*We are each allotted a sliver of space-time wedged between not yet and no more, which we fill with the lifetime of joys and sorrows, immensities of thought and feeling, all deducible to electrical impulses coursing through us at 80 feet per second, yet responsible for every love poem that has ever been written, every symphony ever composed, every scientific breakthrough measuring out nerve conduction and mapping out space-time. I mean, it's astonishing that we're not, you know, spending every day in marvel at the improbability that we even exist. You know, somehow, we – we went from bacteria to Bach. We – we learned to make fire and music and mathematics, and here we are now, these – these walking wildernesses of mossy feelings and brambled thoughts beneath this overstory of 100 trillion synapses that are just coruscating with these restless questions.*

Maria Popova

# **Stretching the Vitruvian Man:** Investigating Affective and Representational Arts-based Methodologies Towards Theorizing a More Humanistic Model of Medicine

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I dedicate this work to my beloved village, without whom none of this would be realized. I am genuinely forever indebted to Bary, Beulah, Dianne, and Lionel for giving me room to breathe, think and work – a magnificent gift. I extend a special feeling of gratitude to my sisters, Jaclyn and Leolah, and brothers, Chris and Steve, who are my biggest cheerleaders. I dedicate this work to my grandfather, who always found the opportunity to talk about my cleverness in my youth, even though I question how realistic his assessment may have been. By loving my mind, he taught me its value.

This work is as much for as it is of Callie Long, who has set for me the gold standard for nourishing, generative and rich growth through collaboration. I also dedicate this dissertation to my brilliant friends who have supported me throughout the process with their friendship, refreshing perspectives and laughter. To my treasured partner, Haven, who gives me the room and opportunity to exist in the beautiful pockets of the world outside of my independent research. Lastly, I dedicate this work to my children—without whom this endeavour would have been finished years earlier—you are beautiful wells of inspiration, each of you. We are all only as rich as our village, and I feel surrounded by abundance.

## Abstract

**Stretching the Vitruvian Man:** Investigating Affective and Representational Arts-based Methodologies Towards Theorizing a More Humanistic Model of Medicine

Westernized medicine can be said to illustrate its history and structure, as well as its current understanding of the capacity and appearance of the human through its visual representations of the body. Scientific images, this paper argues, become a site for interrogating the tangle of idealism, truth, objectivity and knowledge in how knowledge is actively used, replicated, paralleled and otherwise functions. First, asking how depictions of the medicalized body inform the epistemological foundations of medicine, and to what end, this work opens up the question of methodology, arguing that the integration of the modes of arts-based practices can bring medicine toward a much more realistic picture of the world. A parallel argument is a similarly concentrated interrogation of the affective quality of arts-based methodology, which is commonly understood to be the nucleus of work on the political dimensions of non-representational theory. I complicate the dominant scholarly preference for an ontologically rooted affect theory, finding it theoretically non-viable for art and humanistic medicine by thinking through subjectivity, autobiographical accounts of illness and epistemological flexibility. I see a path forward using a biologically and evolutionarily rooted affect theory, noting the ethical implications of its differences for a humanistic approach to medicine.



*Keywords:* affect theory, art, autopathography, empathy, methodology, weak theory

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rewarding by fuelling thinking with emotion. Tomkins writes, “The interrelationships between the affect of interest and the functions of thought and memory are so extensive that the absence of the affective support of interest would jeopardize intellectual development no less than the destruction of brain tissue. To think, as to engage in any other human activity, one must care, one must be excited, must be continually rewarded” (343). The Neutral affect combo of Surprise—Startle is purposeful towards total reset. In its mild form it stops you from what you are doing to get you to pay attention to something novel. The more extreme form, startle, causes a “massive contraction of the body” triggered by a sudden, brief stimulus. Negative affects are inherently punishing. Shame—Humiliation, “the self-protection signal,” the affect of focus in Sedgwick’s “paranoid imperative,” comes from the interruption of joy. The intrusion causes us to focus intently on the cause, to ensure that the feeling can be avoided. Distress—Anguish, “the cry for help,” is deeply social. It is a signal fire to others that something is wrong, and assistance is needed. Disgust is the affect that presses us to expel literally and figuratively: noxious food, sounds, sights and thoughts trigger similar responses. Fear—Terror is the fight or flight trigger.  Anger—Rage is caused by overload from persistent high-density neural firing. Dissmell [sic], “the avoidance signal,” is the trigger to push or pull away from things that shouldn’t be ingested or things that trigger repulsion. Dissmell, combined with anger, looks something like contempt. The facial response to sour milk and a person that triggers contempt may be indistinguishable. It is worth emphasizing that categorical affects are combinable, have subtle and more extreme expressions, are contagious (motivate a mirroring effect) and, interestingly, can motivate

## Introduction

*The Vitruvian Man*, created by Leonardo da Vinci in about 1490, was named for its muses: the Roman architect and engineer, Marcus Vitruvius Pollio, or perhaps more specifically, his intellectual legacy. Vitruvius, who died approximately 1500 years before *The Vitruvian Man* (around 15 BCE), was preoccupied for much of his career with the task of determining perfect proportion in both architecture and the human body, which he documented in several volumes of a major work titled *De Architectura* (c. 30 BCE). The book became a cradle for the canon of classical architecture. Through da Vinci's interpretation in the creation of *The Vitruvian Man*, *De Architectura* also inspired something of an archetype for human anatomy. Interest in Vitruvius' works further spurred a fascination with classical ideals, culture and scientific knowledge that surged in the Renaissance as relics from the ancient world were regularly "rediscovered" and republished. *De Architectura* was revived from the Abbey of St. Gallen in 1414 by Poggio Bracciolini, a Florentine humanist (Krinsky 36). Scholars from the Renaissance looked to classic Rome with even more romanticism than we do now when we look back on the significantly shorter period of 530-or-so years to the Renaissance when *The Vitruvian Man* took shape. *The Vitruvian Man* remains a vessel for the classical ideals that inspired it—an impeccable representation of "perfect" movement, proportion, balance and poetry. It is a mapping of the body: the layered positions create sixteen distinctive postures articulating human movement through science and geometry; a complete blend of art and science.

*The Vitruvian Man*, for me, is a rich figurative vessel that visually discloses the layering of very particular aesthetic ideals and a model of science constructed to mirror these principles. This image of the ideal form was drawn in a historical moment that embraced a burgeoning wedge between the church and reason, and so it sat just on the cusp of tumbling into an episteme informed by secular Humanism that would appear to split science and reason from allegory. Yet, because the symbolic attachments we hold the body against are so strongly integrated into our thinking, these attachments could not be easily abandoned, even if they were no longer respected as a subject for, or alongside, scientific inquiry. Consequently, iterations of the mapped ideal body of science and medicine that, in fact, preceded da Vinci's *The Vitruvian Man* and would proceed from it, would increasingly naturalize the act of depicting an ideal form so thoroughly that the active symbolic power of the medicalized body would be rendered effectively invisible. The same fate is found in the operative elements of these scientific images: much of the work of the image becomes unseen. And, while the functions of the image—its actions in knowledge-making—may be unseen, they are by no means unproductive. This hidden but strongly operative dynamic remains true today. Images in science and medicine reflect and reinforce particular power structures. They direct how we understand and act upon the body.

*Stretching the Vitruvian Man: Investigating Affective and Representational Arts-based Methodologies Towards Theorizing a More Humanistic Model of Medicine* presents two fundamentally entwined, corresponding ideas. The first thread of this twofold thesis consists of an investigation of the impact of visual culture on medicine, asking, "How do depictions of the medicalized body inform the epistemological

foundations of medicine?"; "To what end?"; and, "How might new ways of seeing and engaging radically rework what we believe to be natural and true for medical knowledge and practice?" The second thread calls upon the performative qualities of the methodological strategies I wish to press into medical knowledge and practice. I call for an affect-rich arts-based approach, but in doing so, I also complicate the dominant scholarly argument that ontologically rooted affect theory is ethically and philosophically viable by scrutinizing its function in art and medicine. I ask, "What does a biologically and evolutionarily rooted affect theory do differently for subjectivity, autobiographical accounts of illness and arts-based methodologies?"; and, "What are the ethical implications of this difference for a humanistic approach to medicine?"

This research project is built on several columns of study from visual culture, art history, medical history, medical humanities, cultural and medical anthropology, affect studies and philosophy. Moving toward a humanistic model of medicine requires a centring of the patient in a way that often runs divergent to what our current medical model encourages. Thus, some degree of renovation, expansion or repair is in order. To centre the patient, as a human, embodied, discrete subject, is also to embrace a great deal of interdisciplinary concerns. To this end, I frequently stretch my project quite wide to accommodate several domains and interests in the spirit of the repair. Mending requires resourcefulness and inventiveness, and interdisciplinary work brings novelty and breadth to the undertaking. Yet, as patient centring remains the goal, so this project takes great pains to frequently tighten the scope, to also think through strategies that espouse contingent and intimate feeling, thinking, knowing, and acting.

The intellectual footing visual culture and art history provide for this project are most informed by multiple outputs by scholars such as James Elkins, Marita Sturken, and Lisa Cartwright who take on the topic of the making, flow, and consumption of images, including images of the body, and who build on work by scholars like Irit Rogoff, Nicolas Bourriaud and Donna Haraway. These latter writers are foundational for our understanding of how subjectivity and perception affect our ways of seeing through what Rogoff calls "viewing apparatuses," (18)[1] and in what Bourriaud coined the "relational aesthetics"[2] of what I call "the art experience": how we look, why we look, and what work our looking does. This constellation of ideas go a long way to confront the notion that the act of seeing, in any discipline, is never fully subjective or objective, troubling the beliefs that what we preference connects only to some unshakable subjective essence and that scientific looking has mystical access to a disinfected objectivity. Haraway's *Simians, Cyborgs and Women* (1991) demolished the illusion of either, which, while differently structured, equally presupposes a "conquering gaze from nowhere," that Haraway replaces with the "embodied nature of all vision" (188).

I work especially hard to speak to our everyday viewing habits as they connect to the social, historical and cultural forces that constrict or expand them. I am interested in

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[1] Rogoff explains, "It is this questioning of the ways in which we inhabit and thereby constantly make and remake our own culture that informs the arena of visual culture. It is an understanding that the field is made up of at least three different components. First, there are the images that come into being and are claimed by various, and often contested histories. Second, there are the viewing apparatuses that we have at our disposal that are guided by cultural models such as narrative or technology. Third, there are the subjectivities of identification or desire or abjection from which we view and by which we inform what we view." (18)

[2] Bourriaud connects artistic practices to theoretical and practical affairs that take as their purview the "whole of human relations and their social context, rather than an independent and private space," towards an art experience that is "a social environment in which people come together to participate in a shared activity" (113) where "the role of artworks is no longer to form imaginary and utopian realities, but to actually be ways of living and models of action within the existing real, whatever scale chosen by the artist" (13).

eroding some of the distance we place between the objects of science and the world itself. We have a tendency to mentally separate the looking done in medicine, what Michel Foucault coined the "medical gaze" in, *The Birth of the Clinic: An Archaeology of Medical Perception*, first published in 1963, as if it is somehow not subject to the same forces as everything else. I believe it is especially important to challenge medical clinicians and researchers to examine everyday viewing practices, because while they may have exceptionally specialized knowledge about the output from an MRI, they are no more immune to the power and symbolism contained in its aura than their patients. Indeed, perhaps it could be said that medical clinicians and researchers are even more interpellated,[3] for they are far more entrenched and invested in the myths of their profession.

I am interested in the conceptual disorganization that the art experience provides to the topic of the sick body. Far from finding a deficiency in the critical potential of conceptual disorganization, I look to the potential of this turmoil. What possibilities does a process that nurtures conceptual instability—the refusal to permanently reach a decisive conclusion—hold? How can this disorganization fit into the kinds of critical thought that dominate the academy, and what, if anything, does this mean for the subject matter represented? To investigate this idea, my work draws on methodology as a subject in itself. Here, I orient my thinking much in the way of scholars like John Law or Carole Gray and Julian Malins, who concern themselves with the historical and philosophic context of methodologies and research, insofar as, like them, I often find parallels or stark

[3] Louis Althusser uses interpellation to describe the ways cultural ideas seize us with such strength that we internalize them and believe the thoughts and beliefs we hold to be our own. See: Althusser, Louis, et al. *On the Reproduction of Capitalism: Ideology and Ideological State Apparatuses*. Verso, 2014.

divisions between the procedures of the natural sciences and that of art or humanities. Addressing artists, Gray and Malins write, "One might say that a piece of research is only as good as its methodology!" (2) and I endeavour to blow a seed of encouragement further, complicating it into something like, "Research is only as good as its methodology, and methods bring possible futures into being. Make your methods worthy of the word."

I submit this work into the wealth of important labours in the study and practice of the medical humanities, an interdisciplinary field that has been established since at least the late 19th century, concerned with the humanistic dimensions[4] of medical education and practice as well as the specific study of humanistic medicine, which narrows toward the actual medical practice of clinical treatment towards holistic and patient-centred care. I wish to stay any confusion between similar terms "humanistic" used in this definition, and "Humanism" or "Humanist," which have already appeared in this introduction and, come up in my critique of science and subjectivity. While the terms share some roots, they do each have distinct meaning. "Humanism" is a philosophic movement that came out of the Renaissance as the public grew weary of the church and its perceived abuses of power, and pushed for the elevation of reason and an emphasis on science that could account for man in relation to the world. Humanism is best understood as belonging to a historical moment, and the legacy of Humanism is best understood as a foundational influence for the neo-liberal, self-contained subject (concerning ideas like human freedom and progress) and the positivist belief that science, logic and reason are

[4] The humanistic dimensions of medicine include philosophy, psychology, sociology, anthropology, cultural studies, literature, theatre, film, visual arts, comparative literature, geography, ethics, history, and religion.

the exclusive conduits for knowledge. Beyond the inheritance of Humanism, which nests itself in much of contemporary thought, the term sometimes is used at present to describe a nontheistic world view, which again borrows values from human-centred agency and secular science as a mode with which to understand the world. I underscore this distinction between Humanism and humanistic medicine by clarifying that this paper is somewhat critical of the legacy of Humanism but works toward a holistic, humanistic medicine.

It is also important to note that "humanistic medicine" and "holistic" are often terms associated with pseudoscience, alternative medicine, and treatments that are untested and unregulated. It is imperative that I distance these definitions from the work I do, stating that in this research, and the medical humanities, holistic care refers to the inclusion of a more complete understanding of the ways that intersecting social, physical, psychological, economic and geographic positions collide with an individual's response to illness and their ability to thrive. Humanistic medicine, then, is the conscious act of balancing and refining contemporary medical science and technology with the need to include the patient's voice with two aims in mind, as I interpret it. The first objective is to expand the epistemological field for diagnosis and medicine, and the second is to place a moving, responsive target on what health and healthcare resemble based on the discrete demands of the moment. My grasp of the tradition of humanistic medicine is indebted to and nourished by the work of scholars like Setha M. Low (1984), Sander Gilman (1995, 98), and Cecil Helman, (2007), whose writing has shifted my thinking on the cultural basis of health, illness and disease. I orient my work alongside thinkers like Fredrik Svenaeus (2003), Adam Rodman (2019), and Eve Kosofsky Sedgwick (2003) whose

work directly or indirectly moves towards the Aristotelian concept of phronesis, an ancient Greek term for wisdom germane to practical action, through character and habits. It is from such emboldening thinkers that I found inspiration to urgently connect theory to method.

In talking about the historical foundations of medicine as it is overwhelmingly practiced today in the Global North, there exists somewhat of an impasse where language falls short (as it is wont to do). A term like "Global North" is a replacement of sorts for "Western," which is a reference to the foundational birthplace of Western civilization in ancient Greece and Rome. "Western" is inadequate then, as "west" as a directional indicator is clearly an insufficient descriptor for a particular section of modern-day Europe on a spherical planet. West of what? In this answer, of course, lies the bleak heart of the term, where divisions have been drawn between the "civilized" and "uncivilized." As a replacement, "first," "second," and "third world" are more problematic but seek to layer in economic states and development of industry. "Developed" and "undeveloped" are a softer attempt to draw similar dividing lines but are not as strongly linked in our awareness to the ideological and historical foundations of the "west" that often shape the global conditions of "developed" and "undeveloped" countries alike. "Global North" is misleading as there is no clear linear relationship between geographic latitude and human development (Toshkov). "Global North" and "Western" both speak to ideological belief systems, with "Global North" including contemporary "Westernized" ideology, and "Western" speaking broadly to the historical moments that brought us to where we are. Most describe a kind of modern medicine as "Western" to nod toward the ideological building blocks that created it, despite "Western" medicine being practiced in many

corners of the globe and its many "non-Western" knowledge contributions past and present where "interchange" between cultural knowledge, it must be stressed, is "not all one-way" (Worsley 315). For these reasons, I generally prefer to describe "Western" medicine as "Westernized."

The term "Westernized" is a not-altogether-perfect gesture towards unsettling Eurocentrism in the language of economic, ideological and epistemological development. For me, "Westernized" speaks to a process of development with particular values and histories, and so it feels specific, without overtly subscribing to the belief that Eurocentric epistemologies are inherently more developed, objective, superior or isolated than any other source of knowledge, including knowledges contributed by practitioners of medicine who have done work in, under and outside of the academicization of Westernized medicine. This work was often (and in many cases is still) done in the same geographic regions where "Western" medicine is thought to be rooted, by traditional healers, women, and barber surgeons[5] or indigenous and immigrant communities. "Westernized" thus, seems to let go of stronger geographic tethers in favour of a gesture to the ideas, customs, and practices that activate a discipline.

Jonathan Metzl (2010), and Susan Sontag (1978) have each contributed in framing how I understand how it is that "health" can be taken up, made ideological and

[5] Barber surgeons were the precursor to the profession of dentistry in Europe in the Middle Ages. A barber surgeon would travel to fix teeth, cut hair, practice bloodletting, or give enemas. At this time, practical medicine and surgeries were the domain of the barber surgeon (men) or localized traditional healers (often women). Physicians were book-people that were attached to universities. Interestingly, the odd division that currently exists between dentistry and physicians has its roots in the divide between the practical medicine of the barber surgeon and the intellectual medicine of the physician as it stood in the Middle Ages. It wasn't until the 17th-century that medicine took on surgery as a profession. For more, see: Lars Himmelmann's "From Barber to Surgeon - the Process of Professionalization" *Svensk Medicinhistorisk Tidskrift*, pp. 69-87.

used to harm. I build on this reasoning to complicate the ways many thinkers take for granted the work in which representations of health and illness participate. I turn to non-representational thinking, to affect studies, to think through my claims for method and representation. My work here most closely evolves from a long-standing and deep love affair that I have had with the writings of Sedgwick. While my understanding of affect is overwhelmingly built on work by Sedgwick, and Silvan S. Tomkins (2008), my arguments for the capacity and application of affect-rich encounters move into several uncharted spaces and claims that I would hope Sedgwick (who died in 2009 after a long battle with breast cancer) would find agreeable.

My project offers a close analysis of actual private incidents of illness narratives, leveraged into art experiences. I draw on powerful work by Ingrid Bachmann, Sara MacLean and Dominic Quagliozzi. How can representational practices be elasticated by non-representational methodologies, I ask? I endeavour to illuminate how representational and nonrepresentational methods can coexist as valuable elements in a continuum of oscillating critical practices that are ethically urgent for the medical humanities. There have been some accounts of the rich connection between art and affect. The most notable analysis of this link can be found in Jill Bennett's 2005 book, *Empathic Vision: Affect Trauma and Contemporary Art*. Bennett and I diverge philosophically in our conceptualization of the "work" of art, but our goals—in terms of epistemological political renewal—remain largely in solidarity. To this end, my project can be read as a counteroffer for art and affect studies, for those who, like me, find an ontologically grounded conceptualization of affect to be ethically dubious for medicine, but recognize the important affective work in the art experience.

This project does some thinking through art, looking at visual representations of illness. Far from exhibiting an exhaustive survey of visual autopathographies, I present just three key instances of artists and patients who are grappling with the profound challenges of our precarious existence in conversation with the historical, cultural and philosophical intersections that contextualize the interventions of visual art and autopathography[6] through Bachmann, MacLean and Quagliozzi. It is no small irony that a project with the expressed goal of convincing the reader of the urgent need to make more contact with art, autopathography and arts-based methodologies is also subject to a necessary reductionism whereby I limit my examples considerably. My conventional academic desire to talk through the process of the "what" and "how," admittedly, is sometimes at odds with the "doing" I emphasize so strongly in my research. Know that I see my efforts here as a rallying cry and multi-layered justification for the integration of art and arts-based methodologies into clinics, research and medical education, offering what I hope is a resilient theoretical foundation for the many empirical and qualitative studies that have shown that art-based methodologies can improve clinical observational skills (Johanna Shapiro et al. (2016), C L Bardes, et al. (2001), Jacqueline C Dolev, et al. (2001), Shelia Naghshineh, JP Hafler, AR Miller, et al. (2008), ) or experiments that show how performative arts-based methodologies forge community, sociality and empathy between clinicians and patients (K. Matharu (2009), J. Stokes (1980), Marcy E Rosenbaum, et al. (2005), Johanna Shapiro and Lynn Hunt (2003)) or the discursive possibilities of art and medicine for clinical practice (R. Charon, et al. (1995, 2001),

[6] Autopathography is an autobiographical account of illness. These deeply personal illness narratives are often explored through text and images.

Johanna Shapiro, and Lloyd Rucker (2003), L. Jacobson, et al. (2004)) and countless other topics and reports.

I have found that researching a project of this sort, which has involved a great deal of bookkeeping for medical history, has the interesting side-effect of compelling one to take inventory of a lifetime of health events and think about how the trajectory of one's biological unravelling might ruthlessly spoil any whimsical conceptual trip back in time. And, while—likely like you—I'm tracking my privilege to be alive in the here and now, while orienting my research endeavour in proximity to others, I ought to also acknowledge that every personal peril I fear to face in historical daydreams would be perhaps equally precarious in the here and now were I not also advantaged by being born a white woman in the Global North, specifically Canada, in a time of socialized medicine and in an urban setting that allows for easy, proximate and "free" access to medical care. While I am critical of the modes and history of Westernized medical thought, I want to acknowledge the ways that I have benefited from it, from its technology and knowledges, but also its prejudices in both its research and practice. As a white Canadian, there are several overlaps in my intersectional identity that empower my social status and lend some power to my voice in the clinical setting. While women, in general, are disadvantaged in clinical practices and medical research, when we are advantaged, it is the cis, white woman who is first and best attended to. "Health" is complex and multifaceted. As I cover in Chapter One, *Medicine, the Image and the Problem with Both*, health and wellness cannot be excised from corresponding, cruel and formidable social realities.

My first key question asks how the epistemological foundations of medicine are informed by the visual culture of medicine, and to what end, opening up a call for new ways of seeing that can both problematize naturalized truths in medical knowledge, and also offer a way forward to a more humanistic model for medical practice and research. Taking on this task requires that I layer in a substantially-scaled historical analysis of the medicalized body in Westernized medical history, tracing depictions of the body from early man to the contemporary age of Pathological Anatomy. Chapter One, *Medicine, the Image and the Problem with Both*, takes up this quest to lay out a historical genealogy of the body-object in medical illustrations. In this tracing, I work to question and obliterate any clear-cut distinctions we may be inclined to make between art and science and subjective and objective images or viewing. I introduce and make a case for what I call "the dual function of the image" in the stable appearing theoretical ideology of the natural sciences, finding the importance of the dual function for the structural myths that esteem medicine's limited methodologies.

Much like *The Vitruvian Man*, contemporary images and imaginings of the medicalized body, I show, both illustrate human knowledge, wherein the image acts as a container for information, and also produce and guide knowledge by authorizing constraints that limit the epistemological potential of the discipline. By directly connecting the shape knowledge takes to the visible and obscured qualities of the dual elements I discuss, I am able to enter into a deeper synoptic analysis of the methodological vitality and limitations of disciplinary practices in and outside of medicine, arguing for a polymathic approach that integrates interdisciplinary, arts-based

methodologies to circumvent the conceptual traps to which the rigorous exclusiveness of what I call “the strong theory of medicine” is predisposed.

I describe the specific arts-based methodologies I wish to see incorporated into perceptions and practices of health, grounding the methods specifically in what I refer to as “the contemporary art experience.” This call for methodological vitality entails particular strategies for orientation with images and experiences (both biographical and immediate in nature). Through my synoptic analysis of methodological differences, I carve out the disparities in how we approach looking at art and looking at scientific images to break down the variances in the practical aspects that inform what possibilities and limitations are contained in each approach. I touch on several principal epistemological distinctions, but a primary concern lies with how both functions of the image are activated and apparent in an arts-based methodological approach, offering, I argue, a more realistic and ethically viable picture of the world. I conclude that the image is a powerful political tool that may be used to direct or redirect knowledge. However, I stress that it is, in actuality, not the image itself that holds the full, activated political promise I seek in this research, as many of the challenges that the dual functions illuminate cannot be simply sublimated by the swapping-out or inclusion of a more representative or just image. Thus, the significant agent of change that draws my inquiry is the methodological approach itself. What is required, I claim, is an exploration of the affective qualities of the art encounter: the ways it intersects critical theories and how it can be implicated in a way that orients medicine toward more ethical, care-based practices that can actively oscillate along the middle spaces between sentimentality and essentialism.

Throughout all aspects of this investigation, I am deeply conscious of the social, political and health impacts of what I call "the universal body-object of medicine," and its surprising reach across, and impact on, medical history, research, education and clinical practice. This epistemological framework that has both captured and been captured by medicine's universal body-object is a double-barred cage preventing access from both sides. This enclosure not only causes real harm to those who do not fit the picture of health, but also, it limits our ability to expand our medical knowledge further afield to improve what we know about the capacity of the human body and the sick experience.

I believe an integral part of this project requires an examination of the mythologizing we do around our concepts of "health" and "illness." I ask what effect this mythologizing has on sick bodies, as seen from the perspective of the sick person. I also ask how these myths are enacted through our utilization of sick identities as a means toward precise ends. Incorporating representations from institutional and cultural sources, I conduct a visual and content analysis of the mythologized sick experience, identifying an urgency for resources that present a more realistic expression of the sick identity. A decisive moment occurs in Chapter One when I draw the conclusion that in order to combat the current picture of health, we need to do two things: 1. amplify patient power in the determination of the picture of health to repair the broken link between the patient and embodied knowledge. This shift would press the importance and value of the patient voice for both patients and medical professionals, and, 2. carefully excise the universal body as a marker of ideal health. To achieve both of these tasks, I show, we need to attend to the patient experience. I state that the most effective tool for this is through the

power of the image to direct and reflect knowledge, incorporating methodological orientations that are capable of underscoring patient experience as a central component in a larger network of collaborators. It is this latter concern that leads me into the second thread of my thesis.

Through an interrogation of the performative qualities of affect-rich arts-based methodologies, my second fundamental problem concerns the prevailing centrality of an ontologically-rooted affect theory in academic writing to conceptualize the political work of the art experience. Affect theory looks at the neural mechanisms of emotion and has been woven into compelling research through psychoanalysis, geography, neuroscience, psychology, literary theory, critical theory, gender studies, and more. Work done through affect-rich methodologies seeks to develop affective states where bodies mark each other in real-time and explore how affect moves and directs action. There are multiple approaches to affect theory, and this text takes up two noteworthy trajectories by doing another genealogical sketch: back-tracking divergent branches of the affect family tree.

The first branch I call “Spinoza-Massumi” (after Baruch Spinoza and Brian Massumi), and it is a Deleuzian inflected, ontological theory that understands affect to exist externally, in a pure form before and around the human. The second branch I call “Tomkins-Sedgwick” (after Silvan Tomkins and Eve Kosofsky Sedgwick), and it is a bio-psycho-social ecology tied to biological limits and evolutionary adaptation. This second branch, which I preference in my work, theorizes that biological life forms are determined by their complexity (their range of motion as they change and are changed by their environment).

It is important to my project to find ways to move through affect along routes that are not seated in an ontological construction. Because, while I do understand the experiential methodologies of the art experience to get their political capacity from their affective qualities, I also recognize that the broader political project I am embarking on demands a theoretical model that can comfortably conceptualize illness identity,[7] autopathography, and the activated, affective work of representational theory.[8] The commonly centred ontologically rooted affect theory found in so much academic writing on art generally sits in sharp opposition to stable appearing identity, autobiographical narratives and the political potential of representational work. I make a sustained argument for the vital, lively and affective work that can be done in these aforementioned critical spaces and the how crucial this affective work is for both arts-based methodologies and medicine.

I outline an inclination towards a bio-psycho-social model of affect theory, but I do not do this merely because it snaps on more comfortably to the representational and biographical integrations I make. Much more than that, the bio-psycho-social model, I argue, is more ethically rigorous and inclusive; and I contend this is especially so in the context of medical knowledge and practice. Empathy has been politized and problematized as a conceptual tool for learning from and recognizing the other.

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[7] An illness identity can be understood in several different capacities. In its "strong" form, it is the transformation of individual experiences into a collective illness identity, or it is an individual identity circumscribed by illness. In its "weak" form, it can be a sociable, responsive, or restructuring force. The complexity of illness identity is explored in Chapter Three, section two, *Autobiography unfettered: affect theory and autobiographical openings*.

[8] Representational work covers the majority of what has been produced under the auspices of human knowledge. Representational theory simply refers to how humans solve problems and represent knowledge through complex systems. Within affect theory, it has added and contested significance. For more on this, see Chapter Two, section three, *Art undisciplined: the relational epistemology of the art experience*.

Theorizing empathy necessitates a conversation around subject and other, and this paper draws on empathy work from trauma studies by Dominick LaCapra (2001), work from psychology by Melanie Klein (1988), and affect studies by Carolyn Pedwell (2012) to think through the performative effects of affect, filtered through the methodological lens of this paper and brought to bear on and through my concept of "the shifting subject" to demonstrate that reparative work can be neither complete nor housed in an uncomplicated state of "feeling for" the other. My concept of "the shifting subject" has a particular affinity to LaCapra's "empathic unsettlement" a playful, "middle voice;" a "radical ambivalence" of observer and observed (20). However, what "the shifting subject" does differently is provide a mapping of the uniquely visual dynamics of an engaged empathy-space that requires a strong sense of feeling be paired with a "shapely" subjectivity. The political value of "the shifting subject" does not assert itself singularly, but unfolds over my integration and analysis of the works of Bachmann, MacLean and Quagliozzi as well as in my critique of the shattered and discarded subjects of a Deleuzian or Massumi modulated affect theory in Chapter Three, and lastly, at the end of the chapter, through the work on the active ethics of affect.

Chapter Two, *The Mess of Knowing*, is a vital bridge chapter wherein the linked nature of the two theses becomes apparent. I introduce autopathography more thoroughly in in terms of form and function and use it to trouble the existing issue of the patient as an unreliable narrator, first looking at the doubt cast on patient accounts but also pointing out that the patient experience and the medical institution can seem like two mirrors reflecting the same image back and forth incessantly: both projecting an idealized picture of health or illness. Pushing this analysis further, I ask the reader to think through the

dynamic action of truth in knowledge production. Specifically, I ask that we consider our collective deeply invested faith in exposure. I use the work of Jeffrey K Aronson, Rita Felski, and markedly, Eve Kosofsky Sedgwick, to unravel how it is we centre suspicion as if revelation is mechanically and functionally solution-oriented.

Marking specific ways in which the scientific image becomes a reference to back-up, underline and solidify future claims, I point to how this process adds power to the determined truth-value of the image through symmetry that sees the image prove itself through itself. Any expanded meaning that arises from the image is built on the shoulders of prior iterations. The mimetic and positivist legacy that directs how the image of the medicalized body can be read in the scientific method makes it function tautologically. It is the dual function of the image that traps it, reproducing ideals that are self-confirming and seem to be operationally stronger than the collective work being done to illuminate the stark fact that medicine's standardized body, on which research is centred, is fundamentally different from medicine's actual subjects.

The dual function of the image is able to be operatively stronger because it is a "strong" theory, in a cannibalistic sense, by which I mean that any investigation of its history or social context ultimately becomes another nourishing morsel to sustain the stability and potency of the image. "Strong" and "weak" theory are terms that come from the work of psychologist Silvan Tomkins. Tomkins understands "weak" theory to be a descriptive and site-specific method for investigating close phenomena well enough to engage and respond, but without motivation to attempt to make a truth claim.

We need to trouble the mess of knowledge by investigating how our modes of approach complicate, enliven or obscure the futures we seek. It is this expressed point

that raises the considerable epistemological concern that ultimately compels my focus on methodology. There is something in the action of practices like the art experience that can potentially break us out of the traps outlined in *The Mess of Knowing*: the quagmire of the history of Westernized medicine, articulated through its images and practices, has added potency to myths of health and normalized the undervaluing of patients' perspectives. In my examination of the medical image and its dual operations, I determine that even the most purposeful act of reading and contextualizing the image, and learning a great deal from it, is not an unobstructed path for repairing it.

To study a methodological approach is to learn something of what is esteemed in a discipline; of its hierarchy of value; of how it explains and creates reality. John Law pointed out that it is a fool's mission to attempt to paint the world as a knowable, stable thing (Law 5). In staking this claim, Law was largely critiquing the objectives of the natural sciences. If we further layer in research on the human subject, the fluid, elusive, and multiple dynamics of the world really do demand a methodological vitality that can account for a more realistic picture of what is actually before us. When particular methods become synonymous with common-sense research, we end up with stable-appearing theoretical ideology. When the third-person account of a positivist or applied biology becomes the uncritical manager of the sick experience, the world and the body become known, determinate, and traceable with straightforward procedures that have very, very often not provided health/care for the patient on the table. When knowledge is not a practice it loses its living connection to being in the world and becomes entirely representational.

Medicine deals in the "strong" far-reaching methods of manipulation and control. Fredrik Svenaeus underlines this when he writes, "Medicine attains its meaning through its own history – through the permanence and changes that have characterized medical practice and the theories of medicine in the past," creating a meaning-structure that expresses itself through the actions and institutions of medicine (*The Hermeneutics of Medicine* 119). I stress the importance of recognizing the benefits and limitations of a "strong" understanding of the body-object of medicine. On the one hand, there is comfort and prognosis in the recognition of a treatment and pathological status that is substantiated by the larger, evidence-based meaning structures of medicine. But, on the other hand, it is alarming how insensible we are to the layered, messy, biological, psychological, social, cultural and existential perspectives that at once have critical impact on patient health; are subsumed under the purview of medical science, but utterly escape recognition, study, or practice in the meaning-structure of the discipline.

In advocating for alternative methodologies in Chapter Two, I explore two strategic modes that I see as hopeful to my project: the reparative approach, which is rooted in Sedgwick, opening up vitality, performativity, and mobility, and a phenomenological account of medicine which comes from scholars like Drew Leder (1990), Hans-Georg Gadamer (1996), Kevin Aho (2018) and Fredrik Svenaeus (2019, 2003, 2011). Svenaeus' work is most influential to the ways I think about how clinical practice can decentre the "strong" qualities of medical knowledge and activate corporeality, sensuality, and multiple critical perspectives. The reparative approach is something, I argue, that may be best realized through the tools and modes of an arts-based methodology. For my objectives, a phenomenological account of medicine, while

philosophically independent, provides a valuable roadmap that shows ethics consistent with those I argue are present in an arts-based methodology, leveraged towards a goal of a more humanistic medicine, supplying a precedent for a realistic clinical practice. Both, I hope, work to build a strong case for the incorporation of more affect-rich tools in research and practice, responding to both the "how" and "why" of the project.

Towards the centre of Chapter Two, I distil my critique of the culture of medicine, showing that medical knowledge is hamstrung in thought and practice, presenting several problems. These problems include the belief that medicine is a hard science; a corresponding misplaced faith in exposure, a positivist view of the truth-value of the image; and the understanding that its primary subject is the universalized body-as-object. I identify two needs medicine must address when integrating new, dynamic methodology to gain access to a wider array of experiential knowledge. There must first be a recognition of the value of individual physician knowledge, emphasizing practical reasoning and; second, an appeal for medicine's applied biology to be augmented by the highly valued, active inclusion of the first-person perspective of the patient. In seeking a playing field for "strong" and "weak" theory that can be responsive and access nuanced, flexible and practical ways of knowing, I hope to find and maintain affective power for both strong and weak treatment for objects of study and engagement. In the case of medicine, these objects of inquiry are living, feeling humans, so the stakes are high.

I strongly advocate for personal accounts of illness as a self-evident way forward for integrating the patient perspective. Autopathographies can help define the parameters of wellness as it pertains to a particular patient in a given moment. Art often takes autopathography as a subject, and art had a long history of being viewed as a robust

political tool for inciting action due in no small part to the affective and non-representational qualities of the work. The final section of Chapter Two converges on affect theory, the force-relations between bodies and actions. I first describe affect theory, identifying it as the primary stimulus behind all human activities and as the chief focus of several art historians, critics, theorists and philosophers regarding the importance of art practice for epistemology writ large. In drawing lines between the methodological moves of the art experience and art practice, I emphasize an underacknowledged reality in art and affect studies: there does not appear to be anything inherent in art that necessitates the features of the contemporary art experience as it distinctively appears today; all that is prized by thinkers about the contours of the affect-rich contemporary art experience—the "stuff" that holds the promise of a tendency towards "politico-epistemic renewal" (*Non-Representational Methodologies* 3)—is not something that has been consistently recognizable or attached to art and the art experience broadly speaking. This detail is due to the fact that art has been shaped by the forces that engage it. It is at this juncture, at the end of Chapter Two, that my second thesis begins to assert itself fully.

My advocacy for an affect-rich arts-based methodological approach for medicine that has theoretical latitude to recognize the need for autopathography, sick identity and the necessary integration of the "strong" objectively inflected meaning-structures of the natural sciences requires that I press affect theory in ways it is not often nudged through this investigation; perhaps to the edge of what most affect scholars may be comfortable acknowledging. So much of my thinking is indebted to the robust work done in affect theory by scholars like Brian Massumi, Erin Manning, Sarah Ahmed, Henri Bergson, William E. Connolly, William James, Nigel Thrift, Alfred North Whitehead, Antonio

Damasio, Paul Ekman, Adam Frank, James Elkins, Silvan Tomkins, Grant David Bollmer and Sedgwick. In the final chapter, Chapter Three, *An Alternative Implication for Art and Affect*, I am looking for a middle ground approach from affect theory that is logically consistent, ethically sound, can account for the affective work of arts-based actions, and, importantly, does not dismiss the centuries of important—if habitually unsatisfactory—work that has been done towards deepening our collective knowledge of the material, biological body. Thus, I seek fewer, not more conceptual barriers to an oscillation between representational and non-representational theory, as well as a fluctuation between "strong" and "weak" theory. I believe the representational aspects of art, autobiography, and theory are not only valuable but also necessary when our subject is the sick experience. The middle-ground approach recognizes that numerous actors have already done important work to shift towards a more humanistic medicine and appreciates that we can still find many things nourishing and helpful in this work.

The key argument for my belief that the methodological approach of the art experience could lend something quite rare and valuable to medicine—and knowledge more generally—is my claim that it is useful and functional only because it takes a middle ground between representational and non-representational theory. It is in the final chapter that I flesh out the last of this argument through the geological trace in the legacy of affect theory of "Spinoza-Massumi" and "Tomkins-Sedgwick." The point of conducting such a trace is not to distill all of affect theory into two disparate belief systems, but rather find an effectual and logically consistent channel in the challenge of legitimizing autobiographical narratives for the "affective turn" in the humanities and social sciences and to find methodological vitality that can speak some of the language of

the natural sciences, expediting an emphasis on bodily or embodied experience. By preferencing the Tomkins-Sedgwick bio-psycho-social ecology of feeling model and building on it, I aim to challenge predominant views in affect studies around the "work" of art and stake a claim that a sick identity can actually be productive, activated, and meaningful for medicine. To do this, I complicate the idea that a sick identity is the sole property of the mythologizing cultural or clinical illness identity. I show examples of places where illness identity can be community and affinity driven, as well as virtual, towards "potential movements of deterritorialization, possible lines of flight" to "try out continuums of intensities" ("A Thousand Plateaus" 178). I look at online communities formed around rare illness, technoscientific illness identity, embodied health movements, and the oscillating "strong" and "weak" characteristics of an illness inflected subjectivity wherein a drawn-out illness or disability becomes a significant script that dominates daily action and choices, but, rather than fixing the subject, a sick identity spurs a perpetual attachment to embodied experience where reviewing, redefining, responding and rereading the body is everyday life underway.

I challenge the shattered subject of a Deleuzian affect theory, what Social Psychologist Margaret Wetherell has called an "anti-Humanist negation of subjectivity" where "subjectivity becomes a no-place or waiting room, through which affect as autonomous lines of force pass on their way to something else" (123). Attempts to negate established, layered research and thinking around the realities and histories of social alterity as something that shapes particular people and groups in very real and detrimental ways especially concerns someone like me, invested in the humanistic dimensions of medicine. I contend that there are pathways through the issue of subjectivity and affect.

My argument to support this claim is routed through Tomkins' determinism and theory of personality, combined with the pressure of human temporal limits (time, as we experience it), toward what I call the "soft" subject: a shapely, recognizable identity that has flexible entry into a social system. I conclude that an inside-out, contagious theorization affect that is not wholly split from emotion or cognition does not require that we eject identity and biography from politics and action. By incorporating a porous, "soft"-subject-underway that can maintain a degree of "shapeliness," and subjective action (thus, a response-ability to sociality and creating a social responsibility to others), you get an affect system in which illness narratives, identity, representation and politics of otherness can be accommodated.

Towards the middle of Chapter Three, I trouble the assumption that fantasies of realism are always what is on offer in representations (representations of knowledge as well as visual depictions of life). In doing so, I directly contest the belief in so much work done in affect theory that declares all our attempts to represent knowledge, that is, to describe something as known, is "antithetical to knowledge" (O'Sullivan 25), and diminishes potential. For affect theorists working with art as their subject, this dynamic takes the form of a shunning of the discursive elements of the art object (the "aboutness" of the work). I ask, what is it we seek when we look at art, when we engage with the discursive elements that supposedly lure us into dangerous waters? Are fantasies of realism what we see, look for or are lured by? What does it mean to fail to execute a "good" art experience? The answers to these questions, I think, can go a long way to erase the hard line many affect theorists draw between emotion and cognition.

I am interested in the way the values and movements of an arts-based methodology orient knowledge conceptually and aesthetically, in a way that seems so welcoming for multiple domains with compounding actors. I argue that arts-based methodology oscillates so easily between "strong" and "weak" theory because it is remarkably self-aware. In the contemporary art experience, the image is not paraded as an object that is a container for truth with hidden second functionality, but rather it has many open operations, including the ability to be representational, performative, affective, reparative, and deeply social. We need art that takes autopathography as its subject because we really do need contingent, personal accounts of illness that break through the homogenizing narrative of universal or categorical patienthood, to challenge both the body-object of medicine, and to challenge narratives that advocate for new body-objects that may be equally homogenizing, as it is in the case I make for advocacy efforts that also mythologize the patient experience.

The latter part of Chapter Three examines the ethical concerns for affect theory generally, and the use of arts-based methodology towards a humanistic medicine, specifically. I hope to provide an avenue where the narrative and biographical elements inherent to expressing illness in visual art form become resources, not limitations; replete with the potential for shared experiences that are not vicarious, but meaningful and realistic. I think leaving room for this potential is imperative because it allows for an acknowledgement of the creative and generative potential of representational work in the flow of ideas and knowledge, thus, refusing to reject representation as a critical process. The principal purpose of this work is to show, for a humanistic medicine, the potential and means for resisting the universal body and all its impositions and failures through the

creative incubation of ideas which may fluidly roll across and within art production, the art object and its reception as ideas reach their breaking point or are pulled back into the body that produced them.

This project ultimately hopes to present, in conceptual and practical ways, how it is we can use the art experience or borrow from its methodologies to find affectively rich encounters picturing the body that can break it free from the diminishing dual-functionality of the medicalized body-object. How can we engage with the relational dynamics of medicine in a way that offers some reflexivity, bending back on the rigorous exclusiveness of medicine's body-object, to feel and speak something that reminds us that we are not fighting death, but rather, striving to flourish, and that can look dissimilar for different people in different moments? The material reality of the body is one where cells, bacteria, viruses, mutations, and waste co-exist in changing states that are not bound by the barrier of the skin, that "health" itself is just a fickle formation of any number of symptoms occurring together.

## Chapter 1 Medicine, the Image and the Problem with Both

Virtually every introduction to an art history survey course starts in that same familiar way: an image is presented to the room: a cave wall, perhaps Lascaux in modern-day France, Altamira in Spain or India's Bhimbetka. Mark-making efforts on stone walls that may range from minimal lines to intricate shapes representing animals and humans are presented to students as evidence of our ancestors' preliminary efforts to picture their world and communicate something about it in a complex and visually rich fashion. This effort—the labour to read our world, interpret it and export that understanding back into the word through meaning-laden images that are intended to be taken up and read by others—is a practice we humans have not grown disenchanted with over time. The pedagogical intention of marking this ancient point as a starting line is to root image-making with human expression and knowledge at a foundational moment that precedes any written human history and certainly collective cultural memory.

An enduring legacy of this Upper Paleolithic meaning-making and sharing process persists to this day: of course, traces of parietal art are currently discernible, but so too is a persistent inheritance at the cellular level. Images that communicate joy, peril, food sources and technique interconnect actual survival mechanisms with the past, present and future of modern humans for better or worse. Individuals who could learn and leverage skills and circumstances to their advantage saw a benefit. They were able to live and pass on their hereditary material, becoming the genetic pathways and signposts we use today to trace ancestral haplogroups. The image as a communicative instrument,

consequently, is more than just a symbol of our contingent beliefs about the world at any particular moment or in any specific place. It is also complexly tied to our success or undoing.[9] Belief, threat and prosperity are often what is at stake in the image, sometimes discretely and sometimes complexly knotted together. Indeed, this relationship between the image and understanding, flourishing and diminishing forms the foundation of my entire project in fundamental ways.

Scholars have long been fascinated by the concept of the image, and this attraction, I am sure, stems in no small part from its enigmatic and contradictory nature in popular perception. The tension lies in the way the image is tremendously complex but often is understood to perform as stable (in meaning) and common (in form)—a misconception, to be sure. If one were to break the image into arbitrary configurations, one might be inclined by habit to reduce it to umbrella categories like subjective images (art, popular culture, etc.) and objective ones (security footage, medical images, etc.).

How does the matter of stable meaning work in the "subjective" category? To find an answer, we might look to art. I regularly start my first-year classes asking the question, "How do we find meaning in art?" More often than not, after some back and forth, the consensus the class reaches seems to be something along the lines of this: the artist has an intention that they put into the work, but the viewer gets a say about what the

[9] Though not all are sighted, the contemporary world is organized around images designed to help us make sense of our lives. Being blind or having low vision does not exclude one from the system of representations that manage so much human knowledge in the world. The imposition of the image as a primary tool for communicating ideas about the surrounding environment, as well as imparting how one ought to negotiate social and power relationships, is all the more crucial to people with limited or no sight, as Sturken and Cartwright note, because of the heightened significance of the image that is unseen (9). Being fluent in the meaning-laden, social practice of 'looking' and participating in the power and magnitude of the picture, then, is not a pursuit only engaged in by the sighted. This kind of unexpected, abstract application of the image is somewhat customary in visual culture studies.

work makes them feel and what it means. If this definition rings true to you, reader, so be it, but it is worth noting that it is not a definition that reflects how humans have understood art at other historical moments or places.[10] We ought to also take into account the larger language and meaning structures that are embedded in and around this exchange. It is probably somewhat unsurprising that the stability of meaning can be undone in a genre of image-making so unhesitatingly labelled "subjective."

But, what of the second category? What of the so-called "objective" image? The image is most common in its representational form. Representational images are those that suggest to us that a faithful attempt to render the "real" has occurred. The image is, therefore, understood to be a representation of the "real world." An everyday, arguably Positivist understanding of realism seems to find the "most real" at a point where the hand and eye of the subjective human appear to be the utmost removed.[11] A camera or X-ray might be said to eliminate the labour of seeing and interpreting from the human subject to a more objective end. Photographs, for instance, generally hold more power of objectivity in the court of law than human testimony.

Some might say that security footage can tell the truth about a police shooting. An MRI might be said to offer disinterested empirical evidence of disease. This truth comes from the "believing is seeing" principle,[12] but how much confidence do these technologies really offer? The camera first became commercially available at the turn of

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[10] At different times throughout history how humans have conceptualized the placement of interpretive authority and the root of meaning in art has shifted in significant ways. This is elaborated on in *Mirrors and their reflections: idealized victimhood and authentic experience.*

[11] For a good primer on this fallacy see pages 16-22 of Sturken, Marita, and Lisa Cartwright. *Practices of Looking: an Introduction to Visual Culture*. Oxford University Press, 2018.

[12] Errol Morris introduces the "believing is seeing" principal through a series of experiments that uncover how accuracy and evidence are not a stable product of the image. For further reading see Morris' *Believing Is Seeing Observations on the Mysteries of Photography*. Penguin Books, 2014. Notably, see pages 26, 93.

the 20th century. By that time, there had already been several arguments put forward that were critical of the notion of photographic truth. Arguments have persisted (Susan Sontag (1978), Casini (2010, 2011), Morris (2014), Sturken and Cartwright (2018)) in the denouncement of the truth value of the image. The most noted interpretation of the myth of photographic truth comes from Roland Barthes' book, *Camera Lucida* (1980), in which Barthes argues that the photograph is the meeting place between the here and now and the referent in the image—the point of connection presents a "myth of photographic truth" (85).

In contemporary times, this myth of the truthful image that cannot lie can be straightforwardly dismissed by the common practice of utilizing image manipulation software and filters to twist the reliability of what the lens had captured. In the case of real-time filters, alternatively known as augmented reality, we can be presented with an extended experience that bends the real before image capture even occurs. Prior to and outside of computers and apps, one might make the argument that a photograph may be faked or exclude elements of the scene that would alter how the image was understood. Further, the photographer could have made certain aesthetic choices in composing the formal aspects of the photograph (like composition, lens angle, brightness, contrast, colour, etc. that cumulatively work to extend the "reality" of the moment (Sturken and Cartwright 24-32). What imaging instruments or technologies could be said to be entirely immune to this challenge against the truth value of the image? Aesthetic preferences have been built into the technology of security cameras or even MRI images, and these preferences play a significant role in determining the nature of what we do or do not see in the images produced.

The “stable” meaning that “objective” images might be said to assert has always already encountered some significant human intervention (intervention brimming with a predilection for one of any number of possible outcomes) before the shutter—so to speak—even has a chance to blink its mechanical eye. All this, and we have yet even to address the act of interpreting the truths of these images! The all-too-obvious human element is an integral part of the equation. Yet, we often neglect to factor it in when we find ourselves swayed by the attitude that the image can be objective and somehow self-contains truth value.

Where my students felt free to consider the power of the viewer in art, the power and authority of scientific images can lead the viewer to believe objective representations of fact are clear for all to see (the same?), and that one may be either right or wrong in how they interpret the data. If truth be told (pun intended), I actually believe there is a stronger argument to be made for the realism of meaning-making found in the everyday treatment of art over the conventional functionality of “objective” scientific images. In the case of the former, the meaning-making process is looked-for, desired to be made visible; in the case of the latter, it is regularly obscured. This notion of stability is transposed onto scientific images from the discipline itself.

In *The Philosophy of Scientific Experimentation* (2003), Hans Radder writes that the notion of stability is central to the long history of science and scientific experimentation, where one reads the unknown against elements that are understood to be straightforwardly constant. Yet, stability, in practice, is far richer than mere lack of change and the implication that something is protected from change requires more questions be asked; questions about the nature of stability: “What kinds of disturbances

are involved? What characteristics of the stabilization procedures can explain this robustness?" And, "are those characteristics only of a factual or also of a normative nature?" (3). Radder complicates the taken-for-grantedness of stability in scientific experimentation by seizing a theoretical approach similar to philosophy in actively asking the three questions he presents. To complicate the "objective" image we often take for granted in everyday life, we might ask similar questions. What kind of change must the "truth" of an image hold up to? How does scientific authority affect how we think about and utilize "objective" images? How much of the "objective" image is factual, universal truth, and how much of it is a social production of what we ought to take to be true and right?

While we do seem to be frequently seduced by the sway of scientific-looking when we consume images, there are other ways of thinking about subjectivity and objectivity, and there are other points on the continuum that can inform research around the truth value of images. Sandra Harding, for example, works to bridge relativism and value-neutral objectivism by leaving behind their respective problems and developing their necessary qualities. She makes a case for feminist standpoint theory[13] in determining scientific truths as she claims it provides standards that make way for knowledge that requires researchers and research subjects to use their historic location as a resource for objectivity (142). I point to Harding's work to express that we are not confined to overgeneralized notions of objectivity and subjectivity when we theorize

[13] Feminist standpoint theory identifies the socially situated nature of knowledge, recognizing that some marginalized positions offer a clearer perspective on the nuances and dynamics at play in a system of power, a perspective that is less accessible to those who benefit more from the system. Given this claim, Harding and other feminist standpoint theorists submit that any research that is subject to power relations ought to begin from the lived reality of the marginalized for a chance at greater objectivity (142).

images. But, nonetheless, there is a wealth of demonstrative evidence that shows how generalized and habitual the dichotomous objective/subjective view is—in support of, or to undermine the truth value of an image. The binary persists in how we harness and describe images in diverse, popular applications ranging from art galleries or magazines to hospitals or courtrooms. The way we consume these images, out in the world, reveals strange preconceptions that have been transmitted along waves of social forces, conscious or unconscious, masked or unmasked, and made utterly ordinary by the passage of time.

The certainty that an MRI image or security camera footage is given in popular understanding comes from their scientific clout, but as Harding would no doubt agree, these mechanisms for image-making and the processes of meaning-making that surrounds them are no more in isolation from other cultural contexts than a work of art or an expertly altered makeup advertisement. I would go so far to say that they are just as much an artifact of society as they are an artifact of advances in observation technology. The divisions drawn earlier between categories like subjective images (art, advertising, popular culture, etc.) and objective ones (security footage, medical images, etc.), are exceedingly inadequate. At the same time, the fact that they are operational in the practice of looking is something worth thinking about.

The everyday examples of the image and the act of looking that have been discussed so far help to clarify the idea that all looking is done in the milieu of cultural forces exerting influence, and this pressure colours the power we give to particular images and informs how mutual or one-sided we understand the meaning-making process to be. An important argument I wish to put forward is that the power the image wields is not only its ability to reflect human understanding but also to guide and motivate human

knowledge. A compelling case study for this claim can be found by looking at the impact the work of Robert T. Bakker had on the field of paleontology and the greater public imagination. In the 1950s, images of dinosaurs were, in a word, heavy (Figure 1-1).

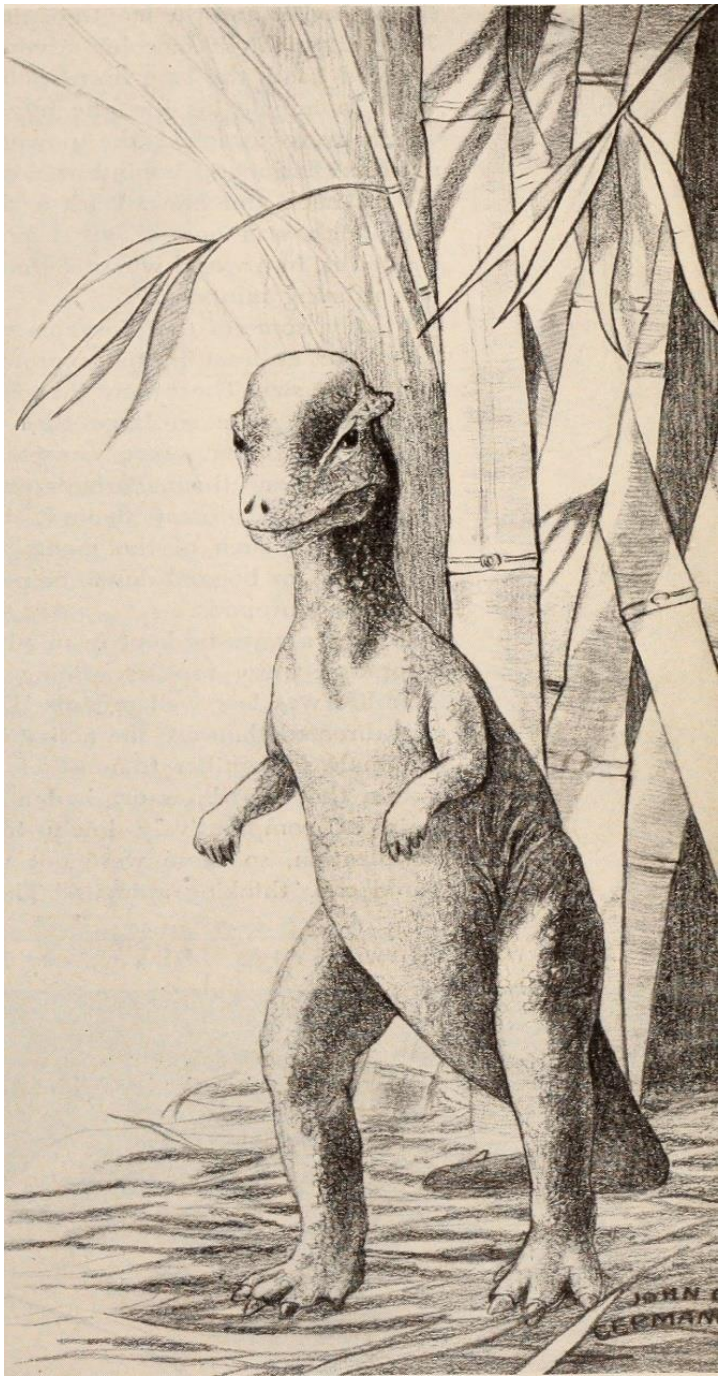

**Figure 1-1** Illustration of a thick-set dinosaur from Colbert, Edwin H. *The Dinosaur Book: The Ruling Reptiles and Their Relatives*. McGraw-Hill, 1951.

