness or ignorance—produced by the “Biomedical TechnoService Complex, Inc.,” Clarke's (2003) term for the congeries of practices, technologies, knowledges, institutions, and profit centers that is medicine today.

Both Brian Fies's *Mom's Cancer* (2006) and Harvey Pekar and Joyce Brabner's *Our Cancer Year* (1994) are concerned with the experience of cancer diagnosis and treatment. Yet a comparison of these two graphic novels can demonstrate the strengths and limitations of the medical humanities in responding to the experience of illness. It can also demonstrate how the graphic medium enables us to generate a new set of reading strategies and thus to articulate a more complex and powerful analysis of illness, disability, medicine, and health. The encounter with these graphic novels raises the question whether the term “health humanities” might not be preferable to its predecessor, “medical humanities,” an issue I will revisit in the conclusion of this essay.

“MOM'S CANCER”

Brian Fies's book, *Mom's Cancer*, has a publication history that testifies to the graphic novel's position outside canonical literature. As the author explains in the preface: “I began serializing *Mom's Cancer* on the Internet in early 2004 as a kind of underground journalism: dispatches from the front lines of a battle into which

my family stumbled unprepared.” Posted anonymously and circulated “outside the system of mainstream comics, through word of mouth,” Fies’s work acquired a huge audience. By summer 2005, a little more than a year after it first appeared on the Internet, Fies’s graphic fiction received the first Eisner Award for “Best Digital Comic” at the field’s legendary annual conference, the San Diego Comic-Con. When it was finally published as a book in 2006 by Abrams Image, Charles Kochman’s introduction praised both its uniqueness—“it signified a shift in the way comics were made, read, even published”—and its universality: “All stories, if they are honest, are universal. Sadly, few things in life are more universal than illness. Each year, approximately 1.5 million people in the United States and Canada are diagnosed with cancer. This is one family’s story. In many ways, it is also all of our stories.” The preface echoes this framing, observing that the author was “gratified to get letters from medical professionals and educators saying that *Mom’s Cancer* helped them understand their patients’ perspectives and asking permission to use it in their curricula.”

Despite its unorthodox publishing history, Fies’s graphic novel could serve as a typical text for the medical humanities, taught as a representation of the theme of cancer (its diagnosis, treatment, impact on the family) and of the so-called universal illness experience. But read carefully, Fies’s graphic novel combines its thematic and aesthetic position endorsing the medical status quo with more subtle aspects that challenge the novel’s conventional medical and literary framing. In its cast of characters and basic plotline, *Mom’s Cancer* draws on familiar tropes from medicine and literature. In its progression from description of patient to history of present disease, to treatment, prognosis, and finally Mom’s cure, it resembles a medical case history. And in its focus on family dynamics, it resembles other classic literary portraits of families in crisis. Fies summarizes both plot and character in the first two panels. Once the characters are established, successive episodes render family members’ interactions as they struggle to manage not only Mom’s cancer treatment but also their different responses to her illness. Each person’s particular training, emotional investment, character structure, and even position in the birth order shape their interactions with Mom, her physicians and nurses, and each other.

The work’s status as a graphic novel also shapes *Mom’s Cancer*. Comics not only work by juxtaposition, but also by contrapuntal visual references and visual and verbal tone shifts, all of which can complicate the linear narrative, breaking its epistemological and visual frame. As McCloud has mapped them in his important study, *Understanding Comics* (1994), a range of disruptive effects is integral to the medium. First, both comic book writer and reader resist normativity simply by continuing to enjoy the combination of words and pictures well past childhood. Then, the combination of words and pictures in a comic panel produces a variety of different narrative strategies and emphases.

In *Mom’s Cancer*, disruptive metaphors of games of chance unsettle the narrative of medical expertise. The story of Mom’s discovery of the cancer symptoms,

her visit to her osteopath, and her brain scan is interrupted by the Parcheesi-like representation of the family's struggles to find her a neurosurgeon. The family's reliance on medical expertise is bracketed (and undercut) by endpaper illustrations of the Parcheesi game piece and a pair of dice. As the family tries to help Mom grasp her treatment options now that she has received the diagnosis of inoperable stage-four lung cancer, Fies mocks any hope that might lie in rationally controlled treatment when he breaks the literary frame with a one-panel illustration of the familiar children's game *Operation*, or as it is now retitled, *Inoperable*. Even the authority of the "Impressive Hospital Doctors" is undercut by a visual reference to the mad doctor from the film *The Bride of Frankenstein*.

