

Realms of Rhetoric in Health and Medicine

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When the editors of *UTMJ* introduced the journal's new "Philosophy and Medicine" section in December 2003, they explained that its purpose was "to provide a forum for students to explore the interface between diverse schools of thought and how they contribute to the practice of modern medicine".¹ This move – providing space in the journal for health researchers from various backgrounds to share their knowledge and experience – reflects a shift in the landscape of health and medicine. As neurologist and professor of Medical Humanities T.J. Murray explained in 1998, "We often use the term 'medical science' but this refers to the scientific knowledge used by medicine. Medicine is not a science. It is a caring profession that uses science."² The shift to a more encompassing idea for health is consistent with changes to the health research agenda in Canada. The Canadian Institutes of Health Research (replacing the Medical Research Council) recognises that advances in biomedicine are a key factor, but not the only factor, in improving the overall health of Canadians. The social sciences and humanities can suggest ways of tracking some of the psychological and emotional – as well as socio-economic, cultural, ethical, and interpersonal – elements of health and health care.

The first article published in the journal's "Philosophy and Medicine" section, by Raymond Jang, studied the relationship between medical education and moral reasoning.³ It asked, among other things, whether and how an "ethics of care" could figure into new doctors' daily practices, where their decisions would be based on both intellectual and compassionate grounds. The second contribution, by Susan Lee and Ari Greenwald, explored patients' roles in medical decision-making.⁴ It questioned how to reconcile patients' autonomy in health care with physicians' greater knowledge about medical matters. Both of these essays focus on interaction in medicine – between physicians and patients, medical theory and practice, scientific and humanistic views of medicine. Studies of human interaction can further be illuminated and extended through *rhetoric*, the theory of persuasion. In this essay, we introduce rhetorical theory into the wide-ranging study of health and medicine, and suggest some ways that a rhetorical perspective can offer insight into medical research and practice.

Rhetoric as Mode of Inquiry

The term *rhetoric* commonly brings to mind empty or deceptive speech ("mere rhetoric"); speech that is somehow suspect, and almost expected in the realms of politics and advertising, for example. (The rhetorical question – the question used for effect, and not really meant to be answered at all – is perhaps the best-known rhetorical device, and one that we usually learn about in high school.) However, while *rhetoric* includes this everyday meaning, it more properly refers to a discipline developed in ancient Greece and Rome that centred on the webbed relations among knowledge, belief, language, argument, speakers, and audiences. Ancient rhetorical theorists (Plato, Aristotle, and Cicero among them) devised a system for producing persuasive spoken and written texts, particularly within political, legislative, and ceremonial contexts; that system was called *rhetoric*.

Over the centuries, rhetoric has expanded to include the theory of both production and reception of texts, both spoken and written, and it has moved well beyond its original applications in public speaking to include more generally the persuasive element in all human interaction. Contemporary scholars of rhetoric note that all language seeks to persuade – even when it appears on the surface to seek only to inform. The success of any persuasive attempt depends on a variety of factors, such as the particular rhetorical strategies a speaker or writer employs, the receptiveness of the listener or reader to the text, and the context in which the speech takes place. Because it depends on all of these factors, rhetoric is best studied not abstractly, but in the specific situations in which it occurs. Some of these situations occur in medicine- and health-related contexts. An awareness of rhetorical principles in medicine can, in turn, benefit medical practitioners and allied health professionals by providing new perspectives on familiar (and sometimes intractable) problems of human interaction.

Persuasion is a central element in many medical situations. Patients without observable symptoms may need to persuade physicians that they are ill and in need of care; physicians may seek to persuade patients that they are well, despite feeling ill. Furthermore, physicians wish to persuade patients to adhere to diets, other regimens, and courses of treatment. Experts persuade the public to consider some conditions as pathological and others not. Pharmaceutical companies try to persuade consumers to request their products and physicians to prescribe them. Moreover, the very terms in which persuasion takes place in health and medicine themselves condition

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outcomes. The phrase “social anxiety disorder” persuades the very shy person that he or she may be a candidate for drug therapy; the word “breakthrough” persuades the public to imagine medical research as a particularly dramatic sort of enterprise; the phrase “fighting disease” persuades persons that they have failed at something when they cannot stop being ill; the term “survivor” leaves the dead person looking somehow culpable. “Caregiver” creates a class of care-receivers and tips the economy of families; “antibacterial” enters public discourse as a term of general praise.

