

12-7-2015

A Bakhtinian Approach to (Re)visioning Heroic Rhetoric in Medical Discourse

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A BAKHTINIAN APPROACH TO (RE)VISIONING HEROIC RHETORIC
IN MEDICAL DISCOURSE

A Dissertation

Submitted to the School of Graduate Studies and Research

in Partial Fulfillment of the

Requirements for the Degree

Doctor of Philosophy

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December 2015

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Medical discourse allows physicians to communicate technical information with one another about patients' illnesses; however, the use of medical discourse to communicate with patients may provide patients with unsatisfactory information about their illnesses. In the physician-patient relationship, physicians often have more power than patients because of their preferred membership within the medical discourse community—a membership to which most ordinary patients are not privy. A rhetorical metaphor that is sometimes used in medical discourse in order to express physicians' power is the heroic metaphor or myth. Heroic images of physicians can intimidate patients so they do not ask necessary questions about their health. This study shows that heroic rhetoric, as applied to physicians, serves to inhibit communications between physicians and patients. A Bakhtinian rhetorical analysis of medical discourse artifacts elucidates the role that heroic rhetoric plays in maintaining the barriers to effective communication between physicians and patients. Revisioning the myth of the physician-as-hero in medical discourse creates a dialogue that imagines more equitable forms of communication between physicians and patients.

ACKNOWLEDGMENTS

Resa Crane Bizzaro has encouraged me throughout the graduate school processes. As a director, Resa continuously helps me navigate the difficulties with writing a dissertation. Thanks to Resa for her mentorship.

After I was accepted into the PhD program at IUP, the first text that I read was Gian Pagnucci's *Living the Narrative Life: Stories as a Tool for Meaning Making*. I was inspired by the text because it provides great examples of narratology. Thanks to Gian for providing me insight.

Sharon Deckert gave me a copy of Althusser's "Ideology and Ideological State Apparatuses." Thanks to Sharon for making me question my world view.

Every summer of my coursework in Indiana at IUP, Patrick Bizzaro has professed one of my classes. In our conversations, Pat always treats me like an equal. Thanks to Pat for his collegiality.

Donna Souder Hodge has helped me with my professional and educational endeavors. In addition to telling me that I must apply to the graduate program at IUP, Donna has talked out most aspects of my dissertation with me. However, it is not all of Donna's selfless work for which I am most thankful; it is her companionship. No matter what happens personally, Donna always listens to and understands me. Thanks to Donna for her friendship.

Joe and Linda LaBarge have generously shared the details of Joe's dying process, some of which are extremely painful. Thanks to Joe and Linda for giving me Joe's story.

Thanks to my father, Ross James Collie, M.D., the first and most influential physician in my life.

Paul and Samuel Mountford are the people for whom I am most grateful. They have taught me more about life and love than anyone else. Thanks to Paul and Sam for sharing their lives with me.

Personal sacrifice comes with earning a Ph.D.; in addition, those with whom we share relationships must also undergo sacrifices on our behalves. John Moser has sacrificed over four years of personal time with me so that I could complete this degree. Thanks to John for his unfailing support.

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CHAPTER I

PROBLEMATIZING HEROIC RHETORIC IN MEDICAL DISCOURSE

Medical discourse is a language used by members of the medical discourse community in order to convey communications in the field of medicine. And discourse communities are always political because they contain inherent power struggles in determining who should be included and excluded from specific communities. Of course, to become a member of the medical discourse community specific threshold qualifications must be met. Education, licensure, and acceptance of professional ethics of are all prerequisites to becoming legitimate members of the medical discourse community. Yet these prerequisites alone do not assure acceptance. In order to gain acceptance as legitimate members of the medical discourse community, people must be heard and acknowledged as members by their peers. Physicians are acknowledged as the most prestigious members of the medical discourse community, and patients are seldom acknowledged as members. The established dichotomy between prestigious physicians and nonmember patients can lead to complications with communications in the physician-patient interchange. An additional issue that intensifies this dichotomy between physicians and patients is the heroization¹ of physicians. The use of heroic rhetoric in medical discourse increases the barriers to communications in the physician-patient exchange.

My Position

I come from a medical family; my father, ex-husband, and ex-father-in-law are physicians, my mother and sister are nurses, and my brother is a social worker. And in an effort to disclose both my positionality and my biases with regards to medical discourse, I acknowledge that I practiced pharmacy for sixteen years. I worked in a retail pharmacy, an

¹Heroization is an unusual word; the Oxford Encyclopedia of Ancient Greece and Rome gives initial credit to its use in describing the actions of Oedipus and its definition is “to treat or represent as a hero” (1).

outpatient clinic, and a hospital. Although I was a competent pharmacist, I had few ideologies in common with my fellow coworkers. Not only were my political leanings divergent from other pharmacists', but I had trouble following the very strict and delineated rules that pharmacists ordinarily accept.

An example of my inability to follow rules happened one time when an associate pharmacist refused to fill a surgeon's order because it was oral instead of written. And for legal distribution of Schedule II medications², physicians must provide signed hard copies of prescriptions. A surgeon had a patient opened up and lying on the operating table and called the pharmacy to order a Schedule II drug. The pharmacist refused to take the drug to the surgeon until he signed his name to the hard copy of the prescription order. But the surgeon could not possibly sign the prescription order while he was operating on the patient. I was so exasperated by the associate pharmacist's refusal to act that I picked up the medicine, ran it to the operating room, and gave it to the surgeon. The associate pharmacist could not comprehend my action because she felt that she had to follow the exact specifications of the law. Of course rules are enforced for the benefit of patients; however, rules should not take precedence over patients' welfare. Indeed, I incurred more than one troublesome episode where my personal ethics conflicted with specific pharmacy regulations.

And I eventually left pharmacy in order to pursue a career in academia. I felt as though my ideologies aligned with instructors more than they aligned with pharmacists. Many academicians, myself included, believe that the process of dialogical communications is an important step to learning. With both colleagues and students, interactions and shared responses are often as valuable as unilateral choices. Collaborations can build a sense of community and

²Schedule II medications: 1) have at least one currently accepted medical use, 2) have a high potential for abuse, and 3) when abused may lead to severe dependence (DEA.gov 1).

trust, and erroneous answers may provide valuable information that can be used in order to synthesize more effective future responses.

My struggle in transitioning between pharmacy and academia in many ways mirrors physicians' struggles between communicating with fellow physicians and communicating with patients. Physicians spend much of their time discussing medicine with other physicians, and they are charged with determining the best possible treatments for patients. Physicians may not regard the importance of clear communications with patients because they are over worked, responsible for many patients, and trained to use medical discourse instead of social discourse in their professions. And because physicians often bear heroic personae as indications of their positions of power, they may find it hard to step out of their authoritative roles and the use of medical discourse in the patient-physician interchange. Physicians can be so focused on finding the correct answer that they may not consider that building rapport with patients may be more important than exacting the perfect treatment. Pharmacy gave me an insight into medical discourse, and academia gives me a means of deconstructing medical discourse so that I may express some of the complications and limitations of its use. Yet, it was not pharmacy or academia that brought me to the study of medical discourse; it was a personal connection.

My personal connection to medical discourse began with a beloved family member's death. My stepfather, Joe LaBarge, had multiple cancers that were successfully treated long before I met him; however, his most recent development of new metastases was especially disturbing to me because he was given the diagnosis by way of email, with no oral communication from his physician or any other healthcare professional.

Joe's Story: Part 1

Joe received an email from his oncologist that had been forwarded to the oncologist directly from Joe's epidemiologist. The email outlined four concurrent metastatic cancers and recommended a follow-up MRI. The email that Joe was sent reads:

PET scan report: C6 & T3 vertebrae suspicious for new sites of osseous metastatic disease (intense uptake); activity at previous site (left axilla of moderate uptake); new moderate uptake left upper lobe, inflammation, infectious process, or new metastatic disease, mild thickening along left lower lobe; increased uptake (density) left femoral shaft; request MRI before June 19th visit with oncologist.

Joe had a P.E.T. scan, or positron emission tomography scan, which uses radioactive substances in order to show where the tumors are located in his body. The epidemiologist's first finding, "C6 & T3" indicate vertebrae in the spine. "C" stands for the cervical or neck region, and "T" stands for the thoracic or middle spine region. "Osseous" refers to bone and "metastatic disease" means that it is a cancer that was originally somewhere else in his body and had spread to the bones in his spine. The second finding indicates that his armpit, or axilla, where the original cancer was found, was cancerous again. The third finding suggests that left "lobes" of Joe's lungs were infected with new cancerous cells. The final finding implies that Joe also had cancer in his left leg or "femoral shaft."

This report is objective and serves to inform the oncologist, but it should not be used to inform the patient directly. The medical discourse used in the email is not appropriate to inform a patient that he simultaneously has cancer in four different places in his body. The worst part of this report is the "M.R.I. recommended." An M.R.I. is an acronym for magnetic resonance

imaging machine. M.R.I.s are used only for diagnosis and never for treatment. And, suggesting a terminal patient obtain diagnoses of more than four concurrent cancers only generates more income for the healthcare community.

When Joe received this email, he did not have a clue that it meant that he really had cancer or that he was terminally ill. Unfortunately though, his wife and my mother, Linda, immediately knew. Linda called me in order to read the email to me. She was hysterically upset. I couldn't comprehend all that she was saying, so I asked her to forward the email directly to me. Along with Linda, I quickly understood the gravity of Joe's disease state even though Joe did not.

Joe was a very intelligent man. He was a priest in Rome for ten years, and he spoke Latin fluently. He earned a Ph.D. in Comparative Religions and was a professor at Bucknell University for thirty years. However, when he first got the news of his metastatic cancer in June 2011, he had no idea that the diagnosis was terminal. He did not understand the technical Latin words of medical discourse his oncologist used. When he finally had a face-to-face meeting with his physician, two weeks after receiving the email, his physician gave him results and terminology and diagnoses, but what he did not give Joe was an accurate dialogue about his imminent death. Joe had surgery on one cancer and left the others alone because they could not be treated. Joe's treatment was based on the physician's advice and expertise about Joe's prognosis. If Joe had known the likelihood of his survival after surgery with all of the information that his physician held, would he have made the same choice to have surgery? Perhaps, but Joe did not comprehend the gravity of his situation completely because he had survived cancer before and he assumed that he would survive it again. And Joe's knowledge of Latin did not help him become literate in the medical discourse community. His physician "reported" findings, but he failed to

tell Joe what it meant in terms of quality or quantity of life Joe had left. Joe accepted all of the suggestions from his physician without question, and he was hopeful that chemotherapy would take care of his metastatic cancer. Joe's physician continued to provide treatments to Joe without discussing his inevitable death.

Joe had several personal issues that caused him trouble in addition to his cancer. Joe worried about the stairs in his house that he could not get up or down anymore; he worried about not having the strength to sing in his barbershop quartet group on Thursdays; he also worried about no longer having sex with his wife. Joe was too proud and too private to talk to his physician about any of these issues; however, if Joe had been encouraged to talk about his daily life with his physician, perhaps his physician could have helped him contact professionals to help Joe get a motorized chair for the stairs, prepare his voice for singing, or discuss methods of having sex in spite of his disease.

Of course, medicine is an extremely imprecise science, filled with hunches, guesswork, and alternative approaches. And even though this study does not cover medical ethics, there are some situations and practices that I consider ethically unsound. I was annoyed at the oncologist for sending an email—without any personal comments—two weeks before any face-to-face appointment. Also, I was irritated about the inappropriateness of using medical discourse to convey Joe's imminent death to him. Additionally, I do not support the generation of income with futile tests.

In coming to understand my dissatisfaction with the lack of appropriate communication from Joe's physicians to Joe, I assume that Joe's healthcare experience is not unique and that my frustration in dealing with Joe's experience is not unique. I assume that sometimes other patients are also disappointed with aspects of their medical care. In many ways, physicians are no longer

expected to take care of patients holistically, and, perhaps, patients do not expect physicians to communicate fully with them. Additionally, patients do not always understand the significance of their illnesses, and they can be easily manipulated by physicians who employ medical discourse as a means of intimidation. But, if physicians listen to their patients' problems in the context of how diseases impact their social lives, physicians could understand patients' problems more holistically and patients could get help towards living qualitatively better lives. While I assume that most patients do not receive emails notifying them of their metastases, the inadequate communication that Joe received from his physician motivated this study on physician-patient communications.

Deconstructing Heroic Rhetoric

The primary purpose of this study is to explore, through rhetorical analysis applying a Bakhtinian lens, how the use of heroic rhetoric within medical discourse contributes to a disruption in the communication process among physicians and patients.

In order to explore the problem of how heroic rhetoric contributes to a disruption in the communication process among physicians and patients, this study is framed by the following questions:

1. Why is the problem of lack of clarity in oral and written discourse between physicians and patients such an issue?
2. How does heroic rhetoric contribute to a disruption in the communication process amongst physicians and patients?
3. What might a rhetorical analysis, using Bakhtinian theory, reveal about the nature of the myth that physicians are heroes?

There are decades of articles on medical rhetoric that disparage physicians for their lack of clarity in discourse when communicating with patients.³ A common assumption for physicians' lack of clarity is that they communicate with patients using medical discourse that patients do not completely understand. Nevertheless, the use of medical discourse in the physician-patient interface is extremely complex, and simple vilification of physicians for its use omits some of the problems with the communications among physicians and patients. And, with all of these articles asking for clearer communication on the part of physicians towards patients, there is still the problem of lack of clarity in oral and written discourse between physicians and patients.

This study hypothesizes that the use of heroic rhetoric in medical discourse influences the ways that physicians act and patients respond to physicians. This study is significant, because when physicians and patients view physicians as heroes, it contributes to an already disrupted communication process.

Rhetorical analysis is the methodology implemented in this study. Rhetorical analysis utilizes principles of rhetorical theories in order to examine how the elements of a text work together so that they create a specific effect. This study examines three separate genres of medical discourse: texts authored by physicians, articles written by rhetoricians, and television episodes of *House, MD*, in hopes of illuminating the effect that heroic rhetoric has on medical discourse used by physicians towards patients. By viewing heroic rhetoric through a Bakhtinian lens, this study emphasizes that the use of heroic rhetoric serves to distance the communication processes of physicians to patients, and of patients to physicians. Because Bakhtin asserts that

³ In researching this subject for this study, I found dozens of studies where rhetoricians disparaged physicians for their lack of clarity when communicating with the rhetoricians' loved ones. Over and over again, the studies asked that physicians perform active listening techniques and respond to patients with the use of *pathos*. Please see Chapter IV for names of and discussions by these rhetoricians.

there are power differentials in discourse communities, this study uses the assertion in order to examine monoglossic communications authored by physicians. Because Bakhtin emphasizes that authors are always already heroes of their own art, this study uses the emphasis in order to look at the heroic rhetoric in communications about physicians that are authored by rhetoricians. And because Bakhtin states that the imaginary becomes reified within the heteroglossia of popular culture, this study uses the statement in order to expose the ideal of the heroic physician in the popular cultural artifact *House, MD*.⁴

Mikhail Bakhtin's theories and the texts cited in this study employ many complex concepts. In order to clarify the concepts' meanings, they need further defining. When discussing discourse communities, rhetoric, and popular culture, the concepts of "monoglossia," "heteroglossia," "hybrid utterances," and "polyphony" are implemented in order to describe how languages are used. Bakhtin's term, "monoglossia," refers to the use of one single discourse—such as medical discourse that is implemented in the medical discourse community. And Bakhtin's term, "heteroglossia," refers to the blending together of a variety of monoglossic discourses by members of particular communities in order to create amalgamated languages that are used in rhetoric and in popular culture. When heteroglossic language is used by a single speaker, Bakhtin refers to the speech units as "hybrid utterances." And, according to Bakhtin, an "utterance" is the essential unit of speech used in discourse. "Polyphony" indicates multiple heteroglossic voices of dissensus. Bakhtin asserts that only with a multitude of discordant polyphonic voices can truth be understood.⁵

⁴ Ironically, *House, M.D.* was Joe's favorite television show and Joe was exposed to the "House mentality" in his last experiences with physicians. Chapter V expounds on the House mentality and Joe's responses to it.

⁵ Dozens of critical texts use Bakhtin's terms without defining them at their most basic and easily understandable level. I attempt to make these terms easy for anyone to understand, especially those not familiar with Bakhtin. For further deconstruction of these terms, refer to Chapter III and Chapter IV.

Bakhtin defines polyphony in terms of the separate and fully conscious heroes in Dostoevsky's novels:

A plurality of independent and unmerged voices and consciousnesses, a genuine polyphony of fully valid voices is in fact the chief characteristic of Dostoevsky's novels. What unfolds in his works is not a multitude of characters and fates in a single objective world, illuminated by a single authorial consciousness; rather a plurality of consciousnesses, with equal rights and each with its own world, combine but are not merged in the unity of the event. Dostoevsky's major heroes are, by the very nature of his creative design, not only objects of authorial discourse but also subjects of their own directly signifying discourse. (Italics in Original; Problems of Dostoevsky's Poetics 6-7)

When we apply Bakhtin's concept of polyphony to medical discourse, we may begin to revision heroic rhetoric with multitude of subjects, each being heard with its own signifying discourse. We may not come to consensus about heroic rhetoric, but we will certainly have conversations about heroic rhetoric that open spaces for alternative ways of envisioning it.

Rhetoric is the ability to detect persuasive aspects of a particular discourse, and its language is comprised of hybrid utterances made up from rhetorical discourse, social discourse, and the discourse under discussion. Whereas, discourse refers to the language used in a specific social, educational, political, or scientific discourse community, and its language is monoglossic discourse emanating from the specific discourse community under discussion.⁶

Even though rhetoric and discourse do not mean the same thing, for the purpose of this study physicians' mastery of both medical rhetoric and medical discourse indicate their

⁶ The definitions of rhetoric and discourse are my basic definitions that come from Bakhtin, Aristotle, and Foucault. The definitions presently become further complicated with the theorists' own words.

possession of power in discursive relationships. If rhetoric is the knowledge of the functions of discourse that serve to inform, persuade, or motivate, then discourse is the study of language's usage within specific discourse communities. These definitions, though, are too simplistic and naive. They do not contain the connections between knowledge and power. Aristotle, in *The Art of Rhetoric*, acknowledges power directly in his definition of rhetoric. He states that rhetoric is “*the power to observe the persuasiveness of which any particular matter admits*” (Italics in the original; 74). Interestingly, Aristotle uses medicine as a specific example to indicate that rhetoric is not persuasion, but the ability to detect persuasive aspects of a given discourse. He claims, “it is not the function of medicine to produce health but to bring the patient to the degree of well-being that is possible; for those that cannot attain to health can nevertheless be well looked after” (70). Indeed, it takes a skilled medical rhetorician to persuade unhealthy patients that their well-being is not dependent on their health. For Aristotle, then, knowledge of the difference between apparent persuasion and actual persuasion gives the knower his or her power. Michel Foucault reiterates Aristotle's sentiments on power as he defines discourse as “a group of verbal performances” that systematically construct the subjects who must continuously negotiate power relations (*Archeology* 107). For Foucault, power is not simply the result of knowledge; it is also a constant negotiative struggle among members both inside and outside the discourse community. Not only does Foucault acknowledge the power struggles inherent in discursive performances, but he further argues that these discursive performances actually construct the performing subjects. So, for physicians who are constructed by their knowledge of medical discourse and the power that it wields, especially with regards to heroic rhetoric, it is easy to see why physicians are reticent to relinquish their power. Physicians' power is sociologically and economically constructed. Physicians hold prestigious and authoritative positions in society because of their

extensive education, their prominent careers, and their salaries, as well as their mastery of medical discourse. Sometimes physicians' authority makes patients afraid to question physicians' diagnoses and advice.

Because knowledge of rhetoric and discourse is often accompanied by power, knowledge of both is associated with inferences of power. The word rhetoric is used when heteroglossic language is necessary, in order to relay persuasive information between the disparate communities of medical discourse and social discourse. And the word discourse is used, as Bakhtin suggests, when monoglossic discourse is reserved for accepted members within the medical discourse community. The previously outlined definitions of rhetoric and discourse are theoretical in nature. Clear delineations between rhetoric and discourse are not, however, usually found in actual situations; rhetoric is unlikely to occur in isolation, outside a discourse community, and similarly, discourse is improbably ever monoglossic or used without regards to persuasion.

Bakhtin himself argues that language is seldom monoglossic and that heteroglossic use of language, borrowed from a particular discourse community and applied in a new context, serves to synthesize new meaning. He declares:

It must not be forgotten that monoglossia is always in essence relative. After all, one's own language is never a single language; in it there are always survivals of the past and a potential for other-languageness that is more or less sharply perceived by the working literary and language consciousness. (*Dialogic* 66)

So even in a monoglossic discourse community such as medicine, there are other discourses that are incorporated into it. More importantly for Bakhtin, heteroglossic use of language requires active understanding of and participation in linguistic meaning. Bakhtin expresses linguistic

meaning in terms of utterances, or units of speech acts. Bakhtin describes the role of heteroglossic utterances:

Every concrete utterance of a speaking subject serves as a point where centrifugal as well as centripetal forces are being brought to bear. The processes of centralization and decentralization, of unification and disunification, intersect the utterance; the utterance not only answers the requirements of its own language as an individualized embodiment of a speech act, but it answers the requirements of heteroglossia as well; it is in fact an active participant in such speech diversity. (“Discourse” 272)

Bakhtin believes that this duality of the utterance – both monoglossic and heteroglossic – serves to provide multiple linguistic meanings simultaneously.⁷ The term active participant becomes especially important in terms of synthesis. If a passive participant is a subject who does not think about utterances’ meanings, then active participants not only analyze utterances’ meanings, but also synthesize the same utterances into new discourse communities whereby meaning is enriched within new conceptual systems. Bakhtin continues:

A passive understanding of linguistic meaning is no understanding at all, it is only the abstract aspect of meaning. [. . .] Thus an active understanding, one that assimilates the word under consideration into a new conceptual system, that of the one striving to understand, establishes a series of complex interrelationships,

⁷ Bakhtin adds that sometimes the multiple linguistic meanings are contradictory. For example, Bakhtin coins the phrase “grotesque realism” in describing Rabelais’ material bodily principle. Grotesque images of bodily functions are ugly and extremely exaggerated. In contrast, realism describes an aesthetic that is realistic and not exaggerated. The paradox of the pairing of grotesque realism is that although it presents a view of exaggerated ugliness, it simultaneously provides a collective realism about the shared bodily functions that make up the material human condition. See Chapter V for more on grotesque realism.

consonances and dissonances with the word and enriches it with new elements.

(“Discourse” 281-2)

If Bakhtin is correct, then members of the medical discourse community not only have power from membership, but they also have greater opportunities for synthesis of their linguistic meaning from medicine into other discourse communities or from other discourse communities into medicine. With power and opportunity, they should have the tools at their disposal to communicate effectively to patients through social discourse. For example, physicians could just as easily tell patients that they are going to die as they could tell patients that they are terminal. Whether or not physicians think about or choose effective communications with patients is the central question of this study.

As the conceptual framework for this study, heroic rhetoric adds to physicians’ already considerable power within the medical discourse community. Physicians’ power emanates from their socio-economic status as well as from their expertise in the knowledge and usage of medical discourse. Heroic rhetoric contributes further to perceptions of physicians’ power by elevating physicians from healthcare providers to heroes through its expectations that heroes always succeed.

Hero, as a concept, is a type of metaphorical language. What does viewing physicians as metaphorical heroes contribute to heroic rhetoric as a concept? Viewing heroic rhetoric as a metaphor means acknowledging that the image of physician as hero is an elevated, unrealistic, mythological view. In other words, people who see themselves as heroes see themselves in an imaginary way. Bakhtin argues that people who create art are heroes of their own art and, as such, are answerable for their own work.⁸ The dilemma is that the creative process leads to the formation of heroic personae by the artists that construct unrealistically inflated views of the

⁸ For a more extensive definition of this theory, see Chapter II.

work that they create. Bakhtin maintains that artists create heroic personae as a way to imaginatively experience the products that they create. The heroic personae are distinct from the artists themselves. So, heroic personae are invented views that artists have of themselves. The problem is that these heroic personae cannot accurately report on the products that the artists create, because they are fictional.

Heroic rhetoric is used to indicate war metaphors within medical discourse, specifically metaphors that symbolize physicians as heroes.⁹ The major assumption of this study is that heroic rhetoric that occurs within medical discourse is a contributing factor to the lack of communication between physicians and patients; heroic rhetoric allows physicians to take on the personae of elevated heroes and heroic rhetoric allows patients to acknowledge physicians as their heroes.

However, heroic personae of physicians do not occur in every physician nor do heroic personae only occur because of the use of heroic rhetoric in medical discourse. The formation of heroic personae is complex, so complex that the various and circuitous routes to formation in individual physicians are beyond the scope of this study. Physicians may enjoy hierarchical power within the discourse community because of their high levels of education, their social statuses as professionals, their large incomes, their medical cultural capital, their alliances within community and legal systems, and their connections with peer physicians. Furthermore, this study does not investigate individual diversity within the medical discourse community. Some physicians may not ideologically align with other physicians because of identity issues such as sex, gender, sexual orientation, religion, ethnicity, or socio-economic background. Never the

⁹ Chapter III, Chapter IV, and Chapter V each examine implicit and explicit uses of heroic rhetoric in various genres of medical discourse.

less, some physicians do form heroic personae and this study looks at the artifacts that are produced—either consciously or subconsciously—by such heroic personae.

In order to investigate heroic rhetoric's influence in medical discourse, additional assumptions are made. There is an assumption that physicians are artists whose art is the practice of medicine. In the *Gorgias*, Socrates challenges Gorgias as to why rhetoric should be considered the greatest art. Socrates goads Gorgias:

The physician will say: Socrates, Gorgias is deceiving you, for my art is concerned with the greatest good of men and not his.' And when I ask, Who are you? he will reply, 'I am a physician.' What do you mean? I shall say. Do you mean that your art produces the greatest good? 'Certainly,' he will answer, 'for is not health the greatest good? What greater good can men have, Socrates?'

(Plato 124)

Whether or not we agree that medicine is the art that produces the greatest good, we acknowledge that Plato considers medicine an art.¹⁰

More recently, Patrick Bizzaro indicates that the difference between a craft or skill and an art lies in the imaginative component of art. Bizzaro declares that in the disciplines of poetry, rhetoric, and science Creative Writing Studies is the engagement of our imaginations in turning data collection into relevant understandings. Bizzaro declares that "The data must be permitted to engage our imaginations" (Bizzaro 11). Indeed when skilled people use their imaginations to synthesize facts in innovative ways to produce better outcomes, they are artists. If physicians use

¹⁰ There may be some debate about whether or not the practice of medicine is an art or a craft. According to Webster's Dictionary the definition of art has changed over time, but it is "an imaginative or technical skill stemming from human agency and creation," (117) whereas craft is "a pastime or profession that requires some particular kind of skilled work" (469). For the purposes of this study, and because Bakhtin, Aristotle, and Plato use the word "art," physicians' practice of medicine is considered an art.

their imaginations to effectively communicate with patients, as well as heal them, then they are artists.