Dinosaur bodies were bulky, and they often looked as if they were being pulled towards the earth like formless boulders or worn-down stumps, bound by their corporeal press against the fundamental forces of the universe. The creatures were rendered static, fixed in place and incapable of social lives or even survival, really – a reflection of the general opinion at the time that they were unintelligent and doomed to die out unavoidably. Bakker describes the illustrations of that era, observing:

> The way brontosaurus and Diplodocus (the biggest dinosaurs) were illustrated, they were like giant, grey vacuum cleaners with very very [sic] short legs. They were depicted slowly pulling themselves across the landscape or sitting neck deep in a fetid swamp. And that's where we were [in the 1950s and 1960s] dinosaurs were sad, cold-blooded, dead ends in the history of life. ("Welcome to Jurassic Art")

Bakker and his mentor, John Ostrom, having discovered and carefully studied a new species of raptor named Deinonychus in the late 1960s, were credited with bringing about a scientific revolution known as the "Dinosaur Renaissance" coined a decade later following the publication of their research. In the journal, one can find the beginning of the dinosaur representations we are familiar with today in print and on-screen: the intelligent, proficient evolutionary marvel with a capacity for complex social relationships. Interestingly, this alternative vision of the dinosaur was not entirely new; it was a concept that had been proposed decades before Baker's notion came to be, according to Baker himself. Still, it had no staying power as an idea. The difference in the endurance of Baker's reimagining can be found in his abundant use of compelling

illustrations. Paleontologist Darren Naish has said of this moment, “part of the reason that the dinosaurs of Dinosaur Renaissance, the dinosaurs of Ostrom and Bakker, drew in so many scientists in the 1960s and 1970s was that it was accompanied by brilliant visuals” (“Welcome to Jurassic Art”). His powerful, lithe dinosaurs became the prototype for other paleo illustrators who now had permission to rethink all the conventions that had been placed on imaging dinosaurs.

The pictures Baker produced contributed significantly in shifting our understanding by faithfully revealing the appearance of dinosaurs, to the best of Baker’s estimation, according to the data available to analyze. The use-value of the image, in this example I present, works to reflect and disseminate knowledge, but it is also does something else that is a bit more interesting. Because, these images that manifest the latest science also go a long way to mark how scientists conceive of the physical limitations and possibilities that could affect the lives of these creatures. The images, then, work to both reproduce current ideas and guide future knowledge as an interconstitutive element in the social management of science. These dual functions of the image are, I believe, quite significant.

To better understand the dual roles of the image in this example, we can think of how Baker—and the other illustrators that followed in his wake—act as proverbial photographers, looking through a distorted lens that separates what they think they know from the phantoms of perplexing creatures that lived over 66 million years ago. Paleo illustrator John Conway notes how challenging this task is, as many biological features, like fat tissue, do not preserve like bone. Illustrators are extremely conservative about adding fat to their drawings. If you imagine someone illustrating a sperm whale (Figure

1-2) using this value system, it would plausibly look as if it had a bulbous forehead, alligator-like jaws, and a much more snakish tail than the whale we are used to seeing, marked as it is in our imaginations so thoroughly by the fat it carries.

**Figure 1-2** A picture depicting a mounted physeter macrocephalus (sperm whale) skeleton located in Morro Jable, Jandía, Fuerteventura, Canary Islands, Spain.

Conway explains, "You could take one of the most familiar dinosaurs, that dinosaur could have camel humps, and we wouldn't know, right? Because you can't tell from a camel's [skeletal structure] that it has humps. Brontosaurus' could have had humps; we don't know!" ("Welcome to Jurassic Art"). At times, fossils are discovered with some soft tissue intact, and this leads to vastly altered versions of the animals. Amendments have not been limited to additions in body mass; they have also included frills and coats of feathers. Conway notes,

> Even the most familiar of dinosaurs may hold great surprises in their life appearance. It seems that every time the soft tissue of a dinosaur is discovered, our views of that animal, and usually all of its relatives as well, are changed drastically. Such revelations show how artificial our images of even the most

> well-known dinosaurs can be. What we are drawing all the time may not be the "real" animals themselves, but artifacts of an artistic tradition. (Conway 25)

In the case of dinosaurs, the image is the primary way scientists and the public experience dinosaurs in the flesh, so the picture of the dinosaur carries a heightened role. I think the most exciting aspect of this exercise in imaging dinosaurs is not that the model we use might be wrong (as it almost certainly is) but rather, that an image is one potential among several options. The fact is, the possibility paleontologists and paleo illustrators do land on is not simply an undisruptive artifact that conveys our current understanding. The image is far more operational: it belongs to a long chain of inferences that have power to stimulate scientific discovery, moving it towards certain potential possibilities and away from other, sometimes no less feasible ones. The image is both a reflection of our knowledge and an instrument of knowledge production that powers particular outcomes.

Cultural and literary historian Sander Gilman's research on scientific imaging indicates that science "understands and articulates its goals" using illustrative models, measuring scientific "truths" "against the form of reality that art provides" (*Disease and Representation* xiii-xiv). There is some risk here, in this dialectical dance with the image and world. As the image becomes the model that vast chain of interpretive inferences are bracketed by and measured against, the chain may form a noose for its object of inquiry: at best, possibilities for movement are limited, at worst, the object of inquiry is strangled and atrophied by an instrumental rationality adeptly moving toward a specific end, but not reflecting on the value of that end. And, reflecting on that end is critical, because it

allows us to see what knowledge is excluded and what (or who), potentially, is left vulnerable, hurt or forgotten. Unlike in my dinosaur case study, objects of medical inquiry are rarely apparitions of another time, long gone. Frequently, they are very much alive and very human.

How human bodies are imaged and imagined in science should be an ongoing concern as the direction knowledge moves is a pressing issue with outcomes that tangibly advantage, mark or otherwise intrude on the lives of real people, like you or me. When we think of the medicalized human body imaged in CT scans, X-rays and anatomical studies as unconcerned with social understandings of illness, we fail to see how medical images of the body with their formations of "general systems" "neatness" and "accuracy" co-produce the image of the universal—able-bodied, white, male, cis, straight—body easily located in critical discourse. If the image cannot be separated from the social and cultural structures that inform looking and production, then considering scientific images can help us recognize the social history of science.

The first section of this chapter, *Medicine's universal body-object: the history of Westernized medicine and the medicalized body*, brings together historical images of the body in science in an attempt to think through the ways the image has shaped the body and how the body has shaped medicine. Medicine, specifically in the Global North, participates in a particular aesthetic that is loaded with meaning that shapes how we understand the self, body, death, illness, and health. Much of this aesthetic can be attributed to a deep-seated fear of death. Of course, diseases can carry great emotional and even physical risk for healthy-identified bodies, but there is a symbolic threat as well. The symbolic warning the sick body poses can be read through the actual or imagined

risk of contamination, which can roll into another menace, wherein the ailing body is taken as a memento of death. Death is a danger that French philosopher Jacques Choron has intimated to be intolerable for Western thought (83), and author John Stephenson has written that death represents a failure of both science and the individual – who each claim mastery over progress and fate (34).

The "abhorrent death" standpoint has striking social implications for how we understand illness and death in Westernized medicine. The cultural anthropologist Ernest Becker bleakly observed the very core of this paradox when he made note that we are haplessly caught at an impasse of seeing ostentatious illusions of power expressed by a decaying, vulnerable body (52). In the second section, *The cult of good health: the mythification of health and illness,* I address how morality is applied to illness. Looking at the broader social implications of health, fear, and images of the body, I discuss who is left out when we picture health in a specific framework that fuses moral goodness with ideal form. The final section, *Refusing medicine's body-object: the picture of health reimagined,* returns to my initial query about the everyday acts of looking and our varied approaches between "subjective" and "objective" images. I examine the methodological approaches we take for approaching the image in both art and science and analyze how the functions of the image are more or less visible depending on our angle of approach. By looking at real-world examples, I investigate the desires that are driving recent efforts to merge the scientific image with the art image. What risks and opportunities might present themselves in the migration of a disciplinary methodology?

## *1.1 Medicine's universal body-object: the history of Westernized medicine and the medicalized body*

This history of medicine is teeming with images. Diagrams, anatomical illustrations and pictures depicting procedures or processes accompany and, in many cases, supersede nearly any written text on medicine one can find. Remarkably, this ample cache of images has been overwhelmingly underutilized when the history of medicine is taken up by historians.[14] Gilman believes that cultural historians are suspicious of historical pictures because they are at high risk of being "misread" (*Health and Illness* 9), a nod to the running belief that there is a pure truth contained in an image. A large part of this fear comes from the collective struggle modern historians face: the constant and often unconscious urge to swap out historically grounded attitudes with the contemporary and likely disparate cultural values which inform the historian's thoughts and feelings—the postmodern concept of the gaze. While there are schools of thought that posit no other perspective could really be possible for the viewer than the one they come to the image equipped with, concerns of this nature are still especially significant for historians who plant their work in the social sciences and have interest in some form of impartiality.

There is a reason for holding fear concerning the risk of images being "misread." Historians do not want to misrepresent. They want to be faithful to real people and real

[14] Gilman identifies this development stating, "The visual arts have only a very ancillary relationship to the traditional [study] of medical history as it evolved at the turn of the century…it is precisely that historians of medicine are cultural historians and that the culture of medicine is as heavily involved with visual culture as any other aspect of modern cultural history that makes the anxiety about the use of the visual image in the history of medicine into a meaningful problem" (*Health and Illness* 10-1).

events. Still, it is interesting to think about the historical medical image as a dangerous battlefield where "true" and "false" readings are engaged in such a brutal and deadlocked encounter that the use of the image as a primary research source becomes too unsafe for the average academic to stomach.

The substantial fear of images is logically linked to real consequences. Beyond the possibility of doing injustice to the topic of inquiry, what is also at stake for the historian is hurled accusations of bias that question any semblance of personal and professional credibility. This genuine threat in academia follows what Eve Kosofsky Sedgwick calls the "paranoid imperative," which has moulded academic research into a verification system drawn towards relations and epistemologies that are self-affirming (*Touching Feeling* 126). The methodology of this system is all too familiar: I conjure the spirit of my worst critic to find those uncertain, exposed moments in my research where my antagonist might pick my work apart by troubling my vulnerabilities and leveraging them into attacks. By thinking through this paranoia, I amend my work, closing in on the self-affirming aspects of my research and limiting the ideas that reach too far into the unknown. The Humanities, usually, is a kinder place for reading images, with a wealth of methodologies that make space for interpretive analysis.[15] Discoverable, transhistorical meaning has a place in many approaches. However, even those processes rarely, if ever, can be said to escape a paranoid imperative (if indeed, that is a goal).

Despite the danger, it is necessary to provide at least an abridged genealogy of the history of Westernized medicine and its pictures around social, economic and political

[15] Some examples of methodologies in the humanities that make ample space for subjective interpretation include constructivist grounded theory, visual analysis, mixed methodology, and narrative inquiry research method and, too, the ahistorical method of deconstruction.

developments to give some texture to my claim that Westernized medicine forms a problematic image of health. To do this, I need to show up and, in some ways, inevitably reinforce a taxonomic understanding of the human body. Yet, I do so to establish my critique of how various forces have shaped contemporary thought about illness. Even so, these efforts to uncover the history of medicine and the medicalized image of the body do participate in the project of adding even more literature to stoke the fire of symmetrical relations. Describing these connections does not get us closer to dismantling the issues around the image of health in Westernized medicine in and of itself.[16] However, it will provide some helpful context at the point where interventions can be made. I begin my project with historical depictions of the sick body to flesh out 1. how and what meanings are attached to images of medicalized bodies and 2. what consequence these representations of the body and our analysis of them have in the reproduction of meaning.

There are broadly three different epistemes to traditional Westernized medicine. In antiquity, there was a belief that human health or disease waxed and waned by balances and imbalances of humours—four distinct, fundamental body fluids incorporating blood, phlegm, black and yellow bile—directly manipulated by material elements. The weather, the proximity of other people, the position of the stars and planets, and what one ate could all affect the ratio of humours and potentially cause disease. The reflective study of anatomy can be found in even the earliest records of medicinal customs. Still, anatomy did not emerge as a scientific discipline, as we understand it, until a relatively later anatomist of ancient times made significant

[16] In *Touching Feeling: Affect, Pedagogy, Performativity*, Sedgwick rather pointedly notes "for someone to have an unmystified view of systemic oppressions does not intrinsically or necessarily enjoin that person to any specific train of epistemological or narrative consequences" (127).

contributions: a Greek medical researcher, physician and philosopher called Galen of Pergamon (129 – 199 CE). Galen worked under the premise that the human organism is intimately linked to their environment, that diseases were not idiosyncratic or remarkable beyond their ability to point to their cause (their particular fluid imbalance), and that treatment involved manipulating exposure to the outside world in order to rebalance the world beneath the skin (Lindemann 91). This perspective meant that any way a body might manifest symptoms, be they psychological or physical, would hold interest only insofar as those symptoms could point a physician to their core imbalance – the now familiar notion of mental and physical splitting had not yet asserted itself in medicine.[17] While it is frequently reported that Galen developed all of his knowledge of human anatomy through animal dissection, this is not entirely true. He was a surgeon for the gladiators of Pergamum and frequently witnessed the interior of the wounded human body through violence (Singer 47). Nonetheless, it is true that his anatomical studies were formed on mostly indirect knowledge gleaned from the dissection of other large mammals, as laws of the time prevented human dissection.

His images are startling to our contemporary anatomical aesthetic sensibilities. If we take as a case study Galen's illustration of a pregnant woman (Figure 1-3), we might be quite quickly struck by how absurdly inaccurate it feels.

[17] While dualism was common in philosophic thought, interestingly, the concept of humours and Galen's treatment of Humourism in particular sat in clear opposition to the Stoics. Resolutely, Galen believed there to be no distinction between the mental and the physical. See, Hankinson R. J. *Galen's Anatomy of the Soul*. Phronesis, 1991 (197–233) for further reading on this topic.

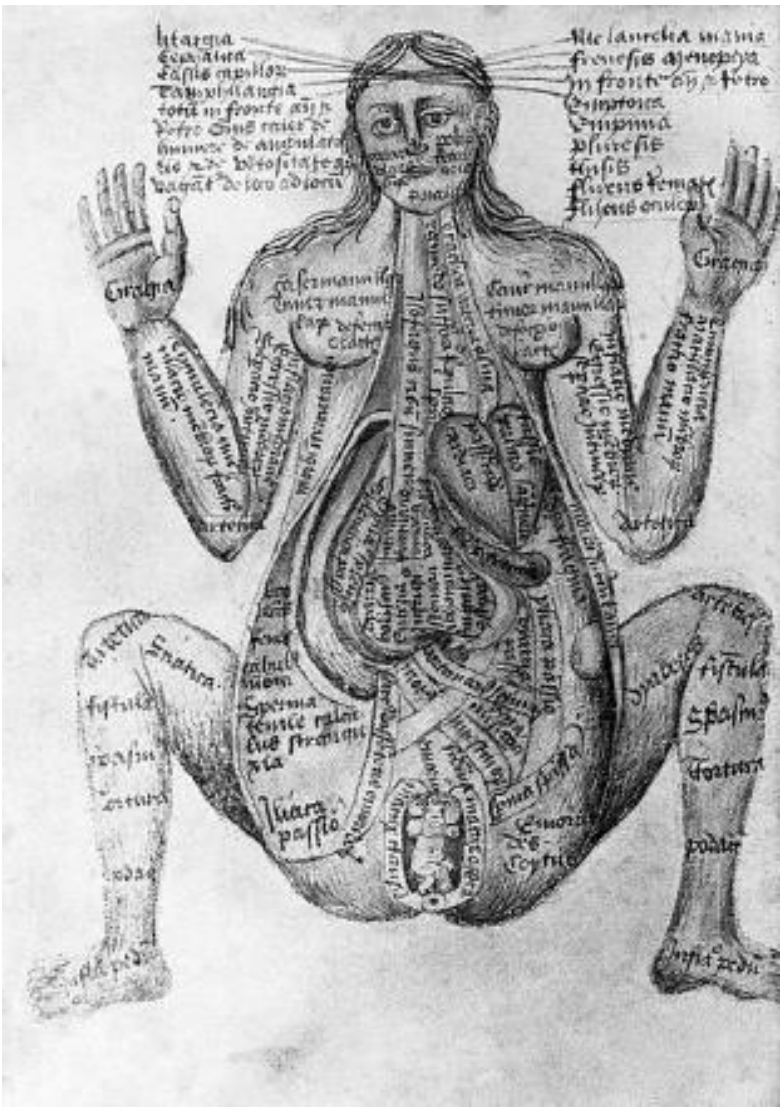

**Figure 1-3** An image of the anatomical structures of a pregnant woman that is ascribed to Galen and transmitted through medieval manuscripts and early printed books.

Knowing what we do about Galen's methods, we might be tempted to merely label his study "inaccurate," perhaps pointing to his rudimentary understanding of medical science in his illustration, or to the frog-like appearance of the woman and draw parallels to Galen's work dissecting animals instead of humans. I ask though, that you do not explain away your discomfort with that fitting rationale. Instead, I invite you to hold

onto your uneasiness for a little while, as we will revisit it shortly. Galen's illustration depicts an active body – the figure is awake, alive and engaged. Her expression is serene, or perhaps reflective. It is through Galen's work that we first see the social link between wellness and temperament in medicine. In Galen's case, an imbalance of fluid is associated with human social and emotional qualities like passion, affection, and dependability.[18] This type of connection between disease and personality typology became an enduring one over several periods, taking different forms. Galen turned his research into two fundamental texts on anatomy, *On Anatomical Procedure* and *On the Uses of the Parts of the Body of Man*, which were translated and republished, forming the backbone of anatomy and medicine, directing learning for the next 1,300 years without much in the way of further contribution.

Several factors paved the path for Galen's endurance as the primary source for understanding the medicalized body in the Western world for a considerable portion of history. Intellectual stagnation instigated by the collapse of the Roman Empire, compounded by massive population decline in the Early Middle Ages, marked Europe mercilessly. Poor living conditions in densely populated cities led to counter urbanization, which slowed the development of ideas. Invasions brought about massive migrations and political upheaval. Christianity flourished in Europe, and there is research that suggests that this may have made human dissection a dangerous undertaking in some cases, as scientific thought and investigation were paralyzed by the church and dissection was now and again deemed blasphemous (Gregory 1180-1). Civil wars were common.

[18] For further reading, Mark Grant writes extensively on personality traits and their connection with food and health in Galen's writing in his book, *Galen on Food and Diet*, (Routledge, 2000).

During the High Middle Ages, some stability returned, however, a robust Christian sensibility and the dominating power of the Catholic church meant that any pursuit of knowledge was knotted tightly to devout religious faith and charges of heresy frequently doomed scholars to torture or death.

The Late Middle Ages brought more war, famine and atrocious living conditions, which allowed plagues and disease to flourish, wiping out populations. The Black Death alone was responsible for diminishing Europe's population by one third.[19] One theory puts forward that the mass deaths caused by this plague were responsible for a paradigm shift that moved focus away from spiritual notions of the afterlife and caused survivors to devote all their mental energy towards earthly concerns. This claim is somewhat ratified by the fact that Florence, an intellectual bloom space and cultural centre of the 14th-century, was especially devastated by The Black Death (Tuchman 789, 790-1). As early as the Late Middle Ages, there was increased interest in the subjects of nature, Humanistic learning, and individualism.

It was in the Renaissance after the fall of the Byzantine Empire that the medicalized body was creatively taken up again as an object of study and reimagined. In his introduction to Galen's *On the Nature Faculties* (1916), translator Arthur Brock recounts how the Swiss physician Paracelsus symbolically burnt the works of Galen on the grounds of his school of medicine; it was a time that saw extreme liberal movements that understood knowledge as the foundation for building new ideas. From an emerging Humanism, there was both hunger for and the desire to depict and understand man

[19] For further reading on the Middle Ages in Europe see Clifford Backman's *The Worlds of Medieval Europe*. Oxford University Press, 2003.

through his divine relationship with nature. Often translated through the language of math and science, as is the case with da Vinci's *The Vitruvian Man*, the human body, in some budding ways, became the object of science. Yet, at the same time, the body cannot be said to be severed from its symbolic attachments in the Renaissance in the same way we may say this of the medicalized body-object today. Why? On one hand, art and science were not yet conceived as disciplinarily divergent, and on the other, the relationship between man and nature was a "cosmografia del minor mondo," a "cosmography of the microcosm" (Turocy 138) where a specific kind of idealism recognized man in correlation with the workings of the universe, and God, more directly.

Out of this moment of fixation on nature, man and the divine, Andreas Vesalius emerged. Vesalius (1514 – 1564) was a Flemish anatomist who studied the work of Galen at the University of Paris. In a political climate much more conducive to research and inquiry, Vesalius studied human remains and conducted autopsies, publishing illustrated manuscripts, most famously, *De Humani Corporis Fabrica Libri Septem*,[20] with illustrations attributed to the Venetian illustrator Jan Steven van Calcar. As an apprentice of the master painter Titian, van Calcar was trained in the Renaissance tradition, a movement infatuated with the revival of classical idealism, progress, order, harmony, and clarity. Titian's painting, *Diana and Callisto* (Figure 1-4), was created with these preferences in mind, and the artwork is an excellent example of the Renaissance's quest for naturalism. The painting features curving bodies draped across the picture

[20] *De humani corporis fabrica libri septem* (On the Fabric of the Human Body) is a compilation of books on human anatomy written by Andreas Vesalius (1514–1564) and published as a set in 1543. It presented itself as a replacement for the work of Galen.

plane, gestures that are reflected in the swirling landscape behind the figures and faces that broadcast expressive and moody features.

**Figure 1-4** Titian, *Diana, and Callisto*. c. 1556-9, Oil on canvas. National Gallery and National Galleries of Scotland, Scotland.

Most of us are reasonably familiar with paintings with the general character of this movement, given the universal appreciation for the masters of the Renaissance in our contemporary culture. Our familiarity often makes us blind to exactly how stylized Renaissance naturalism is when compared to our modern sensibilities. Naturalism, as an ideal, puts forward that art should imitate nature. But, our understanding of life and how it is best pictured has always varied significantly across time and space.[21] The naturalism of the Renaissance is tangled up in particular cultural values that venerate a specific interpretation of idealized bodies with powerful frames and dynamic expressions that model the aesthetic and intellectual archetypes from antiquity. Understanding naturalism, or realism, as cultural is exceedingly crucial because the Renaissance values of the ideal body that typifies order, clarity and progress would ultimately inform the illustrative work of Titian's student and Vesalius' illustrator, van Calcar. Even though we have seen stylistic changes since the Renaissance, because Vesalius and his publication are the foundation of modern human anatomy, the values that these images underline resonate powerfully in both subtle and forceful ways in medical aesthetic traditions to this day.

Consider the flayed man (Figure 1-5) from *De Humani Corporis Fabrica Libri Septem*, often attributed to van Calcar. Here we have an anatomical model for the human muscular system. We see an idealized, powerful male figure that has peeled his own skin

[21] Our ability to parse out realism and naturalism in art can be very obscured by the complexities outlined above, mixed with a heady cocktail of general admiration of the talent of artists from various eras. One simple method I often use to break resistant students from the belief that what looks real is natural and historically consistent is to tell them to imagine they fell asleep on a road trip and woke up in the back seat. If they look out the window and see the finely-honed and highly skilled naturalism of the Renaissance out their car, they would not (not even for a moment!) think they were gazing on some reclining figures in real time, but instead, they would wonder why someone was holding an image to the window. There is no difference in this scenario if you remove the figures and use a pastoral scene without discordant buildings, or other "red flag" markers. Simply put, there is just nothing "realistic" to be found here for your contemporary sensibilities.

from his body to reveal what lies under the barrier of his casing. His head and body are active, wrenching to the right to gape in horror at his flayed face with intensity. The vivid storytelling of the self-inflicted dissection as an ongoing act frozen on a page is indicative of the principles and preferences of the Renaissance. The muscular system is meticulously ordered, with clearly demarcated boundaries and divisions, labelled and categorized by text.

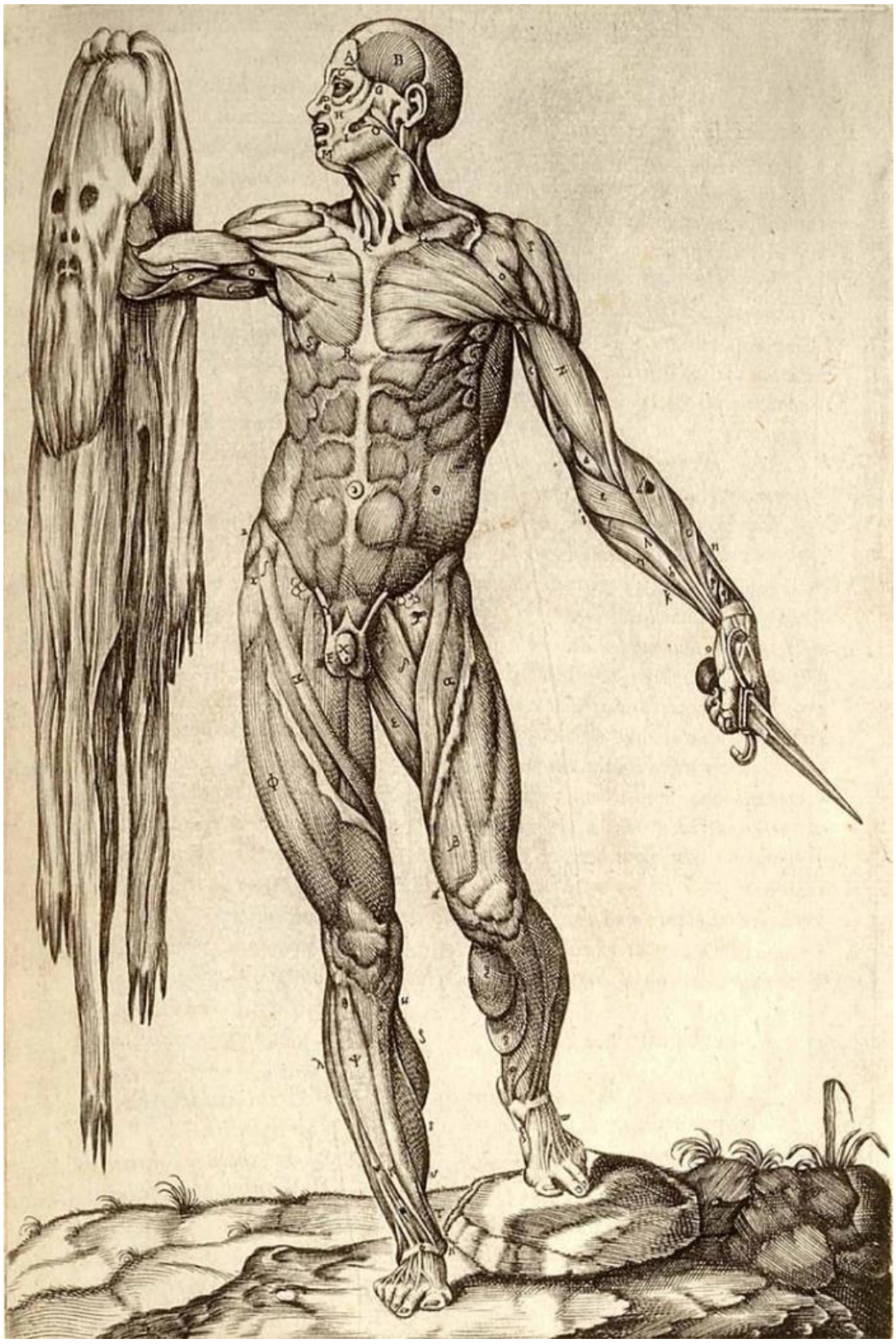

**Figure 1-5** van Calcar, Jan Steven (Attributed to) from Vesalius, Andreas. *De Humani Corporis Fabrica Libri Septem*. 1543.

The work of van Calcar and Vesalius signals a substantial aesthetic departure from Galen; however, these representations and the research of Vesalius are still situated in the same episteme in traditional Westernized medicine as their predecessor. Vesalius maintains the tradition that no knowledge of disease or even individual anatomical difference could possibly come from dissection, as the humours were understood to be muddied by death.

The second episteme, Nosology, came in the late 17th-century when scholars started to classify and study disease. Observations led physicians to reject Humourism and replace it with the categorization of disorders by symptomology and variances (similarities and differences to each other). For context, modern systems of disease classification use pathogenesis (cause), and affected anatomy. English physician Thomas Sydenham (1624 – 1689) was a forefather of this shift, and his work, *Processus Integri* (The Process of Healing, 1692), guided pathology and practice. The emphasis on the cause of disease, as well as treatment, was the central shift in praxis from Humourism to Nosology. Sydenham's work was preceded by the start of the Scientific Revolution, which marked the emergence of modern science. During Sydenham's time, Rene Descartes published philosophical works that would help move humanity into the Enlightenment and vastly influence the course of Western philosophy.

Enlightenment thinking took hold of intellectual thought and spread across borders. The paradigm-shifting findings of Galileo and Newton provided evidence that the universe was a mass system subject to scientific laws and constraints. The rapid

advancement of technique alongside technological innovations fostered both economic growth and "social upheaval," as David Tabachnick notes in *The Great Reversal: How We Let Technology Take Control of the Planet* (2013), describing the impact of the era on power, technology and culture:

> More and more, the promise of technology rather than the judgments of men pushed the direction of society. The point is that these revolutions in science and industry would not have occurred without a commensurate change in how we relate to others and the world around us. Because [technical thinking usurps the superiority of the judgments of human beings], it follows that life experience simply does not provide anyone with the competence to make proper decisions or understand how the world truly works. Instead, true knowledge requires what Francis Bacon calls a "skillful minister" that is able to "apply force to matter" and "torture and vex" nature so that it reveals its secrets. Bacon is describing the new scientific method that becomes the foundation for ever-widening experimentation on the natural world – unlocking the hidden qualities and energies of matter that go on to power scientific and industrial revolutions. (75)

The "skillful minister" who can bend nature through the power of science is an important shift in perspective in this period. At this time, anatomical drawings began to change in a provocative way to signal the turn. I would argue that there is an aesthetic transformation in the way the medicalized body is pictured that starts as early as the mid-

17th-century and extended into the Enlightenment that mirrors the shift in cultural values occurring at this time. This change not only profoundly transformed how we understand and visualize the body, but also how we know the patient. The Enlightenment brought with it the sharp division of the mind from the body, the division of knowledge into disciplines, as well as an almost fetishistic obsession with categorizing the world into things and sub-things. Under these influences, anatomical studies were drawn up to help organize these values visually. One of the earlier and best examples I located of this dramatic shift comes from the English physician William Harvey (1578 – 1657), found in his *De Motu Cordis* (Anatomical Account of the Motion of the Heart and Blood). Harvey's illustration reflects an adjustment in how we saw the body in the Nosology episteme in terms of disease, symptoms, and standards of health. Still, perhaps most interestingly, it reveals how we understand the patient (Figure 1-6).

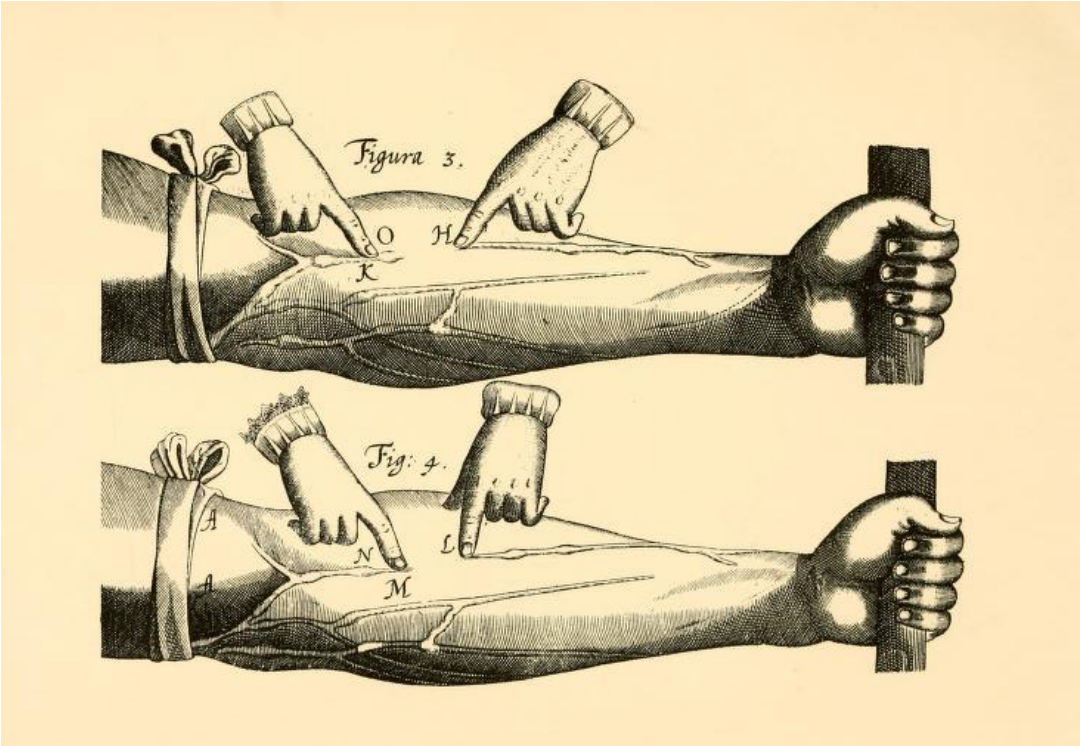


**Figure 1-6** Harvey, William. An illustrated experiment from Harvey's *Anatomica de Motu Cordis et Sanguinis in Animalibus*, 1628, p. 59.

What marks the transformation from an image like van Calcar's flayed man to Harvey's arm is the treatment of the subject. Where van Calcar's body is active and participating in the exploration of his body, Harvey's subject is dismembered. The arm, fragmented from the body, becomes an object. Divorced from their autonomous, dynamic status, the patient is instantly the object of study for the physician, who is now physically present in the image. The physician-as-expert fills the active role the body-as-subject once occupied. This image is also indicative of the principal practice of centring research on the white, male, adult body as the universal baseline marker for healthy body operations. While other images were produced, and other bodies were sometimes studied,

their systems were categorized and understood by their differences to the universal form. The Nosology episteme, with its categorization of disorders by similarities and differences, no doubt found direction in the use of a stable "picture of health." The extreme conclusion of this constricted focus is that we gain a great, great deal of knowledge about the adult, "healthy" white male body. The images produced from studies like Harvey's were instrumental in teaching generations of physicians about the inner workings of the universal body and to no less an extent, the patient-doctor dynamic.

During the 17th-, and 18th-centuries, as the episteme of Nosology governed medicine, research could be disseminated at rates never before possible due to the widespread availability of the printing press, which initiated mass communications and altering how we collectively retrieve knowledge. An upsurge in literacy and access to books and images meant that for the first time, the general population (literate or not) could readily locate pictures of the medicalized body. The images people had access to present a hierarchy of orders, classes, and genus alongside the authority structure of doctor and patient with the implication that the patient—even the healthy would-be-patient—is severed from their own state of health. Medical historian David Harley attributes the rise of Morbid Anatomy[22] in 17th and 18th-century Europe to the shift in power dynamics between patients and physicians, positioning the doctor in an unassailable position of authority on all questions regarding the body of the patient (1-28).

[22] Morbid Anatomy is the branch of medical science concerned with the study of the structure of diseased organs and tissues.

The third shift in framework came in the late 18th-century with Pathological Anatomy. Physicians began to associate disease with variations in tissue type, gaining a better understanding of how a single illness could affect multiple systems of the body.[23] A lawful supply of bodies was opened up when the British Parliament passed the Anatomy Act 1832, providing a legitimate way for researchers to acquire and study the corpses of executed prisoners, and this led to further knowledge of the body.[24] French physician R.T.H. Laennec used the invention of the stethoscope (1816) to help move medicine away from a purely symptomatic approach towards Pathological Anatomy, through non-surgical, technological access to the interior anatomy and physiology of living patients (Bynum 41). Our modern system of medicine belongs to this same episteme. While the use of the stethoscope remains time-honoured and trusted, our technological innovations have also brought us a variety of new non-surgical mechanisms that provide more revealing peeks into the living body. Consequently, anatomical research landed here, at a place where technological developments are being used to draw the newest lines in extraordinary detail on the frontier of body mapping. Anatomical study and imaging are now pinpointed on the features and functions of the less studied, least accessible regions of the living human that macroscopic examination could not register or index, including the non-human anatomical structures of the human body.[25]

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[23] The study of tissue led to a greater understanding of disease at a cellular level, and germ theory, which underlies contemporary biomedicine. The 20th- and 21st-century brought even smaller units and we now can study disease at the level of chromosomes, genes and DNA.

[24] For further reading on the interesting history legal and illegal dissections see Mary Roach's *Stiff: The curious Lives of Human Cadavers*. W.W. Norton, 2003.

[25] Microscopic colonists populate most of the human body. Interestingly, only 43% of all the cells in our bodies are human. The microbiome is made up of bacteria, fungi, viruses, and archaea, all of which possess their own histories and evolutionarily determined genomes that augment the behaviour of the human genome of their host.

If the era of Nosology initiated the undertaking to sever the autonomy of the patient, solidify the physician as director and master of the sick body and disconnect the patient in mystifying ways from their own state of health, then the contemporary age of Pathological Anatomy can be said to have mastered it. Patients are now ushered into dimmed rooms for MRIs, PET scans, and biopsies, where their visual field is obstructed, and they are shielded from much of the mechanics of the procedure. Images and extractions rarely circulate back to involve the patient directly. More commonly, limited conclusions are explained to the patient some time after a procedure occurs. Greater access to imaging methods and lab work has come to mean that doctors habitually trust test results over patient testimony. Technological advancements for diagnosis and treatment, as well as new information on disease prevention and management, have provided rich possibilities for healthcare and saved countless lives.

Still, this modern system of understanding in the history of medicine is as much connected to current social perceptions of illness and bodies as it is to the medical epistemes from which it advanced. Yet, with the scientific advancement of imaging technology and X-ray microscopes, perhaps it feels like now, more than ever, we are approaching a place where we can finally image and imagine the body without the baggage of history or the intrusion of cultural preferences and desires? As if, surely, there is a state of discoverable bodyhood, of biological being, that may sit outside of all that other messy stuff? As if, surely, culture could not inject itself into a directed magnetic field? But, it is not that simple. These newer technologies are not disinterested. Their images propagate, breathing cultural forces like air and exhaling out remnants, which can

change the composition of the environment or maintain the ecosystem. Take, as an example, the MRI (Figure 1-7).

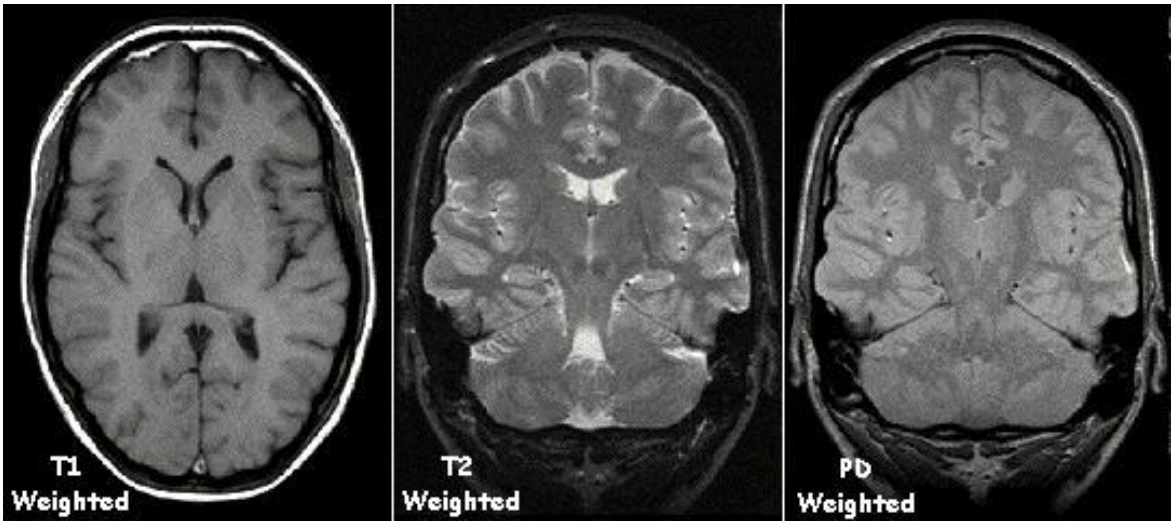


**Figure 1-7** Three examples of T1 weighted (where magnetization is in the same direction as the static magnetic field), T2 weighted (where magnetization is transverse to the static magnetic field) and PD weighted (where magnetization has a long repetition time and a short echo time) MRI scans taken in 2000.

Magnetic resonance imaging is a process that utilizes an MRI scanner, strong magnetic fields, magnetic field gradients, and radio waves to excite hydrogen atoms in the body. These atoms emit a radio frequency, which is measured by the scanner to provide position data. Points of contrast between adjoining tissue are amassed by the rate at which vibrating atoms return to a steady condition. It is worth noting here that the MRI scanner does not produce an MRI image; rather, it generates data. The MRI scanner compiles that data and feeds it into a computer program. Now is the critical point at which the MRI procedure begins to really connect to the far-reaching cultural and

scientific history of imagining and rendering the medicalized body. The image generating technique that is employed must produce a picture that doctors and technicians can make sense of. It must, then, tap into the visual training that they (we) have been brought up in—the aesthetic preferences that mark the medical tradition and correspond to their practice.

Silvia Casini makes this tradition quite clear when pointing out the aesthetics of the scientific laboratory: forming images from non-representational data like sound waves, temperature, or chemicals requires a bridge to physical pictures of things or events. This bridge is the imaginary world ("The Aesthetics of Magnetic Resonance Imaging" 22). By this, she means that imaging techniques can organize the sensible through both an artistic gesture and a scientific one, producing a picture that feels the most "right" through the direct intervention of several actors. In the case of the MRI, the scientific data comes from the interaction between the scanner and the biology of the patient. This data is fed into a computer that is programmed to organize the data as an image that resembles the medicalized body medicine has come to desire. Another often undervalued but substantial mediation between experts and technologies happens at the level of the technician, who tweaks the image produced by the computer program even further, creating an image that represents a possible way of engaging aesthetically with the data.

Lisa Cartwright, a scholar who considers the relationship between modern science and art, finds moments where the two are mutually implicated in the emergence of and reproduction of "life." Cartwright sees moments like this one—the coming together of the scientific data of the MRI scanner and the imaginary-world-crystalizing of the

subsequent actors that produce an MRI image—as proof that medical image generating techniques belong to the discourse of visual culture. Visual culture is the study of images which can be most recognized at an intersection between medicine, iconography, aesthetics, and society (Cartwright xiv). A recognition of the cultural properties of a scan sits in contrast to what we typically believe is most perceptible in an MRI image: the faithful, direct translation of our insides, outside. Casini notes that this perception is simply not true, as "the question of representation as resemblance is what is at stake in medical imaging techniques" ("The Aesthetics of Magnetic Resonance Imaging" 27).

Furthermore, because the images are made in the exchange between humans, machines and aesthetic preferences, what we ultimately create are "images among a number of other possible and equally plausible visual combinations" ("The Aesthetics of Magnetic Resonance Imaging" 31). Programs and technicians make interventions for readability using parameters and standards that take on a vernacular more familiar to art theory, tweaking colour contrast, hue, resolution, transparency, brightness, luminosity, fine detail, scale, and more to adequately visualize the boundaries and elements of the body that we have already catalogued according to a particular stylistic paradigm. Importantly, in these procedures, it is the predetermined research question that directs the method and then the interpretation of the results, and it is always easier to locate what we already know (or think we know) to be true ("The Aesthetics of Magnetic Resonance Imaging" 32).

Casini likens the MRI process to mapping, noting that the body, as a concept—an image—exists before the data is mapped on to it. The image of the body that we have brought with us into this experiment is a pre-measured landscape that provides the

contrast to the contours of the MRI. The data collected in the process forms the spatial resolution ("The Aesthetics of Magnetic Resonance Imaging" 31). It would seem that the ghost in the machine, in this case, is the spectre of the whole history of anatomical representation. Perhaps, if we look hard enough, we might even make out the faintest hint of Galen's frog woman haunting us in the softest thresholds of the imaged MRI.

On this note, having now traced an abridged history of the ways the medicalized body has been imaged in human anatomy in conjunction with the three fundamental approaches of Westernized medicine and corresponding cultural touchstones, it is indeed now time to return to Galen. Let us revisit the feeling of discomfort that you may have made a note of when looking at Galen's anatomical drawing from antiquity. What causes that feeling of uneasiness? Is it the inaccuracy? Yes, it is true Galen's work has errors. But, so too does the work of Vesalius, Harvey, and inevitably, our most recent anatomical representations will soon be found wanting.

The straightforward argument for accuracy as a means of explaining our discomfort with Galen's work becomes a wearing one. It is more likely that the trouble is born from unfamiliarity with Galen's visual ideals: it is coming from the way he chose to represent the body and what he valued most within that representation. The lesson we can draw from Galen's example is that all representations of the body are stylized to highlight particular preferences. While we often choose to think about knowledge and technique as linear and progressive, the reality is that we have settled, for the moment, on a particular set of preferences that form a representation of the body that really could legitimately be otherwise. Our preferences are not our preferences because they are the most accurate. They are our preferences because they fit with a particular view of the world and what we

value within it. There is a legitimacy to how Galen has represented the body and the stylistic choices he made. We are uncomfortable with it only because it is removed from how we image the medicalized body today. It is just too distant.

We are utterly mistaken if we hazard to call Galen's representation primitive. Primitive is a term we are far too comfortable assigning to ancient or non- Westernized images uncritically. When we are blinded by our obsession with technological advancement, our mode of measuring misses so much. Would we call the static, blocky figures of ancient Egyptian art naïve? The question, instead, should one of purpose and style. The purpose of Egyptian art was not to be seen and appreciated.[26] The renderings were practical, clever tools for ritual that amalgamated multiple views of different body parts as a sophisticated solution to conveying necessary information about time, space and a three-dimensional form on a two-dimensional surface.

Galen, like the Egyptians, has utilized conventions that we are not used to and that do not align tightly with our values. Medicine and its pictures are not disinterested. Images are vital objects of study because of the power they wield to project cultural values as fixed truths as well as to direct future knowledge. Because of this, images can be implicated in the forms of knowledge we are left with. Medicine and its picturing can save or destroy lives. Imaging can tell us as much about the innermost recesses of our person as they can reveal which bodies have been excluded from diagnostic models and studies. They clarify which bodies are likely harbourers of contagious disease, along with

[26] Statues and reliefs were often not primarily intended for public appreciation (though certainly this does not mean they are removed from declarations of power and status) instead they were a vessel for the ka (spirit) to engage with the earthly plane and participate in rituals. Directionality, time and space all played important roles in predetermined ceremonies which were dictated in the imagery of the surrounding paintings.

which bodies need protection. And, they can illustrate who ought to be believed and to what degree they are reliable. To be sure, medicine and its images are not disinterested.

*1.2 The cult of good health: the mythification of health and illness*

Particular social norms, codes, desires and fears around the body write the scripts of our visual sensibilities. A commonly shared language of metaphor and value are the tools we may draw on to interpret images in a meaningful way. The idea that complex data can pass between images, their producers, and the viewer is not a notion or experience for the limited few who are trained in the nuances of visuality. Indeed, visual interpretive skills are quite banal; they are a broadly applied practice of everyday relations. The larger question one might ask is if visual information is received actively or passively; critically or uncritically. If we choose active, critical viewing, we might open further questions, questions like, what are the norms, codes, desires and fears around the body that are persistent in our images? For what purpose and to what ends are these meanings directed? These questions are reasonably pressing because they have real consequences for real bodies. In what manner? Well, we could take, for contrast, a comparison of a typical breast cancer awareness image (Figure 1-8) and a classic example of a cigarette box warning on packs of Marlboro cigarettes (Figure 1-9).


**Figure 1-8** An image from a breast cancer awareness article featuring Senior Airman Latisha Chong as a breast cancer "survivor" sporting boxing gloves (accessed 2015).


**Figure 1-9** An image showing the deliberately gruesome close-up of cancerous tissue and mouth disease that serves as a warning on two cartons of Marlboro cigarettes (accessed 2015).

In the first image, a radiant, beautiful and healthy-appearing woman confronts the viewer with a direct stare. She is wearing boxing gloves, which she holds up in front of her as a demonstration of her readiness for battle. She projects confidence, competence and, most of all, control. The ad reads "BREAST CANCER SURVIVOR" in bold, uppercase letters, and below, "Senior Airman Latisha Chong." A solid pink background triggers a longstanding association in the Global North between the colour pink and this particular category of malignancy: breast cancer.[27] The association between colour and brand is an old game in the advertising industry, meant to cement corporate connotations to the perpetual human sensory experience.

The image has seen a few iterations since it was first published with an article in *The Patriot*, a base paper for Joint Base Charleston, S.C. (Charleston Air Force Base & Naval Weapons Station), on Oct 25, 2012, and was labelled open use. In this image the colour pink seems intentional to raise public brand awareness for this cancer by inference. Now, what exactly brand awareness is supposed to mean for cancer prevention or treatment is a crucial question we ought to ask. The image certainly does not overtly ask anything of the viewer: there is no appeal to engage in a breast exam, nor is there a list of symptoms for the viewer to be mindful of. There is only a hero-figure who has conquered a villain: the antihero, cancer, so often positioned as a chaotic lawbreaker violating the order and symmetry of the body. Gayle Sulik is the founder of the

[27] The pink ribbon campaign began as a grassroots movement in the early 1990s. By 1992 the ribbon found its first corporate adoption with Estée Lauder, solidifying its future as an icon in capitalism and, as some critics have called it, a red herring. For further reading on the history and issues of the pink ribbon campaign see Sandy M Fernandez's article "Pretty in Pink" available here: www.thinkbeforeyoupink.org/resources/history-of-the-pink-ribbon/.

Consortium on Breast Cancer, an international working group that analyzes the social, cultural, and system-wide factors affecting breast cancer. She has written about the moral goodness attributed to women survivors of breast cancer and the relatives and friends of breast cancer patients (living or dead). She notes that this cult of goodness is so potent that the visible identification of moral superiority overrides practical efforts for alleviating the suffering of the disease politically, medically, scientifically and socially (133-146). It would seem on this occasion that moral good—as is too often the case—does not equate to a practical good that comes from a gradation of concrete efforts across social, scientific and political spheres.

It has been argued that, in marketing terms, the success of breast cancer awareness ads comes from the lack of competition: there is no opposing view that believes breast cancer to be desirable (King 111). But, while I suppose it is true that breast cancer has ostensibly no Pepsi to its Coke, and be that as it may, I would argue that there is something very desirable about the public face of breast cancer in our culture, and that feature is ubiquitous in how we visualize breast cancer in the media at large and in figure 1-8 specifically. Why breast cancer? What sets breast cancer up for this awkward idolization? Perhaps part of the answer can be found in the fact that breast cancer has one of the highest survival rates of all cancers, at nearly 90% in North America (SEER).[28] Breast cancer is also relatively common: globally, breast cancer is the foremost type of cancer in women, accounting for 25% of all cancer cases ("World Cancer Report"). It is conceivable that the high rate of breast cancer across all social strata, and its relative

[28] Breast cancer survival rates do vary greatly worldwide, ranging from 80% or over in developed countries to below 40% in low-income countries (Coleman et al., 2008). Low survival rates in developing countries are attributed to late detection and lack of adequate treatment. See *Breast cancer: prevention and control*, from the World Health Organization at https://www.who.int/cancer/detection/breastcancer/en/index1.html

survivability have both contributed to its elevated status in the emergence of survivors (in numbers) and the idolization of the illness survivor due to the fact that among them, many are socially, politically and financially well-positioned to be "seen" by the culture at large. The timely rise of the pink ribbon campaign and its subsequent corporatization undoubtedly added a potent mix of confused consumer desire and commodity fetishism into the brew.

Breast cancer is less visible than some cancers: it can be hidden below clothes and with clever prosthesis or reconstructive surgery. In this way, the public face of breast cancer may be relatively unmarked by the reality of the disease, if desired. Of course, none of this supposition is intended to undermine the palpable seriousness of battling breast cancer—quite the opposite. Countless people have slogged through the hellish swamp of breast cancer and seen the crystalized reality of new facets of suffering. A great many have died. The human element of this is of the utmost importance to return to. And, when one does, it all over again becomes apparent that that which causes agony is not an unusual bedfellow to reverence or even, if Westernized culture has shown us anything, worship.

The romantic, moral goodness of breast cancer is not without precedent. In Galen's work, we first see a direct connection between social and emotional qualities and disease. Susan Sontag has written extensively about the different routes that the romanticization of diseases have taken throughout history and the particular metaphoric attachments that cling to them. Cancer, she writes, has long been considered a disease of passion, exacerbated during the Romantic period, where cancer was understood as a manifestation of the wages of repression ("Illness as Metaphor" 20-21). At the same time,

cancer is assumed to be morally entangled with the expression of passion: living too richly, too much sex, alcohol, drugs, sun, cigarettes, and unhealthy food or lack of exercise are all environmental and behavioural connections cancer is regularly tethered to. Contradictions in how we tie illness into metaphors are also common. Coexisting, often incongruous messages somehow still feel clear as day under the right light when in focus.

The strings connecting shame, morality, and illness are often tugged by government health organizations who wish to control the behaviour of their citizens. Figure 1-9 shows a state initiative requiring cigarette manufacturers to place a warning label on boxes in an effort to influence the choices of the consumer. The image presents an intentionally gruesome close-up of cancer and disease with upper-case text that reads "WARNING: SMOKING CAUSES MOUTH DISEASES/NECK CANCER" on the top half of a box of Marlboro cigarettes. A phone number is provided for information about quitting. The sick bodies pictured are quite different than our earlier survivor. These bodies are meant to be abhorrent bodies. We are expected to be repelled by these sick bodies; to recognize them as undesirable and to be motivated by our disgust to stop engaging in smoking from fear of becoming them. In the identification of othered bodies—which often operates to strengthen existing boundaries between social groups—the "healthy" body must protect itself against the implication of affinity with actual or symbolic connections to the "infected."

Unlike the breast cancer campaign, the cigarette imagery engages with the symbolic attachment of death through an inside/outside dichotomy. Cancerous tissue boils up from the neck of one body, splitting the skin painfully. The box on the right

confronts the viewer with diseased teeth exposed in an unnatural snarl. The teeth and mouth sit at the entrance, the gateway to the body's interior, en route to the digestive system. Teeth are a relatively tolerable way to glimpse the skeleton. Both of the cancer-infested bodies appear dismembered, as both images are sliced in a close crop, revealing wounds. Our instinct to repel from these images comes from their symbolic attachment to death and infection. Then, there is the added layer of guilt by association: Sontag writes that any disease that is "acutely enough feared will be felt to be morally, if not literally, contagious" (6). Certainly, it is the goal of the campaign to reduce smoking by making smoking morally "bad" and, in doing so, the campaign participates in a cancer metaphor that sees the sick body as morally "bad" as well.

