An Annotated Bibliography of Literature on the Rhetoric of Health and Medicine

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Introduction

Ten years ago, compiling a bibliographic review of medical rhetoric would have seemed a manageable task. Although studies examining language in medicine go back at least forty years, it was not until the turn of the twenty-first century that a large amount of scholarship sprung up studying the rhetoric of healthcare, proper. Now, an annotated bibliography is a much needed resource for entering and navigating the field. The following introduction first provides a brief genealogy of the rhetoric of health and medicine, and then explains the bibliography’s arrangement and how one can use it most effectively.

Beginning in late the 1970s, rhetoric and composition scholars have had three primary access points from which to approach the study of medicine: canonical rhetoric, technical communication, and the rhetoric of science. Each is dependent on the other but is rooted in its own intellectual history.¹

Since classical times, philosophy, rhetoric, and medicine have shared interwoven discursive roots (see Lloyd, *Magic*). Protagoras, Plato’s Socrates, Plato himself, Aristotle, Cicero, Quintilian—all of the classical rhetorical philosophers—discuss similarities between the medical arts, rhetoric, and politics. The Hippocratic authors formulated their canon during the same period as the early sophistic and rhetorical scholars; thus, they engaged in many of the same epistemological, ethical, and ontological debates (see Lloyd, “Epistemology” and *Magic*).² Judy Z. Segal identifies practitioners of “canonical rhetoric” as those who employ classical rhetoric as well as major rhetorical scholarship of the twentieth century to study contemporary health-related discourse (Segal, “Rhetoric” 229).³ Studies in this annotated bibliography address topics such as epideictic rhetoric, the erotema, the jeremiad, and identification; as a result, these studies exemplify the canonical branch of health rhetorics.

Technical communication’s history of collaboration with the applied sciences and attention to workplace writing genres has constituted the primary starting point from which the rhetoric of medicine grew after the turn of the twenty-first century. A significant number of early researchers in
healthcare rhetoric worked as medical practitioners or communicators (e.g., Brown, Heifferon, Zerbe, among many others). Heifferon and Brown add that Writing Across the Curriculum (WAC) pedagogy in the 1970s made rhetoric and composition’s “reach across other disciplines not only permissible, but also important and valid” (247). Professional and technical writing and communication (PTWC) scholars demonstrate this interdisciplinary “reach” when partnering with medical practitioners to improve healthcare (see Montgomery, Reynolds, Greenhalgh, Heifferon, Barton).

In addition to PTWC scholarship, scholars in the rhetoric of science have blazed a trail for work in the rhetoric of medicine. In Health and the Rhetoric of Medicine, Segal points to Kenneth Burke as the theorist who first opened the field of English to science studies. Burke broadened the object of rhetorical analysis from merely oral speech to all forms of discourse—be they speech acts, run reports, or x-rays. Following Thomas Kuhn’s The Structure of Scientific Revolutions, English scholars began investigating the role of persuasion in scientific history. Like PTWC scholars, rhetoric of science scholars use techniques from rhetoric and composition to explain the evolution of texts, and, thus, ideas, policy, and practice. Recently, many scholars in the rhetoric of science have drawn heavily from science and technology studies (STS). Drawing from anthropological and sociological research methods, STS focuses on the material, empirical practices of scientists and technical professionals, while also investigating the social and political relationships which shape scientific networks. This approach segues nicely with rhetoricians’ interest in public discourse and policy. STS also takes political and social realities into account—an approach that segues nicely with rhetoricians’ interest in public discourse and policy.

Studies in medical rhetoric display an indebtedness to many other disciplinary fields as well: critical cultural studies, women’s studies, disabilities studies, history, philosophy, anthropology, sociology, communication, humanities, and narrative medicine. The interdisciplinary nature of medical rhetoric is both the advantage and challenge of the field. The various methodologies, objects of interest, critical lenses, disciplinary affiliations, and overarching conversations have spread and now overlap to a large extent; any attempt to categorize works proves daunting. Nevertheless, this bibliography provides a broad overview of the types of conversations which have taken place and developed over the last four decades.

This annotated bibliography is organized chronologically, an aspect that sets it apart from other medical rhetoric bibliography lists available
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online. Most lists are arranged in traditional MLA format, organize sources by author’s last name, and are not annotated. The chronological listing here provides a sense of the historical arch of the field, developments in particular research topics and trends, and an overview of major contributors’ works throughout the years. The summaries may include research questions, methods, findings, and information about the authors themselves.

This bibliography may be useful to professors, graduate students, researchers, and practitioners alike. Instructors in various departments may use the bibliography to identify assigned readings or even as an assigned reading within a survey course. For graduate students who would like to specialize in the rhetoric of health and medicine, this bibliography serves as an introduction to the interdisciplinary scope of the field and its existing research, methodologies, and topics of inquiry. Researchers of all disciplines may use this digital text to search for sources related to any number of health-related topics. Medical practitioners will find information about communication strategies, medical records and writing, direct-to-consumer advertising, and bio-defense. Additionally, they will find meta-analyses of medical journal articles and programmatic perspectives on academic medicine, curriculum, and pedagogy.

To assist in all these endeavors, search tags (listed below) have been created for a variety of audiences and purposes. The tags may indicate critical foci (e.g., gender studies), methodological approaches (e.g., genre analyses), topics of inquiry (e.g., policy), or disciplinary affiliations (e.g., STS). To use the tags, conduct a “find” search by using the ctrl+F keys on a PC, or command+F on a Mac. This same function can be used to search for all the annotated works by a single author, a particular research theme (e.g., AIDS), or any other desired term. The digital format of this text will facilitate these types of searches in a way that a physical text cannot.

List of Tags

Classical/Canonical Rhet
Disabilities Studies
Doctoring (regarding the practice of healing and medicine)
Ethics
Gender (includes women’s studies, LGBTQ studies)
Genre
HCP-Patient Com (Healthcare Provider to Patient Communication)
History
Medical Research
Narrative
Pedagogy
Pharmacy
Policy
PTWC (Professional and Technical Writing and Communication)
Public Discourse
STS (Science and Technology Studies)
List of Abbreviations
HCP: Healthcare Providers/Practitioners/Professionals
PTWC: Professional and Technical Writing and Communication
PW: Professional Writer
TPW: Technical and Professional Writer/ing

Works Cited


Endnotes

1. For an interdisciplinary overview of medical rhetoric's topical, theoretical, and methodological approaches, see Judy Z. Segal's piece in the 2009 Sage Handbook of Rhetorical Studies. It would make a helpful companion pieces to the following annotated bibliography.

2. According to Randall Baldwin Clark, medicine and ship navigation were two of the most commonly used metaphors in classical political rhetoric for arguing public policy and law (76-77). Continuing in this tradition, rhetorical scholars of the twentieth century have often employed themes of classical rhetoric to analyze the public discourse surrounding health and medicine. Furthermore, theorists, such as Derrida, have continued the tradition of using medicine, or pharmakon, as a trope for theorizing rhetoric.

3. Segal lists rhetorical theorists, such as Burke, Weaver, Perlman, Booth, Foucault, and Derrida.

4. Most scholars point to Latour and Woolager as the founding theorists; their book, Laboratory Life (published the same year as Kuhn's Structure, 1979) uses ethnographic observation to theorize the research practices of scientists as they use and create “facts.”

5. Health communication closely partners with medical schools in many academic settings. The field has played a significant role in developing and administering the Clinical Performance Examination, a standardized test all medical students in the United States are required to take. In taking the test, medical students are asked to demonstrate communication proficiency via clinical simulations.

6. As Ellen Barton notes in the introduction to JBTC’s 2005 special issue, “the research literature of medicine is vast, even in the area of medical communication, with work in a wide variety of fields, including history, sociology, anthropology, linguistics, literature, communication studies, and behavioral science” (245).

7. Because medical rhetoric is an interdisciplinary field, it is often difficult for medical rhetoric researchers to track down all the sources on the topic. The publications are spread across disparate fields and scattered throughout unaffiliated journals and databases. Indeed, as of now, I am unaware of any one search engine which will identify even 50% of the
sources annotated here. Databases useful for conducting literature searches on medical rhetoric include the MLA International Bibliography, Taylor and Frances, Sage, SciVerse, and JSTOR.

8. The sources annotated in this bibliography were compiled primarily from three other bibliographies available online. Segal’s bibliography in Health and the Rhetoric of Medicine, a portion of which is listed on the [medical rhetoric] blog, provides a helpful starting point for those new to the field: http://medrhet.wordpress.com/bibliography/. Working from Blake Scott’s bibliography, an extensive list compiled at Rhetoric Society of America’s (RSA) 2009 Workshop by Ellen Barton and Sue Wells, and is posted on the medical rhetoric website: http://www.medicalrhetoric.org/Resources.html. This list is particularly noteworthy for its extensive selection of interdisciplinary sources. Finally, RSA provides a selected list of sources on their blog, Medicine and its Publics: http://rhetoricofmedicineanditspublics2011.wordpress.com/selected-bibliography/. All three of the lists generally end with citations from about 2010. This annotated bibliography includes a handful of sources published after that time.

9. The entries focus most heavily on journal articles, collections, and monographs published for a rhetoric and composition and PTWC audience. Some works in related fields, such as disabilities studies and narrative medicine, were also included because they influenced and are useful to medical rhetoric. Also included are a handful of articles written in medical journals. The purpose of including these articles is twofold: first, to illustrate the space that exists for medical rhetoric work there, and second, to highlight ways that research has been successfully presented to practitioner audiences. Although almost no dissertations are covered here, it is worth noting that some of the most up-to-date studies in healthcare policy, international health, and the rhetoric of medicine can be found in that genre.

10. Author information is included for influential scholars outside the field of medical rhetoric who have made an important impact on the field (e.g., Charon, Davis).

1973-1995


In this piece, one of the earliest works in what is now considered postmodern cultural studies, Foucault reviews a vast span of French history. He reconstructs the birth of the clinic, paying careful
attention to the ways that particular socio-political events transformed medical, scientific, and clinical discourse, and in turn, the way that knowledge and subjects were constructed. One key turning point took place after the French Revolutions when hospital clinics ceased to be a sampling area for medical students to examine well-known diseases; instead, they became the primary site of treatment (60). During the same time, there was a change in what Foucault calls the “medical syntax”; discourse changed from a “mixed syntax,” one that valued languages as an inventive and arranging component of knowledge (62), to the “modernist syntax” (107). In the “modernist syntax,” the Gaze, and the Gaze alone, was responsible to perceive, recognize, and rationally identify the cause of the symptoms they saw (107). Language, after this transition, was seen only as a transparent means of describing the perceived; any noise that interfered with the gaze of the physician was a threat to pure knowledge—including rhetoric (109-114). The body of the patient, therefore, became an object of the gaze, and the perceptive physician, the dominant subject.