Rhetorical criticism identifies the persuasive element in the discourse of health and medicine, and asks “who is persuading whom of what?” and “what are the means of persuasion?” The goal of rhetorical criticism is a greater understanding of human action, while rhetorical theory as a whole has considerable explanatory power in a world in which we act upon each other by influence.

In the remainder of this essay, we outline some of the ways in which rhetorical principles are pertinent to medicine, paying particular attention to how those applications can be useful to health practitioners. Rhetorical theory informs our discussion, but our primary concerns are practical. Therefore, we have divided our discussion into loosely thematic categories that move from the heart of medicine toward increasingly global concerns. In short, we move from *text* to *context*. The following sections suggest some of the approaches one can take in studying the connections between rhetoric and medicine.

Everyday Texts in Medicine

Medicine is preeminently a world of texts – of lab notes, medical journal articles, textbooks, case reports, patient charts, regulatory documents, insurance claims, pharmaceutical advertisements, and even prescriptions. These texts not only deliver information, they *structure* it as well. The *form* of texts determines significantly the kinds of information they can convey and governs how information is used. Although the persuasive functions of medical journal articles or case presentations can be trickier to tease out than, say, those of pharmaceutical advertisements, these seemingly neutral texts profoundly shape how both physicians and patients understand, interpret, and experience medical situations.

Medical journal articles, for example, present research in conventional and even regulated ways. Consider the IMRaD (Introduction, Methods, Results, and Discussion) structure that is strongly recommended in the uniform requirements for manuscripts submitted to biomedical journals. Persuasive strategies are also conventional, and they are expected, even if they are far less visible. For scientific findings to be published in medical journals, authors must persuade medical editors of the worth of their work; for findings to be noted and cited, these authors, now with the imprimatur of the journal, must persuade medical readers of that worth. So, not unlike classical speechmakers seeking to persuade classical “judges” of the strength of their claims, medical authors use strategies of argumentation, organization, style, and presentation (basically, Aristotle’s four parts of rhetoric⁵) to persuade the relevant judges of the strength of theirs. Medical journal articles are no less rhetorical than other texts for being scientific – but they are also no less scientific

for being, irrepressibly, rhetorical. (A catalogue of common rhetorical strategies at work in medical journal articles is in Segal.⁶)

Collectively, medical journal articles constitute a *genre*, a common form or structure that is used to communicate similar kinds of information in similar kinds of ways. Think, for example, of newspaper articles or television guides, where the basic structure and purpose of the communication remain the same, but the content changes daily or weekly. Genres are not simply forms; rather they serve special functions, including social functions, in particular communities of discourse. They respond, in recognisable ways, to repeated and, in a sense, typified, rhetorical occasions – from program listings to medical journal articles. Rhetorical theorists Carol Berkenkotter and Thomas Huckin note that “[g]enres are the media through which scholars and scientists communicate with their peers. Genres are intimately linked to a discipline’s methodology, and they package information in ways that conform to a discipline’s norms, values, and ideology.”⁷ In other words, Berkenkotter and Huckin explain that genres “are the intellectual scaffolds on which community-based knowledge is constructed”.