In addition to the assumption that physicians are artists there are also assumptions that physicians' texts reflect physicians' personae, that rhetoricians' texts reflect their beliefs about physicians' personae, and that *House, M.D.* reflects the writers and directors' beliefs about physicians' personae. Although these assumptions may be validly contested, they form some of the perspectives of this study.

There are three places in this study that the concept of heroic rhetoric is investigated in medical discourse: in written communications by physicians because these articles illuminate physicians' beliefs that patients cannot understand medical discourse; in journal articles by rhetoricians because these are the articles that vilify physicians for their choices in discourses when communicating with patients; and in the television series, *House, MD*, because Greg House, the main character, embodies the stereotypical heroic physician who scares patients into remaining silent when they wish to communicate.

Limitations and Possibilities

As with any argument, there are problems and paradoxes that arise and refuse to come to agreement. These dissonances are what make the argument worth discussing. When trying to make sense of the concepts and participants within this study, imagine them in terms of Kenneth Burke's classic parlor:

Imagine that you enter a parlor. You come late. When you arrive, others have long preceded you, and they are engaged in a heated discussion, a discussion too heated for them to pause and tell you exactly what it is about. In fact, the discussion had already begun long before any of them got there, so that no one

present is qualified to retrace for you all the steps that had gone before. You listen for a while, until you decide that you have caught the tenor of the argument; then you put in your oar. Someone answers; you answer him; another comes to your defense; another aligns himself against you, to either the embarrassment or gratification of your opponent, depending upon the quality of your ally's assistance. However, the discussion is interminable. The hour grows late, you must depart. And you do depart, with the discussion still vigorously in progress.

(*Philosophy* 110-11)

The argument in this study is, no doubt, endless. The argument has also been made for decades. As long as the parlor contains physicians, patients, and interested parties—some of whom are rhetoricians—there will be dissensus on how to deal with the conflicts that arise. Retracing some of what has been said before will, no doubt, omit some of the steps that have gone before. However, the important aspect of this study is to enter the argument and stir up controversy. Leaving the parlor with more questions than one previously had is the very point of the conversation. And, no doubt, the heroization of medical discourse elicits many questions!

One rhetorician, Judy Segal, has been particularly prolific in producing articles on medical discourse and its limitations in meeting patients' needs. Segal outlines steps for successful metaresearch on medical discourse in an article aimed at an audience of rhetoricians from interdisciplinary fields. Segal contends that Burke's *A Grammar of Motives* is a seminal text to refer to, if one is to analyze medical rhetoric ("Interdisciplinarity" 316). Burke implements the metaphor of a play in order to analyze the motives for rhetoric. He declares:

We shall use five terms as generating principle of our investigation. They are:
Act, Scene, Agent, Agency, Purpose. In a rounded statement about motives, you

must have some word that names the *act* (names what took place, in thought or deed), and another that names the *scene* (the background of the act, the situation in which it occurred); also, you must indicate what person or kind of person (*agent*) performed the act, what means or instruments he used (*agency*), and the *purpose*. Men may violently disagree about the purposes behind a given act, or about the character of the person who did it, or in what kind of situation he acted; or they may even insist upon totally different words to name the act itself. But be that as it may, any complete statement about motives will offer *some kind of* answers [*sic*]. (Emphasis in original; *Grammar xv*)

In discussing the impact of heroic rhetoric (*agency*) on discourse (*act*) by physicians (*agents*) about terminal illnesses to the patients who have the illnesses (*scene*), there are many alternative *purposes* that are investigated in this study. There are undoubtedly many kinds of answers that arise, and likely even more kinds of questions that arise. As Burke so eloquently states, “Accordingly, what we want is *not terms that avoid ambiguity, but terms that clearly reveal the strategic spots at which ambiguities necessarily arise*” (Italics in the original; *Grammar xviii*). The use of heroic rhetoric in medical discourse is precisely the strategic spot where ambiguities arise.

So if the players are physicians, rhetoricians, and patients and the tie binding them together is heroic rhetoric, then how are the real implications reconciled with the imaginary metaphor as they impact communications and miscommunications between physicians and patients? First, one must recognize that there will never be full awareness of all of the rhetorical devices inherent in medical discourse. Second, one must realize that no matter what kind of communications take place between physicians and patients these communications are much

more complex than can be completely understood or articulated. Third, one cannot fully reconcile the reality of physicians with the imagery of the hero. Fourth, if all language is metaphorical then one cannot dismantle unrealistic concepts. Something must always stand in for something else. One must always view some new synthesis in terms of other concepts that are already known and understood.

Conferring about what cannot change in terms of the use of heroic rhetoric in medical discourse leads to an observance of the changes that can occur; the changes that can occur involve recognition. One can recognize heroic rhetoric in medical discourse. Recognition can lead to knowledge. Knowledge can lead to understanding. Understanding can lead to synthesizing new types of words in new situations. As reiterated from Bakhtin above, “Thus an active understanding, one that assimilates the word under consideration into a new conceptual system, that of the one striving to understand, establishes a series of complex interrelationships, consonances and dissonances with the word and enriches it with new elements” (“Discourse” 281-2). Ultimately, heroic rhetoric can be used in order to discuss the inherent problems with the metaphorical association between heroes and physicians. Even if heroic rhetoric cannot be removed from medical discourse, new understandings of the explicit and implicit information that is passed on to physicians and patients when heroic rhetoric is used can be identified.

CHAPTER II

IDENTIFYING A PLACE FOR BAKHTINIAN THEORY IN HEROIC RHETORIC

I suggest that physicians are artists and practitioners of an art. Although many people may accept the reified binary of art/science, I choose not to envision these terms as mutually exclusive. Certainly, some artists and scientists may invent or create while other artists and scientists may apply techniques or skills. And when physicians synthesize creative communications and treatments for individual patients, they practice art. However, I realize that in proposing that physicians are artists whose artistic personae manifest as heroic personae, I advance the reified concept that physicians are heroes and I create a newly objectified concept that physicians are artists.

In any discipline, we may find artists. In medicine, physicians are the artists who create communications with and treatments of patients. The problem is that physicians may also create, for themselves, heroic personae whose aesthetic reactions to the physicians' work may be unrealistic and lack accountability. The rhetoric of heroic imagery in medical discourse explores the idea that physicians are heroes. Heroic rhetoric begins with "hero" as a sign; this sign metaphorically explains the authoritative role of physicians in medicine. The hero metaphor is so prevalent in society that it has actually become a myth, or perhaps even a monomyth. For the public concerned with medicine, heroic rhetoric may foster society's inability to deal with disease and death.

For physicians with heroic personae, heroic rhetoric may, in some instances, promote physicians' objectification of patients. Although theorists reiterate Bakhtin's ideas about semiology, metaphor, objectification, and reification in various and diverse disciplines, I choose to rhetorically analyze heroic rhetoric in medical discourse by way of Bakhtin's theories because

his answerability offers a resolution to the unrealistic aesthetic reactions produced by heroic physicians. Bakhtin argues that all people who create art are answerable for their own work. Answerability means that, if physicians are heroes, then they are answerable—both to themselves and to society—for their communications with and treatments of patients. Identifying a place for Bakhtin’s theories in heroic rhetoric potentiates the ability for heroic physicians to transform from simply focusing on eradicating diseases to focusing on holistic care of patients.

Bakhtin argues that all people who create art are heroes of their own art and, as such, all are answerable for their own work. As heroes, physicians are still answerable for their communications with and treatments of patients. The dilemma is that the creative process leads to the formation of heroic personae by the artists who construct unrealistically inflated views of the work that they create. Bakhtin maintains that artists create heroic personae as a way to imaginatively experience the products that they create. The heroic personae are distinct from the artists themselves. So, heroic personae are invented views that artists have of themselves. The problem is that these heroic personae cannot accurately report on the products that the artists create. Further, Bakhtin asserts that “The artist’s struggle to achieve a determinate and stable image of the hero is to a considerable extent a struggle with himself [*sic*]” (*Art 6*). Essentially, artists create heroic images of who they want to be instead of who they really are. Artists then struggle to become the heroes that they envision they are.

What does this heroic process mean, then, to physicians whose heroic personae save patients and whose art is producing healed patients? First, it means that physicians are heroes of their own work. Second, it means that physicians are answerable for their own work. Third, it means that physicians may create heroic personae in order to imaginatively view their treatment of and communications with patients. Fourth, it means that because physicians and their heroic

personae are separate and distinct from one another, physicians do not always accurately perceive their communications with patients. The heroic personae of physicians block the actual physicians from discerning their communicative shortcomings. So, physicians' heroic personae may create overly grand imaginary metaphors of themselves and their abilities to communicate. Answerability means that, in medicine, physicians are answerable to patients, and not just to themselves. If physicians are answerable to patients, there will still be patients who want physicians who are saviors, but there will also be patients who want physicians who treat them compassionately. Bakhtin's idea of artists' answerability places the onus for responsibility in the hands of physicians, where it belongs. Answerability also allows for changes in the ways the people view heroic rhetoric in medical discourse.

Metaphor

When people need help in reasoning new and unfamiliar situations, metaphors offer help in presenting unknown ideas in terms of known ideas. While describing scholarly arguments to students, cheering for sports' teams, and policing violence in the streets, people use heroic metaphors. In order to better understand the present function of heroic rhetoric in medical discourse, this study analyzes the heroic ideal as a metaphor. However, "hero" is also a word or a sign that represents a heroic idea, so the analysis of heroic rhetoric must start with signs. If language is constructed of signs that represent objects and ideas, then indeed all words are metaphorical because they are only representatives of the ideas for which they stand; they are not themselves the ideas. In fact, some theorists assert that language is completely metaphorical because all words are signs that signify ideas.

Metaphors are figurative elements in language. Of course, language is a socially constructed set of words or signs that signifies specific objects or ideas. An object, such as a

chair, has the sign “chair.” For objects, signs seem straightforward; however, through further observation one realizes that even chairs may have ideas associated with them. To a woman who is eight months pregnant and has to stand for eight straight hours at her job, a chair offers respite. However, to a man who has been convicted of murder and is strapped down with restraints, a chair connotes death.

When our words move from objects to ideas, the signification becomes even more complex. Consider the concept of “love,” for example. None of us has the same idea about love, nor the same signs to express it. Some people use the picture of a simplistic schematic of a heart in order to express love, but that sign does not speak love to me. Abstract ideas, such as love, become the basis for ideological thoughts and signs. Because ideological thoughts are so abstract and complex, the signs that we employ to express them rely on metaphorical imagery in order to communicate their meanings.

Ideological thoughts or ideologies are represented by ideological or figurative words or signs. Bakhtin responds to a Marxist theory of ideologies and contends that people must incorporate the “*philosophy of the ideological sign*” (Italics in the original; “Marxism” 1214) into the philosophy of language if we are to discuss ideologies. Ideologies are tied to signs, and signs, in terms of language, are words. Bakhtin explains, “A physical body equals itself. [. . .] It does not signify anything. [. . .] There is no question of ideology” (“Marxism” 1210). However, a physical body may also be perceived as an image. When a physical body is perceived as an image, it then embodies its imagery as well as its material reality. This image of the physical body is converted to a sign and becomes an ideological product. Bakhtin clarifies this concept:

A sign does not simply exist as a part of a reality—it reflects and refracts another reality. Therefore, it may distort that reality or be true to it, or may perceive it

from a special point of view, and so forth. Every sign is subject to the criteria of ideological evaluation (i.e., whether it is true, false, correct, fair, good, etc.). The domain of ideology coincides with the domain of signs. They equate with one another. Wherever a sign is present, ideology is present, too. (“Marxism” 1211)

Bakhtin problematizes the sign here, because he claims that it reflects and refracts an alternate reality. And, although Bakhtin suggests that the second reality either distorts or accurately reflects that reality, we must, nevertheless, be aware that reflecting reality is not in and of itself actual reality. How we perceive the sign is, according to Bakhtin, dependent on the ideological field to which we subject the sign:

Within the domain of signs—i.e. within the ideological sphere—profound differences exist: it is, after all, the domain of the artistic image, the religious symbol, the scientific formula and the judicial ruling, etc. Each field of ideological creativity has its own kind of orientation toward reality and each refracts reality in its own way. Each field commands its own special function within the unity of social life. (“Marxism” 1211)

Notice that Bakhtin juxtaposes the binaries of the artistic image with the scientific formula. These binaries are so prevalent in our language, that comparing and contrasting them may happen without much conscious thought. Even so, Bakhtin considers both the artistic image and the scientific formula as belonging to the field of ideological creativity. And, in the field of ideological creativity that is medicine, medical discourse will see the sign of heroic rhetoric in a distinctive way—within the unity of the social interactions among physicians and patients. The ways in which medical discourse uses the sign of heroic rhetoric in its social interactions is the major focus of this study.

Ferdinand de Saussure deconstructs the sign by breaking it into two separate components. In semiology, the “sign” is composed of the “signified” which represents the concept and the “signifier” which represents the sound-image of the word. “Sign” represents the whole word, whereas “signified” and “signifier” are defined as two separate but integral parts of the “sign.” Saussure further asserts that the signified and the signifier have an absolutely arbitrary connection. Additionally, Saussure argues that because the signified and signifier are separate entities of the sign, the difference between the value of a word and its signification may also be separate. The signification of a word becomes complicated by the contradiction that both the concept and the sign are counterparts. Saussure articulates this idea when he says, “But here is the paradox: on the one hand the concept seems to be the counterpart of the sound-image, and on the other hand the sign itself is in turn the counterpart of the other signs of language” (66). For Saussure, the counterparts of signifiers and words are what give them their signification. There is no meaning emanating from a word in and of itself, because significance is only elucidated between the differences in meanings among the words. Saussure sums it succinctly, “in language there are only differences” (70).

Indeed, Jacques Derrida continues the conversation on *différance*. “*Différance*” in French denotes the English verb “to differ” which simultaneously produces two separate meanings and two separate planes on the space-time continuum. Derrida explains:

The verb ‘to differ’ seems to differ from itself. On the one hand, it indicates difference as a distinction, inequality, or discernibility; on the other, it expresses the interposition of delay, the interval of a *spacing* and *temporalizing* that puts off until ‘later’ what is presently denied, the possible that is presently impossible.

Sometimes the *different* and sometimes the *differed* correspond [in French] to the verb ‘to differ’. (279)

In other words, the French word “*différance*” indicates both difference and deferral. Derrida looks at the difference between words in much the same way that Saussure does. Particularly, Derrida looks at sets of words that are considered binary oppositions. Examples of typical binaries are good/evil, white/black, man/woman, science/art, and perhaps even heroic/ordinary. Derrida explains that people understand words in terms of the oppositional meanings of their counterparts. In other words, much of the understanding of “woman” comes from its contrast to the signification of “man.”

The problem with binaries is that one term is always already preferred over the other. Derrida suggests that in order to get at more equitable understandings of words, the binaries should not be inverted. Woman should not become preferred over man; instead people must begin to understand not only what makes binaries different from one another but what significations binaries share in common with one another, so that prejudicial preconceptions may begin to dissipate. As with all binaries, we must deconstruct the binary of heroic/ordinary in order to dismantle prejudicial preconceptions of these two signs; this deconstruction becomes increasingly important as we replace the sign of heroic physicians with the sign of competent physicians.

Derrida adds an additional term to *différance* that addresses the deferral of meaning. This concept is harder to understand than difference, because it changes continuously over time and in various situations. At the moment of understanding of a particular idea, its complete meaning is always already deferred until the next discourse or the next context in which it is used. An example of this would be in considering a theory. A person might read about a theory on his or

her own, and formulate ideas about what the theory means. If that person engages with another person who is familiar with that theory, he or she may add to or subtract from or change his or her ideas about that theory. The view of the theory will continuously change over time, every time the person has another encounter with the theory. The meaning that the person derives from the theory is only stable until the next time the theory is considered.

In semiology, words are signs that represent objects and ideas. When signs are used in order to signify other signs, instead of actual objects and ideas, then Roland Barthes contends that they are metalanguages. Barthes declares that “myth itself” is “*metalanguage*, because it is a second language, *in which* one speaks about the first [language]” (Italics in the original; 82).

Barthes pronounces:

That which is a sign (namely the associative total of a concept and an image) in the first system, becomes a mere signifier in the second. We must here recall that the materials of mythical speech (the language itself, photography, painting, posters, rituals, objects, etc.), however different at the start, are reduced to a pure signifying function as soon as they are caught by myth. Myth sees in them only the same raw material; their unity is that they all come down to the status of a mere language. (81)

Barthes’ notion of first and second systems of signs mirrors Bakhtin’s notion that signs present a first and second system of reality. Both Barthes and Bakhtin contend that signs make up language, and language only seeks to represent reality because language is pure signification. So, when physicians are considered heroic, they lose the associative total of concept and image and become only a linguistic image. The linguistic image is not reality; it is only a myth that

physicians are heroic. Because the words and signs that make up language are metaphorical, language itself is also always metaphorical.

Language is necessarily metaphorical, because people must define new concepts in terms of established concepts that they already comprehend. These concepts are imagined concepts that are not truthful, because they are necessarily signified by the words that stand in for them.

Friedrich Nietzsche brilliantly describes metaphor and its association with truthlessness using a monetary metaphor:

What then is truth? A movable host of metaphors, metonymies, and anthropomorphisms: in short, a sum of human relations which have been poetically and rhetorically intensified, transferred, and embellished, and which, after long usage, seem to a people to be fixed, canonical, and binding. Truths are illusions which we have forgotten are illusions; they are metaphors that have become worn out and have been drained of sensuous force, coins which have lost their embossing are now considered as metal and no longer as coins. (1174)

This passage sums Nietzsche's beliefs that metaphors exist for cultural human relations, for egocentric anthropomorphic perceptions, for psychological repressions, and for people's drive to know truth – not for truth's own sake, but so that people don't get hurt by lies. Ironically though, truth is ultimately unknowable. In his comparison and contrast of "the rational man [. . .] and the intuitive man [sic]" (1178), Nietzsche sees the intuitive person as an "overjoyed hero" (1179) who uses metaphor for art in order to describe a deceptive form of mastery over life. Heroic physicians may, sometimes deceptively, use metaphor in order to magnify their mastery over disease. Bakhtin, like Nietzsche, also acknowledges that artists' aesthetic reactions to actual experiences are unrealistic and deceptive views of reality. After all, artists do not need to self

critique or explain their work, unless they choose to follow Bakhtin's advice and answer for their art. Nietzsche's view of hero and the artist is directly related to Bakhtin's view of hero and the artist, because both acknowledge the possibility of deception on the part of artists.

In addition to acknowledging the possibility that artists can be deceptive, both Bakhtin and Nietzsche realize that metaphorical signs can also represent truth, knowledge, and ideology. Bakhtin, like Nietzsche, describes metaphors as ideological signs:

A sign does not simply exist as a part of a reality—it reflects and refracts another reality. Therefore, it may distort that reality or be true to it, or may perceive it from a special point of view, and so forth. Every sign is subject to the criteria of ideological evaluation (i.e., whether it is true, false, correct, fair, good, etc.) The domain of ideology coincides with the domain of signs. They equate with one another. Whenever a sign is present, ideology is present. *Everything ideological possesses semiotic value.* (“Marxism” 1211)¹¹

Bakhtin asserts that the specific domain of ideology uses specific signs in order to communicate a specific message in that specific domain or discourse community. In medical discourse, physicians, rhetoricians, and patients use heroic rhetoric in order to portray the physician as a hero. The ideology of heroic physicians serves as justification for the authoritative roles of physicians as well as rationalization for patients' abdication of responsibility for their own healthcare. The ideology of the hero is a metaphorical sign of a physician who is more important than ordinary individuals. And while some metaphors conceal knowledge and other metaphors represent knowledge, still other metaphors serve to prevent people from obtaining knowledge.

¹¹ There is some controversy as to whether or not Bakhtin wrote “Marxism and the Philosophy of Language.” Patrician Bizzell and Bruce Herzberg assume that Bakhtin wrote it; however, Katrina Clark and Michael Holquist discuss that it may have been written by Bakhtin's friend, Vološinov. For more information on this controversy, see Clark and Holquist or Holquist.

Some rhetoricians believe that in addition to covering up knowledge, as Nietzsche believes, metaphors actually prevent people from learning truth and knowledge. John Locke contends that words signify our thoughts and ideas, and that if these words are to lead us to knowledge, then we must use them in the least ambiguous way possible. He contends:

Now, since sounds have no natural connection with our ideas, but have all their signification from the arbitrary imposition of men, the doubtfulness and uncertainty of their signification, which is the imperfection we here are speaking of, has its cause more in the ideas they stand for than in any incapacity there is in one sound more than in another to signify any idea. (817)

In addition to Saussure, Locke makes a great point that words, and the sounds that correlate with the words, have arbitrary signification. He also takes the position that misunderstandings in the definitions of words may lead to more disagreement than misunderstandings about ideas surrounding the signified word (822). Locke concludes that figurative language is harmful because it cannot lead to truth or knowledge:

But yet if we would speak of things as they are, we must allow that all the art of rhetoric, besides order and clearness; all the artificial and figurative application of words eloquence hath invented, are for nothing else but to insinuate wrong ideas, move the passions, and thereby mislead the judgment; and so indeed are perfect cheats: and therefore, however laudable or allowable oratory may render them in harangues and popular addresses, they are certainly, in all discourses that pretend to inform or instruct, wholly to be avoided; and where truth and knowledge are concerned, cannot but be thought a great fault, either of the language or person that makes use of them. (827)

And while Locke believes that metaphors insinuate wrong ideas, Bakhtin believes that metaphorical language, though not reality itself, may distort reality or realistically represent reality. Locke seems to indicate, although he does not overtly state it, that some words are metaphorical and others are not. Other words are used for order and clearness, but not for rhetorical purposes. The idea that some words are not metaphorical is in direct opposition to other theorists, such as Bakhtin, who contend that all words are metaphors.

I.A. Richards reiterates Locke's beliefs about the misunderstandings in meaning. Richards also believes that language cannot exist without metaphors. Richards coins terms such as "tenor" and "vehicle" for the two separate parts of metaphor. Tenor is the subject that has metaphorical language attributed to it and vehicle is the actual metaphor. In this study, physicians are the tenor and heroes are the vehicle in the metaphor—had I chosen to rhetorically analyze heroic physicians by employing Richards' theory. Richards, like Nietzsche, Locke, and Bakhtin, realizes the intrinsic misunderstandings that are possible with metaphorical language; and acknowledging the power of metaphor to deceptively create misunderstandings is of utmost importance for dismantling the image of heroic physicians.

The deceptive power of metaphors is most influential when metaphors reify unrealistic ideas in order to maintain the authoritative social statuses of specific members of discourse communities. Metaphors reify not just our language, but also our thoughts and our actions. In fact, George Lakoff and Mark Johnson assert that "metaphor is pervasive in everyday life, not just in language but in thought and action" (3). Metaphors are the way that we make abstract concepts concrete enough to talk about with one another. But, language and thought and action do not come about as a unique experience because all experiences are inextricably linked to our cultural socialization. So, according to Lakoff and Johnson, metaphors highlight, make coherent,

and organize our experiences. Furthermore, “Metaphors may create realities for us, especially social realities. A metaphor may thus be a guide for future action. Such actions will, of course, fit the metaphor” (156). When metaphors accurately predict actions, accurate predictions reinforce the power of the metaphor to make experience coherent. Lakoff and Johnson continue, “In this sense metaphors can be self-fulfilling prophecies” (156). If metaphors create and reinforce social realities, then the metaphor that is the heroic physician can create and reinforce the idea that physicians are heroes who save patients. Bakhtin also believes that metaphors create social realities, and that each specific discourse community has its own social reality within the community. Bakhtin acknowledges that “Each field of ideological creativity has its own kind of orientation toward reality and each refracts reality in its own way. Each field commands its own special function within the unity of social life” (“Marxism” 1211). In medical discourse, the social reality is that physicians are in command. And, physicians maintain their social statuses by reifying their positions as heroes.

While Lakoff and Johnson investigate the heroic metaphor in terms of “ARGUMENT IS WAR” (Emphasis in the original; 4), the metaphor, nevertheless, can be just as easily viewed as physician is hero. The authors contend that “*the essence of metaphor is understanding and experiencing one kind of thing in terms of another*” (Italics in the original; 5). They further explain:

It is not that arguments are a subspecies of war. Arguments and wars are different kinds of things – verbal discourse and armed conflict – and the actions performed are different kinds of actions. But ARGUMENT is partially structured, understood, performed, and talked about in terms of WAR. The concept is

metaphorically structured, the activity is metaphorically structured, and, consequently, the language is metaphorically structured. (5)

If the same application for physician as hero is made in place of argument is war, then the concept of physician is understood as a hero, the activities or work that physicians perform is metaphorically structured, and the language that is used to talk about physicians is metaphorically structured.

Bakhtin believes that when a physical body equals itself, then it does not signify anything, and there is no ideology within it; however, physical bodies may also be perceived as images that are necessarily ideological:

However, any physical body may be perceived as an image; for instance, the image of natural inertial and necessity embodied in that particular thing. Any such artistic-symbolic image to which a particular physical object gives rise is already an ideological product. The physical object is converted into a sign. Without ceasing to be a part of material reality, such an object, to some degree, reflects and refracts another reality. (“Marxism” 1210)

Because Bakhtin acknowledges that all words are already signs, he acknowledges that words are always already ideological. Therefore, although treatments that physicians prescribe for patients may be medications which are actual physical bodies, the concept of “treating” patients is always already ideological. And, we use metaphorical language in order to convey ideology.

We also use metaphors in order to move towards cognitive understandings. Metaphors stimulate thought processes in humans. Patricia Bizzell and Bruce Herzberg summarize Alexander Bain’s theory that metaphors inspire cognition. Bain contends, “It is a natural function of the mind, that is, to generate metaphor, metonymy, and antithesis. Moreover, the response to

such figures is stimulation of the corresponding mental function. The reader, according to Bain, will be more easily instructed or moved when these basic operations are stirred up by the right kind of images” (1142). Bain, like Bakhtin and others, believes that metaphor may lead to an understanding of new ideas. Unfortunately, physicians who have mastery of medical discourse may have an advantage over patients in understanding and synthesizing new ideas.

Although scholars have contradictory views about whether or not metaphorical language should be taught in scientific discourses, they nevertheless agree that metaphorical language is present in scientific discourses. Timothy Giles even goes so far as to make an argument that metaphors should be taught in technical communication classrooms. Whether or not metaphors are taught in scientific and technical communication, there are numerous instances of the use of metaphors in these writings. The numerous articles using medical discourse and medical rhetoric in this study provide abundant examples of metaphorical language. The fact that heroic metaphors are found in scientific writings speaks to their pervasiveness.

Bakhtin acknowledges the existence and use of signs in the various different discourse communities when he claims, “Within the domain of signs—i.e., within the ideological sphere—profound differences exist: it is, after all, the domain of the artistic image, the religious symbol, the scientific formula, and the judicial ruling” (“Marxism” 1211). Bakhtin goes a step beyond Giles in his assertion that metaphors are not only present in scientific discourses, but the conventions of actual scientific formulas are also always necessarily metaphorical. Because we cannot conceive of language except by metaphorical means, the only way to counteract the effects of the heroic metaphor is to replace it with another, less glorified, metaphor. Or, as Bakhtin suggests, physicians can take accountability for their heroic personae and recognize the reification of heroic images and replace them with more realistic images.

