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ARTICLE

How Symptomology Substitutes for Subjectivity

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Abstract

For most of my scholarly life, I have studied subjectivity—insisting, through the method of *currere*, that education is less a noun than an infinitive, an ongoing existential undertaking. In this brief reflection, I turn that longstanding preoccupation toward my own experience of cancer treatment. What I discovered, and what startled me, was not simply illness but the gradual substitution of symptomology for subjectivity: the displacement of inner life by the management of bodily events. At a moment when this themed issue invites minoritized scholars to write from cancer's dirty margins, I find myself confronting a different marginalization—the quiet eclipse of the self by the clinical accounting of its symptoms. This essay provides glimpses of that substitution and asks what remains of subjectivity when the body becomes an inventory of side effects.

Keywords: cancer; chronicity; curriculum studies; queer theory

In this brief analytic work, I recount my experiences of the impact of the past year's treatments for cancer of the neck, especially the effects of a month—October 2025—of daily radiation and weekly chemotherapy, detailing the effects more on my body and less on my subjectivity.[1] As a lifelong scholar of the pedagogical humanities, this awareness has been a kind of epistemic shock. That's my main point: During treatment and for the year after—although I'm still in treatment (Keytruda rather than radiation and chemotherapy) —symptomology has substituted for subjectivity. Reviewing my journals, I see that my diary entries depict less and less about what I'm feeling and thinking—my subjective life—and increasingly, then almost exclusively, my symptoms, in effect, substituting symptomatology for subjectivity.

This shift in the structure of my "lived experience" and my representation of it in diary entries is not exclusively cancer treatment related; I had noticed that in my mid-70s, as ageing turned my body morphed from (in youth) my best friend to, in age, an arch enemy preparing to murder me. My companion and caretaker during this year-long ordeal has been my husband JT with whom I celebrated our 30th anniversary together on September 26, 2025; here I will acknowledge how our interracial gay relationship was received by medical personnel while being treated in Bellingham, Washington, a small city of 90,000

[1] Such as Pinar 1975, 2006, 2025.

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residents some 30 minutes south of the Canadian border, and in Seattle, where I was also treated at the Fred Hutchinson Cancer Center.

1. Cancer free?

Immunotherapy worked: in July 2025 I was pronounced "cancer-free," although 2 months ago a swelling appeared near the site where the malignancy had been. A scan showed the swelling was not malignant. The oncologist seems unconcerned; his nurse—when I pressed her—told me that such abnormalities were not uncommon after radiation, even a year after radiation ends, which it has now been. If it becomes cancer that would be doubly discouraging, as I'm still being treated with Keytruda, the immunotherapeutic drug, an "infusion" (I prefer the term "injection" as the letter "j" conveys the violence of being stuck with a needle and living with the drug's side effects, hopefully one of which is this swelling below my right jaw).

Despite being pronounced "cancer-free" in July 2025, the immunotherapy oncologist strongly advised two years of continued immunotherapy—meaning many months more, until April 2027—as, he informed me, research has shown that is the optimal duration in preventing a reoccurrence. That information sobered me, as did his inability to diagnose regular post-treatment near-falling spells although alprazolam (Xanax) and metoprolol (my cardiologist's recommendation) reduced their frequency and intensity.

The oncologist prescribed Xanax, speculating that somehow it would sooth something irregular happening in my brain, damaged by a stroke I suffered during that horrendous month of daily radiation and weekly chemotherapy. The cardiologist—whom I see regularly after a heart attack over twenty years ago—is convinced these spells were heart related and prescribed metoprolol, which I'd taken before for high blood pressure but had stopped taking when I lost 50 pounds during radiation/chemotherapy, producing not high but low blood pressure, which the hospital emergency room doctors blamed. The combination of the drugs works best, as two drugs together seemed to have done the trick. But long-term use of Xanax has—or so the internet informed me, but I'll double check with the oncologist—unwelcome side-effects, including dementia and mental illness. I have not been feeling so upbeat anyway and have in fact requested a referral to see a psychiatrist.

2. On what remains

All this is to say I do not feel recovered, as one might feel recovered from a cold or the flu. I remain extremely weak from 10 months of living on the couch; I resumed light stretching exercises only 3 months ago. And now I see a trainer (who specializes in old people—I'm 78) twice a week at a Bellingham gym although I cancel when I've suffered a night of insomnia. Then there's the radiation damage done to my neck and shoulder, leaving both extremely stiff —my massage therapist describes it as like working on freeze-dried meat—and somewhat immobile, causing pain when I try to reach too far. I do not intend to paste over the good news —cancer free, which, after I told my husband, is what he shouted out the car window, he feeling elated while I still felt only empty, if momentarily gratified by his excitement.

