

Abstract

Drawing on the work of Jacques Derrida, this essay offers a definition of the term “aporia” within the context of a healthcare system dominated by biomedicine, burgeoning biotechnologies, and neoliberal economic forms of governance. Given these semiotic forces at play, I argue that ethical healthcare will require greater attention to the rhetorical dimensions of “health” and “illness,” particularly in the ways that metaphors are used to create meaning and experience.

Key Words *aporia*, bioethics, critique, Jacques Derrida, healthcare rhetoric, Susan Sontag

Aporia: Towards an Ethic of Critique

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“What about borders with respect to death? About borders of truth and borders of property? We are going to wander about in the neighborhood of this question.”

—Jacques Derrida, *Aporias*

Introduction

In the oft-cited opening lines of her book, *Illness as Metaphor*, Susan Sontag writes:

Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.[1]

Here Sontag speaks of health and sickness in terms of citizenship. This metaphor is resonant within contemporary cul-

ture. Today, we tend to think of ourselves as rights-bearing citizen-subjects, as belonging to this or that particular group, and as social and political beings who derive our identities from this belonging. We are bodies, but no less substantially, we conceive of ourselves as persons whose value or “dignity” is tied up with—but presumably irreducible to—these lived bodies and the socio-political terms of their derivate identities. If we belong, that belonging is always contingent, even if it is not always experienced as such, even if it is experienced as necessary and true. Similarly, those who are “healthy” or “sick” derive their identity from the ways that health and sickness appear for them as meaningful, as relatively coherent concepts, and in the ways in which these meanings organise experience—through diagnoses, pathology reports, myriad tests, government public health campaigns, the language of popular discourse, and so on. These ways of knowing mark us as belonging to one group or the other; our lived body is assigned a prognostic place in the geopolitics of medicine. If Sontag describes health and sickness as different countries, the metaphor is not strained.

As S. Lochlann Jain writes, “Perhaps [Sontag] took diagnosis to be, as the linguistic philosopher J.L. Austin might describe it, a perlocutionary act, bringing one—by the very act of declaration—into a new subject position, one requiring a different set of customs, laws, ethics, regulations.”[2]

Metaphors are like technologies: we use them but invariably they end up using us. Describing the power of medical language, in a short article the physician William Donnelly states:

The language of medical case histories uses its users as much as its users use it. It constrains what its users are permitted to say not just in case presentations and the pages of the medical record but in the day-to-day conversations of students, residents, and attending physicians.[3]

If, then, we speak of health and sickness metaphorically to help describe military, political, or social interventions, as Sontag claims in her book, it is likely that these terms will “constrain” what we shall be able to say, and that the characteristics of the things we describe will come back to haunt us, a kind of reverse metaphoricity. The implicit danger in the reversal is that, because we ourselves have not put them there, we shall be tempted to experience these metaphors as natural, necessary, and true—that is, they will constrain not just what we are permitted to say, but what we are also able to think and to feel from the start. To take just one famous metaphor as an example, in the “war” against cancer, the body is figured as a battleground, and this surely affects the kinds of treatments that will be researched, developed, deployed, expected, and tolerated, sometimes in subtle ways, as the body is caught in the crossfire. But can there be any confusion, in light of a cancer diagnosis, which of Sontag’s two kingdoms has laid claim to us, perhaps irrevocably, unto death?

This short essay seeks to complicate and to challenge the binary system—health and sickness—that Sontag’s metaphor captures. Here I follow Sontag herself, who, in attending to the metaphorical dimensions of health and sickness, suggests that these terms are fluid and contingent (hardly natural categories), that they are somehow our responsibility. I shall argue, however, that our healthcare system, from the clinic to the classroom, tends to re-entrench a system of binary identities—a rigid semiotics of the healthy and the sick, as if there were only two kingdoms, two categories, and as if they were natural and true. I hope to problematise these boundaries in ways that will light the way toward novel approaches to clinical practice, and to resist the further biologisation of medical citizenship and identity.