Myth

When metaphors pervade the majority of discourse communities and they become ubiquitous, they transform into myths. The heroic metaphor is a cultural myth because it is easily recognizable to almost all people in society. Cultural myths extend the ideologies of metaphors because in addition to conveying an instantly recognizable ideal, they also convey a quickly decipherable narrative.

The narrative of the cultural myth of the hero may include an ideology of individuality. Joe Hardin discusses the various cultural myths that help rhetoricians make arguments. Hardin clarifies the meaning of myth as he states, “the word ‘myth’ does not designate something that is not true; instead, it stands for the idea that complex meanings have become attached to certain symbols, characters, settings, or narratives” (80). He even uses the cultural myth of the hero as an example; “How many movies have you seen where the ‘hero’ is an individual who operates outside the system, takes the law into his own hands, and foils the bad guy with determination, guts, cunning, and actions? We see this hero so much that we do not question the link between heroism and individual action, bravery, and initiative [*sic*]” (80). Although Hardin never discusses heroic rhetoric in terms of medical discourse, his observations on this cultural myth can be directly applied to patients’ views of physicians as well as physicians’ views of themselves. If physicians are thought to show initiative, bravery, and individual action, then it is no wonder patients are so ready to relinquish decision-making functions to physicians. In terms of Bakhtin’s philosophy though, the ideology of individuality is problematic.

While ideations of individuality are certainly revered in western culture,¹² the reality of individuals having independent agency in society is paradoxical. On the subject of individualistic ideology Bakhtin asserts:

Individualism is a special ideological form of the ‘we-experience’ of the bourgeois class (there is also an analogous type of individualistic self-experience for the feudal aristocratic class). The individualistic type of experience derives from a steadfast and confident social orientation. Individualistic confidence in oneself, one’s sense of personal value, is drawn not from within, not from the depths of one’s personality, but from the outside world. It is the ideological interpretation of one’s social recognizance and tenability by rights, and of the objective security and tenability provided by the whole social order, of one’s individual livelihood. The structure of the conscious, individual personality is just as social a structure as is the collective type of experience. It is a particular kind of interpretation, projected into the individual soul, of a complex and sustained socioeconomic situation. But there resides in this type of individualistic ‘we-experience,’ and also in the very order to which it corresponds, an inner contradiction that sooner or later will demolish its ideological structuredness.

(“Marxism” 1217)

The contradiction between the individual ideology and the socially structured reality of certain people indeed presents an internal conflict that eventually causes cognitive dissonance in these people. If this study can create some cognitive dissonance in heroic physicians who believe that

¹² Bakhtin suggests that western culture refers to Western European culture as he discusses “we-experiences.” He says, “It [self-experience] is a variant of the ‘we-experience’ characteristic of the modern-day West European intelligentsia” (“Marxism” 1217-8). Hardin, however, recognizes the Western United States and its production of the ruggedly individualistic heroic cowboy as he refers to western culture (80). I include both Western Europe and the United States in the identification of western culture.

they are individual artists acting with sole agency in order to save patients or make money, then perhaps they can begin to see their social agency in terms of doing well for the collective social structure.

Alternatively, some scholars believe that the hero myth does speak to the values of a collective social structure. Contrary to Hardin, Linda Seger believes that the hero myth is “more than true” (318). She submits that the myth is based on a true story that happened to someone, but the myth also resonates with all readers, on some level, at some time. In fact, the hero myth is popular precisely because most people identify with the hero; most people see themselves as heroes. If most people recognize themselves in the hero myth, then the narrative becomes an overriding one. If both physicians and patients identify as heroes, then perhaps both are invested in perpetuating the myth that killing the disease is the only battle to be fought on the forefront of medicine.

The belief that ideology resides in the social structure of organized individuals is also held by Bakhtin:

However, the ideological, as such, cannot possibly be explained in terms of either of these superhuman or subhuman, animalian, roots. Its real place of existence is in the special, social material of signs created by man. Its specificity consists precisely in its being located between organized individuals, in its being the medium of their communication. (“Marxism” 1212)

In fact, Bakhtin believes that ideology is the medium of communication between individuals socially organized in specific discourse communities. The myth of the heroic physician must, consequently, be understood among all members of the medical discourse community.

A myth becomes a monomyth when the metaphor converts to the most universally recognizable sign. Joseph Campbell contends that the hero myth is actually a monomyth, one great narrative where various stories use very similar underlying literary conventions in order to convey the hero. In fact, Campbell argues that the greatest hero of all is God.¹³ The monomyth is a universal journey from reluctance to heroism. Ironically, the artist's own hero is of singular importance to him or her while the journey to heroism is actually a nearly universal undertaking. Indeed, some physicians may actuate god complexes when they are revered for saving patients.

Medicine

There are many articles that discuss the use of heroic rhetoric in medicine. April Marshall, for example, asserts that language and literature employ heroic metaphors about physicians and war metaphors about diseases that directly influence the way physicians and patients perceive not only themselves, but also each other. Marshall suggests that “literature offers us a perspective on our cultural perceptions of certain realities and disease is unmistakably one of the most ambiguous of those realities [*sic*]” (1). While Marshall makes a valid point that literature influences the cultural perceptions of medicine through heroic rhetoric, she does not address the idea that, perhaps, heroic rhetoric is the overriding metaphor employed in medical discourse.

In fact, heroic rhetoric may be an authoritative utterance used in medical discourse in order to express the ideology that physicians are heroes. Bakhtin contends:

In each epoch, in each social circle, in each small world of family, friends, acquaintances, and comrades in which a human being grows and lives, there are always authoritative utterances that set the tone—artistic, scientific, and

¹³ The Christian “God” is demarcated with a capital “G” indicating reverence. However, I choose to think about a more universal “god” that represents the collective monomyth without regards to a religious preference.

journalistic works on which one relies, to which one refers, which are cited, imitated, and followed. In each epoch, in all areas of life and activity, there are particular traditions that are expressed and retained in verbal vestments: in written works, in utterances, in sayings, and so forth. There are always some verbally expressed leading ideas of the “masters of thought” of a given epoch, some basic tasks, slogans, and so forth. (“Marxism” 1244-5)

Bakhtin again cites art and science as binary terms; however, he acknowledges that each of these discourse communities contain “masters of thought” whose declarations represent the authoritative utterances within the communities. The idea of physicians as heroes could come from masters of thought as Bakhtin contends, or from literature as Marshall contends. Nevertheless, the heroic ideal is a principal idea that is prevalent in the medical discourse community in many cultures.

Additionally, metaphors may lead to misunderstandings by hiding prejudicial values under the auspices of rational, neutral principles. Just as Derrida asserts that binary terms conceal prejudicial values within them, Segal asserts that metaphors also conceal prejudicial values. Segal contends, “Metaphor is the most rhetorical of figures, and its ubiquity is the best evidence that we are, each of us, everyday rhetorical beings. Metaphor operates lavishly in health and medicine, but it operates, at the same time, somewhat under cover; such is the way of metaphor” (*Health* 115). Segal declares that when values are explicit then topics may be openly debated; however, when topics are hidden under cover of metaphor one or more of the debaters may not realize the value assumptions that enter the conversation with the metaphor. Segal says, “When values are explicit, they may be openly debated but rhetoric uses metaphor to smuggle values into discourse that proclaims itself rational, even-handed, and value-free” (*Health* 115). An

example of a valued metaphor that Segal provides is when “*medicine is war*” (Italics in the original; *Health* 115). The people who use this metaphor obviously think that the art of medicine lies in killing the diseases rather than in keeping people healthy. Metaphors, like rhetoric in general, may be used for nefarious purposes. And, although heroic rhetoric is not necessarily a valued metaphor, there are instances where it may be used in order to push a valued agenda.

Bakhtin, like Segal, also discusses the potential of people who hold particular views in particular discourse communities to exploit language for their own purposes:

What is more, all socially significant world views have the capacity to exploit the intentional possibilities of language through the medium of their specific concrete instancing. Various tendencies (artistic and otherwise), circles, journals, particular newspapers, even particular significant artistic works and individual persons are all capable of stratifying language, in proportion to their social significance; they are capable of attracting its words and forms into their orbit by means of their own characteristic intentions and accents, and in so doing to a certain extent alienating those words and forms from other tendencies, parties, artistic works and persons. (“Discourse” 675)

Notice that Bakhtin, like Segal, iterates the hierarchical differences among people within particular social spheres. They both indicate that people with more social significance have greater power to exploit the intentional possibilities of language. In medical discourse communities, those people are physicians.

Indeed, physicians may exploit the intentional possibilities of language in medical discourse by bullying patients into compliance. Vyjeyanthi Periyakoil notices an incongruity in the ways that the heroic metaphor is utilized. On the one hand, he says that metaphors provide an

important service because metaphors are important tools that “directly compare seemingly unrelated subjects in an effort to clarify the contextual meaning of a complex and novel situation” (843). On the other hand, Periyakoil argues that metaphors belittle patients who decide against aggressive treatment options because “opting to refuse futile or harmful treatment options now becomes equivalent to a cowardly retreat from the ‘battleground’ that may be seen as a shameful act by the patient” (842). The solution may be to use metaphors that are not as violent as heroic metaphors. Periyakoil, like Bakhtin, realizes that indeed metaphorical language may be used to distort reality or to reflect the truth of it.

And in the discussion of the ways in which western society views death, metaphor may simultaneously distort reality and reflect the truth of it. In terms of the metaphors that we use in western society in order to discuss death, even if the metaphors reflect truth we may need to alter the metaphors if we are to alter the truths that we want to propose for the future. Segal furthers the discussion of the heroic metaphor in the treatment of dying patients. She contends that “so-called *heroic* medicine is the highly visible intervention of the western practitioner” (“Public” 223). Segal concludes that medical warfare becomes metastatic itself when it treats patients who should be allowed to die. Segal concludes:

In the practice of western medicine, from the rescue of the extremely premature baby to the maintenance on life support of the dissipated adult, the enemy is not disease but death itself, which must be kept at bay at any cost. In a war narrative differently read, it is death that the hero fights, instantiated in a variety of disease-enemies. (Ironically, even paradoxically, old age is something to be fought as well, as the commercials tell us, “every step of the way.” It is helpful to keep in mind that this enemy old age is also a social/cultural construction; old age was

much to be desired when it was, as it was until recently, considerably less available.) While the battle metaphor is problematic—not least because the battle with death is one we will all, ultimately, lose—it is especially so because biomedicine in general has not been able to articulate a place for death as anything *other* than defeat or failure. (“Public” 223)

Segal uses a medical metaphor in order to combat the heroic metaphor, by using the term “metastatic” to define medicine’s stance on death and dying. She brings up the highly salient point that both medicine and western culture need to articulate a place for death as a natural progression of the human experience. In fact, she claims that heroic rhetoric expresses the reticence of society to articulate a meaningful place for death.

Further, heroic rhetoric may be implemented as a means of covering up society’s inability to deal with disease and death. Abraham Fuks argues that military metaphors that envision the physician as a hero undermine the ability of modern society to deal with chronic disease states. Fuks views medical discourse as encompassing the heroic:

Medical discourse is replete with the language of war and such phrases as “the war on cancer,” “magic bullets,” “silver bullets,” “the therapeutic armamentarium,” “agents of disease,” “the body’s defences,” and “physician’s orders” are deeply engrained in our medical rhetoric. The mindset engendered by this discourse of war renders the patient as a battlefield upon which the physician-combatant defeats the arch-enemy, disease. The reified disease becomes the object of the physician’s attention, displacing the patient as the interlocutor in the physician-patient relationship [*sic*]. (1)

Fuks contends that the reified disease is more important to the physician than is the patient him- or herself. Whether or not this is the case, there is certainly an impression in the discourse that the disease takes precedence over the patient.

In medicine, the use of heroic rhetoric turns human beings into objects that contain an enemy in need of extermination. Kristen Garrison outlines the history of the use of heroic rhetoric in medicine throughout the twentieth century, and she explains that these metaphors are harmful because using them makes patients' bodies become marked war zones. However, in Garrison's experience, patients usually prefer to use war metaphors and adopt the most aggressive forms of treatment for their disease states. Garrison is convinced that patients are so afraid of their own mortality that they ultimately opt for the most assaultive combat that their bodies can take (1). This fear of eminent death serves to reinforce the heroic metaphors because patients want to be saved by heroes more than they want to (or think they can) save themselves.

Heroic rhetoric that visualizes patients as objects also interferes with patients' views about their own healthcare maintenance. Ivonne Hillmer also discusses illness in terms of war metaphors. And, although she does not discuss the heroic personae of physicians, she nevertheless develops the state-as-person metaphor whereby "a person, particularly his or her body, is conceptualised as a state, which can be at war. The body is conceived as having borders, which can be crossed, that is the body can be 'invaded by enemies [*sic*]' (24). She cites Lakoff and Johnson throughout, especially when they say that "metaphorical mappings are partial, not total. Otherwise the course of an infection would indeed *be* war" (Italics in original; 27). Even though the metaphorical mappings are partial, the important point about the state-as-person metaphor is the fact that patients' bodies do not have their own agency and are therefore not accountable for their own health. This idea is particularly disturbing because patients may be

under the impression that they can visit their physicians who will eradicate the enemy. In this metaphor, there is no impetus on the part of patients to participate in their own healthcare maintenance.

Heroic rhetoric that treats diseases as objects can prohibit new ways of studying human illnesses. Paul Hodgkin discusses various metaphors used in medicine. He believes that language and perceptions evolve together, and that metaphorical perceptions can prohibit other viable ways of thinking about medicine. As many other articles also indicate, Hodgkin says that objectification of disease states makes assumptions about the relationships between diseases and humans:

To see disease as an object and not a process is to emphasise that one can indeed 'get rid' of 'it', that its arrival was probably unbidden and that cure is equivalent to physical removal. As patients we can draw tight comfortable lines around the disease and say that the rest is normal. For physicians the disease, rather than the context in which it occurs or its meaning for the patient, becomes the most important level of study. (1820)

Hodgkin instead suggests that we should look at other ways of thinking and talking about illnesses, including thinking of illnesses as processes that are inextricably linked to humans. In order to do so, we need to mitigate the influence of heroic rhetoric in medical discourse.

The metaphor of the heroic physician can lead physicians to treating diseases without treating the entirety of patients. Henry Sigerist contends that the war against disease has intensified because of global research efforts that started after World War II. He reiterates what George Annas notes:

Medicine is a battle against death. Diseases attack the body and physicians intervene. We are constantly engaged in wars on various diseases, such as cancer and AIDS. Physicians, who are mostly specialists backed by allied health professionals and trained to be aggressive, fight these invading diseases with weapons designed to knock them out. Physicians give orders in the trenches and on the front lines, using their armamentaria in search of breakthroughs.

Treatments are conventional or heroic, and the brave patients soldier on. [. . .]

(314)

Treatments, by physicians, are sometimes heroic. But Sigerist concludes that the biggest problem with treating patients' bodies as though they are battlefields is that physicians tend to accept short-term, single-minded tactical goals instead of implementing long-term holistic care. In fact, this short-term view forces physicians to act heroically. Interestingly, Sigerist contends that it is the treatments that may be heroic, and not the physicians. Whether he gives credit to physicians or scientists for heroically technological advances is not clear. From Bakhtin's perspective though, the heroic image of the physician treating the patient needs ideological evaluation. And, evaluation reveals that the power of the physician-as-hero image interferes with total treatment of the entire patient, even though physicians often do not want to relinquish their power.

Heroic metaphors may also de-personify physicians as well as patients. Colleen Bell provides the allegory of heroic rhetoric as a narrative of counterinsurgency. If insurgency is the disease, then the counterinsurgency represents physicians' medical interventions.¹⁴ She declares that "counterinsurgents a[re] benevolent experts, insurgents a[re] destructive and alien, and the population [is] the battleground of conflict" (326). Bell concludes by deciding that heroic

¹⁴ Bell makes an important point that not only are war metaphors used to describe medical situations, but medical metaphors are also used to describe situations of war. Specifically, enemies are often referred to as "malignant parasite[s]" (325). Andrea Musolff also discusses the use of the parasitic metaphor.

rhetoric serves to de-personify physicians. In Bell's allegory, nobody benefits from the use of heroic rhetoric in medicine. If patients are the battleground, then they are certainly objectified. If patients are objects or battlefields, then they are not accountable for their own health.

Objectification of patients presents quite a conundrum. Ultimately, if patients can go to physicians and get miraculously cured then they have little reason to take accountability for preserving their own health.

In analyzing heroic rhetoric in medicine, Garrison, Hillmer, Hodgkin, Sigerist, and Bell discuss the objectification of patients. And in addition to Bakhtin, contemporary theorists Linda España-Maram and George Lipsitz discuss reification of collective memory in terms of objectification and concretization of ideas.¹⁵ If reification is the objectification or concretization of an idea, then there are three essential differences with Bakhtin's definition of reification as compared with España-Maram and Lipsitz's definitions. First, for Bakhtin, there are two necessary steps involved in the process: from thought to utterance is the objectification step, and then from utterance to synthesis among the power systems within discourse communities is the concretization step. For España-Maram and Lipsitz, there is no separation and objectification is roughly analogous to concretization. Second, according to Bakhtin, synthesis into discourse communities is essential. Although España-Maram and Lipsitz discuss the wide acceptance of the objectification of an image in social language, they do not break language down into discourse communities. Third, Bakhtin contends that when an inner experience or thought is expressed as an utterance, then the thought must fundamentally become objectified. In other words, every thought is objectified once it is spoken because all words are signs that objectify ideas. España-Maram and Lipsitz, on the other hand, believe that objectification or

¹⁵ For an expanded discussion of España-Maram and Lipsitz's theories, please consult Chapter V.

concretization of an idea is a fallacy that can be avoided if speakers acknowledge that the ideas are only ideas and not concrete truths.

Bakhtin iterates objectification as the first step in reification:

Thus the personality of the speaker, taken from within, so to speak, turns out to be wholly a product of social interrelations. Not only its outward expression but also its inner experience are social territory. Consequently, the whole route between inner experience (the ‘expressible’) and its outward objectification (the ‘utterance’) lies entirely across social territory. When an experience reaches the stage of actualization in a full-fledged utterance, its social orientation acquires added complexity by focusing on the immediate social circumstances of discourse and, above all, upon actual addressees. (“Marxism” 1218)

Bakhtin also indicates that objectification is wholly a social interaction. Bakhtin continues his discussion involving the second step in reification:

But once [. . .] [consciousness] passes through all the stages of social objectification and enters into the power system of science, art, ethics, or law, it becomes a real force, capable even of exerting in turn an influence on the economic bases of social life. To be sure, this force of consciousness is incarnated in specific social organizations, geared into steadfast ideological modes of expression (science, art, and so on). (“Marxism” 1218)

Once objectification becomes concretized and reified in a discourse community, it becomes a steadfast ideological mode of expression. So, whether the objectification and concretization applies to patients’ bodies or physicians’ personae, heroic rhetoric is reified in medical discourse communities where it is used and discussed among its members.

Another important aspect of heroic rhetoric that Segal explores is when physicians' authoritative persuasions coerce patients to change their opinions. Segal believes that legitimate persuasion can only occur when the two parties have equal access to the language discourses being used. She explains, "Two people are not engaged in a properly rhetorical enterprise but rather, perhaps, in a coercive one, when only one of them really knows what they are talking about, and the other only knows what the first one reveals" (*Health* 18). If we are ever to seek more equitable communications among physicians and patients, then we must expose hidden metaphorical values and knowledge differentials in medical discourse; because physicians have authority and power and knowledge of rhetorical skills in medical discourse that patients may not possess. And in addition to being more rhetorically skilled, physicians' authoritative roles may actually be justified by heroic rhetoric.

Heroic metaphors promote the authoritative roles of physicians over patients in the physician-patient exchange. Charlotte Rees, Lynn Knight, and Clare Wilkinson examine the effects of several metaphors on physician-patient relationships and find that the metaphors emphasize the opposition quality of these relationships. They conclude that "The metaphors we use to describe student/doctor-patient relationships are fundamental to the reification of those relationships" (735).

Heroic rhetoric implements metaphorical signs that symbolize physicians as the most authoritative figures in the hierarchy of medicine. Virginia Warren believes that heroic rhetoric does more than influence language; it also influences attitudes, moral beliefs, and actions in the physician-patient relationship. Further, because someone in war has to issue commands and physicians are at the top of the medical hierarchy, they are assumed to take on the authoritative role:

First, experts are often needed to repel the enemy. These experts – soldiers and health care professionals – gather information, make and execute plans. Second, both types of experts need to coordinate people and machines, to make quick life-or-death decisions. Hence it is assumed that someone issues commands. A well-defined hierarchy of power and authority is built on the need to make and to carry out decisions swiftly. (40)

Heroic rhetoric serves to justify the authoritative roles of physicians. In patients with chronic or terminal diseases though, decisions may not need to be carried out swiftly. Therefore, there is often time for collaborative decisions between physicians and patients that there may not be for officers and enlisted soldiers. But once well-defined hierarchies are instituted, they are hard to dismantle.

Bakhtin, in addition to Segal, Rees, Knight, Wilkinson, and Warren, believes that authoritative discourse is not easily ignored:

Another's discourse performs here no longer as information, directions, rules, models and so forth—but strives rather to determine the very bases of our ideological interrelations with the world, the very basis of our behavior; it performs here as *authoritative discourse*, and an *internally persuasive discourse*.

(“Discourse” 682)

Authoritative discourse functions to form our ideological interrelations to one another and to mold our behavior. Bakhtin warns that although it is possible for authoritative discourse and internally persuasive discourse to be simultaneously united in a single word, it is much more likely that authoritative discourse and internally persuasive discourse struggle with one another, in an individual, to determine the ideological consciousness of that individual (“Discourse” 683).

In patients who readily accept authoritative discourse, they will be more likely to accept physicians' authoritative roles.

And, for Bakhtin, authoritative discourse does not allow for individuals to appropriate it for their own uses:

It is not a free appropriation and assimilation of the word itself that authoritative discourse seeks to elicit from us; rather, it demands our unconditional allegiance. Therefore authoritative discourse permits no play with the context of framing it, no play with its borders, no gradual and flexible transitions, no spontaneously creative stylizing variants on it. It enters our verbal consciousness as a compact and indivisible mass; one must either totally affirm it, or totally reject it. It is indissolubly fused with its authority—with political power, an institution, a person—and it stands and falls together with that authority. One cannot divide it up—agree with one part, accept but not completely another part, reject utterly a third part. Therefore the distance we ourselves observe *vis-à-vis* this authoritative discourse remains unchanged in all its projections: a playing with distances, with fusion and dissolution, with approach and retreat, here is not possible.

(“Discourse” 683)

Although I do not necessarily agree with Bakhtin that we must totally affirm or totally reject authoritative discourse, I do agree that when physicians use authoritative discourse with patients then patients can find it hard to reject it without also rejecting treatments. When physicians use medical discourse with patients, patients can be intimidated enough by physicians' authoritative roles that they remain silent and distant when they need to ask questions and approach physicians.

Answerability

For Bakhtin, only when artists understand the difference between aesthetic reactions to actual experiences and the actual experiences themselves can the artists become answerable for their work. In this case, aesthetics refers to the whole of lived experiences—as opposed to actual experiences—of artists’ heroic personae. Bakhtin suggests that “we abstractly separate the content of a lived-experience from its actual experiencing” (“*Toward a Philosophy*” 33). Indeed, the subjective ways in which we choose to remember and forget actual experiences are abstract. Instead of remembering accurate facts, we remember an experientially lived narrative that helps us explain ourselves to ourselves and to others. Our aesthetic reactions are often beautifully idealized versions of our best possible selves. Michael Holquist continues Bakhtin’s conversation by claiming, “Aesthetics concerns itself with the problem of consummation, or how parts are shaped into wholes” (*Art* x). Holquist also explains that an aesthetic reaction becomes meaningful as parts are shaped into whole consummating actions. He argues, “Aesthetics is a form of embodying lived experience, for consummating action so that it may have the meaningfulness of an event” (*Art* xi). Bakhtin asserts that aesthetic reactions of the artists are understood from the perspective of the whole live experience of the hero:

What makes a reaction specifically aesthetic is precisely the fact that it is a reaction to the *whole* of the hero as a human being, a reaction that assembles all of the cognitive-ethical determinations and valuations of the hero and consummates them in the form of a unitary and unique whole that is a concrete, intuitable whole, but also a whole of meaning. (*Art* 5)

The aesthetic reaction, then, is the means by which artists assemble their heroes. And because this aesthetic reaction is unreal compared with the actual experiences of the artists, heroes are

necessarily different from the artists themselves. Bakhtin suggests that “[a]n author tells us this ideal history only in the work he has produced [*sic*]” (*Art* 6). Any time that artists utter the aesthetics of their heroes, they do so with idealized views of lived experiences. What this means for physicians is that they idealize the communications with and treatments of patients. Physicians may try to minimize deleterious effects and maximize successful effects. As long as heroic rhetoric functions to acknowledge physicians as the heroes of medicine, physicians’ aesthetic reactions to their work will be idealized reactions.

If, however, physicians begin to dismantle the binary opposition between “heroic” and “ordinary,” physicians may start to view their lived experiences in a more realistic way. In terms of Derrida’s difference, instead of subverting the binary and making ordinary preferred over heroic, we must start to look at the characteristics that both terms share. We may find that “competent” physicians will serve patients better than heroic or ordinary physicians do. And because, as Derrida suggests, the meaning of heroic rhetoric is always already deferred, consciously choosing to replace heroic metaphors with less idealized metaphors may be a place to begin. As heroes, physicians are answerable for their communications with and treatments of patients. And the use of heroic metaphors, as we have seen, is ubiquitous. Rhetoricians and patients recognize and use heroic metaphors as much as physicians themselves use them. Should we choose to deemphasize heroic rhetoric in medicine, then physicians, rhetoricians, and patients must all work together. If, as Bakhtin suggests, heroic rhetoric passes through all the stages of social objectification and is then concretized in power systems of various discourse communities, then heroic rhetoric is actually reified in social discourse, rhetorical discourse, and medical discourse with a steadfast ideology of the physician as hero. Because heroic rhetoric is so pervasive and it is reified in so many discourse communities, it is even harder to mitigate its

effects than if it was only used in one discourse community. Physicians cannot simply change from medical discourse to social discourse in order to avoid heroic metaphors, because heroes are found in that discourse community as well. And, avoiding heroic metaphors in medical discourse, and other discourse communities, does not necessarily change the heroic views that physicians have of themselves. Physicians may continue to view themselves as heroes, even without the use of specific heroic rhetoric to reinforce their views. Nevertheless, we should try to reduce the use of heroic rhetoric when describing physicians and replace it with a more realistic rhetoric. If minimization of heroic rhetoric is to occur, then physicians, rhetoricians, and patients will need to work towards a collective answerability.

CHAPTER III

DEFAMILIARIZING PHYSICIANS' HEROIC PERSONAE IN MEDICAL DISCOURSE

Bakhtin's theory of monoglossic discourse communities is implemented as a means to rhetorically analyze physicians' texts which focus on physician-patient dialogues. Physicians' journal articles and books often reinforce the idea that physicians are heroes, or at least the dominant members of medical discourse, who control the communications with and treatment of patients in the medical discourse community.