**Doctoring, History, Pedagogy**


Barbara Smith was one of the earliest scholars to object to the way that socio-political policy impacted the definition of disease and the unjust delivery of patient treatment. In her article, Smith describes a conflict between mine workers who want to be diagnosed and compensated for black-lung disease according to their level of suffering, and doctors and corporations who wanted to define the disease based on an “objective” x-ray image of patients’ lungs. In one case, compensation was based on pragmatic need while the other used positivist rhetoric to justify limiting compensation. This conflict contributed to the 1968 Miners Strike. Smith argues that policy makers cannot address questions of health and disease without also addressing the socio-economic structures which produce and reinforce them. According to Mol and Berg (1998), this article was not well received or subsequently cited, largely due to the strained political views regarding Marxism and critical social theory at the time of its publication. However, since the 1980s, these types of studies have become more prevalent and more valued within the healthcare and policy systems for their ability to identify the need for change.

**Policy**


Anderson’s work illustrates the strong and rich relationship that has always existed between rhetoric, medicine,
and magic. His book considers surgeon and author Richard Selzer’s literary work, which deals mainly with his experiences as a physician. Anderson focuses on the “convergence of historical presence, artistic perception, and factual constraint” in Selzer’s writing that poetically weaves together strands of discourse usually segregated in the modernist mindset (xvi). Anderson also displays this capacity in his own analysis. As much concerned with the philosophy of writing as it is with rhetoric, the study is a beautiful model of how literary, composition, rhetorical, and historical scholarship can operate as a harmonious, theoretical whole. 

Doctoring, Narrative


In this book, Condit, a speech professor, takes a neutral stance to analyze the history of abortion discourse through a rhetorical lens. She begins in the 1950s, considering rhetorical devices physicians used to petition for a change in abortion laws. She argues that in Roe v. Wade the ruling centered on competing narratives about women and their identities. Because the ruling depended upon the new characterization of women, which expanded their control of choices and not upon the definition of “life” directly, the court decision has left open to the public debate the fetus’s right to life. Condit traces the expansion of the conversation, rhetorically analyzing a variety of media including pamphlets, billboards, slogans, television and magazine advertisements, as well as narrative tropes that have defined either side of the debate. Condit observes that polarized or “overweigh[ted]” rhetorics have brought discursive closure between activists, leaving the majority of the public in the middle with mixed views about the subject. Condit also suggests, with well-documented textual support, that the pro-choice movement has not found a strong enough ground, rhetorically, from which to make its appeals.

Public Discourse


A Literature PhD and medical humanities professor, Montgomery Hunter explains to medical students and doctors that their knowledge practice is not innately scientific—rather, it is narrative. Their daily information gathering and decision making is structured not on empirically controlled experiments, but on narratives, both of patients and of health care professionals: “treatment is undertaken in light of principles of biological science. Yet medicine’s focus on the individual patient, fitting general principles to the particular
case, means that the knowledge possessed by clinicians is narratively constructed and transmitted. How else can the individual be known?” (xvii). This process takes place in the taking of patient history, in case charts and reports, in anecdotal conversation between doctors, and in doctors’ communication with patients, no matter how at times incommensurable their two forms of narrative may seem. Montgomery Hunter gently reminds doctors that the meaning of a patient’s illness is not the meaning of the patient’s life and encourages doctors to remember the shared narrative we all posses, which moves from life to death with or without a biological story to explain it (158).

Doctoring, HCP-Patient Com, Narrative


Schryer presents qualitative research findings from a curriculum consultation she conducted for a veterinary medical school. Through extensive participant observations, interviews, and textual analysis, she found that, beyond learning professional genres as a pragmatic form of communication, the IMRDS (Introduction, Methods, Results, Discussion, Summary) and record keeping genres of medical writing socialized the students into either theoretical science or practicing clinician discourse communities. Additionally, these communities are a part of a power hierarchy in which theory is valued over practice. She suggests curriculum designers find ways to cross the literacies more purposefully so that students would appreciate the values and practices of each discourse community; however, she notes that this would be difficult in a culture where these patterns have been engrained for so many centuries.

Genre, Medical Research, Pedagogy


Although not a founding scholar in disabilities studies, Davis is a distinguished pillar in the field. He argues that cultural studies scholars and theorists, including those in English, have marginalized disabilities studies amidst their very cries for inclusion. In this book, his earliest on the topic, Davis calls disability “the missing term in the race, class, gender triad” and makes a moving argument for why, like other minority categories, disability is in need of theoretical attention and empowerment (1). Deafness presents itself as a useful case study for its rich history in both Europe and America and because deaf culture today largely rejects the normalizing rhetoric and ideological values that view deafness as a disability. Davis went on to edit the now essential *Disability Studies Reader*, first published
in 1997, and now in its third, 2010 edition (annotated below). Besides his position as an English professor at the University of Illinois at Chicago, Davis is now a Professor of Medical Education at the University of Illinois College of Medicine and Professor of Disability and Human Development in the School of Applied Health Sciences.

Disabilities Studies, Public Discourse


Most consider Arthur Frank to be a key founder of narrative medicine as we know it today. While several have considered doctors’ stories and narrative identities, Frank was one of the earliest scholars to investigate the way patients make sense of their pain through a “pedagogy of suffering” and the meaning-making practices of narrative. Frank presents the illness narratives of those with maladies such as ovarian cancer, chronic fatigue syndrome, and disabilities in order to identify patterns in the values and meanings the patients construct for themselves. He identifies three types of stories: the restitution story, which aims to return to a past state of well-being; the chaos story, which finds no purpose or pattern in the ongoing experience of pain; and the quest story, which seeks insight and personal transformation through the experience of suffering. Narrative medicine deals with questions of subjectivity, which requires the storyteller to balance an awareness of her limited perspective with an assurance of the value and authenticity of her personal knowledge and experience. What emerges from these attempts are a postmodern ethic that inscribes dignity on the sufferer and on those who listen to their narratives.

Narrative, Public Discourse


Written by two rhetoric and composition scholars in collaboration with a psychologist, this book is meant to guide clinicians into a greater awareness of their choices regarding the rhetorical construction and meaning of their patient records. The book also seeks to draw attention to the highly fluid, rhetorical role of medical records within the healthcare system and the power they have to shape patient care, effectively or ineffectively: “Psychiatrists, psychologists, social workers, nurses, therapists, counselors; lawyers, judges, caseworkers, parole boards, probation officers; classroom teachers, school psychologists, guidance counselors . . . all need the fullest possible awareness of the complexities and political realities of rhetorical situations(s)” (xii). Chapter 1 reviews the literature on mental health records to date.
Chapter 2 provides a taxonomy of mental health records. Chapter 3 considers ideological biases affecting the composition of records. Chapter 4 unpacks the *Diagnostics and Statistical Manual of Mental Disorders (DSM)* and the language system it constructs. Chapter 5 presents the results of a survey investigating clinicians’ opinions about health records (first published in *TCQ* in 1989). Chapter 6 provides pedagogical and applied strategies for improving records, as well as suggestions for future research. Finally, chapter 7 considers developments that took place between the 1992 and 1994 edition of the text.

*Doctoring, Genre, Policy*

**1996-2000**


Epstein employs science and technology studies theory (STS) and active research methodology (also known as participatory research, in which the researcher interacts with the subject population as a part of inquiry, to achieve the community’s desired results) to explore a particular case in which scientists, politicians, and laypeople combined different forms of expertise to construct clinical trials. These trials were designed to meet the bioethical needs of participants as well as the researchers. Specifically, Epstein interrogates the controversy surrounding the AIDS movement of the 1980s and 1990s. During these decades, patients, activists, citizens, health educators, and policy makers began to demand better healthcare options, treatment, and research, and they struggled while deconstructing and reconstructing what constituted “scientific knowledge” about AIDS: “I seek to identify . . . the linkage of power, knowledge, and order forged . . . How . . . certainty is constructed—or deconstructed . . . how knowledge emerges out of credibility struggles—and how the unusual politicization of AIDS in the United States has altered the conduct and resolution of such struggles” (2-3). The book is a classic example of work in ethical deliberative rhetoric between biomedical/scientific and popular culture.

*Gender, Policy, Public Discourse*


This article considers the advent of the cochlear implant, its rhetorical promotion in the media, and its unexpected reception. Scientists creating the device in the 1970s made a strategic alliance with mass media circuits, which in turn “reconstructed” the cochlear implant as the “bionic ear” in an attempt to persuade those in the deaf community to undergo its surgical
implantation. While the medical community saw this technology as a great achievement, reaching a population that had previously been medically incurable (the totally deaf), the deaf community unexpectedly responded with a counter-rhetoric that reaffirmed their collective physiological and social identity, challenging the narrative of technological salvation suggested by early media coverage of the implant. Blume traces the process of how this counter-rhetoric was constructed, enabled, and effectively deployed, resulting in a campaign which changed the history and identity of the deaf community—the entire story spanning from the post war 1950s to 1995. Blume specializes in twentieth century technological innovation and writes from historical, anthropological, and medical perspectives in various journals outside of rhetoric.

Disabilities Studies, History, Public Discourse

In her fantastical and brilliant fashion, Haraway provides a feminist interrogation of the technoscientific age, surveying everything from the birth of the Internet to the genome project, demonstrating how the excess of technoscience cannot be contained by the Judeo-Christian chronotope. Working at the boundaries of cultural studies and the rhetoric of science and technology studies, Haraway considers the intersections of ownership, capitalism, science, and medicine. Her second chapter, “FemaleMan© Meets OncoMouse™,” is likely to be most useful to medical rhetoricians. In it, Haraway describes the creation and capitalization of an animal that exists solely to provide humans with materials for cancer research. The first patented animal in history, OncoMouse™, is genetically engineered to “naturally” and dependably develop breast cancer for the purpose of experimentation. S/he is the perfect example of the conflation of species, technology, commercial capital, and the archetypal religious scapegoat. Haraway considers hundreds of examples like this one in recent scientific and popular cultural herstory, bearing “modest whiteness”—in the style of a laughing medusa—to the technological web we’ve woven in the name of unbiased, objective, all-knowing science. She argues for a participatory democratic of the politoscientific community in order to make visible the invisible actants and injustices in technoscientific networks.

