"Icons" of Bureaucratic Therapy: An Application of Eco's Semiotic Methodology in an Intercultural Health Care Setting

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Abstract

This is a study of interaction between American Indian patients and the Euro-American mainstream organization that provides health care to Indians. Posted displays of verbal language at three U.S. Indian Health Service (IHS) facilities are the data for the present study. The term bureaucratic therapy is used to characterize the health care delivery organization--a federal bureacracy--and IHS perspectives in this study. This study demonstrates that the application of rhetorical constructs to ethnographic studies has been substantially assisted by Eco's reconfiguration of semiotic ontology. By providing a method for the semiotic analysis of both verbal and nonverbal language, Eco has made possible the perspectival rhetorical analysis of the semantically vibrant cotexts often documented by ethnographic research. These posted displays were found to constitute more than verbal language expressions subject to traditional rhetorical analysis. Rather, they reveal the cultural conflict as iconic sign-functions made up of intertwined verbal and nonverbal elements. These provide evidence of language-created social perspectives consistent with results obtained in other studies at the same facilities and are data for interpretation of the organizational text as a coherent whole. (187 words)

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facilities are the data for the present study. This study examines "icons" (Eco, 1979) observed at three Indian Health Service (IHS) facilities. The "icons" under analysis are publicly displayed printed or handwritten material posted throughout sites that were the objects of extensive ethnographic descriptions in other studies. This study posits that both professionally produced and temporary informational displays at IHS clinics provide data indicating that these organizations are examples of bureaucratic therapy. This revelation is not necessarily by way of the cognitive content of the verbal language printed or written on these displays but rather by way of the "iconic" sign-functional processes (Eco, 1979) of these displayed expressions of communication.

Rhetorical Analysis and Eco's Semiotic Methodology

This study extends previous work on cultural conflict by the authors (Glenn (now Shaver), 1990/1991; O'Hair, Friedrich, & Shaver, 1995; L. Shaver, 1993; L. Shaver & P. Shaver, 1995; P. Shaver, 1991; P. Shaver & L. Shaver, 1992a,b) in which verbal and nonverbal language outputs are seen as evidence of the rhetorically motivated perspectives of an organization and its members and of an organization's patients, clients, or customers.

Several ethnographic scholars (Clifford & Marcus, 1986; Marcus, 1983) have begun to apply rhetorical analyses to ethnographic data. Eco's (1979, 1986, 1990) reconfiguration of semiotic ontology has enhanced the utility of semiotic insights for rhetorical analysis of ethnographically documented interactional texts. One of the authors (P. Shaver, 1991) has utilized perspectival rhetorical analysis (Burke, 1969a, 1969b, 1970, 1979, 1985; Cherwitz & Hikins, 1986) to analyze letters written by media managers and professionals in order to reveal the central dilemma at which their primarily subconscious purposive arguments were directed. Under this approach, language is seen as indicative of perceived social realities because it is the primary mechanism for creating and maintaining social realities. Thus, the operational perspective of a person, a group, or an organization can be revealed by the rhetorical analysis of its discourse.

Utilizing this perspectival rhetorical framework, the authors have analyzed ethnographic data to study, among several sites and contexts, the doctor/patient visit (Glenn (Shaver), 1990/1991), the significance of architectural changes in a health organizational context (P. Shaver & L. Shaver, 1992b), the effects of organizations "speaking" the client in a women's correctional center (L. Shaver, 1993), and the subculture of AIDS among care givers (L. Shaver & P. Shaver, 1995). In these studies, semiotic constructs have provided insight into operational rhetorical perspectives.

In the present analysis of ethnographic data, the authors propose that signs (i.e., signs in the everyday meaning: wall-mounted documents, containing words

and sentences that are purportedly informational) are also data that are subject to perspectival rhetorical analysis. In this instance, these displays are being approached as "icons" in Eco's (1979) sense of the term. That is, the verbal language is taken into consideration as only a part of the total sign-functional process represented by the display. This method of analysis takes into consideration the combined semiotic influences both of verbal and nonverbal language environments.

The Sign-functional Process

Recognition of the generalized impact of environmental influences is consistent with Lotman's (1990) construct of "semiosphere." While this insight is useful in conceptualizing the influence of semiosis for the "taken for granted" (Eco, 1986, p. 85; Solomon, 1988), characteristics of everyday life, a more analytically rigorous methodology is necessary to put to use the semiotic insight as a part of perspectival rhetorical analysis of phenomena that are semantically "fuzzy" or "iconic" (Eco, 1979) as is the case of wall-mounted displays of purportedly informational verbal language.