Fies portrays emotionally wrenching experiences with savage irony by relying on pictorial juxtaposition, again drawing on noncanonical literature. The toxic family process produced by this medical crisis is rendered in terms of each character's family position, fantasy life, and desires when Fies portrays them as anguished dueling superheroes. With equal irony, the family's struggle to understand the results of a brain scan are portrayed as a problem of intellectual incapacity via a graphic juxtaposition of abstract mathematical reasoning and pictorial realism: "So when you see that two months of hard-fought chemotherapy and radiation have transformed this [scan of two months earlier] into this [scan of two months later] . . . your crushing disappointment only betrays your mathematical ignorance" (p. 53). Finally, the alarm generated by the complex negotiations required by chemotherapy, as the patient picks her way between cure and kill, is distanced and diminished when Fies represents it as a circus tightrope act requiring Mom to perform daredevil thrills, feats of strength, and a comedy routine to a laughing audience.

The graphic nature of Fies's work enables a challenge to two core distinctions in medical practice: between illness and health, and between patient and doctor. Although the first-person narrator maintains complete control of the narrative "I," the multi-perspectival graphic narrative counteracts that normative representation of Mom's illness and her physicians. The pictures expose us to what the words omit: the uncertainty of medical practice; the unfeeling, even cruel aspects of medical treatment; the detachment of physicians; and the surrealism of what we usually feel we must accept as realistic, even run-of-the-mill. This strategy exemplifies the insight of postconventional thinkers—that texts inevitably subvert their declared purpose, challenging claims to universality and normativity, which obscure alternative voices, identities, and experiences. Thus, the pictures enable us to contest the claim to realism and universality grounding *Mom's Cancer*. For example, in the panels narrating how the car accident left Kid Sis with a traumatic brain injury, ordinary reality is remade in the mode of Picasso. In one quick frame, we are taken out of the positivist universe of one patient's case study into a multidimensional, cubist universe, where we meet the multiple identities produced by illness and medical treatment.

Identity and illness are unsettled not only from the perspective of the patient

but also from that of the doctor. Consider the novel's most shadowy figure, Mom's ex-husband. Introduced and summarized in two compact pages, Dad begins as "actually stepdad," a "young physician and the coolest guy ever." But Dad's position in the conventional family portrait becomes precarious, as the difficult conditions of his 20-year medical practice increasingly burden him with "too many nights and weekends on call. Too many shortened vacations and missed holidays" (p. 34). After 20 years, his job has become unbearable, and he begins searching for an alternative. A mandala backdrop to the next panel conveys the nonlinear and endless movement from Dad's start as a white-coated young doctor to the NO END of his status as a bearded, long-haired, tie-dyed, Birkenstock-wearing spiritual seeker. The son is resistant to his father's vision, as we learn in a panel that represents a conversation with Dad as a multiple-choice quiz (p. 36). The character of Dad offers numerous possibilities that stay with us, even as the narrator's voice forecloses them.

Pictures and words together also convey some of the complexity underlying medical treatment for *Mom's Cancer*. We learn of the narrator's commitment to Mom's right to privacy, of his insistence that she has the right to determine her own treatment, and of the family's pride in serving well "on the front lines of a battle into which [they] stumbled unprepared." This battle metaphor cues us to unsettling aspects of Mom's cancer experience. As Susan Sontag (1993) has observed:

More recently, the fight against cancer has sounded like a colonial war—with similarly vast appropriations of government money—and in a decade when colonial wars haven't gone too well, this militarized rhetoric seems to be back-firing. . . . The bromides of the American cancer establishment, tirelessly hailing the imminent victory over cancer; the professional pessimism of a large number of cancer specialists, talking like battle-weary officers mired down in an interminable colonial war—these are twin distortions in this military rhetoric about cancer. (pp. 66–67)

Distortions also follow from any universalizing of the illness experience, as a critical reading of the novel's panels will make clear. All but one of the novel's characters share one goal, to retain (or regain) Mom's stable self in the face of each new medical crisis. The panel sequence "Puzzlement" captures the meaning of that goal visually when the communal jigsaw puzzle is completed and ready for its archival photograph.

Roland Barthes (1977) has observed: "a text is not a line of words releasing a single 'theological meaning' (the 'message' of the Author-God) but a multi-dimensional space in which a variety of writings, none of them original, blend and clash" (p. 146). Even when the seeming success of Mom's chemotherapy threatens the narrator's own understanding of the plot of his story, he continues to accept the medical frame. But an afterword added to *Mom's Cancer* as the book was going to press confirms the truth of Barthes's observation. In this last-minute

insertion, we can hear the son's more orthodox perspective in tension with the more critical views of his father, who left medicine to form his "spiritual retreat and healing arts center":

It seems odd to say that Mom's death came as a surprise, but, even hours before the end, we and her physicians always saw a reasonable path to recovery. . . . Mom died free of cancer. She beat it. However, to control brain inflammation she took steroids that, given in high doses over a long period of time, inexorably broke down her body. The steroids had to be reduced, renewed inflammation put pressure on unexpected parts of her brain, and the end came quickly.