Disabilities Studies, History, Public Discourse

One of Segal’s earlier pieces, this article describes three metaphors
that constrain health (care) policy: the body as machine, sickness as war, and health as a market good (“Public”). For example, Segal demonstrates how the medicine as war metaphor constrains the role of doctor to one who fights against disease, death, and old age, leaving no room for a narrative that allows a patient to die with dignity. On the other hand, the metaphor of medicine as business constructs patients as consumers shopping in a competitive medical marketplace, whether or not the majority of patients see themselves as such. Segal expands on these arguments in the sixth chapter of her book 2005 book Health and the Rhetoric of Medicine (annotated below).

Policy, Public Discourse


Stone expresses concern for how managed care has developed a new rhetoric for limiting patient agency within health care. As a professional medical writer, Stone is familiar with both patient and professional documents and the way that patients are rhetorically framed depending on the audience. She uses the Burkean Dramatistic method to demonstrate how, despite rhetorics of empowerment directed toward patients, physicians' use of “compliance” and “adherence” rhetorics act as terministic screens that attempt to limit patient agency over their care “with the goal of minimizing the treatment of costly complications” (202). Because unmanaged Type II diabetes is such an expensive drain on resources, patients with this disease provide an apt case study, and Stone conducts comparative textual analyses of patient education materials vs. medical articles about managing diabetes in order to make her case.

Doctoring, HCP-Patient Com


Although this collection is not grounded in the field of rhetoric, it includes excellent case studies relevant to medical rhetoric. The collection seeks to expose the ways that “medicine” proliferates and multiplies the more it is investigated. Despite totalizing definitions or binaries, such as eastern and western, traditional and biomedical, allopathic and homeopathic, actual observation of healthcare practices and performances reveal complex differences and contextual variables. The authors investigate these differences not by segregating discourse from science but by “combin[ing] theoretical questions with empirical materials” (8). Even so, many of their contributors focus on the rhetorical construction of linguistic or subject categories, such as pain,
frames of judgment, schematics, patient classifications, and the material realities that complicate and multiply these constructions. Mol and Berg’s work is closely related to Science and Technology Studies, Actor Network theory, and Complexity Theory.


This article is the last in a series of five articles published in BMJ dedicated to narrative medicine (in the “Education and Debate” section). Each of the articles is adapted from Trisha Greenhalgh and Brian Hurwitz’s *Narrative Based Medicine: Dialogue and Discourse* (1998), a book written for an audience of (academic) doctors, persuading them of how to instill critical listening and literacy practices into their clinical practice. Their book and article series makes an excellent example of how English scholarship and research can be presented to a medical audience in more than one fashion. The first article in the series answers the question “Why study narrative?”; the second considers narrative approaches to mental health; the third discusses linguistic/talk analysis of stories in clinical practice; the fourth explains how narrative theory and reading skills assist in the development of medical ethics; and the fifth, listed above, regards the balance between narrative and evidence based medicine.


Lingard and Haber argue that students in medical school should receive specific training in oral communication because, according to linguistic theory, “rhetoric directs attention to the relationship between what [doctors] learn to say and what they learn to value, believe, and practice” (Abstract). Therefore, being aware of ways of speaking about medicine would in turn affect a doctor’s way of thinking about medicine. Over the next ten years following this publication, Lingard designed curriculum for medical students based in rhetorical theory and reported her findings in a 2007 article entitled “The Rhetorical Tern’ in Medical Education: What Have We Learned and Where are We Going?”


This special issue, edited by two University of Arizona alums, is the first ever collection of articles gathered under the name “medical rhetoric” (245). Heifferon and Brown “offer a tentative definition” of medical rhetoric as “how we communicate health care concerns” including everything from
ancient attempts to describe pain, to current healthcare policy (247). As is true in technical writing and the rhetoric of science, the editors of this collection sought to “rectify the historic split between science and rhetoric” and to “address and change [negative] perceptions of rhetoric while maintaining an inclusive and interdisciplinary approach to all kinds of textual and medical language study” (246). The five articles chosen for the collection are all textual studies.

Genre, PTWC


Bell, Walch, and Katz’s article considers the development process of drug protocols. They found that, although the rhetorical construction of clinical protocols is highly complex and serves many audiences and purposes, the specific guidelines the FDA provides about composing such documents are vague. The FDA’s lack of specific directions reveal an assumption that scientific “facts” are self evident and easy to present once “discovered” by researchers: no rhetorical instruction necessary. The authors, in response, offer their own rhetorical heuristic for composing drug protocols which attends to the genre’s rhetorical situation.

Pharmacy, Genre, PTWC


Hausman performs a cultural studies analysis of breastfeeding management by examining a medical guidebook for physicians on the topic. She finds that the socially over-determined meaning of breastfeeding, and the doctors’ need to acknowledge the psychological impacts this has on mothers, ultimately threatens physicians’ authority as rational healthcare managers. This threat highlights the doctor’s lack of control over the social choices of women. She argues for medical interventions that take the material conditions of women into account as HCP’s seek to persuade women of healthy medical practices.

Gender, HCP-Patient Com


Munger investigates the history of the paramedic profession by way of medical run reports and how they evolved over time. The reports reflected a need for professional skills training from 1965-72, a need for system wide monitoring from 1973-80, a greater value for patient narratives from 1980-84, and a more diverse professional audience from 1985-95. Munger notes
the growing instability of the genre with the advent of electronic forms of communication and predicts the value of a full switch to more fluid electronic records.


Salager-Meyer surveys 90 French medical articles written between 1810 and 1995 specifically analyzing the rhetorical role that citation practices played over time. She finds that in the late nineteenth and early twentieth-century, references were more discursive, personal, and openly argumentative. In the later parts of the twentieth century, references took on a more structured purpose (“gap filling”) and tone (passive). This structure and tone allowed the authors to appear objectively distanced from material and for the material to appear more “fact” oriented and less rhetorically constructed and debatable. Salager-Meyer notes that her findings match those of similar studies which examined American reference trends.

Welch presents an ethnographic study of medical students in a literature and medicine class. She argues, based on her observations and textual analysis of the students’ works, that “reflective writing enabled them to conceive medicine as an interpretive, personal, and idiosyncratic activity rather than as a stagnant diagnosis-based process” (311). Welch’s work is an example of how narrative medicine paved the way for medical rhetoricians, especially in educational healthcare settings.


In the introduction to their collection, Lay, Gurak and Gravon highlight the dangers of receiving reproductive technologies with a rhetoric of wonder and hope “instead of a rhetoric of concern and ethical consideration” during a time of often uncritical technological determinism (5). The authors consider reproductive technologies a form of what Foucault calls “biopower,” which attempts to subjugate and control bodies through normalization. The authors provide close rhetorical analyses of various forms of “bio-power and its relationship to authoritative knowledge systems, what we call body talk—how language constructs bodies and reproductive technologies” (6).

This book describes Lay’s rhetorical study of a hearing conducted between 1991 and 1995 by the Minnesota Department of Health and Board of Medical Practice, meant to discuss the legal status of practicing, direct-entry midwives. Lay’s analysis took advantage of a “rare opportunity to study medical and midwifery practices in conflict, the use of discourse to maintain professional jurisdictions, the exclusive claim to scientific knowledge and discourse by dominant professions, and the cultural status granted to women’s experience and knowledge of their bodies” (ix). The breadth of the study, founded on principle questions in rhetoric of science, Women’s Studies, and cultural studies, exemplifies active research practices as Lay takes part in discussions between “established physicians . . . nurses and nurse-midwives . . . malpractice lawyers, and direct-entry midwives[,]” all of whom are “sitting across the table from each other for the first time” (Lay ix).


This rhetorical study examines “how we define infertility families, and parents” and how law itself acts as a technology with the power to define normalcy and frame our everyday experiences (3). Based on eighteen months of ethnographic research, Britt argues that the 1987 Massachusetts mandate for reproductive insurance coverage acts as a technology that “sustains rather than resolves, the tensions between the normal and the abnormal” (2). As a form of what Foucault calls “biopower,” the mandate stratifies reproduction by encouraging some groups to reproduce and not others. It also medicalizes involuntary childlessness as “infertility,” locating the phenomena within the body as an object to be fixed, rather than a complex set of over-determined social factors. The ultimate problem, however, is that the mandate creates a double bind of both control and constraint for those who are encouraged to reproduce who are labeled as medically “infertile,” offering biotechnologies as both a hope and a responsibility for appropriate inclusion.


Lisa Keränen examines the often epideictic nature of medical rhetoric; that is, its ability to display and perpetuate communal values and
practices. She specifically discusses the Hippocratic Oath’s history as an epideictic piece, pointing out how various versions of the oath throughout history promote different ethical values. She stresses the need for the oath’s modification to fit modern-day clinical ethics so that the past may be “reanimated” for medicine’s future.


Lyne focuses on rhetoric as a decision-making art with the power to help negotiate the current medical pressures of time constraints, competing values, and human limitations (3). His term, “bio-rhetorics” refers to patterns of medical persuasion that “cut across disciplinary lines and draw from a pool of generally shared meanings” (narratives, metaphors, associations) (4). Using genome discourse as an example, Lyne traces the ways that metaphors in particular have impacted policy, shaped subjective identities, defined ideological arguments, and influenced medical practice. He argues that a metaphor can act not only as a discrete linguistic organism with a determined meaning and effect but also as an environment, providing the necessary conditions for new persuasive appeals, discursive patterns, and metaphors to emerge (9). He specifically calls for rhetoricians to take an active role in the language of bioethics in order to carefully position people toward an increasingly technologically driven world. This special issue also includes an article by Michael J. Hyde contesting Leon Kass’ definition of human dignity in the Euthanasia debate; an article by Mitchell and Happe about the difficulty of defining the subject when seeking participant consent for DNA research; an article by Celeste M. Condit and Deirdre M. Condit on gendered metaphors in genetics; an article by David Depew on tendencies of reductionism in contemporary Darwinian rhetoric; and an article by Keränen on the epideictic nature of the Hippocratic Oath (annotated above). The following issue, 22.2 (June 2001), also contains an article by Jonathan Sterne on the acoustic culture of medicine, which would be of interest to medical rhetoricians studying the rhetoric of listening.


This collection approaches disability studies from a specifically rhetorical standpoint, employing critical theory to consider “how the language of institutional discourse systems determines material practices in ways
that can work to the advantage—and disadvantage—of the disabled person” (11). The contributors cover substantial scholarly ground, providing historical, cultural, economic, educational, legislative, medical, literary, and rhetorical analyses of disability from feudal times until today. Their chief concern is to articulate, interrogate, and challenge how the disabled and disability are and should be rhetorically constructed: not solely as a medical condition, or pitiful product of poor parenting, or individual affliction, or educational ineptitude. Rather, they should be constructed as “a more complex social construct, . . . a dynamic set of representations that are deeply embedded in historical and cultural contexts” (Barton 169)—as a socio-political construct for which all are responsible to confront. And, in her contribution, Pendergrass champions a rhetoric that the “disabled themselves will have the greatest part in crafting” (59). The book is an exemplary case of rhetorical, cultural analysis.