To provide such a methodology, the study of signs and sign-production provided by Eco (1979) is useful. He says, " . . . Without doubt verbal language is the most powerful semiotic device that man [sic] has invented; but . . . nevertheless other devices exist, covering portions of a general semantic space that verbal language does not" (p. 174). Eco (1979) maintains that signs that are not in the form of verbal language can be more usefully differentiated from the elements of verbal language by relation to their characteristic "modes of producing sign-functions" (p. 217) than by a typology of signs. Eco supports this by saying:

> There is a radical fallacy in the project of drawing up a typology of signs . . . . if instead one classifies modes of sign production, one can include both grammatically isolated sign-functions and more global textual units which assume the role of large-scale (undercoded) sign functions, such as . . . so called 'iconic signs' . . . . macro-units which undoubtedly have a significant function but in which it is impossible to isolate signs as grammatical units. (1979, p. 217)

Avoidance of this "verbo-centric fallacy" (Eco, 1979, p. 303) allows rejection of the position taken by Levi-Strauss (1961) that only systems ruled by double articulation can be seen as languages. It is important to avoid such an over-restrictive view of semiosis in order to approach large scale or "fuzzy" sign functions that are central to analyses of ethnographically described contexts. This is so because such analyses

seek to utilize the fullness of semantically vibrant cotexts constituting the interaction under study.

In addition, Eco's (1979) approach makes possible the conceptualization of texts involving more than one kind of sign-production. Eco says, " . . . there are no signs as such, and many so-called signs are texts; signs and texts being the result of a labor of correlation in which many variously intertwined modes of sign-production take part" (1979, p. 256).

Thus, Eco (1979) says that "the most elementary architectural configuration is a text" (p. 260) even if the cultural convention engaged by the expression is not detectable in terms of "more analytical units" (p. 261). Therefore, just as "ready-made rhetorical sentences are examples of overcoding" (1979, p. 263), so expressions, such as the displays under study, that involve combinations of verbal language, architectural ostention, and iconic expression can be seen as rhetorical texts indicative of the world view or perspective of the speaker. This is so despite the impossibility of segregating elemental aspects of the sign-function in question.

Accessing Organizational Texts

The study of the rhetorical use of texts in health organizations is important because such organizational processes can impact health outcomes for patients. However, the complexity of medical care delivery organizations renders direct textual interpretation problematic. Researchers (Billig, 1987; Billig, Condor, Edwards, Gane, Middleton, and Radley, 1988) have demonstrated that human thought and social discourse are made up of oppositions--dilemmatic elements--which are both explicit and implicit. Such an approach is in contrast to the traditional social psychological view that human thought is controlled by consistent, internal schemata or templates. This dilemmatic insight is fundamental to the recognition that positive and negative referents organize the language of organizations. Furthermore, Billig's et al. (1988) viewpoint operationalizes Burke's (1969b) view that oppositional discourse structures the perceptions of participants by composing master metaphors that are agonistic (e.g., contesting and combative). Discovery of the master oppositions--dilemmas also known as "sites of conflict" (P. Shaver & L. Shaver, 1992a)--provides both access to and confirmation of the semiotic coherence of the perspectival language under study.

The Study

Within the area of health communication, the interaction between health provider and patient in particular health organizations has been the focus of many studies. In this study, the focus is on the printed public displays of purportedly informational signs at three Indian Health Service (IHS) clinics.

Indian Health Service is a United States federal bureaucracy assigned the responsibility of providing health care for American Indians. IHS provides the health care for the majority of the American Indian population the U.S. In states with a substantial Indian population, clinics and hospitals are available at various locations for free or token-payment care, provided that the patient can document, according to various federal procedures, their Indianness.