3. Where is the real me? Or is this the old me?

While in remission—apparently my cancer cannot be considered *cured*—I do not feel elated. It's not the "old me" (the pre-cancer me who walked 2 miles each morning, trained on

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weights three times a week with a trainer, and kept quite current with all the corporatized university demanded of me) who has emerged (for now) from this death sentence, but a very old me, weakened, weary, waiting to die, feeling irreparably damaged from the treatment. After Keytruda worked, I asked the immunologist-oncologist why I had even been prescribed daily radiation/weekly chemotherapy with its awful side-effects—near death and apparently irreparable damage done to my shoulder and neck, never mind the stroke and falls (one near-fainting spell wasn't "near" at all, resulting in an ambulance run and consequent hospitalization)—when immunotherapy has only caused a rash (which a prescribed cream keeps under control) and extreme fatigue (plus this swelling below my right jaw?). No satisfying answer from the immunotherapy oncologist, only a reiteration that the chemotherapy/radiation regimen was standard protocol and that there was a chance of success, even though it was stage III and an aggressive cancer at that.

Once again, before an MRI done in Seattle showed the spot in my brain tissue was damage from the stroke and not metastasized cancer, the earlier diagnosis of the Bellingham-based radiation-oncologist had been cancer; he wanted to restart radiation immediately, so I sought a second opinion, again from the Fred Hutchinson Cancer Center in Seattle, some 2 hours' drive away, the last hour always stuck in bumper-to-bumper traffic. (We live approximately 2 miles south of the Canadian border, moving here after three years in South Surrey, a suburb of Vancouver, British Columbia, Canada.) I'd sought a second opinion from the Fred Hutchinson Center after learning the radiation/chemotherapy treatment had (as the radiation oncologist put it) "knocked the cancer back but not out." The doctors there—impressive they were, as are the buildings wherein they work—also recommended trying immunotherapy, which, if it failed, would leave surgery as the final strategy to address the cancer.

That's how the cancer was discovered, a failed surgery in nearby (our home, not Seattle) Bellingham after that summer (2024) of several tests (including a biopsy, which gave a false benign diagnosis). While that Bellingham-based surgeon was unwilling to complete the surgery—he cut me open thinking the growth, a cyst, was benign, but the malignancy had spread during the summer (the swelling had appeared on my neck somewhat suddenly in mid-June 2024) into my shoulder, prompting him to sew me back together and send me off to radiation/chemotherapy. The surgeon at Fred Hutchinson—a handsome Italian-American man (my second long-term gay relationship was with an Italian-American man in Rochester, New York, so I noticed not only his name) in his early 40s maybe—said he was willing to perform the surgery although he warned me that I'd lose the use of my right arm (I'm right-handed) and possibly the whole right side of my body. So my hopes were pinned on immunotherapy.

4. You're not so gay. Or. Are you still gay, after all?

My third gay relationship is with JT. We married soon after the U.S. Supreme Court made that possible—we have been together thirty years as of last September 26 (2025). I cannot imagine I would have lived through the radiation/chemotherapy month (becoming so weak J had to lift me off the couch even when I needed to visit the bathroom) so I ended the onslaught a week early; a decision the radiation oncologist referenced (self-protectively I thought) when he communicated the treatment had "knocked the cancer back but not out." I realize this is a special issue of *Public Humanities* devoted to the experiences of minoritized folks in treatment, which could then, for us as a gay couple, include homophobia JT and I might have experienced during the treatment regime. Additionally, of course, the impacts of

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racism in the face of an interracial couple. The truth is that neither of us discerned any judgements or antipathy from any physician or nurse, neither in Bellingham nor in Seattle.

I realize vividly that I am actually stretching here to include gay content, but sexuality is not the main point of my autobiographical account of being treated for cancer. Perhaps like many gay men of my generation, I still sexualize (in fantasy, not behavior) much of the time, especially at the gym (surrounded by pumped-up 20- and 30-something guys) but even watching TV—oh, "Heated Rivalry"!—or listening to serious podcasts on geopolitical topics (ah, Ed Elson). I loathed the radiation experience—even before its devastating effects became apparent—as I was asked to lie on my back on a minimally comfortable platform, a plaster mask over my face, and my shoulders and head strapped tightly to prevent any movement, so the radiation could be directed at the malignant areas only. I requested and was prescribed a tranquilizer—I took two, which helped—but in panic I also tried sexualizing the event, especially when a 30-something young man took charge of what sexually speaking seemed a little like a weird, unwanted S & M event. I tried to convert the claustrophobic strapping around my neck as a sexual chokehold—not something in the past I've ever myself found sexually stimulating, except sometimes watching it in porn—as the radiation treatment felt like invisible nonsensory rape. You're not my "type" I found myself telling Z—he seemed surprised by my statement but not homophobically so—but I nonetheless sexualized his instructing me to lay down, on my back, then strapping me in. At first, the straps were too tight; patiently, even softly, he explained why—probably not for the first time—but I felt annoyed, as in "get on with it," "fuck me now and get it over with." I learned after treatment concluded that Z is gay, has a younger even more handsome boyfriend, a partner I suppose since they have bought a house together in the border town nearby (Blaine, Washington). Months after the radiation treatment ended, I invited them over; they were polite but shy, and so I asked questions to keep them talking; Z promised to have us over when their newly constructed house was finished sometime during summer 2025, which was last summer.