Disabilities Studies, Policy, Public Discourse


Brodkin argues that rhetorical training for physician’s assistants—particularly those who work in family medicine clinics—would help bridge the gap between objectivist medical and subjectivist patient-centered care. While rhetorical situations in hospitals tend to be fast paced and difficult to navigate, family clinics are known for long-term rapport with patients, and for prevention education more so than intervention. Because of this, family care providers and PA’s particularly who are trained in rhetorical strategies of communication, could make all the difference in successful patient-centered care in the medical clinic.

Doctoring, HCP-Patient Com, Pedagogy


Although not a rhetorical project, Annemarie Mol’s work in ethnographic sociology has much to offer rhetoricians. Mol argues that theorists should shift their focus away from arguments about epistemological construction and focus instead on the material practices that make up how medicine is done. Her ethnography is not of a hospital, patient, or doctor but rather of a disease—atherosclerosis—and the way various people within various settings enact atherosclerosis. Using methods borrowed from actor network theory and science and technology studies, Mol observes both the discursive and empirical interactions that make up the disease and reports on patterns of operation. This includes a good bit of rhetorical analysis and
linguistic theory. Chapter 6 may be the most useful in this regard. In it, Mol tackles the issue of medical deliberation arguing that, while gathering information and choosing a plan of action, the doctor allows the messiness of practice to remain in the foreground of his thought. Then, once he has made a decision about treatment, the practical nature of science is bracketed, and the diagnosis is thought of as a “fact,” until, that is, something causes the doctor to question his past decision, at which time he retracts his steps and allows doubt to enter the picture once again, in order to test whether there was any place where he might have gone wrong. This is a practical process, but it is also a rhetorical one. Mol describes the criticisms she sometimes receives from doctors, for stubbornly choosing to speak of all medical practice as uncertain rather than certain—she chooses to make a scientific reality visible (or audible) by rhetorically insisting upon it. In this chapter, Mol also critiques the American mentality and rhetoric of “choice” in medical care, arguing that the commercial healthcare system constructs an illusion of choice for patients who are in fact constrained by the options presented to them by advertisers and unable to make fully informed decisions about their health.


Setting out to examine “the interactions of agents and their social contexts” through “structuration theory and activity theory” (65), the authors of this article analyze the transcripts of 16 oral case presentations performed by third year medical students. The (oral) case presentation is both a way for doctors to communicate information about their patients to peers and a teaching genre that allows students to demonstrate and collectively practice their clinical decision-making and problem solving skills. Schryer, Lingard, Spafford, and Garwood see the case study as a medical workplace genre that dialectically mediates between neophyte’s individual agency and their need to become part of the discipline’s social “habitus,” ideologically interpolating them into the system, while also allowing them to gain agency within it. They do this by the following: providing a time/space and structure necessary for students to make and insert choices; facilitating improvisation; offering a wide spectrum of (rhetorical/decision-making) strategies for students to choose from based on their activity.
systems and personal preferences; providing a hybrid location overlapping educational and professional space in which students may establish their authority; and by teaching students to “see the world from the perspective of that genre’s characteristic structure, register and syntax”—a perspective that may help or hinder future communication with patients (91).

Doctoring, Pedagogy, PTWC


In this article, Scott argues that one of the rhetoric of science’s primary goals should be to “map the connections and power relations among science’s heterogeneous actors,” what Vincent Leitch calls “the protocol of entanglement” (qtd. in Blake 355). By “elucidating” such entanglements, Scott suggests that rhetoricians may imbue power to those within socio-political, scientific, and especially medical discourse. In a way, Scott extends the call of Herndl in the rhetoric of science (1993), and Longo in technical writing (2000), to incorporate critical cultural studies into the rhetorical fields of English, and here, of medicine.

Gender, Policy, STS

Scott, J. Blake. *Risky Rhetoric: AIDS and the Cultural Practices of HIV Testing.* Carbondale: Southern Illinois UP, 2003. Print. Using a “rhetorical-cultural approach,” Scott conducts a study of AIDS culture and HIV testing practices, focusing on how various parties—doctors, policy makers, corporations, AIDS patients, “risky” or at-risk patients, and the general public—engaged in deliberation and the practice of healthcare amidst the AIDS epidemic in America. Specifically, he considers problematic constructions of “risk” in AIDS testing materials as they varied across cultural strata. He argues that HIV testing “is a disciplinary diagnostic” that requires active, ethical intervention in order to provide just constructions of power within the AIDS community (9). In addition to its cultural studies approach, Scott’s work is strongly grounded in science and technology studies, giving attention to material and empirical practices, closely examining popular artifacts and providing diagrams of deliberative schemes driving systems of communication.

Policy, PTWC, STS

Responding to a call for more critically and culturally aware studies of technical communication, Zerbe provides a pedagogical model for applying a cultural studies lens to scientific technical communication and/or medical writing courses. First, he offers strategies for persuading students that “medicine operates as a discursively governed cultural institution” (185), such as analyzing the rhetoric of medical debates, referencing current, well known medical research endeavors (his example is the genome project), and pointing to cultural artifacts that clearly convey the meaning/significance culture places on such projects (his example is the film Gattaca). Second, Zerbe provides a research assignment for students that highlights the discursive differences between mainstream and alternative medicine. He asked students in his technical and scientific editing course to compare two different cancer treatment websites: one by the National Cancer Institute and the other by a Chinese based “alternative” medicine group. Students analyzed pages based on four questions: “1. Which of the sites do you find more credible? 2. What specific features of the sites . . . contribute to your conclusion? 3. What other . . . life experiences . . . help you reach this conclusion? 4. What would you do to the sites as a Web editor to boost their credibility?” (191). Zerbe describes his own class’s response to the assignment, modeling how teachers can lead students through the analysis.

Pedagogy, PTWC


In this special issue of JBTC, Barton selects articles that represent the interdisciplinary contributions that TPC is making to medical discourse, exemplifying the theoretical, methodological, and overall research and results being generated at the time. Schryer and Spoel suggest genre theory as an interdisciplinary approach to medical discourse that produces results valuable to those in technical communication as well as medicine. Popham (reviewed below) considers standard office forms as boundary objects between the interdisciplinary workings of medicine, science, and business. Koerber applies critical theory to medical standards of breastfeeding and the rhetorical role of metaphors in bodily discourse. Similarly, Turner offers a critical perspective of the two junctures in genetic medicine, arguing that the representational shifts in gene data, screening and application are crucial sites of inquiry for medical rhetoric. Ryan utilizes a combination of fieldwork and textual analysis to analyze the editorial choices of MAMM magazine, as the editors negotiate
An Annotated Bibliography

medical and popular rhetorics about breast cancer.
Gender, Genre, PTWC


Bates conducts a rhetorical analysis of Senator Bill Frist’s 2001 address to the American Society of Thoracic Surgeons. He argues that the speech constitutes a “medical jeremiad” calling physicians to take up their traditional post as a priestly order in society, with nostalgic appeals to pathos that prophetically interpolate the audience as a “chosen people” (263). Frist invokes physicians’ rights and responsibility, as leading members of society, to take an active role in reforming healthcare, not just as “medical entrepreneurs” but as “involved member[s] of a community” (261). Bates sees Frist’s call as a rhetorical response to the growing negative views in America toward physicians and the biomedical system as a whole and as an attempt to combat this historical suspicion by reconstructing collective physician ethos.

Classical/Canonical Rhetoric, Doctoring, Public Discourse


As an English Ph.D. who has taught medical students for several decades, Montgomery offers a wealth of insight into the epistemological training of physicians. Drawing from Aristotle’s definitions of knowledge, she argues against the myth that medicine is a science, demonstrating instead that it is a science-using practice, or phronesis reasoning, grounded in contextual experience. Her book is a critically informed look at clinical judgment, how it plays out in the various settings and scenarios physicians are faced with on a daily basis, and the ways that socio-cultural expectations of scientific mastery clash with the reality of medical uncertainty. This book is in fact a follow up to her 1991 book Doctor’s Stories, but it is written for an academic and general public rather than for medical practitioners.

Classical/Canonical Rhetoric, Doctoring


This text is part of the Allyn and Bacon Series in Technical Communication, edited by Sam Dragga out of Texas Tech University. The series and Heifferon’s text are meant to “meet the continuing education needs of” PTCs and students at the graduate and undergraduate level (xiii). This volume covers the basics of copyright, document design, HIPAA, and various medical genres such as patient charts, exam records, reports, and educational materials. It also
provides guidelines for carrying out a public health campaign and applying for grants. Finally, it ends with an entire section considering the ramifications of multicultural and international communication, visual communication, and electronic medical writing.

Genre, PTWC


Stephen Pender’s 2005 article in *Early Science and Medicine* traces the classical association between medicine and symboleutic rhetoric, from Ancient Greek through early modern England. As the philosopher Cabanis pointed out in the eighteenth century, both rhetoricians and doctors must come to decisions by constructing universal conclusions from a few subjective and uncertain reports—an impossible task. Also, both practitioners are “pragmatic interventionists” in society. Pender argues, with Cabanis, that “rhetorised logic” can offer clinicians in our highly scientized world models of reasoning which would balance the general with the particular in order to offer “practical intervention devoted . . . comfort, or cure” (39, 41).

Classical/Canonical Rhetoric, Doctoring, History


Starting from the understanding that medicine is an interdisciplinary practice, Popham considers the ways that patient forms constitute boundary objects or boundary genres between medicine, business, and science. Specifically, she considers the patient examination form, patient visit form, diagnosis form, insurance form, and the billing claim. She looks for rhetorical patterns that reveal the constructed nature of particular fields sharing the genre. By analyzing examples of reflexion, translation, and distillation in this genre ecology, Popham identifies key tensions between business, medicine, and science, which in turn help us better understand conflicts between these fields in the world at large.