A question of words

It is a question, then, of words. It is a question of what words mean. But it is more than this. Words—and diagnostic images and statistics and prognoses—become flesh. To speak of sickness and health in political terms, then, is not to deploy gratuitous metaphors, mere words, “rhetoric” in the worst sense of the term; rather, we speak in this way because sickness and health are always already inherently political. In “The Conscience of Words,” her Jerusalem Prize acceptance speech, Sontag speaks passionately of the relation between politics and words, suggesting that words have a “conscience,” that they act on us in particular, concrete ways—and if the metaphor can be stretched a little further, we would have to admit that we are caught up in these words’ linguistic “intentions.” We can take Sontag’s words concerning Palestine and Israel, and, without too much of a stretch, we can use them to begin to understand the politics of sickness and health, to understand the relation between these two kingdoms. She asks: “What do we mean, for example, by the word ‘peace’? Do we mean an absence of strife? Do we mean a forgetting? Do we mean a forgiveness? Or do we mean a great weariness, an exhaustion, an emptying out of rancor?”[4] We might pose similar questions if we were to ask what it means to inhabit the kingdom of the well or the kingdom of the sick, and how a dialogue—if not a *rapprochement*—between these two kingdoms could be negotiated. If we sought to define sickness and health, we would come up against a similar proliferation of terms and questions, from one side and from the other: Is health something like a feeling, is it a momentary forgetting of illness or of death, since we are always potentially sick, always being-towards-death? Should sickness be described as a kind of weariness or exhaustion, the strife and then the vertigo that accompanies a shadow on a CT scan? “It seems to me,” Sontag continues, “that what most people mean by ‘peace’ is victory. The victory of their side. That’s what ‘peace’ means to them, while to the others peace means defeat.”[4] The politicisation of a word can make its meaning elusive and fragmentary; sometimes we are left with competing claims, if not with an insurmountable relativism, an impasse. We fool ourselves if we think we are in control, sovereign and autonomous beings. “Peace becomes a space people no longer know how to inhabit. Peace has to be resettled. Re-colonized....”[4]

So too, I would argue, with the experience of sickness and health, due in part to the multiple ways they are defined and measured, each against the other, and the ways their borders have come to be haunted by a certain kind of political finality, judgement, and moral authority. We are meant to

“inhabit” a space of sickness or of health, it seems, on one side of the *cordon sanitaire*, with no space in between, and yet we do not quite know how to inhabit this space, or what, exactly, these terms could mean. In the extreme, diagnoses of health and sickness announce themselves as matters of life and death, but these terms are even more intangible, and frequently return us to notions of health and sickness, a vicious circle. Whether we are “sick” or “healthy,” we are situated somewhere between life and death; we sometimes say that we are in the land of the living, that we are not quite (yet) on the side of death, but while we are alive, our life—our lives, for they are singular threads sutured together like a cut—are haunted ineluctably by the spectres of disease, decline, and death.

I offer Sontag’s image of the two kingdoms in order to complicate a binary that is too often taken for granted, invisibly deployed by many who understand health and sickness in unreflexive, categorical terms. These categories are not epistemological kingdoms, but they designate the fuzzy logic and ever-changing effects of epistemological investments that have seeped into the soil, nourishing—or poisoning—the cultures of sickness and of health, of life and of death. A cultural and political gap separates the kingdom of the well and the kingdom of the sick. Communication between these realms involves imperfect translation (if this is the right metaphor). If we understand the two kingdoms as a metaphorical map, obviously it will not correspond to our real-world geography, although there are real-world places to be ill and prescribed ways to be ill in those places. Sontag says they are “spaces” that we inhabit but often do not know how to inhabit; they are “times,” too—times to be sick, to live, and to die. They are spaces, then, in which we can find ourselves exiled for a spell—unsure how to live, as we navigate between these worlds, with their different customs, laws, and languages, from the street to the clinic to the workplace and home again. Here, and there, we stumble upon terms that will locate and define us, possess and dispossess us, while we find that these terms are rarely ours to make and re-make, we are not sovereign and self-sufficient. These are not language games. Theirs is a vital intimacy. And so if we can imagine a metaphorical map—one that nevertheless has vital and intimate effects—I would invite those who work in the health sciences, whether as nurses or clinicians or as policymakers or academic theorists, to reflect on their place on this conceptual grid. To which kingdom do we belong in our professional lives, and in our interactions with those who are sick or potentially sick? Do we sit on the border between these two kingdoms? Do we occupy a no-man’s-land? Per-

haps our occupation (in this word’s many meanings, simple and sinister) extends further still? Do we patrol and police that border? Do we forgive trespassers?