The way the fear of cancer is leveraged in both examples is actually remarkably similar for such contrasting images. In the second image, the cigarettes, the alleged irrepressible horror of cancer is positioned at the forefront of the two labels. In the first image, the fighter presents us with a boxing parable that shows the mastery of the body and champion status can only be arrived at by way of a battle with a profound threat. The threat is the perceived loss of the vessel to cancerous cells that make the body unmanageable, messy and dangerous. Some of the moral superiority the first image harnesses comes from the successful feat to re-domesticate the body: control is wrestled back, and strength of character is forefronted. This actual symbolic threat of cancer sits quietly, backgrounded somewhere in the descriptive ambience of the image.

Strength of character, in its moralizing use, has no straightforward bearing on whether one is diagnosed with cancer, and, if diagnosed, one's survival rate. A jarring statement to read, perhaps, but if so, it is only because morality is so tightly entwined

with our understanding of health that it seems absolutely wrong to make such a claim. Self-help guides that tout the power of positive thinking and mental fortitude only further this outlook. The critique against health is in many ways a critique against capitalism, racism, sexism, "and all other -isms," as Jonathan Metzl expertly conveys in *Against Health*, where he points out that the language of improvement and betterment that we have entwined with health politics is exceptionally skillful at sweeping the structural violence done to marginalized people under the rug, while at the same time, conveniently tying social and economic misfortune to unscrupulous habits and food choices (Kirkland 4). Indeed, your chances of contracting and subsequently beating cancer have much more correlation to your social and economic power then to your indomitable will. When I think of how indigenous peoples in Canada are affected by diseases caused by environmental contamination (heavy metals, industrial gases and effluent wastes) at a much higher rate than non-indigenous Canadians (Gracey 66) I can not help but think of Vincanne Adams' words: "[the] political causes of disease are as important as the microbial ones" (45).

The way that morality, health and its images are tied together is an essential foundational problem this first chapter converges on. When we participate in the overarching assumption that health is a fixed entity, with "good" and "bad" characteristics that we can visually recognize, then we inevitably are entitled to the next assumption: health is something we can transpose through big-picture, overarching social strategies to places and people that do not fit the picture of "good" health. The problem, though, is that "health" is not the simple state we understand it to be. We do not reside in a pure state of "good health" until we have the misfortune to visit illness for a time. Yet,

this is the language we use. It is how we understand our bodies and our maladies. We wish for "good health." We seek treatment until we are "healthy." We "fall ill." Some of us are deemed "chronically ill." We are told what to eat for "good health," and we remark that a lack of exercise is a recipe for "bad health." This language we use reveals the complicated truth of how we sincerely understand the concept of "health."

According to Metzl, a professor of sociology and psychiatry, and the director of the Center for Medicine, Health, and Society, we see health as (1) a desired state, (2) a prescribed state and (3) an ideological position. Health as a desired state is chockfull of value judgments and hierarchies. Health, as a prescribed state, employs blind assumptions that speak as much about power and privilege as they do about well-being (21-22). Health as an ideological position gives us moral immunity to hurl judgments like weapons disguised as a sincere concern for the other. Metzl writes:

> [When we] reflexively say "obesity is bad for your health," what we really mean is not that the person might have some kind of medical problem, but that they are lazy or weak of will…appealing to health allows for a set of moral assumptions that are allowed to fly stealthily under the radar. And the definition of our own health depends in part on our value judgments about others. We see them—the smokers, the overeaters, the activists and the bottle-feeders—and realize our own health in the process. (22)

In pointing out the casual use of health in our daily lives as the moral compass that positions others and, in turn, defines our own position, Metzl complicates our assumptions about health as a "transparent, universal good." He also highlights how

much accountability we place on ourselves and others to control the functions, processes, organisms and diseases of the body through decency and determination. Visual representations of the body like the ones in these two cancer campaigns engender the moral consequences of being "unhealthy" and the moral superiority of "health." These images picture the binary, moralistic movement in Westernized understanding of "health" and "illness," and they are also a primary vehicle for disseminating the ideas they infer. Such pictures of health in popular culture are often concerned with ageing, healing, and dying, placing natural human processes on one side or another of a boundary between healthy and unhealthy.

The medicalization of natural human processes is not just a critique to be levied against the images in women's health magazines or advertising, however. Lest we forget, medical aesthetics are not symbolically removed from these less scientifically authoritative visual depictions of the "sick" or "healthy" body. Philosopher Ivan Illich argues in "Limits to Medicine: Medical Nemesis, the Expropriation of Health" that Westernized medicine has medicalized human life itself, turning ageing and dying into the epidemics of modern medicine (39). And recall, too, that the line between advertising and images in popular culture and medicine very regularly coalesce, as is the case with a Surgeon General's warning–where marketing campaigns selling "health," in all the implications that word holds, promote the interests of the senior military medical officer in Canada.

Campaigns like the Surgeon General cigarette pack warnings are regularly created in Canada and elsewhere, in the name of public health. The label warnings, which have

been shown to be effective,[29] admittedly, are not the most obvious choice to take issue with on the surface if one (presumably) prioritizes efficacy in preventing lung cancer. However, campaigns like these do belong to a history of public health initiatives that use morality, health and the image for social control by demonizing the sick person and appealing to our desire to other ourselves from those who are deemed "bad." And, we ought to be mindful of the casualties of these efficient schemes. My misgivings come from historical examples of similar efforts. Early 20th-century visual public health initiatives painted pictures of "loose" women that would ruin unthinking men with sexually transmitted infections (Figure 1-10).

[29] The report, "A review of the science base to support the development of health warnings for tobacco packages" from the Sambrook Research International in 2009 found clear evidence that warnings increase public knowledge of the risks of smoking and contribute to changing attitudes and behaviour.


**Figure 1-10** A U.S.A. propaganda poster targeted at World War II servicemen that appealed to their patriotism in urging them to protect themselves from "good time" girls and prostitutes. The text at the bottom of the poster reads, "You can't beat the Axis if you get VD."

"The prostitute," as philosopher Shannon Bell writes, has been formed by Modernity as "the other of the other: the other within the categorical other" that is the "disprivileged" site of "woman" ("Reading, Writing, and Rewriting" 2). Sex trade workers, already vulnerable, are targeted as landing sites for the aggression of men who view themselves

as the unwitting victims of a disease that “belongs” to the women with whom they sleep. This perspective comes from a long-standing medical-legal-moral discourse around sex workers, which Bell points out, produces an image of the sex worker body as a “destroying body, a disease that spreads and rots the body politic” that is as ripe with misogyny as it is contradictions (44-5). In the 1980s, deep in the horror of the AIDS crisis, we were besieged by panicked public health crusades that utilized fear, shame and disgust in an effort to spark behavioural change and awareness from the public (figure 1-11). These kinds of ads played a role in exacerbating the gay moral panic that preceded and doggedly followed the dark decade.

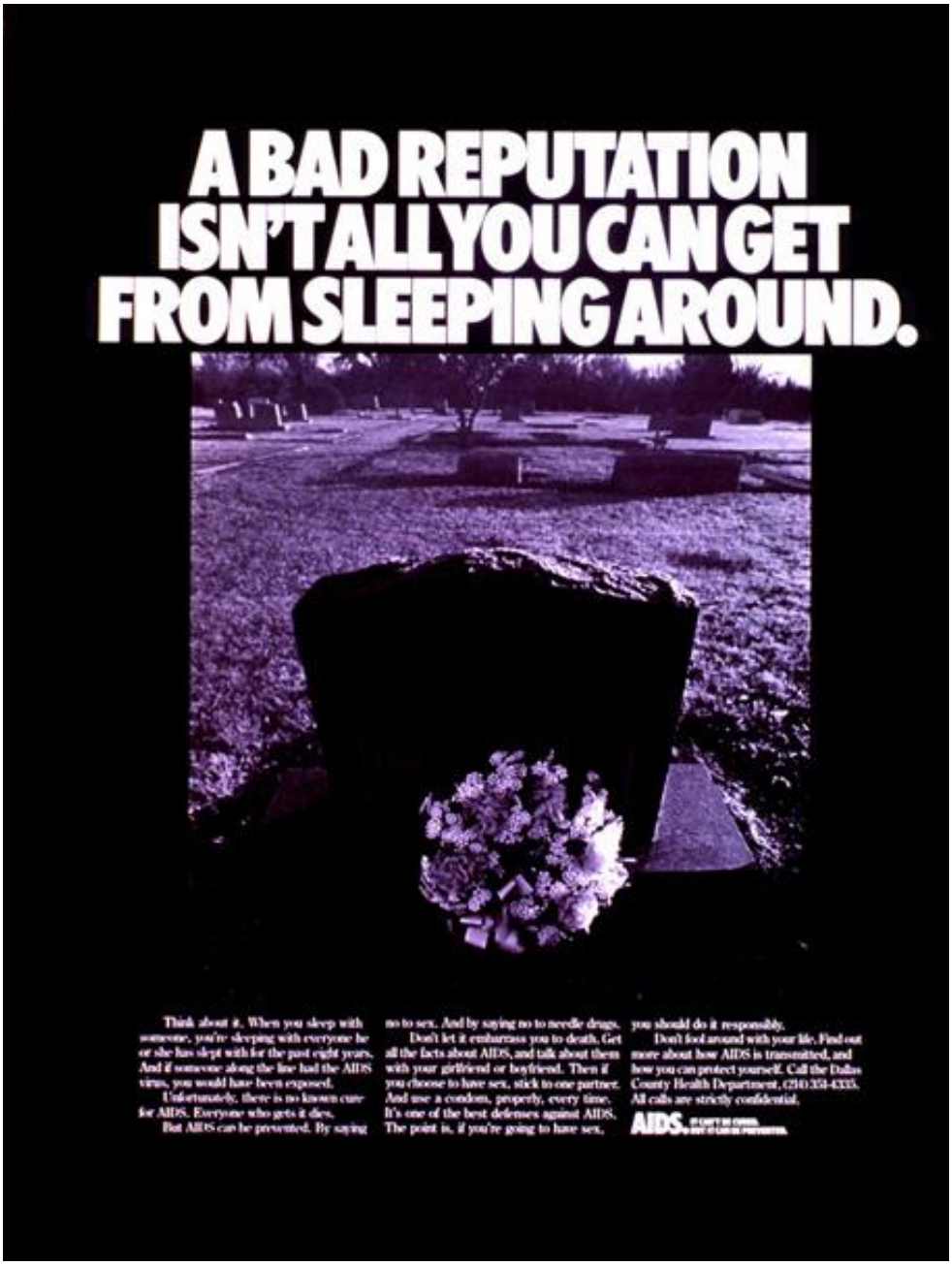


**Figure 1-11** A poster published by the Dallas County Health Department c. 1980 features a grave and some flowers. The message across the top reads: A BAD REPUTATION ISN'T ALL YOU CAN GET FROM SLEEPING AROUND. A lengthy and hard to read caption below photo discusses the risks of having multiple sexual partners and injection drug use. The tone of the poster is designed to shame while offering no alternative than abstinence.

Perhaps, as with the anti-smoking warnings, one could say there was some real success for both of these examples with respect to how the initiatives measured victory, but the far more significant historical consequence of these campaigns lay in their ability to further marginalize, segregate and stigmatize already vulnerable groups and the illnesses that moved through them.[30] The symbolic force of an image can be tremendously powerful. Formal and representative elements produce certain effects on the reader – not in their singularity, but as a unified whole.

The reason we have high frequencies of fear-based campaigns is because of the proven efficacy of poetics over rhetoric in influencing belief. Persuasion scholars have been studying this effect for at least the last fifty years, and studies have shown viewers who are "transported"[31] through a "distinct mental process, an integrative melding of attention, imagery and feelings," in other words, emotional or affective appeal, are much more likely to come away with personal beliefs and evaluations that are consistent with the message being delivered (Green 701). These images can and do affect opinions.

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[30] Studies operated between 1962 and 2014 concluded fear-based campaigns were efficient in influencing attitudes, intentions, and behavior. For more see "A review of the science base to support the development of health warnings for tobacco packages" Sambrook Research International, 2009. However, other studies, specifically in HIV awareness campaigns, have demonstrated that including the input of marginalized groups when creating educational campaigns, while recognizing their strength and resiliency, and avoiding fear-based tactics is also effective. For more on this see: GMHC, GLAAD Call on NYC Department of Health and Mental Hygiene to Pull Sensationalistic and Stigmatizing HIV/AIDS PSA. Gay Men's Health Crisis website. http://www.gmhc.org/news-and-events/press-releases/gmhc-glaad-call-on-nycdepartment-of-health-and-mentalhygiene-to-pull-sensationalisticand-stigmati. Published December 14, 2010. Accessed August 22, 2018.

[31] "Defined as absorption into a story, transportation entails imagery, affect, and attentional focus. A transportation scale was developed and validated. Experiment 1 (N = 97) demonstrated that extent of transportation augmented story-consistent beliefs and favorable evaluations of protagonists. Experiment 2 (N = 69) showed that highly transported readers found fewer false notes in a story than less-transported readers. Experiments 3 (N = 274) and 4 (N = 258) again replicated the effects of transportation on beliefs and evaluations; in the latter study, transportation was directly manipulated by using processing instructions. Reduced transportation led to reduced story-consistent beliefs and evaluations" (701). For more see Melanie C. Green and Timothy C. Brock's "The Role of Transportation in the Persuasiveness of Public Narratives," found in The Journal of Personality and Social Psychology, 2000, Vol. 79, No. 5, 701-721.

Campaigns that utilize fear capitalize on us internalizing the threat. The threat can be death and disease, but often it is also the loss of beauty or social status and social exclusion. The audience understands the risk in "an emotionally genuine manner" (Fairchild 1180), where emotion spurs decision making but also, adversely, fuels a negative image of the diseased other in equal success. Dangerous representations of the sick body yield problematic realities for sick people that can cause tension between self and body, and relegate the sick body into categories grounded in malfunction.

I have initiated my work from a starting point that integrates images from art history, medicine and the media to demonstrate that the way the sick body finds visual expression is complicated, often bound by binary arrangements that present narratives of brave heroism that lead to the re-claimed body or those of the unruly body: abhorrent, exposing the intolerable difference of mortality. In both cases, there is a splitting that occurs. The more obvious splitting comes from the binary that sees the body as well-ordered, controlled, and mastered on the one hand, and disorderly, uncontrolled and wild on the other. This binary, undoubtedly, speaks to a more significant historical dualism that has been nurtured in Western thought alongside the many past depictions of the sick body.

From Plato to Christianity to Descartes and Swinburne, the separated threads of mind and body have woven a tremendously dominant, divided model that understands the mind to be the centre of personhood, a nonphysical, non-spatial, intelligent soul that is the master of the material, vehicle, sensory organ that is the body. Contemporary arguments against dualism from physics (the physical energy for the firing can only come from a physical event), philosophy (how is it the material and immaterial are able to

interact if they are indeed separate?), neuroscience (cognitive processes have a physical basis that can be scientifically detected prior to mental awareness of a thought), and more, have vastly reduced the academic and scientific clout of the mind-body split.[32] Despite the unpopularity of dualism in the academy, our social structures, actions, views and decisions frequently comport with the enduring legacy the split has cleaved in its wake.

One place the legacy of the mind-body separation can be readily found is in this intersection between morality, health and its images. Creating a literal "picture of health" posits not only that there is some kind of attainable, stable and identifiable state of "health," but it also forms a false binary between health and death with illness perched precariously on the centre of this odd teetertotter. In this strange playground, we are alienated from our bodies, and we alienate others who have bodies that do not, or cannot, meet the picture of health we hold them up to. Susan Sontag describes cancer as an "illness experienced as a ruthless, secret invasion" (5). I believe it is only because we have divorced ourselves from our bodies that cancer—the potentiality of a cell, your cell, realized—can even begin to be experienced in terms such as "invasion."

Anne Hunsaker Hawkins' research into pathography[33] has revealed that personal memoirs of sickness belong almost exclusively to recent human history. While diaries and journals have been kept for centuries, few have taken sickness as a concentrated

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[32] For more on the argument from physics, see: Wilson, D. L. (1999). "Mind-brain interaction and the violation of physical laws." In B. Libet, A. Freeman, & K. Sutherland (Eds.), *The Volitional Brain* (pp. 185–200). Thorverton, UK: Imprint Academic. For philosophy, see: "Problems of Interaction*." Internet Encyclopedia of Philosophy*. Retrieved 20 December 2017. For neuroscience, see: Haynes, John-Dylan; Rees, Geraint. "Decoding mental states from brain activity in humans." Nature Reviews Neuroscience. Vol. 7, no. 7, 2006, pp. 523–534.

[33] Autobiographical accounts of illness.

subject. A. Hawkins theorizes that this has to do with changing attitudes around illness and the body, noting that the separation between the individual's life and their illness is set in contrast by a developed "normal" picture of health. All other conditions that vary from this baseline thus become conditions "to be corrected, never accepted" (11). The message received from images like the public health campaigns or our institutional images of medicalized bodies is clear: illness and disease are not matters of the human condition, they are emblematic of that which we have yet to control, either by action or future development.

To be clear, I am not suggesting that we should not aim for survival or quality of life. These are things I value above all else. We do, however, need to think about what framework has formed around how we see illness in the Global West and, importantly, how that framework has become a cage. This confinement causes real harm not only to those who do not fit the picture of health but also it limits our ability to expand our medical knowledge further afield to improve what we know about the capacity of the human body and the sick experience. If our images hold power to guide future knowledge, regulating our images to self-affirming paradigms that continuously seek to narrow health—while, as social critics like Adele Clarke and Peter Conrad note, categories of disease balloon in an atmosphere where biomedicine and technoscience collaborate, giving "health" the significance of moral duty, commodity, status and self-worth (Kirkland 5-6)—then "health" will remain a category that divides the haves from the have nots. This picture of "health" that we have been attending to as a culture, with all the hope frequently applied to scientific advancement, is simply not equipped to handle alternative health experiences and understandings as it is currently constructed.

Medicine and its images have built a system centred on a universal, ideal body. This kind of medical practice becomes both blind and negligent, by design, to groups that do not fit this mould. This statement is not just speculation. Numerous studies and personal accounts have highlighted a crisis in medicine: proven poor patient outcomes for women, LGBTQ+ folx, people with disabilities and people of colour. Pervasive gender, sexuality, ability and racial biases in research have skewed biomedical knowledge in such a way that almost all of the knowledge we have about diseases as well as the effects of drugs and other treatments that affect all genders, sexualities, abilities and racial groups, is based on studies that centre the universal (white, male, able-bodied, straight, cis, adult), patient. This issue has been so prevalent that in 1993, The National Institute of Health (NIH) was subject to a federal law that insisted that women had to be included in future studies. However, despite legal efforts to engage women as subjects worthy of research, women are still, to this day, underrepresented in several key research areas. Where they are represented, it is often the case that researchers do not analyze data by sex or gender. Oddly, even in preclinical research on biological material and animals, male subjects are preselected for trials as this is just how it has always been done, and so it continues (Dusenbery, “The Surprising Reason”). You read that right. Tests are done on male rats because it is traditional. At this point, if I were to see a lab rat, I might half expect him also to be unbearably and perversely white!

The results of clinical studies are extrapolated onto other bodies, and regularly symptoms and reactions for non-universal bodies are, unsurprisingly, atypical. The classic example frequently touted is the gender differences found in heart attacks. Millions of women are suffering heart attacks and dying because patients, families and

physicians cannot recognize the symptoms, like nausea and neck pain, in the same confident way we might spot the physical signs of an aching sensation in a man's chest or arms. Because women have not been a significant part of many drug trials, women are 50-75 percent more likely to experience adverse drug reactions (Rademaker 349). Women's physical symptoms are also disproportionately conflated with psychological ones.[34] Women's sexual and reproductive health is vastly undervalued and understudied. The gender bias of the research permeates into physician education, where it is no doubt reinforced by more considerable patriarchal pressures.

Reverberations of the patriarchal attitudes in medicine are heard in the field, and some categories of medicine are worse than others: a study by the All-Party Parliamentary Group on Women's Health in the UK found that 43% of respondents felt "they were not treated with dignity and respect when it came to their gynecological health." The respondents include such astonishingly basic standards as simply having their symptoms believed by physicians (UK, House 4). In the report, one endometriosis patient said: "I suffered terribly trying to get an accurate diagnosis and then information on all the possible options for my treatment. At times I felt I was fighting a losing battle; my symptoms not always being believed, and sometimes it was implicated it was all in my head" (23). We might be inclined to think that an increase in the number of female physicians in the last 30 years could have done the work of offsetting institutional bias. However, barriers exist systemically for women medical researchers everywhere. A

[34] "many conditions that primarily affect women have been comparatively under-researched entirely. Many health problems that are extremely common among women and exact a huge burden in terms of suffering and economic costs—including autoimmune diseases, gynecological disorders, chronic pain conditions—just haven't been a huge research priority. Many of these neglected conditions that disproportionately impact women haven't attracted research funding and interest in large part because the biomedical community has assumed they are "all your head" (Dusenbery, "The Surprising Reason").

characteristic example of this can be seen in the fact that in the USA, women receive only 20 percent of available funding from the National Institutes of Health (NIH), and the number of biomedical studies by women has stalled in recent years (Dusenbery, *Doing Harm* 9). It would seem change is not coming on its own accord from within the system without a significant battle.

LGBTQ+ populations experience unique health disparities relative to cisgender, heterosexual people. Clinicians and researchers often only have access to incomplete information about the health status and needs of this community.[35] In addition to under-researched conditions particular to this group, perceived sexual orientation or gender identity discrimination in healthcare services hinders health-seeking behaviours, especially among LGBTQ people of colour (Wilson, P. 607). Cori Smith, a trans man, living with endometriosis, filed a $750,000 civil lawsuit in 2017 against the University of Rochester Medical Center for the transphobic mismanagement of his treatment. The lawsuit claimed that, among other mistreatment, Smith was denied a scheduled hysterectomy—treatment for his endometriosis complications—by a doctor who allegedly told Smith that he "didn't feel comfortable aiding in [his] transition" (Stovicek).

In Canada, men who have sex with men are still facing drastic restrictions for donating blood. In the United States, the Food and Drug Administration (FDA) classifies all gay men in the highest-risk blood-donor category possible. Mike Darling (2013) elucidates that "even with a clean bill of health, a gay man is considered more of a threat to the blood supply than a straight man who was treated for chlamydia, syphilis,

[35] Further reading: Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, et al. *Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. National Academies Press, 2014.

gonorrhea, venereal warts, and genital herpes within the past year" ("Banned for Life"). You may be surprised to learn, as I was, that according to the University Health Network in Toronto, country-wide blood shortages in Canada are quite common, especially around the holidays, and that platelets are almost always short ("What to Know About Donating Blood"). The framework, then, can have a multiplying effect when moral definitions of health masquerade as scientific fact.

Issues of stigma in medical science, practice and policy affect people with disabilities as well. How "disabled" is defined in policy carries implications for both benefits and stigma. For example, the Americans with Disabilities Act (ADA) defines disability as "a physical or mental impairment that substantially limits one or more major life activities," demonstrating that disability is a diminished state, not an aspect of a body's capacity. The foundation of "impairment" often becomes a necessary underpinning required for access to services, framing the entire medical experience of disability by what the body lacks. This standard is commonly referred to as "the medical model." The link between funded services and the concept of impairment makes it virtually impossible for the idea of a healthcare model centred on unique ability and diverse bodily capacity to integrate into the health care system, and, consequently, society at large.[36] The alternative model, referred to as "the social model," tends to be more mindful of the barriers and prejudice that cause people with disabilities to face exclusion. The problem with the social model is that most countries in the Global North have not found a way to marry policy with the social model, enabling a positive approach

[36] Further reading: Ulrich, Michael R. "Challenges for People with Disabilities within the Health Care Safety Net." *Health Affairs*, 18 Nov. 2014.

to an alternative picture of physical function alongside funded care for particular health concerns and conditions that frequently require medical attention and rehabilitation.

The current framework seems to offer overmedicalization on the one hand, and a lack of access to services on the other. People with disabilities also contend with physicians educated in the "hidden curriculum," a frame of mind that comes from everyday exposure to bias and stigma that is more persuasive in how doctors view and treat their patients than how the science of medicine characterizes the faculties of particular bodily realities (Shakespeare 1815). Given that a vast number of "disabilities" cannot be "cured" in the traditional sense of the term, the way disability is reflected by medicine has tremendous weight on the lives of those living with disabilities and the society they move within.

Race is another unsurprisingly underrepresented category in medical research. It must be noted that race and medical research is a thorny topic. On the one hand, the argument exists that classification based on skin colour assumes too broad a scope for biological and physical differences that range significantly across global populations. Richard Cooper argues in this vein when he asks, "Is there any reason to believe that variations in skin colour subsume all, or any, biologically important human variation?" (716). But at the same time, while race has far less biological rooting than has historically been attributed to it, there are biological factors that are assigned to common characteristics in particular populations, and these should not be dismissed when we analyze the health status of various racial and ethnic groups. There are also social markers to health that work their way into material realities. Particular genetic diseases have been identified as more common in specific racial and ethnic groups, and similarly,

different responses and reactions to therapies and medication have been detected. Very recent pharmacological studies have shown, for example, Black patients with hypertension have a better response to thiazides than beta-blockers. Smaller doses of Haldol work better to treat Asian patients with schizophrenia (Gamble 180). Racial difference is a dangerous subject given that, as Patricia A. King points out, medical theories were used to rationalize the enslavement of Africans (35). But, indifference or avoidance can be as menacing as the potential risk of difference-finding.

The risk of indifference can be found in this example: it has long been documented that Black women are much more susceptible to premature labour than white women. In recent years, medical researchers have taken notice of the fact that premature Black babies are significantly more likely to thrive than white babies, and research is now emerging that finds race difference in gestation rates. Standard human gestation has been historically determined by white populations, creating a blind spot that missed the fact that Black women who are delivering so-called "early" babies are actually entirely on track (Papiernik 181). Research has further implied there may be alternative gestational rates across several racialized ethnic groups. Blind spots in medical research cause undeniable risks for people of colour. Alarmingly, Black women are two to six times more likely to die from pregnancy complications than white women in the USA ("Centers for Disease Control and Prevention" 1220-2). One can intersect biologically rooted concerns with significant socio-geographic dynamics as well. Environmental factors disproportionately negatively affect racialized groups, and this information is not always factored into research data. How many Black maternal deaths are caused by under-researched particularities in Black maternal health? How many of these

complications are due to environmental and social factors that disproportionately affect Black women and have not been factored into either the research data or education? How many of these deaths are caused by physicians who ignore reported symptoms from patients because the symptoms do not map well onto what we have come to characterize as a medical crisis in the universal patient?

The operative "picture of health" is a compendium of images that have been informed by and direct the scientific study of medicine and the social dynamic of the patient experience over the centuries, forming well-honed, identifiable aesthetic preferences. And, at the same time, it is also a symbolic icon of what constitutes normal or baseline biological fitness in research and practice. The narrow route that medical knowledge frequently takes, in accordance with this picture of health Westernized medicine has been perfecting for centuries, gravely hurts groups that do not fit the familiar profile. I have listed only a few ways that disregarding diverse perspectives and experiences directly impacts particular populations, but, as Dusenbery points out, the skewing of medical knowledge hurts everyone, not just disadvantaged groups.

A narrow concept of health in our medical understanding, formed from the picture of an ideal body, means we, in fact, know far less about human health than we think we do. If we could find a way to open up to alternative bodily experiences, we could significantly expand our understanding of health and disease. Given that women, LGBTQ+ people, people with disabilities and people of colour make up the majority of the global population, this is quite a startling realization to come to regarding the nature and limits of medicine in the Global North: the majority of the human population currently resists diagnostic models. The majority of the human population's bodies are, as

Lisa Cartwright puts it, “constructed as aberrant sites” (*Doing Harm* 109). Furthermore, it is imperative to acknowledge that numerous members of this “majority-minority” have intersectional connections to several facets of more than one disadvantaged population.

What needs to be forefronted in the question of wellness to try to combat the current picture of health includes, 1. an amplification of patient autonomy and self-determination over our own health to repair the broken link between owning our own health and bodies. This shift would perhaps regain some of the power that is currently seated in medicine, increasing the importance of the patient voice for both patient advocates and medical professionals. And, 2. a careful excising of the universal body as a marker of ideal health. To achieve both of these tasks, we would first need to be willing to abandon the objectivist model of medicine that remains culturally and creatively wedded to dualism. We would then need to attend to the patient experience in ways that may run entirely counter to much of our current medical research and practice, and, of course, it stands to reason by my logic that a very effective tool for this reimagining is through the power of the image to direct and reflect knowledge.

*1.3 Refusing medicine's body-object: the picture of health reimagined*

At the onset of this chapter, I marked the way we are inclined to orient specific images as subjective (like art) and others as objective (like MRI images). I do the work of deconstructing these divisions to erode the authority we place on scientific images (especially images produced mechanically, that have the appearance of being free of human intervention) to show a few things. I want to show that any line we draw between "subjective" and "objective" is far more capricious than we treat it, recognizing all knowledge, scientific or otherwise, to be supple and prone to a proliferation of readings. Some of my motivation in closing this gap is also to expose the dual functions of the image in science, which 1. illustrates human knowledge, playing the role of a codex for information, and, 2. guides human knowledge, acting as a primary resource against which new theories are tested and expanded on (as illustrated by my dinosaur case study). In most cases, the second function of the image is far less readily acknowledged or perceived than the first despite its pervasiveness. I do this work to show how the image influences the way we understand our world, and in what way the image guides and potentially limits what we can know.

Eroding the authority of scientific-looking and understanding to leverage the power of the image is a crucial foothold to carve if one seeks to reimagine the established picture of health, of course. But, I have another motivation as well in my earlier look at the inclination to fork a "subjective" and "objective" taxonomy for images. This impetus comes from my intent to focus on the methodological approaches viewers are equipped with when engaging with scientific images vs art and how disparate approaches affect

how we do the "work" of knowing. Allow me to break down the differences in the methodologies we commonly apply to these two somewhat arbitrary groupings of images and what possibilities and limitations are contained in each approach.

In science, there are checks and balances in place that ensure that the images utilized are faithful attempts to render the "real." In dissemination and consumption, the images produced are habitually conflated as a representation of the real world rather than a single, more or less accurate, interpretation of an idea or event based on current and particular knowledge. For instance, the universal patient, as I have gestured to, forms the backbone of what we know about human health, as the comprehensive picture of health has grown from the particular event or idea of the white, male, cis, straight, able-bodied test subject. There is an entrenched confidence in the scientific process that leaves the viewer of scientific images in a role that is passive by social contract: the viewer accepts their purpose is to receive reliable knowledge from the scientific image. Thus, the methodological approach of scientific-looking means that the first function of the image, the function that illustrates human knowledge, is forefronted. In contrast, the second function of the image, the feature that actively reproduces past knowledge and coproduces future knowledge, is veiled.

While medical images of the sick body, especially, should not be disaggregated from the social forces that move in and about their production and reception, they frequently are. Our methodological approach to seeing scientific images gives undue truth value to the medical image, bequeathing it more stability as an enclosed capsule for human knowledge and truth value than it is rightfully due. While the image and the concepts that inform it are always subject to the scientific method (and this is why our images, like our

anatomical drawings and renderings of dinosaur species are, in actuality, ever mutable, despite how we receive them) the operative elements of the image—its double functions—and our way of engaging with scientific images remains largely backgrounded or even unrecognized in the process of meaning-making. The significance of this active but obscured element is that the image retains a power that we, as viewers, are uncritical of, and the knowledge that it produces and that is produced by the image now carries the trappings of fixity and necessity.

It is important to reiterate that how we have historically engaged with images does vary. The scientific-looking we do today, I have shown, emerged predominantly from ideas about science and the natural world that were activated by events and ideas in the 17th-century.[37] Like science, art has mobilized multiple modes of production and viewing over time and space that are inextricably connected to shifting social conditions. Indeed, much like my reference at the start of this chapter, it is the case that we may look to the earliest cave paintings, then through art history, past *The Vitruvian Man*, up to this contemporary moment to find that art has at different moments performed, unsurprisingly, differently. Art has acted as an illustrative tool, providing visual instructions for specialized tasks. Examples of art's instructive value are seen in murals and paintings on silk recovered in Chinese tombs from the Northern Wei Dynasty (386–534 AD) (Figure 1-12). The work demonstrates the proper courtly comportment of "filial sons and virtuous women," reinforcing social norms and values.

[37] See the scientific method, positivism, the development of mechanical/digital image production and other technological developments.

**Figure 1-12** An image of a lacquer painting over a four-panel wooden folding screen measuring 81.5 cm in height, from the tomb of Sima Jinlong in Datong, Shanxi province, dated to the Northern Wei Dynasty (386–534 AD). The image dictates the proper conduct of "filial sons and virtuous women" in Chinese history. The bottom panel illustrates the story of Lady Ban (from Scene 5 of the Admonitions Scroll, attributed to the artist Gu Kaizhi).

Art has functioned as a vehicle for ceremony. Egyptian art, previously touched on, was often purposeful and ritual-focused. The rich reserve of iconography in Eastern Orthodoxy is directly allied with ritualized practice. Contemporary performance work takes up ritual as both theme and method, as can be seen in the Argentinian artist Nelda Ramos' 2012 performance of "Healing Ritual – Magical Device" presented at the Venice International Performance Art Week. Additionally, art has served as a means for commemorating (and, inevitably, amending) historical events. Jacques-Louis David's famous 1801 painting "Napoleon Crossing the Alps" is more an apparatus for propaganda than a historical record of the actual event. The painting shows the Romantic hero thrust into the air by a rearing, heavily muscled horse. His cape lashes forward by the driving wind, Bonaparte urges his troops onward with the powerful command of his sweeping gesture. In reality, a much older-looking Bonaparte traversed the Great St. Bernard Pass capeless, probably dreadfully uncomfortable, and riding on a much humbler and utterly sensible mule ("Great Saint Bernard Pass"). Future versions of this crossing, such as "Bonaparte Crossing the Alps" (1850), painted by Paul Delaroche fifty years later, long after Napoleon's defeat, sought to amend the historical record once again by unflatteringly rendering a pouting man riding a half-starved mule (Figure 1-13).

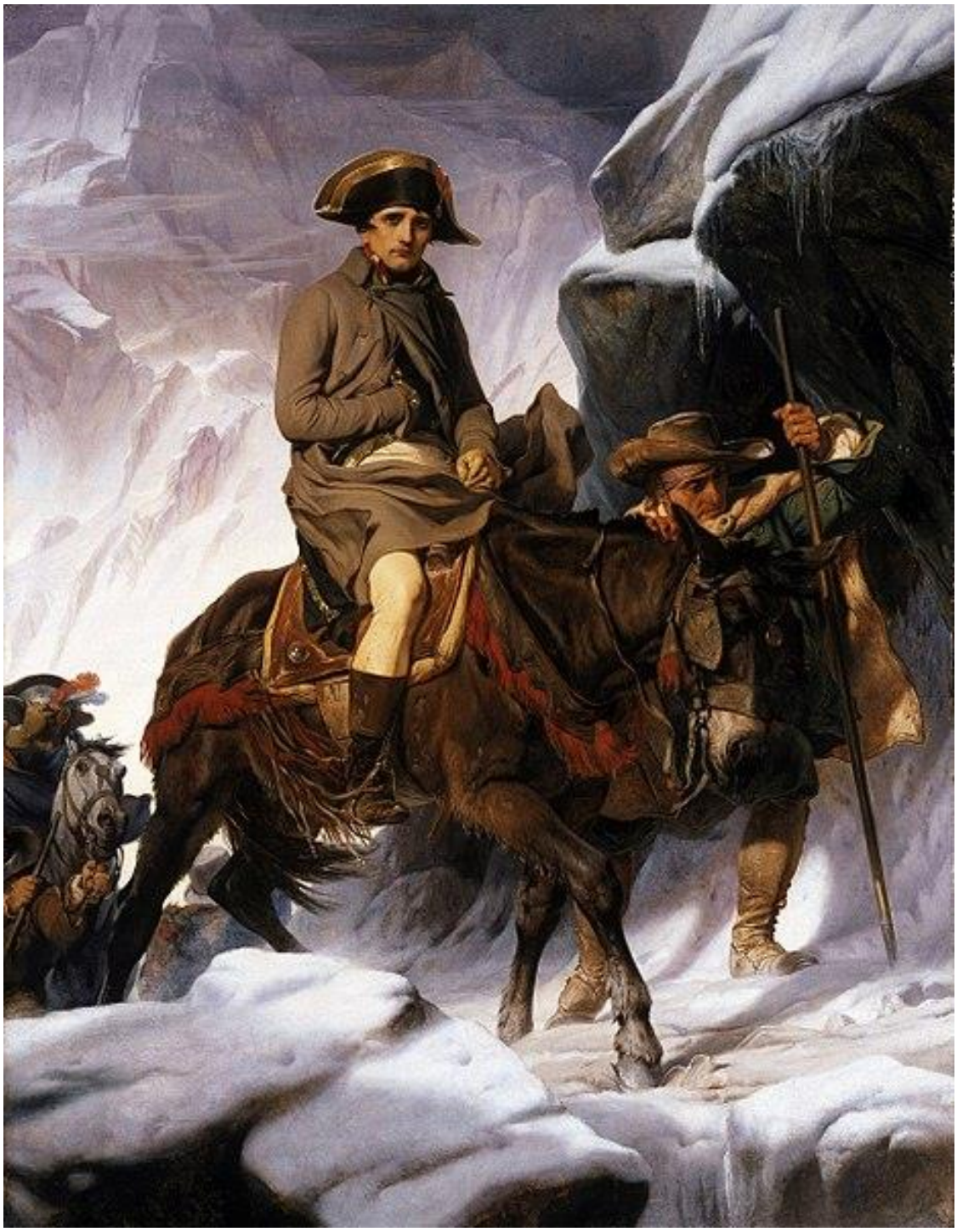

**Figure 1-13** Delaroche, Paul. *Bonaparte Crossing the Alps*. 1850. Oil on canvas. Louvre Museum, France. Napoleon Bonaparte crossed the Alps in May, 1800. By June, he had secured a victory at Marengo, Italy, over Austria. This painting conveys a meek leader uncomfortable with the realities of warfare.

Art has also been an agitative political instrument through its use as acerbic and often painful social commentary; Picasso's 1937 painting, "Guernica," is a strong example. As much as art has been used to interrupt and alter oppressive systemic patterns, it has also been (and perhaps more frequently so) used as a device for reinforcing oppression. Art has behaved in ways that underpin a colonial spirit, reinforcing cruel empires, both big and small. Threading through many of these categories is art's use as a storytelling device for the illiterate, its validity as a purely aesthetic object of beauty, and its use as a means to express intense personal emotions. Through most of art history, art is decorative or representational, and at times it has found itself to be abstract, expressive or even non-visual or time, sound or concept-based.

The role of the artist has had shifts as well. For much of Westernized art history, the artist has been seen as a craftsperson commissioned to create works for powerful bodies, like the church or monarchs, who use art as a means to progress specific ideologies. In the Middle Ages, to be an artist meant you learned a craft, inherited the role from your father and remained anonymous in the work you were contracted to do. A prime example from this time can be seen in the Byzantine mosaics at the Monreale church in Sicily created by an unknown artisan in the 12$^{th}$-century (Figure 1-14). More recently, The Bauhaus movement in the 1920s and 30s pushed for the artist to be seen as an exalted craftsman, with a distinct utilitarian, material-focused attitude common in constructionism.

**Figure 1-14** A Byzantine Church mosaic from the 12th-century by an unknown artisan. The mosaic is located at Monreale in Sicily, Italy.

Alternatively, the artist is revered as a genius, thought to possess inexplicable artistic and expressive instinct, as the mouthpiece of God, or something equally sacred, innate and mysterious. The Renaissance was largely responsible for the individualization of the artist and an increase in their social status. Art was still profoundly shaped by power and wealth, but the ability of the artist to personalize works through their expressive virtuosity became highly valued. Michelangelo was deemed "the divine one" in his lifetime for his awe-inspiring work. Another, more contemporary—20th-century—example is Antoni Gaudi, nicknamed "God's architect," whose magnum opus, Sagrada Familia, remains incomplete to this day. Impoverished artists in early 19th-century France found an easy home in the low-rent, lower-class neighbourhoods of Paris that birthed Bohemian culture, giving power to the perception that artists have mystical access to non-conformist, outsider knowledge that is worth living and dying for.[38]

The function of the viewer has seen both narrowed and expanded importance. Sometimes understood to be the passive receiver of messages about what is just, moral and good, the viewer has been figured as the submissive endpoint of meaning. The interpretive space of a 12th-century, Byzantine Church mosaic, for example, was quite limited. This kind of work was commissioned to illustrate particular and well-known biblical stories for the uneducated masses to reinforce the messages conveyed by the church. An impoverished Spanish parishioner in the Middle Ages was expected to recognize the biblical reference devotedly. At other points in history, the viewer has been understood to be the purveyor of meaning, taking on the chief role of interpretive-creator, infusing the work and rewriting all meaning through the lens of their own cumulative

[38] See "starving artist" trope

experiences. In a 2016 review in the *Denver Post*, art critic Ray Mark Rinaldi wrote, "These days, things are increasingly about making audiences part of the action. You can hardly enter a gallery without some demand that you make the art work yourself, by stepping or scribbling on it, by dancing or singing with it, turning its crank, eating it or tapping a keyboard" (Rinaldi). This observation, while droll, points to a relatively new phenomenon wherein the viewer's importance for the "work" of art is on par with, or sometimes much more valued than the role of the artist or the art object. I will elaborate much more on this arrangement and its power in Chapter Two, *The Mess of Knowing*.

Notwithstanding these rather limited examples, it becomes clear to see that despite the conceptual changes in the role of the artist, art object, viewer and world, and our relentless desire to name the supplantation of movements like the Renaissance with Neoclassicism or Social Realism with Art Brut—alongside their bracketed, corresponding dates—these configurations are not so much indicative of a march toward progress, or a static history, as they are an ongoing conversation. And, as with any great dialogue, at times the conversation folds in on itself, and we revisit things already said, interpreting them anew and sometimes producing remembrances that seem rather novel, for a time.

Contemporary approaches to experiencing art, forged largely by the dynamic fire of postmodern thought, reject systems that require a universalist notion of objective reality, truth, morality or progress. Art becomes a mode for directly confronting and interrogating knowledge as a social process that is subject to value systems that reflect particular historical, political or cultural discourses. Which is to say, this methodological approach to looking acknowledges the role of the artist, viewer, art object and world in the process

of meaning-making, while also recognizing that all meaning is made active (in contrast to definitive and authoritative), contingent on a wiggling world. With this perspective comes the recognition that meaning is made collectively and flexibly. One does not need to be particularly well-versed in the history of the philosophy of art to flow in its undercurrents, just as one does not need to know about the enlightenment or medical history to feel the power imbalance in the doctor/patient dynamic or understand the truth-power of an x-ray. Meaning is not only contained by the image but also by the environment around the image.

There is important art being made that takes the active voices of the artist, artwork viewer and world and pushes them to confront insufficiencies in healthcare models in powerful ways. Since 2017, Montreal-based artist Ingrid Bachmann has been collaborating with artists (Andrew Carnie, Alexa Wright, Emily Jan, Dana Dal Bo), medical professionals (Heather Ross, Susan Abbey, Patricia McKeever, Enza de Luca), a philosopher (Margrit Shildrick), social scientist (Jennifer Poole) curator (Hannah Redler Hawes), art historian (Tammer El-Sheikh), the families of deceased donors, and organ recipients to create work under the project, *Hybrid Bodies*, to reflect on the soft borders that exist between all bodies that overlap in the transplant process. Bachmann's work is remarkable in its ability to demonstrate the coproductive qualities of the art experience, by and large, and the exciting collaborative potential of the *Hybrid Bodies* research-led project, especially, is a model case for synthesizing numerous components of this chapter. Interactive sculptures form the work, *Hybrid Bodies: A/Part of Me* (Figure 1-15), present the viewer with dark mounds perched on plinths or tables with coarse hair-like protrusions made of neoprene rubber.

**Figure 1-15** Bachmann, Ingrid. *A/Part of Me* (detail). 2016. Bone transducer sensors, electronics, sound recordings.

These mounds read as animal; their dimensions are scaled perfectly to relate to the human body in the same way a pet or baby might. Attached to the uncanny heaps are bright yellow wires equipped with bone transducer sensors that, when pressed to the skull of the viewer, convert sound recordings into "vibration patterns which conduct sound to the inner ear through the bones of the skull and uses the skull as a resonating chamber" (Bachmann, "Hybrid Bodies"). The sound is not audible in a traditional sense; it is only "heard" by the viewer who uses their own body to render the acoustics. Moving the transducer along the bones of the skull alters the reverberations (Figure 1-16). By using

the sensor to engage the work, the viewer's body becomes an explicit material link in the circuit between the artist, art object and world.

**Figure 1-16** A woman places the bone transducer sensor near the bones of her ear. Bachmann, Ingrid. *A/Part of Me* (detail). 2016. Bone transducer sensors, electronics, sound recordings.

**Figure 1-17** A woman places the bone transducer sensor near the bones of her jaw. Bachmann, Ingrid. *A/Part of Me* (detail). 2016. Bone transducer sensors, electronics, sound recordings.

The sound recordings come directly from the experiences of transplant patients, documented at the Peter Munk Cardiac Centre in Toronto, Canada, through the work of the multi-disciplinary research team ("A/Part of Me"). Each sensor belongs to an individual voice; to the discrete experience of a transplant patient. Giving voice to the patient experience in this context touches on an urgent problem in the medical practice of organ transplantation: advancements in science and technology have led to more successful, and frequent use of tissue transplantation in recent decades, but the dark shadow of what "Hybrid Bodies" researcher Emily Jan calls "widespread cultural and

individual psychic anxiety" remains a formidable aspect of the transplant process. This aspect is often overlooked[39] as the increasing success of complex transplant procedures are represented more and more as "an unproblematised and fully therapeutic social good, a triumph of bioscientific technology" ("EXHIBITION: Junctures of a Haphazard Kind").

What could it mean for us to house the material, biological, living tissue of another inside our body? Where is the division of self and other when the boundaries between bodies are not articulatable by the easy distance markers of everyday life: bodies separated by countries, postal codes, cities, across tables, or even intimate divisions, skin to skin? When the walls of your arteries are sewn together with the open channels of someone else's heart, a heart that only beats when warmed by the rush of your own blood, where are "you?" When cells swim in your bones that originated in the soft, hollow spaces within someone else, the illusion of the enduring "whole" self derails like a doomed freight train: suddenly and forcefully. As the bone transducer in Bachmann's *A/Part of Me* connects with your skull, a voice in your head echoes the words of a patient: "I have dreams…I am somewhere, and I can't get out."

Medical concerns regarding transplant success are grounded in highly effectual eligibility criteria for both recipient and donor, based on many factors, including compatibility, diagnosis, a clinical assessment of present condition, and some less obvious factors, like projected compliance with post-transplant care. This checklist is

[39] For studies on how transplant procedures cause psychic concern for embodiment, identity and notions of self/other see: Waldby, Catherine. "Biomedicine, Tissue Transfer and Intercorporeality." *Feminist Theory*, vol. 3, no. 3, Dec. 2002, pp. 239–254. And, Ross, Heather, et al. "What They Say Versus What We See: "Hidden" Distress and Impaired Quality of Life in Heart Transplant Recipients." *The Journal of Heart and Lung Transplantation* vol. 29 no. 10, 2010, pp. 1142-1149.

designed to narrow in on the best patient outcomes (Isaac 2-5). But, as successful as transplant criteria are for patient outcomes, in accordance with our modern model of health, they are woefully dismissive of the profound discord that many transplant patients experience that throws into question who they are as subjects to such a degree that it impacts recovery. On this idea, Jan writes,

> Emerging empirical research reveals that recipients commonly experience highly troubling disruptions to their phenomenological well-being, which indicates that high rates of clinically measured recovery are not matched by a sense of personal flourishing (Ross et al. 2010, Shaw 2010). In the context of Western adherence to the founding binary of self and other, the event of transplantation breaks down the boundaries of normative embodiment and of personal identity, i.e. when the donor organ crosses the threshold of the recipient body, ontological questions of self and other frequently arise. This is not simply an abstract concern in that the transplanted organ brings to its new site an alien DNA that will persist for life (Shildrick et al. 2009), and that may circulate throughout the peripheral blood supply.

While the current transplant protocol takes into consideration many ethical and biological factors that impact the success of a transplant, it is not as equipped to deal with the symbolic elements of a transplant. The symbolic connotation of transplanted material may take on distinctive contours if the donor is living or deceased, human or animal, relative or stranger, and if their gender, age, race or name is known. The problem is not that these symbolic elements cannot be measured into transplant considerations and post-transplant care, but rather that the current picture of health in the medical system

imaginary leaves too little space for these specific patient experiences to be expressed in a way that can be heard and felt. In many ways, *Hybrid bodies* so perfectly straddles this issue in parallel to the self-other dynamic of organ transplantation by showing up the spaces that have been written as neutral to be anything but, interrogating the dynamics of give-and-take. Jan continues,

> The problem is that few of these existential questions are acknowledged without biomedical science or by media promotions of the good of transplantation. Unless they suffer a complete breakdown, recipients are left to fend for themselves with few resources to settle their self-doubt. It creates an unaddressed bioethical problem. ("EXHIBITION: Junctures of a Haphazard Kind")

The *Hybrid Bodies* research team, transplant patients and Bachmann's work collaborate to use the art experience as a mode that opens up a material way to experience embodiment as collaborative, flexible, and interdependent. And when doing so, the work stresses medicine's failure to see aspects of the patient's experience. By underscoring patient knowledge in a network of collaborators, *Hybrid Bodies* makes a political stand for a more inherently flexible bioethics that does not take the patient as subject but instead values the patient as an integral collaborator with surprising, valuable and often novel information.

Part of the political power of the art experience comes from the fact that it cannot be separated from action. It is always in action. There is never a point where meaning settles, for if meaning settles, the art object is ejected from the art experience and gives

the impression of a stale, determined thing in the world much like a chair or refrigerator might appear to be. Therefore, we must resist the impulse to make any knowledge we glean from the *Hybrid Bodies* initiative and *A/Part of Me* conclusive. We can return to and reengage this work and future works to reactivate the process—the "work" of art. In *Art and Experience*, John Dewey writes extensively on the work of art as a site for the dialectical process of experience going so far as to claim that the representative nature of art is not a literal reproduction, but rather representative in that the experience of art exposes the viewer to the very nature of their experience (85-109).

The art experience is a self-reflexive epistemological process. Art is a conduit for narrative, for feeling and for affect that is proof of the body's constant immersion in and between what Gregg and Seigworth have called the world's "determinations and inflections" as well as our capacity "to act and be acted upon" (1). This methodological approach with which we engage so-called "subjective" images and objects of art, it would seem, carries a much more nuanced and open relationship with truth-value, the nature of knowledge and the certainty of the object of representation than the methodological approach we often use to relate with the "disinterested" "objective" images of science. Medicine, as this project affirms, could learn something from the methodology of the art experience. An organizational approach that utilizes the dual functions of the image has political potential if a change is the desired outcome. Contemporary practices that surround art production and its viewing could yield extraordinarily productive potential for new ways of thinking—and I will later converge on this claim with more explicit justification—that can be more ethical, care-based and politically energizing for the non-universal, sick body. Art opens a window for alternative experiences to be leveraged into

the dominant social consciousness that can then penetrate disciplinary blockages guarded by even the most unbending of gatekeepers.

There is a shifting margin for what art is, and so there is a changing, relational reality to where the methodological approach of the art experience can be applied. Certainly, there is a usefulness to the gallery space, for the specificity of this environment cues the viewer into a participatory and active viewing experience. White walls often surround the exhibition space, yet, we must not be lulled into thinking it is a blank slate: it gives its own context. If we encounter a series of mugshots on the news, we are likely to have a different interaction with them on the screen or page then we would if we confronted them inside the white cube, for example. The gallery cues the viewer into the art experience, but the gallery is not mandatory.

The art experience can be, and often is, expanded into alternative spaces. Some shows have moved into hospital settings. The *Art in Hospitals* initiative has placed over 3000 world-class, museum-quality artworks in healthcare centres across the UK because, as they assert, "studies show that art can help us stay well, aid our recovery from illness and injury, and support us to live longer, more fulfilling lives" (*Art in Hospitals*). In 2016, 86 artists showed over 200 artworks at the former Los Angeles Metropolitan Medical Center to "explore the corporeal and psychological experience of being human" ("Human Condition").

Other projects have attempted the reverse – to move medical institutions into art galleries. Macmaster University (Canada) started a pilot program in 2009 called *The Art of Seeing* that sought to bring visual literacy skills to family medicine residents to increase their observation and interpretation skills and to bring "a more humanistic

approach to medicine" ("The Creative Art of Medical Inquiry" 250). The program brought residents into the gallery space and face to face with arts-based learning. Intriguingly, data from the pilot program confirms that in addition to fostering better observational skills, looking at art improved empathy and enhanced their understanding of the illness experience. Even more interestingly, it was observed that this learning took place at a juncture where the medical residents experienced "discomfort with not being in the position of expert as is their usual position in the doctor-patient relationship" (254).

Many shows take up the medical subject in contemporary art, like the University of New South Wales (UNSW) Galleries' 2016 show, *The Patient*. Artist Dominic Quagliozzi made work about living with chronic illness and exhibited it at the Keck Medical School at the University of Southern California with the 2016 show, *Shared Matter: Work about Sharing Art, Lungs, & Social Media*. These initiatives all bring something distinct to the collision of art and medicine that differentiates the efforts from art as therapy or art as waiting room beautification (though both are undoubtedly meaningful and valid in their own right). The distinction is a markedly political one. Dutch performance artist Ulay once intensely pronounced "aesthetics without ethics is cosmetics" (Kozole). The move to feature art in hospital spaces as more than just forgotten, neutral decoration, the desire to search for something in the gallery space to enrich the competency of medical students, and the spotlight in the art world on the patient experience all suggest that in many places and spaces the potential for a rich exchange between art and medicine is already being felt.

Art shows in medical institutions and medical professionals in art spaces are two possibilities for forming generative sites where, among other things, the art experience

may absorb the medical gaze into a productive, self-reflective dialogue. When located in visual art, images of the sick body perform differently than they do when located in medical images. In the art experience, the image of the body, as critic and historian James Elkins suggests, is not a stationary representation of the human form, but "a counterpart and figure for the observer" where the viewer's thoughts and self-image become entangled with their response to the pictured body. Some of these thoughts may be overt, but many important aspects of a viewer's response are not cognized so straightforwardly. Elkins evokes Mark Johnson[40] to show that thinking about the body occurs by the immanent mode of thinking by means of the body (*Pictures of the Body* vii). How, considering this, would traditional distinctions between the viewer/viewed, patient/professional open up?

A. Hawkins points to the urgency for medical students who are better informed of the humanistic dimensions of medicine if we are to see a drastic reconsideration of medical practice and education that takes into account an expansive approach to patient care (xi). The research of Zazulak, Halgren, Tan and Grierson provides strong support that arts and humanities training is both a crucial and sound strategy for core medical education courses ("The Impact of an Arts-Based Programme"). The concept of integrating arts-based education into medical training and supplementing existing methodological processes that direct the act of looking with the methodological process of the art experience is provocative. This shift could activate a considerable stretching of the picture of health we so frequently use as a model in medical research and direct patient

[40] See Mark Johnson, *The Body in the Mind: The Bodily Basis of Meaning, Imagination and Reason*. Chicago: University of Chicago press, 1987. Johnson's work relates to Spinoza and has affinity with Deleuze.

care. One thing is sure: the time is overdue to toss out a medical model that narrows down on a picture of health that centres the bulk of its research around a universal, ideal subject. Perhaps we might stretch *The Vitruvian Man* on the rack until the proportions of the human body yield to far greater opportunities and positions. If the ideal becomes a moving target, then it stands to reason that the value of hearing the voice of the patient will, by necessity, flourish, as it is the patient who could contribute rather significantly to identifying the image of health by the shape that target might take at any particular instant.