5. Cancer's winter

I'm writing during another rainy, chilly Washington state winter. It's January 2026—but Z never got in touch, and that's okay. I do not want to remember radiation any more than I do although my atrophied neck and shoulder muscles never let me forget for long, as do the exercises I'm assigned in physical therapy and by my trainer at the gym. There are pleasant, competent women who work at the physical therapy place—in that border town nearby—but of course I'm always wanting the 30-something-year old male therapist, an Afro-Canadian born in Calgary, educated in Michigan; sexualizing Justin is almost effortless.

Being gay has I think almost always feeling permitted (or is compelled) to sexualize any desirable guy I see—somehow it's different from sexualizing women which spells sexist subjugation or reduction of a complex creature to her body—and even my oncologist—not the one who radiated me (he a Princeton alumnus who has both his M.D. and Ph.D. from another Ivy League school, his credentials and pleasant manner not compensating for his lack of sex appeal)—but the masculine immunology man originally from Mobile, Alabama, medically trained in Mexico, now with a Mexican partner and four children. In fantasy, we have been together several times; the last time I saw him I greeted him with "Hi handsome ... I mean doctor." He smiled, made no response, but I imagined his face brighter than usual during our consultation.

So that's the gay part—dirty not in an academically discriminating way, just salacious—I include it partly due to the special issue (titled "Cancer's Dirty Margins") but more because

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feeling desire was the only enlivening subjective element of the cancer treatment.[2] Desire proved almost an inner antidote to the death I felt enveloping me, more from the treatment than the disease. Cancer combined with age, although it was the radiation/chemotherapy treatment that aged me a dozen years (or so it feels, not that I know what feeling 90 would be like nor do I expect to live long enough to find out). My beloved friend Peter Taubman—former graduate student at the University of Rochester in the late 1970s, my age, survivor of four incidences of cancer over twenty years—tells me I'll regain my strength, but surely, he's trying to cheer me, as at this age physical strength has almost vanished, despite all the weights (there were not so weighty) I lifted pre-cancer. I'm reminded of this passage by the brilliant Kathryn Schultz who, reflecting on the loss of her father and on ageing generally, wrote that

> The price of experiencing more life is sometimes experiencing less of it, too. So many losses routinely precede the final one now: loss of memory, mobility, autonomy, physical strength, intellectual aptitude, a longtime home, the kind of identity derived from vocation, whole habits of being, and perhaps above all, a *certain forward-tilting sense of self*—the feeling that we are still becoming.[3]

That's the crux of it alright, the loss of a feeling that I'm still becoming, still "forward-tilting." Intellectually that's not the case, as I edit a journal https://journals.symphonypub.com/index.php/cp/about/editorialTeam—and I am working on a book that has not come quickly or easily. The book has only recently come into focus, which is a satisfying experience. I'm no longer teaching and my retirement-related disaffiliation from the university comes October 31, 2026, so I feel no institutional pressure to pick up the pace of working. I do not have to squeeze publication within the other too numerous obligations incurred by employment at the University. I've still four Ph.D. students, although one (a Brazilian queer Indigenous man who has returned home) has completed his dissertation and is only waiting to defend. As I write these words, that student is on his way for an in-person interview at the University of Singapore. Graduate students do not feel part of the "productivity" demands the corporatized university makes upon faculty. Higher education feels like an almost entirely different situation than the one I entered at the University of Rochester, where I started fifty-five years of university teaching in 1972. There and then, the institutional expectation was that I do something "interesting" and possibly important, but administrators there and then appeared to take the long view, never counting the number of publications and citations each year but only glancing periodically at what I was up to.