Discourse Communities

Discourse communities are exclusive communities that revolve around a specific language and value system. An understanding of discourse communities and their inherent hierarchies begins with an exploration of the ways that dialogue is employed within these communities. According to Bakhtin, dialogue is the key feature in communicative understanding. Dialogue is also the key feature of communicative exchange in discourse communities. Bizzell and Herzberg explain Bakhtin's theory of dialogue:

Mikhail Bakhtin's work is fired by his conviction that language and the forms it takes can be properly understood only as dialogue, as utterances that take place within social situations and that at least partly constitute them. Dialogue, for Bakhtin, occurs both in the literal exchange of utterances between speakers and in the intentional negotiation of meaning and interpretation between author and reader. (1206)

Indeed, for Bakhtin, dialogue encompasses the entire reality of language: "*The actual reality of language-speech is not the abstract system of linguistic forms, not the isolated monoglossic utterance, and not the psychophysiological act of its implementation, but the social*

event of verbal interaction implemented in an utterance or utterances” (Italics in the original; “Marxism” 1221). From a Bakhtinian perspective then, active social interaction comes about by way of responding to dialogue.

Also, discourse as “a group of verbal performances” systematically constructs the subjects who must continuously negotiate power relations (Foucault, “Archaeology” 107). For Foucault, power is not simply the result of knowledge; it is also a constant negotiative struggle among members both inside and outside the discourse community. Not only does Foucault acknowledge the power struggles inherent in discursive performances, but he further argues that these discursive performances actually construct their subjects. For physicians, discursive performances in medical discourse reinforce physicians’ power over patients and construct physicians’ personae of themselves.

Dialogue can expose the power differentials in medical discourse that come about from physicians possessing superior knowledge to patients and rhetoricians. Discussion can help us negotiate meaning that comes from rhetorical strategies, especially strategies such as synthesizing utterances from medical discourse into social discourse. Exchange of ideas can also expose how metaphor usage can hide speakers’ ethical values, values that often echo dominant social standards. Dialogue can, ultimately, expose the inequities between members of discourse communities and outsiders that may lead to disrupted communication processes within discourse communities.

The medical discourse community employs medical discourse. At times, Bakhtin uses the terms monoglossic, authoritative, and professional to refer to different concepts when describing various discourse communities, and at times he uses the concepts roughly interchangeably. For my purposes, the medical discourse community encompasses all of these concepts because

medical discourse is generally monoglossic, authoritative, and professional. Discourse communities are communities in which specific discourses are used by members who are granted access into the communities. Members of these discourse communities enjoy authority and power, as well as specific knowledge of the language and assumptions inherent within the exclusive communities. Subjects must be heard and acknowledged in a discourse community in order to become members; understanding the language is not enough. Admittance into the medical discourse community comes from current members who control rules and discourse production; this control is what gives members their power. So physicians, as acknowledged members of the medical discourse community, logically consider themselves better qualified than patients or rhetoricians to direct conversations employing medical discourse.

Medical discourse, as a form of authoritative or monoglossic discourse must be problematized. What makes up the medical discourse community? Medical discourse surely incorporates health, healing, curative practices, illness, death, and medical institutions. But do its members consist solely of health care professionals? The scientific discourse community and medical rhetoric community may also, at times, be included within the medical discourse community. But the exclusivity of medical discourse allows physicians to limit communications with nonmembers. Physicians' perspectives also play a part in the disruption of communications and refusal to participate in social discourse. So how can social discourse manage to infiltrate medical discourse? Where does medical discourse stand, in terms of how it is informed by—and more importantly—how it informs the social construction of physicians' personae? Heroic rhetoric has a definite impact on the medical community as it infiltrates its discourse. But how does heroic rhetoric influence physicians and the ways that physicians see themselves? Although

there is no one correct answer to these questions of inclusivity, there is little contention that physicians are at the top of the hierarchy of the medical discourse community.

Authoritative discourse is considered monoglossic discourse or language unique to a singular discourse community, wherein access is granted only to members who demonstrate the credentials warranting inclusion in the discourse community. According to Bakhtin, authoritative discourse, such as medical discourse, does not and should not change with its participants because all participants are acknowledged members of the medical discourse community. Authoritative discourse must remain relatively static because it serves the function of relaying important and precise information between health care professionals. The stability of authoritative discourse lies in its ability to transcend individual persuasion and remain consistent and solidified through society through time.

The word discourse is used, as Bakhtin suggests, when authoritative discourse is reserved for accepted members within the medical discourse community. The weakness of authoritative discourse lies in its inability to provide active dialogue with its members. This non-reflexivity may be one of the reasons why the multitude of articles asking physicians to communicate better with patients has not been successful.

Physicians use medical rhetoric as an authoritative, monoglossic, unchangeable language in order to communicate concisely with other health care professionals and to legitimize their membership in the medical discourse community. Authoritative, monoglossic medical discourse between physicians is a legitimate use of medical discourse, as iterated by Bakhtin when he argues that “authoritative discourse itself [. . .] remains sharply demarcated, compact and inert” (“Discourse” 683). So physicians may feel that they have an obligation to keep the demarcations of the monoglossic discourse intact in order to display their medical acumen. While physicians

primarily use monoglossic medical discourse in their profession, their articles reveal that they incorporate heroic rhetoric and social discourse as well as medical discourse in their writings.

Physicians do not usually overtly state that they see themselves as heroes however, their use (either consciously or subconsciously) of heroic metaphors in their articles or in their communications with patients indicates that they may believe themselves to be heroes, or heroic metaphors are so embedded in medical discourse that physicians do not even question it.¹⁶ In *Art and Answerability*, Bakhtin asserts that art and life must become united in the heroes' answerability to that which they produce (*Art 2*). If physicians see themselves as heroes and if they see their art as the ability to treat patients, then they may understand their answerability as the responsibility to fix patients instead of to communicate with them. But lack of communication with patients may make patients feel disenfranchised by their physicians.

Patients may also feel disenfranchised when they realize that they are omitted from adding to knowledge formation within the medical discourse community. Hierarchical knowledge formation is another means of excluding people from specific discourse communities. Foucault provides a theory of history that deconstructs readers' views of history and knowledge in *The Archaeology of Knowledge*, when he asserts that historical discourses are solidified in texts in order to control and limit the ability of individuals to add to such discourses. Foucault reiterates Aristotle's sentiments on power as he defines discourse as "a group of verbal performances" that systematically construct the subjects who must continuously negotiate power relations (*Archaeology 107*). For Foucault, power is not simply the result of knowledge; it is also a constant negotiative struggle among members both inside and outside the discourse community. Not only does Foucault acknowledge the power struggles inherent in discursive performances, but he further argues that these discursive performances actually construct their

¹⁶ See Chapter I for an expanded explanation of the complexities of the formation of heroic personae in physicians.

subjects. So, for physicians who are constructed by their knowledge of medical discourse and the power that it wields, especially with its inclusion of heroic rhetoric, it is easy to see why physicians are reticent to relinquish that power to their patients.

Discourse communities enact specific rules in order to exclude membership by subjects who do not follow the conventions of the community. In “The Discourse on Language,” Foucault succinctly verbalizes the restrictions on discourse that he exposes in *The Archaeology of Knowledge*. Foucault discusses the “social appropriation of discourse” (227) in which disciplines, such as medicine, “constitute a system of control in the production of discourse, fixing its limits through the action of an identity” (224). Foucault discusses three primary constraints on discourse as he states, “those limiting its powers, those controlling its chance appearances and those which select from among speaking subjects” (225). For limits on powers, disciplines enact rules of exclusions in which certain types of speech are prohibited. For controls on chance appearances, disciplines acknowledge only celebrated authors whose reputations are the indicators of texts’ truthfulness. For restrictions among speaking subjects, disciplines impose “rules upon those individuals who employ it, thus denying access to everyone else” (224).

In medicine, these limitations are established when medical journals limit the publication of articles written by rhetoricians because rhetoricians who write about medical discourse usually publish in rhetorical publications instead of medical journals. Foucault concludes by asserting that discourse is a violent act that exploits truths. Medical discourse may indeed be used as much to reinforce physicians’ status as to communicate medicine’s truths; but, medical discourse’s violence lies in its declaration of truths which may not be truths for everyone. When medical journals limit publications by nonmembers, when physicians dismiss patients’ concerns, and when novel medical ideas are dismissed without consideration, Foucault’s violence occurs.

Medical discourse, then, may perpetrate violent acts that exploit patients' truths while denying them full access to those truths.

Physicians may further exclude patients from medical discourse by labeling them as illiterate. Patients are often deemed illiterate by the medical discourse community even if they understand medical language because they have not gone through medical school, residency, licensure, and publications in medical journals. Without the expertise of a language in a specific discourse community humans are illiterate in that community. Charles Schuster invokes Bakhtin, in "The Ideology of Literacy: A Bakhtinian Perspective," as Schuster discusses the definition of literacy that he himself adopts. Literacy is not just the ability to read and speak and write; it is the ability to read and speak and write and be *heard and acknowledged* (Schuster's emphasis) within specific discourse communities. Schuster endorses a view of literacy as power within a discourse community as he contends, "literacy is the power to be able to make oneself heard and felt, to signify. Literacy is the way in which we make ourselves meaningful not only to others but through others to ourselves" (43). In other words, if literacy implies meaning making, then illiteracy connotes meaninglessness. Schuster continues by declaring that "illiterates" are alienated by members of dominant discourse communities; "From a Bakhtinian point of view, illiterates today are cursed [. . .] by dominant cultures within society to endure a state of alienation wherein speaking, listening, reading, and writing become meaningless activities" (Schuster 43). To patients, being "cursed" means that even when they become knowledgeable about their diseases through comprehension of medical discourse, physicians may still not acknowledge them as literate members within the medical discourse community.

Texts Authored by Physicians

The texts that I review are authored by physicians and focus mainly on physician-patient dialogue. These texts do not all directly employ heroic rhetoric; however, they mostly present views of patients as less-qualified than physicians to engage in communications about those patients' healthcare concerns. Some of the texts do provide nice examples of patients as the central concern in the physician-patient interchange, and there are a few suggestions about potential adaptations in the physician-patient interchange that may benefit patients. Some physicians actually embody overt heroic personae. Physicians' texts are diverse in terms of research findings and potential resolutions, but they are similar in their use of medical discourse as an exclusionary tool.

Many physicians do not believe that patients have enough knowledge to make good decisions about their own healthcare. Jozien Bensing provides an analysis of his quantitative research that maintains that patients do not always understand their own quality of care in regards to physician-patient communication. Bensing concedes that the study did not use patient assessments in considerations of their physicians' communications skills "since these [patient assessments] do not correlate highly with what [. . .] [Lebow] calls 'objective' i.e. physician defined measures of care, a result confirmed by DiMatteo and DiNicola [*sic*]" (1301). Without using heroic rhetoric or overtly acknowledging the authoritative control of physicians, Bensing, nevertheless, argues that physician assessments of communication should be used instead of patient assessments of communication because physician assessments are considered superior to those of patients. Bensing's findings are based on physicians' understanding of medical discourse and not on patients' understandings of their own bodies. The fact that Bensing considers physicians' measures of care more "objective" than patients' measures of care

indicates that—as a physician—he considers physicians less biased than patients. This view of the physician-patient dynamic supports Bakhtin’s assertions that the medical discourse community is authoritative, monoglossic, and unreflexive. This view also supports Foucault’s assertions that discourse is limited and controlled by excluding patients and elevating the physicians’ status to heroes who are the only ones qualified to make decisions. According to Schuster, these patients are not able to signify because they are not heard or understood. Bensing’s dialogue exploits medical knowledge in order to reinforce the dominant hierarchy of physicians in the medical discourse community.

Other research, such as one study testing cancer patients’ perceptions of their diagnoses and treatments, illuminates the idea that mutual participation in medical decisions is a bad idea because of the misunderstandings that patients have about their diseases and the misconceptions that physicians have about patients’ needs. W. J. Mackillop et al. found that even when physicians explained to their patients that they were being treated palliatively, only a third of dying patients understood that they were being treated palliatively instead of curatively and most physicians “failed to recognize their patients’ misconceptions” (1). The physicians involved in the study were unable to determine whether misunderstandings emanated from miscommunications with physicians or denial. Even so, they conclude:

Physicians may overestimate their patients’ desire to become actively involved in decisions about their care; here, we have demonstrated that physicians also overestimate their patients’ understanding of their illness. ‘Mutual participation’ in medical decisions is a legitimate goal in the physician-patient relationship, but it may not be what every patient wants and, unless communication improves, it is not what every patient needs. (4)

While I agree with Mackillop et al.'s deduction that communication between physicians and patients should improve, their suggestion that patients don't know enough to know what their wants and needs should be is patronizing. Further, this study erroneously assumes that physicians' assessments overestimate patients' knowledge about diseases when it is equally possible that physicians do not attempt to assess what patients know about their diseases.

Although on the surface this study seems to advocate mutual participation as a legitimate goal, it subversively supports physicians' roles as authoritative hierarchical heroes who should take care of patients' needs without exchanging mutual dialogue. If, as Foucault suggests, knowledge is a constant negotiative struggle between members within and outside the discourse community, then the physicians in this study are reinforcing the idea that physicians have more knowledge than patients. This reinforcement seeks to solidify the medical discourse community by excluding patients from dialogic interactions.

Another means of solidifying the medical discourse community is by prompting patients to ask their physicians three questions from among a large group of preassembled questions that have been formulated by physicians. J.M. Galliher et al. study a group of patients that participate in the Ask Me 3 (AM3) online program compared with a control group that does not participate in AM3. AM3 encourages patients to pick three questions from a database of what established physicians consider to be the most important questions for patients to ask physicians.¹⁷ Galliher et al. conclude that "In a patient population in which asking questions already occurs at a high rate and levels of adherence are fairly high, we found no evidence that the AM3 intervention results in patients asking specific questions or more questions in general" (159). Although this is only one study about one online question prompter, it does indicate that patients may be reticent

¹⁷The AM3 program does not prescribe which three specific questions that patients should ask their physicians; AM3 asks patients to pick from the database the three questions that are most important to them. Questions can be in the area of disease, disease progression, prognoses, medications, lifestyle changes, etc.

to accept external advice on questions concerning their interactions with their physicians. Or, perhaps, the questions that physicians consider important in specific situations may not be the same as the questions that patients deem important. Whatever the case, this study highlights further solidification of authoritative medical discourse because physicians seek to limit dialogue and control the questions that are asked (even if they are disguised as an interactive online program). Prompted physicians' questions are an example of the social appropriation of discourses of which Foucault speaks because physicians seek to control and limit the questions that are asked by patients.

In one more case of appropriation of discourses, two physicians focus on physicians' feelings instead of patients' feelings. Sometimes physicians feel badly about their patients. Richard Gorlin and Howard Zucker claim that physicians' feelings of impotence, frustration, inadequacy, guilt, sadness, and disapproval inhibit physicians in responding positively to patients. Gorlin and Zucker resolve to add humanism to medical programs so that physicians may learn how to deal with emotions that erupt as a result of treating patients. Gorlin and Zucker claim, "By acknowledging his or her own emotional position, the physician is able to consider the relationship with the patient more objectively" (1059). Acknowledging their emotional positions helps physicians understand themselves and perhaps treat others better; but, physicians are no more objective than any other group of people. The reason that the physicians think that they are more objective is that they analyze physician-patient interactions from their own perspective. In fact, the entire article is written from the perspective of physicians. Its focus is to help physicians acknowledge and justify why they dislike patients. In one instance, the authors contend that "it is natural to react with dislike and anger to an assaultive, noncompliant drug addict with infective endocarditis" (1062). Addressing patients as "noncompliant" and "drug

addicts” instead of “human beings” is a prime example of an authoritative discourse that values physicians’ perceptions and knowledge above patients’. Physicians, as Foucault says, “constitute a system of control in the production of discourse, fixing its limits through the action of an identity” (“Discourse” 224); in this case the action of identity is the active personae of heroic physicians. Gorlin and Zucker’s article is an example of discourse that is monoglossic and for physicians’ benefit, even at the expense of patients.

An additional study by P.J. Rosenfield and L. Jones echoes Gorlin and Zucker’s study with regards to analyzing the emotions of medical students. Rosenfield and Jones find that medical students actually cope with anxiety about illness and suffering by lowering their feelings of empathy. Rosenfield and Jones state that “Education should aim to endeavor to teach students how to deal with their responses so that they can tolerate patients’ distress and treat them effectively” (927). The authors indicate that “an awareness of the tension between the poles of pathology and health” (927) can benefit physicians because physicians can learn to manage their anxiety with regards to their patients. The education endeavors to desensitize medical students to their empathetic reactions towards patients by focusing on objective treatment strategies that address ailments instead of patients’ emotional wellbeing. The study does not reveal whether or not this education is effective, but, like the previous study, it places the emotions of medical students above the emotions of patients. Empathetic care should seek to teach medical students how to accept and embrace patients’ emotions instead of just tolerating patients’ emotions. In an egocentric manner, this monoglossic discourse focuses on medical students’ emotions and not patients’ emotions. These medical students are being taught cultural power and heroic rhetoric.

Studies may explicitly support physicians’ dialogic mutuality with patients while they implicitly value physicians’ objectivity in authoritative medical discourse. The study by Arnold

Werner and John Schneider investigates the teaching of interview techniques to physicians. Werner and Schneider claim that effective interviews involve exploratory (open ended) questions, awareness of patient and physicians' feelings, active listening, and accurately labeling the patient experience (1232). Indeed, medical schools are taking the initiative to teach specific physician-patient interview skills such as the use of exploratory questions, emotional questions, and active listening (1232). But there is obviously a reticence to learn on the part of student physicians or a lack of emphasis on the importance of dialogic instruction on the part of the instructor physicians. Werner and Schneider find that the teaching of interview techniques costs a lot of money and some medical students are reticent learners, either because of personal difficulties in facing emotions or because they don't value empathy; they value objectivity. The authors conclude that "'therapeutic' behavior is too complex to be learned through any single type of supervisory experience" (1237). Werner and Schneider blame failure to change physicians' behavior on the complexity involved with trying to change physicians' perspectives from objectivity to emotionality, instead of on physicians' unwillingness to learn. However, if equitable dialogic exchange was a mandatory component of a medical degree, physicians would probably learn to excel at it. This article provides an example that authoritative medical discourse often values objectivity over emotionality. And, as Foucault suggests, verbal performances construct subjects. In this case, the verbal performances of physicians as both instructors and students construct heroic personae that value the perception of objectivity over the perception of emotionality. When objectivity is valued over emotionality, patients' emotional needs may be overlooked as unimportant.

A further indication that the medical discourse community is authoritative, unreflexive, and exclusive is that member physicians frequently blame disruptions in communications on

nonmember patients. A study by Han Li et al. that investigates the interruptions that occur in physician-patient interviews suggests that although physicians do not interrupt patients more than patients interrupt physicians, the interruptions are different in nature. Physician interruptions are more often intrusive while patient interruptions are more often cooperative. For example, physicians divert the path of patients' questions if they find the questions unimportant, whereas patients add to the conversation to show that they understand how to follow physicians' instructions. Additionally, physicians are much more successful in having their interruptions acknowledged than are patients. Li et al. state, "Physicians are firmly in charge of the process and/or content of the conversation. [The study] also indicates that patients would like to participate fully in the medical interview but are held up by physicians. If patients wish to say what they have to say and ask what they want to ask, they not only need to learn to ask questions, but also do so successfully" (152). While I am not surprised by these findings, I am astonished that the authors place the responsibility for the communication problems on the patients and not the physicians. In addition, Li et al. do not state how patients are to "do so successfully" when they realize that physicians' authoritative advantage over patients. Further, the authors acknowledge that in regards to medical dialogue physicians are in positions of power over patients when they claim, "Question asking sometimes requires patients to interrupt physicians, and this can be a daunting task since physicians have authority over patients" (152). And Li et al. question patients' capacity to be trained: "Can patients be trained to interrupt their physicians skillfully and successfully?" (152) This question condescends to patients. Tasking patients to adapt to physicians' authoritative and aggressive stance in dialogic exchange really puts the onus for communication on patients. Charging patients to follow the conventions of medical discourse

is absurd because patients do not understand the conventions, or they would already be members of the medical discourse community.

Verbal performances, in addition to authoritative roles in the medical discourse community, can construct physicians' subjectivity. Arnold and Sandra Gold's article propagates heroic views of themselves as physicians. They provide a retrospective overview of how medicine used to be humanistic but is not any longer. The authors provide examples of family physicians that used to make house calls and take care of both the physical and emotional aspects of patients but who no longer make house calls or treat the emotional aspects of patients. The Golds call for the practice of medicine to become humanistic once again through nurturing patients' emotional well-being. The authors make great points about medical practice; however, their claims are not supported by specific evidence. For example, they claim, "We know from many studies that patients who trust and feel comfortable with their physicians are less likely to sue them even when mistakes are made. More significantly, patients who feel that physicians listen to them are more compliant" (548). If the Golds are referring to specific studies then the studies should be cited so that readers do not have to accept the Golds' claims on faith, especially since other studies indicate that compliance is not based on patients' perspectives about how well physicians listen to them. The Golds make a salient point that hidden agendas are often inconsistent with explicit curriculum, because medicine promotes humanity but rewards physicians for treating as many patients as possible in a short amount of time. If physicians don't reward medical students for holistic care or give medical students time to nurture the emotional well-being of patients, then medical students think humanity is not important. These insights help explain the persistence of emotional avoidance by physicians. This article simultaneously reinforces the Golds' authority and challenges the communication strategies of the dominant

discourse community to which they belong. The Golds' paradox is, indeed, a necessary situation from a Bakhtinian perspective.

From patients' perspectives, then, what is the relevance of physicians' communication strategies? Do patients value physicians who communicate clearly, attentively, and empathetically? R. Zachariae et al. find that physicians' abilities to accurately estimate patients' satisfaction with their physicians' communication behaviors are directly proportional to patients' actual satisfaction with their healthcare. Although the correlation is small, Zachariae et al. indicate that attentiveness and empathy are important aspects that contribute to patients' satisfaction. Zachariae et al. argue "That both Attentiveness and Empathy predicted satisfaction with personal contact suggests that both the physicians' behaviours with regard to listening, letting the patient ask questions, giving information, and explaining the biomedical aspects and their ability to respond to the patients' emotions are important to the patient-physician relationship [*sic*]" (663). Patients care more about attentiveness and empathy when it comes to physicians' behavior than they do about technical abilities. The authors find that "It is an erroneous assumption that patients want technical expertise rather than good communication" (658). Generally, Zachariae et al. conclude that patients value communication over expertise from their physicians.

Conversely, David Thom finds that patients do value technical expertise in their physicians. Thom looks at the associations between particular physician behaviors and how well those behaviors translate into trust on the part of their patients. Thom declares that "Caring and comfort, technical competency, and communication are the physician behaviors most strongly associated with patient trust" (323). On the other hand, he finds that the least important behaviors are gentleness, eye contact, asking patients their opinions, and treating patients as though they

were equals. Thom does not specifically delineate what “equal” means, but these findings, if substantiated, are astounding and they somewhat contradict the study by Zachariae et al. Collectively, the two studies attempt to objectively categorize the most important physician behaviors in the physician-patient interview; however, the fact that they contradict one another indicates that objective categorization may be difficult to substantiate. The two studies investigate patients’ satisfaction and trust which indicates that some physicians care about patients’ perceptions, even if it is solely to communicate better with patients but not to include them in the medical discourse community.

There are, however, some physicians who not only care about communications with patients, but these physicians actually make novel suggestions for alternate means by which to progress towards understanding patients. Sara Tucker suggests that the medical community accept death denial as an implicit acknowledgement of patients’ reticence to communicate about their disease states. Accepting death denial is one potential adjustment for the medical discourse community to consider. Denial of death is a reasonable choice for some patients. Including this choice in medical discourse would open patients’ options for dealing with, or in this case not dealing with, death. Tucker deconstructs the concept of death denial while she argues that we must offer society an alternative to the rhetoric on death and death denial. In the first place, fear of death in western society may lead to poor decision-making on the part of physicians, patients, and families of patients. In the second place, death denial may be a logical choice for dealing with death. Tucker suggests:

Denial is blamed for poor adaptation, poor care, and added suffering. What is neglected completely in the clinical medical literature is the consideration of denial as a legitimate choice, not a problem; the choice is to not verbally discuss,

or perhaps to not even consciously deliberate in private. If denial is an obstacle to frank discussion, perhaps avoiding the frank discussion is an acceptable option, in respect of autonomy. (1107)

Tucker brings up very valid points about western cultures' views of death and its denial. Death denial is a valid choice, and it should be considered for acceptance within the medical discourse community.

Narrative medicine is a second potential adaptation for physicians within the medical discourse community; it focuses on patients' feelings about themselves. R. Charon advocates the use of narrative medicine in order to form empathetic bonds between physicians and patients. Narrative medicine is the ability to acknowledge, interpret, and act on the narratives of others and of ourselves. Charon contends, "By bridging the divides that separate physicians from patients, themselves, colleagues, and society, narrative medicine offers fresh opportunities for respectful, empathic, and nourishing medical care" (1902). Narratives are an important feature in all social interactions; they elicit empathy through personal storytelling. The transformation of narratives into medicine may help physicians better understand patients' personal personae. For example, one woman explains to her female neurosurgeon that she herniated the disc in her lower back while giving birth, as her son's head forced its way through the birth canal. Both women bond over the pains incurred while giving birth. The female physician is immediately able to empathize with her patient's pain. This potential adaptation makes use of storytelling already present in social discourse and acknowledges its benefits in medical discourse.

Informed consent documents are a third potential alteration in medical discourse; informed consent documents are legal documents that have the potential to promote mutual dialogue between physicians and patients. Jay Katz is both a lawyer and a physician, and he

investigates the physician-patient relationship in *The Silent World of Physician and Patient*. Katz talks about his own socialization into the medical discourse community: “During my socialization as a physician I had been taught to accept the idea of physicians’ Aesculapian authority over patients” (ix). In order to try to remove some of physicians’ authority over patients, informed consent documents were instituted. While informed consent documents were introduced in medicine because both health care workers and patients were frustrated by misunderstandings in or disregarding of patients’ preferences by physicians when patients could not speak for themselves, physicians do not always consult informed consent documents even when they exist. Katz asserts that the informed legal consent document is not taken seriously by physicians because physicians still sustain ultimate authority in medical situations. He further argues that physicians and patients must have sustained, honest, open communications in order to help patients to understand what their preferences really are, and informed consent documents should be an impetus for these kinds of communications. He states that “The idea of informed consent suggests that trust must be earned through conversation. [. . .] For conversation to be meaningful, both parties must be entitled to make decisions and to have their choices treated with respect” (xiv-v). Katz challenges the authoritative medical discourse community in his quest for mutual dialogue. He maintains, “We need to inquire why physicians have been so insistent in their demand that all authority be vested in one party—the physician” (xvii). Medical conduct is “deeply embedded in the ethos of all professions. In their political struggles both to gain control over their practices through exclusive licensure laws and to secure freedom from lay control, all professions have sought to impose their authority on the public” (Katz 29). Because of these exclusive licensure laws that protect physicians’ authority in the legal system, judges usually side with physicians. Lack of legal support for patients’ misunderstandings of the documents that they

sign makes informed consent documents almost meaningless. And when physicians incompletely discuss informed consent documents with their patients, patients feel neglected. Katz continues, “When physicians did not listen to patients, or responded perfunctorily to their questions, or dismissed their doubts and concerns, patients felt abandoned” (207). The lack of mutual dialogic exchange can prevent physicians and patients from finding the correct treatments for patients. Katz ultimately concludes that physicians and patients must learn to trust each other, in order to come to the best treatments for patients (229). Informed consent documents could be used in medical discourse in order to encourage mutual communication between physicians and patients, instead of to secure authoritative control by physicians.