Genre, PTWC


Preda conducts a rhetorical analysis of medical journal articles on Acquired Immunodeficiency Syndrome from 1981 to 1989 published in the top five prestigious journals, which have been involved in the conversation from the first year of the virus’ emergence until now. Preda investigates how rhetorical metaphors and narratives of “risk” relate to scientific hypotheses about transmission and infection of AIDS, and, in turn, how these rhetorical patterns effect research funding, prevention, and advocacy. Preda relies heavily on
the rhetoric of science, actor network theory, and speech act theory to conduct his analysis.
Gender, Medical Research, Policy


Segal builds on classical rhetorical theory, Burke, and Foucault in order to conduct her investigation of the persuasive elements of clinical and public medical discourse. After providing a genealogy of medical rhetoric in the introduction, Segal uses chapter 1 to "re-re-present" the recent history of medicine (1800-present) in light of kairotic, rhetorical shifts (17). Chapter 2 considers the physician's construction of a patient with invisible pain symptoms vs. perceptible ones and how these differences impact the doctor-patient interaction, treatment, and outcomes. Chapter 3 argues that illness narratives or pathology publication rhetoric is epideictic and outlines several tropes that define the values of this genre. Chapter 4 uses Burke's Grammar of Motives to analyze the persuasive components of hypochondria. Chapter 5 describes the difficulties that arise from the incommensurable narratives of death held by doctors on the one hand (death as failure) and patients on the other (death-as-part-of-life). Chapter 6 elaborates on Segal's 1997 article about medical metaphors (health-diagnosis, medicine-war, body-machines, medicine-business, person-genes) and how they shape/constrain healthcare discourse and policy. Chapter 7 considers the imperative of ethos construction on the part of physicians in order to successfully persuade patients regarding treatment decisions. Segal concludes with an argument for what rhetoric has to offer medical practice, that is, insight into everyday success and failure of healthcare endeavors.

Classical/Canonical Rhetoric, HCP-Patient Com, Public Discourse


Award-winning and highly acclaimed doctor, literature PhD, and professor at Columbia University College of Physicians and Surgeons, Rita Charon has played an instrumental role in founding, theorizing, and professionalizing narrative medicine as a clinical field. In this, one of her landmark works, Charon outlines the theoretical basis for narrative medicine and its practice based on its roots in "literary studies, narrative theory, general internal medicine, and bioethics" (x). The book is a primer for those coming into the field and a manual for those teaching the subject, particularly in medical contexts. She
offers four types of divides between patients and health care professionals, five narrative features of medicine, five close reading strategies, and three movements of narrative medicine: attention, representation, and affiliation. “A clinical cousin of literature-and-medicine and a literary cousin of relationship-centered care, narrative medicine provides health care professionals with practical wisdom in comprehending what patients endure in illness and what they themselves undergo in the care of the sick” (vii). The book is broken up into four parts: 1) “What is Narrative Medicine?” a theoretical and practical introduction; 2) “Narratives of Illness,” considering our own and others’ stories of life and the body; 3) “Developing Narrative Competence,” which covers reading strategies, movements and pedagogical practices; and 4) “Dividends of Narrative Medicine,” which looks at the ways that the field impacts patient care, bioethics, and the future of health care.


This article in JMH discusses the use of metaphors in medical immunological journals disputing breastfeeding as a source of infant immunity to disease. Although popular “lore” among women said that breastfeeding was beneficial to the baby, and although these assertions were backed by certain nineteenth-century medical studies, it was not until one particular scientist, Lars Hanson, translated these theories into the dominant medical discourse of the twentieth century that the idea became accepted. The major factor involved in this translation was a metaphor: scientists believed immunity was carried through blood (only). So, Hanson chose to describe the bios carrying the immunity to the baby as “gamma-globulins of milk” to imply a relationship between blood and breast milk that would seem intuitive to readers. Koerber takes a science studies approach to this case, performing a mixture of textual analysis; political, historical, and cultural research; and employing Latour and Woolgar’s theory of networks, as well as feminist theories of knowledge and social values.


Scott analyzes the outcomes of Project BioShield—pharmaceutical companies’ partnership with the government to produce a biodefense industry—in order to propose a new conceptualization of kairos. Modernist conceptions of kairos, which assume rhetoric’s agentive control of risk,
are inaccurate and incomplete. Such models do not take into account the “cultural-political dynamics . . . rearticulations and unintended, undesired effects” that can transpire when one seizes the “opportune moment” (116). Invoking Carolyn Miller’s concept of agency and the “contagion” metaphor of rhetoric, Scott offers a postmodern concept of kairos that recognizes “the interdependency and distribution of rhetorical agency” which, instead of seeking to avoid or insure against risk, finds ways to adjust and mutate in response to it (136).


Situated in cultural studies, medical history, and literature, Keller performs close readings of vernacular medical literature from the seventeenth century, side-by-side with historical and political scholarship of the time. In doing so, she considers how medical “knowledge” of the female body has impacted the agency of women and their place in society. Chapters 4 and 5 in particular examine the birth of modern obstetrics and embryology, interrogating how patriarchy impacted the formulation of subjects in these fields. Keller invokes Latour in her claim that the inscription of the early modern body is a “matter of concern” that has impacted the formation of the modern, liberal, gendered subject (18).


In this article, Keränen analyzes “the dense tangle of legal, ethical, spiritual, and communicative tensions that typify code status determination,” in order to investigate “the present state of death and dying in American hospitals” (180). To do this, she examines a “Patients’ Preferences Worksheet”—an end-of-life decision-making form at a large, urban, acute care facility—and how it is used through extensive observations and interviews there. Her results reveal that the mixture of vernacular, technical, and intuitional rhetorics composing end-of-life genres create “the illusion of choice amidst a prescribed array of technological interventions which often, in the final moments of life, come to be viewed by participants as unduly sustaining corporeal presence” in “heartrending” ways. Ultimately she finds that the inhuman rhetoric of the worksheet has the potential to either curtail patient autonomy or to promote a humane end of life. Either way, we must continue in the process of what John Lyne calls “moralizing the life sciences” through our rhetorical construction of death and dying (202).

After writing her 1998 argument for rhetorical education in medical schools, Lingard went on to become a professor of medical communication at the University of Toronto. In this article, Lingard presents a critical reflection of her rhetorical teaching practices working with medical students, identifying strengths and weaknesses of the approach. She and her associates found that the rhetorical lens was most effective for teaching standardized professional genres of communication, for highlighting the social nature of clinical teamwork, and for making pedagogical connections between “communication patterns and patient safety” (124) (see Whyte 2009). On the other hand, difficulties that Lingard and her associates are still trying to bridge into their rhetorical training of medical students include “the material dimensions of communication,” the distributed nature of medical team education, and the difficulty of measuring rhetorical outcomes for institutional purposes. Lingard is now a professor at the Department of Medicine University of Western Ontario (UWO).


Birthed out of TCQ’s 2000 special issue on medical rhetoric, this collection lays the foundation for a corpus of research for the field, as it is the first edited collection specifically dedicated to the rhetoric of healthcare. Contributors include major scholars such as Judy Z. Segal, Michael Zerbe and Rhetoric of Science scholar Steven B. Katz, all of whom explore “a multitude of complex information systems and our place within those systems” considering healthcare to be “both a rewarding site for rhetorical investigation and an opportunity to enhance medical practice” (2). Indeed, many of the articles contribute knowledge, not only to rhetoric but also to fields of medical practice.


Ariail and Smith (chapter 13) offer pedagogical perspectives gleaned from research they conducted as associate writing professors of a program “funded by and housed within a freestanding medical university” (243). The authors work with faculty to develop composition pedagogy, presentations, workshops, and a writing
center (243). Their chapter focuses largely on the importance of helping students develop an interpersonal relationship with their instructors. This relationship in turn enables instructors to more clearly explain the purpose and exigence of various healthcare genres to which novices in the field have not yet been exposed. Ariail and Smith argue for a writing pedagogy of “helping” which emphasizes relationship building and partnering with students to achieve their goals. Their work is a perfect example of the types of interdisciplinary opportunities rhetoricians and professional communicators are being offered in the academic setting.

Pedagogy, PTWC


Out of the traditional tripartite of medicine—diagnosis, treatment, prognosis—prognosis remains the most resistant to scientific control. Barton and Marback (chapter 1) explain why prognosis is also the most intrinsically rhetorical in nature, because the physician must persuade the patient both of the prognosis’ accuracy and to accept the physician’s suggestion for treatment. At the end of life, a “poor” prognosis often calls for the withdrawal of treatment; however, physicians must also try to maintain a rhetoric of hope for the patient, as they persuade them to come off of life support. Barton and Marback analyze end-of-life consultations, sketching out the genre’s attributes and the way that hope operates within the four phases of the genre. In a successful consultation, physicians persuade patients to translate their hope into agentive decisions about end-of-life care. In a failed consultation, patients continue to cling to a hope for a future of life, without moving forward in a decision-making process. It is in these failed attempts at persuasion that “the rhetorical exigencies of modern medical prognosis are most dramatically exposed” (22).

Doctoring, Genre, HCP-Patient Com


Bernick, Bernhardt, and Cuppan (chapter 6) draw from their many years experience as writers in the pharmaceutical industry to describe the way authors navigate complex rhetorical audiences, purposes, and composition constraints in their development of the Clinical Study Report (CSR). The authors walk readers through the whole process of clinical tests and FDA approval, highlighting the rhetorical difficulties inherent in this crucially persuasive document written by multiple teams of authors, over a long span of time, with strict
regulatory oversight. The study is a helpful guide for anyone writing for the sciences, or studying PTWC.

Genre, Pharmacy, PTWC


Jane Detweiler (chapter 12) provides a narrative description of one new Occupational Therapy program’s efforts to compose a Doctoral program with few other models to choose from. Like many budding healthcare fields trying to establish a professional identity and expert-level training, the program had to grapple with what they wanted their students to be equipped for, and how they could construct writing activities that would encourage and measure those outcomes. Questions about differing levels of expertise, pedagogical philosophy, and academic leanings all played a part in the team’s efforts to “design a Doctorate.” Pedagogy, PTWC


Dinolfo (chapter 10) provides a media-rich analysis of the benefits, strategies, and purposes of medical videography. His survey, based on many years as a professional medical videographer, demonstrates how this form of composition is used to teach, train, engage and inform healthcare professionals and patients alike in the academic and popular world. As a workplace genre, medical videos have the ability to model challenging rhetorical situations, to immerse viewers in clinical learning situations and lived clinical experiences, to make visible the invisible physical world, and to provide access to complex skill training. Videos are also used by continuing education programs to engage HCPs in the medical discourse community and in the latest conversations about effective clinical care. Videography also benefits patients by providing an educated interlocutor “who bridges the gap between clinician and patient” more effectively than is possible in many clinical settings (193).

Genre, HCP-Patient Com, PTWC

Emmons, Kimberly. “‘All on the List’: Uptake in Talk About Depression.” Heifferon and Brown 159—80.

Based on interviews and textual analysis of commercial pharmaceutical websites, Emmons argues that direct-to-consumer advertising for depression drugs has been largely successful through their combination of two already grounded genres: the women’s popular magazine quiz and the DSM medical checklist (DSM stands for Diagnostics and Statistical Manual of Mental Disorders). By linking the two genres, pharmaceutical companies
successfully target women consumers, persuading them to identify themselves as gendered victims of a disease (depression) and to ask their doctors about the advertised drug.