At this moment in the history of medicine, we may, in fact, be particularly primed for more interventions that directly utilize the methodological tool of the art experience in medical research and practice. It is an intervention that responds to a need we are starting to see more and more, popping up in numerous places as medical researchers and educators are expressing the desire for modes that open up medicine to new ways of seeing and new ways of envisioning the patient/doctor dynamic as it relates to statistical health outcomes. A. Hawkins notes the importance of this particular moment for the connection between patient experience and patient outcome:

> The concern that contemporary Western medicine, in its emphasis on biochemistry and technology, is neglecting personal and social dimensions of illness has been voiced over and over for many years. A landmark of sorts in this call for reform is George Engel's essay in *Science*, suggesting that a "biopsychosocial" model replace the traditional biomedical model. It is possible, though, that the implementation of such reforms may be more feasible now than ever before…Given the enormous challenges facing medicine today—economic,

> political, social, ethical—there is a window of opportunity for medicine to constitute itself as a profession devoted primarily to the welfare of sick persons, rather than to the treatment of disease, as is the case now. (XI)

The art experience could be a valuable part of the puzzle Gilman is searching to complete. If the image of the patient has, at least since the 15th-century, been playing out the desire for, as Gilman records, a demarcation between ourselves and the chaos represented in culture by disease (*Disease and Representation* 4), as well as what Choron (83), Stephenson (34) and Becker (52) all note, is our cultural desire to master death and the body from the perspective porous skins and decaying forms that are very much of the world, then the art experience does something quite politically radical that scientific looking, for now, cannot. The art experience makes schisms like patient/doctor, artist/viewer, sick/healthy, life/death refreshingly, joyfully, and often painfully, intertwined. In this interplay, if the margin between healthy and diseased is salient to our definition of self, other, morality or mastery over nature, we may be obliged to find new interpretations of self. The power of the art experience is that it can be heavy-handed, puncturing images of the medicalized body to string together with both biological and social properties; rejecting the medicalized image as a container for fixed truths about the sick body, and hailing it as a hub that gathers social forces and radiates potency for good, bad or neutral interplays of knowledge. Visual art, autopathography and the art experience form sites for the contestation of the authority of the positivist scientific images and beliefs that underpin so much of Westernized medicine and make the dichotomies mentioned above unreasonable. Art has a way of highlighting such incommensurabilities, and these can, as Sara Brophy and Janice Hladki note, “unsettle

frames" making the art experience "frame-testing work" through its ability to underscore "contentious, contingent relationships between histories, experiences, epistemologies, and visualities" (8).

I do make a claim that visual art practice opens up the medicalized body to alternative expressions and new knowledge. Still, I do not want to lose sight of the fact that this chapter, *Medicine, the Image and the Problem with Both*, is primarily concerned with the limits of the image. Therefore, my scrutiny must include images that are born from multivariant forms of contemporary art. The truth is, new modes of visualizing the sick body and new ways of imagining the patient/doctor or sick/healthy relationship are not inherently, necessarily destined to be less oppressive, more care-based or even helpful on their own. Deepening this stratum, Chapter Two, *The Mess of Knowing*, will explore how exposing medical professionals to autopathographical accounts of illness or alternative bodily experiences does not guarantee an exchange that is in any way intrinsically immune to concerns around a vicarious experience or the fetishization of suffering.

Is the viewer in the contemporary art experience safe from the socio-political-biological blinders that scientific looking is often accused of wearing? There is no reason to say no. And, we ought to also critically engage with critical questions about any new knowledges that are realized in the art experience. Are these new ways of thinking always useful? Can the new ways of thinking fostered by the methodological approach contemporary art practice tangibly enrich medical science or the patient experience? These are essential questions, and they indicate the need for a richer understanding of what the art experience can, in fact, provide. In short, it is not the image itself that holds

the full activated political promise I seek in this research, for the art image is likely as at risk (or perhaps, nearly so) of the many traps that plague the medicalized image. So, a crucial content that draws my inquiry is the methodological approach itself. What is needed is an exploration of the affective qualities of the art encounter, the ways it intersects critical theories and how it can be implicated in a way that orients medicine toward more ethical, care-based practices that can actively oscillate along the middle spaces between sentimentality and essentialism.

## Chapter 2: The Mess of Knowing

The terms pathography and autopathography are predominantly attached to text-centred descriptions and documentation of disease through personal experience. The words themselves reflect this relationship to text: -graphy, comes from the Greek -graphiā, meaning "to write" and patho-, from pathos, meaning "suffering." Pathographies have different expressions and seem to often do different "work" depending on their context and reception. To write about one's own suffering (-auto) has early roots, and certainly, many case studies that illustrate this record are highlighted by Sontag in *Illness as Metaphor*. Overwhelmingly, Sontag's inclusions are autopathographical accounts — which is to say they are autobiographical accounts of affliction told by the sufferers themselves. The employment of the term pathography dates back to Sigmund Freud's usage in his 1910, *Eine Kindheitserrinerung des Leonardo da Vinci*. Translated to *Leonardo da Vinci, A Memory of His Childhood*, this work envisages pathography more disinterestedly, as a study of the effects of illness on the life of da Vinci, through Freud's clinical gaze. Despite being clinically analyzed, there is something quite discrete about how pathography is framed that marks a distinction from the more familiar medicalized account of the body-as-object. For one, of course, there is a distinction from a typical pathological analysis, because Freud is interested in writing about suffering in terms of how the "inner resistances" of the body impacted the artist's life and work (a holistic, somewhat nuanced and less "hard" investigation of illness), but perhaps even more fascinating, is the way that Freud takes pains to frame pathography as a solution to (and, in opposition with) the literary crime of biographical idealization:

> It would be futile to delude ourselves that at present, readers find every pathography unsavoury. This attitude is excused with the reproach that from a pathographic elaboration of a great man, one never obtains an understanding of his importance and his attainments, that it is therefore useless mischief to study in him things which could just as well be found in the first comer. However, this criticism is so clearly unjust that it can only be grasped when viewed as a pretext and a disguise for something. As a matter of fact, pathography does not aim at making comprehensible the attainments of the great man; no one should really be blamed for not doing something which one never promised. The real motives for the opposition are quite different. One finds them when one bears in mind that biographers are fixed on their heroes in quite a peculiar manner. Frequently they take the hero as the object of study because, for reasons of their personal emotional life, they bear him a special affection from the very outset. They then devote themselves to a work of idealization which strives to enroll the great men among their infantile models, and to revive through him, as it were, the infantile conception of the father. For the sake of this wish they wipe out the individual features in his physiognomy, they rub out the traces of his life's struggle with inner and outer resistances, and do not tolerate in him anything of human weakness or imperfection; they then give us a cold, strange, ideal form instead of the man to whom we could feel distantly related. It is to be regretted that they do this, for they thereby sacrifice the truth to an illusion, and for the sake of their infantile phantasies, they let slip the opportunity to penetrate into the most attractive secrets of human nature. (Freud)

Pathography, then, by Freud's account, does the work of documenting illness narratives but also of humanizing the sick person by highlighting innate human weakness. That crucial mark of embodiment that separates us from mythical figures like

Gods and angels is the imperfect and provisional condition of the healthy body. Journalist Mark Lawson refers to pathographies as "confessionals" (M. Engel 1435), a turn of phrase that suggests there is something perhaps as much revelatory as titillating waiting in the pages for the reader. One of the more compelling contemporary interpretations comes from clinical pharmacologist, Jeffrey K Aronson. He calls self-produced illness memoirs, "patient's tales" (1599) and he has amassed quite a collection (hundreds of book-length autopathographies, most written in the past 40 years!) which he uses as primary research. In *Autopathography: The Patient's Tale*, Aronson draws out common themes that recurrently appear. The work is remarkable because it is incredibly (given his discipline) qualitative, but also quantitative, and thus it provides a wealth of hard data on the subject. Some points of note from his findings include:

1. Autopathographies are experiencing a literary boom

2. Men are more prone to publish[41] illness narratives than women[42]

3. The works "describe serious, dramatic, or fashionable illnesses—mostly cancers and neurological problems."

4. The authors of autopathographies write with a desire to relate with other patients, "obtain catharsis," to be critical of health professionals, and to profit (1599).

In one of Aronson's outcomes, he states that reading the illness narratives of patients can "help doctors understand their patients better and teach them things they won't learn

[41] Or, perhaps men are better positioned, both socially and financially to get published? This gendered dynamic begs for further investigation.
[42] The data splits gender using this limited binary. Aronson also records, "when the sex specific illnesses (cancer of the breast, endometrium, ovary, and prostate) are omitted, the proportion [of men over women] is even higher (1659).

from textbooks," which sounds promising in terms of the epistemological value of these accounts. But, regrettably, this hopeful recommendation is attached to a rather remarkable qualification: "fabrication is probably common, but obviously not quantifiable" (1599). So, it would seem Aronson prescribes a dose of elucidation with a chaser of skepticism. I believe the threat of fabrication needs not eradicate the epistemological value of these works per se. Still, it is clear that it has this effect for Aronson, and that he generalizes this to be the case for others. I believe this to be so because Aronson makes other determinations and recommendations that seem to diminish the validity of autobiographical accounts, such as the suggestion that doctors should be encouraging their patients to write "if only because writing about one's illness can be therapeutic" and that "the web is a good place to post such material, even when it is not suitable for publication between covers" (1659).

As a humanities scholar deeply invested in the value of the humanistic dimensions of medicine, it is easy to become exasperated by Aronson's facetious treatment of patient accounts. The subtext seems to read: "these accounts are dramatic, exaggerated and perhaps entirely flawed. They might even not be any good by literary standards, but hey, at least we know they can be therapeutic!" Despite my despair about such a glib treatment of patient accounts, I do not actually think that such a reactionary response on my part is particularly useful, nor is it even fair for what Aronson's analysis can offer. In his defence, Aronson does make an unusually concerted effort to incorporate humanistic elements into his examination. He muses, for example, about the relationship between autopathographies and the religious confessional, finding that "there have always been many stimuli to autopathography" and he goes to great lengths to provide the conclusions

he draws from many a textual analysis around the question of what might motivate this kind of autobiographical account:

> Some simply want to communicate with others in order to help them to understand what it is like to be a patient and to come to terms with their own illness, reasons that are often linked to the patient's own similar needs, both emotional and intellectual. These include a desire to remove the stigma associated with diseases such as depression or cancer. But sometimes this need for emotional or intellectual catharsis is hidden from the author; for example, in her book about diabetes, Needles, Andie Dominick clearly needs to pay homage (and perhaps in some way to apologize) to her dead sister, also diabetic, whose life, she writes, "stares back at me." (1600)

Still, I wish to raise some criticism against the two closely linked and central themes that emerge in *Autopathography: The Patient's Tale*: denial and falsehood. Denial rears its head in somewhat familiar places, like the denial of death or of the illness itself. There is the denial of treatment, and there is the hiding of the disease from others. Falsehood, Aronson conceives, is strongly associated with denial. Fabrication, we learn, is a "phenomenon that is in part born of denial" and is inherent to the genre: "there is probably more fiction in autobiography than there is autobiography in fiction" (1601). As a case in point, he looks to author E.J. Moran Campbell's passage in *Not Always on the Level* when Campbell writes, "are the stories true? I think so. A few of the episodes have been "assembled," but none is invented, and the descriptions of the major characters are as accurate as my memory permits. I cannot, of course, verify the dialogue" (qtd. In Aronson 1601). In reading Aronson's issues with Campbell's honesty, I am struck by

how truth and lies operate seemingly differently for Campbell than they do for Aronson. To my mind, Campbell seems to be making a rather self-conscious comment on the nature of experience and memory in his statement, affirming the reality that is present when the two collide. For Aronson, Campbell's statement seems to be a red flag that warrants suspicion about the validity of his account more generally. Aronson later speculates on the totality of Campbell writing that, "although he seems to be baring all, I sense that he is, in fact, concealing much. Some sections are given in alternative versions, written when "high" and "low," but they cannot have been written during major episodes of mania or depression, since he confesses that at such times he is unable to write" (1601).

One wonders, should Campbell have been able to write at moments of depression or mania, would his account be more or less truthful? Is there less truth in his reflection on the "highs" and "lows" recorded, presumably from an emotional and temporal distance? And, if yes, what time limit could be deemed acceptable for timely recording? Aronson goes on to meticulously list examples from his collection that have moments he has identified to be fabricated. Like the Sherlock Holmes of pain and suffering, he combs through accounts to raise the alarm. He alleges Simon Hattenstone, Richard Selzer, William Styron, Jean-Dominique Bauby, and Oliver Sacks have all counterfeited aspects of their autopathographical accounts. The "tale" in Aronson's *Autopathography: The Patient's Tale* it is revealed, has a double meaning, signalling, "both a true narrative and a lie." The mythological aspects of the sick experience and its textual formulation are stylistic, Aronson believes; they add a certain organization to weave a narrative through and even provide a structure to understand the illness itself. And so, these lies serve a sort

of usefulness, we are told. Recall that Aronson thinks "reading patients' tales can help doctors understand their patients better and teach them things they won't learn from textbooks" (1599). When reading Aronson's conclusions, I am struck by a sensational and seemingly insurmountable obstacle: one might wonder what a physician might learn from an account of illness while concurrently remaining deeply suspicious of the patient's voice. If one is acutely concerned about—or dedicated to—uncovering and isolating truth and lies, of what value is any of the knowledge gleaned from a narrative about which one feels paranoid? For Aronson, the answer is that the text provides an opportunity for the physician to "accumulate" experiences "vicariously" (1602) and thus, presumably, know something of the quality of the illness – a small window of commiseration that might be leveraged in the clinical setting. For me, the Aronson quandary seems to point to a need on behalf of many for autopathographies that move beyond the text. *Autopathography: The Patient's Tale* does a very good job, I think, highlighting the distinct issue concerning exposure and suspicion that overlap in both text and medicine. And yet, at the same time, Anderson's work points to a progressive desire to look to qualitative and humanistic elements to better the quality of care for patients by forming connections and opening up conversations about particular embodied experiences, which is, in fact, encouraging.

Text is tricky. There are many ways to approach a text, but we have become really good at one specific approach in academic culture, described by literary theorist Rita Felski as the practice of reading texts in such a way that the reader is searching for and "cataloging omissions" to find fault, or to "lay bare contradictions, of rubbing in what [the author failed] to know and cannot represent" (574). Aronson's trajectory is a clear

example of this, but I should be self-critical and admit that so too is my initial kneejerk reaction to Aronson. Certainly, Aronson is guilty of pointing to oversights writers of autopathographies are blind to en masse through his conceptualization of denial. In an earlier utilized quote, we saw Aronson chiding the author Andie Dominick for being blind to her need for emotional catharsis, "clearly" needing "to pay homage (and perhaps in some way to apologize) to her dead sister." As well as figuratively, he also quite literally charts the "catalogue of omissions," producing a table of data on the kinds of denial in autopathography. One column reads "type of denial" (e.g. "The disease is itself a form of denial"), and the corresponding column, "Example," lists the type of disease and their literary substantiations (e.g. "Anorexia nervosa (Sheila Macleod)").

I do think autopathography can prove immensely valuable for both patients and medical professionals, but the right angle of approach is evidently a crucial concern if we are to find ways to recognize and integrate their epistemological value in medical practice. Foregrounding the already tired and dangerous trope of the unreliable patient through reading for truth in autopathographies surely offers little variation from the clinical culture of the parent-infant inflected doctor-patient relationship; the paternalistic model of medicine that has come to be challenged in the last twenty or so years. As I said, in many ways, Aronson represents a modicum of what I am aiming for with this project: investigations of illness narratives that move us towards a more humanistic approach to medicine. Yet, his work, though quite earnest, complex and interdisciplinary, hardly represents the ideal collaboration I am searching for due in large part to his (quite commonplace) hunt and expose technique. The decidedly deconstructionist modes of approach that inflect so many of our critical conventions seem to do a very good job of

getting in the way of important work. At any rate, in this case, they seem to place some hard limitations on the value of written narratives of illness.

The issue, I think, largely comes from how we approach and consume these texts, and therefore it is not a limitation inherent to the object or subject of the text itself. But, nonetheless, as I am always invested in how our modes and beliefs are enacted in everyday life and the fact remains that in all circles, be they academic, public or medical, (to the exclusion of a faction of disciplines and readers), close reading is strongly associated with truth. Through this particular critical practice, written autopathographies are always rather in danger of becoming sites for the sport of exposure. What I am saying is that like the experience of pain, reading seems to come with a certain amount of external skepticism, and we have to ask a lot from our readers to consciously push past that. Because, there is value in pushing past that. Leah Bradshaw points to the absurdity of the truth-hunting narratives in *Narrative in Dark Times* (2007) as she shows up the truth of storytelling to be categorically different from the truth claims of philosophy, "the eternal and immutable truths (two plus two equals four; the good is beyond being; the forms are prior to our experiences of things in the world)" (22). Bradshaw reveals that the truth-seeking behaviour of philosophy shows up only an objective for truth, whereas storytelling struggles toward reconciliation; towards "recovery of the world" (23), a reciprocal process of transformational exchange wherein objectivity must be abandoned.

The "problem" with autopathography is not a problem with the genre so much as it is a problem with the reader – more accurately, it is a problem with the modalities of reading that are deeply ingrained in all of us. What is going wrong here? Where exactly is the opportunity for finding epistemological value in autopathographies missed? The

following section will take up the task of further troubling the mess of knowledge by investigating how our modes of approach complicate, enliven or obscure the futures we seek.

*2.1 Mirrors and their reflections: idealized victimhood and authentic experience*

In *The cult of good health: the mythification of health and illness* and, *Refusing medicine's body-object: The picture of health reimagined*, I covered Anne Hawkins' robust argument for autopathography. A. Hawkins' research lays a pivotal foundation regarding the importance of autobiographical accounts of illness for the medical institution. Her theory follows the concept that all of the (enabling and disabling) myths we carry around illness and "health" can potentially be revealed when the medical establishment attunes itself to autobiographical accounts of sickness. For A. Hawkins, attention to the humanistic dimensions of medicine would bring healthcare workers towards this critical awareness—an essential ability—to identify myths,[43] to be sympathetic to their depth and power, and to use what they uncover to formulate individuated patient care. The risk, for A. Hawkins, in treating the disease over the patient, can be seen in prolonged dying, indignity and suffering.

I am much indebted to A. Hawkins' work on the power of autopathography. However, as my reading of Aronson has clarified, I really do question a straightforward concept that medical students can cultivate a sensitivity to the symbolic implications of written accounts of illness and use this knowledge to treat the disparities and homogenizations of health and illness that infect the establishment. My mistrust has nothing to do with the capacity of current or future medical students to critically grasp autopathography or the perplexities of social attitudes. My work has attempted to show

[43] Mythic thinking, for A. Hawkins "places events and individuals in a broad context, so that the particular is seen in relation to the universal" (xvi).

that medicine is not detached from everyday understanding. This principle necessitates that the myths A. Hawkins references are present within and outside of the medical institution. There is an inherent, structural complexity to deciphering what qualifies as a myth while engaging in and producing work that, as I have shown in the introduction to *Medicine, the Image, and the Problem with Both*, is validated by its symmetrical relationship to existing "truths" and away from other, sometimes no less feasible "truths" or "myths." In other words, an institution that engages in reflexive myth-making alongside non-institutional myth-makers does not, merely by its façade of organized confidence (symmetrical relations), produce reliable sorters for parsing out which fears are credible and worthy of attention.

It is a reality that in the contemporary epoch of Westernized medicine, the patient is believed to be a characteristically untrustworthy source for their own bodily events. The micro-modes that Pathological Anatomy engages in foster one part of this apprehension to involve the patient directly (the MRI will tell us everything we need to know!). The patient voice, as Elaine Scarry exclaims in *The Body in Pain*, "must be bypassed as quickly as possible so that they can get around and behind it to the physical events themselves" (6). But, pain is not sufficiently measurable or imaged with current medical technology, and without referential context, it does not enter easily into a sharable framework. The result, as Scarry so eloquently points out, is "that to have great pain is to have certainty; to hear that another person has pain is to have doubt" (7). We certainly see this suspicion in action in Aronson's analysis of denial and falsehood. If the patient is positioned as an unreliable narrator, and truth value is the objective, then what worth does the patient's narrative hold before it even reaches the hands of the reader?

To this growing, ill-fated equation, we might add Jonathan Metzl's critique of "health" as a concept, how it is teeming with value judgments and hierarchies. Health as a prescribed state employs blind assumptions that speak as much about power and privilege as they do about well-being. Can a physician really study a form of autopathography and decipher that the patient is in a particular state of mental or physical health? Can they come to know a truth about the sick experience? The short answer, I think, could be yes. But, my more extended response would be that I believe it is unlikely if the healthcare worker is trying to engage with autopathography at the tail end of an extremely complex structural problem that is infiltrating both the patient's narrative and the healthcare worker's interpretive power, without some kind of intervention that disrupts this chain reaction. With a glance at the external and internal forces that press into this seemingly broadminded integration of autopathography and medicine, we can see that these questions are not simple ones.

What is the sick experience, anyway? What does that mean? How much of it is finely honed by the trickle-down effect of the visual depictions of the body that populate Westernized medicine? For example: how many people with cancer find themselves facing an endless supply of books, media and advertising that demonstrate how they ought to be worthy cancer patients by fighting the cells in their bodies by means of charging forward in a charity's walking event, wearing particular hues, buying specific ribbons, wrapping their chemo-ravaged crowns in colourful scarves, donning beautiful wigs (Figure 2-1), and exhausting every salve, lotion and balm layered on a brightly painted face to mask the ever-creeping illness and fatigue? Be brave. Eat well. Hide your

symptoms. Get out. Find normal. Cling to normal. Look normal. Be normal. Reproduce normal. There is a great deal of sculpting at work here.


**Figure 2-1** A man in a wig and makeup opens his eyes for the big reveal in a screengrab from a viral video. The video, called "Ne serait ce qu'une seconde" ("If only for a second"), was produced by a French non-profit, The Mimi Foundation, a charity with a mandate to extend financial help directly to cancer patients. The heartwarming, but not unproblematic video, is a so-called "public awareness initiative," and it was created by placing 20 cancer patients in a room with a team of stylists, who "made them completely unrecognizable with hair and makeup and sat them in front of a mirror." The video pairs text ("to forget the illness, if only for a second") with soaring music as we see "sick" bodies visually code-switch into "healthy" vibrant and jovial bodies, if only for a second.

The experience of sickness is frequently very finely curated. Chicago performance artist Karen Finley carried out a controversial work in 1990 called "We

Keep Our Victims Ready."[44] In the work, Finley exposes her body, smearing cake against her skin and highlighting aspects of her form that society tries to control and conceal. She conducts this ritual while speaking about abuse. The work itself is noteworthy, but it is actually the title of the work that has always hit like a gut punch for me. The phrase, "we keep our victims ready," I think, perfectly encapsulates how we build shadowy rooms equipped with all the accoutrements of idealized victimhood, always waiting, always ready for the victim to arrive and take up residence. The victim must become malleable, moulding their body to contour perfectly with the wound space in which they are placed. The difficulty with any kind of autopathography—including the form I advocate for—as a fix-it solution for lack of empathy or understanding in the patient-doctor relationship, is that the patient experience and the medical institution can seem like two mirrors reflecting the same image back and forth forever: both projecting an idealized picture of health (or illness, for that matter) that does not always fit the circumstances at hand.

The solution, therefore, cannot merely assume that the earnestness or knowledgeability of medical professionals and their willingness to listen can get us to a good place per se (although, that is never a bad place to start from, to be sure!). The problem, I think, is a much more considerable epistemological concern that ultimately

[44] The performance is masterful, difficult to watch and ultimately launched a lengthy legal battle about censorship and morality: "In 1991, a lawsuit was brought against the NEA after its chairman, Frohnmayer, rescinded grants for four performance artists out of fear of criticism from conservative media representatives and politicians. The four artists who were denied grants joined together to sue Frohnmayer. Referred to as the "NEA Four," they are: Karen Finley, Tim Miller, John Fleck, and Holly Hughes--three of the rejected artists are gay and deal with homosexuality in their work; the fourth, Karen Finley, is an outspoken feminist. In 1993, courts ruled in their favor and all received compensation surpassing their grant amounts" (Drake, Sylvie. "STAGE REVIEW : Finley Exposes Plenty in 'Victims' : The Performance Artist's 'We Keep Our Victims Ready' Exhibits a Kind of Purposeful Schizophrenia as It Uncovers the Nastiness We Would Rather Sweep under the Rug." *LA Times*, LA Times, 11 Nov. 1991).

compels my focus on methodology. There is something in the action of practices like the art experience that can potentially break us out of the traps outlined above that have to do with precisely how the general population has internalized a mode of approach in this contemporary moment.

The mire of the history of Westernized medicine—its images and modes of thought—have created a predicament wherein myths of health are as stubborn as they are self-contradictory, where the patient's perspective is undervalued, overwritten by the scripts of the system. The mechanical and technological facets of medicine are misconstrued as something other than interpretation and representation. If the investigation into the medical image and its dual operations[45] written into these pages serves a purpose, that purpose must be the knowledge that even the most dutiful act of reading and contextualizing the image is not an unobstructed path for repairing it.

I seek to investigate the framework that houses the problematical equation I have outlined above. By exploring how we have so profoundly misplaced our faith in exposure, we can come to know what that faith tells us about the challenges of homogenous critical approaches to the social, historical and scientific aspects of "health" and "illness." Then, turning to the art experience, I will survey an experiential knowledge that lends itself to oscillating critical practice, asking: why has this mode of approach emerged, and what does it do differently?

[45] Which I have argued, 1. illustrate human knowledge, playing the role of a container for information, and, 2. guide human knowledge, acting as a primary resource against which new theories are tested and expanded on.

*2.2 In exposure, we trust: the problem with truth and "strong" theory*

Methodology becomes an urgent concern when the epistemological question of "how do we know?" and "what is true?" in medicine has historically been plagued in its production and reproduction by symmetrical relations. A methodology that questions "in what way does our mode of approach in searching for knowledge affect what knowledge we gain?" as an option, can actually be quite radical. Eve Kosofsky Sedgwick laid the essential foundations for this idea in *Touching Feeling*, asking, "What does knowledge do—the pursuit of it, the having and exposing of it, the receiving again of knowledge of what one already knows? How, in short, is knowledge performative, and how best does one move among its causes and effects?" Sedgwick is invested in knowledge's performativity as she calls for us to pay close attention to the ways we invest sole authority, authenticity and energy in particular critical modes that often do not make sense for the outcomes for which we search. To be precise, we overinvest in the same forms of investigation that seek to provide overarching, large-scale solutions to big, complicated problems.

We seem to trust that if we can just unpack the subjects of our inquiry well enough, if we can just do the work to trace the lines far enough back in time, if we could just find and mark all the places where one thing led to another…well, we could fix it, couldn't we? Sedgwick points out the obvious but astonishingly blunted reality that having an unmystified assessment of a problem does not "intrinsically or necessarily enjoin [one] to any specific train of epistemological or narrative consequences" (*Touching Feeling* 124). In other words, knowing the origin of something, for instance,

developing a demystified view of medicine's universal body, is ultimately separable from the question of whether the energies of scholars, patients, health activists or medical professionals ought to be best used in the tracing and exposing of medicine's images.

Yet, despite the seemingly self-evident nature of this claim about research and knowledge, we seem blinded by our hunger to uncover truths in the familiar places we always look, and in the same ways we have been continuously looking: the physician searches for the unregistrable pain in the MRI; the academic combs texts and archives, probing for evidence to back up her claims. For both of our explorers, there is an imperative that suspicions must be investigated and confirmed. In many facets of our thinking in this contemporary moment—maybe more than ever before—we have misplaced our trust in exposure.[46] We have conflated the revelation of a thing known with forward-facing answers and, in so doing, a thing known with a thing solved.

By narrowing our approach to a mode of inquiry that feels so single-focused, like the two mirrors reflecting the same image back and forth forever, we are faced with an impression that replicates contingent relations into universal ones. Or, at least, this is what regularly happens if no other approach is recognized and enacted. Sedgwick does not aim to suggest that our seemingly singular critical habit is not useful, or that it does

[46] I think about how our contemporary moment is more plugged into information than ever before. It seems like we also desire to uncover truth more urgently and disseminate it more rapidly. Perhaps this push is a reaction to the somewhat equivalent rise of "fake news," in the age of information, but whatever might inspire it, the uncovering of "truth" seems to, at the same time, have less bearing than ever before on the revision of policy and politics. Donald Trump, for instance, seems more immune than any prior world leader to exposure. It would seem that no truth, no matter how alarming it may be, can really hurt his presidency. Perhaps I will have to eventually correct this footnote because I am wrong, but what remains real is that imagining the impeachable offenses of past presidents applied to Trump with equal consequence feels laughable. The increase in what we can access and "see" through more and more complex and wide-spreading media, joined with our every ballooning faith in exposure and the apparent disparity between those things and the declining active political power of the truth is unsettling.

not bring us knowledge; rather, her argument stands on the idea that a hermeneutics of suspicion,[47] a widespread "paranoia,"[48] has not only entered our critical habits but correspondingly, our critical habits have become a compulsory injunction that methodologically centres suspicion: it is a "paranoid" critical practice.

Suspicion is, in many ways, a useful vehicle en route to knowledge because its methods function quite well to uncover history. Marked by anxiety, a hermeneutics of suspicion is by nature on the alert for the dangers posed by oppressive or misleading truths. In this sense it is anticipatory, but it is also anticipatory in its methods: the "good" academic seeks to eliminate surprises, both by researching their material meticulously and by anticipating the counter attacks to the arguments they present, squashing them before they can be lobbed at their writing. Bad surprises must always already be known so their force can be diminished. The act of finding symmetrical relations mitigates surprises: if the academic can confirm and defend their theory against existing theory, their work earns legitimacy. In this way, the paranoid position finds tangible success in its reflexive mimicry. However, the paranoid position is not a useful mode if it is alone in colouring the shape and sentiment of knowledge.[49] Sedgwick writes that this critical

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[47] Coined by Paul Ricoeur to describe the common methods that pervade the writings of thinkers like Marx, Freud, and Nietzsche. To have a hermeneutics of suspicion is to have a commitment to unmasking truths. It has become a modern style of interpretation that circumvents self-evident meanings in order to draw out less visible and less flattering truths. (Ricoeur 356). See: Ricoeur, Paul. *Freud and Philosophy: An Essay on Interpretation*. New Haven: Yale UP, 1970.

[48] Sedgwick labels the tendency towards a hermeneutics of suspicion the "paranoid position" after the work of Melanie Klein, as it is negative, reflexive and anticipatory, and therefore an "affective as well as cognitive mode" (128). The term paranoid is not, therefore, used in the clinical sense per se, though there are certainly numerous overlaps in how clinicians have mapped paranoia over behaviour at various times in the history of psychology. See: Klein, Melanie, and Rivière Joan. *Love, Hate and Reparation*. Hogarth Press, 1967.

[49] Many alternative modes of inquiry apply "self-avowedly paranoid critical projects," Sedgwick notes, and, in fact, it is important to note that "paranoid exigencies" are often essential for "nonparanoid knowing and utterance" (129).

mode of inquiry is uniquely gifted at being contagious, having an "inescapable interpretive doubling" stylistic bent and therefore moulding its subject of inquiry in a rather interesting way:

> It sets a thief (and, if necessary, becomes one) to catch a thief; it mobilizes guile against suspicion, suspicion against guile; "it takes one to know one." A paranoid friend, who believes I am reading her mind, knows this from reading mine; also a suspicious writer, she is always turning up at crime scenes of plagiarism, indifferently as a perpetrator or as a victim; a litigious colleague as well, she not only imagines me to be as familiar with the laws of libel as she is, but eventually makes me become so. (126-7)

Because it can never be too early to have already known about bad surprises in the defence against them, the bad surprises are on the one hand inevitable, and, let's be honest, probably on the very same hand, brought into being (or, at the very least, crystalized) by the exact methods of the inquiry that engaged them. Sedgwick notes that "it takes one to know one" paranoid assertion is often followed by the defensive "just because I'm paranoid doesn't mean they're not out to get me." The last utterance, especially, denotes the self-evident appearance of the imperative force, which leads into the predictable mantra, "so you can never be paranoid enough" (131). But, again, Sedgwick notes that even if you are right—if the thing you suspect to be true is uncovered and shown to be real—the method does not necessarily lend itself to your goal. This last point cannot be emphasized strongly enough. Being paranoid and doing

the work of articulating your position and the position of your enemy is not at all a useful mode for getting rid of enemies.

The paranoid practices that have become synonymous with knowledge writ large are, as Sedgwick points out, problematic only because they act as if they are both a way of knowing and a thing known, characterized by "an insistent tropism toward occupying both positions" at once (131). In this way, paranoid thinking mimics the problems noted by Casini about the standardized MRI image, in that it is just one possible way of visualizing data among other possible modes ("The Aesthetics of Magnetic Resonance Imaging" 22) yet, the preferred MRI aesthetic has become functionally understood to be a faithful representation of reality. The fact that it is prone to reflect the current understanding of the medicalized body is jumbled with the idea that it can reveal new truths. Perhaps the MRI may, in moments, do both; however, it also persists as a tautological conundrum that, in many real ways, limits its potentiality for medical innovation.

I have argued that the scientific image has two operative elements in medicine. Contrary to this, I do—as a matter of fact—believe images, in general, are not limited to just two operations, and I will elaborate on the flexibility of the image further as my argument unfolds. It is, I believe, the combination of the circular critical practices of a hermeneutics of suspicion and the positivist legacy of scientific authority that nourish the apparent two function and single vision of the image for medicine's knowledge. The hangover of the positivist truth-value of mechanically derived images that are thought to expose knowledge (a quite literal faith in "positive exposure" in this case!) certainly lends itself to a totalizing hermeneutics of suspicion. The image, in the medicalized

context, is taken-as-truth (evidence). Its meaning is authoritative and contained. The image becomes a reference to back-up, underline and solidify future claims, which add power to the determined truth-value of the image through symmetry or near-symmetry; it proves itself through itself. It is in this last point that we see the paranoid imperative.

The image does expand in meaning and attributes, of course, but these expansions are built on the foundation of prior iterations. The evolving image, in this context, is a skyscraper, not a diverse city with incongruent silhouettes. The memetic and positivist inheritance that directs how the image of the medicalized body can be read makes it function as if it were tautological. It is the dual function of the image that traps it, reproducing ideals that are self-confirming and seem to autonomously barrel upward even as I, and countless others before or after, do the work of illuminating the actuality that medicine's standard body, its prevailing model on which past and present research are centred, is largely not a reflection of medicine's actual subjects.

The dual function of the image makes any investigation of its history or social context just another resource to be used to solidify the stability and potency of the image. Just saying that medicine has a universal body invigorates the truth of medicine's universal body. Tracing its history justifies it. Providing images of the ideal body adds to its dominance in medicine's visual culture. Ultimately, I must concede that in Sedgwick's terms, 1. deftly drawing out medicine's universal model and revealing its nooks and crannies in academic literature, as I have done, serves to reinforce its bedrock position in medicine, and, 2. devoting energy to blowing the whistle on the unjust (and frankly, impractical) state of affairs in medicine by describing each bias very, very well might be useful for rousing sweeping change, but then again, it likely will not.

By Sedgwick's measure, the strength of my exposure (which has already reached far across history to run probing fingers against the cool stone walls of the Palaeolithic Lascaux caves, and stretched along geographic markers to stake out the study of medicine across continents, all the while reaching between and across intersectional identities), becomes a "strong" theory (in the overarching, all-encompassing sense of the term). I intensify my "strong" theory when I do the work to qualify more and more experiences that ought to be accounted for as instances that prove medicine's fatal flaw, while also enabling the reliable anticipation of future incidents before they come to pass. In this assertion, I think, Sedgwick is quite right. A "strong" theory of this variety is negative, anticipatory, and, ultimately, memetic. "Strong" theory is strong by means of its proportions. It grows as it folds new agents, ideas and institutions into its porous membrane. It is not "strong" by dint of its effectiveness.

If I concede that "strong" theory is not intrinsically strongly operative, a second unspoken but rather direct underlying current in critical practice and research surfaces for me more urgently than ever before: what is it, exactly, that I want my research to do? – a thorny question! I want my research to serve several roles—not the least of which is to satisfy the requirements of my degree—and, truth be told, many of my desires slide gleefully and without prejudice along a scale that bridges altruistic, noble goals and egocentric, self-serving ones. But, ultimately, what I am arriving at here is this: surely, we ought to design our work to facilitate good in the world; to at least lean into good, no? If "strong" theory is too bloated to be effective for action, we may need an energetic and responsive "weak" theory instead.

Sedgwick's notion of "strong" and "weak" theory comes from psychologist Silvan Tomkins. On theory, Tomkins writes,

> ["Strong" theory] is capable of accounting for a wide spectrum of phenomena which appear to be very remote, one from the other, and from a common source. This is a commonly accepted criterion by which the explanatory power of any scientific theory can be evaluated. To the extent to which the theory can account only for "near" phenomena, it is a "weak theory," little better than a description of the phenomena which it purports to explain. As it orders more and more remote phenomena to a single formulation, its power grows. (433)

While this quote emphasizes the power of "strong" theory's growth, it is essential to distinguish that the effectiveness of "strong" theory is its ability to telescope itself, not its ability to describe and respond to its source. In Sedgwick's terms, a paranoid anticipates an enemy, articulates them, and solidifies the self and other as enemies. Further risk seems only to be mitigated in a "strong" theory by securing more (conceptual) territory to guard against future bad surprises; arguments become progressively more totalizing. A "weak" theory, on the other hand, offers ways to minimize negative affects, preventing them from getting stronger. "Just because you have enemies," writes Sedgwick, "does not mean you have to be paranoid" (*Touching Feeling* 127). Moreover, what rides along with this extraordinary revelation is an equally powerful parallel idea: practising other forms of knowing that circumvent or oscillate with a hermeneutics of suspicion does not automatically denote a denial of the gravity of

dangerous abuses of power (128). "Strong" theory has been called "decryptive,"[50] and it is distant and anticipatory. "Weak" theory is, as Tomkins writes, "descriptive," seeking to know about close phenomena well enough to engage with it, but not well enough to pin down and solidify it. The difference in the motivations for looking is the heart of what gives such different effects to the separate causes of "strong" and "weak" theory. One method seeks to be both truth and a way to expose truth, while the other seeks to be site-specific, responsive, and to seek out surprises, even if they may be painful.

As a natural science, medicine deals in the "strong" far-reaching currency of manipulation and control. The medicalized body is an object with a language of hidden relations that the medical professional has extensively studied so the body-object can be adequately understood. "Medicine attains its meaning through its own history - through the permanence and changes that have characterized medical practice and the theories of medicine in the past," underlines Fredrik Svenaeus, and this creates a meaning-structure[51] that presents itself through all of what we call "Western" medicine. The scope is mainly historical. The geographic differences between practices in Sweden and the United States are generally rooted in the economic organization of healthcare, and little else (*The Hermeneutics of Medicine* 119). The meaning-structure is a pattern of exposure and action that, Svenaeus notes, is given distinct form in the practice of medicine in Westernized spaces (120). This structure requires the body to be a body-as-object in order to maintain its "strong" theory status and reach. The presenting patient is forced into the

[50] Paul Saint-Amour calls "strong theory" "decryptive" as it is "bent on decoding or unmasking a vast array of phenomena in order to avoid bad surprises" For more, read: Saint-Amour, Paul K. "Weak Theory, Weak Modernism." *Modernism/Modernity*, vol. 25, no. 3, 2018, pp. 437–459.

[51] This meaning-structure is the locus of my doubt of the myth-making/myth-discerning interpretive power of the institution of medicine in the introduction to Chapter Two, *The Mess of Knowing*.

shape of the universal body of medicine. The universal body-object is kept ready and waiting; it becomes the shadowy room for the presenting patient to conform to and reside in. The body-object comports itself much like the ideal proportions of *The Vitruvian Man*, forming an ideal configuration that the real body stretches to fit.

The body is read in the language of the natural sciences when it is exposed, and the physician, accordingly, acts using applied biology. Undeniably, this method has more than a little measure of success. As a patient, I emphatically want to feel confident that my healthcare provider has access to a wealth of knowledge about my body as an object of science. However, what is mostly missing from this conventional clinical model is the understanding that my body may resemble the object of medicine's gaze in many ways, but it is, at the same time, not the body of medicine.

The "strong" theory, body-as-object of medicine is quite a different beast to the "weak" theory, being-in-the-world, site-specific embodied life: the first is understood, and the second is experienced. The universal is mapped onto the particular. Thus, there is a gap in understanding concerning, among other things, phenomenology (things as they appear in our experience) that feels especially awkward, given that medicine favours language around "practice," "clinical judgment," "interpretation" and "the patient-doctor relationship" while simultaneously reducing felt, embodied experience to "mind" and therefore, clumsily, thinking of it as immaterial (in all senses of the term!). This assessment is, I believe, a powerful critique that must be made against both medicine and "strong" theory. However, crucially, such a critique of medicine and "strong theory" is not the same thing as an utter renunciation of either, and I want to be very clear about this conviction.

A hermeneutics of suspicion and the arms-length, causality of science do uncover some aspects of reality very well. And, a tautology is not a death sentence for knowledge: all modes of inquiry, even localized ones, are modes of, as Sedgwick writes, "selective scanning and amplification" and, therefore, always at more or less risk of being to some degree tautological. The problem is that on the one hand, this way in which we seek knowledge has become singular in appearance. The general state of inquiry now lends itself to "strong" paranoia as the sole mode for uncovering reality in practice. And, on the other hand, as Sedgwick clarifies, "because of its wide reach and rigorous exclusiveness, a "strong" theory risks being strongly tautological" (135). By returning paranoid knowing to its place as one critical practice[52] among other equally generative modes, a hermeneutics of suspicion may be utilized productively, embracing alternative ways of understanding. Thus, the paranoid position is a valuable one as long as it is activated as one dynamic methodology, among others, reinvigorating its possibility as a channel for political or cultural change.

It may at first feel to most that medicine is not a happy home for multiple and fluid forms of conceptual engagement that can, at times, be messy or vague, but if so, it is only because we like to imagine medicine as a home for infallible, hard science. The professionalization and substantiation of the monolith of Westernized medicine have been dependant on this pathway for at least the last five hundred years. The path has been quite intentionally diverted from the concentric environmental and social intersections that have more substantial bearing and association with gendered, or culturally, socio-

[52] Practice herein being understood as active conceptual engagement.

economically and historically marked medical practices.[53] The explanative, third-person scientific standpoint has governed medicine, but medical knowledge is arguably "broader than biochemistry and physiology, as it includes psychological, social, cultural and existential perspectives" (Svenaeus, *A Defense* 460). Some have gone further still and argued that medicine is not a science at all, despite being dominated by the modes of science. Adam Rodman, an internal medicine physician and faculty member at Harvard Medical School, interrogates this belief:

> Is medicine a science? I am going to argue that the answer is a resounding no, at least if you think of science in the traditional positivist sense, like physics. We're not even a social science. Because, medicine is, for better or worse, an epistemological minefield. With every patient and every decision, we need to weigh evidence coming from a variety of sometimes contradictory epistemologies and do our best to apply it to an individual. I'd argue that our field has far more in common with engineering or law or even the clergy than it does with any science. ("I Know Nothing")

[53] The myth of progress and shifts in thinking have meant that this distancing by Westernized medicine is not simply an inside-outside distinction between professionalized, Western, masculinized "higher order thinking" and the practical, on-the-ground gendered work of midwives or spiritually or ecologically inflected traditional indigenous medicine (to speak deliberately broadly of both, from the point of view of Westernized Medicine). The distancing can also be witnessed in the history of Westernized medicine, where professionalization itself has been historically marked by a distinction that reviles the ideal of holistic health indicators. Recall here the tale of the Swiss physician Paracelsus, who symbolically burnt Galen's works at his school of medicine as an act of devotion the changing tides of history that now worshiped positivist knowledge, research and inquiry as the foundation for building new ideas. It was Galen's humourism, of course, that understood the health of the body to be directly manipulated by material elements. While perhaps we were quite within our scientific rights to have eliminated the alignment of particular stars from our running inventory of health impacting phenomena, the legacy of a rejection of holistic and very real impacts of the lived conditions of the patient have been such that Westernized medicine has been excruciatingly slow with the reintegration of, at times, even the most basic consideration of social, economic and environmental factors into health research (see the history of the impact of smoking on health outcomes and the companionate resonances between the crutches of Westernized Medicine and capitalism, for example).

It stands to reason, from my perspective, that a physician would aspire to be liberated from constraints that sought to inhibit them from drawing upon a variety of experiences to chart a way through disease, using different types of practical knowledge to understand how to best care for the individual patient in front of them. But, to make room to access a wider array of experiential knowledge in the institution, there must be:

1. A recognition of the value of individual physician knowledge emphasizing practical reasoning and,
2. An appeal for medicine's applied biology to be augmented by the highly valued, active inclusion of the first-person perspective of the patient.

This combination could oscillate between "strong" and "weak" theory that can be responsive and access alternative ways of knowing that can be flexible, practical and nuanced. There are many modes of approach that would help centre the experiential knowledge of the physician and the individual experiences of the patient. I will continue to explore autopathography generally, as well as art practice specifically, as experiential, reparative approaches to the practice of medicine that can offer unique insights into the particulars of "health" and "illness." But, since, at this juncture, reader, you may be wondering what exactly does the oscillation between "strong" and "weak" theory look like in a direct, applied practice, more than questions about how the medical institution could best support it, I offer a simple, persuasive example.

The phenomenological approach is one avenue touted by many who advocate for an upheaval of the philosophy of medicine through clinical practice. Advocates of this approach[54] seek to develop an account of the illness that proceeds from a first-person perspective, incorporating what is referred to as the second-person perspective—the healthcare professional participating in the undertaking of meeting patients—and finally, contrasting and connecting this active experience with the third-person perspective—the institutional, historical, mechanical and biological understanding of diseases and their treatment—to form a plan of action (Svenaeus, *A Defense* 461). This approach is particularly attuned to the need to both describe and define illness as both a thing felt and a thing that is more or less articulated in our various knowledge banks.

By attending first to the patient experience, then to the active meeting space of physician and patient before turning to institutional knowledge, not only is the patient's voice foregrounded, but the experiential knowledge of the physician is given prominence as well. Far from being rendered irrelevant, the applied biology of health care is activated by its immediacy to facets of the body that have historically been underestimated: the mental experience of being embodied which is still, in medicine, regrettably and regularly considered to be the "mind," and therefore a "non-physical" matter.[55]

A phenomenology of medicine preferences experience and oscillates the responsive "first" and "second-person" perspectives with the "strong" "third-person" understanding of the medicalized body-as-object. As Svenaeus proposes, clinical

[54] Foremost thinkers include: Drew Leder, Kay Toombs, Havi Carel, all of whom work closely with Merleau-Ponty, and Hans-Georg Gadamer, Kevin Aho and Fredrik Svenaeus, theorists whom proceed from Heidegger.
[55] The dogmatic mind-body split invariably, embarrassingly rears its ugly head.

medicine should be "a practice…with the aim of healing the ill person seeking help" with a focus on well-being (*The Hermeneutics of Medicine* 2). And well-being, in this case, intimately connects thriving with the activated body: Hans-Georg Gadamer writes, "health is not a condition that one introspectively feels in oneself. Rather, it is a condition of being involved, of being-in-the-world, of being together with one's fellow human beings, of active and rewarding engagement in one's everyday tasks" (113). I feel it is necessary to emphasize that what is herein being proposed is not that one can heal from a disease such as cancer strictly by being active in one's treatment (though, again, this is, nonetheless, a good start).

A healthcare model that decentres the "strong" model of health proposes that leaning into a personal account of illness will straightforwardly better define the parameters of wellness as it pertains to a particular patient in a given moment by being attentive to several modes of knowledge production that are plugged into each other and activated.[56] Clinical practice, according to Svenaeus, must extend "do you feel pain?" to include questions like "How does the pain affect your everyday life?" and "Can you tell me about the situations that make you anxious?" This perspective has something in common with pathographical accounts. Here, there is a possibility for the "good" and "bad" attributes of "health" and "illness" to be explored and contrasted to their overlaps with models in both biology and culture. The fact that the answer to "Can you tell me about the situations that make you anxious?" will introduce "meaning [into] issues that cannot be accommodated in the scientific theory" (as the very point of a scientific theory

[56] Activated in the sense of being at once both a way of knowing, but not a thing known, thus, being less susceptible to some of the traps of knowing previously outlined through Sedgwick.

is to disavow individually experienced meaning in order to make detached observations about objects through causal laws or statistical generalizations) is the proof we need that shows we are missing something in our analysis (Svenaeus, *A Defense* 466).

To distil my critique more neatly, I am not saying that medicine has not made earnest attempts to build clinical practice or analyses that are nuanced (it has),[57] or that bedside manner is not a primary and humanistic concern for medicine (it is).[58] As Adam Rodman noted above, medical science has a "variety of sometimes contradictory epistemologies" that give it more commonality with other disciplines than it may have with the natural sciences. A critique I am making is that the culture of medicine (its meaning-structure), is primarily hampered by:

1. the illusion of its compatibility with hard science
2. the corresponding faith in exposure
3. the positivist view of the truth-value of the image
4. the understanding that its subject is the universalized body-as-object

[57] One rather famous publication that blends a naturalistic and holistic approach to clinical practice comes from the action-theoretic approach to health cultivated by Lennart Nordenfelt. First published in the late 1980s, his work, *On the Nature of Health*, is concerned with patient welfare as a feature that depends both on biology and their choices in everyday life. Health, according to Nordenfelt, comes from the ability of the individual to have outlined goals that are attainable. Health, by this definition, can be upheld in difficult circumstances, even those that make important life goals hard to obtain. In this sense, disease is not inherently antithetical to possessing good health, though it might work against our abilities to attain our goals. Further reading: Nordenfelt, Lennart. *On the Nature of Health: an Action-Theoretic Approach*. Kluwer, 1995.

[58] Studies like "Role modeling humanistic behavior: learning bedside manner from the experts" show that researchers are interested in the "why" and "how" of teaching medical residents the humanistic aspects of medical care through bedside manner for the future development of clinical faculty. See: Weissmann, Peter F., et al. "Role modeling humanistic behavior [sic]: learning bedside manner from the experts." *Academic Medicine* 81.7 (2006): 661-667.

All of these outlined structural myths have led to the esteeming of a methodological approach that is mainly singular, wide-ranging and turned away from the value of the patient's voice, encouraging a tautological and reductionist bent that often only gathers data that fits symmetrical relations in the "strong" theory of medicine. Why? Because, earnestly, this is where the answers are believed to reside because the meaning-structure of medicine has formed this into being by reflecting itself back onto itself.

An example: I find it thought-provoking that the current focus and research on bedside manner as a high-priority skill in clinical practice is regularly centred on empathy with a specific eye for doctor-patient trust development, with the aim to facilitate higher instances of treatment compliance, lower levels of patient anxiety, and higher patient satisfaction (often explicitly connected to some form of personal gain for the physician, through patient retention, loyalty, physician reputation and decreased litigation, etc.). [59] More rare is the consideration of bedside manner for its ability to nurture new sources of

[59] Some of my findings include statements such as: "The significant relationships among the factors showed that positive physician interactions, such as including the patient in treatment decisions, were associated with higher satisfaction with treatment regimen" (Beusterien, K., et al. "Physician-patient Interactions and Outcomes in Systemic Lupus Erythematosus (SLE): a Conceptual Model." Lupus vol. 22 no. 10, 2013, pp. 1038-1045). "A provider's bedside manner can impact professional reputation in the community, affect the loyalty of patients, and even impact effectiveness" (Person, A., and L. Finch. "Bedside manner: Concept analysis and impact on advanced nursing practice." The Internet Journal of Advanced Nursing Practice vol. 10, no.1, 2009, pp. 1). "One relatively consistent finding is that physicians who adopt a warm, friendly, and reassuring manner [referred to elsewhere as an empathic demeanour] are more effective than those who keep consultations formal and do not offer reassurance." Di Blasi, Zelda, et al. "Influence of Context Effects on Health Outcomes: a Systematic Review." *The Lancet*, vol. 357, no. 9258, 2001, pp. 757). "Simply sitting instead of standing at a patient's bedside can have a significant impact on patient satisfaction, patient compliance, and provider–patient rapport, all of which are known factors in decreased litigation, decreased lengths of stay, decreased costs, and improved clinical outcomes." Swayden, Kelli J., et al. "Effect of Sitting vs. Standing on Perception of Provider Time at Bedside: a Pilot Study." *Patient Education and Counseling*, vol. 86, no. 2, 2012, pp. 166).

knowledge.[60] Rarer still is a consideration of the ability of collaborative interaction between the health provider and patient to rupture the edges of medical knowledge more broadly. In my research, I have found that sometimes knowledge production is touted as a positive, somewhat surprising side-effect of establishing basic rapport.[61] It would seem that in the patient compliance and anxiety-alleviation framework, bedside manner is nuanced only in so far as one is trained to extend themselves to ask superficially, "are you better today?" and "do you feel pain?" instead of relying solely on the test data.[62] However, collecting the answers to the straightforward (yes or no?) questions and test data still more or less provides information that serves to accelerate the funnelling of the first-person perspective into the universal body that is the object of medicine's gaze. And, in the same gesture, the overreliance on data diminishes the usefulness of experiential knowledge to which the practitioner undoubtedly has access.[63] It is the meaning-structure and culture of medicine that puts pressure on its practitioners and researchers to face solidly in the direction of a hard science medical model over a humanistic one. To look in both directions means to embrace the site-specificity of the encounter between patient and physician, trusting in the knowledge that both bring to the table based on their

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[60] Findings such as: "Eighty-two patients reported that the team could learn something from them. Based on a multiple-choice question with 7 possible answers including, "nothing" and "other," the most commonly cited points to be learned from patients were information about that patient's medical problem, what it is like to have that medical problem, how patients are different from each other, and examination skills (reported by 59%, 46%, 44%, and 43%, respectively)" (Fletcher, Kathlyn E., David S. Rankey, and David T. Stern. "Bedside Interactions from the Other Side of the Bedrail." *Journal of General Internal Medicine*, vol. 20, no. 1, 2005, pp. 59).

[61] For example, correcting human error: "[the patients] viewed bedside handover as an opportunity to amend any inaccuracies in the information being communicated." "They see their role as important in maintaining accuracy, which promotes safe, high quality care" (McMurray, Anne, et al. "Patients' Perspectives of Bedside Nursing Handover." *Collegian* vol. 18, no. 1, 2011, pp. 19).

[62] Superficially, in the sense that bedside manner is a bit of an act of showmanship, and it is ultimately the extension that is valued, less so what is expected to be gained from the patient's participation and response.

[63] Practitioner knowledge is diminished insofar as it is structurally secondary to the third-person perspective of medicine's historical and cultural meaning-structure.

experiences and contrasting this knowledge with the broader understanding of medical history; it means embracing the humanistic dimensions of medicine, and this isn't an easy sell when it implies a disavowal of the totalizing "seriousness," clout and conviction of a hard natural science.

A phenomenological approach to medicine certainly provides a responsive framework for how we might enact "strong" and "weak" theory in the clinical setting. In another thought-space, Sedgwick's provided path has methodological advantages for critical theory through what she calls the "reparative position." Emphasizing practice over theoretical ideologies, Sedgwick forms the "reparative position" from the work of psychoanalyst Melanie Klein's object relations theory.[64] Klein is a fit for Sedgwick as Sedgwick is, of course, interested in relational stances that dictate how we relate to—our mode of approach for encountering—the text and each other. Named so for its likeness with the varied range of resources one employs for surviving, repairing and moving past depression, the reparative position has, at its core, the deep understanding that "good and bad tend to be inseparable at every level" ("Melanie Klein" 637). Where the paranoid position is one of "terrible alertness" to the dangers posed by self-produced adversaries, the depressive position is "anxiety-mitigating" (Touching Feeling 128). For the Kleinian subject, power is a form of relationality, not a zero-sum game where for one to have power, someone else must be disempowered. When power is a form of relationality, it:

[64] As a founder of object relations theory, Klein's perspective on the subject is widely influential. Object relations theory conceives of interpersonal relationships existing in both an internal and external realm. How an individual comes to understand their relationship to others comes from a synthesis of these two realms. When emotions like envy, suspicion, desire or fear are embodied they become the "objects" that sit separated from the subject of focus. See: Hinshelwood, R. D. *A Dictionary of Kleinian Thought.* Aronson, 1991.

> Deals in, for example, negotiations (including win-win negotiations). The exchange of affect, and other small differentials, the middle ranges of agency—the notion that you can be relatively empowered or disempowered without annihilating someone else or being annihilated, or even castrating or being castrated—is a great mitigation of that endogenous anxiety, although it is also a fragile achievement that requires discovering over and over. ("Melanie Klein" 632)

Sedgwick reminds us of the need to pursue critical and creative engagements that push paranoid reading back into the realm of practice and away from stable-appearing theoretical ideology. In doing so, paranoid and reparative critical practices become fluctuating and diverse relational stances. Imagining how these critical approaches are marshalled as vacillating relational standpoints through tangible examples can be difficult. For Sedgwick, it involves narrative strategies in reading and writing that include "disentangling the question of truth value from performative effect" (*Touching Feeling* 129), knowing that the "efficacy and directionality" of action resides somewhere else than in its relationship to fact per se (141), allowing oneself to be pleasure- and nourishment-seeking, understanding that the writer is complex (both "good" and "bad"), "requiring and eliciting love and care" in an environment that is frequently antagonistic (137), and reconciling with the challenging notion that if a text (or a person) presents you with something that rubs against your own stance, you can still find places in the script for reparative, responsive action, resisting the urge to shut down or volley an attack. The

reparative strategy also includes understanding that an "ecology of knowing" occurs at the intersection of "strong" and "weak" theory. She points to examples like close reading[65] in literary theory, where important phenomenological and theoretical tasks can be accomplished in site-specific ways.