Medical care for Indians began under the Department of the Interior in the nineteenth century as an aggregate population medical care program, a "fort-Indian" approach to health treatment. The original type of medical care that was given to the American Indian was based on the particular situation in areas in which Indians, primarily during the 1800s, were removed from their lands and forced to live in inhospitable and strange environments. Quite often the move resulted in different climates, food sources, and living conditions. These changes often created catastrophic health problems for the Indian populations (Twaddle & Hessler, 1987; Kane & Kane, 1972). In taking responsibility for the health of Indians under the "special" relationship of Indians to the federal government, government representatives at the seats of influence in the West--the forts in the West or religious missions--doled out modicums of health care to Indians who were forced to seek assistance with two major problems created by the relocation--poor health and insufficient food. The fort-Indian health provision is the fundamental foundation of IHS, an aggregate approach to health care that is in contrast to the assumptions of the Indian patients that they are to receive individual, personal health care rather than aggregate medical attention.

The Sites

The ethnographic data is from three IHS clinics. Two are in Oklahoma and one clinic is in New Mexico. Clinic 1 is in a large Oklahoma city and is a storefront clinic that contracts with IHS and a private not-for-profit foundation to provide health care for these urban-based Indians. The clinic has the following services: a walk-in clinic, appointments with a family practitioner (the only doctor on staff), appointments with a gynecology/obstetric nurse practitioner (who is at the clinic on a part-time basis), a pharmacy, and a dental clinic.The clinic is underfunded with a patient load that is excessive for the staff, medicinal supplies, and services available. The buildings are converted stores in the downtown portion of a large city in a poor neighborhood with a high crime rate. Unlike non-contract IHS facilities, the primary administrator is an Indian woman. However, like IHS facilities across the U.S., the doctor at the clinic is an Anglo male, while the nurses, support staff, and receptionists are primarily Indian women with one Indian male.

The patients are Indian women, men, and children of all ages, representing the 34 federally recognized tribes for which the Federal government has agreed to provide health care. Patients can be described as being on a continuum from Indians who are traditional (e.g., many of whom speak English as a second language) to Indians who are fully acculturated to Anglo society (e.g., identified as Indian only by documentation). While the patients are primarily Indians in a lower socioeconomic group, some patients are middle-class, choosing to use IHS because of the convenience or because their jobs provide health care that requires co-payments beyond their capacity, or because they have been accustomed to using IHS throughout their life. For many Indians in Oklahoma, IHS is their fall-back health system when they are unemployed or employed without health benefits.

Clinic 2 is a traditional IHS facility (as opposed to Clinic 1, which has a contract with IHS) and is one of the largest in Oklahoma. The 1980 building was specifically built for IHS. Located in a town of 30,000, the clinic's primary source of patients is the Chickasaw Nation, although Indians from many nations use the facility. The Chickasaw Tribal Headquarters is situated in the town. As in all Oklahoma IHS facilities, Clinic 2 has similar patients as those described in the section on Clinic 1. Clinic 2 has a hospital and the following services: a walk-in clinic; appointment opportunities with specialists (e.g., gynecologist/obstetric, pediatric, family practitioner, orthopedic), an audiology clinic, an optician, an emergency room, physical therapy facilities, a pharmacy, and a dental clinic. Unlike Clinic 1, the administrators at Clinic 2 are primarily Anglo, middle class, and male. As in Clinic 1, the doctors are primarily Anglo, male, and middle-class. Like Clinic 1, Clinic 2 has a majority of support staff who are female and Indian. Clinic 2 is larger than Clinic 1. However, as noted in other studies (L. (Glenn) Shaver, 1991/1990), the federal bureaucratic therapeutic culture is present in both organizations.

Clinic 3 is one of the largest (IHS) facilities in New Mexico, and unlike the Oklahoma facilities, services three primary tribes: Navajo, Pueblo, and Apache. While members of other tribes are eligible to receive treatment at Clinic 3, the reservation system in New Mexico results in a more homogeneous Indian population. Clinic 3 is very similar in availability of services and demographics of staff to the large hospital and clinic in Oklahoma--Clinic 2. Clinic 3 is a much older building, dating back to the time that Indian health responsibilities were directed by the Bureau of Indian Affairs (BIA).

Data Collection

Ethnographic data, including field notes and photographs, were collected at Clinic 1 during four visits at various times during 1989 and 1990 and a one week time-span at a later date of 1989. Data from Clinic 2 were collected during six years

(1984-1991) of naive and planned participant observations at Clinic 2. Clinic 3 was visited six times during 1991 and 1992. Additional information was collected through informal interviews with employees and patients at all three sites.