There are certain physicians who understand their authoritative roles. Some physicians overtly acknowledge that they are heroes whose art is saving patients. *The House of God*, a novel by Samuel Shem, describes his experiences as an intern at the prestigious Beth Israel Hospital in Boston in 1978. The novel illuminates the tragic nature of an internal medicine rotation where patients are referred to as GOMERs (Get Out of My Emergency Room). This text brilliantly juxtaposes the lived experiences of the hero with the actual experiences of a physician. *The House of God* is a perfect example of the incorporation of Bakhtin’s assertion that art and life must become united in the heroes’ answerability to the art which they produce (*Art 2*). The hero is the narrator of the novel and blatantly discusses his heroic answerability. The narrator, intern Roy Basch, expresses his excitement at his recognition of his heroic persona that practices an art. He declares, “I was a physician. For the first time that day, I felt excited, proud. They believed in me, in my art. I would take care of their brother, and them. Take care of the whole world, why not? [*sic*]” (41). Basch transitions from actually taking care of one patient to imagining taking care of the whole world—in one leap. At another point in the novel, Basch inserts himself

directly into a war metaphor where he is the hero: “I see us – hot, sweaty, Iwo Jima – heroic – hovered over a gomer [*sic*]” (4). Although this novel employs as much social discourse as it does medical discourse, it nevertheless reveals the authoritative position of physicians as heroes who practice the art of saving patients. This novel is a perfect example of Shem’s answerability to the art which he produces because he takes responsibility for physicians’ heroic personae. It is also a depiction of the explicit recognition by one physician of his own heroic persona.

Joe’s Story: Part 2

When we left Joe’s story, Joe was hopeful that chemotherapy would take care of his metastatic cancer. That was in June 2012. In October 2012, Joe died. My mother, Linda LaBarge, is still distraught over his death. I interviewed Linda after I received the email that precipitated this study topic; however, since then we have not really discussed medical discourse because of her emotional state.

When I picked up *The Silent World of Physician and Patient* for inclusion in Chapter III, I noticed that it had a circular, embossed identification marker, “JAL,” on the first page of the book. Around the circle it expounded: “From the library of Joseph A. LaBarge.” I opened the text and it was underlined with black, blue, and red ink. Joe obviously used a ruler to underline particular passages, because the lines were absolutely straight. Joe underlined the same passages that I would have! Joe was obviously aware of the authority and power that physicians have in the physician-patient interchange, because he had really studied this text. Why did Joe have this text in his library? Did Joe teach any classes using Katz’s text?

I thought that Joe did not understand the email that he received telling him about his metastases, but he may have just been in denial. Clearly Joe did understand the dynamics of the

physician-patient interchange, as well as much of the language used in the medical discourse community.

I wonder about Joe's connection to medical discourse. The connection that Joe had with Katz's text puzzles me. What puzzles me even more is that this connection involves me. I now had this book on my shelf, in the section on texts written by physicians. How did it get there? Did Joe participate in the medical discourse community? The bigger question to ask is what constitutes a member of the medical discourse community? Physicians are certainly members. However, some auxiliary groups of people, such as Joe, may participate in the community without actually being granted membership. Are medical rhetoricians heard and acknowledged members of the medical discourse community?

Establishing a Continuum

The physician-authored texts are diverse, both in terms of subject matter and in terms of resolutions to problems; however, they are similar in their use of medical discourse and their inclusion of heroic personae. Physicians express their heroic personae in various ways. In fact heroic expressions form a continuum, in terms of the ways that heroic personae are actualized. Some physicians reinforce the status quo of the authoritative medical discourse community; some physicians care about patients' concerns, although patients are still considered outsiders in the medical discourse community; some physicians seek nonmedical adaptations in order to include patients in the medical discourse community; and some physicians analyze their own authoritative voices while uniting social discourse with the medical discourse.

Bakhtin's theories also exhibit a discursive continuum, from authoritative or monoglossic discourse to multiple or heteroglossic discourses. Medical discourse is a form of authoritative language. As Bakhtin states:

The authoritative word demands that we acknowledge it, that we make it our own; it binds us, quite independent of any power it might have to persuade us internally; we encounter it with its authority already fused to it. The authoritative word is located in a distanced zone, organically connected with a past that is felt to be hierarchically higher. It is, so to speak, the word of the fathers. Its authority was already *acknowledged* in the past. It is a *prior* discourse. (“Discourse” 683)

The prior establishment of medical discourse carries with it an authority already fused to it. Medical discourse requires that its users acknowledge both the language and the hierarchical power that is attached to it. As such, medical discourse is less reflexive and heteroglossic than social discourse which easily appropriates other languages within it.

Some physicians’ articles reinforce authoritative discourse. Medical discourse is used throughout the physicians’ texts in order to establish membership and *ethos* by the author, to exclude nonmembers, and to reinforce the stability of the discourse. In fact, maintaining the hierarchical values may be more important than helping patients. The texts that are written from physicians’ perspectives often seek to maintain the hierarchical values that are woven into medical discourse. Authoritative physicians reinforce the idea that physicians are superior to patients, that they have more knowledge about patients, that they know what treatments are best for patients, and that they understand what patients need without actively hearing what patients ask for. By reinforcing these values, physicians maintain authority and *ethos*. Unfortunately, the reinforcement of these values also excludes patients from their own healthcare decisions.

Bakhtin acknowledges that various authoritative and social discourses cohabit with one another in constantly evolving heteroglossic discourses:

At any given moment, languages of various epochs and periods of socio-ideological life cohabit with one another. [. . .] Language is heteroglot from top to bottom: it represents the coexistence of socio-ideological contradictions. [. . .] In actual fact, however, there does exist a common plane that methodologically justifies our juxtaposing [. . .] [heteroglossic languages]: all languages of heteroglossia, whatever the principle underlying them and making each unique, are specific points of view on the world, forms for conceptualizing the world in words, specific world views, each characterized by its own objects, meanings and values. As such they may be juxtaposed to one another, mutually supplement one another, contradict one another and be interrelated dialogically. As such they encounter one another and coexist in the consciousness of real people.

(“Discourse” 676)

As Bakhtin points out, not only do medical discourse and social discourse form ideologically different worlds, but they represent diverse points of views and values of the world. He indicates that juxtaposing discourses may mutually supplement one another or they may contradict one another.

In the physicians’ texts that are written from the patients’ perspectives, the use of heteroglossic discourses signals the two perspectives that are juxtaposed with one another in the texts. There is a contradiction between social discourse that illustrates patients’ perspectives and medical discourse that illustrates physicians’ perspectives. There are contradictions in points of views and values between physicians and the patients that they aim to treat. Some physicians indicate that attentiveness and empathy are important aspects of patients’ satisfaction. Conversely other physicians find that patients do value technical expertise in their physicians,

even over listening and empathizing. The two studies investigate patients' satisfaction and trust which indicates that some physicians care about patients' perceptions, even if it is just to communicate better with patients and not to include them in the medical discourse community. However, physicians' views and values may still prove incongruent with patients'.

Alternatively, medical discourse and social discourse mutually supplement one another in other texts that are authored by physicians. Death denial is one potential adaptation that argues that denial of death is a reasonable choice for some patients. Narrative medicine is a second potential adaptation that focuses on patients' stories about themselves. And, informed consent documents are a third potential adaptation that can potentiate mutual dialogue between physicians and patients. Synthesis of nonmedical solutions into the medical discourse community provides mutual benefits for both physicians and patients.

Bakhtin talks about synthesis from combining discourses. Juxtaposing social discourse with medical discourse serves to illuminate the absurdity in both. Bakhtin declares, "Against this same backdrop of the 'common language,' of the impersonal, going opinion, one can also isolate in the comic novel those parodic stylizations of generic, professional and other languages we have mentioned, as well as compact masses of direct authorial discourse" ("Discourse" 678-9). Whether we consider medical discourse an example of professional or authorial discourse, it is nevertheless juxtaposed with social discourse in order to acknowledge the absurdity of the exclusive language that cannot effectively communicate and its attached value system. Shem overtly acknowledges that physicians consider themselves heroes whose art is saving patients in his novel that combines social discourse with medical discourse.

Now that we see that there is a continuum of responses that physicians have in their written texts, how do the various physicians' responses influence heroic personae in medical

discourse? Many physicians are aware of their heroic personae, and some physicians are trying to change the authoritative nature of medical discourse, as acknowledged members within the medical discourse community. And there is a changeable nature to what constitutes dialogue in medical discourse. The changeable nature of dialogue means that there is potential for broader inclusion of diverse members into medical discourse. For example, medical rhetoricians, scientists, medical administrators, or even patients should be considered – in specific situations – members of the medical discourse community. Of course, for inclusion, we must refer to Schuster who contends that literacy is not just the ability to read and speak and write; it is the ability to read and speak and write and be *heard and acknowledged* within specific discourse communities. Even if physicians are willing to include members in certain instances, the medical discourse community as a whole will not include these people as members until these groups are uniformly heard and acknowledged within the medical discourse community.

CHAPTER IV

DEMYTHICIZING PHYSICIANS' HEROIC PERSONAE IN MEDICAL RHETORIC

Even though the medical discourse community is considered mostly monoglossic in nature, no discourse is solely monoglossic. The heteroglossic integration of social discourse with medical discourse is the practice that allows for dialogic interactions about medicine with people, such as rhetoricians, who are not accepted members of the medical discourse community.¹⁸ This heteroglossic integration of social discourse with medical discourse, as we shall soon see, may also provide a solution to the barriers of physician-patient interactions.

Bakhtin's heteroglossic theory provides insights into rhetoricians' texts because rhetoricians write in heteroglossic ways that do not strictly follow the authoritative, monoglossic discourse of medical professionals. According to Bakhtin, there are three important stratifications of language: genre, profession, and society ("Discourse" 675). When rhetoricians write, they often use the genre of an argumentative article that combines medical rhetoric with social discourse. And, rhetoricians are not always considered acknowledged members of the medical discourse community. So, even when rhetoricians make valid arguments for increased clarity in communication by physicians towards patients, as outsiders, rhetoricians are less likely than physicians to be taken seriously by some medical professionals.

Why aren't rhetoricians always taken seriously by physicians? After I decided to write my study on medical rhetoric, I attended the Conference on College Composition and Communication. I sat in on a special interest group that focused on medical rhetoric. As I listened to the conversation on physicians' reticence to implement rhetoricians' advice unfold, I realized that some of the medical rhetoricians in the room thought completely differently than I

¹⁸ For a complete discussion of the definitions of monoglossia and heteroglossia see Chapter I.

did. One woman indicated that because rhetoricians know more (I suspect about communication) than physicians, physicians must be intimidated by rhetoricians. There were several others in the room who nodded their heads in agreement to her assumption. I, however, could not agree. In my interactions with physicians, I have not found them to be intimidated by anyone. And while I agree that rhetoricians may know more than physicians about communication, physicians may think that they have superior knowledge about medicine than anyone else in the medical discourse community. In addition, physicians may make suppositions that the value system within the medical discourse community is superior to those systems outside the community. Not only do some physicians believe that they have more knowledge than other people engaged in medical discourse, but some may believe that killing disease is more important than communicating with patients – for the purposes of both giving patients information and asking patients their preferences. Simply put, physicians’ status at the top of the medical discourse community gives them a hierarchical advantage for power and control over others in medicine. A hierarchal advantage may contribute to physicians’ reluctance to take advice from others, as well as to their creation and perpetuation of heroic personae.

Rhetorical Strategies

The ability to detect and implement rhetorical strategies gives certain people advantages over others in discursive interactions. Aristotle reminds us that knowledge of the difference between apparent persuasion and actual persuasion gives the knower his or her power.¹⁹ For patients who do not understand the actual persuasive elements inherent in medical discourse, their own interests and concerns may not be acknowledged or addressed if they do not know how to present them to physicians.

¹⁹For more information on Aristotle’s rhetoric, refer to Chapter I.

Heteroglossic discourse and hybrid utterances are persuasive elements, often consisting of utterances borrowed from one discourse community and synthesized into another. The juxtaposition of these heteroglossic voices highlights the social, economic, and cultural differences that come with these incongruent discourses – in this case medical discourse and social discourse.

In addition to heteroglossia, Bakhtin describes utterance as the complete unit of speech used to make meaning and significance. Significance, or what Bakhtin calls the theme, is meaning actively understood within the specific context that the utterance is spoken. Bakhtin says, “*Only an utterance taken in its full, concrete scope as an historical phenomenon possesses a theme*” (Italics in the original; “Marxism” 1224). Further, utterance is only understood in an active response to someone else’s utterance: “To understand another person’s utterance means to orient oneself with respect to it. [. . .] *Any true understanding is dialogic in nature.* [. . .] In essence, meaning belongs to a word in its position between speakers; that is, meaning is realized only in the process of active, responsive understanding” (Italics in the original; “Marxism” 1226). In medical discourse then, significance is not complete because physicians have expertise in medical discourse that patients do not possess, so patients cannot fully develop active responses to the physicians’ utterances.

According to Bakhtin, utterances are the complete units of speech activities first because they realize active responses, and second because they finalize the speech act. Bakhtin explains that utterances indicate a preparatory stage of response whereby the speaker demonstrates that he/she is finishing a complete thought (“Problem” 1233). The finalization may be indicated by a change in intonation, a conventional phrase, or a question. Bakhtin contends that “The speaker ends his utterance in order to relinquish the floor to the other or to make room for the other’s

active responsive understanding. The utterance is not a conventional unit, but a real unit, clearly delimited by the change of speaking subjects [*sic*]” (“Problem” 1235). Indeed, an utterance may contain one simple word or one sentence but the reason that it is a complete unit of speech is because it is ALL that the speaker wishes to say. A word or sentence cannot, without the input of the speaker, elicit a response. Bakhtin cites three linked concepts that speakers use in order to indicate a finalized wholeness of the utterance: “(1) semantic exhaustiveness of the theme; (2) the speaker’s plan or speech will; and (3) typical composition and generic forms of finalization [*sic*]” (“Problem” 1237). As indicated in the discussion on utterance from “Marxism,” theme is meaning actively understood within the specific context that the utterance is spoken; the speaker’s speech plan is evident when we listeners “imagine to ourselves what the speaker *wishes* to say” (“Problem” 1238); and, generic forms of finalization are determined by the “*choice of particular speech genre*” (Italics in the original; “Problem” 1238). An utterance’s dialogic nature and finalization are two of the three defining features for the argument that utterances are the defining unit of speech.

The third and perhaps most important feature for asserting the utterance’s status as the true speech unit is its expressive aspect. Bakhtin declares that words, sentences, and language have no expressive features inherent in them. Emotion and evaluation and expression are not present in language until a speaker infuses the language with such emotion and evaluation and expression. Bakhtin says, “Thus, emotion, evaluation, and expression are foreign to the word of language and are born only in the process of its live usage in a concrete utterance” (“Problem” 1243). The expressive components of our utterances are assimilated from others’ utterances. Bakhtin concludes:

Our speech, that is, all our utterances (including creative works), is filled with others' words, varying degrees of otherness or varying degrees of 'our-own-ness,' varying degrees of awareness and detachment. These words of others carry with them their own expression, their own evaluative tone, which we assimilate, rework, and reaccentuate. ("Problem" 1245)

Bakhtin's views on the utterance speak to the heterogeneous nature of utterances, and the observation that utterances are often synthesized from one discourse community into another. I agree with Bakhtin that the power in the utterance – whether seen as a sentence or a complete active thought – lies in the ability of its utterer to actively understand it and to synthesize it into other discourse communities. In terms of rhetorical devices, active understanding of utterances may be the most important one to utilize in language expertise. And physicians often master utterances in medical discourse, in ways that patients often cannot.

Physicians often have persuasive advantages over patients in the use of medical rhetoric, including better knowledge and use of heteroglossic discourse and hybrid utterances. The metaphor, and perhaps even the myth, of the heroic physician is an image that carries with it an associated ideology that views the physician as the hierarchically authoritative figure with ultimate knowledge. Ideologically, the physician-as-hero in medical rhetoric may interfere with collaborative communication processes between physicians and patients.

Texts Authored by Rhetoricians

Arguing for better communication between physicians and patients is the same assertion that rhetoricians have been making for decades. In texts authored by rhetoricians, there are various suggestions for better communications between physicians and patients. Whether or

not the texts specifically address heroic rhetoric, they either implicitly or explicitly recognize the power differentials present between physicians and patients.

Patients are often considered less important than physicians because they are only seen as objects that host the illness that needs extermination. In a correspondence letter, E.W. Linfors and F.A. Neelon argue for the necessity of bedside rounds in order to force physicians to humanize patients. They believe that bedside rounds benefit patients with active participation in their own healthcare. This article focuses on patients' benefits, but it also indicates that bedside rounds help physicians uncover previously unknown information, especially with regard to patients' emotional well-being. Linfors and Neelon quote Siegler who states, "The physical presence of the patient demands that he be regarded as a subject rather than as an object and this [presence] facilitates the pedagogical goal of humanizing medical care [*sic*]" (1233). These rhetoricians acknowledge that patients are sometimes objectified by physicians, especially if physicians only recognize disease states instead of interacting with actual humans. However, these rhetoricians do not explicitly acknowledge the authoritative communicative control that physicians have over patients.

In one article that overtly discusses physicians' authoritative advantages, Bernard Barber provides a traditional view of the physician as an authoritative hero:

The long established pattern, to which most participants in medical care are deeply committed, has a number of consistent characteristics. The physician is superordinate, the authority, sometimes a person to be venerated. The patient and others are subordinate, respectful, even deferential. The physician is active, knowledgeable and secure in the system: the patient and others are passive, ill informed, frightened and dependent [*sic*]. (939)

Although Barber argues for equitable partnerships between physicians and patients, he acknowledges that the superordinate-subordinate relationships between physicians and patients are still commonplace. And while Barber does not directly discuss physicians' heroic personae, he discusses physicians as superordinate, respected, and venerated.

Physicians often prefer medical or technical discourse to social or interpersonal discourse because it gives them power and control over the physician-patient communication process. Debra Roter and Judith Hall review literature that deals with actual communication processes in medical discourse and apply a quantitative meta-analysis to the communication studies. They look at scientific task-focused behavior as well as socioemotional behavior and conclude that "much greater progress has been made in the measurement of conventionally defined technical performance quality than in the measurement of interpersonal performance quality" (178). Technical performance quality includes expertise in standards of practice as well as medical discourse, whereas interpersonal performance quality implies competency in both empathetic responses and social discourse. If Roter and Hall's conclusions are correct, then some physicians may use medical discourse in order to sustain their control over patients.

Even though physicians often take on the authoritative role in physician-patient communications, rhetoricians suggest that more equal control can be achieved, in heteroglossic interviews, with more active communication from patients. Moira Stewart reviews physician-patient interactions in order to assess outcomes. She finds that patient outcomes can be improved with good communication. Physicians should ask many questions that look at physical, emotional, and therapeutic concerns. Patients should "share in decision making when a plan for management is formulated. They should be encouraged to ask questions and given clear verbal information" (Stewart 1429). The problem with the study is that it focuses on the communication

process without regard to the power differential involved between physicians and patients. Avoidance of the power disparity may be why some published studies have done little to alleviate the communication difficulties in the physician-patient interchange.

Rhetoricians also suggest that if physicians begin to implement conversation analysis, with regards to physician-patient interviews, then physicians will alter their interviewing techniques accordingly. Douglas Maynard and John Heritage study conversation analysis in medical interviews, because conversation analysis examines interviews as naturally occurring interactions. Maynard and Heritage recommend capturing the interview on audio or videotape and then examining the utterances of both parties. They conclude that conversation analysis should be incorporated into medical curricula. They state that “Physicians must work at tools for analyzing communication with patients in order to assume partnership in understanding disease. The conversation analytic approach and research tradition, we believe, is such a tool” (434). Once again, this study implies that the physicians’ best interests are fulfilled when they communicate more effectively with patients; however, physicians may seek authoritative control over the situation rather than effective communication. In this study, the rhetoricians’ motives for better communication are in direct conflict with physicians’ goals for authoritative control over communication. These rhetoricians fail to consider the power differential in communications between physicians and patients.

While some rhetoricians disregard the power disparity between physicians and patients in the communication process, other rhetoricians recognize that the power disparity allows physicians to limit physician-patient communication based on physicians’ own priorities. Either way, physicians’ control over physician-patient communications must be acknowledged in order

to dislocate the controls and move towards collaborative communications between physicians and patients.

Some rhetoricians believe that physicians probably direct patients' focuses on treatment regimens rather than on their impending deaths. Anne-Mei The et al. discuss collusion in physician-patient communication with reference to terminal diseases. They claim that physicians encourage patients to focus on one treatment option at a time, so that patients will remain hopeful and neglect dwelling on their impending deaths. The The et al. study interviews physicians, patients, and patients' families in order to ascertain how these parties come together to collude in stories of recovery in order to avoid discourse on death and dying. In addition, The et al. find that physicians' stories of previous patients' miraculous recoveries provide unrealistic hope. They state that "This recovery story is the dominant social discourse, and, in general, it is difficult for patients to deviate from it" (1380). The et al. report:

Although all parties individually would have occasional doubts about the validity of this plot, they would not acknowledge this publicly so as not to be seen as undermining the others' trust in future recovery. This public adherence to the recovery plot, however, could not be maintained to the end of the illness trajectory. When patients experienced a relapse or when patients and their relatives observed how the condition of fellow patients deteriorated, doubts could be discussed. (1379)

The authors conclude that neither physicians nor patients want to acknowledge impending death. Whether they are cognizant of it or not, physicians speak utterances that may be misunderstood by the patients to whom they are speaking. As an example, the word "treatment" means a course of action to physicians, whereas it tends to mean cure for many patients. Physicians are experts

and authoritative figures, so patients cannot help but attempt to believe physicians' utterances even when patients misconstrue the utterances that they are attempting to understand.

Indeed, specific utterances spoken by physicians can change the whole tenor of the physician-patient interview. Rhetorician Julia Frank writes that interviews between physicians and patients should establish the foundations of collaborative dialogue, in addition to making diagnoses. She contends that simple declarations such as, "We don't know what's wrong with you" can "enlist the patient's co-operation in his own care, and establish his position as an equal member of the team [*sic*]" (1464). Perhaps if physicians admit that they do not know all of the answers, then patients may feel as though they can help physicians find the answers. Frank does not explicitly acknowledge the power differentials between physicians and patients, but her suggestion that physicians declare that they simply do not know what illnesses patients have implies that she comprehends these power differentials. Not only does this utterance implement social discourse within the heteroglossia of medical rhetoric, but it also counteracts the effect of the heroic metaphor as it concerns physicians and replaces it with another metaphor. I have suggested that this new metaphor might be called "competent physicians," because when physicians indicate that they do not have all of the answers then patients can see them as more human and less mythic.²⁰

Time may be another factor that contributes to the heroic personae of physicians. Because physicians control time with regard to office visits and daily rounds, they control another important commodity in physician-patient interactions. In addition to controlling medical expertise and medical discourse, physicians also control the time that they invest in physician-patient interactions. Robert Klitzman wanted physicians to understand time from the same

²⁰For a more extensive conversation on my concept of "competent physicians" consult Chapters I and II.

perspectives as their patients, so he had his student physicians become hospitalized patients. Waiting for long periods of time in waiting rooms, getting medicine that causes diarrhea, and having tests performed instead of getting to have conversations with physicians made these physician-patients empathize with patients in ways that they had not previously. Klitzman concludes:

Time is a central concept in estimating course of disease and treatment responses, yet physicians tend to see it as wholly objective. Subjective experiences of time need to be more fully included and examined in research and understandings of patient experiences. Awareness needs to increase that difference in aspects of both the form and content of time—in perceptions, experiences, and interpretations—occur, and can have critical implications. (153)

Patients may experience time as subjectively longer than do physicians because of pain or fear or depression surrounding their illnesses. From a Bakhtinian perspective, time control seems to be a figurative sign that symbolizes that physicians are more important than are patients.

Many rhetoricians explicitly acknowledge that physicians' roles in physician-patient exchanges are hierarchical, even when physicians do not discuss heroic rhetoric. Myfanwy Morgan provides an overview of physician-patient relationships. She contends that the relationships are social in nature, and conflicts exist between physicians' values and their patients' values. Morgan states that value conflicts are "particularly likely to occur in relation to abortion, homosexuality, AIDS and other conditions or behaviours invested with moral evaluations" (51). These conflicts may serve to disrupt good patient care. She claims that "for half the patients seen, the main factor related to a reduction in symptom severity was the patients' satisfaction with the initial consultation" (53). If patients were given a definitive

diagnosis during the initial consultation, they tended to feel better immediately. I do not know whether or not this is a reproducible or statistically significant study, but I do like Morgan's resolution. She resolves that addressing patients' concerns and beliefs could alleviate potential conflicts with physicians, and resolves to change from the hierarchal model of the "voice of medicine" to the collaborative model of the "voice of patient" (55). She uses the example of patients who believe that antibiotics should be used for viruses and suggests that "Eliciting and addressing such lay beliefs could avoid potential conflicts and enhance doctors' job satisfaction, as well as promoting the quality and effectiveness of patient care" (53). While I agree that addressing beliefs could enhance some physicians' satisfaction, I doubt it would enhance all physicians' satisfaction. Morgan makes another good suggestion when she asks that physicians actively listen to patients more than they talk at patients. I agree with her suggestion, but I question how we can institute physicians' change from hierarchal voices to collaborative voices.

Whether or not patients have agency in the physician-patient exchange is of concern to rhetoricians. Rhetoricians discuss collaborative voices in terms of agency. If agency is the ability of agents – in this case patients – to act, then the action is collaborative dialogue between patients and their physicians. Rhetoricians assert that sometimes patients do have collaborative voices. James Wilce studies medical discourse anthropologically. He uses conversation analysis and discourse studies in order to look at the ways that various discourses, such as scientific discourse and ritual discourse, come together in medical discourse. Ritual discourse is Wilce's term for social discourse. Wilce concludes that some patient communicators are empowered and others are stigmatized by physicians. Wilce says, "Some studies consistently uncover patient-practitioner collaboration and a degree of agency on the part of patients, whereas others find in

somewhat similar settings a straightforward reproduction of power relations” (209)²¹. I suspect that these findings are a result of vast differences in communicative styles and degrees of observance of authoritative roles by both physicians and patients. The straightforward reproduction of power relations is of major concern here. In some instances, reproduction of power relations occurs because physicians understand the meanings and significance of utterances in medical discourse, whereas patients may not actively understand these utterances. And according to Bakhtin, for patients neither significance nor utterances are complete when patients cannot fully realize active responses to the physicians’ utterances.