Moreover, Sedgwick suggests that the reader might resist the impulse to discard a text or build counterarguments against it while reading. Instead, the reader can strategically note these moments and recognize them as separable from nourishing insights the text can offer up. For, these are the moments that can—as many a researcher can attest to—rise surprisingly bright and jovial from the elements that reside in the deepest recesses of contentions. I, for one, am forever indebted to Aronson for offering me such a moment.

The reparative methodological strategy, therefore, opens access to breakthroughs and solutions that may have been masked or outright avoided by a hermeneutics grounded in suspicion. There is a higher capacity for bursts of the unexpected following a critical mode rooted in hope and pleasure. So, there is real power here, and interestingly, at the same time, I think it is reasonably predictable that describing a methodology in these emotional terms (hope, pleasure, nourishing, win-win, love, care) brings with it the risk of hostile reception: the uncomplicated, dismissive (and ironically, paranoid) reader would perhaps view a reparative approach as vulnerable to criticism and irresponsibly

[65] Close reading appeared in the UK in the 1920s through the work of T.S. Eliot, I. A. Richards, and William Empson. The literary practice of close reading functions by adopting the view that the autonomy of a text is of more value than authorial intention, ideology or cultural context. Quite similar to formalism in visual art, close reading is concerned with gradations and the interrelation of the components and form of the work in regards to its complex unity. See: Graff, Gerald. *Professing Literature: an Institutional History*. The University of Chicago Press, 1989.

cheerful. The paranoid position, after all, has the look of the respected academic: dressed smartly in tweed, he is at the ready to recite corresponding studies while absentmindedly adjusting thick-framed glasses. The reparative position, with its touchy-feely language and ill-defined objects, must look entirely detached from reality by contrast. Perhaps we imagine her in the formless linens your holistic therapist or high school art teacher might wear: her affect is pleasant and reassuring, but her methods disorganized and unpredictable. On the contrary, this is not at all a reasonable assessment! It is essential to clarify that while the reparative position and paranoid position may create very different realities through their dealings with their objects of inquiry, they do not necessarily view reality differently:

> [Each mode has] its own, different prime motive [for looking], at any rate—the anticipation of pain in one case, the provision of pleasure in the other—and neither can be called more realistic than the other. It's not even necessarily true that the two make different judgments of "reality:" it isn't that one is pessimistic and sees the glass half full. In a world full of loss, pain, and oppression, both epistemologies are likely to be based on deep pessimism: the reparative motive of seeking pleasure, after all, arrives by Klein's account, only with the achievement of a depressive position. But what each looks for—which is again to say, the motive each has for looking—is bound to differ widely. (138)

In many ways, an overreliance on a hermeneutics of suspicion prolongs oppressive reality by articulating it and crystalizing it endlessly. An injection of the reparative approach can open up the possibility of change by letting in surprises (even when they are disastrous) and being responsive to outcomes by possessing the ability to pivot and move in new directions, afforded only to a model that utilizes the small-scale "weak" theory. The pleasure-seeking characteristic of the reparative mode is what motivates a response to the inevitable and unavoidable painful outcomes when they do come. It offers resources for moving forward and seeking a better reality rooted in care for the self and other.[66] On the disparity between the two positions in their articulation of the concepts of hope and possibility, Sedgwick writes,

> To recognize in paranoia a distinctively rigid relation to temporality, at once anticipatory and retroactive, averse above all to surprise, is also to glimpse the lineaments of other possibilities…to read from a reparative position is to surrender to the knowing, anxious paranoid determination that no horror, however apparently unthinkable, should come to the reader *as new*; to a reparatively positioned reader, it can seem realistic and necessary to experience surprise. Because there can be terrible surprises, however, there can also be good ones. Hope, often a fracturing and even a traumatic thing to experience, is among the energies by which the reparatively positioned reader tries to organize the fragments and part-objects she encounters or creates. Because the reader has room to realize that the future may be different from the present, it is also possible for her to entertain such profoundly painful, profoundly reliving, ethically crucial

[66] For more on the necessary quality of care for the other see: Tomkins' understanding of the sociality of feeling in the section, *A genealogy of affect: key modes and methods of affect theory*

> possibilities as that the past, in turn, could have happened differently[67] from the way it actually did. (146)

Seeing beyond a hermeneutics of suspicion requires recognizing paranoid reading as separate from theory with a capital "T." We cannot get to this point by thinking through paranoid critical habits. Identifying the challenge of this experiment does not in and of itself move us closer to success. Reparative critical practice can be frustratingly elusive,[68] as Sedgwick points out. It is a habit of thought that one irregularly, often only briefly achieves (128).

An investigation into methods is crucial as, on one level, the study of the methodological approach reveals a great deal about what is valued and what is unimportant to a discipline. On another level, methodology becomes a vital concern if one recognizes that methods do not merely describe reality but form reality too. When we place our faith exclusively in methodologies that expose truth with precision and accuracy, we build a reality that is unable and unwilling to accommodate the wide variety, fluidity and messiness that comes with the human subject. To condemn methodological approaches that take into account messy findings as indicators of inferior or shoddy research practice is to subscribe to, as the science and technology studies scholar John Law points out, the irrational belief that the world is anything but fluid,

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[67] In an endnote Sedgwick clarifies this point "I don't mean to hypostatize, here "the way it actually did" happen, or how to deny how constructed a thing this "actually did" may be—within certain constraints. The realm of what *might have happened but didn't* is, however, ordinarily even wider and less constrained, and it seems conceptually important that the two not be collapsed; otherwise, the entire possibility of things' *happening differently* can be lost" (151).

[68] So, I must acknowledge the reparative position may, in this way at least, resemble my high school art teacher.

elusive, or multiple. In addition, the questioning of methodology is, I believe, an obligatory act as the particular rules methodologies impose are taken for granted as necessary. Behind the supposition that the rules of methods are indispensable lies a deep chasm of assumptions that have been as naturalized as they have been hidden.

The methods that dictate what facts we need to gather and how we need to assemble them are also telling us specific stories about what is central to our concerns and how we should proceed from here (Law 5). When particular methods, like a hermeneutics of suspicion, become synonymous with common-sense research, or rigour, we end up with stable-appearing theoretical ideology. When the third-person account of a positivist or applied biology becomes the uncritical manager of the sick experience, the world and the body become "known" as a determinate, tracible thing with a corresponding and straightforwardly identifiable procedure that very likely may not either resemble or aid the patient on the table. Knowledge loses its ontological features in this space, appearing wholly epistemological: knowledge is cognized to be merely representation, and not performative.[69]

[69] Knowledge takes epistemology as its subject, while at the same time being ontological. Anyone who has ever written research will know the transformative effect the act of writing has on the knowledge they are (purportedly just) reporting on: writing is not so much a recording or description of the research knowledge as it is an ongoing act of creative (dis)assembly. Revelations, relationships and insights burst forward or are submerged in often alternating euphoric highs and discouraging lows. Whatever this page looks like now, I assure you, it has looked differently in the past and there is a very good chance it will look different in the future. Writing is also fast friends with all manner of concurrent actions beyond the keyboard. In writing, knowledge lives as much on the page as it does in the act of constructing sentences or feverish house cleaning, long showers and solo walks in nature. Knowledge, as Rebekah Sheldon writes, "is performed on and through the material substrata we call writing, reading, thinking, and listening and in concert with history of ideas from which all this emerged and into which it seeks, as we say, to make an intervention, to push the discourse in new directions" Further reading: Sheldon, Rebekah. "Double Agency: Knowledge: Performativity." *ARCADE,* Stanford Department of English, 2015

In advocating for alternative methodologies in this section, I have narrowed in on two strategic modes that are relevant to my project: the reparative approach (with its heart of vitality, performativity, and mobility) and a phenomenological account of medicine (concerned with corporeality, sensuality and perspective). It is paramount that I note the somewhat obvious fact that there exists a great variety of methodological diversity in and across all disciplines. Indeed, I am not finished integrating methods into my particular undertaking. However, the problem has never been—at least, not while I have been alive and thinking—that we lack range, the rather sticky problem continues to be the dominating affect and, as Law points out, the hegemonic effect of specific versions or accounts of method.[70]

Overarching theories can be useful, but that does not mean they are always inherently nourishing, favourable, or even effective. Indeed, this section, I hope, has done the work to show how methods can often enable the realities they seek to disable. Finding alternative practices while recognizing the "work" of methodology (specifically, its ability—or inability, as it may be—to carve out futures that look different than the past) is necessary to address the deeply rooted meaning-structures that need reimagining. Working towards a method that consciously and continuously oscillates between "strong" and "weak" theory is vital if one wishes to achieve a decryptive and descriptive view of near and far phenomena, allowing us to (more or less, better or worse, always actively) contextualize our subjects and still engage with our subjects, without painting them as

[70] Law furthers this point, noting that strong regularities and standardisations are very powerful means to an end, but they set limits for knowledge: "Indeed, that is a part of their (double-edged) power. And they set even firmer limits when they try to orchestrate themselves hegemonically into purported coherence" (7).

fixed objects. A method that has the epistemological flexibility to oscillate in such a way is unlikely to approach the world as always already known.

*2.3 Art undisciplined: the relational epistemology of the art experience*

From an increase of interest in the embodied experience, affect, and theories of practice, several key thinkers began to take seriously the promise of "politico-epistemic renewal" that is opened up in the wake of a rejection of positivism, control, explanation and prediction (*Non-Representational Methodologies* 3). In the early 2000s, something called non-representational theory emerged from the discipline of human geography. Its central theorists were Nigel Thrift, J.D. Dewsbury and Derek McCormack. An umbrella term for work that seeks to better cope with the supple, wiggling world we move within, non-representational theory is interested in constant becoming and change, looking to methodologies that place emphasis on performativity, experimentation and vitality. It is primarily concerned with embodied experience and the way everyday life expresses itself. Art, dance, and even gardening all qualify as sites of relational action that give no advanced notice of what they will become, and thus, they offer up an alternative to the problems outlined in representational thinking through a marriage of corporeality, materiality and sociality. Nigel Thrift believes research and researchers ought to move towards the precipice of the conceptual in order to fight against single-focus epistemologies and overbearing methodologies, in the direction of happenings that nurture a "full range of registers of thought by stressing affect and sensation," and towards a "poetics of the release of energy that might be thought to resemble play" (Thrift 12).

Non-representational theory seeks to cultivate affective states where bodies affect each other in real-time. All of those who work in and with affect theory are interested in

the ways in which affect moves and directs action.[71] Like most research, the human subject is of great interest in that affect shapes its capacity to act and be acted upon. "The capacity of a body is never defined by the body alone but is always aided and abetted by, and dovetails with, the field or context of its force-relations," note Gregg and Seigworth in the text, *The Affect Theory Reader* (Gregg 3). In terms of form, it is interesting to note that the authors of this seminal text comment that their collection of essays does not resemble any kind of "integrated lockstep," and this clarification speaks to the extraordinary tensions present in affect theory. Affect theory, they say, "[operates] with a certain modest methodological vitality rather than impressing itself upon a wiggling world like a snap-on grid of shape-setting interpretability" (4). Gregg and Seigworth suggest that the reason methods that preference affect and the unexpected seem so jarring in our current critical academic climate is that compartmentalisms have always been valued over thresholds and tensions, pointing out that "approaches to affect would feel a great deal less like a free fall if our most familiar modes of inquiry had begun with movement rather than stasis, with process always underway rather than position taken" (4).

Several writers have taken up the subject of art, in particular, in relationship to affect and "politico-epistemic renewal." Most notably, Jill Bennett's book, *Empathic Vision: Affect Trauma and Contemporary Art* (2005), has become a formative text in the field, demarcating how affect and art might fit together. Her work divides affect and emotion, arguing emotion is experienced in the present, becoming a representation of

[71] Though how, exactly, affect moves and directs action is the source of great debate that does cut major ideological divides through affect theory. Indeed, this rift is the central focus of Chapter Three, *An Alternative Implication for Art and Affect*, and has tremendous implications over the kind of argument I seek to make.

itself when recalled later: one "thinks rather than simply feels emotion" as it becomes a form of "distanced perception" (22). However, she notes, there are actions that can move us through actual somatic experience, like reliving an event through memory or encountering a compelling artwork that produces a fresh wave of emotion that, while perhaps familiar, is manifestly experienced in the present. As she is interested in trauma theory, it is clear to see why this distinction might ring loudest for Bennett: it would be imperative that the affective resonances at work in the art be experienced as emergence, where thought and emotion are feeding back into what Brian Massumi calls the virtual, "autonomy of relation." Where the "aboutness" of the work, its traumatic birth or expression, is, in fact, understood as a "functional limitation" of the work's affective properties (*Parables for the Virtual* 35).

When translated into language more familiar to trauma theory, the equation around the "work" of the art that takes trauma as its subject—as its feel-space—would be something more like, "real and not vicarious."[72] Less interested in the content of the artwork (that which is a representation of something else), Bennett settles on the idea that art is "a vehicle for the interpersonal transmission of experience," wherein the affective response doesn't inspire identification or sympathy, but rather it arises from open engagement with the registers of sensation in the work making the experience, "transactive rather than communicative" (7).

[72] Dominick LaCapra, a driving force in trauma theory, presents the idea of empathic unsettlement as a position one takes that is in the middle of the active and passive voice, enacts a kind of play that resists dichotomous binary oppositions, occupies the in-between voice of "radical ambivalence of clear-cut positions" (20). Empathic unsettlement, thus, becomes a form of virtual and not vicarious experience (40).

While I take a differing view of how art entangles affect (following in step with the foundations I have been laying, it is a view which is both transactive and communicative. This interpretation I will elaborate on later in much more detail), I think Bennett's work is compelling and strikes on something important in the way that art can be something more than representational. She writes that art can be seen as, "not merely illustrating or embodying a proposition, but as engendering manner of thinking" (8) and by this she means that the actual act of engaging with art—the art experience—is a place of knowledge production that harnesses not only the unexpected but also encourages a manner of thinking that is, by my text's definition, "weak" in that it is not driven by any particular chain of interpretive inferences. The political potential of art, thus, is bound to its process, and this is something to which I certainly subscribe.

I believe that art deals in affective resonances wherein, contrary to Bennett, meaning and materiality cohabitate without difficulty. Art deals in affect through its methods, which inform all aspects of the art-making process, not the least of which is the art encounter. While the act of encountering art might seem featureless (in the prescriptive sense: there is no "one way" to look at a painting) and intuitive, how we engage with art is actually driven by several conventions and these customs form something of a broad stroke for the methodology of the art experience. Our mode of approach affects how art is experienced, and it impacts the "work" of that encounter. There are supported emancipatory properties in the art experience (art has and can activate change).[73] Still, there is also a fragile truth hidden behind this assertion that is

[73] To ground this claim, I will offer only a few examples among many more I could readily chose from: Albert Bierstadt's soaring, paradisiacal American landscapes have been directly credited with motivating mass migration as well as influencing President Abraham Lincoln's signing of the Yosemite Grant Act. His work was a powerful signal in a country torn apart by the Civil War. For more, see: Joseph, Dana, and

rather underacknowledged in the research: there does not appear to be anything inherent in "Art" that necessitates the features of the contemporary art experience as it distinctively appears today. That is to say, all that is cherishable about contours of the contemporary art experience—the "stuff" that holds the promise of a tendency towards "politico-epistemic renewal"—is not something that has been consistently recognizable or attached to art and the art experience writ large. This is due, primarily, to the fact that in different times and places, like everything else, art has been shaped by the forces that engage it.

In *Refusing medicine's body-object: The picture of health reimagined*, I talked about how art has utilized divergent methods and modes over history and geographic locations in direct relation to shifts in social conditions and preferences. As I said from the onset, it is entirely unsurprising that in wide-ranging spaces and at tremendously diverse moments, art has performed differently. The great philosophical question "what is art?" remains unsettled not because we have not quite found the right answer, but instead because all the correct answers we have found are tied to specific expressions of art and do not map easily (or at all) onto any large-scale continuum of "Art"—if there could even be such a thing. When the social purpose of art shifts, naturally, so too do its methods and modes. When its modes change, so too do art's methods, and social purpose…and on and

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Michele Powers Glaze. "Albert Bierstadt: Witness To A Changing West." *C&I Magazine*, 1 June 2018. During the reign of Elizabeth I, the queen used confrontational, powerful portraits of herself as tools of propaganda, presenting herself not only as a subject for devotion and veneration, but also as a physical manifestation of her state. Her portraits were commissioned as gifts to foreign monarchs who were so moved by her finely crafted persona and power that they showered her in marriage proposals. For more, see: "The Queen's Likeness: Portraits of Elizabeth I." *National Portrait Gallery*, National Portrait Gallery, www.npg.org.uk/research/programmes/making-art-in-tudor-britain/case-studies/the-queens-likeness-portraits-of-elizabeth-i. Artwork has also been the direct instigator of political action (or reaction) with many works inciting actual riots, like the Robert E. Lee Monument by Henry Shrady, or artist Gustave Courbet's L'Origine du monde ("The Origin of the World").

on it goes. For instance, the meaning-structure of art is often most affected by who (or what) is perceived to have interpretive authority (be it the artist, critic, curator; artwork, church, ruling power, etc.).

In this contemporary moment, the viewer is endowed with a great deal of interpretive power. In a gallery, one might turn to their viewing partner and ask, "What do you see?" which is coded language for, "Tell me how you interpret this painting. Tell me the meaning you give it. What does it mean?" and, of course, it also stands for the much less coded, "What do you note, visually?" the answers the viewer gives (whatever they may be) are imbued with a relatively (historically speaking) generous amount of authority because the viewer currently enjoys a great deal of space in the power differentials that reflect meaning-making in the meaning structure of art.

By contrast, in the Netherlands, during the 16th-and 17th-centuries, there was a different boundary for the interpretive relationship a viewer could have with art. In this historical moment, a type of genre painting called "Vanitas" was immensely popular. Vanitas paintings are exquisitely rendered still lifes that include ubiquitous elements. Tight, layered compositions often feature objects like skulls, ornamental glassware, vases, crockery, textiles, books and candles. Flowers, insects and animals, dead or alive, are also frequently portrayed in the moody, high-contrast paintings. Each element is decidedly symbolic, and the audience of the time, whether literate or not, would have a solid, foundational cultural knowledge of the specific meanings that each component underwrites. Belgian artist Philippe de Champaigne's Vanitas titled, *Natura Morta Con Teschio* (Figure 2-2), for example, is a meditation on the fragility of man.

**Figure 2-2** de Champaigne, Philippe. *Natura Morta Con Teschio*. 1671. Oil on panel, 28 × 37 cm. Musée de Tessé, Le Mans, France.

In the miniature painting, a waxy red and yellow tulip vibrantly exemplifies life. However, plucked and placed in water, its temporal connection to death is ultimately inescapable.[74] On the right sits an hourglass, emphasizing the passage of time. Between the two framing elements, a human skull injects the definitive subject in this drama: man. This style of genre painting was popularized at a time of economic prosperity in Northern Europe following a span of political upheaval between the Netherlands and Spain.

[74] It is likely that the association between cut flowers and the death of man comes from the biblical passage "Man…cometh forth like a flower and is cut down" (Job 14:2).

Themes of goodness and badness are complexly entwined with excess in a Vanitas still life painting because they were designed to act as vibrant, biblically loaded, pictorial sermons — warnings against overindulgence. But, amusingly, Vanitas still lifes were also beloved and sought-after by the wealthy. The subject matter regularly featured tulips and shells, which were expensive, rare ephemera in and of themselves in this era, popular with rich collectors.

The 1630s marked the height of the Dutch frenzy for tulips, called "Tulipmania," which saw the cost of bulbs rise to absurd heights. A tulip, known as "The Viceroy" (Viseroij), was offered for sale at between 3,000 and 4,200 florins, depending on weight (Nusteling 252). For perspective, a florin has 54 grains of nominally pure gold (3.5368 grams) (Bernocchi 66). While it is difficult to precisely identify the purchasing power of a florin in 1630 Northern Europe, by comparison, 3.5368 grams of pure gold (1 florin) x the asking price of 4,200 florins = $914,592 Canadian, as of Dec. 2019. Another point of context: according to Nusteling, during Tulipmania, a skilled craftsman made 300 florins a year (258), which would have a comparable gold value of $65,328 in Canadian dollars. Putting aside equivalent contemporary value, the cost of a single tulip bulb remains 14 times the yearly salary of the skilled craftsman – an exorbitant amount.

Shell collecting was another pastime of the wealthy in the 17$^{th}$-century. According to Leonhard, rare shells like the spiral Wentletrap could cost up to 500 florins (183), working out to $108,880 contemporary Canadian dollars. Thus, with their trendy use of both symbolically and fiscally rich florals and fauna, a Vanitas still-life painting setup involved significant cost. These paintings that warned against excess were also—quite literally—symbols of the wealth and luxury afforded to the privileged in this era.

For the wealthy and poor alike, Dutch still life paintings functioned like not-so-secret but nonetheless cryptographed messages that the audience was charged with untangling. In addition to the perils of gluttony, the transience of life and the inevitability of death, another common theme in these Dutch genre paintings included the vanity of pleasure. Severely moralistic, the works were intended to reinforce values that were understood to be righteous (though perhaps not always lived) according to Dutch standards at the time.

Philosophically, it might be fair to say that paintings like, *Natura Morta Con Teschio*, were designed to have a sharply definitive interpretation, an absolute truth of sorts, that was intended to be widely understood and mostly stable. The art object was understood to "hold" this truth, deliberately placed into the properties of the object by the artist (or, by extension, the patron). To be more explicit: a skull represents man, impermanence, the fragility of human life, and the brevity of our existence. The skull is painted; thus, the painting is imbued with these meanings through representation. The viewer's role was understood to be something closer to a passive, faithful, and dutiful receiver than a meaning-maker.

Outside of the obligatory caveat of acknowledging the perils the historian faces when historicizing (interpretive frameworks, and so on… ) I do think it is a rather fair assessment to state that this 16$^{th}$- and 17$^{th}$-century Dutch movement and its accompanying conceptual arrangement of the relationship between the world, artist, art object and viewer finds the locus of meaning rooted in the art object and the authorship of that meaning disconnected from (or, more accurately, independent to) the viewer. If this proverbial tree falls and a 16$^{th}$-century Dutch peasant isn't around to hear it, it still makes

a noise. And, if this statement feels like something you are keen to problematize, I think the impetus is intensely interesting: the fact that we can conceptually back-gaze now and challenge the "work" the art is doing in this arrangement (its meaning structure and the relationship between the world, artist, art object and viewer) is—more than anything—a marker of the particular methodological movements that are characteristic of the "work" of art now in this contemporary moment. For one thing, it denotes our conviction that art is subject to repeated readings that can be written and rewritten. For another, it signifies our readiness to disconnect the locus of truth-value from the object itself and authorship from a singular force and thrust them in other possible locations and directions.

What other qualities and relations can be drawn out from this perhaps still somewhat vague expression "the contemporary art experience?" If we look at the work *CHROMO 3* (figure 2-3), presented in 2013 at The Ontario College of Art and Design by Canadian artist Sara MacLean, we can trace contemporary rules of engagement in art practice in multiple stages.

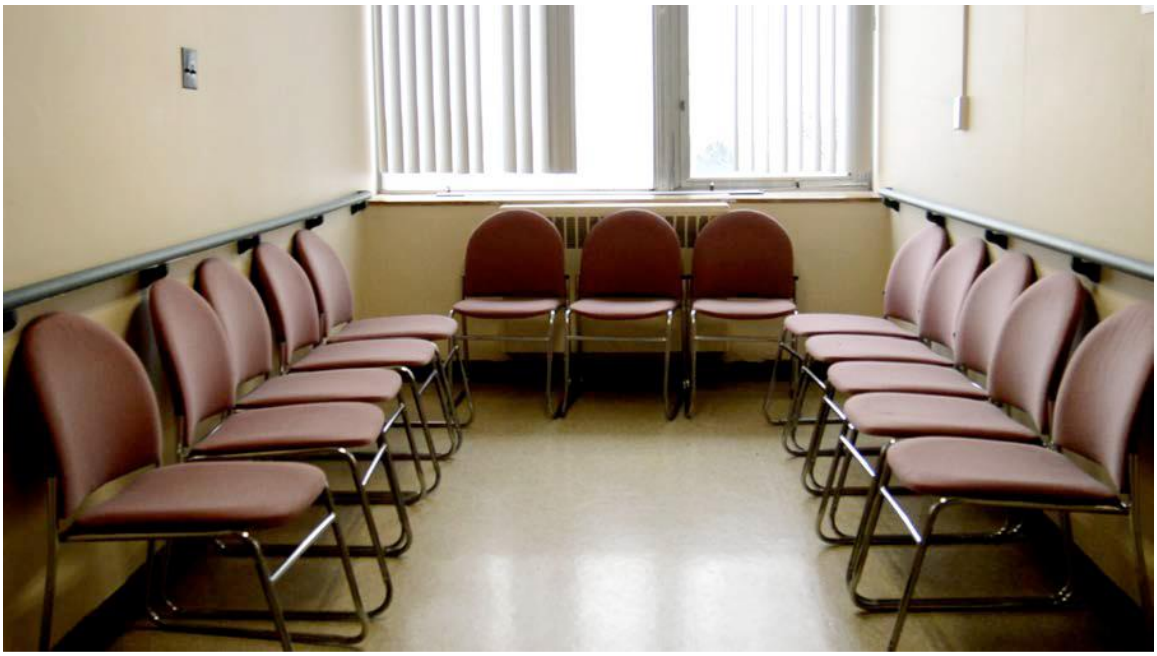

**Figure 2-3** MacLean, Sara. *CHROMO 3 – Enclosure 1* (film still). 2013.

MacLean produced a series using video to explore her experience as a patient with a genetic disorder, attempting to communicate "human experience from, through and to the body" (iii) by documenting the clinical environment of her treatment. *CHROMO 3*, the final installment of the series, opens with rotating shots of different hospital waiting rooms. There are no bodies present, but the waiting room chairs evoke the absent body. The camera, which is handheld and never quite stable, links the viewer to the first-person perspective of the body guiding the lens. As the hospitals and waiting rooms cycle, so too do the acoustics, which does work to flesh out the spaces with different layers and degrees of hollowness or softness, made unusually conspicuous by the continuously fluctuating scenes. Illness is a state with which we are all directly and indirectly familiar. Particular hospital waiting rooms hold intimate histories for many of us. Waiting, as a theme, flourishes in lingering moments and constant repetition. Waiting

is present in the spaces and movements; it is featured in the cuts, as the body sits still, fidgets or moves through empty hallways (figure 2-4).

**Figure 2-4** MacLean, Sara. *CHROMO 3 – Enclosure 1* (film still). 2013.

The viewer enters the second phase of *CHROMO* as waiting room cycles transition to a rotation of exam rooms. In reflecting on this portion of the film, MacLean writes, "If waiting rooms are a space created by patients waiting, exam rooms are the end of that temporal sphere. In my experience, the anticipation of an event is simply prolonged upon entry into the exam room. More often than not, another wait of significant duration may occur, this time in isolation, before someone enters" (70). The film continues its episodic cycles: waiting rooms intersected by exam rooms, interrupted by results draw us into the final section, the in-patient ward (figure 2-5).

**Figure 2-5** MacLean, Sara. *CHROMO 3 – Enclosure 3* (film still). 2013.

Time is underlined and stretched in this section through languid camera movements and intermittent time-lapse sequences. The body feels contained by the room, and we stay here for some time before we are discharged and head to the exit. The film ends before the doors open, refusing to reveal to the viewer any space at all beyond the hospital walls.

Some of MacLean's artistic process is revealed in her musings about the in-patient ward phase of the film. She writes,

> As the hospital bed itself becomes the latest enclosure, the environment shrinks again (or perhaps we expand to fill it), and the boundaries between the interior and exterior are blurred and slippery. In one scene, we exit the room, and there is a shuffling walk out of the in-patient ward to a glassed-in walkway. We linger over a long sunset as viewed through a window overlooking a courtyard. The hospital walls frame the exterior space on all sides, while the sunset and the outlines of trees are, in fact, reflections on the glass windows on the opposite end

> of the courtyard. This is the first section where my own presence is noticeable, briefly here as a shadow in the center [sic] of the frame, backing away from the window. (73)

There is clearly a consideration for several key strategies prevalent in contemporary practice around MacLean's execution upon which we can draw. One crucial approach, I will call "the shifting subject." The subject here refers to the protagonist in the work, but I also employ the term "subject" broadly as an expression that can encompass both the subject matter of the work and the bodies that move around it. There is a shifting subject together in the way MacLean theorizes and affects her artistic process. Revealingly, in the passage above, the language "we expand," "we exit," "we linger" denote her readiness to oscillate between the viewer's experiences and her own, which is given a moment of recognition, "as a shadow in the center [sic] of the frame, backing away from the window." Her creative choice to embody the subject through the eye of the camera that predominantly maintains its attachment to the movements of the protagonist, and her decision to evoke the body through its absence at multiple moments, leaves space for the viewer to enter the narrative while also encapsulating a depth of her history that moves beyond language – animating but not mimicking her encounter with genetic disease. "The shifting subject" allows the viewer to enter and imprint themselves, but the openness that MacLean establishes is anything but an impersonal, neutral space. Her history is not wiped clean, nor is it overwritten by the viewer; rather, it is encountered and transformed into the site of new experience.

Attention to the "work" that art does is another strategic choice in MacLean's actions. *CHROMO* is not a film in a conventional sense. It is executed as a performance. The film is projected onto opposite ends of an exhibition space set up to resemble a hospital waiting room (figure 2-6).

**Figure 2-6** MacLean, Sara. *CHROMO 3* (installation shot). August 7th, 2013. OCAD University Great Hall, Ontario, Canada.

The viewer sits in this environment as they feel their way through the work. Facing the projected film, the viewer connects with a sense for the artist, the viewer's own role as subject, and, by way of the seating arrangement, the other viewers are similarly engaged in the force relations of a multitude of bodies, with all the tensions,

feelings, hope and dangers the encounter holds. Occasionally, a gradual fading and intensification of stage lighting illuminate preselected seats, conjuring, in a startling way, the sudden cut of a name called across a quiet room full of strangers who have been waiting for so long that many have half-forgotten to anticipate the nurse who now stands expectantly before them. The lighting shift is neatly designed to increase "the sense of embodied risk in the audience" and "re-activate bodily and intercorporeal awareness"[75] (78) by further implicating the viewer's responsibility—indeed, response-ability—in the unfolding action that "activates a space of shared corporeal experience" (79). Again, *CHROMO* is not a representation of MacLean's experience with hospitalization in the simple sense. It is an event that evokes a layered descriptive, interpretive and affective performance that willfully plays with the ebbs and flows of meaning along with the multiple bodies and spaces involved in the art experience. MacLean is tuned into the methodological concerns inherent with contemporary practice as she cultivates an event-space that is in harmony with her viewers, the art experience and unresolved possibility.

MacLean's project is a helpful counter to the work of de Champaigne. The contemporary perception of the audience holding significant meaning-making power over the content of a work through an intimate exchange does not cohere with the viewer's experience of art in Northern Europe in the 16$^{th}$ - 17$^{th}$ century, nor indeed does it for many other paradigms from art history that I could readily draw upon for examples. So, it

[75] Intercorporeality is an idea from Merleau-Ponty to describe the showing up of social cognition by paying attention to the relation between one's own body and that of the other. Merleau-Ponty writes, "In perceiving the other, my body and his are coupled, resulting in a sort of action which pairs them. This conduct which I am able only to see, I live somehow from a distance. I make it mine; I recover it or comprehend it. Reciprocally I know that the gestures I make myself can be the objects of another's intention" (Merleau-Ponty, Maurice. *The Primacy of Perception: And Other Essays on Phenomenological Psychology, the Philosophy of Art, History, and Politics*. Northwestern University Press, 1964. pp. 118).

follows by my logic that the methods we more or less consciously employ in encountering and engaging with art toward feeling, meaning-making and action-taking, are not safeguarded by the object of Art-with-a-capital-"A."

Here, I want to take a moment to get on a bit more solid ground and better convey what I mean by "contemporary" when I talk about art practice. "Contemporary," generally, refers to now, but in art historical terms, "contemporary art" reaches back well into the 20th-century as well. In human terms, "contemporary" art is fresh-faced and new while simultaneously settled deep into retirement living. Clearly, there is a wide range of movements within this idiom! For our purposes, "contemporary art" simply refers to how art is situated today, both historically and culturally. Just as there is a shifting and always contested boundary that defines what art is, there is an ongoing, mutable and relational reality to what (or perhaps, how) art does. Contemporary art practice is not something that can fully belong to any one tradition (like, Western) or one culture, as it is subject to unending borrowing (over time and space) and is, as Michael Rothberg writes in a different context, "productive, not privative" (3). So, "contemporary" is here used as an overarching term that recognizes this shifting boundary while remaining attentive to contingent social understandings that inform how we think about art and the role of artist, art object, viewer and world.

The pressures that stimulate contemporary art approaches are many. From the modernist toolkit, contemporary sensibilities have held onto experimentation, a desire for newness, a rejection of certainty and a proliferating concern for process and material. Postmodern thought brought the denunciation of grand narratives, and singular interpretive authority as well as a deep skepticism of objective truth, progress and stable

knowledge. Postmodernism collided art and everyday life and brought new materials and modes of display. Identity politics and feminism have highlighted the importance of the body as a site of knowledge and experience. Globalization, which Roland Robertson writes, "refers both to the compression of the world and the intensification of the world as a whole" (8) has brought a trans-local and transnational model of art practice. This shift has influenced how we consume art in both physical and economic domains, having the effect of heightening a self-conscious concern to connect response-ability (from the response ethics of Kelly Oliver (2015)) to responsibility within a global framework (Appiah, 85). A layered reaction to interconnectedness has further been explored through responses joined to the mounting distress around the human impact on the environment as well as the rapid rise of the digital age, and the global interhuman infectious networks in the wake of COVID 19, each in their own ways, expanded the concept of a linked transpersonal ecosystem. There is more to articulate here, but suffice it to say that being apprised of the many influences has less immediate sway on contemporary viewing than the wide-ranging, common, and residual culmination of effects that lead a viewer to know that, at the most rudimentary level, they are co-producing meaning when engaging with an artwork and that artwork is in dialogue with its artist and the world.

Approaches to thinking through art, gestated both internally and externally, offer surprising possibilities for "newness" in how we relate to others and mobilize ideas into the world. These means of engagement associated with the present moment come from our social understanding of the function and nature of art, allowing us the freedom to enter into dialogue with the work in a way that is strikingly different. However, at the same time, the fidelity of the contemporary art experience to the nowness of art viewing

does not preclude our strategies from churning in energetic negotiation with historical movements and influences from art's history and critical theory (among an endless list of stimulating forces). In any case, it is not foundational to my point to present a full inventory or trace a history of the contemporary art experience and its causes nor is it necessary for the reasons that I have evoked in problematizing "strong" theory or advocating for art's modest methodological framework—and, indeed, how awfully counterproductive to art and its openness would such an endeavour be.

Still, it the goal of this project to gesture towards several strategies that surround art production and its viewing that yield extraordinarily productive potential for new ways of thinking that are more ethical, care-based and politically energizing. To begin working through how this regenerative impetus ensues, it is helpful to think of "art practice" less like an individualized, artist-driven gathering of all the things necessary for the production of artwork and more as a conceptual framework that includes, among further possibilities, an active relationship between the artist, artwork, world and viewer.

I am advocating for the swaying give-and-take between multiple critical approaches. Art practice can be a robust, tangible instance where this arrangement plays out in surprising ways. When we approach an artwork as "good" contemporary viewers, we are attuned to the currents of feeling and content that move through and around the work and all facets of the encounter as we consciously and unconsciously search for signs and meaning. While, in some cases, paranoid epistemological practices may cause us to close off from work, I believe there exist internal mechanisms in contemporary art practise that, when grasped, are deeply sympathetic to, and encouraging of, reparative practice. That is to say, the rules of engagement locate viewers in a place where the social

understanding of art urges us to not purely participate in a search for imbued meaning but to self-consciously participate in a full exploration of the ample space offered to interrupt and negotiate meaning through our own knowledge and associations. In this sense, we mindfully seek to articulate and share the creative act of forming objects from fragments in a conceptual space where we are much less scared of being wrong than we might be in most other facets of our everyday intellectual lives. So, art practice is conducive to Sedgwick's reparative positioning, as our rules of engagement open up opportunities where we can speak about, and empathize with the paranoid habits that surround aspects of the world, work and its reception and think through why a hermeneutics of suspicion is adopted as a strategy for coping with dark, intrusive anxieties.

An elegant example of art offering a way through paranoid habits can be seen in the *Teetertotter Wall* project (2019) by Ronald Rael and Virginia San Fratello (Figure 2-7).

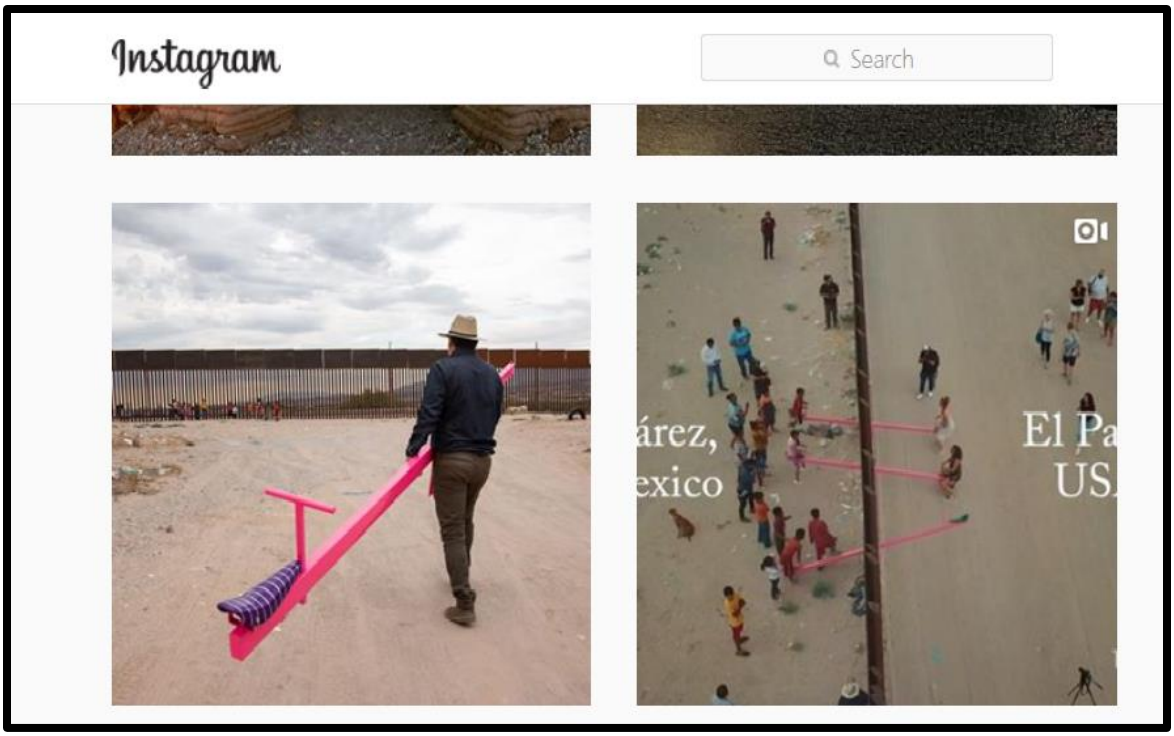


**Figure 2-7** On July 29th, 2013, Ronald Rael announced the success of the installation of *Teetertotter Wall* on his Instagram account @rrael (screenshot), writing, "One of the most incredible experiences of my and [Virginia San Fratello's] @vasfsf's career bringing to life the conceptual drawings of the Teetertotter Wall from 2009 in an event filled with joy, excitement, and togetherness at the borderwall [sic]. The wall became a literal fulcrum for U.S. - Mexico relations and children and adults were connected in meaningful ways on both sides with the recognition that the actions that take place on one side have a direct consequence on the other side. Amazing thanks to everyone who made this event possible like Omar Rios @colectivo.chopeke for collaborating with us, the guys at Taller Herrería in #CiudadJuarez for their fine craftsmanship, @anateresafernandez for encouragement and support, and everyone who showed up on both sides including the beautiful families from Colonia Anapra, and @kerrydoyle2010, @kateggreen, @ersela_kripa, @stphn_mllr, @wakawaffles, @chris_inabox and many others (you know who you are). #raelsanfratello #borderwallasarchitecture #teetertotterwall #seesaw #subibaja" (https://www.instagram.com/p/B0fY2R6hfKr/?utm_source=ig_embed)

In the work, bright pink seesaws puncture a section of the U.S.-Mexico border wall outside El Paso. The multi-layered project seizes upon the entrenched—yet very different— anxieties held by many U.S. and Mexican citizens. Requiring a cross-border participant to operate, *Teetertotter Wall* utilizes play, collaboration and pleasure in close

alliance with very real, very dark fears. The work creates a space where the viewer must weave in and around the energies of both approaches at the same time, providing a self-conscious platform for this exchange. Contemporary approaches to visual art encourage an oscillatory critical stance, allowing for the self-awareness of existing paranoid emergences that are opened by non-paranoid knowing. Because art allows for a kind of participatory openness, we can position paranoid thinking in the realm of practice, seeing these strategies not as untrue, but as pieces of an ongoing, potentially generative intellectual process.

Like any organized system, the methodological approaches of contemporary art practice are marked in some sense by rules. However, these rules are not as enforced as the conventions in other frameworks.[76] Still, there is no shortage of tenets. Repetition, for instance, is appreciated as a formal device. Still, the recirculation of memetic ideas is often only welcomed when a heavy-handed irony accompanies it or when it manifests self-consciously in work. The "good" contemporary artist is usually positioned to be interpretive or ampliative. They are cultivators of feeling, potential and response through events, assemblages, and objects. The "bad" contemporary artist is one who produces work with a fixed meaning, who tries to lock down how and when thoughts and feelings can be conveyed. The "bad" contemporary artist possesses fascistic qualities and wields power over meaning and action.

[76] That isn't to say that there isn't a strong sense of "good" and "bad" within the conventions, or that there isn't a great deal of policing in art schools and circles regarding the "rules," but rather, my observation indicates that the almost manic hunger for newness and surprise in contemporary practice dictates the imperative that any rule is, at the end of the day, breakable.

Calling work "didactic"—a term for work that is weighed down by a limited, specific truth, or functions to the exclusion of surprise, possibility, or contingency—is to deliberately discredit the power of the work and efforts of the artist by noting the political, emotional, and experiential impoverishment of the endeavour. The "good" contemporary artist is concerned about leaving space in work, about not injecting their authorship over it to the point where the work asphyxiates. In order to breathe, the work needs space for feeling and meaning to foster and layer. Art is both representational and non-representational theory in practice. The "good" contemporary artist has similar qualities to the "good" non-representational theorist, or perhaps even more accurately, non-representational ethnographer, who recognizes their work to be impressionistic, and inherently creative. Phillip Vannini speaks to the methodological and conceptual undercurrents of this ethnographic tradition:

> Though [non-representational ethnographers] are inspired by their lived experiences in the field, they do not claim to be able, or even interested, in reporting on those in an impersonal, neutral, or reliable manner. Thus, non-representational ethnographic styles can be said to be styles that strive to animate rather than simply mimic, to rupture rather than merely account, to evoke rather than just report, and to reverberate instead of more modestly resonating. ("Non-Representational Ethnography" 317-8)

Art has recourse to diverse expressions, purpose and drive; it is both active and responsive. Therefore, it has a natural affinity to negotiate multi-valent and sensual worlds. The artist-as-non-representational ethnographer breaks from faith in exposure,

objectivity and the sense that the world is always already formed, interpreted and represented. Art seeks to push discourse in new directions, but unlike many other research outputs, art places significant faith in the action (the art encounter) rather than putting all faith in the revelation of hidden truths. Art practice, as Nicolas Bourriaud explains, "strives to achieve modest connections" by close encounters, "open up obstructed passageways" when other dominant modes of thinking "threaten to become the only possible thoroughfare from a point to another in the human world" (8). Interdisciplinary, art practice is both conducive to and enthused by cross-disciplinary collaboration. It is fundamentally experimental, actively seeking out surprises.

Art is ripe for continual, unstable and exchangeable representation through not only reprised narratives, which transpire in various physical contexts, but in the ongoing intellectual commitment to art that carves out a place of significance deep in the body and one's consciousness. This arrangement begs to be conceptually re-engaged via memory over one's lifetime. This activated memory function is one way I consider how art becomes a way of knowing, but not a thing known. It avoids the mimetic trap that some critical practice inhabits: the insistence on occupying both positions simultaneously. Contemporary approaches to art take the open-ended nature of experience seriously and join, in all their complexities, multiple points of view. These are some ways the art encounter becomes a committed political project that facilitates reparative relationships over a firm understanding of the world. It is a process amenable to the dissolution of shame-based dynamics. Art has potential to interrupt many of the forces that proliferate such discrediting undercurrents: in the swirling, continuous constellation of object-making that transpires between artist, world, artwork and viewer there emerges an

appreciative, empathetic "mutual pedagogy" as described by Jason Edwards, that has little if any hierarchy and much less shame (113).[77]

I believe autopathography in visual art practice today can more readily sidestep the epistemological traps of written accounts, but only because the art experience urgently preferences the action of the encounter; a routine that is not altogether missing from handling written stories, but is too often obscured by other, more familiar critical and scholarly modes that fast-track suspicion and facilitate the search for "real" knowledge by way of mistrusting and exposing, the pivotal critical reading strategies instilled in most of us through schooling of one form or another. This kind of engagement perpetuates existing dynamics in medicine. Sedgwick, as we have seen, offers something of a solution through reparative approaches to taking up the text, that we may appropriate. Still, she readily notes the significant challenges that are inevitable with text: specifically, changing the motivation for looking asks much from a reader. Even the most dutiful reader must swim upstream against overwhelming habits to encounter texts from a place of fluctuating and diverse relational stances. Recognizing that our faith in exposure is misplaced and quite different from effective action or performative effect is not an easy thing to do.

There is nothing overtly superior to artwork over written accounts (or at any rate, there is no claim of this sort that I am either gunning towards or even particularly inclined to argue). I lean toward the belief that it is probably merely a trick of human history that has landed us in a place that gives art practice and the art encounter a remarkable amount

[77] Edwards sees a mutual pedagogy as an alternative pedagogy in which learners are involved in "a long-term relationship" and therefore more inclined "to engage in a more open, concerned, empathetic, friendly and less punitive and judgmental, exchange of experiences and views" (114).

of critical flexibility over meaning-making and its mechanisms.[78] As I said at the onset to the chapter, it is the methodological approach at present, practised in the art encounter, that offers the political promise of renewal—an "ecology of knowing" that engages multiple bodies (the artist, artwork, viewer and world) and importantly, occurs at the intersection of "strong" and "weak" theory. And, it is also the low bar (the ease of engagement) that makes art practice an appealing tool for wringing out affectively saturated patient accounts and posing challenges for the traps of medicine.

Because of the positivist legacy and the culture of medicine, the ingrained habit of mistaking medicine's treatment of the body as a hard science, the third-person account of applied biology is often the uncritical manager of the sick experience, picturing the world and the body as a "known," determinate, tracible thing with corresponding and straightforwardly identifiable procedures. When the ontological features of knowledge are deactivated, it becomes representational, 1:1, a thing known. Because this problem is rooted in methods that are not self-consciously performative, I think it is urgent and valid and that we look to methodologies that offer fewer conceptual barriers to an oscillation between representational and non-representational theory as well as a fluctuation between "strong" and "weak" theory.

A vacillation between "strong" and "weak" theory is obligatory because an overarching, all-encompassing "strong theory" is anticipatory, good at exposing hidden

[78] Likely, a not so insignificant factor here is that we prefer to write our records of human knowledge more often then we picture it. And when we picture it, it is rarely without a written explanation. And, the stylistic and geographic division between an autobiography and a historical text in the hand lacks the formal and topographical deviation from, say, a comparison between an anatomical chart and an artist executing a performance art piece in a public square. When the way we encounter the work feels different because it is experienced differently, we undoubtably have somewhat of a leg up switching conceptual gears.

truths, but it is also negative, and ultimately, memetic and thus not always strongly operative for political revitalization. If we are really interested in committing to the humanistic qualities of medical practice and science, we must be attentive to how the world expresses itself in all its wiggling and uncertain ways. An oscillation between "strong" theory that is capable of accounting for a broad spectrum of phenomena that appears to be remote and thus has the appearance of stability alongside a corresponding, equally valued, energetic and responsive model must be called for.

"Weak theory" that describes "near" phenomena, that responds to the source, tempers "strong" theory's telescopic, progressively more totalizing growth by offering ways to know about close phenomena well enough to engage with it, but not well enough to pin down and solidify it. Injecting new methodologies that open up the possibility of political renewal without disavowing the incredibly constructive and life-saving qualities formed through the existing meaning structures of medicine is crucial. As well as trying to unpack the sick experience biologically, sociologically, economically, historically, etc., we can also put energy into borrowing modes that let us activate it, experience alongside it, and self-consciously recognize how we co-produce it. The art experience offers an effective and established way to make "weak theory" strongly operative in humanistic medicine by lending its motivations for looking, which seeks to be site-specific, cooperative, responsive, and to seek out surprises, even if they may be painful, complicating the habits of thought that seek to be both truth and a way to expose truth.

At the heart of my belief that the methodological approach of the art experience could lend something quite rare and valuable to medicine—and knowledge more generally—is the claim that this mode of approach finds a useful and functional middle

ground between representational and non-representational theory. This claim side-lines my work somewhat from many well-established contemporary thinkers in affect studies, including Bennett. These scholars advocate for the non-representational method hierarchy placed over the representational, or for many, in lieu of it. Thus, these researchers look to work that gives no advanced notice of what it will become as a replacement that solves the problems earlier outlined with representational thinking.

The division between the approaches may not be immediately apparent, but I will elaborate further to show significant and consequential differences that shape and inform the path forward I propose. For one thing, an oscillating approach does not close the door on the possibility of welcoming back the text-based or otherwise representational aspects of art, autobiography, and theory, which I believe are not only valuable but also necessary when our subject is the sick experience. The middle-ground approach is also a far less radical disavowal of the structures of thought our human-centred world is built around, and, therefore, seems to be a more realistic entry point if one seeks the change that I (and non-representational theorists) so desire. Furthering this point, a centrist approach allows for a conscious pivot vs "burn it down" mentality that can be alienating and dismissive of the inherited knowledge and value that medicine and its experienced workforce can offer the cause. Numerous actors already do great work to shift towards a more humanistic medicine, and this work ought to not be hastily dismissed for asking too many of the "wrong" questions in the "wrong" way.

An oscillating approach between representational and nonrepresentational processes also leaves space for recognizing the value of autopathography, written theory or stories while acknowledging the patterns of the reader or viewer, thus highlighting the

importance of our methods of approach in the outcomes we grow. The following chapter, *An Alternative Implication for Art and Affect*, articulates the nuances of this assertion much more clearly, qualifying the claim against dominant opinions in the field and exploring the potential of a middle-ground approach, while better defining the split between representational and non-representation work.

## Chapter 3: An Alternative Implication for Art and Affect

Affect studies is gaining popularity for its ability to pose a real challenge to "sticky" issues of social justice, which have been traditionally approached from their social and historical causes. Affect is best described as the force of intensity in the relation between human and nonhuman bodies; it is the visceral element in our ability to act and be acted upon (Seigworth and Gregg 1). Generally heavily nonrepresentational, affect research is often pitted against representational work: the traditional discursive and cognitive modes for making sense of, and writing about our world.

A push toward affect and away from critical theory is in line with a growing desire for action over a preoccupation with thinking theory — an epistemological shift for several disciplines, to be sure, but perhaps not a total shift, broadly speaking. The "novel" impulse toward affect can undoubtedly be seen in the scholarly interest across disciplines in corporeality, feeling, emotions, and in the current prominence of aesthetics. Marguerite La Caze and Henry Martin Lloyd reinforce this widespread influence, noting that "proponents of the "turn" to affect locate it at the nexus of several intellectual vectors" but, La Caze and Lloyd are quick to recognize that "interest in affects themselves has been relatively constant throughout the history of philosophy," suggesting that the "turn" to affect may be more of a renewed spotlight rather than a total pivot (2).

In line with La Caze and Lloyd's assessment, I reach back to pre-Cartesian traditions in philosophy and many later points of orientation in order to carve out particular claims that will distinguish how I understand affect to function. Finding a way

into art and affect by way of a road less travelled allows me to entangle many of the theoretical problems from the second thread of my twofold thesis: in joining pressing questions about autopathography, representation, the sick identity and the ethical dimensions of affect for medical knowledge I ask, what does a biologically and evolutionary rooted affect theory do differently?

Predominantly, the thinking organized around art and its affective resonances is grounded in the experience of the art object. I will certainly spend some time here myself, considering the relationship between content and feeling (a contrast between what the work "says" and how it touches us, viscerally), with history, happening, and potential (a more nuanced and accurate word triad to take on interests we might think of as "past, present and future-oriented"). Protracting out, for a moment, from the tight focus on the work itself, I do not want to forget to attend to the spaces bordering the work. What of the aesthetic and special considerations of the room, gallery or the context in which otherwise we experience the work? Do these spaces that "house" the affective encounter require similar theorizing? Art historian, critic and curator, Jennifer Fisher, takes up this point of consideration in the study of art and affect. Fisher writes on the impact of the ambiance of an exhibition, turning to affect to articulate the "mood states" of the space in which the art experience plays out. Fisher sees affect as a present and worthy question that is seldom factored into the theoretical or practical concerns of the discipline of curatorial studies—to its detriment. She writes,

> What is called for is a way of theorizing curatorial practice that discerns that which can be found before, beside and outside signification. Beyond the meanings that they engender, exhibitions stage art as an ontological event. Beholders enter into a threshold of sensibility that actualizes both vision and that which exceeds vision: those experiential zones of the mysterious, the auratic and ritualistic. (27)

Fisher calls for a post-medium curatorial paradigm[79] that immerses both the subject and the energies of affect (32). She understands the importance of convivial sociality in the art event in its ability to open "cognition beyond signification" and "make invisible elements explicit" (28). Whether they are conscious of it or not, Fisher argues, the curator plays a key role in configuring the affective press of an exhibition. I think that what Fisher is really bringing to the foreground here is that movement (through practice and action) are significant epistemological elements of experience. The viewer is not a passive receiver of experience through sight sense; rather, they participate actively in and with the environment, acting and moving in the space as the space acts and moves against or with them. This activated, dynamic of coproduction with a focus on the action-environment will become paramount in the final stage of my argumentative movements as I direct the use-value of the art experience towards the structural myths of medicine where the methodological vitality of the art experience could agitate and collapse the tower of stable appearing ideology.

For Fisher, the curator acts as a sort of instigator for this experience, sculpting the mood-scape and inducing directional flow in the space. Importantly, this intervention

[79] Fisher contrasts a post-medium paradigm with a post-modern critical one, which "positions the subject in relation to an object and operate[s] on the register of signification (32).

should not be viewed as a definitive map of the way the art experience is designed in a conclusive sense, for that would much defeat the point of the endeavour; instead, it is a push; a driving impetus with affective inflection meant to spark the exhibition space with an energetic charge using elements like sensation stimuli, spatial orientation and temporal rhythm angled in a particular direction.

While it is true, as Simon O'Sullivan says, "You cannot read affects, you can only experience them" (126), I do spend so much time dwelling on and justifying the "aboutness" of art because I am deeply invested in the political potential of the image beyond the dual functions I outlined in Chapter One. Put another way, with a Sedgwickian tonality, that sentence may be changed to: you cannot read affects, but you can read affectively. I think that there is a compelling argument to be made in this section about how discursive functions may be positioned in a compatible embrace with affect. It is paramount to be able to theorize the relational aesthetics of an experience with autopathographical art—with something of a trace of the patient understanding, from individually felt emotions to their translation into narrative experience, and to the performative action—if we want to elevate and empower those who are frequently ignored by the systems of medicine.