Heifferon, Barbara A. “Pandemics or Pandemonium: Preparing for Avian Flu.” Heifferon and Brown 51—76.

Heifferon (chapter 3) considers a Center for Disease Control (CDC) podcast about ethical community planning for pandemics, in order to identify rhetorical strategies for promoting compliance (or adherence) in community members with varying beliefs and values. Specifically, she promotes Harvey Kayman’s model for community deliberation in the midst of crisis, which trains various community leaders and news media personnel in advance to use logos-centered rhetoric to maximize effective action and minimize pathos-driven chaos. Heifferon also makes an argument for how rhetoricians can contribute to public health decisions, recognizing that the ongoing changes regarding our nation’s health-care system offer increasing opportunities for communicators specializing in policy, business, and legal writing, as well as medical rhetoric.

Martins, David S. “Diabetes Management, the Complexities of Embodiment and Rhetorical Analysis.” Heifferon and Brown 75—90.

Martins (chapter 4) works from a patient-centered perspective to analyze the effectiveness of Diabetes education and management. Drawing from a broad range of rhetorical theory, he proposes an embodiment model which takes into account the daily habits, ideologies, and values of individual patients in an effort to understand and tailor information and technology literacy education to patients’ specific needs and existing literacy skills.


Mebust and Katz provide a textual analysis of educational literature created for genetics counselors, focusing on the complex and often conflicting social and epistemic roles such counselors are expected to play, and the difficulty this poses to communication. The pamphlets reflect these complexities, asking counselors to act as both “objective” advisors to patients in their decision-making process, as well as compassionate, psychological counselors to families struggling to process difficult information about their potential future. Mebust and Katz demonstrate the way that medical communication is often complicated by healthcare professionals’ multi-layered social roles, and the difficulties this poses to their
rhetorical choices and professional relationships.

Doctoring, HCP-Patient Com, PTWC


Writing from a workplace communication standpoint, Susan Popham (chapter 7) studies business letters written from a medical office to insurance companies, requesting patient coverage. Popham demonstrates how rhetorical purposes are often achieved primarily through knowledge of workplace culture, and not necessarily because of traditional, “strong writing skills.” Although the letters demanding coverage for children and cancer patients propounded with obvious grammatical errors and are rarely “clear” in their style, the writer was nonetheless able to secure funds necessary for her patients, based on rhetorical leverage defined by the particular communication practices within her industry.

Genre, PTWC


Reynolds (chapter 8) meditates on the fragile epistemological nature of “The Rhetoric of Mental Health Care,” highlighting the problems that come with attempting to define and scientize socially constructed categories of behavior. Providing some history regarding the spread of mental “diseases” over the last century, Reynolds questions the rhetorical assumptions often propagated by psychiatric medicine. He argues that the categories created by National Institute of Mental Health do not constitute truths but rather help construct truths for social, business, research, and professional purposes.

Medical Research, Policy, Public Discourse

Segal, Judy Z. “Female Sexual Dysfunction’ and a Rhetoric of Values.” Heifferon and Brown 33—50.

Segal (chapter 2) provides a clinical, cultural, and popular analysis of epideictic values embedded in the rhetoric of female sexual dysfunction. Seeking places of intervention, Segal asks, “what are the contemporary commonplaces of goodness and pleasure” which shape our judgments of women and female sexuality as honorable or dishonorable (35)? She finds that, in medical discourse, a woman is more valued when her particular complaints “cleave to the model” physicians are familiar with, and when her complaint is more about a dysfunction than about desiring to gain pleasure for its own sake. Similarly, in public discourse, motives are important to sexual dysfunction and moral weight is attached to the woman’s desire for pleasure. A woman should be seeking
to support her social connection before seeking to please herself. In literary discourse, more possibilities stand open for questioning what pleasure is and how it should be attained. Segal also discusses the implications of the trend for young girls to offer oral sex; she wonders whether their choice not to receive pleasure is a form of agentive empowerment or yet another form of female performance expectation.

Classical/Canonical Rhet, Gender, Public Discourse


Zerbe (chapter 11) investigates whether or not medical journal research reflects healthcare’s growing emphasis on patient-centered care and holistic medicine. To do this, Zerbe surveyed hundreds of IMRAD (Introduction, Methods, Results, and Discussion) articles published in two top-tier medical journals between 1983 and 2004. Specifically, he compared three, 3-year spans of articles in The Journal of the National Cancer Institute (JNCI) and the Journal of Clinical Oncology (JCO) to see if research questions in the field have changed over time. His data shows that more and more, journals are including IMRAD studies which “consider human beings as a whole, rather than solely a disease that happens to be carried by a human being”—studies which consider factors such as quality of life, the impact of disease on extended family, perceptions and attitudes toward disease, doctor-patient communication, effective information dissemination, and cost-benefit analysis (207). These results seem to imply that empirical studies have grown to include more holistic, patient-centered inquiries into health and wellness.

Genre, History, Medical Research


Hyde provides a careful examination of the philosophy of conscience based on Heidegger’s and Levinas’s respective interpretations of how we hear our conscious and how we should then act on it: “The act of listening is as important to the truth of conscience as is its own evocative voice; the call of conscience is consummated only in the hearing and the understanding for what it has to say” (8). According to Heidegger, the call is grounded in the realization of “the temporality of Being” and the self’s drive to become better. Levinas, by contrast, is more aware of the call as is it comes through the face of the other, and our awareness of a being “otherwise than Being: God” (8). Both views, says Hyde, are important for “understanding who and how we are as human beings inhabiting a world” (10). Hyde applies
these theories, and those of classical rhetoric, to a close reading of public discourse surrounding the euthanasia debate. He provides rhetorical analysis of personal stories as well as specific, historic examples—such as the 1988 JAMA publication, “It’s Over, Debbie,” which sparked vehement controversy. Essentially, Hyde actively engages in a current, deliberative rhetoric. To do so, he employs critical analysis and ethical philosophy to persuade his audience to respond to the call of its own conscience and to the call of those suffering. The discussion is framed by Hyde’s own story of his father’s death and concludes by imagining a better ending for his father’s life. Hyde also discusses these issues in articles published for the Quarterly Journal of Speech 79 (1993) and for the special issue of the Journal of Medical Humanities 22.1 (2001).

Classical/Canonical Rhetoric, Ethics, Public Discourse


The collection provides a helpful overview of the field of narrative health as it has developed over the past two decades and of its current areas of inquiry. According to Arthur W. Frank, the growth of biomedicine and technoscience has led to an “increasing separation of health from illness, bringing about a new species of health stories,” which he differentiates from illness stories (xi). The patient is constantly bombarded with stories of what health and the body should and shouldn’t be, and must choose which stories will become his or her own. The stories that become most accepted by society constitute a “pedagogy”; this pedagogy teaches people what they ought to want, expect, do, and be in their bodies. The rather extensive collection is broken into four sections. Part 1 provides an “Overview of Narrative and Health Communication Theorizing,” which can serve as an excellent introduction to the field. Part 2 looks at “Personal Narratives and Public Dialogues.” Part 3 has a professional communication focus, as it considers “Narrating and Organizing Health Care Events and Resources.” The final section, Part 4, regards “Narrative Sense-Making About Self and Other.” The collection considers everything from the ethos of Biomedically Invisible Illness (BII) patients (Japp and Japp) and “safe sex” in India (Singhal, Chitnis, Sengupta) to workplace education (Ragan, Mindt, Wittenberg-Lyles) and alternative medicine (Sharf).

Doctoring, Narrative, PTWC

This article might be called a specimen of modern forensic rhetoric; it investigates the controversy surrounding a 2005 study by Wong et al. published in *The New England Journal of Medicine* regarding the timing of epidurals during labor. Koerber, Arnett and Cumbie evaluate public allegations made against the Wong et al. as well as the media, of purposefully misrepresenting the study's research data to the public. In particular, a notable Canadian physician named Dr. M.C. Klien published several articles arguing that the research methods and composition practices of Wong et al. “failed to meet their ethical obligation to facilitate public understanding for their research findings” (366). Koerber, Arnett, and Cumbie find that, although the media did play a role in distorting the message of the journal article (a practice often decried by the public), Dr. Klein’s allegations, that the very design and presentation of the study were misleading, may have been correct. Thus, not only the media, but researchers themselves are accountable for how the public perceives scientific knowledge. Koerber, Arnett, and Cumbie employ Habermas’s concept of the ideal speech situation to “expose the ways in which scientific or medical research can be designed and reported from the beginning to either foster or hinder accurate media coverage and, as such, to either facilitate or preclude public debate and understanding of complex issues” (386).

**Ethics, Medical Research, Public Discourse**


This issue of *TCQ* acknowledges the growing need and opportunity for technical and professional communicators to partner with research healthcare communication as it expands electronically. The articles represent three ways in which TPCs can do this. First, TPCs can apply traditional rhetorical analysis to online health communities; this is exemplified by Spoel, who considers two Canadian midwifery websites. Second, TPCs can offer their skills as subject-matter experts to better construct materials for various online audiences; Tomlin argues that since 1997, PWs in the pharmaceutical industry have transformed from “medical writers” to “communication specialists” as they better articulate complex rhetorical purposes for drug companies. Similarly, Willerton describes the rhetorical process of composing expert subject-matter material for online health sites like WebMD®. Finally, according to Koerber, TPCs can partner with interdisciplinary teams researching and developing healthcare materials as subject-matter experts in communication. Dim, Young, Neimeyer,
Baker, and Barfield model this process by reporting on their involvement in work at St. Jude’s Research Hospital to develop handheld informed-consent technologies, and how they worked to resolve usability, communications, and ethical dilemmas innate to the device meant for parents of child cancer patients. Mirel, Barton, and Ackerman, in turn, report on their development research in telemedical technologies, which they conducted with a team of health-care professionals to improve both the interface itself, as well as the research design. They suggest that TPCs consider modifying their research methodology and practices in order to contribute to interdisciplinary fields like medicine in a way that will be acknowledged.

Classical/Canonical Rhet, Medical Research, PTWC


Rundbald conducts an award winning quantitative analysis of nine medical research articles’ methods sections to determine the rhetorical uses of passive voice and metonymy, comparing her results to norms in other scientific genres. Results show polarized author representation, being either completely visible or completely hidden, with visible authors being active, and hidden authors being passive through possessive/causative metonyms. Participants in the studies, although faceless and genderless, are nevertheless portrayed as active, while researchers referenced outside of the study are completely dehumanized as “recent audits and systems” so that “the degree of impersonalization is greater for the nonauthorial professionals than for the authors” (272—73). Representational/locative metonyms also serve as a rhetorical “socialization” strategy, “confirm[ing] group membership by exhibiting their associations with research and health organizations” (273). This article won the 2007 NCTE Award for Best Article Reporting Qualitative or Quantitative Research in Technical or Scientific Communication.