As part of a vast healthcare infrastructure, real and metaphorical, we play our part in lending and legitimising the meaningful terms by which health and sickness are negotiated and taken up phenomenologically. We serve as border-patrols, responsible for maintaining a two-kingdom universe, knowing that more than words are at stake. Perhaps we hope to translate between the kingdom of the well and the kingdom of the sick. But more than this, we proffer the concepts or terms by which those who are healthy and those who are sick will hope to understand *themselves*, their own health or their own sickness. This happens in the clinic, in the hospital, in academic health sciences disciplines, in government policy, and in the many bioindustrialized territories that extend in complex networks, discourse, out of sight.

Therefore, we must seize every opportunity to pursue critical work in the healthcare–industrial complex; we must find the means by which to study the effects of our discourses and to claim an intellectual and moral responsibility for them—to understand the many rhetorics of healthcare.* To offer a critique means to challenge what has come to be taken as second-nature or “commonsense,” to see how we are captured by the linguistic “intentions” of the words that we speak and by which we are spoken. This might include exposing hidden power-relations and the ways that they function, and taking a sustained look at the politics of evidence—the politics of the production of knowledge—in nursing and health sciences. To those critics who dismiss such work as merely theoretical and of no practical value, it means that we must challenge their view that theory and practice are two separate kingdoms (here yet another cherished binary), and we must demonstrate how theory and practice inform one another. This means a commitment to a pluralistic and interdisciplinary approach to scientific research; it means questioning authority, whether this authority comes in the guise of the evidence-based movement (EBM), the rise of best-practice guidelines (BPGs), of so-called knowledge translation, transfer, and mobilisation, of medical and nursing managerialism, of the culture of risk and risk-management, or the drive to quantification and post-positivism in general. To be sure, interdisciplinarity will be a great challenge in a world of ever-increasing professionalisation and professional identity—“specific intellectuals,” as Foucault called them (see Papadimos and Murray[5]). Advances in genomic medicine, for example, will have implications that extend beyond the laboratory, and it is right that philosophers and historians and political theorists

(to name just a few) weigh in on the perils and promises of our burgeoning biotechnologies. With so much at stake, we cannot afford to be territorial; indeed, the perspective of a relative outsider might offer some remarkable insights. To state the case for interdisciplinarity somewhat comically: one does not need to be a bug to be an entomologist! From the clinic to the classroom, too often we find a professional narcissism that seems to pride itself on remaining closed to other points of view, as if the categorical terms of our professional discourses defined us irrevocably, locking us into fixed (but comfortable) identities. If I am critical of BPGs, for example, in no way is this critique a sweeping rejection of those nurses who employ BPGs in their practice; on the contrary, critique is the opening of a scholarly dialogue, one that asks us each to engage at a critical distance from our own self-involvement and self-interest. Critique is not to destroy; it is to enable, to foster an exchange of ideas. This, in turn, means that we must struggle always to acknowledge the power and privilege of the position from which we speak, to be aware of the ways our own discourse is complicated by race, gender, sexual orientation, dis/ability, and so on. At its best, these struggles are evidenced in the everyday ways that nurses, for example, advocate on behalf of patients whose subject-positions and wellbeing hang in the balance. This is all the more challenging in a multifaith and multiethnic society, where appropriate and respectful care should begin by listening and by limiting the ready judgement of what we thought we already knew. In brief, it is humility and courage in the face of aporia.

Aporia

The term “aporia” comes from the ancient Greek *aporos* and literally means “without passage” or “impasse.” In classical rhetoric, an aporia is an expression of doubt, emerging when competing and compelling arguments are presented from both sides of a problem. If we arrive at an aporia, it means we are in doubt, we are perplexed, we are confused about how (best) to proceed. There is seemingly no exit, an intrinsic undecidability. An aporia is a contradiction, a puzzle or a paradox. Without it and the questions it prompts, it is impossible to imagine such a thing as science.