Looking at work that offers some reflexivity, bending back on the rigorous exclusiveness of medicine's body-object, and most importantly: speaking something alongside feeling provides us with a distinct patient voice. To deny the voice of the subaltern patient for fear of totalizing or fixing their narrative carries a certain sad irony when the efforts they make to verbalize or personalize a narrative is inherently a confrontation of a system that frequently excludes them. I fervently contend that there is

much more methodological vitality and movement in the art experience than affect theory ordinarily imagines.

I will briefly outline a range of approaches in affect theory in *A genealogy of affect: key modes and methods of affect theory* to highlight the methodological possibilities and limitations, as I see them, between the more common approach, which I call "Spinoza-Massumi" and an alternative route which I call "Tomkins-Sedgwick." The goal in embarking on this exercise is to find an efficient and logically consistent channel in the challenge of legitimizing autobiographical narratives for the "affective turn" in the humanities and social sciences. And equally, to find methodological vitality that can speak some of the languages of the natural sciences, facilitating an emphasis on bodily or embodied experience. To be able to do both of these things realistically is to be empowered to challenge predominant views in affect studies around the "work" of art, and stake a claim that autopathography is productive, activated, and meaningful for medical science, and this becomes the focus of the next section.

In *Autobiography unfettered: affect theory and autobiographical openings* I trouble the divide between form and content in art theory, fully articulate the nuances of a sick identity through its liberating and constraining expressions and introduce an argument for a "soft" subjectivity that, among other things, is related to the limits of human perception and everyday life. Through the work of this section, I present a case for the affective value of autopathography that does not diminish its discursive properties. In *Affect, autopathography and art: the relational encounter of the art experience* I evaluate the desire to instinctively map the critique of critical and scientific thought and methods onto the methodological processes of the art experience, thinking through the

motivations for spiting “aboutness” and event. Lastly, *Empathy and situated knowledge: the active ethics of affect* will take up the problematic belief that affect and ethical outcomes are natural bedfellows, troubling the ethical promise of affective medicine, and pressing scholars who engage in humanistic, affectively grounded medicine to be vigilant.

*3.1 A genealogy of affect: key modes and methods of affect theory*

Representational research lends itself well to disciplinarity, while nonrepresentational work is transdisciplinary—it deals in multi-sensual exchanges that cut across intellectual frameworks. Affect's movement gives it the potential for "politico-epistemic renewal" (Thrift 3). Affective resonances in the art experience have long been a vital concern for the contemporary artist and those who actively engage with work, as these resonances are grounded so much in the feeling, sensory and corporeal experience of embodied life which compel us to make and look at art.

Frequently, work done within affect studies claims that it is the modes employed by representational work that give problems like oppression a feeling of inevitability. However, the idea that our modes and understandings shape our world is not a lens affect studies need only to direct outwards. There are multiple approaches within affect studies that hold disparate understandings of what affect is and how one might best move along its causes and effects. Three particular points of contention can be found in how the human is understood, what role emotions are thought to play and what directional flow affect moves along (or, perhaps better put: where does it reside?). How these three problems are resolved bracket what methodologies make the most sense for scholars thinking through affect. Because affect is operationalized by scholars who are interested in finding a way through oppressive social realities, the tools made available by their approach becomes a vital concern. And so, it seems crucial that my interest in the possibilities and limits afforded by methodology, while arguing for affectively rich practices, must extend into affect theory as well.

To be clear, I am not suggesting that how affect is understood changes the "work" affect does,[80] just that, how affect is conceptualized often determines the direction we aim to best look for and receive it. To show this effect plainly, I will briefly sketch out the two dominant approaches in affect studies, tracing a genealogical line across ideas and influential figures to come to a better understanding of what tensions and possibilities present themselves in how affect is mobilized in research. How affect is understood and mobilized has a direct bearing on the power and influence afforded to affectively rich autopathographical accounts that are challenging how the medicalized body is pictured and experienced. Finding a way to integrate autopathography affectively and effectively is especially central to me, as it seems like the most significant conversations around art and its affective resonances have been concerned with a particular convergence of vector points in affect theory that inflexibly rejects any concept of identity. Such a rejection, of course, would make personal accounts of sickness a non-compliant and wayward subject for an affect theorist operating within the dominant paradigm. So, we must jump a branch or two over to explore more than one line in the family tree to survey the conceptual inheritance of each offshoot.

The first branch, which we can call Spinoza-Massumi,[81] will be taken up through the 17th-century Portuguese philosopher Baruch Spinoza and contemporary Canadian philosopher and social theorist Brian Massumi. The second branch—Tomkins-

[80] Affect is outside and within ideas we might have about it, unlike the image of the medicalized body, for example, which, I argue, often conducts its "work" based on how it is understood. (see: the dual function of the image, first discussed in the introduction to Chapter One, *Medicine, the Image and the Problem with Both*).

[81] I provide a much-abridged summary in this section. It should still be noted here that other important scholars who make great contributions in this particular dialogue alongside the mentioned Massumi, Spinoza and Deleuze, include: Erin Manning, Sarah Ahmed, Henri Bergson, William E. Connolly, Félix Guattari, William James, Eric Shouse, Nigel Thrift, Alfred North Whitehead among others.

Sedgwick[82]—will be approached via 20th-century psychologist and personality theorist Silvan Tomkins and through a brief return to the work of Eve Kosofsky Sedgwick. For a more concrete application of both methods, I will then turn my attention to a central idea from contemporary feminist social epistemology by way of Sandra Harding, and her work, *Whose Science? Whose Knowledge? Thinking from Women's Lives*.

I am choosing to bring in feminist social epistemology as a case study because it generally takes identity to be socially and historically constructed, tends to be opposed to ideas of the "natural" and is a committed political project for uncovering and breaking out of oppressive social realities. It is, in short, a descriptive and normative example that is at once a gesture to a representational counterpoint for non-representational thinking, and (more importantly) a focus upon which I might direct my two branches of affect studies for methodological comparison. Each branch holds particular epistemic commitments that are further clarified as new voices and ideas are added.

The Spinoza-Massumi branch begins with the 17th-century Portuguese-Dutch rationalist philosopher, Baruch Spinoza. His key work, *Ethics*, introduces a philosophic system based on the idea of substance monism, where everything flows necessarily from nature as a mode or attribute of nature. Nature, or in 17th-century terms, God,[83] comes into being through a circular logic: all things that exist are some mode or attribute of a monistic system, together, forming the whole. Spinoza writes, "By substance, I

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[82] Again, there are other key contributors I do not have room to fully mention here, including: Antonio Damasio, Paul Ekman, Adam Frank, and Daniel Lord Smail.

[83] Spinoza used the term God, likely because to do otherwise would be quite dangerous during his time. Spinoza viewed most organized religion as dangerous. He believed it wrong to anthropomorphize God – which is why "nature" is a comfortable substitution to make in his writing. To Spinoza, if God could be said to exist, it would be in his radical materialism—in the sum total of the natural and physical laws of the universe—not the traditional paternal figurehead. For further reading see: Israel, Jonathan I. *Radical Enlightenment Philosophy and the Making of Modernity 1650 - 1750*. Oxford Univ. Press, 2002.

understand what is in itself and is conceived through itself" ("A Spinoza" 88). This organization is quite different from Descartes' dualism, which would come to dominate modern Western philosophy, and Spinoza positions his idea as a counter-argument for dualism. He argues that "mind" and "body" are only different ways of interpreting the natural element.

One by-product of a neutral substance monism is that thought and extension become attributes of an active system. Any illusion we have of free will, Spinoza claims, is just a misrecognition of our place within the system. We can free ourselves from this illusion, we are told, through habits of introspection and action where the power to act comes with the power to understand. Affect, for Spinoza, is the state of a body being affected by another body or thing. Affects increase or lower our potential to act, and Spinoza charts affects by type: joy, sadness and desire. Joy increases our potential, sadness lowers it, and desire fills us with a striving for perseverance. Concerning the ethical implications of the system Spinoza conceives, he determines that we cannot find ethics or reason in desire, for we desire things that are both good and bad for us. By leaning into positive affects and away from negative ones, we increase our power to act, understand our place in the whole, and develop adequate ideas which allow us to see our passions for what they are, overcome them, and free ourselves from the illusion that we are free actors who are in control. Spinoza distinguishes between self-interest and subjective choices:

> We do not have an absolute power to adapt things outside us to our use. Nevertheless, we shall bear calmly those things that happen to us contrary to what

> the principle of our advantage demands, if we are conscious that we have done our duty, that the power we have could not have extended itself to the point where we could have avoided those things, and that we are a part of the whole of nature, whose order we follow. If we understand this clearly and distinctly, that part of us which is defined by understanding, i.e., the better part of us, will be entirely satisfied with this, and will strive to persevere in that satisfaction. For insofar as we understand, we can want nothing except what is necessary, nor absolutely be satisfied with anything except what is true. ("A Spinoza" 244)

Spinoza shows us that by moving towards self-interested (though not subjective) choices, we move towards an ethics that is good for everyone because we come to understand that we are all innately connected. In Spinoza's monistic system, the idea of the self-contained subject is obliterated. There is no divine plan for us, but there is a determinism whereby things occur necessarily. The conclusion that a will must be acting upon us comes from our desire to know. When we are no longer able to determine the cause of a thing, we are prone to inventing a will, and we must be cautious of this. The notion, "where there is a will, there is a way" is an illusion. Where there is knowledge, there might be a way. Knowledge is what allows us to make the most out of causality. Knowledge is a journey to free ourselves from the illusions that limit us. Our bodies come with a built-in compass to find happiness, once we are able to determine what brings joyfulness, happiness is just a matter of making sure that we only encounter joyful things (positive affects) in our life. Happiness pushes us to exist.

The Spinoza-Massumi branch is not without other influencers, but nevertheless, a clear line can be drawn from Spinoza's ontology to contemporary Canadian philosopher

Brian Massumi, with the most important middle figure being Gilles Deleuze.[84] Deleuze modified Spinoza's affect by noting that Spinoza's reason was just a misrecognition of the effect affect has on the body. He, therefore, cleaved a strong divide between ideas and emotions, and affect in its pure form. In *Parables for the Virtual: Movement, Affect, Sensation*, Massumi writes on this split, contending that we must,

> Reserve the term "emotion" for the personalized content, and affect for the continuation. Emotion is contextual. Affect is situational: eventfully ingressive to context. Serially so: affect is trans-situational. As processional as it is precessional, affect inhabits the passage. It is pre- and post-contextual, pre- and post-personal, an excess of continuity invested only in the ongoing: its own. Self-continuity across the gaps. Impersonal affect is the connecting thread of experience. It is the invisible glue that holds the world together. In event. The

[84] Deleuze was a continental, post-structuralist philosopher interested in aesthetics, the history of Western philosophy, metaphilosophy, and metaphysics. He is well known for his inversion of the traditional metaphysical relationship between identity and difference (see: Deleuze, Gilles. *Difference and Repetition*. Bloomsbury, 2014). Here, Deleuze is interested in a metaphysics suitable for math and science in which substance is exchanged for multiplicity, essence with event, and possibility for virtuality. In launching a critique on the dogmatic nature of thought, Deleuze highlights the importance of sense, event and difference. His version of the world is a threefold schema of the virtual, the intensive and the extensive. Ideas are virtual, and virtual things are just as real as things in the physical world. Ideas exist as bundles of multiplicities of differential relations that are structured and actualized through the various spaciotemporal dynamisms of the physical world (the extensive world). The extensive world is a world of extensions. It is the world as it appears to us, it is the world of actualized forms. An Idea becomes actualized in the extensive world through the realm of intensivity (intention). Intensivity differs from extensivity by virtue of the fact that things in the realm of the extensive can be divided. You can take a body of water and divide it in half and get two different volumes of water. But, if the temperature of the body of water was 90 degrees, when separated it does not divide in two. Therefore, this is a part of the intensive realm (that which cannot be divided without changing the nature of the system). Examples of aspects of the intensive realm include temperature, differences in speed, rate of change, flow, etc. that make the physical world possible. Deleuze builds a philosophical equivalent to science's morphogenetic fields: in biology, a group of cells able to respond to discrete, localized biochemical signals by changing, forming new structures or organs are called a morphogenetic field. What we call the laws of nature are, in actual fact, simply habits of nature that appear to be stable laws the longer they persist. For Deleuze, identity functions much the same way. There can be no universal, essence or same, making Deleuze's understanding of difference not an epiphenomenon of sameness, but rather an ontology of difference.

> world-glue of event of an autonomy of event-connection continuing across its own serialized capture in context. (217)

Cognitions and emotions are the closure of affect in its purest form. Another critical intervention we can attribute to Deleuze is his transformation of Spinoza's subtractive monism[85] to a monism = pluralism, with affect-as-force of becoming at its centre, usurping Spinoza's "nature" from the core and ensuring a processual open system that can be infinitely rich, complex and expansive. Massumi develops these ideas further in his own work. He is less interested in categorical affects[86] than in the broader vitality of affect in the relations between bodies that form connecting memory, unfolding along ongoing events. Massumi identifies affect in the virtual and affect in the actual as "a two-sided coin" (35). On one side of this parallel, sits the virtual: affect in its pure autonomous, relational potential. The other side hosts affect in the actual: the infinite potentials of affect actualized in real events and processes. Still, though these two sides look different, the actualizations are not severed from their ability to dip back into infinite potentiality, that is, affect in the virtual. Thus, they are not divided, but two attributes of the same process, simultaneously participating:

> Emergence, once again, is a two-sided coin: one side in the virtual (the autonomy of relation), the other in the actual (functional limitation). What is being termed affect in this essay is precisely this two-sidedness, the simultaneous participation

[85] Where all modes and attributes are derivative.
[86] Categorical affects arise from the idea—which has various and contested expressions—that foundational affects can be identified and compartmentalized. Fear, disgust, and puzzlement are examples of affects that have been catalogued by scholars from Darwin to Tomkins.

> of the virtual in the actual and the actual in the virtual, as one arises from and returns to the other. Affect is this two-sidedness as seen from the side of the actual thing, as couched in its perceptions and cognitions. Affect is the virtual as point of view, provided the visual metaphor is used guardedly. For affect is synesthetic, implying a participation of the senses in each other: the measure of living thing's potential interactions is its ability to transform the effects of one sensory mode into those of another… Affects are virtual synesthetic perspectives anchored in (functionally limited by) the actually existing, particular things that embody them. (35)

The autonomous quality of affect is found in its ability to escape "confinement in the particular body whose vitality, or potential for interaction, it is." Cognitions are the capture and closure of affect and emotions are the most contracted expression of capture, bursting with a surplus of escaping, unactualized affect. Massumi writes, "Actually existing, structured things live in and through that which escapes them. Their autonomy is the autonomy of affect" (35). So, affect is also the autonomy of things – that which gives them autonomy.[87] Massumi seeks empirical evidence to support the double sidedness of affect in scientific studies that points to "the mystery of the missing half-second."[88] To align his argument, Massumi needs to make a case for affect prior to things like assumptions, perceptions, cognitions and emotions.

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[87] The "autonomy" of affect is not intended to suggest that affect is an independent thinker or actor, rather a nod to the idea that affect is the world in emergence and motion.

[88] Massumi writes of experiments performed on subjects with cortical electrodes—scalp electrodes that stimulate peripheral nerves and measuring the response to that stimulation—implanted for medical purposes. When mild electrical pulses were applied to both the electrode and contact points on the skin, the stimulation only registered if it persisted longer than a half second. He cites Benjamin Libet's "Unconscious Cerebral Initiative and the Role of Conscious Will in Voluntary Action." From *Behavioral and Brain Sciences*, vol. 8, no. 4, 1985, pp. 529–566 in reference.

The experiments Massumi incorporates, he says, show a half-second delay between a body being exposed to a stimulus and reacting. Massumi understands this delay to demonstrate the moment where affect in the virtual (pure, autonomous affect, full of potential) strikes the body, overwhelming it, before being wrung out and reduced into affect in the actual (thoughts, ideas, responses and even perceptions).[89] For Massumi, it is affect's ability to overwhelm thought and emotion that gives it its political potential. What matters most, he says, is increasing the power to act, and therefore, he advocates that we repel away from restrictive frameworks (including discursive and representational ones) that seek to distill the potentiality of affect further, and towards encounters that attend to affect's situational, processual nature. For all its complexity, Massumi's affect theory rather modestly supports actions that promote a politics of becoming, to great political potential.

As a point of contrast, an affect theory rooted in the biological, as writes Anna Gibbs, "seems unhappily at odds" with the kind of epistemological and ontological rhizomatic expansions affect affords given historical affinities between the biological and "its erstwhile connotations of political fixity, for example of gender" (335). Yet, I think there is a compelling argument that links affect to a biological, innate function that is not so much an accusation or confirmation of affect's fixity, so much as it denotes a path for the unburdening of our cultural understanding of biology from the trap of inertia. This is an argument that has been touched on in one shape or another by both Gibbs and also

[89] Massumi notes "if the cortical electrode was fired half a second before the skin was stimulated, patients reported feeling the skin pulse first. The researcher speculated that sensation involves a "backward referral in time"—in other words, that sensation is organized recursively before being linearized, before it is redirected outwardly to take its part in a conscious chain of actions and reactions" (28-29) Thus, the body is a receiver of impulses quicker than it is a tool of perception.

quite well by Elizabeth A. Wilson in *Neural Geographies: Feminism and the Microstructure of Cognition*. Gibbs points to and bemoans,

> …The apparent perversity of the wholesale rejection of the biological in the face of the recent (especially feminist) concern with the body in Cultural Studies. In the event, it seems that the body has been conceived in this field largely as a body of words, the sum of discourses about it. Perhaps this is not altogether surprising when one considers the prevalence of textual models (and the role of English Departments) in the development of Cultural Studies generally. Moreover, the long dominance, especially in mainstream psychology, of cognitivism and behaviourism, and the concomitant empiricism and even scientism of so much work in this field, as well as the dominance of linguistic models in places, such as psychoanalytic thought, that might have provided a challenge to this, has meant that there has been little inducement for feminist Cultural Studies to reconsider either questions of nature and human nature or the question of whether "essentialism" was too simple a concept in the first place, especially given the complexity of relations between nature and culture as they are now thought, at least, in some disciplines outside the Humanities." (336)

Feeling the "complexity of relations between nature and culture" is the key to understanding the biological link between an organism, like a human, and its environment, where a body may be stifled at times by either itself or its environment, but nonetheless, never wholly determined.[90] The branch of biologically rooted affect theory (The Tomkins-Sedgwick branch) begins with 20th-century psychologist Silvan Tomkins. Tomkins wrote *Affect Imagery Consciousness* (1962) to explain human behaviour and

[90] Returning us to Spinoza's legendary gem: "No one yet has determined what the body can do" (155)

motivation through an affect system where biological responses to stimuli carry meaning through increases or drops in neural firing.

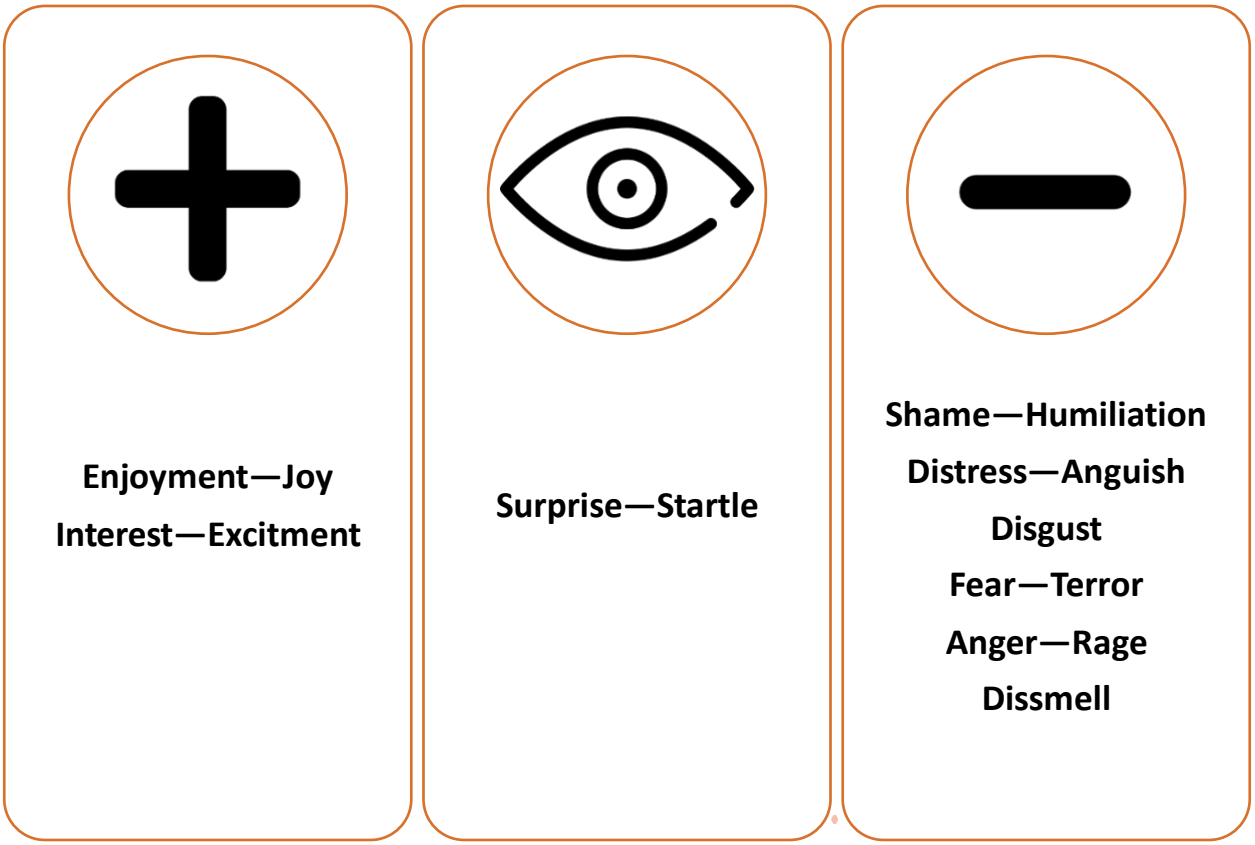
Tomkins theorized that the affect system evolved alongside increasingly complex organisms that move through space as a way to respond to and act in their environments.[91] Like the Spinoza-Massumi branch, in Tomkins' conceptualization, there can be no conscious thought without affect, nor can there anything be sought or avoided. Where the conceptualization differs is that here, affect is internally generated, not externally (in the spaces and things exterior to the body). Affect is thus an interior, biological motivator that confers urgency for any and all action, directing our attention to good or bad things. The affect system, therefore, supports the organism in three vital ways:

1. Survival
2. Affinity with community and,
3. Discovery of the new through,
    a) maximizing positive affects
    b) minimizing negative affects and,

[91] The more complex the organism, the more complex the meaning system may appear, but, Tomkins' system does not seem to boundary this capacity for strictly sentient (used in the somewhat limited sense of possessing neurological substrates) or ambulatory organisms, or design any kind of preferential treatment. A plant, for example, has tiny pores called stomata that are mechanisms allowing the plant to reduce water loss. Environmental cues (light, water, temperature, gas concentrations) affect stomata opening and closing. Furthermore, the organism moves in space in the sense that it has directional growth in response to its environment (reaching toward light at the surface, and towards water, below). An apple tree, then, has a number of possible biological responses to stimuli and an affect system that causes it to move through space, respond and act in its environment. The question of complexity, for Tomkins, its measured in degrees of freedom and offers a distinct take on determinism. He writes, "By complexity we mean, after [the scientist Josiah Willard] Gibbs, the number of independently variable states of a system." This scale leads to "the acceptance of both the causality principal and what may be described as the information, complexity, or degrees-of-freedom principal" where "two systems may be equally determined [by bodies, or environments], but one be more free than the other (62).

c) minimizing affect inhibition.

Tomkins' work privileges the human, but only by virtue of its relative complexity and availability for study, not by any inherent superiority. Through his work with infants, Tomkins came up with a non-exhaustive list of nine innate affects. He grouped these into categories of positive, neutral and negative (Figure 3-1).




**Ftable Figure 3-1** A chart of Tomkins' Positive, neutral and negative affects. Positive affects are inherently rewarding. Enjoyment—Joy often comes in the wake of a decrease in stimulus, be it pain, hunger or otherwise. Like all affect, it provokes a mirrored response, and contagious joy contributes to a mutual reward system that encourages humans to be more social and helpful. Interest—Excitement, the "track, look, listen" affect, makes learning rewarding by fuelling thinking with emotion. Tomkins writes, "The

> interrelationships between the affect of interest and the functions of thought and memory are so extensive that the absence of the affective support of interest would jeopardize intellectual development no less than the destruction of brain tissue. To think, as to engage in any other human activity, one must care, one must be excited, must be continually rewarded" (343). The Neutral affect combo of Surprise—Startle is purposeful towards total reset. In its mild form it stops you from what you are doing to get you to pay attention to something novel. The more extreme form, startle, causes a "massive contraction of the body" triggered by a sudden, brief stimulus. Negative affects are inherently punishing. Shame—Humiliation, "the self-protection signal," the affect of focus in Sedgwick's "paranoid imperative," comes from the interruption of joy. The intrusion causes us to focus intently on the cause, to ensure that the feeling can be avoided. Distress—Anguish, "the cry for help," is deeply social. It is a signal fire to others that something is wrong, and assistance is needed. Disgust is the affect that presses us to expel literally and figuratively: noxious food, sounds, sights and thoughts trigger similar responses. Fear—Terror is the fight or flight trigger. Anger—Rage is caused by overload from persistent high-density neural firing. Dissmell [sic], "the avoidance signal," is the trigger to push or pull away from things that shouldn't be ingested or things that trigger repulsion. Dissmell, combined with anger, looks something like contempt. The facial response to sour milk and a person that triggers contempt may be indistinguishable. It is worth emphasizing that categorical affects are combinable, have subtle and more extreme expressions, are contagious (motivate a mirroring effect) and, interestingly, can motivate themselves: fear causes hair to stand on end, which triggers more neural firing, which amplifies fear.

Positive affects push the organism toward forming social bonds and problem-solving. Negative affects repel the organism from danger, and neutral affects surprise and startle, resetting attention. Affects carry a signature of meaning that further develops into deeper emotions and ideas, combining with memory to form what Tomkins calls "scripts." Scripts, ideally, make us better at life. Survival is undoubtedly linked intimately with the ability to analyze new situations successfully and recall findings for future problem-solving. Scripts are organized traces of stimulus-affect-response sequences, what Tomkins calls, "scenes." Scripts can also be understood loosely as personality because they are made cohesive through the assigning of themes, narratives and purpose. Because Tomkins' script theory is also a theory of personality, a convergence of interpretation, evaluation, prediction, production and control, we are thus able to augment

how people are socialized to handle their affective lives to better or worsen a dominant script in any series of scripts. Tomkins' feedback system means that human movements cannot be seen in isolation but as a part of a bio-psycho-social ecology.

Like the Spinoza-Massumi branch, the Tomkins-Sedgwick limb is not without meaningful intersections (I do not aim to oversimplify carelessly). But, I will just focus on a foundational connection that is visible between Tomkins and 20th-century literary critic Eve Kosofsky Sedgwick, whose influence in my work has already been stressed. Sedgwick wrote *Paranoid Reading and Reparative Reading* after becoming frustrated by critical theory's interpretive inferences, as well as feminism's dogged anti biologicalism, accusing both of engaging with a hermeneutics of suspicion. Like Massumi, Sedgwick advocated for situational, affective approaches instead of overarching social prescriptions dictating what must happen next. Unlike Massumi—who is decidedly a proponent of nonrepresentational work—Sedgwick, of course, understands situational, affective approaches to be possible within and outside of discursive work.

Sedgwick finds room for discursive-affective practice by connecting a hermeneutics of suspicion with Tomkins' negative affects and affect inhibition. In doing so, she is able to show that important work can be done and found in paranoid knowing if we reengage it as the affective mode that it is, and locate it among other potential approaches. She, therefore, invigorates representational work by its affective potential and activates the text through oscillating critical practices. Into this equation, she brings the compatible work of early 20th-century psychoanalyst Melanie Klein's object relations theory, which identifies the psyche to form with others and the environment, with particular attention to bio-mental forces, reparative acts and positioning (as opposed to

Freud's stages of progress or regress). From this inclusion, she forms a critical reparative approach that is ambivalent, reparative[92] and inconclusive to demonstrate one alternative possibility.

Stepping away from affect and our tree metaphors for a moment, I want to enter into this conversation a thinker from feminist social epistemology. The voice in this transitory case study comes from Sandra Harding, and her work, *Whose Science? Whose Knowledge? Thinking from Women's Lives*, which utilizes feminist standpoint theory—the idea that all knowledge is situational—and the Marxist belief that some social standpoints, specifically marginal ones, hold epistemic superiority by virtue of their outside-in status that brings a more objective understanding of power dynamics. This epistemological theory is an especially interesting notion for my research, as I am interested in the exclusionary history engendered by the "strong" theory of medicine's body-object.

Expressing dissatisfaction with the fast-fading hard objectivism and popular social relativism as the two dominant socio-scientific modes for uncovering truths, Harding argues that hard objectivity is a myth, and social relativism is useless because it cannot provide an "adequate" why to answer any question. She feels that a strong objectivity can be injected into research through feminist social epistemology by recognizing that some social positions bring increased objectivity, so by grounding research in women's lives, we can come to more objective truths. Harding supposes that this form of strong objectivity would invigorate research across all disciplines as it

[92] Though, not inherently conservative.

understands both researchers and those who are studied to be "gazing back" at their own cultural particularity, and thus bridging both hard objectivism and cultural relativism by also interrogating which groups can make the most objective knowledge claims.

To summarize, the Spinoza-Massumi approach offers a materialist, anti-Humanist and ontological understanding of affect that marks a sharp divide between affect in its autonomous state and ideas and emotions. The outside-in directionality of affect means that it resides in the spaces between human and nonhuman objects and events. The Tomkins-Sedgwick approach takes a biological, evolutionary and social understanding of affect that has an inside-out directionality. Because affects carry a signature of meaning, they cannot be fully separated from emotions or ideas in this inside-out directionality. Both approaches recognize that the body is not affectively contained; there is significant slippage between the individual and other, challenging autonomous Westernized subjectivity as is it broadly understood.[93] Harding presents a descriptive account for injustice and oppression that attempts to both uncover causes and present social prescriptions for combating them.

Angling both branches of our affect theory tree toward Harding for comparison quickly brings us to a common issue: Harding presents fixed categories of oppressed groups about which both Spinoza-Massumi and Tomkins-Sedgwick thinking would be apprehensive. Particularly egregious, perhaps, is the prevailing desire to group "women"

[93] In Western subjectivity, broadly categorized, the Neoliberal subject is entrepreneurial, by dint of his competitive ethos, self-contained by the boundary of his skin. He is free, and values freedom above all else. Self-determining wisdom and skilfulness drive the Neoliberal toward more freedom through his ability to make the right choices that result in economic reward. Total agency, self-reliance, self-responsibility, privatisation, future-orientation and a pre-written view of the future are all rejected by any approach that understands the body to be porous in its thoughts, feelings and actions.

as a single set, even as we are understood to take up more than half the population and be cut through with innumerable points of intersectionality. Still, Harding makes a gesture towards more participation and inclusion in her work that, generally speaking, both approaches would support.

The Spinoza-Massumi branch fosters a particular approach we can apply to Harding by way of how the human-emotion-direction problem is taken up. This methodological framework brings with it an ideological backdrop that teaches us to be highly skeptical and dismissive of individuated accounts of social relations and to flag and repel away from the prescriptive models in Harding's theory where emotions and ideas seek their own continuance. Any effort made to carve out a clear vision of identity, either centred on the single body or discrete groups, is antithetical to the anti-Humanist perspective. In the end, the Spinoza-Massumi approach understands that there is more possibility to be found in action and experience than in further clarifying the subject to be written by society and history or in uncovering a linear causality that projects the past into the present and forward, into the future.

The anti-Humanist Spinoza-Massumi branch is decidedly anti-biographical, where the Tomkins-Sedgwick approach sees a fundamental role for care for the other and what I might modestly and cautiously label "the personal" by nature of how the affect system supports the organism. I will crack this claim open more, shortly. Emotions and ideas become predominantly additive, not subtractive. In the Spinoza-Massumi approach, ideas and emotions are the reduced, wrung out remnants of affect in the actual, processed in the body. Ideas and emotions, therefore, are reduced images of affect that can become more and more disconnected from immanent experience when we turn away from

experience to follow trails of our own intellectual and emotional making. The danger of this trail is still present and acknowledged in the Tomkins-Sedgwick approach. However, Sedgwick argues that we are not doomed to narrative consequences if we affectively engage with texts, emotions and ideas, never losing sight of feeling.

By conceptualizing emotions and ideas as additive, coupled with the inside-out directional flow of affect, we are able to approach discursive work with an open, oscillating critical practice. The result of this is that we can set aside any discrediting moments in Harding's work where we might otherwise be tempted to throw accusations of closure and oversight, and look to the text for unanticipated moments. This approach opens up the possibility of asking questions like: "What might be discovered by leaning into feelings of interest and affinity within Harding's dynamic?" and "What relational affinities are still available in Harding's "positions" that we might otherwise have missed if we dismissed the work as being too "fraught with ought" or "too restricting?" Additionally, and I think most importantly, "How can we activate Harding's socially positioned identities while still absorbing something powerful and important from the epistemologically precious experiential knowledges that those positioned thusly have to offer?" In this last question, I think one can do both. Indeed, I believe it is crucial that one does do both.

By genealogically tracing ideas and significant figures along the two dominant branches of affect studies, a clearer picture is provided regarding what tools each branch best supports. The Spinoza-Massumi approach is invested in the vitality of affect in nonrepresentational work. The Tomkins-Sedgwick approach is interested in maximizing affect in discursive work and actions. To dismiss a work as too autobiographical or too

prescriptive is to inhibit affect. For Tomkins, inhibiting affect is hostile to thriving. Furthermore, snubbing heavily discursive research or paranoid critical practices cause us to miss out on important work that can be found in the cracks between tautological thinking.

In a section already saturated in metaphor, I fear you might be reluctant to read another. Still, it would seem to me that where Sedgwick would rearrange the neatly stacked papers on my desk to see what unexpected surprises we might find, Massumi would instead flip the whole desk over. And, while there are those who would argue that upturning everything is the only way out of the "sticky" mess our emotions and ideas have made of theory, I am inclined to believe that there are fewer possibilities, not more, in nervously fleeing from representational, descriptive or "strong" work out of fear of the traps it may hold.

It is not my intention, with this all-too-brief analysis and case study, to only further the divide between these two approaches in affect theory for the sake of splitting hairs. After all, there is undoubtedly more commonality here than difference. Still, I maintain that it is quite a useful task to draw out what tensions present themselves between these two modes and to maintain an inventory of movements—if for no other reason than to be better equipped for finding thresholds of further possibility. Of course, there are different approaches to affect studies to be considered beyond these two, lest I paint affect theory as its own internal, perpetual system of dualism, and it is this rich variability that maintains the politico-epistemic possibility of affect studies as a productive contributor to the epistemological fabric of human understanding.

*3.2 Autobiography unfettered: affect theory and autobiographical openings*

Affect theory is, in many ways, a response to and move away from the linguistic turn of the 20th-century, which sought to centre language as the way we understand the world. It is easy to think of an autopathography as a language tool for grasping, accepting or, at the very least, documenting a personal history with illness and its effects on the subject across any number of frameworks: familial, social, political, physical, financial, or otherwise. It is also, as I said earlier, easy to locate many argumentative moves in affect theory that would find incompatibility with affect and autopathography, understanding biography to belong to the realm of the linguistic turn, to be too limiting, to be impossible.

Many autopathographies are transparently language-based, as is the case with written works. Some acquire visual configurations, such as the artwork that takes autopathography as their subject. The visual, aural, textural and spatial modes of art practice can allow sickness narratives to slip into fields that might better communicate some of the things that the medium of the written word may limit. However, there is an "aboutness" to works of art that still envelops them in the coverings of language through discourse. The "aboutness" of a work may seek to bring into focus something relating to human nature or social institutions. And, this presumption of incompatibility between affect theory and biography brings a not insignificant tension to this thesis. Affect theory, generally, seeks to eclipse language with the body and material world in order to scramble the limitations we place on human nature and social institutions; starting from praxis, not coding; social production, not social construction.

In theorizations of art and affect, the eclipse generally looks like the suppression of the content of the work. What is left, I suppose, is the form of the work, its physical proportions, objecthood and affective resonances. Make no mistake: there is meaning and content to be explored in these other elements that make up the art experience, what we dispassionately call formal concerns:  line, shape, form, value, texture, space, colour, balance, tone, emphasis, pattern, movement, rhythm, or unity. Does the work confuse the viewer visually through textures, lines and patterns that confound spatial reasoning? Does the colour inspire feelings of calm or anxiety? How the work sits in space carries affective resonances. Is the painting larger or smaller than the body? Does it force the viewer closer or farther away because of its scale? How might the viewer's movements be limited or dictated by the art object? Is the work high or low on the viewer's sight-horizon? Does the work alter the soundscapes of the space as the body encounters it, such as is often the case when entering Richard Serra's steel sculptures?[94] Or does it strike the viewer with terror, surprise or awe, like in the example of Yoko Ono's *Cut Piece*,[95] or Chris Burden's *Shoot*?[96]

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[94] Richard Serra creates large steel sculptures that the viewer may weave through like a maze. *Tilted Spheres* (2002) is a 39-foot long by 14-foot high sculpture located at Pearson International Airport in Toronto, Ontario, Canada. Four arching steel fins obscure sightlines and dictate the movement of the viewer while creating a distinctive warping of the ambient airport noise—forcing the viewer to awaken to the auditory terminal cacophony by its sudden alteration.

[95] Ono's most famous performance, *Cut Piece* (1964), rather simply featured the artist herself, sitting on a stage with a pair of scissors in front of her. The audience took turns approaching her and using the scissors as they saw fit. Most cut off a piece of her clothes to keep as a sort of memento. Some were cautious, some were more aggressive, cutting large sections from her clothes and undergarments to expose her body. The work plays with risk and trust in intimate proximity to each other.

[96] Chris Burden's *Shoot* was a 1971 performance piece in which the artist asked a friend to graze his arm with a .22 rifle shot from 16-feet away. In the documentation of the performance, the viewer sees the marksman in the gallery. He raises the rifle and takes aim. Burden visibly stiffens, juts his left arm further from his body and holds momentarily before the gunman fires. Burden thrashes back against the wall before lurching forward toward the others and stumbling off screen. The rifle's aim was slightly right of the target and the wound was not a graze, but a through and through. Burden was taken to a hospital for treatment. The work was intended to be a kind of shock to unquestioned obedience as well as a sensationalizing of desensationalized violence in the wake of the Vietnam war.

Already here identified as a distinct voice in the discussion on how exactly it is that affect and art may be theorized, is Jill Bennett. Unquestionably, Bennett roots her ideas in a Deleuzian interpretation of affect. Because of this, she needs to make a case for divorcing the representational aspects of the artwork—in her case, art that takes trauma as its subject—from the affective resonances that live in and around the objects in the field of the experience space. The divorce means that Bennett may speak—in terms of political urgency—to the feeling state of the encounter with the works, but much less so to the precise traumas from the lived experiences of the artists who create the work; traumas that inform or are communicated through the work. More precisely, she must divorce the affecting histories that inform the artists from the affective "work" of the art in the encounter in many respects. The works that Bennett discusses, recall, are said to be "transactive rather than communicative" (7), and the transactive currency here is affect.[97] As a Deleuzian, Bennett understands affect to lead one to thought.

As examined in my breakdown of the affect theory family tree, the concept of being in Spinoza's monism evolved into a theory of becoming through Deleuze's intervention. Deleuze replaced the idea of a constant force (nature) with all the things about existence that are continually changing, always in flux. This substitution was not entirely inharmonious with Spinoza's philosophy, which was already focused on contingency, motion, change and surface-level appearances. The difference was that Spinoza tethered his becoming to being, beneath that ever-changing surface, and Deleuze moved to untether becoming from the force-core of something like nature or God. What now becomes fundamental is the constant process of becoming—the process of the world

[97] See *Art undisciplined: the relational epistemology of the art experience* for more on Bennett's argument.

in motion. This change meant that philosophic concerns like being, identity, a static system of thought or any kind of defined truth, are accepted as incompatible with becoming.

Identity—a sick identity, or otherwise—could be seen as a concerted effort to peg down becoming, to limit it and diminish its potential or complexity. Efforts to organize identity and thought away from their rhizomatic mapping and towards a ridged structure where you impose order can leave you with fixed truths that do not sit well over a wiggling subject. The universal body of medicine is my returning target in this regard – it is especially easy to aim at precisely because it is not a moving one! For Deleuze, we cannot think of identity as something that is predestined, preplanned and executed, because it is not a static thing, always determined by the connections that contribute to its make-up in a given moment. Autopathography, as an autobiographical account of illness, seems to demand (by surface definitions of the term) that there is something about the sick experience that is fundamental to the identity of the agent that engages in collecting and recording such a narrative. For Deleuze and Massumi, this act of documenting an essence that correlates with an identity or a subjectivity is incompatible with a philosophy of becoming.

Todd May explains the problem of identity for Deleuze in the form of an anecdote about a man who is attracted to a woman who works at a record store. The man notes that she listens to trumpet-centred jazz music. The man takes up the trumpet in an effort to be more appealing to the woman. May notes that there is nothing about the man that predetermined his identity of "trumpet player" that was sitting there all along, dormant since birth. Rather, it is the culmination of a succession of moments that lead this man to

"trumpet player," and it will be a succession of moments—yet to unfold—that will determine how "sticky" that title ultimately appears to be. The woman at the record store may continue to play a significant role in this becoming, or she may not (May 166). The man's identity is not static; it is a series of moments among moments, bouncing in tune with a network of influences that are themselves continually unfolding.

It is a mistake, then, according to a Deleuzian, to understand your identity as defined by anything, such as an illness event, or permanently changed by it. Doubling down on such a concept of self would, in effect, block the rhizomatic tendril from forming other links with a stopper that is illness-identity shaped. New, exciting or even disastrous connections to other networks from that segment become impossible. A sick identity, a realized autopathography, and even a Sunday horoscope each seize upon our strong desire to solidify an essential marker that tells us some indispensable truth about ourselves, to a Deleuzian. It is the same desire, as Stephen West writes, that drives people to watch the news, read the books, "hyper-focus on one little tree-sized section of the rhizome and then spend the rest of their life looking at things from their narrow, one dimensional, hierarchical world view making declarations about the way that things are" (West).[98] For these reasons, a self-described Deleuzian affect theorist cannot comfortably allow for autobiography, a historical description of a contained identity acting in the world. The sense that one should not strive for a firm identity of any sort is reflected in the ideal roadmap Deleuze and Guattari provide for living:

[98] At this point, the author glances knowingly at her reflection in an imaginary mirror she keeps beside her desk for moments such as these. Her reflection nods slowly.

> This is how it should be done: Lodge yourself on a stratum, experiment with the opportunities it offers, find an advantageous place on it, find potential movements of deterritorialization, possible lines of flight, experience them, produce flow conjunctions here and there, try out continuums of intensities segment by segment, have a small plot of new land at all times. ("A Thousand Plateaus" 178)

The idea that fixed identity, especially a rigid "sick" identity, can be oppressive does have ample resonance with aspects of my own work. The breast cancer patient, who was positioned as a heroic being in a case study from *The cult of good health: the mythification of health and illness,* must always wage war against her body until she can be said to have won or until she has been lost to the cancer-body. To identify by illness is to have an illness identity (Charmaz 637).[99] An illness identity can also be (and one may argue, is always) imposed upon the patient through the universalizing models built into medicine. In recognizing these complex and often harmful dynamics of sick identity, must we, then, write-off an illness identity as wholly static and oppressive for the sick person; as a blocked illness-identity shaped rhizomatic tendril? Well, in some ways, such as in the imposition of medicine's body-object, I think this is clearly so, but in how

[99] For someone dealing with a major illness or chronic illness(es), frequently illness becomes a defining aspect of one's sense of self. Illness identities often highlight coping mechanisms that may be internal, but are frequently external (such as the case of social architypes of the sick experience and particular diseases), now internalized. The identities may bolster social connections. One way this is done is by finding and forming community through affinity (See: Kristin Barker's "Self-Help Literature and the Making of an Illness Identity: The Case of Fibromyalgia Syndrome (FMS)." and, "The Radicalized Self: The Impact on the Self of the Contested Nature of the Diag-nosis of Chronic Fatigue Syndrome," by Juanne Clarke and Susan James.) Another way is through augmented social positioning – see: the venerated sick person vs the abhorrent sick body, in 1.2 *The cult of good health: the mythification of health and illness*). In any case, forming a sick identity seems to be a responsive act; reacting to fear, uncertainty and change. The sickness is thus incorporated by way of a restructuring of personal biography (see: Gayle Sulik's, '*Our Diagnoses, Our Selves': The Rise of the Technoscientific Illness Identity* and Kathy Charmaz's "The Body, Identity, and Self: Adapting To Impairment").

sickness is internalized into selfhood more generally? No – there is something richer and more complex going on here that we should not be so quick to call ridged or limited.

For one, the clinical illness identity[100] is often challenged by a kind of illness identity that is useful for forming community and affinity; as in the instance of a virtually realized rare illness identity. Through connections made in virtual-social spheres, individuals often find ground to question medical diagnoses, perhaps narrowing in on other medical and lived realities that may have been overlooked as they were shuffled into one common catchment or another by their stable-appearing diagnosis (Borkman and Munn-Giddings 127–50).[101] The very act of finding community and affinity is in the spirit of a rhizomatic extension, an act of experimentation with the breaks and openings the sick experience offers. It would seem to be an example, not an exception to Deleuze and Guattari's call to "find an advantageous place" to "find potential movements of deterritorialization, possible lines of flight" and to "try out continuums of intensities" in new places.

Now, undeniably, there is still space here to homogenize the sick experience, to organize through social affinity and produce a normalized truth of the breast cancer experience or, say, a chronic fatigue syndrome sufferer identity, and there are examples

[100] The kind of identity arrived at through the act of medicalization. Sulik writes, "Medicalization is the process through which the medical system has jurisdiction over common human conditions and experiences, including diseases and health conditions. Conditions that fall within the auspices of a medical framework become subordinated to the definitions, practices, and controls of the medical system" (465).
[101] There are plenty of examples of illness that are frequently overlooked or misdiagnosed that can be charted along the varying realities of the "majority-minority" that move this concern into the realm of something we ought to take seriously and not easily dismiss or group in with common rhetoric around "cyberchondria," "Dr. Google" or "keyboard diagnosis." See, *The cult of good health: the mythification of health and illness*.

of places where this is done, where symptoms and experiences are policed.[102] Grassroots movements that attract people for social action called "health social movements," according to sociologist Phil Brown, tend to address concerns like access to services, inequalities and illness experience. The latter concern of the illness experience is specifically referred to as an embodied health movement, and these movements work to "address disease, disability or illness experienced by challenging science on etiology, diagnosis, treatment and prevention" (50). Psychologist Alan Radley and sociologist Susan Bell, as well as sociologists Phil Brown and Stephen Zavestoski, explain that embodied health movements are distinct in that the actors involved "frame their organizing efforts and critique of the system through a personal awareness and understanding of their experience" (Brown and Zavestoski 682). While on the one hand, this allows for an activistic injection of experiential knowledges into debates about prevention and treatment, as Radley and Bell note (albeit in a positive light) strong narratives "are powerful tools that transform the individual illness experience into a politicized collective illness identity" (367), which lands us back into a mythologizing framework.

Of course, one may subscribe to the perspective that the most effective route to agitating the establishment is to find power through the channels the establishment respects. Indeed, Radley and Bell note (again, positively) that embodied health movements have found successful advocacy through their ability to carve out the "legitimacy of the cause" by exposing and articulating the "grounds of its identity" (367),

[102] Sometimes in quite overt ways, like by moderators in online forums who set rules about what can and cannot be accommodated, talked about or asked, acting as gatekeepers for forward facing content.

here understood to be a formed, collective identity. But, I would temper this strategy with two points: Sedgwick has cautioned us about the epistemological traps of strategic moves that fend off attacks and bad surprises through a "the best offence is a good defence" strategy, and Audre Lorde famously signalled that "the master's tools will never dismantle the master's house" (111). Both Lorde and Sedgwick follow their respective claims with an "at least, not alone" sentiment, and that is the real trick here – both in the sense that it is the crucial maneuver I am pressing for, and in the sense that it is technically challenging to execute.

We cannot disrupt the danger of the universal patient using the logic that justifies the erasure of contingent patient experience. The advocacy effect of a united "strong" voice directed towards science and medicine, holds, if I may couch this in a Sedgwickian vernacular, the ability to do some things well, and others poorly. It is essential that we see these agitative breaks, when they do come, as opportunities wherein "strong" theory may be used to support more nuanced instances of "weak" less tautological understanding of the sick experience. Again, we must look to practice-based initiatives that disentangle truth value from performative effect. Otherwise, the more successful the campaign, the more likely it is that the new image of the "whatever"-sufferer identity takes the crown as the new normalized ideology of a homogenized and universal understanding of the patient experience, thus erasing the contingencies found in the lived realities of anyone located under the umbrella.

In shared resemblance, there is ample opportunity for illness to become that essential marker that tells us some indispensable truth about ourselves. Being removed from the formal systems that order medical knowledge does not (alone) offer embodied

health actions liberation from this trap by dint of its current outsider status. Still, what we have in this example is a literal network of complexity that can and often does open up new ways of seeing and understanding diagnoses and actions, often leading to moments of advocacy and negotiation.[103]

There are examples of exciting strategies that seem to be more successful at circumventing a homogenized illness identity. Through technological development and the availability of commercialized health indicators like genetic testing and monitoring devices, people have been able to find more autonomy in overseeing some aspects of their health and wellbeing. Much of the commercial development of monitoring and diagnostic tools are a response to the needs and advocacy work of those who have claimed an illness identity: Gayle Sulik writes in *Our Diagnoses, Our Selves: The Rise of the Technoscientific Illness Identity* that the advent of the technoscience consumer is a response to the needs of the formed sick identity of the patient, which is resourceful and imaginative, seeking out ways to "breathe life into the biological realities of regular human beings, those who get hungry, tired, sick, old, and sometimes chronically or terminally ill." Herein, the folding in of the sick identity is figured to be a creative and an emancipatory break for the sick person, who now seeks out ways to accommodate the inevitable risk and limits of their biological reality, thinking of the self from within

[103] A possible example: Sulik calls medical consumerism (tracking biodata; the quantified self) both "a social response to medicalization" and "a form of socio-political empowerment" (465). She notes that the origins of this movement in medical consumerism are tied to social movements in the 60s and 70s by "women, people with disabilities, medical subjects, and other reformists and civil activists" who made moves to challenge the power and authority of and demystify the dominant systems of medical establishment and their "jurisdiction over normal body processes" (466).

flexible frameworks that can offer hope while simultaneously embracing the inescapable uncertainty of life.

Unlike the standard critique of identity found in a Deleuzian or Massumi inflected affect theory (that it diminishes affect; that it intellectualizes and traps the material world), I believe that illness identity may be mobilized in "weak" ways that instead bridge the unfolding body with the self to give some shape to "self," without imposing any promise of permanence. Illness identity can assemble the body and the self correspondingly without inherently limiting affect. Think through this observation: I suspect that anyone who has experienced drawn-out illness, chronic illness or disability will most readily support the assertion that a regular checking in with how you feel (reviewing, redefining, responding and rereading) is par for the course, not the exception, in terms of the lived everyday reality of being sick and these actions can undoubtedly coexist with an identity that extensively hinges on the having of cystic fibrosis or any number of other major conditions. Sulik research reveals, "As patients assess, redefine, and reinterpret their experiences of illness, they make adjustments (sometimes major ones) to their attitudes, beliefs, behaviours, and identities" which can lead to the fulfillment of drives and a "reformulation of identity" (471). Sulik's findings seem to be in support of my claim that there is tremendous flexibility as well as potential afforded by the sick identity, contrasted with the idea that a sick identity must diminish a capacity to act and be acted upon.

To my reasoning, it would seem to be when the sick identity is absorbed into a broader culture—when it is telescoped and homogenized by a "strong" theory of a sick identity—that the sick identity of a breast cancer patient, a cystic fibrosis patient, or even

the profusely oversimplified identity that is merely determined by survivor status is most at risk of becoming a fixed monolith. The fixed monolith is the mythification of illness. Reflecting on my call for more nuance in the sick identity, I think it is fair to question the overwhelming urging of work done in affect studies to dismiss an identity that claims autobiographical, identity or subject territory to be closed off or fixed. The very fact that "medical frameworks embed" themselves into both "belief systems and everyday practices" (Sulik 465) means there is always already something discursive and affective happening (even if it is negative or oppressive, or good at reproducing its own history). I feel that there is undoubtedly movement to be explored here. Autobiographical articulations and both the "hard" and "soft" subjectivities they bring need not be ejected from affect theory; rather, they require conscientious integration and a careful approach.

The shattered subjects of a Deleuzian or Massumi modulated affect theory are the neglected bodies in a combat zone between opposing sides. On one flank is the desire for epistemological vitality, and, on the other, alleged epistemological stagnation. The use-value of the subject is only realized here when it is exploded and discarded. Social Psychologist Margaret Wetherell has grieved the loss of the subject in (broadly painted) affect theory, for its tendency toward an "anti-Humanist negation of subjectivity" where "subjectivity becomes a no-place or waiting room, through which affect as autonomous lines of force pass on their way to something else" (123). The threat I see is the threat of a subjectless affect that attempts a total negation of established, layered research and thinking around the realities and histories of social alterity as something that shapes particular people and groups in very real and detrimental ways – a concern that is exceptionally important for medicine to take stock of. And, yes, attempting to

reinvigorate the subject, to revive it and to drag it across the field to friendly territory does carry its own risk, of which Lisa Blackman (2008) and Ali Lara (2017) are vigilant. The risk comes from the ever-present danger of mishandling identity, flattening the subject (for instance, dooming it to victimhood, or some other reality), and rendering it "apolitical or theoretically non-valuable" (Lara, 33).

Critics of affect are quick to point out, as Lara proficiently outlines, that affect theorists "circumvented scholarship that [seeks] to decentre the normative subject…work that has become increasingly valuable for bringing to subjectivity an analysis of race, sexuality, gender, disability, and additional forms of alterity." I think this accusation is especially true of a good deal of affect theory grounded in Deleuzian thinking, with its propensity to reject experience that is given autobiographical, narrative form for being too back-facing.[104] Lara continues outlining a criticism of the affective turn where it is viewed as "yet another instance of a refusal to engage in legitimate questions of oppression and being, as brought to the academic table by those who lived those bodily productions." Asking, "whose subjectivity matters?" Lara notes that a critique of this nature speaks "more broadly to a tendency within hegemonic theory to avoid taking

[104] There are, of course, exceptions to this generality. Sara Ahmed's 2004 book, *The Cultural Politics of Emotion* is one example. The book is a deep dive into the political implications of emotion and how emotions imprint and align bodies with particular cultural ideologies. Interestingly, though Amed's work is often considered to be grounded in Deleuze, she herself does not consider herself to be a Deleuzian (*Living a Feminist Life* 15). And, she has said in "Feminist Politics: An Interview with Sara Ahmed" that "the desire for Deleuze, which is not necessarily Deleuzian (he is a philosopher who interests me, whom I find interesting), can be questioned in part because it allows scholars to by-pass certain political questions and categories; it might be "desirable" for some to talk more about becoming molecular than about whiteness, for instance. The word "structures" is useful as it allows us to keep our attention on how the social coheres in specific ways. Racism is a word that I use to describe a certain kind of effect. I think that what we need to do is actually to find the best language to describe how the world takes shape in very particular ways, which involve systematic regularities, and patterns or distributions, as well as inequalities. So I do not think we can start by talking about acts as things that just happen" (Tuori 259).

seriously subaltern theories that address the messiness of the marginality, identity, materiality, and politics of lives and liveliness" (33).

A middle-ground approach that biologically grounds affect, I argue, finds a way through this "exploded subject" problem in affect studies in several ways. Firstly, I find that Tomkins' conceptualization of the functional limitations placed on a body understands determinism to be a sliding scale of more or less power to act, based on complexity and constraint, allowing what we could call subjective intent and subjective action, with the caveat that the subject is not cogitated as impermeable. Part of the reason I think that we may frame the subject as a "soft" subject without bursting the internal logic of this affect theory that occurs to me by way of Tomkins' concept of script theory, which is a theory of personality. Personality, while in flux, is solid enough for long enough that we may make sense of its integration and role in a social system. Understanding the nature of an inside-out, contagious theorization affect that is not wholly split from emotion or cognition means we do not need to eject identity and biography from politics and action. Subjectivity, I believe, just becomes softer, more malleable and fluid than it may appear elsewhere in the study of subjecthood or identity politics. And, soft subjectivity also comes with a caution to tread lightly, because it can never be fully pictured in a solid state. Still, it is not as if we cannot certainly get a feel for it.