The Posted Language

The data observed are consistent with coherent interpretations posited by the authors in previous analyses of patient/doctor visit taxonomy, time, and architecture in health organizations. The foci in this study are the "iconic" sign-functions of publicly displayed posted information. Examination revealed these displays to be "icons" characterized by rhetorical and ideological overcoding and code-switching functioning semiotically. The experiential impact of such devices is demonstrated by Hummel's (1987) analysis of bureaucratic languages:

> Bureaucratic specialized language is specifically designed to insulate functionaries from clients, to empower them not to have to listen unless the client first learns the language. For a client who has learned the language is a client who has accepted the bureaucrat's values. Language defines both what problems we can conceive of and what solutions we can think of. Once a client uses the bureaucracy's language, the bureaucrat may be assured that no solutions contrary to his [sic] interests and power will emerge. . . . . Once we recognize the mind-changing function of language, it is only one further step toward recognizing the ultimate function of bureaucratic language: a bureaucracy's language is usually so constructed as to prevent both bureaucrats and outsiders from ever formulating questions that might attack the underlying assumptions of the bureaucracy itself. (p. 181)

While Hummel (1987) has successfully characterized communication in bureaucracies and the impact on clients, the power of perspectival rhetorical analysis, as informed by Eco's (1979) semiotic methodology, allows investigators access to the perspectives of organizations as "speakers" in a way that Hummel's audience-centered analysis does not.

Analysis

Upon analysis, the dimensions of the posted displays can be summarized in a 4-way matrix: overcoding/code-switching and permanent/temporary signs. Overcoding refers to the inflexibility of definitions of legitimate and acceptable behavior of the patients in interaction with the organization. Code-switching refers to the impact of purported informational displays that have the actual purpose of limiting patient access to the resources of the organization, while appearing to be

helpful. These "icons" of publicly displayed printed materials are: (1) professionally produced permanent signs on plastic or wood, attached with screws and brackets to doors, entry ways, and corridors or professionally produced signs that are on paper or poster board that appear to be less permanent but are obviously not a handmade display and (2) and temporary signs that are wordprocessed or handwritten on poster board or on paper in pen or with markers.

Overcoding

The overcoding manifested in the inflexibility of definitions of legitimate and acceptable behavior of the patients in interaction with the organization is negative to the patients. The patients are inundated with signs that are placed at each vital turn and entry prior to entering the building and inside the building, including rest rooms and snack areas. These represent the procedural and process oppositions--the master opposition-between the organization and the patient. That opposition is the perceived IHS organizational mission of aggregate care--the "fort-Indian" construct versus the Indian patient's assumption that health care will be personal health service.

Listed below are topics of behavior found in signs at the three IHS clinics, behavior deemed by the organization as necessary to be regulated:

1. Cleanliness
2. Attention to time
3. Conduct of one's child/children
4. Parking
5. Smoking
6. Seat belt use for self and children
7. Rules against soliciting
8. Restrictions against asking how long one will have to wait
9. Where one can and cannot have drink and food.

What are the consequences of interaction between patient and health service organizations as a result of overcoding? Indian patients are constantly reminded of their insignificance in the organization. The implicit messages is: "After all, the health care is free; does the patient expect to be treated as though this were a private health care organization?" In fact, that is exactly what the patient expects.

Media messages, interactions with patients in private health care delivery systems, and common knowledge about everyday information, including health care, all suggest to the patient that the organization--represented by its functionaires--is designed to: (1) attend personally to patients' needs; (2) treat the patient the consideration with which organizations normally treat patients, clients, or customers; and (3) interact on an equal basis with the patient. Contrary to these positive expectation and, in spite of past experiences, the patient is met with the perspectival

rhetoric of the organization that reveals its negative expectations of the patient's behavior.

Perhaps one of the best illustrations is the following: Except for physically disadvantaged patients, the only way to access the walk-in and appointment clinic at Clinic 3 is to walk up two flights of stairs. Beside a large mural of an Indian woman and child, are several "icons" of the organization. Immediately to the right of this painting that typifies Indian motherhood, a permanently affixed sign reads:

PLEASE READ & OBEY

Following that sign, are various other instructions for proper behavior of self and one's children while obtaining health care at the clinic.