Recently, the term was made popular in critical theory by the late French philosopher Jacques Derrida, who describes “aporia” as follows:

the nonpassage, or rather ... the experience of the nonpassage, the experience of what happens [*se passe*] and is fascinating [*passionne*] in this nonpassage, paralyzing us in this separation in a way that is not necessarily negative: before a door, a threshold, a border, a line, or simply the edge or the approach of the other as such.[6]

An aporia marks a threshold, a border, between two (or more) kingdoms. Safe passage across this border becomes the (im)possible question of translation and of translatability. Along with the metaphor of “translation,” Derrida employs other familiar metaphors: “the space of citizenship or nationality; natural, historical, or political borders; geography or geo-politics; soil, blood, or social class.”[6] But these metaphors are always already overdetermined by the language—the terminology—in which they are claimed, and by the place and emplacement that they carry with them. It is not just a question of words.

Derrida emphasises three types of “border limits”:

(1) The first represent those borders that “separate territories, countries, nations, States, languages, and cultures.”[6]

(2) The second type is somewhat more abstract: “the separations and sharings [*partages*] between domains of discourse, for example, philosophy, anthropological sciences, and even theology, domains that have been represented, in an encyclopedia or in an ideal university....”[6] The second type therefore concerns the limits of disciplines and of knowledge in general, of the (im)possibility of (inter)disciplinarity.

(3) The third type of border limit is more abstract still—we might even say more figurative or metaphorical, though we would immediately need to add that this type nevertheless involves the most substantial or concrete *effects*. Derrida describes the third type as:

the lines of separation, demarcation, or opposition between conceptual determinations, the forms of the border that separates what are called concepts or terms—these are lines that necessarily intersect and overdetermine the first two kinds of terminality.[6]

Keeping in mind Sontag’s metaphor of the two kingdoms, we could map each of Derrida’s three ways that the border between sickness and health is established and maintained. If this border zone, this no-man’s-land, is aporetic, it is due in large part to this third type of border limit—the overdetermining manner in which our concepts or terms are put to work (a term Derrida borrows from Freud, for whom “overdetermination” signifies the way that many unconscious elements are at work in a symptom, thus complicating the symptom’s aetiology). Again, it must be said that we ourselves lend and legitimise the terms of sickness and of health, acting as conduits—in the clinic, in the hospital, in academic health sciences disciplines, in government policy, and beyond. The terms that line up along this border inevitably return to haunt—to overdetermine—and ideologically to patrol the purportedly more “obvious” or “self-evident” borders of

scientific materialism (represented by Derrida's first type of border limit, above), as well as the borders of scientific and professional disciplinarity (the second type). We ourselves are the invisible, aporetic site of intersection. In defining sickness and health, these concepts or terms define our experience, "the experience of the nonpassage, the experience of what happens [*se passe*] and is fascinating [*passionne*] in this nonpassage, paralyzing us in this separation." [6]

]Health and sickness are aporetic, when we take a moment to consider the many metaphors and experiences that haunt the meaning of these emblematic terms. The vast healthcare-industrial complex itself suggests an aporia that is too frequently papered over by the rhetoric of efficiency, management, and best-outcomes. For example, there will always be debate over the just allocation of resources, and while we continue with our cost-benefit analyses, we recognise on some level that these calculations are fundamentally at odds with a life and health that are promoted as "priceless." But debate is costly and inefficient; it has a way of being sidelined or silenced. In recent years we have seen the rise of the biomedical model in healthcare settings (such as biopsychiatry), coupled with the vested interests and the power of the pharmaceutical industry to perpetuate and profit from this model—even inventing disorders for the purposes of marketing their drugs to consumers (e.g., Social Anxiety Disorder). In academe, university departments of Psychology have jumped on the bandwagon of Cognitive Behavioural Therapy (CBT) in their clinical training, all but abandoning a psychodynamic model of mental health care, because CBT is more cost-effective and appears to work for certain high-profile "disorders," such as phobias and obsessive-compulsive disorder (though the definition of what "works" privileges quantity over quality, another binary that has become entrenched).

Patients or clients—and what we call them is *not* insignificant—are forced to navigate a complex and overdetermined nexus of resources; they are called upon to conceive of themselves and their lived bodies—healthy or sick or somewhere in between—as genetic bodies, as bodies-at-risk, as bodies-under-surveillance, as bodies that cost the state a certain amount of money, and so on. The patient's—or client's—identity emerges from within a tangled web that includes Big Pharma, innumerable government lobbies, government agencies and public policymakers, academia and its research sponsors (hungrily promoting "commercialisable outcomes"—an obsessive-compulsive disorder on the institutional level), the convergence of research and business with its multiple public and private "stakeholders" (whether expressly greedy or ostensibly altruistic), and a for-profit in-

surance industry, to name just a few of the players whose terms and terminology fill the air like a miasma. Increasingly, patients—or clients—understand themselves according to the technoscientific, biomedical, and bioeconomising terminology of neoliberal governance, where the economy and free-market capitalism form the dominant grid of intelligibility for every form of life (and death)—a neofascism deploying the vocabulary of "excellence," "evidence-based," "key performance indicators," "accountability practices," "outcomes," and the like. These are the naturalised and legitimised concepts and terms of our healthcare Newspeak, drawn from the rhetoric of the corporate sphere, recklessly imported into the health sciences.