Other textual genres also shape how medicine is practiced. Manuals of diagnostic criteria (such as the *Diagnostic and Statistical Manual of Mental Disorders* and the *International Classification of Diseases*) provide classifications that shape how researchers and practitioners identify, understand, study, and treat diseases. Carol Berkenkotter and Doris Ravotas note that “nosology [the classification of disease] as practice (and genre) in psychiatry is informed by assumptions that have been appropriated from the biological classification of plants and animals.”⁸ They argue that by applying Linnaean botanical classifications to psychiatric conditions, manuals such as the *DSM* reify diagnoses and make distinctions among conditions appear natural and inevitable. These nosologies, in turn, influence psychiatrists’ record-keeping activities, where Berkenkotter and Ravotas find the individual expressions and experiences of clients are absorbed “into a monological account reflecting the therapist’s professional interpretive framework.”⁸ Similarly, sociologist Aaron Cicourel notes that physicians translate patients’ accounts of distress into a set of complaints matching the store of diagnostic criteria.⁹ Sociologists Geoffrey Bowker and Susan Leigh Star write that information available to any practitioner “is at best what can be stored using the currently available technology: the encyclopedia comes to mirror the affordances of its technological base.” “In this process,” they say, “people naturalize the historically contingent structuring of information; they often begin to see it as inevitable.”¹⁰ Bowker and Star show that classification itself is never neutral, while researchers like Cicourel and Berkenkotter and Ravotas demonstrate some of the practical effects of the classifications used – and used necessarily – in the practice of medicine.

Everyday medical genres are not only written; they can be oral as well. Case presentations constitute a genre, for example, whose rhetorical study can be illuminating for medical practice. Lorelei Lingard, Catherine Schryer, Kim Garwood, and Marlee Spafford (Lingard and Schryer are rhetorical theorists) studied the teaching of case presentations in medical schools. Their research was guided by the question, “How (and how well) does the learning facili-

tated by the case presentation genre socialise the novice into the values and goals of a health profession discipline?”¹¹ The authors found disjunctions between presentation ideals held by students and those held by faculty – disjunctions that, they suggest, may influence how new doctors move from educational to professional contexts. A central rhetorical principle, *purpose* (what is the discourse meant to accomplish?), is key to understanding their findings. According to Lingard *et al.*, students’ primary purposes in case presentations are to demonstrate their competence, seek guidance, and deflect criticism, while the purpose of faculty is effectively and efficiently to communicate knowledge of the patient’s case to care team members. This opposition of purposes, Lingard *et al.* argue, may negatively affect how students integrate faculty feedback into their work. The authors conclude that, if the dual purposes of case presentation instruction as both the *teaching of students* and the *mentoring of doctors* were more openly addressed, students would be better prepared for the transition to the workplace.

While physicians regularly encounter certain everyday texts of medicine – medical journal articles, diagnostic manuals, and case presentations – other texts circulate in more subtle ways. One such text is the Hippocratic Oath. The Oath is typically recited at medical school graduation ceremonies (and is not elsewhere very much in evidence), yet it is understood to be one of the foundational ethical documents in medicine. Rhetorical theorist Lisa Keränen notes that the Oath is perhaps significant less for the moral approach it advocates than for the model of professional practice it implies.¹² She points out that the Oath is neither a single coherent text, nor a text that, in any form, corresponds neatly to the values of contemporary medicine. Its recitation at graduate ceremonies then must serve social, rather than strictly moral, ends. Keränen links the practice of ritual recitation of the Oath to medicine’s professionalization movement in the 1850s, and argues that recitation of the Oath in a communal setting binds practitioners to one another, situates them in a tradition, and reiterates a set of values to unite them as a profession. The Oath, that is, performs an essentially rhetorical function.

Rhetoric in the Consulting Room

Like medical journal articles and professional oaths, doctor-patient interviews constitute a medical genre. Unlike journal articles and oaths, however, doctor-patient interviews are an interactive genre. They are dynamic and dialogic; they unfold in real time and depend on the exchange between or among speakers with their own attitudes, beliefs, ideals, priorities, knowledge, and motives. While certain other medical genres (such as case presentations) share elements of dialogue, doctor-patient interviews highlight the different persuasive resources available to speakers from different backgrounds. In case presentations, interlocutors belong, essentially, to the same universe of discourse: the medical universe. In doctor-patient interviews by contrast, the participants belong to different discursive universes. Physician-anthropologist Arthur Kleinman has called these the universe of *illness* (the patient’s experience of bodily distress) and the universe of *disease* (the physician’s interpretation of pathology of the body)¹³ – a distinction also drawn by physician Eric Cassell.¹⁴ Anthropologist Elliot Mishler

similarly describes the disjunction between the “voice of the life-world” and the “voice of medicine.”¹⁵