The expectations of most patients in these circumstances are not met. Rather, the restrictions negatively impact the interactions between the patient and the receptionist, the screening health provider, and, ultimately, the doctor. Such inflexibility of expectations of behavior by the organization toward the patient constitutes restraints on the patient that have far reaching consequences, many of which are not immediately observable, but can be perceived through mutually shared understanding of human interaction. The patients are essentially disenfranchised as an active, enthusiastic, and effective health partner in their health system.

The use of signs to prescribe correct behavior in these public health organizations is in striking contrast to the absence of such signs in private or private/group health organizations. One sign in a private care office in New Mexico instructed the patients behavior, but the content of the sign instructed the patients not to wait in excess of a certain amount of time before they reminded the receptionists that they had waited longer than the time considered acceptable in that organization. This is quite different to an IHS sign that says:

DON'T ASK HOW LONG YOUR WAIT WILL BE. WE DO NOT KNOW.
YOUR NAME WILL BE CALLED IN THE ORDER THAT IT WAS GIVEN.

The overcoding represented in these "icons" is similar to architectural changes at an IHS clinic discussed in an earlier work (P. Shaver & L. Shaver, 1992b). The changes at that clinic said more to the patient about the perspectival worldview of the organization toward the Indian patients than the organization intended to say. These public displays constitute perspectival rhetoric, reinforcing the message that behavior by the patients will be intolerable and unacceptable unless in conformity to these signs--"icons" of the organization.

Code-switching

In addition to inflexible demands regarding behavior, the purported informational displays operate to legitimize the limiting of patient access to the resources of the organization. Many of these displays are in the guise of helpfulness. In all three IHS clinics, the resources of the clinics are very carefully restricted and

negatively defined in relationship to patients and visitors. This limitation of resources includes the use of space and activities in those spaces as well.

Under this type of "icon," signs addressed the use of or the restriction to the following resources:

1. Telephone
2. Certain machines (e.g., copiers, washer and dryer in the snack area of one hospital, restricted to patients only)
3. Emergency room service (i.e., When the IHS facility is closed, the patient may go to a designated facility, but the patient must report the visit in 72 hours and must justify the visit as an emergency under unposted guide-lines.)
4. Information on procedures (e.g., obtaining of referrals is based on a complex systems of procedures that are not given to the patient)
5. Places available for human activity necessitated by long waits for health services (e.g., areas for eating and drinking and letting children play)
6. Rules for obtaining health care (e.g., entering the IHS and local clinic system and directions to various clinics)
7. Instructions for receiving care during the hours that the clinic is closed
8. Instructions on how to cancel appointments
9. Sanctions for breaking rules (e.g., missed appointments result in loss of health service for a year; tardiness results in having to reschedule for another time)

Patients who use IHS facilities are generally limited in financial resources. They often live many miles from the IHS clinic and must make careful preparations for such trips, often depending on friends or family. IHS centers are crowded, and long waits are normal. Because such trips are difficult to plan, families usually have to combine several reasons for going to IHS. Several family members will combine trips for: personal health problems, pharmacy needs, social welfare questions, and so forth. Because several people with many needs are at the clinic, they have social, sustenance, and physical needs that are not consistent with a federal bureaucratic organization. Bureaucratic therapy appears to limit patient access to the resources of the organization in order for the organization to maintain its status quo.

Again, the perspectival rhetoric of the organization is perceived through both the topics and the purpose of the "icons" in that the IHS organization, as most systems, seeks to protect itself, its functionaries, and its resources against the possible encroachment of outsiders--the Indian patients. These public displays are not information sources. Rather than provide help, these displays restrict the resources of the organization and legitimize inattention to patients. This is so because these are patients who are taking care of children, eating, drinking, and

living through a long day while they access the organization for their health needs, thereby justifying the long trip that depletes the family's energy and resources.

Professionally Produced Signs

The public displays can be analyzed in terms of their construction as well as their messages. Many of the signs in the clinics were professionally produced. In the Oklahoma clinics, these were the to-be-expected signs announcing hours of operation, directions to clinics, rules on food and drink, and so forth. The most pragmatic signs (i.e., the types of informational signs found in most public buildings) were the permanently affixed signs at both Oklahoma clinics. These are similar to others observed in governmental bureaucratic organizations.

In New Mexico, a difference was observed between the professionally produced permanent signs. The overcoding signs and the code-switching signs that were highly explicit, revealing the negative perspectival rhetoric of the organization, and were permanent and professional. Oklahoma's permanent and professional signs tended to be more neutral informative explanations.