This collision of narrative perspectives decenters both the Author-God and the Doctor-God, while offering us a Vietnam-era military metaphor as an alternate frame for this medical tale: "We won the battle but we lost the war."

"OUR CANCER YEAR"

Mom's Cancer not only offers us a conventional narrative of the emotional and physical stages of cancer discovery, diagnosis, and treatment, but it also takes a tentative step outside that medical frame to explore the shadows it casts. A 1994 graphic novel that situates the cancer experience broadly in a dense nexus of social and political threats to human health is Harvey Pekar and Joyce Brabner's *Our Cancer Year* (1994), which begins: "This is a story about a year when someone was sick, about a time when it seemed that the rest of the world was sick, too. It's a story about feeling powerless, and trying to do too much. . . . Maybe doing more than you thought you could and not knowing what to do next. It's also a story about marriage, work, friends, family, and buying a house."

In its inter-subjective view of cancer, as in its treatment of medicine, *Our Cancer Year* differs dramatically from Fies's graphic novel. In *Mom's Cancer*, the patient and family come together to affirm the notion of patient autonomy. As Fies puts it in the preface, "No one will care more about your life than you do, and no one is better qualified to chart its course than you are. You are the expert." In contrast, from the introduction of its two protagonists to the conclusion, in which Joyce's five teenaged refugee friends arrive for a visit as Harvey rests up after chemotherapy, *Our Cancer Year* repeatedly demonstrates alternatives to the reliance on experts and the concept of the isolated individual. It's "our cancer" not "Harvey's cancer," and the best treatment decisions are made not by Harvey alone but in concert with those who care about him.

The characters' identities are also more multi-dimensional than in Fies's book. Harvey—whose non-Hodgkins lymphoma could have been the focus of his introduction as Mom's cancer was—instead describes himself in terms of his work, creative activity, and financial status. Joyce defines herself as a caretaker, in her own family and in society. But she is also "a sort of 'comic book'" journalist who writes about peace and social justice issues." And as she tells us in an afterthought, she's also a feminist: "Oh! And my name isn't 'Pekar.' It's **Joyce Brabner.**" In other

words, issues of work, money, social justice, peace, and feminism take center stage in the introduction, while the narrative introduces Harvey's cancer only after introductions are over, when Harvey muses, "Maybe I should start this thing by mentioning that in 1987 I noticed that I had a small lump in my left groin."

Though the discovery, diagnosis, and treatment of Harvey's cancer follow a course not much different than Mom's, its narrative representation has a much broader scope. Pekar and Brabner intertwine the cancer story with several others unwinding at the same time: the troubling gentrification of the Cleveland neighborhood in which Harvey and Joyce live, which requires them to buy and attempt to renovate an old house; the relationship that develops between Joyce and the participants in a student peace conference, which takes her first to New York and then to Tel Aviv; the personal struggle of Delores, Harvey's African American home care aide, to free herself of her abusive husband; and the human turmoil that results from the beginning of the Gulf War, as Operation Desert Shield escalates to Operation Desert Storm. Pekar and Brabner's strategy of multiple narratives at different scales prevents the distorted representation of illness that Sontag felt resulted from the "military rhetoric about cancer." Comparing Harvey and Joyce's experiences with lymphoma to the experiences of Uri and Dana in Tel Aviv, Zamir in the Palestinian territories, Saroem in Cambodia and Los Angeles, and even Delores right there in Cleveland, the graphic novel puts cancer in perspective for readers. Rather than oscillating between over-optimism and excessive pessimism, we see cancer as one among many threats to human health. This long list includes disease and illness, but also warfare, gang violence, domestic violence, and the economic inequities that make access to decent health care impossible for the working poor in the United States.