A critical examination of medical discourse elicits the social constructions that may prevent physicians from changing their personae. Howard Waitzkin provides a critical theory of medical discourse. He argues that “medical encounters tend to convey ideologic messages supportive of the current social order” (220), and that those contexts that are neither scientific nor in line with the current social order are ignored or redirected by physicians in their encounters with patients. Waitzkin uses the example that health means the “ability to work” (222). Physicians enforce this ideologic message by excusing or refusing to excuse patients from work. But as Waitzkin points out, work has many more social implications than medical implications. When control for the ability to work is given to exclusively to physicians, then the other more social aspects, such as childcare considerations, of whether or not patients can work are neglected. Remember that Segal states that value assumptions may be hidden in metaphors: “When values are explicit, they may be openly debated but rhetoric uses metaphor to smuggle values into discourse that proclaims itself rational, even-handed, value-free” (*Health* 115). If we think about Waitzkin’s metaphor of work and apply Segal’s definition to it, we see that work is

²¹Perrino, Rose, Silverstein, and Wilce (2008) provide examples of usages of collaborations in physician-patient discourse, whereas Engeström, Gillotti et al., Heritage & Maynard, Maynard & Frankel, Sachs, and Waitzkin show findings of physicians’ authority in physician-patient conversations.

not value-free. The ability to work is entirely based on physicians' perspectives about health. Waitzkin summarizes physicians' enforcement of social norms when he asserts that "When physicians transmit ideologic messages that reinforce current social patterns – at work, in the family, and in other areas of life – they help control behavior in ways that are defined as socially appropriate" (225). The rhetorical apparatus of work may lead to misunderstandings by hiding prejudicial values under the auspices of rational, neutral principles. Physicians who are in hegemonic control of the social order reinforce the metaphor that health is simply the ability to work. This metaphor for work implies a Marxist view where people are only valuable to society because they produce work or because they reproduce more workers. We must acknowledge physicians' control over social mores, if we are to dislocate the controls and move towards collaborative communications between physicians and patients.

Once physicians do decide to make changes to language in order to decrease professional dominance, Waitzkin and Theron Britt suggest that they should:

Let patients tell their stories with far fewer interruptions, cutoffs, or returns to technical aspects. Especially at the beginnings of encounters, patients should have the chance to present their narratives in an open-ended way. Physicians should provide full explanations to patients, giving information in comprehensible terms without jargon. Patients also should take a more active role in questioning, challenging, and directing the flow of conversation. (Waitzkin and Britt 445-6)

If both physicians and patients make the effort to converse in social discourse when possible, then medical discourse will interfere less with patients' communications.

When physicians listen to patients' narratives, they may understand that some of the patients' problems are personal problems and not medical in nature. Waitzkin and Britt contend that:

Physicians should try not to marginalize these connections by reverting to a technical track. Further, physicians' explanations and suggestions should avoid messages of ideology and social control, especially then these messages encourage patients' adherence to social expectations that cause them grief.

Attempts to reduce ideologic and controlling language should occur particularly when contextual difficulties involve work, social class, and economic insecurity, gender roles and the family, the troubles of aging, personal behaviors outside the mainstream, including substance use and sexual preferences, and emotional distress deriving from social causes. (Waitzkin and Britt 446)

Physicians can listen, reserve judgment, and help connect patients with other professionals who can help them navigate personal issues.

Joe's Story: Part 3

Joe was a medical rhetorician!

When we left Joe's story, I had questions about his knowledge of and interaction with Katz's text on the power differentials in physician-patient communications.

I asked my mother and Joe's wife, Linda, why I had Joe's copy of Katz's text on my bookshelf. Linda told me that Joe taught classes on biomedical ethics for years, and after Joe's death she sent me Katz's book. I was shocked that Linda had neglected to tell me about this important piece of information, given that I was writing a study on medical discourse. However,

I realize that Linda has been distraught over Joe's death and we really have not discussed him since his death.

As a teenager, all Joe ever wanted to do was play baseball. And, Joe was solicited to play professional baseball right out of high school. However, his mother insisted that he go into the Catholic priesthood. He studied at the Gregorian University in Rome, Italy. For reasons unknown to me, Joe became disillusioned with the priesthood and later resigned from it. Throughout the rest of his life Joe was still Catholic, but his interests changed from religion to ethics.

Shortly after resigning from the priesthood, Joe obtained a Ph.D. in Religious Studies from the Catholic University of America, in Washington, D.C. Joe married a former nun and they had three children together. Twenty years later, his wife realized that she was lesbian and divorced Joe. Joe became as disillusioned with marriage as he was with the priesthood.

From 1970 until 2000 Joe was on the faculty of the Religious Studies Department at Bucknell University in Lewisburg, PA. He also taught biomedical ethics classes at Geisinger Medical Center in Danville, PA. Joe took a one year sabbatical from Bucknell, to be a visiting scholar in bioethics at the Kennedy Institute at Georgetown University in 1976-77. In 2000, Joe retired from Bucknell but stayed in Lewisburg. He intermittently dated women since his divorce.

One day in 2001, Linda posted on an online solicitation to a dating site called Oneandonly.com. Linda's post read, "I am looking for someone with whom I am emotionally, sexually, and intellectually compatible, and with whom I have reciprocal fervor." Joe replied to Linda's email and he was hooked; they married six months later.

Before retiring, Joe wrote several essays on biomedical ethics that involve spirituality and morality. One essay, "Spirituality and Morality," examines the ethical, spiritual, and moral issues behind universal health care, among other concerns. Joe contends that spirituality and morality

are intrinsically related and he “calls for a new integration and synthesis of spirituality and morality – based not on largely static and sometimes mechanistic understandings of spirituality and the moral life, but on metaphors of social journey, conversion, and artistic creativity” (1). While Joe’s emphasis in medicine is on ethics and mine is on medical discourse, we have a common connection to medical rhetoric. We have both had concerns about patients’ welfare. I am sorry that I was unaware of the connection that we shared while he was alive, because medical rhetoric is a complex subject and I would have welcomed his insights on it; however, his decline and death is what started me on the path to analyzing medical rhetoric.

Dislocating Physicians’ Discourse

Arguing for better communication between physicians and patients is of concern to rhetoricians. In texts authored by rhetoricians, we see various suggestions for better communications between physicians and patients. Whether or not the texts specifically address heroic rhetoric, they either implicitly or explicitly recognize the power differentials present between physicians and patients. The question is, how might we achieve better communications between physicians and patients? The answer might be to dislocate medical discourse during dialogues between physicians and patients.

Physicians are more comfortable using medical discourse than social discourse, because it gives them power and control. Even though physicians often take on the authoritative role in dialogic physician-patient communications, rhetoricians suggest that more equal control in heteroglossic interviews can be achieved with more active communication from patients. However, a critical examination of medical discourse elicits the social constructions that may prevent physicians from changing their personae. We must acknowledge physicians’ control over

social mores, if we are to dislocate the controls and move towards collaborative communications between physicians and patients.

We do need an alternative discourse that minimalizes the heroic personae of physicians and humanizes patients. Bakhtin asserts that active understanding is necessary in order to elicit dialogic communication where both parties are heard and acknowledged and can signify:

The listener and his response are regularly taken into account when it comes to everyday dialogue and rhetoric, but every other sort of discourse as well is oriented toward an understanding that is ‘responsive.’ [. . .] Responsive understanding is a fundamental force, one that participates in the formulation of discourse, and it is moreover an *active* understanding [*sic*]. (*Dialogic* 281).

Schuster acknowledges Bakhtin’s assertion and demonstrates its implications for those who are not heard or acknowledged or cannot signify. He explains, “This active responsiveness is precisely what is missing for those branded as illiterate. Through acts of social, political, and economic exclusion by the dominant culture, they have been denied genuine listeners, denied response on the part of those whom they are purportedly addressing” (45).²² If patients are illiterate in medical discourse, if they are not heard or acknowledged and they cannot signify to physicians, then how can we change this social dilemma in medical discourse?

Audre Lorde may have the answer. She writes an essay that includes a potential answer within the title: “The Master’s Tools Will Never Dismantle the Master’s House.” Lorde contends that we need a new language and a new way of writing in order to make our own arguments, because if we simply reiterate hierarchical language then we will not be heard by those who already control the language. If we look at the master’s house as medicine, then the

²²For more on patient signification, see Chapter I.

master's tools are medical discourse. The masters are physicians. If we synthesize Lorde's argument into our own, then we would say that medical discourse will not dismantle medicine. If patients want to be heard and acknowledged and to signify, they cannot do so using medical discourse. Patients have to choose an alternative discourse in which they are heard and acknowledged and can signify. Patients are already literate in social discourse, so social discourse is the perfect discourse to use in communications with physicians. Of course, I do not think that medicine or medical discourse should be completely dismantled. But perhaps medical discourse may be disrupted and dislocated during physician-patient interactions, for the benefit of patients. We know that physicians control medical discourse more than they control social discourse, so requesting that physicians change to social discourse when talking with patients could put them on more equal terms with patients. This resolution is feasible because patients could simply ask physicians to speak to them about their illnesses and treatments using social discourse. The problem with this resolution may be its implementation, because it puts the onus for change on patients and because if patients continue to view physicians as heroes then they may be too intimidated by physicians to ask them to change discourses.

CHAPTER V
RESISTING & REIFYING THE MYTH OF THE HEROIC PHYSICIAN IN
POPULAR CULTURE

Bakhtin's popular culture theory of carnival is implemented in order to show possibilities for resistance to and reification of medical rhetoric as a dominant discourse in *House, M.D.* Bakhtin's concepts of inside-out, grotesque realism, consecration of inequity in hegemonic control, degradation, and parody are used in order to expose resistance to and reification of medical rhetoric from a carnivalesque perspective. *House, M.D.* is a popular culture artifact by which I analyze the heroic physician from patients' perspectives. The assumption is that patients often partake of popular culture objects, such as television programs. *House, M.D.* is examined in order to expose the simultaneous parodic criticism for and acceptance of a stereotypical heroic physician. España-Maram and Lipsitz's theories on reification of cultural memories are evaluated in order to discuss possible resistance to viewing physicians as ordinary humans, and the inherent problems with such resistance that can result in reification of the myth of the heroic physician by patients.²³

I discuss specific episodes of the television series *House, M.D.* with regards to trivialization and reification of the myth of the heroic physician. The episodes represent Gregory House as a brilliant, drug-addicted physician who is admired in spite of his irreverent behavior, because he solves problems. House rarely spends time with patients; he doesn't believe that patients are honest or reliable. He makes his subordinate interns see to patient care, and he sends these interns on illegal missions to discover patients' habits that may precipitate the discovery of the patients' diseases. House receives most of the information on his patients from his

²³Chapter II explores three major differences in the meaning of reification from Bakhtin's perspective as opposed to España-Maram and Lipsitz's perspectives.

subordinates and from patients' charts. House, in general, doesn't get along with the interns, other physicians, administration, or patients; however, he is tolerated and often indirectly admired because he is so adept at discovering patients' diseases without ever actually examining their bodies.

My focus is on patients' perspectives; however, because patients usually do not write articles about their own experiences with physicians, there needed to be another means to access patients' perspectives. Reading "Box Office Poison: The Influence of Writers in Films on Writers (in Graduate Programs)," by Wendy Bishop and Stephen Armstrong provided just such a means. The article looks at the absurdly unrealistic personae of writers who are portrayed in various films. Bishop and Armstrong cite Dale Bauer who suggests that "If the culture didn't project so much onto English Professors, they wouldn't have to be so systematically trivialized and parodied, on the one hand, or revered and sentimentalized, on the other hand" (97). Physicians might be simultaneously trivialized and revered as well as writers. And when I found out that *House, M.D.* was Joe's favorite television show, I wondered what kind of cultural influence a heroic physician such as House might have on Joe and other patients like him.

And because television shows like *House, M.D.* have a cultural influence on those who watch them, I make the same assumption that Stuart Hall and others have made: that television often reflects society. And while I understand that there are no physicians who are really exactly like House, I expect that many aspects of House's personality and actions are predicated on a trivialization of and reverence for stereotypical heroic physicians.

In order to analyze the stereotypical heroic physicians in *House, M.D.*, I examine its discourse. *House, M.D.* contains a heteroglossic mixture of medical discourse and social discourse. The use of carnival in *House, M.D.* serves to expose the power differentials between

medical professionals and patients, and simultaneously reifies the heroic status of physicians in the minds of potential patients. As an expression of popular culture, *House, M.D.* serves to satirize medical discourse and reify cultural memories of heroic physicians in the minds of patients. And, patients, because of such reification, are already ready to defer to physicians' judgments without question.

Popular Culture

Parody and reification of cultural memories in popular culture are used in order to rhetorically analyze texts authored for patients who may be influenced by the texts.²⁴ Popular culture studies emanates from the literary theory of cultural studies. These theories are used to examine texts that are popular with the masses. The irony, of course, is that often popular culture artifacts are disseminated by huge, multinational corporations that are, thus, able to control the dominant discourse production. *House M.D.* is a television show that is an artifact of popular culture, and provides a view of an arrogant physician. If enough people watch the way that House condescends to his patients, people may collectively start to believe that some physicians are actually condescending. Because of the ubiquitous nature of television, huge numbers of people acquire reified collective memories that are nearly identical to one another. The subject that is parodied is the hero of the text, in this case House. Paradoxically, *House, M.D.* simultaneously reifies and satirizes House in popular culture because House is revered as a typically great physician who is absurdly flawed.

In a broad sense, culture is the study of social expressions in which groups of people partake. Cultural studies includes social eating habits, working habits, sexual habits, familial associations, etc. Ever since Marx's "Capital," culture has taken on a political ideology. As

²⁴For a more extensive discussion of reification of cultural memories, see Bakhtin, España-Maram, and Lipsitz in Chapter II.

Rivkin and Ryan state, “Culture is both a means of domination, of assuring the rule of one class or group over another, and a means of resistance to such domination, a way of articulating oppositional points of view to those in dominance” (1233). Whether or not this domination and subversion can exist simultaneously is questionable. While I believe that there is evidence in popular culture of the articulation of both domination and subversion, I nevertheless worry that the dominant voice is often the most resonating voice for the audience. However, Rivkin and Ryan offer hope for subversive voices to triumph when they exclaim that “Culture comes from below, and while it can be harnessed in profitable and ultimately socially conservative ways, it also represents the permanent possibility of eruption, of dissonance, and of an alternative imagination of reality” (1234). Perhaps undermining the dominant discourse in the medical discourse community may lead to an alternative concept of reality in the physician-patient interchange. Because, if enough people question the authority of medical discourse perhaps it will not be so revered in the future.

Reification refers to making a concept appear to be concrete when the concept is actually abstract or ideal. Bakhtin discusses the multiplicity of language usage, specifically in terms of reification. Bakhtin affirms that multiple language discourses use various forms for “making conceptualization and evaluation concrete” (“Discourse” 675). So, the idealized concept of the hero is reified in medical discourse because physicians believe that they are heroes, and also in popular culture because popular culture artifacts portray physicians as heroes.

Reification, as a concept, has roots in political discourse. Karl Marx talks about reification in terms of a commodity-driven capitalistic society. In *History and Class Consciousness*, Georg Lukács expounds upon Marx’s idea. Lukács cites Marx as he declares that laborers reify their own work when they see their abstract power in terms of a real commodity.

Lukács states, “What is characteristic of the capitalist age, says Marx, is that in the eyes of the labourer himself labour-power assumes the form of a commodity belonging to him [*sic*]” (87). In other words, the laborer thinks that his labor is a real commodity belonging to him; however, labor is an abstract commodity that is really controlled by the capitalists for whom the laborers are working. The most troubling problem with reification of an abstract construct is that it buries the real relationships between people in the capitalistic society. Lukács comments that “The essence of commodity-structure has often been pointed out. Its basis is that a relation between people takes on the character of a thing and thus acquires a ‘phantom objectivity,’ an autonomy that seems so strictly rational and all-embracing as to conceal every trace of its fundamental nature: the relation between people” (83). Likewise, reification of cultural memories in popular culture serves to make our memories seem objective. In reality though, these reified memories simultaneously conceal the power-relationships that are at play and the fact that our past histories are not collective.

According to Althusser, ideological apparatuses are the concepts that conceal the ideas upon which the apparatuses are based. We no longer have genuine ideas because they have been reified by ideological apparatuses that we accept as our individual thoughts. Althusser explains Marx’s production model, defines ideology, and argues that the individual is always already a subject because of his or her acceptance of and participation in inscribed practices within ideological apparatuses (699). In contrast to the previous repressive apparatuses that transparently use punishment to keep producers producing, the whole ideological system is based on – legitimately – producing producers of production for the ruling class, in order to keep the rulers ruling and to keep the producers unknowingly complacent.

Producers are complacent and complicit in ideological apparatuses because they buy into the ideologies upon which the apparatuses are based. As Althusser explains, the idea of spirituality has disappeared and has been replaced by the ideological apparatus of religion and its associated rituals such as going to mass, kneeling down, and showing penitence (697). If we accept that culture is an ideological apparatus, then Althusser defines ideologies in various ways that serve to inform the complexities of popular culture. One of his definitions of ideology is that ideologies are ideas that have disappeared (697). What is visible and stands in for the ideas are practices, rituals, and ideological apparatuses. If we accept that medicine is an ideological apparatus, then what is the idea behind medicine? What are the practices and rituals that define the apparatus? Perhaps the departed idea upon which medicine is based is the idea that physicians help patients. Then, the practices and rituals are physician-patient interviews, treatments, and prescriptions. In medicine, physicians often reinforce hidden ideas that support and control the current social order. For example, patients who come into emergency rooms (ERs) complaining of severe pain are often treated as though they have drug-seeking behavior. The idea that is hidden is the idea that the drug use is bad. The ER physicians support the dominant ideology when they decide that particular patients are involved in illicit drug-seeking behavior, and physicians control the dominant ideology when they refuse to prescribe drugs for these particular patients. There are, however, many situations in which drug use is necessary. The fact that House abuses narcotics in order to alleviate the pain in his leg serves to subvert physicians' reinforcement of the ideas that support and control the current social order; because, physicians are expected to use drugs properly and House exposes the fact that some physicians abuse drugs.

Hegemonic control by owners of capitalistic corporations in the current social order is ever-present in popular culture. And John Storey explores ways that the populace may destabilize hegemonic control. If reification means viewing an abstract idea as though it is a real object, then the populace sees their abstract power in terms of a real commodity. Storey explains that people continue “to adapt for their own purposes the commodities and commodified practices of the cultural industries” (43). Storey examines this concept in terms of juke-box boys. Juke-box boys get to determine which songs they listen to, which jeans they wear, whose swaggers they emulate, and ultimately which commodities and commodified practices become popular (43). However, even though juke-box boys have power to destabilize hegemonic control, they may not be aware that the producers of the commodities from which popular culture is made are those who have the ultimate power to decide which songs are selected to put in the juke-boxes, and receive the money from the production of those songs. Whether or not these adaptations serve to totally undermine hegemonic control is not known, but the act of adapting is a form of appropriation in and of itself. Storey’s text presents many and contradictory voices that serve to inform popular culture. His citation of Bennett’s quote serves as a concise summarization of popular culture:

The field of popular culture is structured by the attempt of the ruling class to win hegemony and by forms of opposition to this endeavour. As such, it consists not simply of an imposed mass culture that is coincident with dominant ideology, nor simply of spontaneously oppositional cultures, but is rather an area of negotiation between the two within which – in different particular types of popular culture – dominant, subordinate and opposition cultural and ideological values and elements are ‘mixed’ in different permutations. (10)

The negotiation of cultural differences by the populace is the basis of popular culture; popular culture seeks to expose the abstract and socially constructed nature of class.

Consecration of inequality refers to reification of inequality whereby the stratifications in social and economic classes are looked at as concrete and somehow *natural* when, in fact, they are abstract and socially constructed. In “Rabelais and His World,” Bakhtin borrows Rabelais’ suggestion that the festive carnival is one of the only places where consecration of inequality does not occur. In fact, “all were considered equal during carnival” (686). In opposition to the formal feast of the state where people are somber and the hierarchy is reinforced, carnival is predicated on laughter and is unofficially led by the popular sphere of the marketplace (686). Carnival cultivates the idea of grotesque realism. In grotesque realism “[t]he material bodily principle is contained not in the biological individual, not in the bourgeois ego, but in the people, a people who are continually growing and renewed. This [grotesque realism] is why all that is bodily becomes grandiose, exaggerated, immeasurable” (688). The television series, *House, M.D.*, demonstrates grotesque realism while simultaneously reifying the physician as hero, under the pretense of attendance to the biological individual. As much as Bakhtin’s theories on popular culture depict the disruption of the reification of inequality of social statuses of individuals in carnival, España-Maram and Lipsitz point out that reification simultaneously reinforces the power structures and exposes the inequalities that are always already present in society.

Popular culture allows for the simultaneous reification and critique of dominant ideologies. España-Maram suggests that cultural studies, in addition to reinforcing dominant ideologies, arms scholars with powerful tools to critique dominant ideologies and to examine the ways that marginalized populations develop channels of resistance and oppositional strategies through popular culture (516). The complication in seeing a television series as popular culture is

that, even though popular culture critiques the dominant discourse, ultimately huge mega conglomerates produce these shows in order to make money. Conglomerates, España-Maram asserts, have control over the dominant discourse through the guise of creating popular culture. Furthermore, popular culture serves to reify historical memories with the ideologies that the powerful promote through production of artifacts of popular culture. Just so, reification of the ideology of the heroic physician can be seen in *House, M.D.*

Historical memories can be produced from popular culture. George Lipsitz asserts that historical, collective memory is an imagined view of the past that is prejudiced by the present. The past is directly related to the present because the past is always already influenced and changed by the present. In the creation of imaginary collective memories, popular culture artifacts serve to simultaneously reinforce the ideologies of the ruling classes and subvert these same ideologies by the working classes. Lipsitz believes that the evolution of a commercialized leisure class produced massive disruptions in the traditional forms of historical memory (6). Popular Culture is a medium by which people may create signs and symbols that are appropriate to their audiences and to themselves; it is a medium by which people who are not part of the dominant hegemony can express themselves (13). However, popular culture that is controlled by the dominant hierarchy may appear to call into question the dominant discourse with heteroglossic voices but may actually reinforce dominant stereotypes through reification of collective memory. Further, Lipsitz declares that collective memory remains concentrated in – and controlled by – the dominant hegemony. Collective memories of the oppressed cannot challenge the hegemony of the dominant. While the popular culture of *House, M.D.* challenges the hegemony of the dominant medical discourse community, it also simultaneously reinforces it with its stereotypical view of House as a heroic physician.

Parody is an art form that exposes resistance to and reification of heroic personae in popular culture. Bakhtin maintains parody's presence in reaction to every type of discursive genre. He concedes, "It is our conviction that there never was a single strictly straightforward genre, no single type of direct discourse – artistic, rhetorical, philosophical, religious, ordinary everyday – that did not have its own parodying and travesty double, its own comic-ironic" ("Prehistory" 53). Bakhtin claims that parody does not apply to any one genre as a whole, but rather to "the object of representation" who is the "hero of the parody" ("Prehistory" 51). A specific concept of parody that Bakhtin refers to is known as inside out, where the established hierarchy is turned inside out so that producers seem to rule and rulers seem to produce. Bakhtin also describes the typical style of parodic language where sarcastic encomium is followed by invective, and the line between them is blurred. And even though he does not specifically discuss television series, Bakhtin's views on parody can be applied to the genre of episodic television. In the television series *House M.D.*, House is the physician who is the hero of the parody. I am amused that satire can lead to reification.

Television Episodes of *House, M.D.*

House, M.D. is a metaphor; it may be a metaphor for a constructed space that is not a home. Alfred Lord Tennyson's "The Deserted House" is a metaphor for a dead body. In psychiatric medicine, a "nut house" is slang for an insane asylum. In this case, *House, M.D.* maybe a metaphor for a nutty house of medicine with an inside out physician; or, patients may simply house the diseases that House likes to diagnose.

Inside Out

The idea of inside out is meant to turn the established hierarchy upside down. In *House, M.D.*, a physician appears as a patient. And, the language of medical discourse is reprocessed in

order to poke fun at it. In the initial episode, “Pilot: Everybody Lies” (Singer 2004), the first time we see House he is limping down the hall of the hospital, leaning on a cane for support. He is dressed in street clothes, with no white coat or name tag. Dr. Wilson, an oncologist and perhaps House’s only friend, is walking beside him wearing a white coat. Wilson starts the carnivalesque conversation in the inside out world of *House, M.D.*:

Wilson: “29 year old female, first seizure one month ago, lost the ability to speak, babbled like a baby, present deterioration of mental status.”

House: “See that? They all assume I’m a patient because of this cane.”

Wilson: “So, put on a white coat like the rest of us.”

House: “I don’t want them to think that I’m a physician.”

Wilson: “You see why the administration might have a problem with that attitude.”

House: “Um, people don’t want a sick physician.”

Wilson: “That’s fair enough; I don’t like healthy patients.”

House appears as a patient, when he is really a physician. From the first conversation, we realize that we have entered Bakhtin’s world of carnival where nothing is as it seems. Carnival is predicated on laughter and is unofficially led by the popular sphere of the marketplace. Carnival is the time of “a second life, a second world of folk culture is thus constructed; it is to a certain extent a parody of the extracarnival life, a ‘world inside out’” (“Rabelais” 687). House does not look or act as a physician, although he is a brilliant one. House also has problems with the administration.

These issues become more apparent in the following dialogues, and they reflect the views of the popular culture about administration and patients. In addition to reflecting the views of the popular culture, the show also reflects popular culture’s attitudes on the pomposity of medical

discourse. The language of medical discourse is reprocessed in the series in order to poke fun at it. Bakhtin talks about the technique of the comic-parodic reprocessing of language:

This usually parodic stylization of generic, professional and other strata of language is sometimes interrupted by the direct authorial word (usually as an expression of pathos, of Sentimental or idyllic sensibility), which directly embodies (without any refracting) semantic and axiological intentions of the author. (“Discourse” 678)

When we apply Bakhtin’s theory to *House, M.D.*, we find that the medical language is interrupted by the direct sensibilities of its directors and writers. Bryan Singer directs this episode, and so it is his meanings and values, as well as those of the writers’, that interrupt the parodic stylization of the language of medical discourse. The heteroglossic discourse is evident because medical discourse is mixed with social discourse. Even though House and his colleagues use very scientific medical words, usually to indicate diagnoses, most of the conversations use social discourse. In fact the social discourse is very informal, using as many contractions and slang terms as possible. Words such as I’m and don’t are used very frequently, and words such as guy or doctor are used as often as medical discourse is used. This reprocessing of language adds to the carnivalesque nature of an upside down house of medicine.

The conversation between Wilson and House continues:

House interrupts: “The one who can’t talk? I like that part.”

Wilson: “She’s my cousin.”

House: “And your cousin doesn’t like the diagnosis. I wouldn’t either. Brain tumor. She’s gonna die. Borrrring!”

Wilson: “No wonder you’re such a renowned diagnostician. You don’t need to actually know anything to figure out what’s wrong.”

House: “You’re the oncologist. I’m just the lowly infectious disease guy.”

Wilson: “Yes. Just a simple country physician. Brain tumors at her age are highly unlikely.”

House: “She’s 29. Whatever she’s got is highly unlikely.”