Classical/Canonical Rhet, Genre, Medical Research


Bennett takes a close look at the history of and rhetoric surrounding the ongoing FDA ban which prohibits queer men from donating blood, excluding them from a meaningful and much needed performance of civic identity. Bennett exposes the public, scientific, and political rhetorics sustaining the ban; the economic and phobic motives driving them; and how queer men have responded

Using the recent shift in professional medical opinions about fibromyalgia (FM) as a case study, Graham explores how change occurs within the “often strict and authoritarian structures of Western biomedicine” (378). Constructing what he calls “an object-centered agency narrative,” Graham demonstrates how new PET brain scanning and the images it produced were key to shifting perceptions of FM and may even have been instrumental in the FDA’s approval of the drug Lyrica as a form of FM treatment. PET, as a black box, gained quick legitimating through its coordination with previously legitimized technologies like X-rays (387-88). Additionally, the cartography metaphor as an epistemological concept was already familiar and accepted by the biomedical community when PET appeared (389). From a rhetorical standpoint, the medical community was so frustrated with the epistemological uncertainty of FM that “any data, no matter how preliminary or problematic, [were] likely to be greeted with enthusiasm” (393). Connections like these led to a quick acceptance of PET evidence of FM, which in turn allowed the FDA to recognize and legitimize the ontological existence of
FM with their approval of Lyrica.
Medical Research, Policy, STS


Although no special introduction is given to this issue, perhaps because there were no guest editors, Written Communication dedicated one of their twenty-fifth anniversary issues to “Writing and Medicine.” At the start of the year, the journal planned to print only three articles and a review piece; however, when the special issue was released in July—later than expected—there were in fact six rigorous research articles (see “Editor’s Introduction” to Written Communication 26.1 (Jan 2009)); a testament to the field’s productivity.

PTWC


In this study, the authors conduct qualitative and quantitative analyses of 22 instances in which physicians offer patients the chance to participate in clinical trials. The 22 encounters were selected as a representative sample out of a database consisting of 42 video-taped encounters. The researchers’ goal was to survey how physicians rhetorically couched these offers, and whether their framing of the offers were ethical or not. Their results showed that the physicians in their study regularly mentioned purpose, benefits, and risks of the trial to patients (>85% of the time). Secondly, physicians regularly presented purposes, benefits and risks with a “positive valence”—that is, in positive rhetorical terms (≥60% of the time). And lastly, physicians’ positive valencing was “often in terms of clinical care of the individual patient (≥78% of the time), via either implied direct benefits or minimized side effects” (310). Evaluating these results, Barton and Eggly found that doctor’s positive valencing was motivated by the “best-option principle”: the belief that individual patients really will benefit most from the trial intervention. This belief is reflected in their rhetoric. However, doctors ethically balance their positive rhetorical valance of the trial’s benefits with a more neutral rhetorical valance when describing the general purpose of the test (to find out if and how it is beneficial or harmful to patients).

Ethics, Genre, HCP-Patient Com


Newman examines medical texts, illustrations, and photographs of medical writers at a time when “the elocutionists were reviving delivery for their rhetorical pursuits” and “medical
researchers and practitioners were shifting their efforts from dissecting lifeless cadavers to observing living bodies” (275). These two moves prompted medical writers to develop a vocabulary which allowed them to capture the motions and movements they were observing. The results of these rhetorical developments are what Newman calls “gestural enthymemes”: visual arguments that employ a kinetic movement of ideas, a form of pictorial delivery which parallels linguistic style. Particularly, she identifies three patterns of enthymematic arguments: climax, anadiplosis, and catacomgesis. She then considers the way that these devices were translated from medical drawings into the age of medical photography, examining the relationship of rhetoric and technology to the past and present. 

Owens, Kim Hensley. “Confronting Rhetorical Disability: A Critical Analysis of Women’s Birth Plans.” Hass 247—72. Owens argues that birth plans (unofficial, advanced directives about what women do and don’t want to happen during their hospital birth) are women’s attempt to rectify or compensate for the (perceived?) “rhetorical disability” that comes during childbirth—a condition induced by their physical and authoritative lack of power largely supplanted by/ relinquished to technological expertise. Based on surveys, five birth plans, and over 100 online birth narratives from five different parenting Web sites, Owens concludes that, while birth plans do not necessarily “enable women to resist particular interventions, control their births, or overcome rhetorical disability,” they nevertheless holds value as an educational catalyst for mothers, who “write themselves into birth” and “into particular understandings of their relation to knowledge medicine and society” (268). 


This team of researchers analyzed 72 forensic letters by physicians responsible for identifying and describing potential instances of child abuse. The rhetorical situation is complex, however, because of the legal ramification innate to the “expert witness,” a figure being challenged in the time and place of this study. Through analyzing the letters and interviewing both writers and readers of the letters, Schreyer et al. found that specific adjectives and adverbs were used strategically by writers, to “allow for a range of interpretations and [to constrain] those interpretations at the same time” (215). These strategies also allowed physicians to rhetorically navigate dangerous legal waters.

Teston conducts an elaborate analysis of how Standard of Care documents (national guidelines intended to standardize treatment of each known cancer) rhetorically and materially impact medical deliberation and decision making in the face of uncertainty. Teston observed Tumor Board meetings where treatment decisions are discussed and undertook textual analysis of complex, online Standard of Care documents. In doing so, she finds that although the documents have authoritative purpose, they do not explicitly link patients’ individual experiences to expectations for physician intervention. She also proposes an updated model of Toulminian analysis which takes into account the non-linguistic rhetorical appeals so fundamental to digital texts, investigating the relationship between claim and evidence in these documents and their role in structuring activity group genres.


Sarah Whyte et al. report findings from a study in which they used the Burkean dramatistic method to analyze the rhetorical successes and failures of 756 preoperative surgery debriefings. By considering the motives, attitudes, and behaviors of the HCP’s conducting the surgeries (surgeons, physician’s assistants, nurses, technicians, etc.), researchers were able to map the relationship between the perceived purposes and goals of the participants, and the participants’ perceived success of the debriefings. Researchers were also attentive to how the practitioners adapted to change in the operating room during surgery when events did not transpire according to plans, necessitating new biomedical action. The research was headed by Lorelei Lingard, a professor in medical communication who argues for rhetorical training of medical students. This study demonstrates that verbal rhetorical communication plays an essential role, not only in personal or humanitarian practice of medicine, but also in the clinical out-workings of the science of medicine and what it considers “medical knowledge.”


Recently published in its third edition, this text is essential to those interested in disabilities healthcare. Grounded
in critical and cultural studies, the collection includes perspectives from a wide variety of fields, including history, sociology, anthropology, gender and race studies, art, and literature. Originally published in 1997, each edition has added further landmark essays in the field, so as to constitute a now 656 page anthology used in many different graduate programs. This edition is broken up into seven sections: Part I: Historical Perspectives, Part II: the Politics of Disability, Part III: Stigma and Illness, Part IV: Theorizing Disability, Part V: Identities and Intersectionalities, Part VI: Disability and Culture, Part VII: Fiction, Memoir, and Poetry. For those studying medical rhetoric, the essays follow several themes of interest. Susan Sontag and Georgina Kleege deal with the role of metaphor in constructing disabled subjectivities. Douglas Baynton looks at the nineteenth century debates about the validity of American Sign Language vs. oral education literacy. James C. Wilson considers the disabled body as a flawed edition of a genetic text. Simi Linton specifically considers the role of language in oppressing people with disabilities. David Michelle and Sharon Snyder, as well as Thomas Couser analyze the role of narrative in shaping the disabled life. Many authors investigate complex visual rhetorics, such as the rhetoric of prosthetics (Gillingham, Mullins, Barney and Smith), photographic rhetorics (David Hevey), and the rhetoric of “beholding” (Rosemarie Garland-Thomson). These are just a few examples of selections that would be of use to medical rhetoricians.

Disabilities Studies, Narrative, Public Discourse


This study, written for a medical audience, considers the importance of patient transfer: “Handoff communication is best understood as a dialogue between health professionals—an interaction that fosters empathy, equity, and common ground, in addition to transferring necessary information” (181). Handoffs can occur from physician to physicians, between teams of HCPs, and between or within services and specialties. In each instance, the length and content of the handoff communication will vary. For example, the authors studied transfers from emergency physicians to hospitalists, looking for the variables which determine appropriate types of handoff communication. While emergency physicians are usually attuned to “acute interventions and admission criteria,” internists are usually looking for broader patient information, a difference which can make the handoff more difficult.
In order to strike a balance, the researchers suggest ongoing strategies which individual teams can use to develop safer and more efficient transitions. The authors promote interdisciplinary research teams with both academic and clinical doctors working together, suggest particular tools of analysis provided by other emergency medicine researchers, and encourage emergency medicine to lead the process of developing “well-designed tools, procedures, and communication” which will improve handoffs for all HCPs (182).


While most research about online health advice critiques the rhetor’s (lack of) credibility, Segal considers “all parts of the rhetorical triangle,” taking into account the audience and complex subject matter of Internet health communication. Her article provides a thorough review of the literature on Internet health to date, a rhetorical view of the situation, and suggestions about where research and scholarship need to go. In particular, she argues that current research “isolates the use of health-information Web sites from the contexts of that use—from, for example, personal contexts . . . contexts of health and medicine . . . and cultural contexts” and suggest that rhetoricians are particularly equipped to study these complexities in concert (365).


Keränen’s book is a study of the rhetoric surrounding the 1990s “NSABP Datagate” scandal, in which it was discovered that a highly influential breast cancer researcher had falsified data, impacting the life and death treatment of hundreds of thousands of women. Keränen particularly focuses on the construction of character in these debates and how the perceived characters of researchers impacts the collective character of science and biomedicine: “I demonstrate how various participants in science-based controversies . . . make sense of scientific claims based on whom and what they find trustworthy, and how rhetorical processes can foster or undermine trust and thereby shape scientific institutions and practices” (3). Theoretically, Keränen suggests that character can be detailed in three parts: ethos, persona, and voice. She uses this method to track the competing characters concocted by the public and assigned to people involved with Datagate.