Four panel sequences from *Our Cancer Year* illustrate how this graphic novel troubles all the standard frames of the medical humanities, shifting the conception of the patient from individual and normate to non-normative, intersectional, even collective; changing the understanding of illness from the narrowly medical to the broadly socioeconomic, and blurring the boundaries between health care worker and person requiring health care. The first episode, which occurs partway through Harvey's chemotherapy for non-Hodgkin's lymphoma, identifies the patient as the *couple*. Harvey comes with Joyce for his chemotherapy treatment, concerned that his compromised immune system may make treatment impossible. Sure enough, the blood test results come back, and his doctor tells the nurse he can't receive chemotherapy. In a telling interchange, the treatment room nurse brutally kicks Harvey out of her territory. And as they leave the chemo room, Joyce hears the nurse effusively greet an elderly woman patient as "Miss America!" She muses: "Those are the good patients. The bad patients are the noisy troublemakers, like us. Wait a minute . . . when did this become our cancer?" Joyce's defiant stance calls attention to the damaging hierarchy structuring medicine. The doctor outranks the nurse, but the nurse holds sway on her turf, the chemo room. There, the nurse expresses her authority over the patient

by differentiating good patients from bad and exiling the latter from care. The inter-subjective view of illness in *Our Cancer Year* moves beyond the attention to the family system impacts explored in *Mom's Cancer* to confront directly the structural failings of medicine itself.

The second and third panel sequences expand our notions of illness and treatment. In January 1991, Joyce wakes in the middle of the night to hear a phone message from her young friend in Tel Aviv: "I love you. And G—good bye." The traumatic nighttime phone call comes back to Joyce the next day at the grocery store, and she suddenly bursts into tears: "For some reason, she's no longer able to figure out which brand of chocolate pudding is the better buy. An older woman comes over, selects a package for her, and puts it in Joyce's cart. "It's okay, honey," she says, "There's a lot of what you've got going around right now." Joyce's two preoccupations—war and cancer—collide in painful absurdity in a third sequence entitled, "Norman Cousins meets Stormin' Norman." "Joyce brought home a Marx Brothers video to help Harvey take his mind off his pain. 'We'll turn it off,' she tells Harvey, 'if you can't get into it. But Cousins convinced a lotta people stuff like this helps. This one's your favorite, right?" Suddenly, the TV reports a "direct hit in the city of Tel-Aviv," only to be replaced—when the video finally loads—by a fight scene in the Marx Brothers' *A Day at the Races*: "I've had my eye on you guys. What're you fighting for?" "We no fight'n. We pals!" Both panel sequences demonstrate the scaled pathologies of the present moment. We are left wondering: as she works for personal and social healing, is Joyce engaged in a task as meaningless as shopping for chocolate pudding, as absurd as a Marx Brothers movie?

The fourth panel sequence challenges the distinction between health care provider and person requiring care. Though Delores has been hired as a home health care aide to assist Harvey with the practical details of his treatment, she suffers herself from a range of injuries: "She'd been assaulted by her father as a kid, mugged by street criminals, and raped by a cop who stopped to 'help' her, when her car broke down. Delores is a single parent. Her fifteen year old daughter, locked up in a reformatory in Columbus, was a constant source of concern." Care and support go both ways. After Delores has helped Harvey through his last chemotherapy treatment, she calls to tell him, "I'm at the hospital, getting treatment for facial wounds. My boyfriend and me got into a fight." As Delores explains, her boyfriend had violated parole, arrived at her house and assaulted her, then held the police at a standoff for a while, and was finally thrown in jail. "I don't want nothing more to do with him." Delores says. "Any man that hits a woman." In a final panel set off visually as direct address to the readers, Harvey explains, "Subsequently he was back in touch with her by phone, though, and I wondered if she was going to give him another break, this woman who had been hurt and abused by men all her life." Delores suffers from the violence against women that results from racial and economic injustice. As Crenshaw's (1991) analysis of the "dynamics of structural intersectionality" explains: "multilayered

and routinized forms of domination . . . often converge in these women's lives. . . . Many women of color, for example, are burdened by poverty, child care responsibilities, and the lack of job skills" (p. 1245).

The final panel sequence forms the conclusion of *Our Cancer Year* and demonstrates that healing practices transcend the expert vision of medical professionals. Though Harvey's radiation treatments are finished, his recovery is stalled by depression. "Brush my teeth, shave, do the same things day after day for years. For what? Just so I can stay on a treadmill to death. I haven't felt happy in months. Life isn't worth a shit to me now. It's just a burden. But why can't I just die?" He tells Joyce, "I don't know what to do. I don't know if my problem is physical, mental, or both. I'm so tired, I'm so scared . . . maybe you should put me in the hospital again." Yet Joyce, like *Our Cancer Year* itself, refuses the narrowly medical context. Instead, Joyce arranges a visit from her five student peace-activist friends, hoping they can teach Harvey that "Every one of us is dealing with big problems. We won't be able to fix everything. . . . But, we can help each other feel better." Healing work and peace work converge. The students recall their experiences of being under SCUD missile attacks during the Gulf War, while Harvey awaits the results of his post-treatment CAT scan. The good news that the scan is clear moves Harvey into the position of healer. As the novel concludes, he takes one of the students on an outing to see a waterfall: "It's not an enormous waterfall or anything, but if you feel like a ride, we could go see it. There's a good used book store near there, and a place that sells popcorn and ice cream." The wordless final page celebrates the day of simple pleasures as a moment of shared healing.