One means of studying the ways in which medical practitioners and patients approach states of health, illness, and disease is narrative analysis. Kathryn Montgomery Hunter notes that medicine is steeped in narrative, or story.¹⁶ When a patient visits the doctor, she presents a narrative account of her symptoms; then the doctor, whose own work is made up of interconnected narratives (e.g. patient histories, case presentations, patient charts) compares that narrative against a sort of mental index of illness narratives to find a match – a diagnosis. Hunter focuses on doctors’ stories, studying how doctors talk to patients, each other, and themselves. She explains how their stories function epistemically: narrative structure is a way of knowing what shapes clinical judgement and guides decision-making.¹⁶ Arthur Kleinman looks at the flip side of narrative, at patients’ stories, to study how they give order and meaning to illness experiences, particularly in the case of chronic, debilitating, or life-threatening conditions.¹³ Arthur Frank, a sociologist specializing in illness narratives, offers a taxonomy of such stories: “Restitution narratives,” – with the story-line, “Yesterday I was healthy, today I’m sick, but tomorrow I’ll be healthy again” – are less useful to the patient’s personal development, according to Frank, than “quest narratives.” “Quest stories meet suffering head on; they accept illness and seek to *use* it.”¹⁷ In Frank’s view, the ill person is morally advanced somehow, and becomes exemplary, when his or her own illness is read through a quest narrative. Narrative analysis illuminates the patterns of meaning that patients and physicians marshal to make sense of illness and disease; these patterns can be framed, rhetorically, as “terministic screens.”

In the view of rhetorician Kenneth Burke, terministic screens describe the ability of terms to shape how we interpret human action in the world. He writes, “We must use terministic screens since we can’t say anything without the use of terms; whatever terms we use, they necessarily constitute a corresponding kind of screen; and any such screen necessarily directs the attention to one field rather than another.”¹⁸ As the studies described above show, the terministic screens of biomedical practitioners are shaped largely by an idiom of disease, where patient care is generally predicated on the scientific model: the practitioner’s expert knowledge enables him or her to re-present a patient’s subjective illness experience in “objective” medical terms as a diagnosis. Patients’ terministic screens, on the other hand, are determined more significantly by the experience of illness, including pain, suffering, fear, limited ability, financial loss, and even dread.

An important case of the negotiation of doctor screens and patient/family screens is in decision-making for the end of life. A research project at a Canadian psychiatric hospital studied the process of consensual decision-making (decision-making by hospital team members in conjunction with family members) on Advance Directives for seriously ill, cognitively impaired patients.¹⁹ Rhetorical analysis found that, despite efforts of the multidisciplinary hospital team to foreground the input of family members, there were structural elements of the decision-making meetings that privileged a medical “screen.” Meeting structure itself, in other

words, functioned persuasively. For example, the medical account of the patient, provided by the physician, routinely was presented before the social account of the patient (the quality of life account), provided by the social worker and family members, and had a special prominence. Rhetorical analysis also found that the framing of treatment options by hospital team members went some way to influence the choices of family members – so a decision-making hierarchy was maintained, even while the decision-making model was consensual. For example, hospital team members tended to present decisions not to treat as “letting nature take its course” and resuscitation orders, for example, as “aggressive.” In the everyday language of patients and family members, the aggressive choice may seem the negative one (compared to the natural choice), even though, in the everyday language of physicians and other care-providers, “aggressive” is not a negative term, and aggressive treatment may indeed be valued positively.