Who will dare question whether this is the best model? Patients have lost the concepts and terms within which such a critique could take place; increasingly, they see themselves as "clients," and many have been duped by the false promise that such jargon "empowers" them. Meanwhile, an ethos of business-as-usual carries the day. And it is more complex still, because nursing and medical management and delivery—all of us who work in the anarchic fields of the health sciences—we, too, find ourselves within this tangled web, worked over by these instruments, defined, forcibly identified. In a remarkably short time, this way of speaking has become second-nature to us. This terminology has become a way of thinking—a way of life—that threatens to eclipse all other ways of thinking, concealing from us that there is in fact a crisis. As Judy Segal writes, "the terms of a discourse constrain not only the outcomes of debate but also what it is possible to argue at all." [7]

Here, then, is an aporia, a contradiction that is beyond rational solution; it cannot be resolved in a conventional way, by the ramping up of Enlightenment reason. An aporia cannot be resolved simply by appeal to scientific logic or to the techniques of modern rationalism. An aporia therefore shows the limits of scientific logic and rationality, exposing its "blind spots." It shows where they fail, delivering us over to the ethical and the political:

where we are exposed, absolutely without protection ... and without prosthesis, without possible substitution, singularly exposed in our absolute and absolutely naked uniqueness, that is to say, disarmed, delivered to the other, incapable even of sheltering ourselves.... [6]

From what place, then, shall we speak? Must we not speak, start to speak, from the recognition of a certain impossibility of speaking and starting? If so, we would speak or start as a displaced person, neither claimed for nor by one kingdom or the other (and imagine how this shift in perspective alone

would reconfigure the geopolitics of AIDS, starting from the ways that “responsibility”—or moral “culpability”—are inscribed geographically, racially, socioeconomically, sexually...). This calls for an ethic of critique. I do not mean “ethics” in the normative sense because “ethics” tends to imply a sedimented set of practices, a set of rules or a code. There are too many of these already, and to what avail? Instead, I am calling for singular attention to our very own practices, and a thoughtful attention to those discourses that make our particular practices seem to us to be true or right. This means to question what is taken-for-granted, to question the aporias, the blind spots in the ways that we conduct our research, and in the ways that healthcare is managed and delivered. We have the duty to claim responsibility for the effects of our discourses and actions, a responsibility that extends beyond the limits of our own work, our own disciplines, and our own nationalisms. If we are *in them*, we must not be *of them*. We must squarely face those places of paradox and impasse, and together begin to imagine something new, to forge new metaphors—new ways of speaking and thinking and relating.

***Note**

In the rhetoric of healthcare, there are relatively few properly “critical” studies. See, for instance, Heifferon & Brown[8], Lyne[9], Segal[10,11]; Segal[12] offers a bibliography including some interdisciplinary writings in the “field,” acknowledging that much of the research “consists of ‘rhetorical’ commentary by nonrhetoricians in disciplines such as anthropology, sociology, psychology, philosophy, history, and cultural criticism.”[12] Often, the “‘rhetorical’ commentary,” as Segal calls it, is not concerned with the production of meaning and affect—not to mention subjective identity—through language or even nonlinguistic forms of persuasion. That which is tends to fall within the more empirical tradition of communications studies, rather than to the work of rhetorical theory and criticism. Very few scholars adopt a critical poststructuralist perspective, as I do here; see, for instance, Doyle[13], Lupton[14], and Morris[15]. Elsewhere, Dave Holmes and I have suggested that a poststructuralist understanding of human subjectivity resonates powerfully with the fragmented and contested body-subject of biomedical technologies, in which the shift to molecular (genetic) identities, for example, spells the end to modern autonomy, reason, and truth (see Murray & Holmes[16]).

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