CONCLUSION

Although medical humanities returns us to the human part of the medical experience, moving beyond medicine's reliance on scientific rationality, that approach is limited if we don't question the frames within which we operate, frames both literary and medical. We have seen how the simultaneously linguistic and pictorial, linear and spatial modalities of graphic fiction enable us to complicate the medical view of one patient's illness and treatment. Economic deprivation, racism, chronic disability, and warfare all threaten human spiritual and physical well-being, producing negative health effects. While in *Mom's Cancer* those phenomena are, by and large, deemed extra-medical and only viewed as the province of Mom's self-indulgent, wacky ex-husband, *Our Cancer Year* insistently forces us to see their interrelation with, and profound effect upon, medical treatment. We learn that physicians' offices and hospitals are not the only places where treatment takes place, and that pharmacology and surgery are not the only options for cure.

My comparison of these two graphic fictions moves me to reconsider my allegiance to the term "medical humanities." Is that label too narrow for the ways

we should be thinking about illness and treatment? Recently, several scholars seem to think so, producing work that moves beyond the walls of the clinic to consider how race, gender, class, ability, ethnicity, and nationality—to name but a few of those mutually imbricated, intersectional identity categories—shape the health care we receive (Canguilhem 1991; Hawkins 2000; Stanford 2003). In a related field, Norman Daniels has advocated a change from the model of medicine to that of health, as part of his call for a “broader bioethics agenda,” noting that “Bioethics’ traditional focus on clinical relationships and exotic technologies has led the field away from population health, health disparities and issues of justice. The result: a myopic view that misses the institutional context in which clinical relationships operate” (pp. 22–35). Could a similar myopia afflict the medical humanities? We know from postconventional thought that the terms we use contain within them the unacknowledged boundaries of our thinking. And we have seen that such epistemological restrictions can produce nescience—that unawareness or ignorance that was my Word of the Day. It is tempting to conclude, then, by advocating that we, too, move beyond the medical frame to redefine our research area as the “health humanities.”

Yet merely switching frames isn’t the solution. Each new framing narrative produces a new norm and thus a new category of Other. Consider how Daniels indicts those focused on medicine for their “myopic view that misses the institutional context in which clinical relations operate.” In an unconscious display of ableist normativity, he uses the term *myopic* as a criticism. There’s more going on here than a simple failure to catch one’s own prejudice: the comment also testifies to an imaginative gap between the perspective of medicine and that of disability, with consequences worth exploring.

Medical humanities and disability studies scholar Diane Price Herndl (2005) has argued that the distinction between disease and disability produces conceptual limitations for researchers, resulting from the different histories and contexts of the two fields: “Disability studies originated from the activism of people with disabilities; the medical humanities evolved as a way to try to balance the heavily technological bent of physician education that stressed science too heavily.” Different structural consequences result from those different histories, in Herndl’s view, shaping each field’s sources of support, intended audience, and ultimate goals. Medical humanities as a field relies on medical institutions for funding, addresses an audience of physicians and health professions, and focuses on improving “the status quo.” In contrast, disability studies “takes as its primary goal changing policies, environments, and minds” (p. 595). Herndl delineates the problematic mutual exclusivity that structures the scholarship produced by these two closely adjoining fields:

medical humanists are too committed to a medical model of the body that sees it as the “*there*” that is really there . . . [while] disability scholars are so committed to a model of an almost infinitely malleable social construction of the body that

scientific disciplines may ignore us. The medical humanities has [sic] the attention of many physicians and the institutional space to make changes in medical practice. We [the disability studies] have the critical consciousness to redirect that change so that it better serves the need of patients. (p. 595)

Herndl's move to question the structural frame of both fields is exemplary. Whatever label we choose, such a strategy of continuous reframing is essential if we want to do useful work. If we wish to move beyond nescience, we can no longer afford to limit our scholarship to one perspective. And we can no longer get away with defining our research fields as mutually exclusive, whether we define them as medical humanities, health humanities, or disability studies.

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