Medical Metaphors and Models

In the first two sections of this essay, we explored the ways that individuals perform rhetorically in medical contexts. We’ve looked at the kinds of information they exchange, how they exchange it, and what sorts of filters or screens shape their interpretations and interaction. In this section, we expand our discussion from acts of *doing* to acts of *thinking*, noting how conceptual models shape how biomedicine operates on individual, interpersonal, institutional, and legislative levels.

Metaphor is the quintessential rhetorical device. While “metaphor” is itself a common term, it is often seen as no more than a linguistic ornament or figure of speech – a decoration to spruce up otherwise “plain” talk. Metaphors are certainly useful as ornaments, but they also have a more pervasive function in everyday life, functioning just below the threshold of ordinary perception. We often think and speak in metaphor without even realizing that we’re doing it. Kenneth Burke playfully defines metaphor as “a device for seeing something *in terms of* something else. It brings out the thisness of a that, or the thatness of a this”.²⁰ Cognitive linguists George Lakoff and Mark Johnson define metaphors as mappings of sets of conceptual correspondences. We don’t just *describe* something in terms of something else, they argue, but we also *understand* and *experience* it in those terms. We have no choice about thinking metaphorically, Lakoff and Johnson claim, because “metaphorical maps are part of our brains”.²¹

Metaphors are common elements of medical speech and medical thought. For example, rhetoricians Celeste Condit and Deirdre Condit examine two common genetic metaphors – genes as “blueprints” and genes as “recipes,” and they invite us to think about the conceptual consequences, and indeed the social consequences, of thinking about genes in terms of one or the other – blueprints or recipes.²² They report that some critics of the enthusiasms of genetic researchers for example have found the blueprint metaphor too static, deterministic, and masculine – and arguably, too hospitable to rapid technological advance. These critics prefer the recipe metaphor, which they say is more dynamic, open to variation, and amenable to a feminist perspective. Condit and Condit themselves speculate that the two metaphors are in fact more sim-

ilar than they appear, since both blueprints and recipes are essentially sets of instructions. Indeed, the recipe metaphor may backfire, they say, and hasten the acceptance of genetic technologies by linking them with processes usually associated with family, nurturing, and a sense of security.

One of the most widely cited works on the operations of metaphor in a medical context is an essay by anthropologist Emily Martin on representations of reproduction – in particular, the tendency in biological accounts of human reproduction to treat eggs as not simply female entities, but *gendered* feminine (that is, having qualities – like passivity – stereotypically associated with girls and women), and sperm as *gendered* masculine (having qualities – like adventurousness – stereotypically associated with boys and men). Martin notes that sperm production is typically described as an activity producing felicitous excess, while egg production is described as simply “wasteful.” (“So many eggs are formed only to die in the ovaries,” she quotes a biology textbook as saying.) “How is it,” Martin asks, “that positive images are denied to the bodies of women?”²³ Martin finds that textbook accounts of the biology of reproduction also reproduce, at the same time as they are derived from, stereotypical images of the masculine and the feminine. The egg as feminine is irredeemable: if it is not utterly passive in its encounter with sperm (typically, it is “transported” or it “drifts” along), then the abrasive zona is aggressive and sets a trap (as one textbook says, to “capture the sperm with a single bond”).

Metaphor is also one of the primary means through which certain concepts are transported between different discursive universes, such as between the discourses of medicine and health policy. Judy Segal has suggested that key metaphors in biomedicine are borrowed into the debate on health policy and constrain it – metaphors such as *health care is a business* (more of a metaphor than it may seem), *medicine is a war*, and *the body is a machine* (or more recently, *the body is a computer*: with hard- and software, over-programmed, overloaded, etc).²⁴ If health care is a business, then care can be distributed differentially. If medicine is war, then intervention is a moral imperative. If the body is a machine, then repair is a sort of requirement of age. Kenneth Burke sets up a rhetorical view of the relation of biomedical terms and health policy debate when he explains that observations are not free, but are constrained by the terms we use to make them. Many of our observations, he says, “are but implications of the particular terminology in terms of which the observations are made.”²⁵ (For a related discussion, see Malone.²⁵)

Rhetoric and the Boundaries of Medicine

Rhetoric, then, is a means of studying relations and intersections within medicine – between medical texts and medical practice, between experience and expertise, among people, and even among metaphors. In this essay, we’ve moved from topics relatively internal to medicine (such as how medical texts shape medical practice) toward increasingly global topics (such as how conceptual models influence medical knowledge-making). In this final section, we step toward the edges of medicine to see where biomedicine intersects with other models of health and health care.