6. No future: cancer's temporality warp

The forward tilting of which Kathryn Schulz writes is all gone for me; it does not matter if I finish this book before October or even before I die. I try to think of scholarship now as more a pastime although I confess writing felt like a lifeline during that awful month of radiation and chemotherapy. That was the subtext of the subtitle of the book I wrote then: *The Subjectivity Necessity of Nonviolence*, not a topic I ever imagined I'd undertake but did so in reply to my close colleague and friend Hongyu Wang who, in her most recent book (although her commitment to nonviolence antedates it by a decade), called on the curriculum studies field to take up the topic.[4] Now I'm working on the Indigenous challenge to curriculum

[2] And for me—in the mode of Pier Paolo Pasolini—homosexual desire and an embodied sense of the sacred have been reciprocally related, including in Genesis 9:24 wherein Noah's son Ham sexually violates his father (Pinar 2006, 10).

[3] Schulz 2022, 38 (italics added).

[4] Wang 2014, 2024.

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studies in Canada. My waiting to die—perhaps Cazden's concepts of living in a "chronic mode" and the "already dead" (subjectively at least) are more precise. Some concept akin to Boyer's "the undying" signals, not empty time, even if treatment seems to have emptied me of subjectivity—as this writing testifies—my subjectivity being that inner empty space where I have thoughts and feelings, undergo existential experience, but now not so empty, cluttered as it with symptoms.[5]

My body has always predominated in my life—certainly sexual desire did during my youth—but now it has turned on me—my quip is "when I was young my body was my best friend; now the son-of-a-bitch is trying to kill me"—so that the body's predominance is, I suppose, continuous. No orgasms anymore (although the occasional epiphany, as when the book I'm writing came into focus), but no relief from inner tension (despite the daily dosage of Xanax), just a spread sheet of what's wrong—that swelling just below my jaw, the ongoing insomnia (which compounds the fatigue Keytruda creates and old age intensifies)—a chronic (to invoke Cazden's concept which he extends well beyond any physical) condition, a being towards death that's no longer regenerative—Heidegger's concept I could once affirm as bringing my life into focus—but only the sense of being on death row, no prison—our home is large and comfortable, surrounded by woods, hardly a spare prison cell, although I do feel sometimes like a shut-in.

In the waiting room of the cancer center in Bellingham the death-row feeling always resurfaces, as we who are assembled are mostly old decimated creatures; we stare (nonthreateningly, even sympathetically) at each other, many of us depending on "walkers" or wheel-chairs to reach the bays where the poison—chemotherapy, or in my case, the Keytruda—is "infused." So—as this writing underscores—it feels as if my subjectivity has been replaced with symptomology, an especially stinging fate for someone who has studied subjectivity for most of his life, substituting the Latin infinitive (*currere*) for the noun (curriculum) to denote the existential experience of academic study as the core of educational experience.[6] But then, no self-pity, no remorse: after all, I'm already dead.

William Pinar is the Tetsuo Aoki Professor of Curriculum Studies at the University of British Columbia, Vancouver, Canada. Pinar has also served as the St. Bernard Parish Alumni Endowed Professor at Louisiana State University (LSU), the Frank Talbott Professor at the University of Virginia, and the A. Lindsay O'Connor Professor of American Institutions at Colgate University. He has lectured widely, including at Harvard University, McGill University, and the University of Wisconsin-Madison, as well as the Universities of Chicago, Helsinki, Oslo, Tokyo, and Vienna. The former President of the International Association for the Advancement of Curriculum Studies and the founder of its U.S. affiliate, the American Association for the Advancement of Curriculum Studies, Pinar serves now as the Honorary President of the Association for the Advancement of Interdisciplinary Education Studies (https://aaides.org/). He is the author, most recently, of *A Curriculum of Conviction, Courage and Resolve: The Subjective Necessity of Nonviolence* (Routledge, 2026).

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References

Boyer, Anne. 2019. *The Undying*. New York, NY: Farrar, Straus and Giroux.
Cazdyn, Eric. 2012. *The Already Dead. The New Time of Politics, Culture, and Illness*. Duke University Press.

[5] Boyer 2019; Cazdyn 2012, 5–9.
[6] Pinar and Grumet 2026.

https://doi.org/10.1017/pub.2026.10202 Published online by Cambridge University Press

Pinar, William F. 1975. "*The Method of Currere*." Paper presented at a meeting of the American Educational Research Association. https://eric.ed.gov/?id=ED104766.
Pinar, William F. 2006. *Race, Religion, and a Curriculum of Reparation*. Palgrave Macmillan.
Pinar, William F. 2026. *A Curriculum of Courage, Conviction, Resolve: The Subjective Necessity of Nonviolence*. Routledge.
Pinar, William F., and Grumet, Madeleine R. 2026 (1976). *Toward a Poor Curriculum*. 50th Year Anniversary Edition. Routledge.
Schulz, Kathryn. 2022. *Lost and Found*. Random House.

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