I think that a middle ground approach may thus offer an answer to how exactly it is that affect may offer up spaces of resistance that directly challenge power through

"subjective action" even if those actions occur in a deterministic system,[105] as well as how affective actions can frequently happen alongside (not despite) discursive representations, cognition and emotion. In *The Wounded Storyteller*, an analysis of autopathography within the framework of narrative theory, Arthur Frank notes that,

> Illness was not just the topic of her story; it was the condition of her telling that story. Her story was not just "about" illness. The story was told "through" a wounded body. The stories that ill people tell come out of their bodies. The body sets in motion the need for new stories when its disease disrupts the old stories. The body, whether still diseased or recovered, is simultaneously cause, topic, and instrument of whatever new stories are told. (1-2)

I find this citation essential for several reasons. First, it infers that the act of making autopathographies arise from a body feeling and responding to itself and the world. Second, it speaks to the interruption disease has on our understanding of our world. Whether it is a projected future now crumbled, or a body-knowledge in need of restructuring, illness is one of many forces that "disrupts the old stories," and, therefore, Frank's thought concludes, the body persists as the acting, feeling agent through and on which new patterns emerge and imprint. This active arrangement of a sick identity, to me, is the bonding force that enables me to draw connections between the work of

[105] Leys asks in "The Turn to Affect: A Critique," "How might power be challenged if the subject is seemingly deterministically produced through forces of affect that leave no room for spaces of resistance?" (434).

autopathography, illness identity, and Tomkins' bio-psycho-social ecology of feeling and of personality.

In his theory of personality, Tomkins offers us the option of something we might cautiously call identity that is written and rewritten, never stagnant. I believe that this movement allows for the political dimensions of affect while giving some form and authority to a kind of contoured thinking and feeling personal (re: personality) subject even as that subject is collaborative, porous and trans-personal. Tomkins' script theory—where human behaviour falls into alterable, but detectible patterns that are coloured by our affective experiences and their intensities—seems to allow for a subjectivity envisioned as a process underway in tandem with something with discernible shape and contour. A "formly," "shapely," identity, I propose, is an epiphenomenon of the operation of scripts underway and always in the process of writing and rewriting.

We simply cannot be so quick to dismiss the person-as-now-fashioning by their long-range impermanence, for a number of reasons I have already laid claim to, and not the least of which is this stark lived reality: that we are human. Human bodies, along with other ecosystems, are open systems in a closed universe. What I mean is that, as Tomkins shows us, we are biological beings that have a degree of freedom determined by our complexity and the constraints of the environment that presses back upon us. It is understood that the total amount of energy in an isolated system does not change, but within the closed universe, everything is impermanent, even death. Atoms are repurposed. Again, we are human. Some things in this reality are very hard for us to keep in the purview of our everyday lived reality. We are driven by many forces. At this very

moment, somewhere, there just might be an astrophysicist who abandons her work, feeling a biological surge of intense emotion about a piece of cake.

One constraint to the human is the rather important press of our temporal limits. Now, of course, this side of the study of material time is the purview of physics, of Einsteinian spacetime. Yet, the study of time is also broader than that in the analysis of perception and operational systems of units. Biological and natural science place unit systems on the flow of oxygen, in the measurement of brain activation, or cell death. Time plays a vital role in motivation, cognition and emotion. Time horizons do actually affect motivations. Studies have indicated similarities in the time horizons, behaviours and motivations between those who are very old, and those who are very young but facing collapsing time horizons through events like terminal illness or political violence wherein "the fragility of life [is] acutely primed." In such cases, researchers found "the subjective sense of time left was affected and, in turn, equated age differences in preferences and desires" (Carstensen 1914). These findings seem to suggest that something like the perception of future time colours the drive to action, providing a sense of urgency to particular feeling states, informing behaviour:

> When time is perceived as open-ended, goals that become most highly prioritized are most likely to be those that are preparatory, focused on gathering information, on experiencing novelty, and on expanding the breadth of knowledge. When time is perceived as constrained, the most salient goals will be those that can be realized in the short-term, sometimes in their very pursuit. Under such conditions, goals tend to emphasize feeling states. (1914)

A theory of personality merges conceptual transactions with physical, material transactions in a constant, responsive feedback system that aims toward a better life, which itself is a moving and sometimes self-conflicting target.[106] Having a soft-formed sense of identity at any given moment is paramount for the formation of scripts that function as case-based analysis predictors to maximize positive affect and minimize negative affect. Thus, a presenting subjectivity ought not to be a mandatory limiter for future selves.[107] It takes a little time and effort to flip the script. These changes are rarely immediate—except when startling novelty may suddenly force a reset—and this slowness is probably for a good reason: if we are learning to get better at life, it will serve us well to make these changes incrementally, to be responsive, to fold in as many small scale happenings as we can digest in a span of reasonable (within our human limits) time.

One of our concepts regarding the limits and possibilities of time has given us the notion of the expanding universe. There was a point in a past time before the universe cooled enough for electrons and nuclei to combine into atoms, when starlight could not traverse great distances. Now, on a moonless night, with the unaided eye, we can see the light emitted from Andromeda 2.6 million years ago. Sometimes we can be stunned because the complexities of our bodies, other ecosystems, and the universe can press

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[106] To me, this goes a long way to explain how it is that things come to be valued, something that behaviourist theories that reduce experience to stimulus-response often fail to account for. Memory, cognition and the feeling-quality of experiences mechanize for affective judgments about things.

[107] Though having said that, it could be limiting, in its dysfunctional state, where scripts are inflexible and refuse new input, essentially limiting affect. In action, this might look like an agoraphobic man who fears "something" bad will happen and refuses to leave the home. Tomkins' script theory offers a framework for understanding the systems that do the most powerful overriding for a person. What is most important to take away here is that the theory of personality Tomkins provides is wholly able to tolerate and support enormous variation among people. Said rather perfectly and unpretentiously by the Tomkins Institute: "It keeps us from falling into the trap of prematurely closing off the question of what makes a person tick" ("What We Learn"). Refusing to wholly reject the subject, even the dysfunctional one, is a refusal to ignore the scrappiness of a soft-formed subjectivity as well as the messiness of experience and identity as they relate to representation and social construction.

upon each other in ways we can easily see and feel. Sometimes the body might miss out or may have to wait.

Arthur Frank calls the obligation of seeking medical care a "narrative surrender." By this, he means that the sick identity is the entrance of the sick body into the cultural monolith of stable appearing theoretical ideology. This monolith is realized by the historical dynamics of medicine, the scope of which is located across practices ranging from billing category breakdowns to what is prioritized in medical curriculum or studies. In this space, says Frank, first, we get the physician asserting authority over their patient's experience, "imposing specialized language," and next, this description of the experience, this solidified sick identity, is mimicked and internalized in the voice of the patient themselves (6). It would be uncomplicated to call an autopathography a breach in the "strongly" realized sick identity through the direct injection of the patient's voice, and autopathographies are commonly viewed in this straightforward way. In joining several argumentative moves throughout this paper, I have tried to show that there is much more active transfer here than that statement allows for. Instead, I say that a sick identity can be both "strongly" and "weakly" realized, and the sick subject, equally, can be "hard" and "soft." And, recognizing the implications of these differences is quite useful for thinking about an effective critical approach.

"Strong" realizations tend to be harmful and homogenizing. "Weak" realizations are harder to aim towards but can offer a great deal of potential and political power, often challenging larger systems whose authority we take for granted as absolute. So, I argue that sick identities can function alongside and beyond fantasies of realism, sometimes clearing the problematic self-contained subject. By incorporating a porous, "soft"-

subject-underway that can maintain a degree of "shapeliness," and subjective action (thus, a response-ability to sociality and creating a social responsibility to the other), you achieve an affect system where autopathography, identity, representation and politics of otherness can be accommodated and are not too dangerous to think about (lest we become preoccupied) nor too foolish to take seriously.

Autopathography is thus here imagined neither as a self-contained account nor, as Leigh Gilmore says, an "inflation of the self to stand for others" (5). It is not an object charged with truth, nor is it a document to comb through and expose lies, as Aronson might be inclined to do. Autopathography is a site of rich affective possibility that may give some shape to an experience, conferring a body feeling and responding to itself and the world, marking and underscoring unsettled stories still in the process of being abandoned and underway. It is an ongoing performance of the body persisting as the acting, feeling agent through and on which new patterns emerge and imprint. An autopathography might be better or worse at performing these acts by way of rhetorical devices, or in my purview, the materialization of the art experience, through approaches that allow for autopathography to enter affective-discursive realms that facilitate sociality.

*3.3 Affect, autopathography and art: the relational encounter of the art experience*

As an artist, I find the strong desire to strike a clear break between the artwork as a cultural object—as a thing marked by its content, context and production—from the affective, aesthetic work of the art experience so perplexing. I do question how such a monumental disentangling could even be possible. Scholars like Erin Manning and Massumi (2013), Bennett (2005), and O'Sullivan (2001), place "art" firmly in event-oriented happening, and they either have something close to disdain for any effort to infuse work with representation or they position themselves as intrigued by the discursive characteristics of the work, despite their focus on the much more serious matter of affective resonances. Massumi, for example, notes,

> For [art] to be thinking in the act, the relationship between the different practices would have to alter a bit: the art could never be looked on as illustrating a concept, but always enacting concepts actively. The philosophy can never be looked on as commenting on – or certainly not judging the art. (Manning and Massumi "Relational Soup" 00:05:45-00:06:06)

O'Sullivan calls art "effective [immanently] over and above its existence as a cultural object" (25). To lobby for this break between content and event is to ostensibly mark the "art" in the action of the art experience, and remove any trace of it from the painting, sculpture, the culturally and historically "marked" body of the artist, or other material or agent.

While I have tried to make it clear that the "work" of "Art" is a bit of an uncatchable changeling within art history and philosophy, in my upbringing as an artist, I have yet to feel any conceptually or aesthetically backed urgency to wedge the "aboutness" and action wholly apart. As I have already gestured there have likely been times in the distant past where a viewer might look to a painting for a definitive truth about how the world came to be (or some expression within it, conclusively dictated), but, for a number of reasons, that is no longer the strategic approach of the contemporary viewer. O'Sullivan assesses the art experience as "antithetical to knowledge," by which he means, optimistically, that the art experience is highly agitative to fixed truth, and what Jean-François Lyotard calls "fantasies of realism" (O'Sullivan 25). This is a sentiment that is both in line with my philosophy, and those scholars outlined above, but there is a major difference in our outlook. The disparity is located in this conundrum: for one to flee from or shun the discursive elements of the art object (the "aboutness" of the work) one must assume that fantasies of realism are what we see, (look for? or, are lured by?) if we accidentally take in an artwork too passively (is this, I wonder, a failure to execute a "good" art experience?). To me, this whole line of thinking smacks of an application of the methodological decay of science or critical theory (and its corresponding traps) painted liberally onto the methodological vitality of the contemporary art experience.

Regarding this transposed trap or lure of the desire for fantasies of realism in the contemporary art experience, an example comes to mind. Jeff Koons' *Made in Heaven* (1989),[108] billboard, emerged into the world at the behest of curator Marvin Heiferman,

[108] While I'm sure there are other examples to be found that could question the supposed desire for fantasies of realism, I admit, I struggle to think of any that do not fall into the category of protest art. The protest art examples that do come to mind seem to me to merely be in danger of being read as only protest (sans art); protest works which would still be received with the level of deep irony intended by their initial

who asked Koons to make an advertisement of sorts for the Whitney show *Image World: Art and Media Culture* and which was, itself, an artwork. In the full-sized billboard, Koons and Ilona Staller, a famous sex worker in the pornography industry, pose seductively before a frothy sea. A nude Koons folds himself over Staller, who is herself draped over a rock. Staller is clad in white, lacey lingerie, heels and filigreed, elbow-length gloves. Her blonde hair is crowned with a ring of flowers. Belonging to the more extensive series of mostly photo-based work by the same name, the billboard functioned as an advertisement for the unmade adult film, *Made in Heaven*.

Quite deliberately, Koons is trying to unsettle the traditional (if we can even call it that) art experience with the billboard, a large piece in a series that already labours to blur the line between "high" and "low" culture. What I mean is that without any of the usual conventions to draw attention to the work's "artness," like the spatial codes and conventions of the recognizable gallery or public art installation, or deference to more familiar modes of art production (what we call a traditional definition of art: formal, expressive or aesthetic properties), use of juxtaposition, irony or other tactics to disrupt the visual and conceptual fields that surround it, the work looks, reads and feels like standard advertising. It is so utterly, invisible; rendered thus by its banal, glossy 1980s "sex sells" aesthetic that camouflages the work in an ocean of the other comparable billboards displayed in lower Manhattan.

The choice to make the work clichéd and invisible becomes the ultimate transgressive act that Koons gleefully bestows upon the masses. The critical lens of the work is aimed

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coupling with "art" as a co-medium. To the degree in which they are still taken to be insincere and mushrooming layers of meaning, they make poor additions to this "invisible" art configuration I am trying (albeit unsuccessfully) to picture as potentially existing.

against the art world, more locally, and broadly, at the loftier umbrella of the conventions of art and the art experience, philosophically speaking. The attack on the art market comes from the fact that it is only Koons' art-star prestige that ultimately salvages the aggressively trite work, elevating it into art status by an institutional definition. Herein, the work gains its standing and recognition (plucking it out of the sea of banality) by way of the enormous monetary worth of Koons' oeuvre in the art marketplace and his correlating (and likely causational) significance in art history. Through Koons' deliberately "tasteless" depiction, and the work's irrefutable historic and monetary value, he is questioning the hidden processes by which art is levelled up to "high culture," and in so doing, he is leaving the viewer to puzzle over why art would be worth caring about at all.

Koons' fame and significance thus, become a major nodule in the rules of engagement, acting very much like the exhibition space in a conventional gallery: his position cues up the viewer to approach the work critically, to linger on it, to consider its larger implications, to feel alongside it and to participate in meaning-making. What Koons' *Made in Heaven* may be guilty of is being prohibitive to the democratization of the art experience: most of its original viewers took in the artwork passively, thinking it to be a real ad for an actual film, or not thinking much of anything at all. Today, it is often seen in the context of art-historical accounts. The work is undoubtedly guilty of many types of excess. Still, I do not think we can say that the work presents fantasies of realism, because, depending on your approach, you either see an advertisement or art. And, if you are positioned to be privileged enough to be engaging in the art experience, not only are the discursive and cultural elements of the work liberated from any trap of

fixed truth, but also, they are frequently (and certainty in this instance) utterly indispensable.

The saga of the artist, Koons, and the institution that he is simultaneously both critical toward and embracing of, are the foundations of the edge on which you perch to feel your way around this art. They are what orient your experience conceptually and aesthetically. But, moreover, they are the impetus that allows you to come to engage in the very act of the art experience, as Koons' steady gaze meets yours from the billboard. Here, the discursive elements of the work amplify affective resonances like surprise, startle, joy, or disgust. In the art experience, the "aboutness" of the work is capable of increasing its affective potential. The "aboutness" is also capable of closing off the work, ejecting it from "Art." Either way, it hardly seems divergent to the affair of the unfolding epistemological potential of the experience or the lively methodology we seek.

I find *Made in Heaven* to be maddening, an icon of hyper-masculinity, and also nauseating, in case you were wondering. To me, it belongs to a whole legacy of wealthy white male art stars born somewhere between 1955 and 1965, who delight in nothing more than poking the art market with art-shaped garbage to see how much people will spend on it. While we are on the subject, I am also convinced that Damien Hirst's latest *Cherry Blossoms* paintings, with their lifeless splotches of politically, formally, narratively and aesthetically vacant oil paint are the latest and greatest trolling of the art market – time will surely reveal something of an answer for those who are patient enough to wait. One more thing: in case you were still questioning, at the very same time, I also find *Made in Heaven* to be politically urgent. Art has a way of aligning disparate and conflicting realities simultaneously for the producers and consumers of art, as well as for

those who profit in the middle spaces as “art made” moves toward “art seen.” Or, even as “art possessed,” sometimes entirely unseen, stored away and acting as a vessel just as symbolic and functional as money itself is for value, power, and history.

I’m reminded here of Sara Ahmed’s thoughts on “Happy Objects”: “To be affected by something is to evaluate that thing. Evaluations are expressed in how bodies turn toward things. To give value to things is to shape what is near us” (Gregg 35). Koons’ billboard is both brilliant and tired. It is droll and critically relevant. It is a substantive, unforgiving protest against the art world, and it also holds great investment value! Such is the way with the aesthetic and relational happening that is the art experience. It gets in. It unfolds. It can take on shape and value, but still, it is never at the limit of extending. Continuously unstable and exchangeable, always welcoming multiple domains with compounding actors, it does not so much as shape the world in any precise way, as it shapes the world as wiggling, changing, contradictory and imaginatively complex.

If politically pressing event-based affect could be disentangled from the discursive elements of a work, why are we able to readily locate emotion in formal properties? And, why is it we might be as affectively moved by work that completely rejects aesthetic properties like scale, harmony, colour and balance? Are we ready and able to claim that affect is really gone or wrung out if the art object is dematerialized and wholly devoted to the mind, to concept? Eve Meltzer asks this question about the resonances of conceptual work in *Systems We Have Loved: Conceptual Art, Affect, and the Antihumanist*.

Conceptual work is often loath to associate with historically acclaimed aesthetic and formal concerns like beauty and the sensible. Nonetheless, such works stimulate rewarding interest, excitement, or joy, and can startle and surprise us, or issue forth

punishing distress, anguish, anger, rage, disgust and humiliation. Meltzer calls this the "affective side effects" of the conceptualist turn where "pure discourse" creates "a space for feeling" (21). This feeling space comes from a particular pleasurable effect that often brings the viewer the satisfaction of "having watched the art world performed, rather than having watched yet another performance in the art world" (Jackson 42). As is the case in our early demonstration through the work of Koons, this world-performing comes from the "corrosively ironic" systems of the contemporary art experience that may allow work to evoke an affective response—whether conceptual, formal, etc.—by, as cultural theorist Sianne Ngai says, rendering "visible different registers of a problem (formal, ideological, sociohistorical)"(3) through gestures that illuminate "how totalizing this or that system feels and how utterly preconditioned our discursive networks are" (Melzer 88). And, rather than just presenting a case for a kind of structuralist formation of the world, the sensation we are presented with is a pull towards something more than subjectivity, objectivity, and systems of clean organization, invigorating the overwritten subject-of-the-system with the touchstone of the vital, affective life in action.

Representation, discourse, systems, structures, signs and symbols can have a dynamic lifeforce in the contemporary art experience without the characteristic danger of the faith in exposure, authenticity, singular truth value or subject-fixing baggage that is usually dragged along with it. Furthermore, as I have already suggested, I contend that this statement equally applies to what might be called the opposite of the dematerialized, conceptual artwork: art that enjoins itself entirely to the sensible and the formal and aesthetic properties that pronounce such an experience.

Formalist or expressionist works that embrace or snub principles of integrated and total order, of colour harmony, of line and rhythm, of composition scale and repetition, may seek to evoke sensation, responsiveness, and event and pull themselves free of representation, realism, and symbolic order. However, to think for a moment that an artwork might strike a viewer affectively wholly without content (or the inflection of meaning, as Tomkins' theory suggests), indeed demands a sustained faith in the external and autonomous nature of affect to the sacrifice of ideas and emotions. As Monica Greco and Paul Stenner (2008) note, "Drawing an overtly sharp (and value-laden) distinction between affect and emotion serves, paradoxically, to perpetuate the illusion that such words refer unproblematically to states of the world, thus bypassing the need to think carefully about the conceptual issues at stake" (11). It is clear to me, at the very least, that to encounter a bold and elemental painting like Barnett Newman's *Voice of Fire* (1967)[109] is to open the floodgates of the bio-psycho-social ecology of feeling.

The vertical red and blue lines of *Voice of Fire* are aggressive, and when I am standing near the painting, I find they tower over my body like a primal predator. The work is hard and nationalistic, with its rigid lines, and stark, flag-like appearance. My instincts raise alarms left and right, as my body responds biologically. The hairs on my arms rise, causing rivers of cool shivers to roll down my back.

Scientists have been studying the effects of colour and light on human perception since antiquity. We know that nerve fibers in the retina of the eye are extremely sensitive

[109] The National Gallery of Canada, which houses the powerful work describes the work and Newman's process: "Limiting his colours to red and blue, Newman created this powerful vertical canvas to be suspended from the ceiling of the massive geodesic dome designed by Buckminster Fuller. While simple in form, this work conveys a range of meanings. The artist intended it to be studied from a short distance; here, its enormous scale transforms the space and tests our sensory experience" ("Voice of Fire").

to three different colours, which manifests the entire world in a dance of cool and warm tones that cast off each other in intense and contrasting colours and tones. This effect gives dimension to things seen and give us our depth perception. Newman's *Voice of Fire* throws a wrench in our biological and mechanical ability to make such spatial distinctions, by filling our visual arena with vibrating and unreconcilable colour fields that throb against the controls of human perception. I am looking at a flat picture plane, but my mind tells me the surface folds, wraps around itself, pushes both forward and back. The effect can be nauseating.

For me, Newman's work is an exhilarating and ringing example of the bio-psycho-social ecology of feeling, of affect, as an internally generated biological system that emerges simultaneously, closely tied to thought and emotion, but not completely free from it. And, likewise, the aesthetic and formal concerns of the work are not wholly extractible from its narrative content or its relationship with the visual world. How exactly does one unzip the seam between our feeling for redness and red? Of course, one must first find the experience of red nonconsciously.

To what purpose is the search but to negate all or some of the constellations of actors that enliven churn of the art experience in the first place, if the political and affective dimensions of the art experience not only accommodate the bodies and scripts written, but utilize them? Is the motive really to abandon ideology? If so, one may rest assured that the discursive elements in the contemporary art experience would struggle to perpetuate ideology as it is envisioned elsewhere by the anti-Humanist affect theorist. Is the move to delink thought and emotion—meaningful takeaways—from the purer political potential of the work? I struggle to find this divorce as an autonomous

ampliative force in any of the concretely political examples I draw on in this text. The situation, to me, accords with an affect theory that is not strictly inhuman and not strictly pre-subjective, where affect is not absolutely free of association, carrying meaning and emotion simultaneously as feeling steps on the gas.[110]

Another example: Abstract Expressionists of the 1940s and 1950s, with their preoccupation with spontaneous, automatic, and subconscious creation, may have figured themselves to be dancing the pure dance of an anti-figurative, anti-representational aesthetic. Still, ironically, I can think of no work that better or more obviously evokes not only the figure, but also the biographical history of the subject. Just look at how Elkins describes the father of Abstract Expressionism, Jackson Pollock's 1953 oil on canvas painting, *Grayed Rainbow*; think about the language and feeling we may be left with as we enter the constellation of bodies in the art experience:

> There is gesture, first of all: the marks on Pollock's *Grayed Rainbow*… are records of the exact bodily motions that made them… The drip paintings are about leaning, stooping, and stretching as well as all the things that Pollock's contemporaries found amusing about the new technique: drooling, peeing, and stomping around… The horizontal surface, and the awkward bending and reaching (and crawling and tiptoeing) are all part of that purpose, and they leave

[110] To clarify, affect and emotion in a Tomkinsesque system are not wholly the same thing, but there is no heavy cleaving between the two. Affect occurs independent of pronounced cognitions and beliefs about the world, yet affects are not meaningless. "Each containing its own unique experiential signature, each attaching a specific type of meaning to information as it is taken in, stored and recalled," affects carry an inflection of meaning, a characteristic feeling, and are "the biological system that underlies emotion" ("Nine Affects") Awareness of an affect is a feeling. A new affective trigger brings "a feeling plus memory of prior similar feelings" constituting emotion. Affect and emotions have distinction from interpretations: there is nothing about sobbing, for example, that tells us anything concrete about the object in the world that elicited it. It is a mental state, as biology philosopher Paul Griffiths says, separate from the concept of belief (243). In contrast, inhuman/transhuman affect see affect as anything but personal, where "feelings are personal and biographical, emotions are social" and "outside of consciousness" (Shouse 1).

> their traces in the work. The allover paintings are compelling in this regard because they exhibit specifiable degrees of anger against the figure. Some continuous swoops are lazy, half-controlled gestures, and the kind of motion that made them would have been something gentle but imprecise, like strewing seeds. (In *Grayed Rainbow*, such marks are mostly white loops and strings.)… Other marks are more violent, and there are spatters, gobs of paint, and even hand- and footprints that speak about less comfortable motions. (*Pain and Metamorphosis* 15)

When I say "I can think of no work that better or more obviously evokes not only the figure but also the biographical history of the subject," I say "the subject" here, deliberately and in the strongest sense, over less direct and more flexible terms like "the body" or "a body." I do so because I find that there are few examples from art history where the self-contained, formed subjecthood of the artist is as valorized as it is in Abstract Expressionism, and most so in action painting.

Because Pollock and other artists in the movement prized the act of the making of the work more than (or at least as much as) the art object itself, and they captured this action through the rejection of competing narratives, it is, in fact, the saga of the artist genius that becomes the represented subject of the work, pressing us into a sociality of affective contagions as bodies mirror bodies. Elkins is noting something of the same thing, though in a different context, as he thinks through the way bodies find representation. He continues by saying of the work, "there are many kinds of gestures and associated emotions in the painting and that the body is the vehicle of their meaning. If we do not think of the body—no matter how faintly or quickly—the gestural language remains inaudible" (*Pain and Metamorphosis* 15).

I fondly recall an afternoon in an art gallery, surrounded by five other students, staring intensely at a Pollock painting—the name of which I have long forgotten—searching for a cigarette butt that was rumoured to have fallen somewhere between globs of paint and whipped splatters. Looking at a painting this way is very much like the way of seeing one employs when one finds oneself not in a gallery, but in a history museum. Here you stand, scanning relics you are not allowed to touch for some visual cue that will tell you something concrete, something verifiable, about an event long past. Of course, one is not bound to see a Pollock in this way. Still, at the same time, I can tell you that standing in front of that Pollock painting is the only time I recall looking at an artwork made after the turn of the last century with such an intense eye for historical reverence and relic-like objecthood.

With "The Death of the Author," published in *Image, Music, Text*, Barthes rather famously implores that our fetishistic attachment to the author is what stimulates our need for biographies, memoirs and histories to make us more equipped to read truths in the work: we look for van Gogh's "madness" in his sun-spotted fields and seek Monet's failing eyesight in murky ponds—oh, and of course, discarded cigarettes in a swirly acrylic soup. All our fidelity to the author, Barthes tells us, distracts us from the real work of language. Our author is actually something of a "scriptor," in a long procession of influences that emerges along with the text. A founding father for the shape of the contemporary art experience, Barthes and his ideas are so ubiquitous they persist largely internalized and invisible to most art lovers. Barthes sees the author as a voice providing us with a ready-formed dictionary to be taken up by anyone's special inventiveness.

To be clear, I do not mean to imply that the "hard" subjecthood and the long shadow of the Abstract Expressionist God-figure is indeed a fatal impediment to the art experience, only to point (with some humour) to its rather strong appearance in a movement that seeks to reject narrative in favour of the event. In such a way, it performs a strong parallel to my argument for the necessity of an affect theory that gingerly harbours the dark outlaw of non-representational critical theory: the "aboutness" of the work. Pollock's God status or biographically laden body-trace both become just another dynamic perch for the "work" of art. I would suggest that the author is capable of being at once an ideological figure, a process underway offering something of a message in a bottle through the ready-formed dictionary and the soft-formed subject whose lived experiences can be more or less grasped, and to whom we have fidelity; perhaps we may even say moral obligation.

Narratives in art are never frozen. The art experience vibrantly activates them. Narratives generate meaning through the multiple actors who metaphorically take them for a walk. Sick stories see multiple tellings and retellings through the emergent and productive complexity of contemporary art practice, where knowledge is relational, performative and gestated through active affiliation with the past, present and future. In the constellation between artist, art object, viewer and world, there are tools that may be utilized to sustain devotion to it all dexterously: to the never-fully-graspable narrative the sick artist (a tangible person, with a lived experience), traces of that script woven into the work through denotative and connotative elements, and narrative ruptures encountered through memory, tellings and retellings. Always, the political potential of contemporary art practice is realized through the body's ability to affect and to be affected.

Another approach to contemporary art practice that distinguishes it from everyday experience is the intensely self-conscious expectancy for meaning-making (meanings yet unmade, to be made). While we more or less reflexively engage in meaning-making in all encounters, within the art experience, we are hyper-cognisant of our efforts to both draw out and imbue significance. It is not so much, or not just a poststructuralist commitment to discourse and signification, but a lens on our obsession with discourse and signification. This deeply attentive practice calls attention to (and even seeks out) intensities that pass body to body and implicates knowledge as something that is embodied and pulled along through social relations. Contemporary art practice embraces fluctuating and diverse relational stances where the action of meaning-making requires that we attune ourselves to reciprocate and co-participate in the passage of affect through and between many bodies.

Paranoid thinking, "strong" mythologies and "hard" subjective projections are not, of course, incapable of settling into all of the dynamics between the art object, artist, viewer and world. Perhaps these tricks hold their most significant purchase in the moments of the creation of the art object, as the artist finds herself creatively motivated by the desire to solidify some thought, feeling or event into some kind of truthful representation, say, perhaps, a particularly "strong" history of what it is like for all suffering from endometriosis. Contemporary art practice, though, is set up in a way that makes such stoppages impotent. At worse, such art might be boring and thus disrupt the event of the art experience by disengaging some or all actors. But discursive elements that lay claim to stable appearing truth ultimately may become another element in the performative process of meaning-making in and around the other architects in the

constellation; paranoid influences and motivations are essential confluences of relation, but they have no governance over how the happening unfolds.

A viewer, for instance, curious, or even inculcated to ponder the rationale of an artist; to think about the social forces and drives that informed the work, is not the same as a reader impelled to uncover these stimuli as the truth of the artwork. Rather, these pressures—the collective ideas that inspired and produced the art object in part—which may be offered or denied, I believe, enter into meaning-making as a "good internal object" which is to say, as "a relation that is conceived as virtually intersubjective, profoundly ambivalent, and a locus of anybody's special inventiveness" (Sedgwick "Melanie Klein" 629).

The viewer, thinking through art practice is, therefore, able to approach "the violent conflicts and dangers" (632) that result from and are produced by a stable appearing theoretical ideology with less risk of being inescapably gripped by them. The viewer is in a fertile position to perceive the "local, contingent relations between any given piece of knowledge and its narrative/epistemological entailments for the seeker, knower or teller" ("Paranoid Reading" 124). Consequently, the bad-objects of art that operate through the dual function of the image—when the image seeks to be a container for truth or knowledge, and, works to direct knowledge, to be the model that vast chain of interpretive inferences are bracketed by and measured against—are defused by breaks and openings that buoy epistemological unsettlement, moving paranoid thinking back into the realm of practice. So, while stable appearing ideology may attach at any time among and between the moving parts of the constellation, in the process of thinking and rethinking, and in the face of multiple, changing narratives, paranoid thinking faces a

considerable challenge to supersede rather than fluctuate alongside reparative modes of thought.

This is not an argument for frenzied, aimless and impotent meaning. As a mark of liberation, "there are no wrong answers in art's meaning-making" is not quite right. To say this in such a way is overly simplistic and also implies that any interpretation is of equal consequence, importance or relevance to the moving parts contained within. If that were the case, the art experience would quickly and justifiably fall victim to the criticism of an endless proliferation of meaning to the point of obliterating all use-value in our real lives or the accusation of falling into "a crude reductionism" (Leys, 411). Of course, there are more or less nuanced reads that sit closer to or farther from the contingent elements at play! The man who sees hidden signs of the Illuminati in every artwork he looks upon may, I think we can safely say, has less engagement with the contingent and relational elements at work. This is to say that in the art experience, one is primed to be much less afraid of being wrong, and at the same time, there can be reads that are more sociable with intersubjective action of the art experience.

So, it is not the case that there are no right or wrong answers in meaning-making, but more accurately, that the art experience functions in such a way that we are constantly hyperaware that no single person, object, or even event of experience is capable of arriving at a definitive answer. There is no faith in exposure, only process and content, and, here, we are free to explore the possibilities in a playground where hard truth has little control in the radical, powerful and politically important work underway. Where invasive paranoid critical practice tends towards the imperative that "there must be no bad surprises," insisting that all news "must always already be known," contemporary art

practice stresses that something may never be exclusively known and that which is known can be displaced by on-going knowing, fostering a reparative practice while never promising any particular outcome.

Turning to the medical field, the schematic body of medical illustrations are reductive and recall that they are so both as stylized interpretations of their subjects, and in constructing their subjects. They are also, counterintuitively, surprisingly anti biological, with their defined edges and flat colouration. Affectively drained, medical illustrations frequently reject the body, exhausting it completely and dispossessing it from the biological, feeling body in favour of the intellectualized, symbolic, organized dissected body shown through a schematic organization (Figure 3-2).

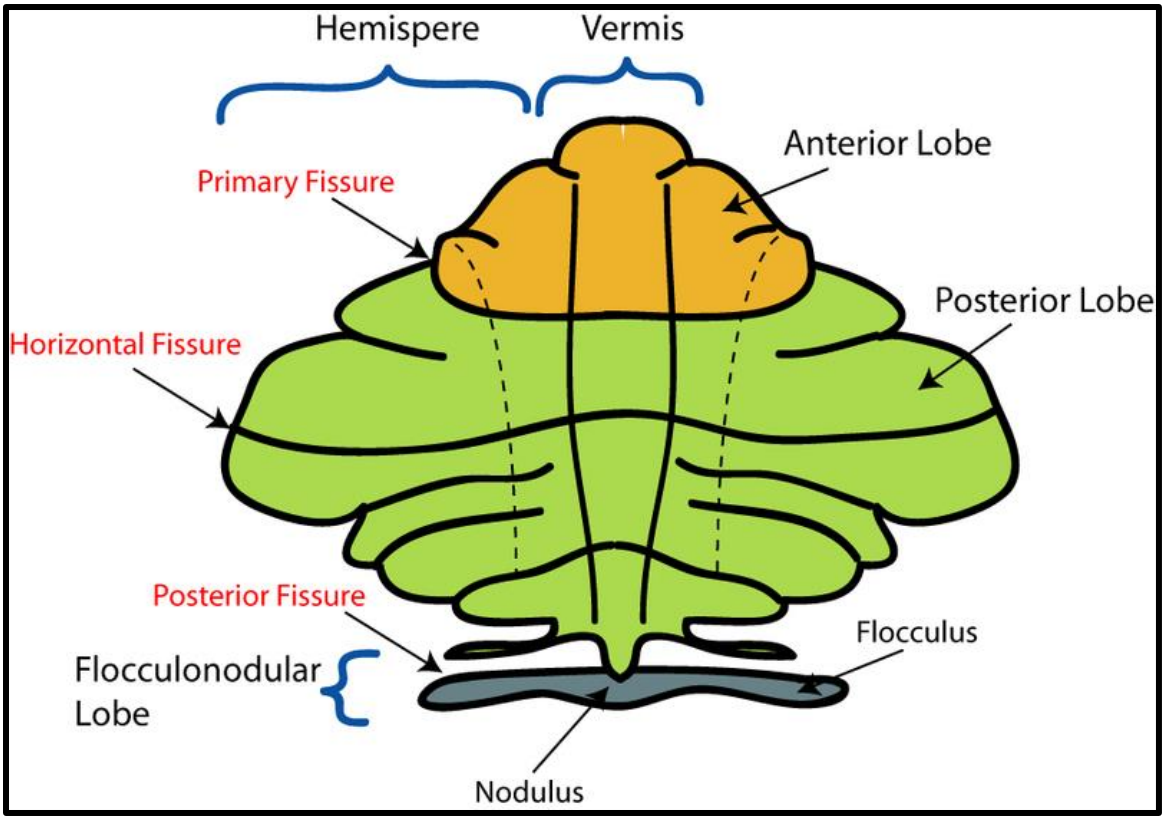


**Figure 3-2** A medical illustration from 2005 of the significant anatomical divisions of the cerebellum (Latin for "little brain") that has widespread use as a diagram for educational purposes regarding the anatomy of the cerebellum. The cerebellum is located behind the brainstem at the back of the brain. Responsible for brain functions related to movement and balance, the cerebellum has several functions, including motor learning and coordination. The diagram is a schematic representation that reduces the body to a single organ, and then provides a cross-section of a segment of that organ. The image is deprived of its organic elements: there is no trace of the qualities of tissue one might encounter handling a real cerebellum.

Pictures of dissected and reimagined body parts in medical texts, with tidy and simple shapes and corresponding labels, tell us a great deal about the body-object and very little about the patient into whom we impose the object. Images are schematized in such a way (as is so for the MRI) to better locate what we already picture to be true; to expedite visual information into a clean format. In viewing medicalized images of the body imagined in this way, we are given no indication of the desires, sounds, smells,

textures, weights, or consistency of the body, either as a fragment or aggregate. The body is imagined to be comprised of hard, dry blocks with rounded corners. The organ is painted in bright, unnatural colours so as to identify and structure divisions. The sensing, feeling body-as-subject, is eradicated, but interestingly, the viewing body—the reader—is also deprived.

The sensual, feeling encounter is a dulled one, as fleshy bodies are mediated through schematized representations that shout the meaning structures of science and are mute to the actual feeling bodies they purportedly signify, further divorcing any sense of the patient as a feeling, living actuality. The body belongs to another language here, and it is not often the language of the body. Elkins thinks through this kind of substitution of the body in uses ranging from warning signs to religious iconography when he writes,

> At the end of the body—at the far extreme of schematization, at the pitch of dryness and intellection—are representations that are no longer about the body, where the artists are really thinking about other matters... A body might be almost entirely vanished into a symbol, as in the shrunken figures in Egyptian hieroglyphs; or it might suffer a metempsychosis, emerging as language—as in the word "body."…To be more nearly free of the body, a form must have some other purpose...When a body is used for a symbolic purpose, then it can become, in a new way, invisible: it can enter the realm of things that are not seen, but are read. (Elkins, *Affect and Logic* 321)

A consultation with the medicalized image of the body-object is an encounter with an image nearly free of the body. The body is a vessel drained of sensual expression,

corporeal experience and bodily knowledge so that it may be topped up with something else — something entirely different that belongs to "the definitions, practices, controls of modern medicine" within a framework that "depends upon highly specialized knowledge" and "the transformation of bodies and identities" (Sulik 463)[111] through the intervention of a universal, schematized other-than-body.

We need art that takes autopathography as its subject because we really do need contingent, personal accounts of illness that break through the homogenizing narrative of universal or categorical patienthood, to challenge both the body-object of medicine and to challenge narratives that advocate for new body-objects that may be equally homogenizing (such as advocacy efforts that equally mythologize the patient experience). It is politically urgent that we recognize we can use the discursive and affectively rich qualities of the art experience or simply borrow its methodologies that incorporate these qualities to realize affectively rich encounters picturing or encountering the body that can break it free from the diminishing dual- or object-functionality of the medicalized body.

[111] The language inserted into this idea comes from Gayle Sulik's research. In, Our Diagnoses, *Our Selves': The Rise of the Technoscientific Illness Identity*, Sulik writes about how technoscientific efforts to know the body under the skin have cemented the biomedical model of disease and the tools used to know and manage human bodies and identities. "That is, individuals negotiate and produce a sense of self through the framework of technoscience and its practices. These include biomedical classifications and diagnostics (i.e. technoscientific confirmations of particular diagnoses or genetic predispositions) as well as social relations and other structures. Individuals engage with technological choices and options, access technoscientific identities through biopolitical economies of health and illness, engage in discourses and practices of biomedical risk and surveillance, and receive institutional and interactional reinforcement for enacting particular forms of identity. As technoscientific biomedicine shapes our lives to greater degrees, it also holds greater potential to shape the identities that already develop in the face of illness" (464).

*3.4 Empathy and situated knowledge: the active ethics of affect*

When we look at the world through the lens of affect theory, we are forced to think about what motivates us in a new way with consequent ethical considerations. If the body is a reactive object, constantly being pressed upon by other forces and more or less determined by them, and the ideas we form about our actions and motivations are a sort of secondary undertaking of justification, then our everyday models for personal accountability are laughably shallow. At the end of the day, we are all just sacks of wet feelings motivated by hunger or curiosity, are we not? The idea of ethics based on a closed-system world centred on nature and its affect pulsations is gestured to in Spinoza's *Ethics*, and it is a curious construction to ponder.

Should we find this world view and ideal model and align with it, we might make a choice as a collective society to, say, prevent severely epileptic people from driving. This decree, seemingly dispassionately arrived at, would recognize individual and collective risk and make a determination, ostensibly without malice, for good. We might extend that further: we may seek to remove all punitive aspects from sentencing; instead, we grasp that external forces shape so-called "subjective" choices. From this perspective, of course, a punishment of any kind is comical because it would be hard to imagine how one might penalize a series of events and happenings when the subject is too slippery to stay in the cage. Furthermore, we must not be guilty of imagining the criminal as unique in this thought experiment: our judges are just as fallible in the face of our formally held standards of rational justice. Indeed, studies have found that a hungry judge will rule

more punitively than a satiated judge.[112] The phenomenon is referred to as ego depletion, and it understands willpower and self-control a limited, biologically rooted resource that diminishes as we otherwise deploy energy to power our living, moving, thinking, and feeling bodies.

One may get the impression, then, that through affect studies, a new justice may emerge that sees reason emancipated from the passions that inflect it, that a new kind of compassionate and even-handed dealing with ourselves and others may emerge if we understand the drives of the body biologically. This outcome is undoubtedly close to the ethics that Spinoza envisioned. I am not qualified to weigh in on the future of justice in my country or any other (and nor would I trust myself to—I admit that too often I fall into traps of anger-driven vindictive thinking when reading about world events!), and while I do not, per se, endorse this model to the farthest reaches of coherent shared responsibility, I will say that it would probably do us all a world of good to check in next time we find ourselves consumed by despair or short-tempered, and ask ourselves if we might be in need of a catnap and some alone time. We might also give more appropriate weight to the social responsibility for cyclical violence and traumas.

Of course, the entire scenario hypothesized and outlined above is a rather obvious connection to draw when thinking about the ethical dimensions of any affect theory, not just an ontologically understood affect theory. Affect makes us think about our material bodies and their relation to our thoughts, feelings and space. The impetus of the turn to

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[112] Research conducted in Israel and the USA, examining more than 1,000 judicial rulings on parole requests found that 65% of requests were granted when the judges were cognitively fresh (well rested) and recently fed. The percentage drops through the day to almost none. If a break and a meal is undertaken, approvals were seen to return to 65% again (see S. Danziger, "Extraneous Factors in Judicial Decisions," 2011).

affect, needless to say, was driven by a desire to return to the material; to find radical breaks in the representative, textual and discursive heaviness of cultural studies. But, beyond the more obvious considerations, there hides a less apparent ethical question (or perhaps we might say dilemma) in a theory that holds up neurological attributes in the equation of its ontological or even bio-social foundation.

The ethical question I wish to address concerns an often-unseen systemic problem with affect theory. Whether affect is understood to be biological and evolutionary, with an inside-out directionality, or autonomous, with an outside-in anti-Humanist ontological foundation, both models accept that affect is felt through neurological stimulus. Since neurological stimulation can be and is dampened or interrupted by a number of events, be they a disease, chemical balance, genetic inheritance, trauma, or something else entirely, like the ministrations of a medical device, there can also be disorders of the affect variety. Empathy, psychiatrist Simon Baron-Cohen shows, requires the facility to perform relationality neurologically.[113] Since Tomkins shows that empathy is an affect that motivates sociality, driving us toward cooperativity for survival, the obvious direction to face in the ethical question around affective disorders may appear to be towards those who have affect disorders that prevent the thriving of collective communities. Indeed, Baron-Cohen writes:

[113] An organizational feature for a diagnosis of autism, psychopathy, narcissism and borderline-personality disorder is the brain's material failure to practice the affect of empathy (See Baron-Cohen, *Science of Evil: On Empathy and the Origins of Cruelty*, 2012). Other neurological interruptions for relationality may be symptomatic of brain damage or degenerative neurological disorders.

> Empathy is one of the most valuable resources in our world. Erosion of empathy is an important global issue related to the health of our communities, be they small (like families) or big (like nations)...Without empathy, we risk the breakdown of relationships, we become capable of hurting others, and we can cause conflict. With empathy, we have a resource to resolve conflict, increase community cohesion, and dissolve another person's pain. (*Zero Degrees* 124-5).

The obvious (and, frankly, comfortable) directional choice overlooks a more challenging philosophical problem for affect theorists. The problem is one much more familiar to medical history: the glitch is that disorders (in this case, affectively inflected) present us a model for an abject body. More troubling still, because this disorder happens at the root of the embodied experience, it presents us with an abject body ontologically.

I came to this problem by way of the brilliant writing of communications scholar Grant David Bollmer. Thinking through affect and autism, Bollmer asks what we are to make of those who "cannot experience what neuropsychology understands as the embodied, biological foundation for human relation" in the face of theories that privilege "the biological facticity of bodies and brains in the production of cultural, social and political relation?" (300) Indeed, what are we to make of this? Can it be reconciled, or are we now faced with categories of people that are ontologically abject? Our utopian thought experiment of Spinoza-like dispassionate reason would look much darker if the slope slipped us into questioning what to do about the affectively abnormal while positioning such people as ontologically inferior. While many affect theorists, like Massumi, are looking to neuroscience to discover the God particle of affect theory, Bollmer notes, "neuropsychology looks to human bodies and discursively orders them in

accordance with a graduated hierarchy of material, neurobiological capacities for affect" (301).

The disaffected, then, require more thinking from affect theory and elicit a cautionary warning cry from all the disembodied, fixed or abject characters from history—the politically marginalized folks that affect theorists often fear to look directly in the eye—for the alienated masses no doubt see something familiar in this dynamic, as their cry echoes back. We ought to ask our affect theories to think through what difference, if any, can be drawn between the lived reality of a psychopathic serial killer and someone like James Fallon, the neuroscientist who accidentally discovered he was a pathological psychopath while studying a mix of "normal" brain scans alongside his study group of killers. The question makes me wonder if there might be something missing in how some conceptualize affect, especially with those who conceptualize affect with a dichotomy between mind and matter? Certainly, this example points to some desire to find other potential levelling moments in the playing field between the vitally affective and the cognitively interpretive, thus making disagreement about meaning rather vital again to cultural analysis.[114]

Bollmer's grievance is with affect theorists who project an ontology onto the material world while conveniently ignoring the fact that affect theory structurally produces abnormal subjects through both discursive and material categories. This effect is likely deeply seated in a blind spot for any affect theorist who is so staunchly fearful of discourse that they hide away from it. Bollmer writes,

[114] Leys explains that by enacting a dialectical inversion of cultural studies, affect theorists "make disagreement about meaning, or ideological dispute, irrelevant to cultural analysis" (472).

> In universalizing the body's capacity to affect and be affected, the pathologies identified by the neuropsychology of affect are likewise pathologized in cultural theory, producing bodies that cannot exist as a normative part of the social because of their inability to properly modulate or experience the affective flows that somehow "naturally" ground sociality through their "material" transmission and contagion. (Bollmer 303).

Bollmer seems to reveal that for a theorization of affect to be politically viable, it must account for the normative preconditions for political belonging that are too often couched in arguments for pure biology. He elaborates:

> Affect cannot be separated from this discourse [defined in part by Western neuropsychological truth claims about bodies] as if its possibilities are not shaped by medical processes of mediation that include discursive means of producing the normal and the pathological. If we disregard the discursive aspect of affect then we also ignore the very real construction of differences and margins that remove specific bodies from recognition as "citizens" and "humans." (304)

This critique for ontological exclusion is particularly hard to resolve or move past in a Spinoza-Massumi inflected affect theory that understands affect to exist externally, in a pure form before and around the human.[115] While Bollmer sees no way through, I

[115] In 2013, Erin Manning, a key player in the Spinoza-Massumi branch, made a strong effort to fold in autism to particulars of this conceptualization of affect. Instead of viewing people with autism as "asocial" she argues they are, in fact, "suprasocial"—wherein they are bombarded with an infantile experience of "relational potential" and "hyperrelationality" ("Always More Than One" 8). Manning's argument is that

believe it is decidedly easier to reconcile the criticism within a Tomkins-Sedgwick account because, in this understanding, affect pulls on the psychology and neuroscience of emotion which positions affect biologically.

Instead of understanding affect ontologically, my Tomkins-Sedgwick account understands affect as a separate and basic system of human functioning moored to biological limits and evolutionary adaptation. Affects are "comprised of correlated sets of responses involving the facial muscles, the viscera, the respiratory system, the skeleton, autonomic blood flow changes, and vocalizations that act together to produce an analogue of the particular gradient or intensity of stimulation impinging on the organism" (Demos 19). We are all more or less determined by our complexity—our range of motion as we affect our environment and are affected by it. Allowing for both environment (stimuli) and holding a foundational assumption of individual variation, this understanding of affect holds no singular or pure state of affect or, interestingly, an ahistorical account. Tomkins spent a great deal of time researching the genetic as well as the temporal effects on affect (that is far more thorough than the recognized episodic understanding of a Massumiesque affect): he noted how affective responses were subject

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most "normal" people lose hyperrelationality as they develop into subjecthood. Because people with autisim do not lose hyperrrelationality, they do not individuate and therefore hold more accurate understanding of the world as something that is not full of selves and hard objects, positioning people with autism as more open for radical potentiality. Key here is Manning's reversal of the argument Bollmer makes, but the tricky part is that inverting a hierarchy does not erase the problem of a hierarchy. Because Manning draws on psychological writings about child development and autism to make her claims, Scholars like Blackman ("Immaterial Bodies" 104) and Bollmer note the inherent problem of her use of "psychopathology to theorize the ontological" (303). Also, there is the biting critique of "her almost Orientalist positioning of "autistic perception" as a more ontologically authentic way of experiencing the relationality of the world" (Bollmer 303, via Ian Hacking's "How we have been learning to talk about autism: a role for stories"). What we are left with, when the dust settles, as Bollmer shows us, is evidence of how affect and relationality can in fact be its own chain of interpretive inferences that form the hard objects of the world.

to environmental and evolutionary selection. He traced different ways domestic animals were bred for varying temperaments (83-95).

While his account of affect is closer to feeling and emotion, an indirect "form of thinking" (Thrift 175), and subsequent theorists, most notable Sedgwick, have emphasized the role of the discursive in affective life, I do concede that there are moments where a bio-psycho-social ecology of feeling model does not fully escape some parts of Bollmer's critique on a hierarchy of being. Even though all living bodies exist on a spectrum or gradient of affective capacity, the piece wherein Tomkins identifies the affect system to support an organism in three keyways (1. Survival 2. Affinity with community 3. Discovery of the new through, a) maximizing positive affects, b) minimizing negative affects, and c) minimizing affect inhibition) must face Bollmer's critique in that some bodies have the capacity to be better at life than other bodies. Specifically, more directly to Bollmer's evaluation, some bodies would seem to fall down the scale toward less vitality, if we agree that a vital capacity for affinity with community requires an experience of empathy that is arrived at through the material and neurological relation between bodies. Now, clearly, there are cut and dry arguments to be found where some bodies are undoubtedly better at life (read: survival) than others. Still, there are significant and, perhaps, in some ways, inevitable political challenges in declaring certain bodies to be positioned over others on a sliding scale of affective power.

I do think there are valid places where we could push this critique where a social relation account of affect may not yet be entirely sufficient, and this is a task I may just take up in the future. For now, it is beyond the scope of this paper. Provisionally, I will say that I still trust that there is mobility to be found in a bio-psycho-social ecology of

feeling model because the distinction of a bodily capacity account of affect over an ontological one is a question of active capacity or affective power, and not ontological actuality ("a universal autonomic ground for embodied agency") (Bollmer 323). So, bodies cannot be disaffected as such, but rather exist in a spectrum of unpredictable determinism.

The "reality" or realism of a capacity account of affect is perhaps just what Bollmer aims for, where it is capable of being historical and can never be factored "outside of its cultural, political and discursive mobilization" (304). There is, I think, more generous space afforded to think through the ethical problem Bollmer identifies in the affective-discursive paradigm. Because, while it ultimately may have little effect on how affect is mobilized in an event like the art experience, if we are to advocate for a methodology rooted in affect theory for invigorating the most problematic corners of medical knowledge, it would not be particularly political or radical to build on a system that is equal to medicine in its culpability for having a body count—or, as Bollmer corrects us, a "count-as-body" (322)—where an inventory and attributes of body parts determine who does and who does not qualify as normative and worthy.

While I clearly do not subscribe to an ontological view that discursive elements in illness narratives are irreparably dangerous, I have continued to advocate for the delicate footwork involved in ethically handling the "aboutness" of either artwork or identity. Sedgwick has shown us the ethics of paranoid critical practice are at times limited by the features of a hermeneutics of suspicion that produces bad objects, projecting into the world (and vice-versa) hostile and envious adversaries. Klein calls this "projective identification" and writes that these projected "bad parts of the self are meant not only to

injure but also to control and to take possession of the object" (Klein 8). When we engage in paranoid critical reading, even in practices with a deep commitment to social justice, it sometimes seems that the kind of ethical engagement enacted is the ethos of making visible, spotlighting power imbalances and exposing how these disparities have come to pass.

While investigations that hold faith in exposure are in many ways needed, we should be sensitive to the problems they present. A deconstructive critique often has the effect of complicating our understanding of the workings of the self and other, repression and liberation, empowerment and disempowerment while simultaneously reproducing the structure of binary oppositions through competition for power. In this form of engagement, ethical encounters with the other might resemble a reorganization wherein the historically disempowered are enabled through social or structural change to seize more power, and the historically empowered suffer a loss of power. This dynamic is one that easily inspires a passionate response.

On the side of the disenfranchised, there is a sense of comeuppance that can readily be validated through the lens of injustice. For those who are lucky enough to have been empowered, any loss of power becomes an injustice as they are ill-equipped to appreciate the utter banality of disempowerment, and thus feel their disempowerment as a radical infringement on the normal and sanctified state of basic human dignity and entitlement.[116] The universal does not recognize himself as such. The us-versus-them dynamic produces distrust and terror from all sides. In the academic treatment of these

[116] Here, I think about the activation of the swinging pendulum effect where the #metoo movement inspires a rise in men's rights activists, incels and the popularity of terms like snowflakes and social justice warrior. I think about the Black Lives Matter movement and its ugly mirror-twin, All Lives Matter.

subjects, from within a paranoid critical position, care for the marginalized other is sometimes sustained through a "good" designation over a "bad" condemnation. By this, I mean that the disempowered are seen as "virtuous" and worthy of empowering, to the result that often what is "good" is also reified into a position of perpetual victimization.[117] In this dynamic, it is hardly good to be "good." When an ethos of care is advanced from this "strong" blanketing approach, the possibility for ethical engagement with the other is extremely sticky even though the intentions that underpin plenty of activist work within this framework may be multifaceted, deeply sensitive and thoughtful.

Reparative acts, in contrast, foster a deep and abiding care for the other, conscious of its own limits and its pitfalls (not all surprises are good surprises). Nurturing the perception that good and bad are inseparable conditions, affectively rich, contingent engagements with the world utilize one's own resources to assemble from part-objects (fragmented perceptions of the world), a somewhat compromised whole. Sedgwick notes that these assemblages are not to be confused with complete objects:

> [The] rhetoric of reparation does not assume that the "repaired" object will resemble a pre-existing object—there is nothing intrinsically conservative about the impulse of reparation. Once assembled, these more realistic, durable, and satisfying internal objects are available to be identified with, to offer one and to be offered nourishment and comfort in return. ("Melanie Klein" 637)

[117] A faith grounded in exposure presents the "cruel and contemptuous assumption that the one thing lacking for global revolution, explosion of gender roles, or whatever, is people's (that is, other people's) having the painful effects of their oppression, poverty, or deludedness sufficiently exacerbated to make the pain conscious (as if otherwise it would not have been) and intolerable (as if intolerable situations were famous for generating excellent solutions). Such ugly prescriptions are not seriously offered by most paranoid theory, but a lot of contemporary theory is nonetheless regularly structured as if by them" (Sedgwick, *Novel Gazing* 22).