In the western world, medicine is based on a scientific, biomedical model – most North Americans’ main (and often only) model of health and health care. However, as several landmark studies have demonstrated (especially Eisenberg *et al.*²⁶), Canadians and Americans consume far more alternative health care (such as chiropractic, traditional Chinese medicine, and naturopathic medicine) than had been previously imagined. This revelation has sparked research into the relationships between mainstream and alternative models of health, and rhetoricians are among those at the forefront of this research.

The incorporation of midwifery into mainstream medicine, for example, has raised questions about how different approaches to health (in this case, approaches to childbirth) come into contact with one another, and how these approaches are constituted in texts, both oral and written, and made *persuasive*. Rhetoricians Mary Lay and Philippa Spoel have studied the licensing and regulation of midwives in the United States and Canada, respectively. Focussing on public hearings on the licensing of lay (that is, not fully medically trained) midwives in Minnesota, Lay considers testimonies from midwives, parents, medical personnel, and lawyers, as they invoke issues of gender, knowledge, and power in their arguments.²⁷ Spoel, with her co-author, midwife Susan James, investigates the self-regulation of Ontario midwives, studying the “key ideological and practical tensions that inform midwifery’s rhetorical negotiation of its new and uneasy status within the dominant healthcare system”²⁸ Both Lay and Spoel and James see in the negotiation of systems a competition of arguments, and demonstrate that rhetoric is an important element of the emergence of midwifery as an increasingly conventional practice.

The integration of alternative health philosophies into mainstream medicine poses rhetorical problems not only for alternative health practitioners, but for mainstream practitioners as well. In scientific studies of alternative medicine, medical researchers grapple with questions of method, professional ethos, and models of health and disease. Unlike pharmaceuticals, chiropractic treatments, for example, cannot easily be tested through conventional scientific methodologies such as randomised controlled trials: because treatment involves the unmistakable physical action of moving the spine (often with an audible popping sound), it is difficult to control or blind. Such methodological difficulties raise the important question of what it means to do scientific research when conventional scientific methods can’t be applied. This question brings up the related problem of professional *ethos* – an individual or profession’s character, reputation, and authority – in the scientific study of alternative health. What does it mean for a medical researcher, as a member of a professional community, to study fringe practices such as homeopathy, especially in the case of positive studies, which find some degree of efficacy? And finally, how do medical researchers reconcile their professional worldviews with findings that are incompatible with them? Acupuncture, for instance, has been identified as effective for pain management but its founding philosophy – enabling the flow of Qi, or energy, in the body – is incompatible with a biomedical understanding of health and disease. The question of how health professionals acknowledge the usefulness of such practices within their own dis-

ciplinary framework is a useful question for rhetorical study. (See Derkatch for more on this topic.²⁹)

Conclusion

Rhetoric, as a discipline, is a decidedly interdisciplinary enterprise. While some rhetorical critics are specifically trained in rhetorical history, theory, and analysis, scholars from many disciplines play a role in forming and elaborating a rhetorical view of the theory and practice of medicine. In this essay, we’ve cited works by humanists, social scientists, and medical practitioners, all of whom investigate – and illuminate – in various ways the interactive and persuasive elements of health and medicine. We offer them as examples, as ways of imagining what rhetoric of health and medicine might look like. Such rhetorical studies all share, ultimately, an interest in developing a greater understanding of the various complicated, complex, and sometimes conflicting factors at work in the field of health and medicine, both as it is currently and as it will be.

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