At this point we see the sarcasm because House likes patients who cannot talk and therefore cannot communicate; we assume that is the opposite perspectives of actual physicians who want to communicate with their patients. Also, we find out later in the episode that Wilson is a liar because the patient, Rebecca, is not his cousin and he cannot even remember her real name. House and Wilson banter back and forth with one another about practicing medicine without actually knowing anything, and complementing one another in a parody of pretence about being simple country physicians.

The conversation continues:

Wilson: “Protein Markers for the three most likely brain cancers came up negative.”

House: “It’s an HMO lab, you might as well send it to a high school kid with a chemistry set.”

Wilson: “No family history.”

House: “I thought your uncle died of cancer.”

Wilson: “That was different. No environmental factors.”

House: “That you know of.”

Wilson: “And, she’s not responding to radiation treatment.”

House: “None of which is even close to dispositive. All of which raises one question.”

House opens a bottle of pills of Vicodin and shoves a handful in his mouth. “Your cousin goes to an HMO?”

Wilson: “Come on. Why leave all of the fun for the coroner? What’s the point of putting together a team, if you’re not going to use them? You’ve got three overqualified physicians working for you. Getting bored.”

House: Looks at Wilson, but gives no response.

Even though we do not know why, we suspect that House is aware that Wilson is lying to him about having a familial connection to the patient because House suspects everyone of lying. We see that House is disgusted with HMOs, as are many real life physicians and patients who may be watching the series. And House must be respected as a physician in some ways, because Wilson is consulting with House and because House has a team of overqualified physicians working for him. We also get the idea that Wilson knows that House is more interested in the abnormal physiology of disease that coroners get to witness than he is with living, healthy patients. And finally we see that House, as well as being chronically disabled, is a drug addict; none of these attributes is what we think of when we think of revered physicians. Instead, House fits the profile of a sick patient.

Next, House is with his team: Drs. Foreman, Chase, and Cameron. They are gathered around a white board that they use in order to assess specific diagnoses:

Foreman: “Shouldn’t we be speaking to the patient before we start diagnosing?”

House: “Is she a physician?”

Foreman: “No, but . . .”

House: “Everybody lies.”

Cameron: "Dr. House doesn't like dealing with patients."

Foreman: "Isn't treating patients why we became physicians?"

House: "No. Treating illnesses is why we became physicians. Treating patients is what makes most physicians miserable."

Foreman: "So you're trying to eliminate the humanity from the practice of medicine."

House: "If we don't talk to them, they can't lie to us. And we can't lie to them. Humanity is overrated."

We gather from this conversation that House would rather look at supposedly objective science than rely on patients' histories. We find that House believes that everyone lies. And we find that House is much more interested in uncovering the nature of the illness than he is in treating the patient. It is these exact same views that physicians and rhetoricians are trying to figure out how to get rid of, yet House is modeling them to his team!

The conversation continues:

Foreman: "First year of medical school, if you hear hoof beats you think horses not zebras."

House: "Are you in first year medical school? No. First of all, there's nothing on the CAT scan. Second of all, if this is a horse then her kindly family physician in Trenton makes the obvious diagnosis and it never gets near this office. Differential diagnosis people. If it's not a tumor, what are the suspects? Why couldn't she talk?"

Chase: "Aneurism, stroke, or some other ischemic syndrome?"

House: "Get her a contrast MRI."

Cameron: "Creutzfeldt-Jakob disease?"

Chase: "Mad cow?"

House: "Mad zebra."

Foreman: "Wernicke's encephalopathy?"

House: "No. Blood thiamine level was normal."

Foreman: "Lab in Trenton could have screwed up the blood test. I assume it's a corollary that if people lie, people screw up."

House: "Redraw the blood tests. And get her scheduled for that contrast MRI ASAP.

Let's find out what kind a zebra we're treating here." House dismisses his team.

House uses animal metaphors in the conversation which may expose his blatant objectification of patients. House also takes charge of the differential diagnosis conversation; he immediately, concisely, and accurately evaluates the team's suppositions, and he dictates which studies will be ordered. House also makes us, as the audience, aware that this is a special team that diagnoses special diseases because regular physicians diagnose likely diseases. So, now we start to believe that there are valid reasons as to why House is a respected physician.

As House waits for the elevator, the hospital administrator, Dr. Cuddy, joins him:

Cuddy: "I was expecting you in my office twenty minutes ago."

House: "Really. Well that's odd because I had no intention of being in your office twenty minutes ago."

Cuddy: "You think we've nothing to talk about?"

House: "No. I just can't think of anything I'd be interested in."

Cuddy: "I sign your paychecks."

House: "I have tenure. Are you gonna grab my cane now, stop me from leaving?"

Cuddy: "That would be juvenile. I can still fire you, if you're not doing your job."

House: "I am here from nine to five."

Cuddy: "Your billings are practically nonexistent."

House: "What fear?"

Cuddy: "You ignore requests for consults."

House: "I call back, sometimes I misdial."

Cuddy: "You're six years behind on your obligations to this clinic."

House: "See, I was right this doesn't interest me."

Cuddy: "Six years times three weeks. You owe me better than four months."

House: "It's five o'clock. I am going home."

Cuddy: "To what?"

House: "Nice."

Cuddy: "Look. Dr. House. The only reason that I don't fire you is that your reputation is still worth something to this hospital."

House: "We have a point of agreement. You are not going to fire me."

Cuddy: "Your reputation won't last if you don't do your job. The clinic is part of your job. I want you to do your job."

House: "As the philosopher Jagger once said, 'You can't always get what you want.'"

Cuddy is articulate, and uses more formal speech than House. Her words are all business. She wears a business suit as opposed to House's wrinkled shirt and jeans. Both Cuddy and House acknowledge House's paradoxical value to patients and simultaneous lack of adherence to the rules. House's contradictory nature may reflect the views of the popular sphere that wants to believe that it is highly valued for its work while it is irreverent towards the rules. In this scene, there is a glaring juxtaposition linking the harsh words and intimate glances between these two individuals. House and Cuddy are standing really close to one another, and there is obviously

sexual tension between them. We assume that House's charisma must compensate for his caustic retorts, otherwise why would Cuddy be attracted to him?

House's team members talk to the patient, as they wheel her to get an MRI:

Patient Rebecca: "You're not my physician. Are you Dr. House?"

Chase: "Thankfully, no. I am Dr. Chase."

Cameron: "Dr. House is the head of diagnostic medicine. He's very busy, but he has taken a keen interest in your case."

The conversation indicates that the patient does not know who her physicians actually are. Many of us, as patients, may have at times been as confused as Rebecca because we have had similar experiences where we get billed for consultations with specialists whom we have never met. And Dr. Chase indicates that he is thankful that he is not Dr. House, although we do not know why.

In the next scenes, we see example after example of House's irreverent behavior: House keeps popping pills; Cuddy takes away House's television privileges until House agrees to clinic duty; Rebecca sees House loitering outside her room, bent over his cane; and, House pressures Foreman to break into Rebecca's house to see about possible contaminants that may be making her sick. Overusing drugs, avoidance of work duties, avoidance of direct contact with patients, and burglary are socially unacceptable actions, but we nevertheless accept them from House.

We also see House watching soap operas and reading tabloids. The fact that he watches soap operas and reads tabloids indicates actions that are in direct contrast to what we think that typical physicians do with their time. We assume that many physicians are busy treating patients, not being engrossed in the basest forms of popular culture. This is further evidence of Bakhtin's carnival where physicians are inside out and they participate in common pastimes.

Meanwhile Foreman participates in a base pastime by breaking into Rebecca's house in order to look for clues about her illness. He finds a ham in the refrigerator and realizes that Wilson was lying about being Rebecca's cousin because Wilson is Jewish and does not eat ham. Foreman informs House about the ham, and House surmises that Rebecca may have tapeworms in her brain from the undercooked ham. Rebecca is so fed up with her erroneous treatments that she refuses to take the treatment for tapeworm based only on House's speculation. The doctors decide to x-ray Rebecca's leg and they find tapeworm eggs, so Rebecca consents to treatment. The episode ends when Rebecca is treated and cured with two pills. The exact treatment that Rebecca takes is not specified. Rebecca tells Cuddy that House is the best physician ever. Cuddy rolls her eyes in disgust at the patient's unrealistic assumption.

Rebecca keeps asking to meet Dr. House. House figures out that the patient has neurocysticercosis or pork tapeworm and wants to treat her accordingly. However, Rebecca does not want anymore treatments; she wants to go home and die, so House finally goes to talk to her:

House: "I'm Dr. House."

Rebecca: "It's good to meet you."

House: "You're being an idiot. Hmm. You have a tapeworm in your brain. It's not pleasant, but if we don't do anything you'll be dead by the weekend."

Rebecca: "Have you actually seen the worm?"

House: "When you're all better, I'll show you my diplomas."

Rebecca: "You were sure I had vasculitis too. Now I can't walk and I'm wearing a diaper. What's this treatment gonna do for me?"

House: "I'm not talking about a treatment; I'm talking about a cure. But, because I might be wrong, you wanna die?"

House tells the patient that she is acting like an idiot. Hopefully most physicians do not actually do this, but maybe many would like to. When Rebecca challenges House's authority with a question, he does not answer her but deflects and arrogantly brings up the fact that he has multiple diplomas. Rebecca confronts House again and wonders how she will benefit, indicating that she understands that his benefit in their interaction lies in uncovering the disease. House responds by correcting her and explaining the difference between treatment and cure. Rebecca responds in kind, with the same type of deflection that House uses against her:

Rebecca: "What made you a cripple?"

House: "I had an infarction."

Rebecca: "A heart attack?"

House: "It's what happens when blood flow is obstructed. If it's in the heart it's a heart attack; if it's in the lungs it's a pulmonary embolism; if it's in the brain it's a stroke; I had it in my thigh muscle."

Rebecca: "Wasn't there something they could do?"

House: "There is plenty they could do, if they had made the right diagnosis. The only symptom was pain. Not many people get to experience muscle death."

House behaves familiarly with Rebecca very quickly, and he talks about himself instead of about her. This is an open and truly honest conversation in direct opposition to what House believes is possible between any two people, let alone between physicians and patients. Also this conversation makes House vulnerable, and lets the audience know the exact nature of his disability and concomitant drug abuse. Now we find out House's perspective on death:

Rebecca: "Did you think you were dying?"

House: "I hoped I was dying."

Rebecca: “So you hide in your office, refuse to see patients because you don’t like the way people look at you. You feel cheated by life, so now you’re going to get even with the world. But you want me to fight this. Why? What makes you think I’m so much better than you?”

House: “You’re scared you’ll turn into me.”

Rebecca: “I just want to die with a little dignity.”

House: “There’s no such thing. Our bodies break down, sometimes when we’re ninety sometimes before we’re even born. But it always happens, and there’s never any dignity in it. I don’t care if you can walk, see, wipe your own ass. It’s always ugly, always. We can live with dignity; we can’t die with it.”

We learn that House hoped he was dying when he lost his leg muscle, and that humans do not die with dignity.

Through this conversation with House, Rebecca decides that she wants to die and House conveys her message to his team:

House: “No treatment.”

The team wants House to tell the administration that the patient is incompetent to make that decision, but he refuses.

Wilson: “He’s not going to do it. She’s not just a file to him anymore. He respects her.”

Cameron: “So because you respect her, you’re going to let her die.”

House: “My work here is done.”

The conversation ends with the irony that House would try to save an unknown patient at any cost, but would let a respected patient decide to die. The decision to respect a patient’s wishes to die goes against what many actual physicians fight for, and it goes against many people’s ethics.

But, the conversation acknowledges the reality that patients have the right to die on their own terms, not their physicians’.

As we can see from the analysis of the pilot, even though Bakhtin’s theory of inside out makes people appear different than they really are, it also exposes the truths about the ugly realities that exist. In this case, what is exposed is how both the medical community and western society fail to deal with patients’ emotions about death and dying. Patients have many and varied emotional responses to their own impending deaths, and these responses need to be respected by all of us. And in addition to validating patients’ emotional responses to death and dying, we must also respect their emotional responses to their bodily functions and malfunctions.

Grotesque Realism

Grotesque realism is another of Bakhtin’s important carnivalesque concepts. In grotesque realism “[t]he material bodily principle is contained not in the biological individual, not in the bourgeois ego, but in the people, a people who are continually growing and renewed. This [grotesque realism] is why all that is bodily becomes grandiose, exaggerated, immeasurable” (688). Just as consecration of inequality is unofficially led by the popular sphere of the marketplace, so too is grotesque realism. *House, M.D.*, in the following examples, demonstrates grotesque realism while simultaneously reifying the physician as hero, under the pretense of attendance to the biological individual.

One episode of *House, M.D.* that exposes grotesque realism is “No Reason” (Shore 2005). A grotesque tongue calls attention to the public sphere’s inability to speak. The episode opens with a full screen view of a swollen tongue. House thinks it’s hilarious to try and listen to the afflicted patient talk. We, as the audience, find it odd that House actually sees this patient. The tongue is five times the normal size. The scene shows a huge biopsy needle going into the

enormous red swollen useless tongue. This scene draws attention to our tongues. When we watch the scene, we cannot help but grab our own tongues in pain. The tongue on the screen becomes our collective tongue that cannot speak utterances. Our tongues may, at times, be beautiful and sensual, but grotesquely deformed tongues expose their baseness.

Another instance of grotesque realism in *House, M.D.* focuses on a beautiful dancer who loses her skin. A prima ballerina becomes grandiosely deformed in “Under My Skin” (Straiton 2008) which is an episode about a ballerina’s skin falling off. Because of a rare infection, her skin sloughs off faster than the artificial protective skin can replace it. The patient loses eighty percent of her skin. She turns from a beautiful ballerina into a red, oozing deformed monster. House declares that the patient has toxic epidermal necrolysis, and admits that he treated her with an antibiotic without first confirming that she had an infection. The patient does not care if she is ugly; she only wants to dance again. The situation is ironic because nobody wants to watch an ugly ballerina perform. We all ache for the ballerina and her predicament, and – except for the patient herself – we are all in on the collective reality that she is too hideous to perform in public. As an empathetic act, we become self-conscious about how we are seen in public. When we are unable to gaze upon even the most beautiful among us, the situation is grotesque.

An additional episode of *House, M.D.* deals with the grotesque realism of crucifixion. We may, at times, feel crucified by the public. In “Small Sacrifices” (Yaintanes 2010) a man has himself nailed to a cross once a year, as a deal with God to keep his daughter healthy. Four years earlier, the patient’s daughter had cancer. Three weeks after his initial self crucifixion, the patient’s daughter was cancer free. Now the patient repeats the process every year in order to keep God satisfied. The screen shows the nails being pounded slowly and decisively into the patient’s flesh. Several men raise the burdened crucifix. We see intensely hot sun, blood spilling

out of the patient's mouth, and puncture wounds in the patient's hands and feet. House is only interested in the patient because of the crucifixion, not because of his wounds. House suspects that the patient is atoning for something bad that he has done in the past, and he does not believe the patient's story about his daughter's cancer. House calls the patient crazy and stupid, and claims that ritual is what people do when they run out of rational. When the public sphere thinks about crucifixion, we immediately think of Christ. But in *House, M.D.*, we experience a grotesquely twisted scene of carnival that forces us to empathize with the patient by contemplating our own crucifixion. Even if we cannot contemplate our own crucifixion, we can, hopefully, empathize with the patient. At the center of the public sphere are our children, and many of us would suffer a crucifixion in order to atone for the sins of our children and give them everlasting life. Indeed, many of us do indeed make many sacrifices for the benefit of our children.

Further, grotesque realism is present in an episode of *House, M.D.* where House exaggerates a story in order to shock children. "Two Stories" (Yaintanes 2010) is a tale about a man who coughs up a lung within a story about House talking to a group of grade school students on their career day. Cuddy forces House to talk to school children about his profession. Perhaps in order to punish Cuddy or because of his irreverence for the situation, House tells the story in an extremely grotesque manner. We sense that House knows he is inappropriate because he does not use his real name. Instead, House fraudulently calls himself Dr. Hourani when addressing the class of kids. House is dishonest and graphic in telling the story of the man with a chunk of his own lung in his hands. As House recalls the story, we see the patient cough. Red blood and white tissue come up in the patient's mouth. The patient supposedly coughs his lung all over the nurse and physicians that are in the room, except that we viewers know that the

tissue is not really lung tissue. The physicians in the room ignore the fact that the patient is coughing up blood because they are flirting with a new nurse. The physicians finally notice what is happening to the patient when a huge hunk of dark red tissue appears in the patient's hand. A large portion of hard dead tissue takes up the entire screen. As House reveals the story to the fifth graders, he claims that none of the other physicians could figure out what was wrong with the patient but it is he who realizes that the patient must have inhaled a piece of food down the wrong pipe. House does exploratory surgery on the patient and finds a single pea in his airway. House saves the patient by removing the pea.

The scene is doubly grotesque because the coughing up of a lung is exaggerated and untruthful, and we are forced to see the story's inappropriate nature through the collectively innocent eyes of school children. Furthermore, the children idolize House as a heroic physician for an embellished story of heroism. So, what is the point of all of this grotesque degradation of the collective material reality? The point is that the degradation of one grotesque patient is juxtaposed with the renewal of life as signified by the youthfulness and innocence of the school children to whom House is recalling the story. And as Bakhtin argues, through degradation comes renewal. Bakhtin acknowledges that carnival is distinct from other formal parodies because "it revives and renews at the same time" that it degrades ("Rabelais" 687). We are able to laugh at the absurdity of the supposed prevailing truths. We laugh because it is funny that House convinces innocent children that a man coughed up his own lung, when we audience members know that House inflates the story. In the most ironic twist of all, while the audience trivializes House by laughing at his story the children simultaneously reify him as a heroic physician.

Regeneration and Renewal

House becomes a renewed hero in the series finale. In “Everybody Dies” (Shore 2012), House is in a burning building trying to decide whether he wants to escape or to become enveloped in the flames. As he meditates on his decision, House sees ghosts from his past. He sees ghosts of a team member who committed suicide, a different team member who died, team members who are still alive, and his ex-wife. As he meditates, House thinks many thoughts: death is not interesting, but life isn’t interesting anymore. House falls through the second floor of the burning building.

The burning building may be a metaphor for death and rebirth from the ashes, like a phoenix. Is the hospital or House burning? Is the metaphor a comment on House’s arrogant, self-destructive, and selfish behavior? The ghosts may signify all the relationships that House has had or that he failed to have, or they may indicate House’s close proximity to death.

Wilson the oncologist is, ironically, dying of cancer. House doesn’t want to lose his last days with Wilson, but ironically it is House who is in the burning building.

Wilson and Foreman see House through the window of the burning building, and then the building explodes. The two witnesses confirm that House died in the fire.

At the funeral Wilson gives the eulogy in a particular Bakhtinian carnivalesque parody where encomium is followed by invective:

Wilson: “Gregory House saved lives, he was a healer... House was an ass. He mocked anyone, patients, coworkers, dwindling friends, anyone who didn’t measure up to his insane ideals of integrity. He claimed to be on some heroic quest for the truth, but the truth is he was a bitter jerk who liked making people miserable. And he proved that by dying selfishly, numbed by narcotics, without a thought of anyone. A betrayal of

everyone who cared about him. (Phone ringing in background.) Phone. A million times he needed me. And the one time that I needed him . . . (Phone keeps ringing.) Oh, come on. This is a funeral. Just get it. (Then Wilson realizes that it is his own phone ringing and gets it.) Huh huh, well this is embarrassing. Swore I turned this off. (Wilson looks at the screen.) This isn't my phone! The screen reads, "SHUT UP YOU IDIOT." Wilson has an instant realization of who must be sending the text message.

We do not know how Wilson figures out where House is hiding, but Wilson leaves the funeral and gets on his motorcycle and finds House at Wilson's house:

House: "Hi."

Wilson: "How?"

House replies that he got out through the back of the burning building, and switched his dental records with an unknown victim that was burned in the fire.

Wilson tells House that House has ruined his life as a physician.

House: "I'm dead. How do you want to spend your last five months?"

Wilson does not reply to House's question; however, we see House and Wilson driving down the road together, on their motorbikes.

In his eulogy, Wilson starts by calling House a savior and a healer, and then quickly moves on to calling him an ass and a bitter jerk. This is an example of the typical style for carnival which is facetious encomium followed by invective. Bakhtin explains the parodic style:

The passing from excessive praise to excessive invective is characteristic, and the change from the one to the other is perfectly legitimate. Praise and abuse are, so to speak, the two sides of the same coin. If the right side is praise, the wrong side is abuse, and vice versa. [. . .] The praise, as we have said, is ironic and

ambivalent. It is on the brink of abuse; the one leads to the other, and it is impossible to draw the line between them. (“Rabelais” 690).

The fact that abuses are directed towards House is particularly funny, given the circumstances that this is House’s eulogy, and eulogies are supposed to be encomiums. Further, this abusive language serves an additional function. Wilson calls House an ass and House calls Wilson an idiot, which is abusive language. And according to Bakhtin, abusive language is a special type of degradation that leads to regeneration. Bakhtin argues “Degradation digs a bodily grave for a new birth; it has not only a destructive, negative aspect, but also a regenerating one” (“Rabelais” 688). In *House, M.D.*, House’s regeneration is a rebirth. Like the Greek phoenix, House burns up in the flames and is reborn from the ashes.

Wilson overtly states that House is on a heroic quest. But throughout the series, House is a reluctant hero. In this last scene, House transforms from a disinclined to a mythical hero. And, ironically, he does it by literally walking away from medicine in order to spend the last five months with his only and dying friend, Wilson. House is heroic partly because he operates outside the system in staging his own death. As noted earlier, Hardin explains the characteristic actions of the hero when he says, “How many movies have you seen where the ‘hero’ is an individual who operates outside the system, takes the law into his own hands, and foils the bad guy with determination, guts, cunning, and actions? We see this hero so much that we do not question the link between heroism and individual action, bravery, and initiative” (80). House also takes the initiative to change his circumstances permanently because he abandons his persona as a physician as he rides his bike down the road with Wilson.

House takes the initiative to burn his old life so that he may start a new life, his only objective being companionship for Wilson during Wilson’s final days. We get the sense that

House has become comfortable with himself, because he is not embarrassed to be seen with a limp when he is a motorcycle buddy even though he was embarrassed by it when he was a physician. Throughout the course of this series, we go from trivializing to revering House. And the hero is renewed. So now, how do we transform our views of a renewed hero into a reified hero?

Joe's Observations on *House, M.D.*

Joe and I had several conversations about this television series, and Joe did not think of *House, M.D.* as a potential platform for reification. Joe was highly educated; he read books and wrote articles about medical rhetoric. But, Joe did not consider whether or not House influenced his views about actual physicians. The observations that Joe did detect in *House, M.D.* are, however, astute and worth contemplating.

Joe pointed out how arrogant House is, how he is only concerned with himself. Joe actually called House narcissistic, claiming that House is arrogant, egocentric, shows no empathy for others, and cannot accept any criticism. Joe may be accurate; House may be a narcissist. House is arrogant, as demonstrated in an episode called "Meaning" (Sarafian 2006) which highlights House's belief that he critically analyzes differential diagnoses more logically than do other physicians. "Meaning" looks at a paraplegic with brain cancer who wheels himself into his swimming pool. Everyone thinks it is a suicide attempt, but House realizes that his brain was on fire and he probably rolled into the pool to cool himself off. House is egocentric because he puts his needs to diagnose the patient above the patient's comfort and safety, although he rationalizes his decisions by claiming that the end justifies the means. In this episode, House explicitly acknowledges his lack of empathy, because he actually admits to Wilson that the patient's wife thanked him and he had no feeling about her thanking him. House later tells

Cuddy that the patient actually has Addison's disease, and all he needs is a cortisol injection and he will be able to walk and talk again. Cuddy forbids him to give the injection, because House's claims are based on conjecture and not on tests. House hears Cuddy's criticism, although it is unclear whether or not he is able to accept the criticism. House reluctantly follows Cuddy's orders and sends the patient home without the injection. However, before the patient leaves the hospital Cuddy injects the patient with cortisol just in case House is correct. Of course House's diagnosis is accurate, and the patient is able to walk and talk once again. Cuddy and Wilson decide to hide the truth about House's correct diagnosis from House because: House got lucky, everybody lies, and House can learn more from following the rational rules of the hospital than he can from making a correct diagnosis. House is so arrogant that the realization that he was right again might make him intolerable to his coworkers.

As this episode demonstrates, Joe may be correct and House may be a narcissist; however I think that House actually does have the capacity for emotion and self criticism. The fact that House is concerned enough with his lack of empathy towards the patient's wife to consult Wilson shows that House is worried about his lack of empathy. So he does have feelings of apprehension, at least about his own shortcomings. Also, House shows the ability to accept orders as he submits to Cuddy and sends the patient home without treatment. The fact that House follows Cuddy's command means that House can defer to others. If he were a true narcissist, House would not be able to acknowledge Cuddy's merit.

Joe thought that the banter in *House, M.D.* was really great. It made him laugh. In "Fidelity" (Singer 2004), Joe liked the banter between House and Wilson. At one point when they are discussing infidelity, House notices that Wilson is dressing snazzier than usual, and he accuses Wilson of dressing to seduce a woman who is not his wife. Of course House is correct

about Wilson's motives, but Wilson tries to avoid admitting his infidelity to House by saying that he is dressing well because he takes pride in his profession. House wants to know exactly who Wilson is dating:

House: "Daughter of the patient? She would certainly have the neediness you need."

Wilson: "I'm not gonna date a patient's daughter."

House: "Very ethical. Most married men would say they don't date at all."

Wilson: "There was no date. I had lunch with one of the nurses."

This scene was amusing to Joe because the physicians are using very generic, nonspecific, common slang words, and yet House is insulting Wilson's neediness and infidelity. Joe noticed that this conversation shows how mean House can be to his friend.

He didn't call it grotesque realism, but Joe discerned the exaggeratedly graphic nature of the show. He talked about the explicit goriness of "No Reason" (Shore 2005) where the patient has a swollen tongue. House focused on the fact that the man with a swollen tongue could not talk, but Joe thought about all the other activities that the patient could no longer perform. Joe said that the patient could no longer taste, chew, swallow, or eat well. He also contemplated what sexual activities, like kissing, would be like with that big tongue. Finally, Joe considered how it would look if the patient decided to wag his tongue in jest; he thought it would poke more fun at the patient who performed the wagging than it would at the intended recipient of the gesture. Joe imagined the results of a hugely swollen tongue from the perspective of grotesque realism.

Joe loved the last episode, "Everybody Dies" (Shore 2012), because House got away with his own death. Joe believed that House faced his own death, and actually overcame it. Joe thought that all the various ghosts demonstrated to House their disparate perceptions about death. The fact that the ghosts came to House as he was contemplating burning himself up in the fire

gave House the opportunity to get close enough to his actual death to obtain a glimpse of what it represented. Although Joe did not read Bakhtin's "Rabelais and His World," Joe's analysis shows that he nevertheless understood the concept of House's own denigration and renewal in *House, M.D.* I wonder how the idea of "Everybody Dies" connected to Joe's notions about his own death.