From ethnographic data collected while observing the Midwestern Pain Group (MPG), Graham and Herndl use Foucault’s enunciative analysis to describe the “disciplinary inculcation and practitioners’ experience in the highly regulated practice of pain management” (149). Although the theories and practices defining the group are highly rigid and resistant to change, the authors argue that classical stases theory has the ability to extend Foucault’s model by “mak[ing] visible both the means and the obstacles to discursive transformations . . . allow[ing] us to understand some of the concrete and messy rhetorical work of invention involved in attempting to change a discursive formation” (164). Using Prelli’s matrix of higher and lower stases, Graham and Herndl identify three points of stasis which have allowed the interdisciplinary MPG to recognize and discuss the changes they want to take place in current pain discourse and treatment.

**Classical/Canonical Rhetoric, Doctoring, STS**


Leach and Dysart-Gale offer the rhetorical question as a tool for analyzing the “duel functions of rhetorical criticism”: to “prob[e] the terms of belief systems” and to “examin[e] the functions of discourse and the formal resonances and mismatches that produce rhetorical effects” (2). Their edited collection rhetorically questions two commonplace and unchallenged social assumptions about health and medicine. The first is the assumption that good health care relies on scientific evidence. The second regards particular self-imagined subjectivities which medicine asks people to take on in their relationship to health services—identities which pave the way for specific medical arguments. The authors use the example of “at risk” populations to illustrate this second commonplace. Leach and Dysart-Gale identify and describe eight different classifications of rhetorical question: erotema, anacoenosis, anthypophora, dianoea, aporia, psyna, ratiocination, epiplexis, exuscitatio. They suggest that these questions provide rhetorical structure to various health-related genres (such as IMRAD research), and that by analyzing the use of questions we can better understand the work of medical inquiry, the construction of medical knowledge, how it travels, and how it has transformed in recent years. The ultimate goal of the collection is to use rhetorical theory to investigate “the ways in which pressing questions”
in health and medicine “are posed, debated and answered” (7). Classical Rhetoric, Medical Research, Public Discourse


Cwiartka investigates the relationship between material laboratory practices, textual reports, and narrative rhetoric, specifically surrounding experiments with mice. Scientists use “knockout mice” to research what happens when particular genetic material is removed or modified in a mammal. Often, data about mice and humans are woven together in reified (oversimplified) stories, in order to tell a deterministic tale about the power of genes over human behavior. Rather than simply argue against this premise, Cwiartka considers the specific constraints which make knockout mice experiments necessary and productive, as well as how data produced in said experiments is rhetorically presented for persuasive means. She also suggests ways for improving the material and composition practices of research so as to allow for well-interpreted results. Cwiartka develops an “action-attention-language triad model” of analysis which considers both the phenomenological and material aspects of laboratory work. The model holds much potential for future scientific rhetorical analysis, since it connects linguistics, rhetorical situation, and material practice in one, broader rhetorical triangle. The triad considers everything from spatio-temporal constraints of research, to “attention cognition,” and the process of rhetorically reifying data into “facts” over time through language. While much rhetorical analysis is focused on the subjective/phenomenological, Cwiartka’s model places a strong focus on “doability”—the pragmatic process of narrowing experimental focus, material interaction, practical judgment, identification, re-identification, and interpretation. Medical Research, STS


Derkatch provides a detailed analysis of why standard biomedical research methods prove incompatible with complementary and alternative medicine (CAM), such as chiropractic and acupuncture therapy. CAM interventions qualify as, what the UK Medical Research Council calls, complex interventions in health care. Complex medical interventions “comprise a number of separate elements which seem essential to the proper functioning of the intervention although the ‘active ingredient’ of the intervention that is effective is difficult to specify” (130). Such interventions rely heavily on communication practices with the patient, as well as complex physical treatments. As such,
complex CAM interventions do not easily fit the three tenets of traditional clinical trial research primarily used to test drugs: a clear definition, control of outside factors, and standardized intervention (132). The personalized communication and treatment of CAM interventions are hard to control, and developing a placebo is also impractical when researchers are not working with a specifically defined “active ingredient.” Therefore, “CAM consequently sponsors a model of health care at odds with both the rhetorical conditions governing clinical practice and the guiding philosophies of CAM practices themselves” (131). Derkatch provides an excellent history of evidence based medicine (EBM) and patient centered care’s (PCC) development and their impact on research trends. She suggests that, although EBM’s research models do not fit CAM’s purposes, CAM has successfully used randomized control clinical trials to bring more discussion and attention to CAM, and to question the epistemology governing biomedicine. Additionally, she argues that PCC has not and cannot be adapted to the biomedical model of enacted practice, as proponents claim that it can.

Dysart-Gale provides a historical survey of children’s literature about death and dying from the 17th century to the end of the 20th century. Her purpose is to identify the rhetorical strategies and cultural values embedded in these texts. These, in turn, reveal adults’ understandings of death and what they consider necessary information for coping with it at various points in history. She finds that books are heavily shaped by any given epoch’s epidemiological and medical state (156). In the seventeenth century, when infant mortality was high and one in four children died before the age of ten, texts like Janeway and Mather’s A Token for Children are focused on preparing children spiritually to face death with faith and courage, that they may be received into heaven according to Calvinist values. In the eighteenth century and even early twentieth century, books are more concerned with preparing and comforting those who survive the death of a child. Additionally, physicians figure more prominently and medical procedures are depicted in greater detail. After the creation of the Salk polio vaccine in the 1950s, when child deaths became significantly less common, children’s books dealing with death focused not on disease but accidents, the emotions of those bereaved, and normalizing responses to death. Once the AIDS epidemic hit in the 1980s and andazidothymidine (AZT) was being used as a successful treatment for
children, children’s books focused on the social acceptance of kids with AIDS or the death of adult family members with AIDS. Books rarely depicted children actually dying of AIDS. When they did, they returned to seventeenth century tropes of saintly children dying bravely and going to heaven. This pattern reveals an ongoing reliance on narrative structures to communicate difficult concepts about life.

Ethics, Genre, History


Keränen analyzes the rhetorics of the United States TOPOFF (“top official”) exercises: large-scale government simulations of bioterrorist attacks meant to improve high level officials’ decision making and communication. She finds that the collective rhetorics of these elaborate exercises perpetuate autopoiesis, or self-reproducing rhetorics of risk which help strengthen the biodefense industry. They do this through three rhetorical maneuvers. First, they transform “uncertainty into spectacular risk”; second, they “blur reality and simulation into visions of chaos and casualty”; and third, they exploit the tensions between reassurance and concern (83-84). The study describes the history of these activities, their textual rhetorics, and how the test results have been used to perpetuate and secure further funds and research for military biodefense. Keränen questions the actual need for such exercises and the rhetorics which support them, arguing that funds would be better directed toward problems with proven statistical threat, rather than speculative ones.

Policy, Public Discourse


Leach calls for rhetorical research into the decorum (rules of conduct) of physician-patient communication. She traces the discursive history of medical manners from classical times to today, demonstrating that communication, ethics, and etiquette have been aligned in different ways throughout time. Currently, the American Medical Association sees communication as an ethical issue. However, a counter rhetoric is forming which suggests that etiquette may be a more “common sense” approach to teaching physicians how to communicate and care for patients. Humanists would most likely claim that etiquette is a mere surface performance, while ethics is a deep-level, empathetic concern for patients; however, people such as Michael W. Kahn and Atul Gawande argue that proper care for patients cannot take place unless physicians have a base-level list of criteria for interacting with and treating patients. Kahn in particular offers a six-point list of manners which he says will make for a “good enough”
physician, even if (realistically) perfect empathy and emotional understanding are not always achievable. Leach argues that although it may be tempting for rhetoricians to rally with the humanist cause against Kahn and Gawande’s checklist manifesto, a more productive stance might be to “incorporate rhetorical sensibilities about prudence and decorum into the checklist” (191). Indeed, Kahn even leaves room on his list for this very contribution by qualifying particular directives with, “if appropriate.” Phrases like this imply that, although some aspects of medicine are indeed a science, knowing when particular behaviors are appropriate is still an art. Leach also calls rhetoricians to investigate what patients want from their physicians, in terms of decorum, and what patients’ own rhetorical strategies are for interacting with physicians.

Classical/Canonical Rhet, Doctoring, HCP-Patient Com


While research shows that direct-to-consumer advertising for prescription pharmaceuticals (DTCA) has been strongly present for centuries, Segal is interested in identifying what current DTCA is attempting to persuade consumers of. Building on her assertion (made in her past publications) that DTCA rhetoric is epideictic, Segal outlines the moral structure, or “pleasure economy” which these advertisements compose. To do this, Segal employs the structural theories of Perlman and Olbrechts-Tyteca (1969) which state that rhetors build their arguments based on negative/positive binary pairs. In the case of DTCA, pharmaceutical companies have to a) demonstrate that their products are associated with a “good” (or, real) kind of pleasure, and b) dissociate (distance, de-articulate, redefine) that “good pleasure” as different from the kind of pleasure commonly associated with illicit drugs. Thus, binary pairs are invoked which distinguish between the bad/unacceptable pleasure of illicit drugs, and the good/ permissible pleasure of pharmaceuticals. Some examples include immediate/delayed, solitary/social, unnatural/natural, unproductive/productive. This pleasure economy is illustrated in examples of migraine rhetoric, a malady often treated with narcotics. As Segal points out, the migraine sufferer is often suspected of moral weakness, and it is not the drugs she is prescribed, but rather her use of those drugs which is seen as licit or illicit; is she using the narcotic to stop pain, or induce (bad) pleasure? To avoid the moral suspicions associated with such drugs, pharmaceutical companies must advertise their drugs as promoting good or real forms of pleasure: sociability, authenticity, and...
productivity—pleasures that help others rather than simply the female self.

Classical/Canonical Rhet, Gender, Pharmacy


Spoel investigates the relationship between micro- and macro-level medical discourses and the hybrids they create. She does this by examining an emerging speech genre in Canada’s budding midwifery practice: the informed choice consultation. One of midwifery’s three main principles, informed choice, Spoel argues, is both ideological and rhetorical in nature, drawing from biomedical models of “informed consent,” but placing a religious emphasis on the equality and autonomy of the patient. Using discourse analysis, Spoel compares two conversations between two different midwives and their patients, as they discuss diabetes screening. The conversations reveal varying levels of discursive hybridity, in that they manifest both mainstream and alternative models of medical communication. Her first conversation excerpt, between a midwifery student and patient, contains stronger resonances of the biomedical, professional-expert model of communication, in which the doctor provides informed authority. Spoel's second excerpt, between a practicing midwife and her patient, displays a more dialogical and cooperative model of communication. Spoel concludes that both excerpts reflect macro-level ideological tensions surrounding informed choice; however, they also point to the flexibility of local genres within situated rhetorical practices. Gender, Genre, HCP-Patient Com
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