Instead of splitting good or bad objects, the reparative approach embraces objects as ethically complicated, intertwined and experientially changing wholes. They are experientially changing in the sense that from a position of affective methodological vitality, respective parties know themselves and each other unremittingly. Jason Edwards expands on this point:

> [These] relationships are . . . those in which respective parties know each other well, over a significant period of time and in a variety of contexts. [These] relationships are also likely to be realistic, complex and strong enough that both individuals feel safe enough to use each another for what they need, and those in which both parties try to repair the damage that their bonds to one another inescapably cause. (111)

What this reparative position does not do is assume that its repaired objects are perfectly formed or that reparative work is a one-off transaction. On the contrary, it recognizes its work as situated and contingent, wherein objects are understood as imperfect approximations that are composed of damaged fragments and pieces of former reparations attempted. In this state, we do not fear surprises. Therefore, we remain open to that which presents itself as new, unexpected and different while remaining ever attentive to the unintended consequences that can and do occur. Moreover, when reparative acts inadvertently create a more damaged whole, the object is not professed to be fixed. Consequently, it may be repaired anew into something "better" or "good enough" (Edwards 111).

Developing a reparative approach necessitates a commitment of time. Reparative relationships are unending negotiations involving repeat readings where meaning frequently shifts as emotional states, contexts and environments fluctuate. The ethical promise of the reparative, "weak" approach lies in its hope, and its capacity for continual re-formation, where damages done can be lovingly and empathetically restructured.

While we may see bodies in most representations, some pictures of bodies are better at embodying or evoking affective responses. A key affective response, as I have outlined, is the feeling of empathy. Empathy is important because, as Tomkins' theory of affect shows us, it drives an organism into social relation, encouraging collaborative thriving. Empathy is also a chief concern if one wishes to leverage affectively rich methodologies in domains such as medicine toward a more compassionate and nuanced treatment of the medicalized body. The more a pictured body exemplifies sensation, the more my body reaches out in kind.

The familiar notion of the five senses is a myth. Where this myth comes from, I cannot definitively say, but it may go back as far as Aristotle's *De Anima*, which contains an organizing structure demarcating sight, sound, touch, smell and taste. I cannot even correct the misconception of the five senses with a more accurate number for you, as there is no definitive list for the limits of human sensation. As Spinoza memorably noted, no one knows what the body can do or, indeed, where it ends.[118] What qualifies as

[118] The unabridged quote, "However, no one has hitherto laid down the limits to the powers of the body, that is, no one has as yet been taught by experience what the body can accomplish solely by the laws of nature, in so far as she is regarded as extension. No one hitherto has gained such an accurate knowledge of the bodily mechanism, that he can explain all its functions; nor need I call attention to the fact that many actions are observed in the lower animals, which far transcend human sagacity, and that somnambulists do many things in their sleep, which they would not venture to do when awake: these instances are enough to show, that the body can by the sole laws of its nature do many things which the mind wonders at.

sensation depends on where you draw the line for your requirements. Proprioception is the body's interior and exterior sense of itself. It is how we can locate our elbow with our fingers without the aid of touch or sight. We sense temperature and, thanks to inbuilt biological systems, gravity. Itch, hunger, and even echo-location are considered human senses.[119] If our definition of discrete sense factors includes internal and external physical categories of received information, say, mechanical (including touch, hearing and proprioception), chemical (with taste, smell and internal senses), and light, then we can see that the potential for any of these to overlap with the sensation of something like pain is extraordinary. Pain has long been associated as a general condition of being alive, the general prospect of sensation and a tool for monitoring and directing the human body towards thriving and away from harm (Elkins Pain and Metamorphosis 23).[120] Perhaps this is why pain seems to be the ultimate target for the success or failure of empathy, and thus the success or failure of human connection. Elaine Scarry makes several foundational arguments for this in *The Body in Pain: The Making and Unmaking of the World* where she reveals,

> because the person in pain is ordinarily so bereft of the resources of speech, it is not surprising that the language of pain should sometimes be brought into being by those who are not themselves in pain but speak on behalf of those who

Again, no one knows how or by what means the mind moves the body, nor how many various degrees of motion it can impart to the body, nor how quickly it can move it." From Parkinson, G. H. R. *Spinoza: Ethics*. Oxford University Press, 2000, section 3, 76.

[119] For further reading, see Jarrett, Christian. *Great Myths of the Brain*. Wiley Blackwell, 2015.

[120] For more on human senses and the correlation to pain, see Elkins, James. *Pictures of the Body: Pain and Metamorphosis*. Cambridge University Press, 2000, 22-27 alongside Sacks, Oliver. *The Man Who Mistook His Wife for a Hat*. Summit, 1985. Feher, Michel, Ramona Naddaff, Nadia Tazi, and Bruce Mau. *Fragments for a History of the Human Body*, *vol. 2*. Zone, 1989, 350-70 and Scarry, Elaine. *The Body in Pain*. Oxf. U.P. N.Y, 1988.

> are…and [these] occasions thus become avenues by which this most radically private of experiences begins to enter the realm of public discourse." (6)

Still, in doing so, the patient's voice must somehow be heard because to "bypass the voice is to bypass the bodily event, to bypass the patient, to bypass the person in pain." Although, sometimes having a voice heard is not enough. Scarry notes the strange stickiness of doubt and pain: "to have great pain is to have certainty; to hear that another person is in pain is to have doubt" (7). Lastly, Scarry shows how artifacts (like a painting or book) can "contain and expose some of those attributes," suggesting that the imagination works to distribute the facts and responsibilities of sentience out onto the external world; that the imagination tends to be ethically uniform on the issue of sentience; that the imagination is bound up with compassion; that the imagination has an inherent tendency toward largesse and excess; that the work of the imagination is not here and there, now on and now off, but massive, continuous, and ongoing" and that same imagination often disguises "its own activity" (325).

Because I have initiated the claim that art-based methodology is more realistic and reparative for its subjects, it is vital that my analysis of affective encounters engages with the ethical dimensions of these exchanges. The affective work of the art experience has distinct ethical implications for any concern of difference for both the medicalized subject and the subject of illness in art. Scholars, including Alexis Kargl, Yvonne Kwan, Christie McCullen, Kirsten Rudestam, and Dana Takagi (2016), have recognized that affect factors into the sociology of inequality in three crucial ways. First, of course, it performs in the long-overlooked dynamic of sensation and perception for subjecthood.

Secondly, affect factors into the sociology of inequality by acknowledging "feeling and affect as materialist politics," and lastly, by showing up the temporal aspects of affect (Kargl 2, 20) where "the past is living rather than dead…[living] in the very wounds that remain open in the present" (Ahmed *The Cultural Politics of Emotion* 33). The affective wound is especially poignant for artwork created as autopathography. More and more, artists are driven to make work about their sick experience as an equally expanding audience seeks out such work. Curator Rebecca Dean observes, "There has been a growing number of artists looking into a biological context to make their work…Artists moving beyond the representation of illness to their embodiment of illness." (Low "Death and the Artist").

Embodying illness through representative and experiential means creates an opening that may serve as a communal wound-space, or fissure, inviting a reparative engagement with the self and other made porous by the captivating way the subject frequently and fluidly transfers. This effect, which I have been calling "the shifting subject," is something I have explored in the context of MacLean's work, with her eagerness to oscillate between the viewer's experiences and her own, recognized through the "shadow in the centre of the frame" (MacLean 73). It is also something we witness in Bachmann's project, as the bone conductor echoes the voice of the patient in the viewer's skull, literally becoming the private, inner voice of the body. "The shifting subject" is something I likewise encounter when I look at the work of American artist Dominic Quagliozzi.

Quagliozzi produces autopathographical art that documents his struggle with Cystic Fibrosis—a genetic disease that causes progressive lung damage from chronic

infections and inflammation—and its related complications. His series, “Image Crafting” is an assemblage of paintings that show the first-person perspective of a sick body at different moments. In the first painting I present for you, *Blanket Mountain,* the body is laying with one foot exposed, almost touching the cold metal rail of a hospital bed (Figure 3-3). In another, *Blue Tube*, the body is positioned in such a way that the viewer is looking “down” at feet planted on a hardwood floor (Figure 3-4).

**Figure 3-3** Quagliozzi, Dominic. *Blanket Mountain*. 2013. Acrylic, silicone, human hair on canvas, 32” x 34”.

**Figure 3-4** Quagliozzi, Dominic. *Blue Tube*. 2013. Acrylic, silicone, oxygen tubing on canvas, 32” x 34”.

Smooth, warm wood contrasts with a textured, cool-toned housecoat that offers—by its very name—a clue to where this scene takes place. This observation is challenged only by the unlikely juxtaposition of a canister of oxygen, the presence of which we are formally alerted to by the visual line of the snaking nasal cannula that runs along the

body to the cylinder. *Wipe*, positions the body sitting, legs exposed, over a clinical tile floor as one glove-covered hand grips the right knee (Figure 3-5).

**Figure 3-5** Quagliozzi, Dominic. *Wipe*. 2013. Acrylic, silicone, nitrile glove on canvas, 32” x 34”.

Planted between the knees, a box of tissues can be spotted. The tissue box introduces an uneasy focal point as it almost seems to float, unchained by gravity. In

*Sugar Hand*, the viewer gazes down at an alien-yellow hand whose finger is in the process of being pricked, blood tested and assessed while the toes of two yellow feet barely assert themselves at the bottom of the frame (Figure 3-6).

**Figure 3-6** Quagliozzi, Dominic. *Sugar Hand*. 2013. Acrylic and silicone on canvas, 32” x 34”.

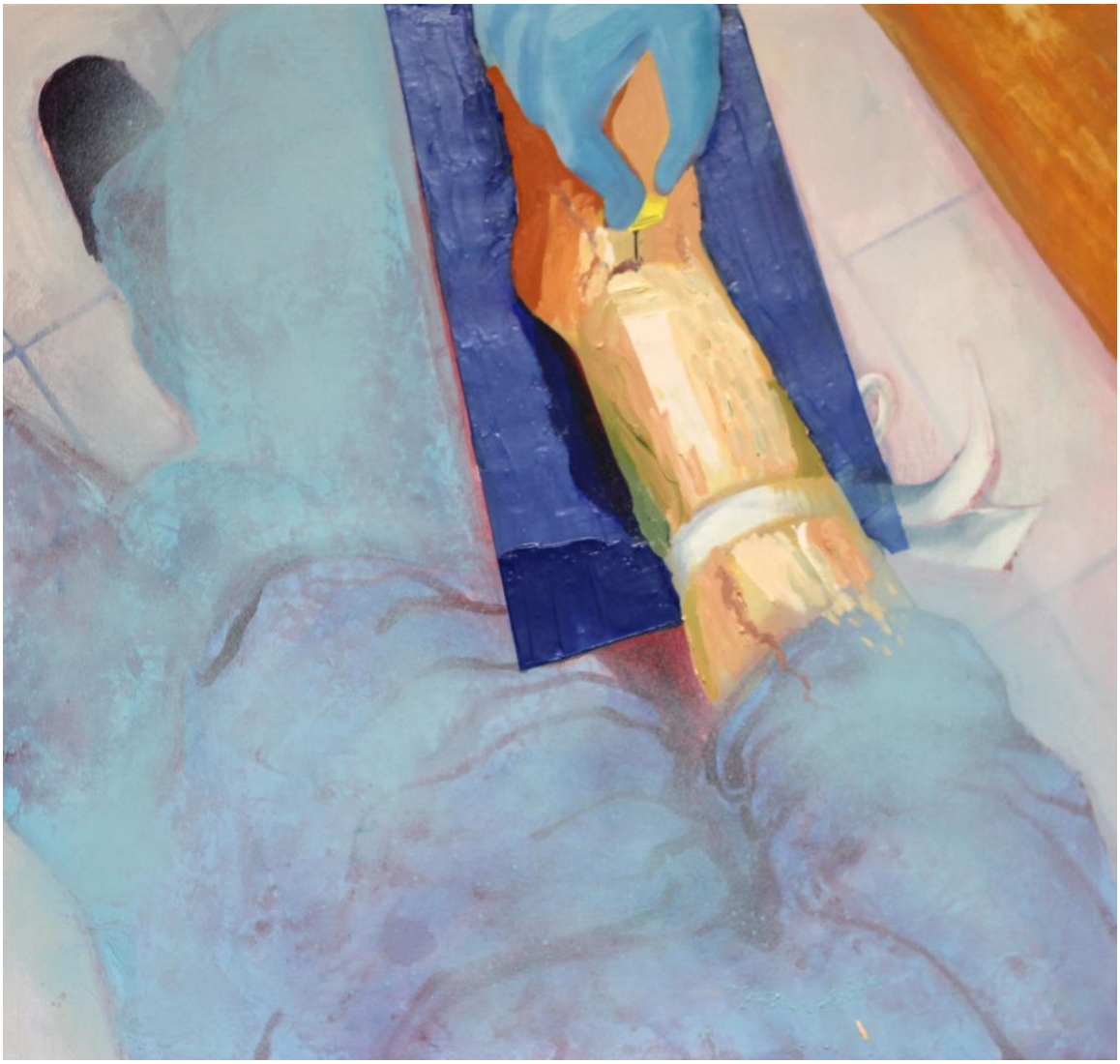

**Figure 3-7** Quagliozzi, Dominic. *Little Pinch*. 2013. Acrylic and silicone on canvas, 32” x 34”.

Reclining in a specialty chair, the body of *Little Pinch* (figure 3-7) is fully garbed in patient attire. The subject extends an arm as a nurse begins the process of drawing blood. A dark vein declares its presence both beneath the skin of the arm and, boldly, onto the fabric of the gown. *Piss Cup* invites the viewer to look downward into the

porcelain bowl of a toilet, as one hand clasps a cup that is being filled with urine, and the remaining hand supports the penis (Figure 3-8).

**Figure 3-8** Quagliozzi, Dominic. *Piss Cup*. 2013. Acrylic and silicone on canvas, 32” x 34”.

Quagliozzi's work hits you fast and hard. The first-person perspective, oriented ever-downward in relation to the body, gives the impression that you are falling into the work: both into the body of the subject but also through it, crashing towards the floors, walls and pooled urine that draw the eye into the environments. It is a dizzying effect, and it lends itself well to the illness narrative with which we are presented. In viewing the work, my body often seems to become the body, the subject of these images, and "my" freefall reinforces this connection as "I" detect the looming risk of collapse, perhaps loss of consciousness or balance. I am pulled by the visceral, vital affective forces of these images that resonate between myself, the work, Quagliozzi, and beyond.

But, as much as I have inserted myself into this narrative, I also look for Quagliozzi. I look for cues that divulge the secrets of the intimate labours his body endures. I see the concurrence of medical bodies, articles, and things, in hospital but also home, and I feel them rendered as signs of affliction and torture, not as healthcare. I think about Quagliozzi, I think about me, I think about bodies and what it means to be in a constant state of infirmity. I think of the word "infirmity": the prefix "in," which can mean "in, on, or not," "firm," to make something physically solid or resilient, and the suffix "-ity," indicating a state of being. There are multiple ways this work interrogates in-firm-ity as both a sick identity and as a porous, "formly" subject underway.

I am journeying through Quagliozzi's work as an illustration of how visual art practice can be a bloom-space of a particular hue of empathy, one that might be most expediently located alongside and within what Dominick LaCapra calls "empathic unsettlement" (20). LaCapra, who adapts psychoanalytic concepts to historical analysis and employs sociocultural and political critique to explain trauma and its effects in both

culture and people, observes that trauma testimonies raise questions about what role affect and empathy take in historical understanding and post-traumatic writing. Identifying a need for a "middle voice" between narratives on understanding the other (which are often plagued with under-standing) and being the represented other, LaCapra presents the idea of empathic unsettlement as a position one takes that is in the middle, playful, and resistant to objective truths. LaCapra borrows the "middle voice" from the work of Roland Barthes, who conceptualizes it as a grammatical position between the active and passive voice that enacts a kind of play that resists dichotomous binary oppositions. As LaCapra applies it, the middle position provides an in-between articulation of an "undecidability and the unavailability or radical ambivalence of clear-cut positions" (20).

I find the "middle voice" to be an interesting piece to the puzzle of the so-called death of Barthes' author-God, and I think that it is the often-overlooked opening that allows us to show responsibility to the subject and their specific experiences without disregarding active elements at play in constituting meaning, knowledge or subjecthood. To make art from the "middle voice" is to create with the understanding that one is affected by the action, that one is written into the work: one makes "oneself the center [sic] of the action," and "to effect writing in being affected oneself…to leave the writer inside the writing," to be a body in the fray; a feeling body that is carried out as action. So, I will here rest an unapologetically long quote that provides some nuance on Barthes' thinking, which rejects the dichotomous treatment of the active and passive voice:

There remains to be discussed one last grammatical notion which may illuminate the activity of writing at its very center [sic], since it concerns the verb "to write" itself. It would be interesting to know at what moment this verb began to be used intransitively, the writer no longer being the one who writes something, but the one who writes—absolutely: this shift is certainly the sign of an important change in mentality. But does it really involve intransivity? No writer, of whatever period, can be unaware that he always writes something; we might even say that it is paradoxically at the moment when "to write" seems to become intransitive that its object, under the name "book" or "text," assumes a special importance. Hence, it is not, at least primarily, on the side of intransivity that we must look for the definition of the modern verb "to write."

Another linguistic notion may give us the key: that of diathesis, or, as the grammar book puts it, "voice" (active, passive, middle). Diathesis designates the way in which the subject of the verb is affected by the action; this is obvious for the passive; and yet linguists tell us that, in Indo-European at least, the diathetical opposition is not between active and passive, but between active and middle. According to the classic example given by Meillet and Benveniste, the verb "to sacrifice" (ritually) is active if the priest sacrifices the victim in my place and for me, and it is middle voice if, taking the knife from the priest's hands, I make the sacrifice for my own sake; in the case of the active voice, the action is performed outside the subject, for although the priest makes the sacrifice, he is not affected by it; in the case of the middle voice, on the contrary, by acting, the subject affects himself, he always remains inside the action, even if that action involves an object. Hence, the middle voice does not exclude transitivity.

Thus defined, the middle voice corresponds exactly to the modern state of the verb "to write": to write is today to make oneself the center [sic] of the action of speech, it is to effect writing by affecting oneself, to make action and affection coincide, to leave the "scriptor" inside the writing—not as a psychological subject…but as an agent of action…While in the modern verb of middle voice "to

> write," the subject is constituted as immediately contemporary with the writing, being effected and affected by it. (*The Rustle of Language* 17-9)

So frequently when the art experience is taken up into affect studies, or when Barthes is referenced in theory, the "creator" is understood to be obliterated or is wholly dismissed as extraneous, making any conception of empathy restricted to a feeling state annulled from an immediate social response-ability and responsibility to the other. Such is the casualty if we must conceive of subjectivities as only significant and useful when they persist in the event, outside conscious and rational activity. To not only understand that the artist persists in the constellation of the artist, art object, viewer and world, but to also have fidelity[121] to them, is to recognize something in "soft" subjecthood, to recognize the relevance of the relational reciprocity that can come from nurturing space for the other. This kind of discreet care given to the injection of the epiphenomenon that is the "formly," "shapely," person does not inherently prevent us from also seeing those fundamental qualities of a subjectivity that has distributed agency within its environment.

LaCapra remarks that any zoomed out objectivity should not foreclose the possibility of empathy or be conflated with objectivism, nor should empathy be associated with a sort of surrogate experience. Empathic unsettlement demands a multi-layered attentiveness to contextualization and the struggle to be as conscientious as possible to the voices of others whose alterity is recognized. Empathic unsettlement, consequently, becomes a form of virtual and not vicarious experience (40). With this

[121] In this sense, "fidelity" is a very different beast to worship in the cult of the author-God, the differences between the two I have attempted to parse out here.

concept, LaCapra is building on Marianne Hirsch's extensive work on empathy and ethics,[122] adding, most notably, his recognition that when one over-identifies with those who are traumatized, one fetishizes trauma, which in turn becomes the basis for what I have been calling "strong" identity, vicarious victimhood and the kind of bad-object-making that we have been attending to in this paper, that lends itself to the impasses of paranoid thinking.

LaCapra explains that events can be taken up by and interpreted through art to produce a "feel" for experiences, "wherein correspondence itself is not to be understood in terms of positivism or essentialism but as a metaphor that signifies a referential relation (or truth claim) that is more or less direct or indirect" (14). This mode of engagement "poses a barrier to closure in discourse…from which we attempt to derive reassurance or a benefit" (41) and when enacting it, we are reminded that narrative accounts are not factual statements that promise a singular proposition of existence, but that they consist of poetic and rhetorical elements – stories that endow events with different kinds of meaning.

The reparative habits of thought present in the art experience migrate focus away from fixed meaning, encouraging a destabilization of the first-person, but not an annihilation of situated knowledge or the epistemological value of the realities of a particular lived—and living—life. The art experience, with its self-conscious, oscillating analysis, makes use of "the shifting subject." It is "the shifting subject" in art practice that allows for multiple narratives and encourages the particular configuration of empathy of

[122] See Hirsch, Marianne. *The Generation of Postmemory: Writing and Visual Culture After the Holocaust.* New York: Columbia University Press, 2012.

which LaCapra writes. Sometimes the shift occurs spatially, through real, illusioned, or imagined physical orientation, like in Quagliozzi and MacLean's work. Other times, it tugs us along through strong, familiar emotions and mood states.

Quagliozzi's *Image Crafting Series* is produced not only by an artist grappling with a debilitating illness but also by a person who is negotiating the world as a sick body infused with burdensome meaning. As I've said, to be sick in the world is to occupy those shadowy rooms of reductive characterizations, each with their own special, and complex flavour of casualties. Perhaps painted as vulgar, unhealthy, abnormal, perhaps lavishly branded brave, heroic and angelic, any "strong" perception projected into and onto the sick body by the world ultimately only acts in the service of giving us the illusion that we are marking a convincing distinction between the "sick" body and the "healthy" one. The need to parse out the difference, which cuts across multiple domains that claim pictures of the body, is an ethical concern that speaks to the overwhelming anxiety of the inescapable, unwieldy and undividable reality: that all bodies persist in a state of disorder.

The subjects of *Image Crafting Series* are many. There is the subject of the artist (his body in the work, as well as his role as the artist), the subject matter of a sick body, the viewer (in the role of observer but also gripped by and taken into the work), there is the artwork, which plays at being an object while simultaneously inhabiting a sort-of-body that holds meaning and grounds the affect-rich experience that unfolds about and between other bodies, and there is the world (the external show of meaning and action, vital and wiggling, ever open to change). These subjects, which indeed occupy positions

of identifiable difference, begin to sway and shift through art practice as they are laid open to the mindful, flowing interrelationships of a constellation.

In encountering Quagliozzi's work, I occupy the space of the sick body and the witness – never permanently grounded in either camp. Instead, I pitch and pivot, unsteady, as I work through multiple narratives and multiple readings of the work. The "strong" values that hold the sick identity does not thrive here, as reductive characterization takes on an undeniable absurdity in this variable space. I am, as a viewer, under no illusions that I am afforded a concrete understanding of what it means to Quagliozzi to live with Cystic Fibrosis, gifted to me by the art object. More precisely, the affective quality of the work, in conjunction with its discursive qualities, moved through the methodologies of the contemporary art experience, engenders a relational language between bodies that advances from sensuously encountering Quagliozzi's work and finding empathic unsettlement through a reparative practice.

Conceivably, we could describe the relationship of "the shifting subject" as one of companionship where the margins of subjects are preferably permeable, and each subject generates and nurtures the other. There is a deindividualization that ensues in the wobbling dance of "the shifting subject," yet, at the same time, "the shifting subject" is in full dialogue with differences and alterities that are stumbled upon in the constellation of the viewer, artist, art object and world. Considered reparativly, these differences would be less anticipated, threatening or inescapable. In thinking through art, we might embrace the mutability of the individual, and see both its flexibility as well as its contextualization.

I am reminded here of Katherine Hawkins' insistence that "the spine of any particular psychic configuration is the nexus of many associations, people, experiences, and aspects of damage and gift" (277). "The shifting subject" is in a constant state of dis/assembling as we search for companionship and sustenance from creative work. "The shifting subject" and LaCapra's empathic unsettlement help illustrate the way that art can allow the viewer to work through multiple world views, traumas and narratives responsibly and, perhaps, transformatively. Reparative creative practice can produce ethically rich encounters through a form of empathy that may enact social change by being sufficiently attentive to models of difference that resist reductive characterizations.

To understand the contemporary art experience to be a reparative approach is to realize that art practice makes space for difference in a way that avoids a problem sometimes seen in critical writing on affect, and, indeed, as a now-and-again-trap of post-structuralism: the escalating ambiguity of subjects/objects, the "infinitising trivialization," the endless and unspecified proliferation of difference ("Tendencies" 108), the unmitigated explosion of boundaries, and the binding and unbinding subjects and objects into oblivion until they lose any clarity about their social context and therefore rendering them politically impotent. Sedgwick, for one, is deeply concerned with the political actualities difference holds. Reparative reading practices allow for multiple meanings while staying ever vigilant of the convergences and interruptions of signification that mark difference and the political realities that can settle in these spaces.

I genuinely feel that empathy is one particularly potent tool that autopathography is especially good at producing, and I believe empathy may be mobilized for productive, world-making acts. But, importantly, it is not a terminal point. Too often, empathy is

posited as a conclusive outcome of the integration of an affect-rich focus into theory, a magical intervention that is equivalent to ethical dealings with the other. Carolyn Pedwell has written about empathy as a political obsession, observing that it is generally viewed as a "positive affective attribute to use for social justice" (McMahon 00:01:00) but in making the assumption, that there is something inherently positive or ethical about empathy, we are, again, shunning more active questions like "what is it that empathy does?" Treating empathy as the teleological goal of art oversimplifies the vital importance of performativity for art and knowledge.

Pedwell's thinking raises a fundamental critique of liberal models of empathy that proclaim the deeper and more precise our knowledge of the other is, the more prone we are to treat them ethically in the interest of social justice (Pedwell, "Carolyn Pedwell"). This type of discourse on empathy seems to submit that to do meaningful work between bodies with immeasurable differences, empathy must provide an "accurate" reflection of what the other is feeling. The problem with equating empathy to understanding the other truthfully is that it sets up a dichotomy that identifies objectivism as one outcome and the projecting of one's own perspective and context onto the other as the opposing option.

We have seen through LaCapra the immense problems such a binary connection turns up. Pedwell insists: "We must understand empathy as a social and political relation that involves the imbrication of cognitive, perceptual and affective processes but [also as] linked with conflict, power, oppression and inequalities [and something that has] the potential for transformation" (McMahon 00:02:16). That is, we need to stop thinking about empathy as a fixed goal that can be equated to truth or ethics and start reflecting on it more carefully. The kind of empathy that is nurtured by contemporary art practice—the

type of empathy that we have been converging on—understands itself to be relational, not a singular experience belonging to one body but produced in concert with a multiplicity of bodies, emotions, contexts and feelings that are never removed from politics or structures of power. Empathy, Pedwell relays, "is a feeling produced among other feelings" (McMahon 00:13:33), feelings, for example, like love (a reparative sentiment) and shame (an emotion of paranoid modes of thought).

A reparative philosophy provides a language for articulating why thinking through art opens up access to care-based ethical relations. Through the ongoing to-and-fro constellation of artist, art object, viewer and world, continuously in dialogue with the past[123] and the making and re-making of meaning, a world of new objects and ideas are made possible. This world-making possibility is developed in concert with empathetic approaches that begin with a different motive for looking: one where we do not already start with the facts that we will unearth. When the idea that empathy can simply be "good" and a purpose-sought solution is complicated, empathy becomes recognized as a moving part, "felt differently in different contexts, with different political consequences" (McMahon 00:10:55). Art practice, accordingly, engages us in feeling-relations that point at the contradictions, associations and oscillations of affect, reparative reading and the fluctuating, diverse modes of critical engagement. Reparatively engaged empathic responses to the bodies present in autopathographical narratives seek to acknowledge

[123] An active engagement with the past and "complex relation to temporality that borrows both backward and forward" is characteristically different from paranoia's "unidirectionally future-oriented vigilance…that requires bad news must always already be known" (Paranoid Reading, Reparative Reading 130).

ethically crucial possibilities: that there is ontological movement in subjects; that the future may be different from the present.

## Conclusion

The aim of this work is to show up the methodological vitality of the art experience, with its affective, and ethically sustainable qualities that can break through so much of the epistemological and practical minefields facing medicine and those who seek to advocate for a more humanistic model of medicine. I presented two major maneuvers. The first was to ask how depictions of the medicalized body inform the epistemological foundations of medicine, to what end, and how new ways of seeing and engaging might radically rework what we believe to be natural and true for medical knowledge and practice. In the second, I ask what a biologically and evolutionarily rooted affect theory does differently for subjectivity, autobiographical accounts of illness and arts-based methodologies, and what the ethical implications of this difference for a humanistic approach to medicine might be.

The trailing metaphor of *The Vitruvian Man* is intended to show that ejecting symbolic value and art process from scientific inquiry has diminished the epistemological strength of scientific inquiry in critical ways. Likewise, the concealed traditions of idealism that *The Vitruvian Man* also represents can tell us something about the state of the medicalized body-object. *The Vitruvian Man*, a representation of divine geometry, is the scared manifestation of man in the perfect image of God, who himself is prefigured as the geometer architect of the world. The ideal body-object of medicine is the singular cake topper, the celebrated figure that speaks to who has power, and who does not. The universal body is held up as the architect and measure, atop several tiers, scaffolded by

the justification that a normal state of health is measurable, and framed by the widely held assumption that medical science happened upon this configuration through a natural evolution of objective scientific knowledge. In asking for a stretching of *The Vitruvian Man*, I am asking for a deep and theoretically rigorous reconciling of art and science and a broadening of the strong, third-person perspective of medicine to allow for the injection of the patient voice in all its multivalences. Like the bio-psycho-social ecology of feeling, which produces scripts that make us better at life, images that communicate or exude joy, peril, resources, and method have always interconnected with actual survival mechanisms.

The image contains operative elements that make it more than contiguous marks captured on a wall, screen, page or sign. The image and our modes of looking are representative of our contingent beliefs about the world at any particular moment or in any specific place, but, importantly, they also bring reality into being. The image, therefore, is complexly tied to our success or undoing. The belief that images can hold stable meaning and be objective makes them powerful and effective tools for writing and conserving particular truths. Where art-based practices seek out realism by looking for the modes of meaning production in the image, the objective promise of the scientific image regularly obscures this function.

In the same vein, the image enacted in the domain of the contemporary art experience orientates the act of looking in the milieu of cultural and material forces exerting pressure. The positivist authority of the “objective” image of the medicalized body obscures the social forces that colour the power we give to particular images, giving

the appearance that they exist outside of the political realm. Thus, the medicalized image of the body utilizes the power to reflect human knowledge as a-political, scientific and natural, when it is anything but, and also to guide and motivate human knowledge, narrowing the political and material potential of the body. In the process of this dual function of the medicalized body-image, real harm is enacted on bodies who significantly deviate from universalized pictures of health. For this reason, we need to pay attention to how human bodies are imaged and imagined in science and medicine and be conscious of the active elements—and limits—of the scientific or clinical gaze. When we understand that the medicalized human body, imaged through schematic anatomical charts, CT scans, X-rays and other representation to be bound up with a social and mythological understandings of illness, we are able to point to the aesthetic preferences that reflect medical archetypes of "health." These preferences, I have shown, can be traced along the various values and epistemes of traditional Westernized medicine.

As medical science and aesthetic preferences evolved, there was a widening in the gap between the patient and their role in self-governing their own health. The Physician became the "skillful minister" (Tabachnick 75), exclusively qualified to oversee the patient, alienating them from their understanding of their own material bodies. Our contemporary era of Pathological Anatomy, I have presented, has been effective in obliterating any need for the patient voice, more in favour, as it is, of the mechanics of technological diagnosis, lab testing and imaging that might start from the patient, but rarely involves them beyond their presence at a moment of capture. The body enters into the body-object of medicine, where its handlers are rarely concerned about its intersections between medicine, iconography, aesthetics, and society. Medical

professionals are often unmindful of this fact because the system teaches them that they are otherwise occupied; their tasks are framed as unconcerned with such things. However, medicine, its knowledge, practice and its pictures are anything but disinterested.

Medicine and its picturing can save or destroy lives. As easily as they can tell us about the status of our organs, they also show up which bodies have been excluded from diagnostic models and studies. As deftly as they can tell us which bodies are at risk for disease, they can also nimbly disclose which bodies are worthy of protecting. As efficiently as tests can determine positive or negative results, testing protocols can order who ought to be believed and who is better off being ignored.

I have shown that disease carries social and emotional qualities in and outside of medicine. Some ailments are signal fires that show up flaws that may be socially condemnable. Other conditions can be worn like a badge of honour, paraded around nobly, like a soldier might after returning from defending her nation in a foreign country. Sometimes disease solidifies belonging, in a particular group or class. These statements are realities, I have argued, only because morality is so tightly entwined with our understanding of health, to the effect that the great structural violence the politics of health does to marginalized people can be hidden under more individuated questions around food choices and sexual activity (Kirkland 4). Morality, health and its images are tied together. They inform the clinical and scientific gaze which galvanizes medical research and practice. If health is understood to be a stable entity, with characteristics that we can visually recognize, then we inevitably are entitled to the assumption that health is something we can apply through overarching social strategies in all corners of society.

Health is often an ideological position that says more about power and politics than the material realities of a soft and vulnerable body that is at once ageing, healing, and dying.

Looking at multiple studies and research about medical bias and research disparities (All-Party Parliamentary Group on Women's Health (2017), P. Wilson (2007), Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities (2017), Ulrich (2014), Shakespeare (2009), Gamble (1994), Papiernik (1990), Centers for Disease Control and Prevention (1990), Darling (2013), Dusenbery (2018, 2019), I have illuminated how the skewing of medical knowledge is enacted and how it ultimately is harmful to everyone as frameworks of bias have a multiplying effect. I have also shown an epistemological urgency to address how morality, health and its images can limit our ability to expand our medical knowledge regarding the capacity of the human body and the sick experience. If our images hold power to guide future knowledge, regulating our models to self-affirming paradigms narrow epistemological potential by simply not being equipped to handle alternative health experiences and understandings.

There is a crisis in medicine that is not new: evidenced by poor patient outcomes for women, LGBTQ+ people, people with disabilities and people of colour. I have tried to highlight that biomedical knowledge has been distorted to the point that almost all we know of diseases and their successful treatment is based on studies that centre the universal white, male, able-bodied, straight, cis-gendered patient. The reality is, we know far less about human health than we think. Without embracing openings to alternative bodily experiences and expressions that allow us to re-picture health, expand our understanding of diseases and their impacts, we remain in a medical framework where

the majority of the human population, what I have termed the "majority-minority," challenge diagnostic standards.

A significant bioethical problem that I highlighted through Jan's work is the link between insufficient care for the patient's "phenomenological well-being" and patient outcomes, underscored here through a lens directed at transplant patients. Medicine has shown itself to be ill-equipped to network with the symbolic elements of a transplant. It is not that the symbolic elements of a transplant can not be integrated, but rather, it seems that the current picture of health in the medical system imaginary lacks avenues for patient pathographies to be expressed in a way that can be heard and felt in their treatment. Bachman's *Hybrid Bodies* initiative seized on this need as it seamlessly parallels a significant concern in the organ transplant symbolic and material reality, the self-other dynamic, with a platform for the patient experience to be heard and felt. Jan presses the need for processes to be set in place in medicine that allow patients and physicians to explore existential questions that can quell this unaddressed bioethical problem ("EXHIBITION: Junctures of a Haphazard Kind"). What *Hybrid Bodies* does that is most exciting to me, is stress the weight of patient knowledge in a network of collaborators. In seeing the value-added epistemological potential of utilizing the surprising, useful and often novel information the patient can contribute, *Hybrid Bodies* becomes a robust political project for a bioethics that can bend to fit a multitude of experiences. *Hybrid Bodies* is one example where the movement between the artist, artwork viewer and world can be leveraged to challenge insufficiencies in healthcare models in powerful ways.

Because the scientific method makes methodological moves to form images that are understood to be at once functional and faithfully "real," the symbolic and inventive aspects of the scientific image are often disguised as truth. Thus, its images are easily and regularly conflated as a representation of the real world rather than a single, more or less accurate, interpretation of an idea or event based on current and particular knowledge. Scientific-looking employs a methodological approach that is suited to recognize the first function of the image, the feature that illustrates human knowledge. It is much less suited to recognize the second, the function that actively reproduces past knowledge and coproduces future knowledge. In this undertaking, I have tried to underscore that the power of the image comes from the methodological moves we engage in our mode of approach, and I have looked at how the vitality of our tactics can perform potentiality and confinement. My initial endeavour here was to work to fully dismantle the "subjective" and "objective" taxonomy for images, and in doing so, to brush off much of the authoritative aura of the artifact that is the "objective" image of science. I insist that we find ways to be actively critical of the knowledge that produces and is produced by the image, and its trappings of fixity and necessity.

I have shown how ways of looking are not stagnant across disciplinary or historical boundaries. Art, at some points, has analogously engaged the viewer in much the same way as scientific-looking has. A sharp distinction between art and science is a comparatively new phenomenon. In fact, it was through technological advancements by artists that gave us linear perspective and the development of optics, which walked hand in hand with the readings of images on the lens of Galileo's telescope (Richmond 81). A Renaissance man was not a "Renaissance Man" because he excelled at many things, a

Renaissance man was a “Renaissance Man” because contemporary disciplinary boundaries had yet to shuffle intellectuals into deep corners far away from each other: the “many things” were just not especially different things. In this contemporary moment, as I have displayed, the siloing of knowledges and methods have led to two very different kinds of meaning-making and world-making in art and medicine, in particular.

By highlighting contemporary approaches to experiencing art, I have injected into the dialogue an indeterminate map for meaning-making that rejects systems requiring a universalist notion of objective reality, truth, morality or progress. As a mode for directly meeting with, and interrogating knowledge face-to-face, in a social process, the art experience provides a more vital framework. The structure of the art experience is just as subject to value systems that reflect particular historical, political or cultural discourses as science or medicine: paranoid critical practices are just as prevalent here. What is different, as I have tried to show, is that the methodological approach to looking in the art experience acknowledges the role of the artist, viewer, art object and world in an unending process of meaning-making, while also recognizing that all meaning made is contingent on the whims of a wiggling world. When we can see that meaning is made collectively and flexibly, we can see that meaning is not only resting on the image but also spilling in from, and onto, the environment around the image.

I have outlined several strategies in the art experience that gives it political potential for ways of knowing, but I have deliberately avoided compiling a definitive list. Such an effort would be ineffectual and insufficient. Instead, I have distinctly articulated several consequential—though broad—moves. These have included “the shifting subject,” rhetorical and visual modes that allow for narrative without trapping it, and the

yearning “to act and be acted upon” (Gregg and Seigworth 1). Further, I have stressed the theoretical, biological and applied importance of making space for an energetic sociality that appeals to nuanced and careful relationships. I have included a claim for the epistemological vitality of an ambivalence to truth-value, the readiness for repeat and revised readings, and a desire for surprise. I have outlined how arts-based methodologies bring a tendency toward self-reflexivity in the epistemological process, a constant recognition that method is a way of knowing, different from a thing known. It actively supports a tendency for oscillating critical practice that can at once hold on to “strong” and “weak” theory as well as paranoid and reparative critical practices. And, the last gesture I will gather here is the affective qualities of the art experience that enjoin the ethical capacity of empathy through the reparative approach which lies in the capacity for continual re-formation, where damages done can be lovingly restructured. When these possibilities are forefronted as distinguishing features with an unsettled empathy, affect is itself politicized because what is being declared is this: the capacity of a body—what a body is and what it can do—is not alone defined or produced through structures of power or biological essentialism but in the in-between-ness of the context of its force-relations. There is potential to compassionately alter the political consciousness amid the constellation of artist, art object, viewer and world.

Medicine, as this project affirms, could take something vital from the methodology of the art experience. The right angle of approach must always be of crucial concern. As I said, if a healthcare worker is trying to engage with a patient’s sick experience at the tail end of the complex structural problem of the mythification of health, which infiltrates both the patient’s narrative and the healthcare worker’s

interpretive power, it is exceedingly difficult for either party to distinguish what would best help the patient from what ought to be done to attack the disease. Autopathographic accounts of illness are powerful and important, but they do not, alone, fix this problem. As I wrote in *Mirrors and their reflections: idealized victimhood and authentic experience*: the patient experience and the medical institution can seem like two mirrors reflecting the same image back and forth forever: both projecting an idealized picture of health or illness that does not always fit the circumstances at hand.

The arguments I form around what I call the dual functions of the image show that even the most devoted act of reading and contextualizing the image is not a clear path for repairing it. We have long placed far too much faith in exposure as a guaranteed solution to the problem at hand. Autopathography can lend a voice to the patient experience. Still, it is the methodological tools of the art experience that actually enables us to find ways through the stubborn and self-contradictory myths of health. The scientific method that holds up medicine is anticipatory: suspicions must be investigated and confirmed. When the search for confirming, symmetrical relations is the methodological core of your practice, when you can only prove yourself through yourself, you are going to be very good indeed at uncovering some vital things that impact patient outcomes, but utterly blinded to other, equally impactful and dynamic concerns. Medicine has a moral obligation to find ways to include methodologies that are flexible and ethically vibrant, ones that are energetic and responsive, that enact “weak” theory, and are, therefore, capable of being more realistic. The earnest integration of this kind of methodology into the monolith of Westernized Medicine is not only epistemologically useful but also, I think, essential.

The affective dimensions of the art experience are fundamental to the active politics of the framework. I have worked to show how autopathographical accounts of illness can find a home as well as coherent logic nonrepresentational theory. In doing so, I have argued for a middle ground approach that allows for the representational, including the "aboutness" of art to maintain dynamic playfulness while also making space for politically important situated knowledges and subjectivities. I called on Hans Radder's argument in *The Philosophy of Scientific Experimentation* (2003). Radder reminds us that our notion of stability, which is central to the history of scientific experimentation, has us measuring the unknown against elements that are understood to be straightforwardly constant. Radder alerts us to the reality that stability, in practice, is far richer than mere lack of change. He shows that we ought to question our initial taken-for-grantedness and misjudgment that stability, as a concept, is equivalent to protected from change. This is as true of scientific experimentation as it is of the other extreme in nonrepresentational theory: the belief that change is unescapably threatened by cognitive expressions and patterns that hold the shape of consistency.

I have outlined some potentially useful strategies for actively working to combat the picture of "health." First and foremost, it would seem that an amplification of patient autonomy and self-determination over one's own health is a logical place to start. Autopathography is just one way that this conscientious effort may be enacted. Embodied health initiatives have had some success as well, though, as I pointed out, they do follow an authentication pattern that is not without some risk of homogenizing the patient experience. Still, they are tremendously effective at unseating some of the power the patient had lost to medicine, increasing the value of the patient voice for patients and

medical professionals alike. I have also advocated for a careful excising of the universal body as a marker of ideal health by abandoning the objectivist model of medicine that remains culturally and creatively wedded to dualism, and by attending to the patient experience in ways will run counter to much of our current medical models.

I don't anticipate or even advocate for an entire shakedown of the medical model. Still, I do think that a careful and committed injection of new methodological frameworks, and the acknowledgement of the activated and vital structures that are hiding within the so-called scientific method of medicine, are paramount. Medicine is not the single-focus pillar it masquerades as. Rodman recognized this when he said that medicine has "far more in common with engineering or law or even the clergy than it does with any science" ("I Know Nothing"). G. Engel has insisted that the traditional biomedical model be entirely replaced by a "biopsychosocial" one (129). And, A. Hawkins directed that medicine shape its profession as one committed to the welfare of sick persons, over the treatment of disease (XI). Such a central change in perspective requires we also let go of our cultural desire to master death, as illuminated by Choron (1978), Stephenson (2007) and Becker (1985).

The gallery might be good at triggering the viewer into a particular way of seeing, but it is not the only place to lodge the art experience. In my clarification of practical applications for arts-based initiatives and methodological uses, I point to shows staged in hospital settings (*Human Condition* (2016)), that have taken themes such as the exploration of "the corporal and psychological experience of being human" ("Human Condition"). Some directly pick up the patient as subject matter, as I pointed to in the University of New South Wales (UNSW) Galleries' 2016 show, *The Patient*. Quagliozzi

has shown his autopathographical work at the Keck Medical School at the University of Southern California (*Shared Matter: Work about Sharing Art, Lungs, & Social Media* (2016)).

Just as we may imagine projects that uproot the art experience from the white cube and transpose it into medical institutions, we can think through the reverse. I offered a key example of what is perhaps the most institutionalized ritual of medicine, medical school—the making of medical professionals—being moved into the gallery space. Macmaster University's pilot program *The Art of Seeing* endeavours to bring visual literacy skills to medical residents, aiming for "a more humanistic approach to medicine" ("The Creative Art of Medical Inquiry" 250). All of these initiatives, inside or outside of medical and art establishments, removed from predictable beautification or specialized therapeutic labours, are marked by their political activity. The examples provided also show there are already many endeavours underway that signal an eagerness to find moments for productive exchange between art and medicine.

Exchanges between art and medicine are not exclusively valuable for medical professionals and artists. Autopathographies leveraged into the public domain with an eye for reciprocal exchange is stimulating for questioning the everyday mythologies of illness. Curator and scholar Rebecca Dean has written in *The Patient: Biomedical Art and Curatorial Care* (2018) about the large-scale touring exhibition *The Patient: The Medical Subject in Contemporary Art* and its accompanying ebbs and flows of reciprocity between not only the viewer and work, but also an economy of care she locates between the curator and artist (142).

Opening up to affectively rich engagements that overlap clinical research and illness studies with art initiatives would compel the medical gaze into a self-reflective dialogue where it could be taken up as research. In this space, the medicalized body can be imaged and imagined as a counterpart to the viewer, entangling bodies in the dynamic of "the shifting subject." Entangled bodies, felt through the body, pose a formidable challenge to long-established divisions between the observer and the observed and the patient and practitioner. We can use the art experience directly or borrow its methodologies. Both options offer opportunities to find affectively rich encounters with pictures of the medicalized body and sick experiences that can free us from the dual-functionality of the medicalized image and the body-object, increasing the potential of the body.

My research has folded in work by scholars such as Gilman (1988, 1995), A. Hawkins (1999), G. Engel (1977), Knibb (2015), Podedworny (2015), Wekerle (2015), Zazulak (2010, 2015), Halgren, Tan and Grierson (2015), who have made arguments, as compelling as they are diverse, that urgently call medical students who are skilled in the humanistic dimensions of medicine. I have blended key ideas from scholars such as Metzl (2010), Kirkland (2010), Svenaeus (2019, 2003, 2011), Gilman (1988, 1995), A. Hawkins (1999) and Jan (2018) to make clear the need to drastically reconsider medical practice and education with an eye for an expansive approach to patient care. More and more, medical researchers and educators are resonating with this need. I have argued for integrating arts-based education into medical training and supplementing existing scientific and clinical methodological processes with the strategies of the art experience to complicate the act of looking and the image of the medicalized body. Finding entry

points into education, through the naturalization of visual culture learning is a strong conduit for this amalgamation. On-going, professional development that takes medical professionals out of the hospital and into the gallery, like *The Art of Seeing* does, is an evidence-based strategy to hit many of the primary concerns of this paper. Interdisciplinary methodological tools can be leveraged in clinical practice to open up space to seek specialized knowledge from the patient. The opening may come through exercises and actions that give voice to the existential aspects of a patient's phenomenological well-being, a deficiency in care outlined by Jan (2018), and Svenaeus (2019, 2003, 2011), or, as A. Hawkins (1999) frames it, the neglected personal and social dimensions of medicine, through the break of arts-based autopathographical accounts, as we see in Bachman's *Hybrid Bodies* project (2016), or even in Aronson's *Autopathography: The Patient's Tale* (2000), where we are told that illness narratives of patients "help doctors understand their patients better and teach them things they won't learn from textbooks" (1599).

In taking one of these routes, the integration of the looking strategies of the contemporary art experience will necessitate a stretching of the picture of health, the ideal model in medical research that directs patient care, by forming a more realistic image of everyday life and subjectivity in breaking down the illusion of the objectively derived, natural body-object of medicine. So, too, will it demand medicine find ways to account for the environmental, social and psychological as equal players with the biological components of the picture of health. Forming a holistically understood picture of health that takes into account the patient's varied embodied proportions (both inside and out), means the ideal body of medicine is not merely determined by the subject at hand, but

remains a moving target, at the ready for revision, reassessment, and rehabilitation. Here, the inherent value of hearing the voice of the patient must flourish, as the patient becomes fundamental to identifying the image of health by pointing to the shape that the target might take at the moment.

For medical research, this change would require a commitment to drastically broaden the long-established conventions and preferences for focused trials and subject groups – a massive undertaking in its totality, to be sure, and one that will be continuously deeply encumbered by a wider net of social injustice that informs not only what research is valued, but also what research is funded. But, it only seems like an enormous undertaking because we are used to large-scale solutions. As Sedgwick has shown us, small scale, one-step-at-a-time headway can be dynamic and powerful, good at squeezing past the traps and pitfalls, all the better equipped to find new ways forward through both good and bad surprises when they inevitably do appear.

One casualty of the meaning-structure of medicine that I briefly touched upon is the devaluing of individual knowledge and practical reasoning of medical practitioners. I identified a need to place more value in this experiential knowledge (the applied biology of health care) in addition to the patient's. I borrow one practical solution from advocates of a phenomenological approach to medicine and thinkers like Leder (1990), Gadamer (1996), Aho (2018), and Svenaeus (2019, 2003, 2011). Svenaeus, in particular, proceeding from a first-person perspective (patient knowledge), combines the second-person perspective (the healthcare professional and their experiential knowledge) and lastly, compares and connects with the third-person perspective (institutional knowledge)—to form a plan of action (Svenaeus, A Defense 461). This approach is

operative because it understands illness as a thing more or less nested in various communal knowledge banks. It also serves as an example of a simple well-being clinical practice that can, as I observe, incorporate characteristics of a methodology that is comfortable with oscillating critical practices. The responsive "first" and "second-person" perspectives are placed first, with the "strong" "third-person" knowledge of the medicalized body-as-object recognized constructively. Svenaeus show us a practical approach where participating in oscillating practices can open treatment up to new insights and possibilities in healthcare and wellness. He shows us how alternating procedure—the mode of approach—can reveal hidden truths in biology and medicine.

There are also efforts underway that lay foundations that provide excellent opportunities for injecting creative and oscillating critical practice into healthcare. I see applications in initiatives that are contemplating the folding of pedagogies from the humanities into biomedical and clinical education by scholars like Allan Peterkin and Anna Skorzewska (2018) and Rita Charon (1995, 2001). Charon stresses the importance of "narrative medicine," an idea that hybridizes close reading of literature with evidence-based medicine, that comes from "the ability to acknowledge, absorb, interpret and act on the stories and plights of others" (1897). Slow medicine, and slow medical education, advocated by Delese Wear, Joseph Zarchoni, Arno Kumagi and Kathy Cole-Kelly (2015), sees value in "slow and thoughtful reflection and interaction in medical education and clinical care," with an aim to "offer ways for learners to engage in thoughtful reflection, dialogue, appreciation, and human understanding, with the hope that they will incorporate these practices throughout their lives as physicians" and to "fully incorporate their experiences into a professional identity that embodies reflection, critical awareness,

cultural humility, and empathy" (Wear 289). The principles of slow medicine are exceedingly helpful in that they recognize that even in hectic clinical and curricular spaces, the deliberate manner of slow medicine can be integrated. Slow medicine is also in many ways, a critique of the oppressive, internalized tendencies of capitalism that make institutional change seem counterproductive given the unreasonable demands and strain we have normalized in the practice of clinical medicine.

All of the initiatives mentioned above, and many more that I have taken an interest in over the long span of this research, could broaden applications and uses for the methodological and conceptual concerns this work has congregated. Not only is it my hope that some of the methodological strategies presented here could find creative applications in the future work of others, but I also hope the ways I have complicated the entanglements between the mythological aspects of the sick experience and sick narratives might act as a helpful resource for focused advocacy efforts, like the case of the varied and important embodied health movements that have become more and more common. Perhaps we could all put in the effort to ensure that we are a little more careful about how we all participate in the building of shadowy waiting rooms of idealized victimhood for the sick body?

I have tried to clarify that my critique of medicine recognizes the many people who are working very hard to think through patient-centred care and the humanistic dimensions of medicine. I have also tried to clarify that both the dual function of the image and the "strong" scientific theory of medicine are not persistently operative because they are realistic or epistemologically precise, but remain operative because they are gilded—blindingly so—in the mythological aura and accompanying authority of

objective truth and necessity. The critique I am making is that the culture and meaning-structure of medicine are hamstringing patient care by continuing to harness structural and applied theory that reinforce the illusion of its compatibility with hard science, a corresponding faith in exposure, the positivist view of the truth-value of the image and the understanding that its subject as the universalized body-as-object.

We have landed, tautologically, in a very particular conception of care in healthcare. We must recognize our methodological approach reveals a great deal about what has historically been valued and what is unimportant to medicine. It is easy to point to overworked, under-supported healthcare workers and question how it is we expect to ask more of these folks, and this question is valid. But, perhaps the most politically urgent move anyone can make at this point is to integrate an alternative approach that works first and foremost toward ethics of care that can realistically describe reality and self-consciously form it too; to move to accept the challenge to confront the hegemonic effect of single-focused versions or accounts of method; to move to realize both a decryptive and descriptive view of near and far phenomena; to always search for a lively and living exchange in the spirit of interdisciplinarity, and care.

So, as I see it, my project finds ways to apply or think through embodied knowledge and methodological vitality in four key domains: visual culture and scientific looking, clinical practice and medical research, affect theory and critical thought, and lastly, creative practice. Thinking across these four domains is done with the express purpose of finding theoretical footing that can accommodate the activated political power of the sick experience in a way that is theoretically consistent and capable of attending to the patient perspective, underscoring patient experience as a central component in a

larger network of collaborators. By my assessment, most, if not all, research endeavours that fall under the purview of this project's concerns—which all succeed in harnessing a level of methodological vitality and oscillation—have significant overlap in most, if not all of these domains.

A structural analysis of the methodological vitality and limitations of disciplinary practices in, outside and through medicine, seeks places for the amalgamation of arts-based methodologies to circumvent the conceptual traps of a "strong" theory of medicine. Through the work in each quadrant, I am building and layering a recipe of sorts of the key devices the task at hand requires to be integrated and theorized cohesively in all corners. The recipe includes devices like the dual function of the image, our faith in exposure, the universal body object of medicine, the sick identity, the shifting subject, and "strong" and "weak" theory. I do the work to try to ensure the theoretical groundwork is reparative, cohesive and ethically viable. I use the work of Bachman, Quagliozzi and MacLean to enact, theorize and demonstrate how arts-based methodological frameworks respond to these same devices, teasing out the epistemological work underway.

I see my project as particularly important but also challenging, as so much theorizing around embodied research categorically rejects biography and any kind of an identity, including a sick identity. Finding moments of political necessity and activation in pathography and sick identity in a way that can have movement and consistency across several domains is, I believe, politically urgent and necessary when medicine is the subject because the living history of Westernized medicine makes the obliteration of the subject a political minefield with casualties that are not merely of the philosophical

variety, but material. There is a lot of work being done that already fits the mould of what I advocate for in many domains, and I don't think the work of this project is particularly prescriptive in endorsing or even claiming expertise over the specific approaches that are being utilized, rather, I understand my work as an effort to provide theoretical underpinning for these projects already underway, providing a consistent model for thinking about the work in action, the "work" of these processes as it relates to their methodological frameworks, and all the limitations or potentials that coincide with process.

In the end, the stretching of the Vitruvian Man is not just about demanding more inclusive research and clinical practice for those who do not fit the ideal mould of medicine's body object. I think it is also a call for a stretching across disciplinary boundaries and knowledge banks. It is not a call for a new methodology so much as it is a call for a reach towards different and sometimes counterintuitive methods towards a methodological vitality that is more realistic and hopeful. The stretch is flexible, bendable and reparable, but I also think, importantly, it has coherence and appeal to many researchers and practitioners who are already hard at work producing research that could be theorized, in part, using the tools that I hope I have provided.

As I wrap up, I want to acknowledge that it is especially urgent to be asking questions like these in a time of a global pandemic that disproportionally targets marginalized groups who suffer under social and medical violence. To ask questions of how the image and imagination regarding the body object of medicine might make it harder, not easier for us to find new answers in medical research and discovery is a concern, as we strive to understand COVID 19 physiologically. How our social

understanding of contagion and illness feed back and forth between the domains of public health and popular culture, gaining immeasurable and often startling representations, is something we ought to pay attention to. So too, I think, we ought to make a note of the responses that are already underway from our creative spheres: the writing and making that call and respond to the swirling cultural and viral forces that have so significantly stuttered the world as we knew it.

How do we picture this illness? How do we respond collectively with empathy and hope? How might we proceed so that the world-making capacities of our processes and knowledges bring into being a future that might look different than the world looks now? – these are the questions my project presents.

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