Although Joe did not study inside out, the comic-parodic reprocessing of language, grotesque realism, or renewal, he did intuitively understand their parodic nature. Understanding parody is why Joe could relate to *House, M.D.* and its comedy. That may be the genius behind Bakhtin's theories of carnival; as members of the common sphere, we can participate in carnival as it seeks to parody the language and actions of particular members of authoritative discourse communities, even if we are not cognitively aware of them.

Exposing Heroic Personae in Popular Culture

We leave *House, M.D.* with a view of House as a hero who has been parodied and revered, simultaneously. But, how do our minds translate what we see in House to what we see in actual physicians? The answer lies in the reification of a cultural memory of House as a stereotypical heroic physician.

We examine a made up character, House, from television and realize that he may reflect the personae of physicians that we have seen. We make so much fun of House that we open our minds enough to also see House's brilliance. We then begin accept House's faults because he makes diagnoses that save patients' lives. And every time that we witness actual physicians who have some of the same characteristics that House has, we begin to think that those are the common traits of actual physicians.

After much reinforcement in witnessing arrogant and selfish traits in brilliant physicians, we collectively assume that actual physicians act this way. And every time that we encounter actual physicians who are arrogant and selfish and brilliant, it reinforces these traits that some of us assign to physicians. We create a stereotypical myth or at least a stereotypical metaphor for physicians. Then every time we encounter physicians who reinforce these stereotypical traits, we assume that they are characteristic heroic physicians. After much reinforcement, we form a collective cultural memory of heroic physicians' personae. We take an abstract idea about heroic physicians and make it a reified concrete object in our collective memories. But, how do authors create these reified characters?

The writers and directors of *House, M.D.* present the heroic personae of physicians with common language that represents the common view of the public sphere. Bakhtin discusses the implementation of this approach in the comic novel:

But the primary source of language usage in the comic novel is a highly specific treatment of "common language." This "common language" – usually the average norm of spoken and written language for a given social group – is taken by the author precisely as the *common view*, as the verbal approach to people and things normal for a given sphere of society, as the *going point of view* and the *going value*. To one degree or another, the author distances himself from this common language, he steps back and objectifies it, forcing his own intentions to refract and diffuse themselves through the medium of this common view that has become embodied in language (a view that is always superficial and frequently hypocritical) [*sic*]. ("Discourse" 678)

Although *House, M.D.* is a television show and not a comic novel, common language is used in precisely the same way that Bakhtin describes for comic novels in order to parody physicians and their medical discourse. And, the comically presented common view actually becomes imbedded in our language. The word “physician” may elicit the common view that physicians are arrogant heroes.

But, is the popular sphere aware that watching *House, M.D.* may lead to reification of the cultural memory that physicians are arrogant heroes? I think not. I do not believe that people are consciously aware of the process of reification of cultural memories. And the problem with the reified heroic personae of physicians is that it gives physicians power and control over patients and their health decisions, and it makes it much less likely that patients will challenge physicians’ authority and decisions. Perhaps undermining the dominant discourse in the medical discourse community may lead to an alternative concept of reality in the physician-patient interchange. But, as we have seen in *House, M.D.*, at least some attempts at undermining physicians and their medical discourse community also serve to reify them. So, how do we attempt to undermine or dismantle the reified heroic physician?

Whether or not we can uncover the potential for reification of the dominant view of physicians as heroes is another matter. If we are able to uncover the role of the dominant hierarchy in maintaining the accepted social values of heroic physicians through reification, then how can we begin to dismantle this role?

CHAPTER VI

(RE)VISIONING HEROIC RHETORIC IN MEDICAL DISCOURSE

Vilification of physicians omits some of the problems with physician-patient communication. We have examined articles on medical rhetoric that disparage physicians for their lack of clarity in discourse when communicating with patients. With all of these articles asking for clearer communication on the part of physicians towards patients, why is the problem of lack of clarity in oral and written discourse between physicians and patients still an issue?

Even though I still maintain that the decades of articles have not dismantled the barriers to physician-patient communications, I do want to recognize that the articles serve several purposes. They acknowledge the problem of physician-patient communication and keep it kairotically relevant. Because published writings present alternative viewpoints, these writings can be a form of activism and they likely play a part in the incremental changes that have contributed to improvements in dialogic interactions among physicians and patients. The commentaries help to develop a more equitable language between physicians and patients. Regardless of whether or not the articles on medical discourse address heroic rhetoric, they are one of the best ways to change physicians' perspectives on communications.

Bakhtinian Possibilities

Bakhtin's theories successfully elucidate many of the barriers to communications between physicians and patients. Bakhtin describes the uses for and manipulations of language brilliantly: select individuals control the power in discourse communities, artists from various disciplines create heroic personae, and popular culture simultaneously trivializes and reifies heroic personae.

When I initially decided to investigate medical discourse, I thought immediately of Bakhtin's "Discourse in the Novel" and its use of discourse communities as a concept for evaluating physicians' discourse. I think that Bakhtin has done for language what Marx did for politics. Marx's theories are based on class struggles that revolve around control of labor production, whereas Bakhtin's theories are based on class struggles that revolve around the use and control of monoglossic languages within specific discourse communities. As far as understanding issues of power and control within particular discourse communities, Bakhtin's theories unmistakably illuminate the issues.

Art and Answerability is Bakhtin's answer to heroic rhetoric, because it theorizes artists' accountability for their art and formation of their heroic personae. In addition, *Art* explores the separation between artists and their heroic personae. I decided to use these theories in works authored by rhetoricians, because rhetoricians discuss heroic rhetoric and physicians' accountability in the medical discourse community.

When I decided to scrutinize patients' perspectives about heroic physicians in popular culture, I initially thought of España-Maram and Lipsitz's theories on reification of cultural memories. But when I read "Rabelais and His World," I realized that I could again use Bakhtin in order to rhetorically analyze popular culture and the whole study. Bakhtin's theories on carnival such as inside out, comic-parodic reprocessing of language, grotesque realism, renewal, and reification are perfect for multiple genres of popular culture.

Bakhtin's theoretical contributions to understanding medical discourse, heroic rhetoric, and popular culture are considerable in and of themselves; however, Bakhtin's theoretical contributions to dismantling heroic rhetoric are also significant.

Bakhtin helps us begin to dismantle heroic rhetoric by reminding us that artists are separate from their heroic personae. In revisioning the myth, we must keep in mind that the actual physician and his or her heroic personae are two separate entities. Bakhtin specifically discusses the differences between real authors and idealized heroes:

What is constantly ignored in all such juxtapositions [between authors and their heroic personae] is that the whole of the author and the whole of the hero belong to different planes – different in principle; the very form of the relationship to an idea and even to the theoretical whole of a world view is ignored. It happens again and again that one actually starts disputing with the hero as one would with the author, as if it were really possible to quarrel or to agree with *what exists*. (Italics in the original; *Art 9-10*)

Bakhtin makes an important point as he states that we cannot actually interact with the heroic personae of artists because the heroes are theoretical ideas that do not constitute real people. We need to dismantle the heroic ideas while simultaneously talking to and interacting with actual physicians.

But the only way to dismantle the metaphor of the hero is to substitute it with a less iconic metaphor. We cannot conceive of language except by metaphorical means; so, we must counteract the effect of the metaphor by replacing it with another, less glorified, metaphor. The term “competent physicians” may be a suitable replacement.²⁵ What I have learned from writing this study is that the first step in dismantling the concept of heroic physicians is becoming aware of the heroic metaphor that is used to name physicians and their power, as well as society’s dependence on the myth/metaphor.

²⁵For a contextualized discussion of my concept of “competent physicians” see Chapters I and II.

Indeed, the heroic metaphor identifies the aesthetic reaction that most heroes, including heroic physicians, share. If physicians are thought to show initiative, bravery, and individual action, then it is no wonder patients are so ready to relinquish decision-making functions to physicians. In terms of Bakhtin's philosophy though, this aesthetic reaction enables artists to become audaciously self-confident and in no way bound to answer for their real life experiences with patients. Bakhtin explains:

The three domains of human culture—science, art, and life—gain unity only in the individual person who integrates them into his own unity. This union, however, may become mechanical, external. And, unfortunately, that is exactly what most often happens. The artist and the human being are naively, most often mechanically, united in one person; the human being leaves 'the fretful cares of everyday life' and enters for a time the realm of creative activity as another world, a world of 'inspiration, sweet sounds, and prayers.' And what is the result? Art is too self-confident, audaciously self-confident, and too high-flown, for it is in no way bound to answer for life. And, of course, life has no hope of ever catching up with art of this kind. 'That's too exalted for us'—says life. 'That's art, after all! All we've got is the humble prose of living.'

When a human being is in art, he is not in life, and conversely. There is no unity between them and no inner interpenetration within the unity of an individual person.

But what guarantees the inner connection of the constituent elements of a person? Only the unity of answerability [*sic*]. (*Art 1*)

I am interested in the fact that Bakhtin considers the three domains of human culture to be science, art, and life. In the example above, science is medicine, art is physicians' practice of medicine, and life is society. Bakhtin says that life and art are falsely and mechanistically related to one another, except in the inner interpenetration of a person. If we accept Bakhtin's view that heroic physicians are answerable for themselves within the inner connection between heroes and humans, then physicians must answer for their art of practicing medicine. One way to do so is by refusing to see themselves as heroes outside of society and starting to see themselves as ultimately answerable to patients. If physicians revision their heroic personae into service personae, they may focus on serving patients in all capacities—and not just heroically saving patients. Collectively, we can all participate in polyphonic discourses that stir up the dialogic discourse on heroic rhetoric.

(Re)visioning Heroic Rhetoric

Awareness that the status of physicians-as-heroes interferes with communications may be the first step in developing a more equitable language between physicians and patients. If physicians, rhetoricians, and patients are all complicit in furthering the concept of heroic rhetoric, then how do we reconcile the real implications that this imaginary metaphor has on communications and miscommunications between physicians and patients?

We will never be aware of all of the rhetorical devices inherent in medical discourse. No matter what kind of communications take place between physicians and patients they are much more complex than we can completely understand or articulate. We cannot fully reconcile the reality of physicians with the imagery of the hero. If all language is metaphorical then we cannot dismantle unrealistic concepts. Something must always stand in for something else. We must

always view some new synthesis, such as this study, in terms of other concepts that we already know and understand.

So, we have conferred about what we cannot change in terms of heroic rhetoric in medical discourse; however, the changes that we can make involve recognition. We can recognize heroic rhetoric in medical discourse, and recognition can lead us to knowledge and understanding of the ideological implications that heroic rhetoric imposes on medical discourse. We can begin to synthesize new types of words in new situations. As reiterated from Bakhtin, “Thus an active understanding, one that assimilates the word under consideration into a new conceptual system, that of the one striving to understand, establishes a series of complex interrelationships, consonances and dissonances with the word and enriches it with new elements” (“Discourse,” Holquist, 281-2). We can, ultimately, use newly synthesized phrases, such as heroic rhetoric and competent physician, in order to discuss the inherent problems with the metaphorical association between heroes and physicians. Even if we cannot remove heroic rhetoric from medical discourse and medical rhetoric, we can offer new understandings of the explicit and implicit information that is passed on to physicians and patients when heroic rhetoric is used.

If, however, physicians begin to dismantle the binary opposition between “heroic” and “ordinary,” physicians may start to view their lived experiences in a more realistic way. Physician-patient interactions may continue to incorporate more and more social discourse. In terms of Derrida’s *différance*, instead of inverting the binary and making ordinary preferred over heroic, we must start to look at the characteristics that both terms share. We may find that “competent” physicians will serve patients better than heroic or ordinary physicians do. And

because the meaning of heroic rhetoric is always already deferred, consciously choosing to replace heroic metaphors with less idealized metaphors is one place to begin.

As heroes, physicians are answerable for their communications with and treatments of patients. The use of heroic metaphors, as we have seen, is ubiquitous. Rhetoricians and patients recognize and use heroic metaphors as much as physicians themselves use them. If we choose to deemphasize heroic rhetoric in medicine, then physicians, rhetoricians, and patients must all work together.

If, as Bakhtin suggests, heroic rhetoric passes through all the stages of social objectification and is then concretized in power systems of various discourse communities, then heroic rhetoric is actually reified in social discourse, rhetorical discourse, and medical discourse with a steadfast ideology of the physician as hero. Because heroic rhetoric is so pervasive and it is reified in so many discourse communities, it is even harder to mitigate its effects than if it was only used in one discourse community. Physicians cannot simply change from medical discourse to social discourse in order to avoid heroic metaphors, because heroic metaphors are found in all discourse communities.

And, avoiding heroic metaphors in medical discourse, and other discourse communities, does not necessarily change the heroic views that physicians have of themselves. Physicians may continue to view themselves as heroes, even without the use of specific heroic rhetoric to reinforce their views. Nevertheless, we should try to reduce the use of heroic rhetoric when describing physicians and replace it with a more realistic rhetoric. If minimization of heroic rhetoric is to occur, then physicians, rhetoricians, and patients will need to work towards a collective answerability.

Acknowledging that physicians occupy the highest level of the hierarchy within the medical discourse community may be a second step in developing a more equitable language between physicians and patients. Now that we realize that there is a continuum of responses that physicians have in their written texts, what does this mean for heroic personae in medical discourse? Many physicians are aware of their heroic personae, and some are trying to change the authoritative nature of medical discourse. Furthermore, there is a changeable nature to what constitutes dialogue and who has access to membership in medical discourse. For example, medical rhetoricians, scientists, medical administrators, or even patients may be considered – in specific situations – members of the medical discourse community. Of course, for inclusion, we must refer to Schuster who contends that literacy is not just the ability to read and speak and write; it is the ability to read and speak and write and be *heard and acknowledged* within specific discourse communities. Even if physicians are willing to include members in certain instances, the medical discourse community as a whole will not include these people as members until they are uniformly heard and acknowledged within the medical discourse community.

Asking physicians to use heteroglossic social discourse may be a third step in developing a more equitable language between physicians and patients. In one way or another, all of these articles authored by rhetoricians call for better communications between patients and physicians; however, we still see problems with these communications in medical discourse. We do need an alternative discourse that minimalizes the heroic personae of physicians and humanizes patients. Bakhtin asserts that active understanding is necessary in order to elicit dialogic communication where both parties are heard and acknowledged and can signify:

The listener and his response are regularly taken into account when it comes to everyday dialogue and rhetoric, but every other sort of discourse as well is

oriented toward an understanding that is ‘responsive.’ [. . .] Responsive understanding is a fundamental force, one that participates in the formulation of discourse, and it is moreover an *active* understanding. (*Dialogic* 281).

Schuster acknowledges Bakhtin’s assertion and demonstrates its implications for those who are not heard or acknowledged or cannot signify. If patients are illiterate in medical discourse, if they are not heard or acknowledged and they cannot signify to physicians, then how can we change this social dilemma in medical discourse?

Audre Lorde may have an answer when she claims that medical discourse will not dismantle medicine for patients who want an equal voice with physicians. If patients want to be heard and acknowledged and to signify, they cannot do so using medical discourse. Patients have to choose an alternative discourse in which they are heard and acknowledged and can signify. Patients are already literate in social discourse, so social discourse would be the perfect discourse to use in communications with physicians. Of course, I do not think that medicine or medical discourse should be completely dismantled. But perhaps medical discourse may be dislocated during physician-patient interactions, for the benefit of patients. We know that physicians control medical discourse more than they control social discourse, so requesting that physicians change to social discourse when talking with patients could put them on more equal terms with patients. This resolution is feasible because patients could simply ask physicians to speak to them about their illnesses and treatments using social discourse. The problem with this resolution may be its implementation, because it puts the onus for change on patients and because if patients continue to view physicians as heroes then they may be too intimidated by physicians to ask them to change discourses. Discussing the heroic ways that patients view physicians will hopefully add to the conversation on the implementation of this resolution.

Remembering that although trivialization of heroic physicians in popular culture may seek to disrupt the heroic personae of actual physicians, the fact that it simultaneously reifies heroic personae may be a fourth step in developing a more equitable language between physicians and patients. *House, M.D.* provides a view of House as a heroic physician who has been parodied and revered, simultaneously. But, how do our minds translate what we see in House to what we see in actual physicians? The answer lies in the reification of a cultural memory of House as a stereotypical heroic physician. And the problem with the reified heroic personae of physicians is that heroic personae gives physicians power and control over patients and their health decisions, and it makes it much less likely that patients will challenge physicians' authority and decisions. Perhaps undermining the dominant discourse in the medical discourse community may lead to an alternative concept of reality in the physician-patient interchange. But, as we have seen in *House, M.D.*, at least some attempts at undermining physicians and their medical discourse community also serve to reify them.

Educating physicians about the impact that their heroic personae and dominance have on patients may be a fifth step in developing a more equitable language between physicians and patients. There are now so many organizations that can help physicians communicate with patients. Almost every organization whose membership includes physicians provides assistance for physician-patient communications, from the National Institute of Health, to each medical specialty organization, to every medical journal. Physicians should be encouraged to consult these organizations for help with physician-patient communications.

Medical rhetoricians and ethicists who teach at medical schools help form positive views in student physicians about communications with patients. Although practicing physicians may have trouble changing their established communication patterns, new physicians can learn the

necessity of dialogic communications with patients. The best places to inculcate this practice may be in clinics and hospitals where practicing and new physicians can listen to and learn from one another.

Direct teaching from established physicians to student physicians is an influential means of modeling communication processes. Although some physicians may still believe that patients are unreliable sources of information, more and more physicians realize the importance of making bonds with patients through dialogic interactions. The more physicians are taught positive communication skills, the more likely these physicians will in turn teach positive communication skills to student physicians.

Perhaps the most powerful form of education comes from learning by experiencing patients' perspectives. Klitzman wanted physicians to understand the perceptions of their patients, so he had the physicians become patients. When the physicians were forced to see medical care from patients' viewpoints, they validated patients' concerns. Physician-patients have an opportunity to learn the frustration of not having open and immediate communication with their physicians.

Instead of relying on a single method of educating physicians as to the importance of physician-patient interactions, a combination of these methods will reinforce the communication practices learned elsewhere. Besides heroic rhetoric, there are many factors that may influence physician-patient communications. Continuing to study the issues that affect physician-patient interactions may be a sixth step in developing a more equitable language between physicians and patients. Studying the effects of socialized medicine on physician-patient communications may help to answer some important questions about the changing roles of physicians from private practice and organizational medicine to socialized medicine. A majority of the articles that I

encountered that are authored by physicians are written by physicians in Canada and the United Kingdom, not in the United States. Canada and the United Kingdom have had longstanding socialized medicine. Whether or not the United States will transition into socialized medicine with the advent of Obamacare as its facilitator remains to be seen. But changing roles of physicians in their service of medicine is a consideration for future study.

The effects of technology on physician-patient communications is another area of potential investigation. Physician web sites, social media, the internet, and personal technology devices impact all of our forms of socialization. For instance, patients have the ability to look up information about diagnoses on Google, which can give them just enough information to be concerned without enough information to fully understand particular conditions. The possible positive and negative effects of technology on physician-patient communications are growing as rapidly as the technology itself.

Ultimately patients need physicians who communicate well no matter what the circumstances, and studying how patients access medicine and what their concerns are is crucial in providing open and honest physician-patient communications.

Joe's Story Reexamined

The whole reason for this study is to help patients, such as Joe, feel comfortable asking questions, making decisions, and sharing collective accountability for their own healthcare. In reexamining Joe's situation though, I realize that the initial assumptions I made about Joe's response to the news that he had malignancies was in conflict with the assumptions that I now make. I initially believed that when he first got the news of his metastatic cancer in June 2011, Joe had no idea that the diagnosis was terminal. Joe was hopeful that chemotherapy would take care of his metastatic cancer.

However, I now suppose that Joe probably did understand that the malignancies were fatal. Joe probably comprehended a lot of the Latin words that his physician was using. Whether or not the physician provided actual dialogue with Joe on his impending death, Joe also played a big part in how he decided to interpret the physician's discourse. Joe may have legitimately decided to be in denial about his death, or he may have legitimately decided that his physician's suggestions for excision of metastases and chemotherapy were the best courses of treatment given the available information. Whatever Joe's thoughts and motivations, he had the right to deal with his approaching death according to his own beliefs.

Denial of death is a reasonable choice for some patients. Including this choice in medical discourse would open patients' options for dealing with, or in this case not dealing with, death. If physicians sense death denial, they need not confront the patient. Physicians can wait until they sense that patients are ready to discuss death and dying. I suspect that many physicians already incorporate denial of death as a strategy in patients for whom denial is apparent.

While I still believe that sending Joe the email about his impending death without an office visit constitutes poor communication on behalf of Joe's physician, I now also believe that I did not have the right to interpret or misinterpret Joe's motives. Just because I was outraged at the manner in which Joe received the knowledge that he was dying, it does not mean that Joe should have been outraged.

Joe had a great outlook on life. He could have been angry about his situation, but he chose the most optimistic outlook he could have. He thought that he might be cured of cancer once again. And when his physician finally suggested that Joe forgo chemotherapy, Joe was in agreement with the decision.

At his last office visit with his physician, Joe asked the physician to explain to him the exact physiological manner of his impending death. The physician declined to answer Joe's question, saying that he did not know. So, Joe went on the internet and looked it up. The internet said that Joe would likely know that his death was imminent when his lungs filled with fluid. And that is exactly what happened.

On the day before his death, an ex-priest friend came to talk to Joe. He asked Joe if he wanted to consult with a priest. Joe said that no, he was at peace with all of his relationships. Joe indicated that he was spiritually alright. Like Joe, House focuses on life rather than on death. And House may be correct when he says, "We can live with dignity; we can't die with it" (Singer 2004). And Joe lived with dignity and grace. In writing this study, I have not only learned a lot about physician-patient interactions in medical discourse, I have also learned a lot about Joe. I respect the decisions that Joe made.

Considering Patients' Perspectives

Crucially, we must all respect differences in the ways that patients process the knowledge of their diseases and deaths. We must realize that the ways that physicians and rhetoricians process information are not necessarily the same ways that patients do. If better communication between physicians and patients is to occur, then we must consider physician-patient interactions from patients' perspectives. We must begin to dismantle the myth of the heroic physician, if we are to revision actual physicians' discourses.

Patients may have a hard time dismantling the myth of heroic physicians though, when they are bombarded with heroic physicians in popular culture. In addition to House of *House*, *M.D.*, there have been heroic physicians in television and the movies since the 1930s. Dr. James Kildare of *Dr. Kildare* is a brilliant physician who tells patients how they are supposed to

behave. Dr. Ben Casey of *Ben Casey* is a brilliant physician with the rugged individualism of a cowboy. Dr. Marcus Welby of *Marcus Welby, M.D.* is a brilliant physician who is too perfect because he never makes a mistake. If patients think that their physicians will be like Welby, then they are often in for a rude awakening. My favorite mythic heroic physician is Dr. Hawkeye Pierce of *M*A*S*H*. On both the big screen and the television screen, Pierce is a brilliant physician who drinks, womanizes, and initiates pranks. More recent brilliant physicians include Dr. Derek Shepherd of *Grey's Anatomy* and Dr. William Rush of *Rush*. Notice that all of the mythic physicians are brilliant, no matter what other characteristics are also used to define them. With all of this reinforcement of heroic physicians in popular culture, there is no wonder that patients expect that their actual physicians will also be brilliant heroic physicians.

Because of the contradictions between reified ideas of heroic physicians and actual events with their own physicians, patients may experience cognitive dissonance. In an attempt to reconcile the differences between images and reality, patients may project the traits of television physicians onto their actual physicians in order to justify physicians' actions. Patients may direct their anxiety surrounding their healthcare experiences at people other than their physicians, as they assume that their physicians are brilliant and will do whatever it takes to diagnose their problems. Patients may entirely defer to physicians because they believe that physicians can find one perfect, heroic cure for their ailments.

Let us now juxtapose the reified ideas of mythic heroic physicians with actual physicians. When patients come to see physicians, they do so because they already fear that something is wrong with them, that they are in some way unhealthy. They may be worried that their insurance will not pay for their visit, or they may not even have insurance. Likely, the initial examination will not provide patients with a complete answer. Patients may wait for prescriptions to be filled,

or they may have to have additional procedures performed and wait for physicians to notify them of the results. Even when they get the results, patients may not realize the full implications of the results with regards to their illnesses. Without adequate time to prepare, patients may even be quickly admitted to the hospital. Additionally, the treatments may hurt patients more than they help; patients could have adverse reactions to medications, different illnesses than physicians initially thought, or additional complications that were not previously diagnosed. Physicians may refer patients to one or more specialists, and they may not realize that their multiple physicians do not always communicate fully about patients' statuses. Patients may end up having more anxiety about the physician visits than they originally had about not being well, and they may not fully understand their diagnoses.

On the other hand, patients may attempt to arrive at consonance with the situation by ignoring their actual physicians' behaviors. Some patients do not recognize that physicians can be overworked, preoccupied with other patients or personal problems, careless, or even mediocre. Patients do not realize that physicians are often pressured to choose from various alternative partial treatments the one treatment that they consider best at the time, without consideration for patients' particular circumstances. When physicians fail to follow up with patients' requests, patients might dismiss the failures. For example, if physicians do not call patients with test results patients sometimes assume that the test results have not been received, when in reality physicians have the results but they neglected to call the patients.

Physicians can alleviate patients' cognitive dissonance by taking steps to dismantle reified images of heroic physicians and changing patients' perceptions. If physicians unambiguously explain that they do not know all of the answers and they include patients in the

patients' own healthcare decisions, then patients will be able to see their physicians as capable, fallible, individual humans.

Patients have varying degrees of familiarity with medical discourse. Physicians need to give patients their diagnoses with the appropriate medical discourse; however, this is not enough to constitute clear communication. Physicians must also explain what the medical discourse means to patients using terms that patients can comprehend. If physicians fail to use social discourse and familiar analogies with patients, then patients will not understand their diagnoses. Further, patients will not remember the medical words if they are not couched in social words. Patients should be given adequate time to digest the information given to them by physicians, and physicians should actively listen. Physicians should listen to what patients say, without interruption, and refrain from rebuttals until the patients have completed full vocalization of their thoughts.

Patients should be allowed to process information about their illnesses and make their own decisions about possible treatments. Of course, patients benefit from listening to advice from their physicians, but the ultimate wishes of the patients should be taken into account when proceeding with particular courses of action. And patients may actually comply more with their treatments if the treatments are created collaboratively. The definitive form of respect for patients is letting them decide what dignity means through their illnesses. We must also realize that what dignity means to patients may change over the course of their illnesses. Letting patients decide their courses of action helps patients feel their own empowerment and may allow them to dismantle images of heroic physicians.

We need to respect difference. Each patient acts differently from physicians and from other patients in stressful situations. Even though patients may make decisions that are not the

decisions that we think that we would make in similar situations, we need to follow their wishes. Once we are sure that physicians have adequately informed patients about their illnesses and potential treatments, we must accept those patients' decisions. This includes respecting the option of no treatment at all. This also includes respecting the choice of denial. We do not have to agree with a decision in order to respect it.

Patients want to be respected. Using social discourse, providing adequate consultation time, instituting active listening, and appreciating patients' requests regarding their treatments are some of the ways that physicians can demonstrate respect for patients. Even with all of the reified ideas of mythic heroic physicians that patients are likely to experience, if actual physicians take the time to listen to patients and respect their perspectives then patients may be more likely to respect physicians as individuals – regardless of their heroic personae.

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