Temporary Signs

In IHS facilities in both states, temporary signs were used. These were more negative in all clinics than the permanent signs, but negative permanent signs, as has been discussed, were also present in New Mexico. The marker or pen signs on poster or paper tended to express immediate frustration with patient demands or presumed claims on the resources of the organization (e.g., time use of the staff, telephone, information) that had so apparently angered or frustrated the staff that signs cropped up in response to the problems.

These signs were often poorly printed with grammatical errors. Exclamation marks, underlining, and capital letters were used for emphasis. The temporary signs did not relate to immediate health problems or interaction between the doctor and patient (except for the time factor). In reality, the overcoding and code-switching in the temporary signs represented the immediate problems or ongoing conflicts between the functionaries of the organization, who, having adopted the rhetoric of the organization, served as "front-line soldiers" to protect themselves and the system from the "inappropriate" behavior of patients and the demands on the resources from the patients. Ironically, most of these functionaries were Indian themselves having been co-opted by the system (Hummel, 1987; Glenn (now Shaver), 1990/1991).

In New Mexico, the permanent overcoding and code-switching "icons" represented a departure from the temporary versions in Oklahoma. One answer is that the two clinics in Oklahoma are much newer than the one in New Mexico. Different perspectives in the 1980s have guided some IHS decisions on public

displays that are, indeed, permanent. Regardless of the "causality" of the differences, the effects of the overcoding and code-switching "icons" that were permanently affixed were more pronounced and immediately noticed by researchers. Such responses were confirmed by Indian patients who have used the New Mexico facilities for some time.

In short, the overcoding and code-switching of both professionally produced permanently affixed signs and temporary signs represent the perspectival rhetoric of the organization--the master oppositional perspective between the aggregate mission (i.e., "fort-Indian" health care) for health care of IHS and the perspective of indiv idual and private health care for the Indian patients at the clinics.

Conclusion

Ethnographic data, as used in this study, allows for an analytical approach to kinds of "speech" that are not in the nature of verbal language. This study has focused on the cultural conflict on American Indians at IHS clinics--the sites of bureaucratic therapy. Semiotic insight provides the methodology for the rigorous analysis of the rhetorical labor of overcoding and code-switching (Eco, 1979). Eco sees such semiotically sensitive rhetorical analysis to be conducive to a: "new rhetoric [which is not a] . . . subtle fraudulent discourse but . . . a technique of 'reasonable' human interaction, controlled by doubt and explicitly subject to many extra-logical conditions. (1977, p. 278)

The problem, however, with the rhetorical analysis of nonverbal language is that it further complicates the already tenuous distinction that Eco (1979), in an attempt to maintain his positive view of rhetoric, makes between rhetorical overcoding and code-switching and ideological overcoding and code-switching. Not only does Eagleton's (1991) analysis of ideological language throw such a distinction in doubt, but Eco (1979), himself, ultimately accepts the interpretive process as inherent in semiotic analysis, noting that semiotics, doubling as both a theory of codes and sign-production, is also a form of social criticism.

Similarly, the concept of perspectival rhetorical analysis necessarily involves the interpretation of the contextualized viewpoint of speakers based on the text produced. Such an interpretation is necessarily a critique, which, in like manner, is subject to interpretation. Nevertheless, the fact that interpretation is a critique does not mean that it is not a text. White (1985) has said that texts can be read with three goals in mind in order to establish confidently shared understandings of: (1) what they mean; (2) what they do not mean; and (3) about what they are unclear. Eco (1990) goes further by saying that texts must be seen as a coherent whole:

> An open text is always a text, and a text can elicitinfinite readings without allowing any possible reading . . . . But a text is an organism, a system of internal relationships that actualizes certain possible connections and narcotizes others . . . How to prove that a given interpretive conjecture is, if not the only right one, at least an acceptable one? The only way is to check it upon the text as a coherent whole: any interpretation given of a certain portion of a text can be accepted if it is confirmed, and must be rejected if it is challenged, by another portion of the same text. In this sense the internal textual coherence controls the otherwise uncontrollable drift of the reader. (pp. 148-149)

The ethnographic data used in this study and previous studies by the authors demonstrate a system of internal relationships that "actualizes certain possible connections" (Eco, 1990, p. 148), allowing for acceptable interpretations by examining the text (i.e., the "speech" of the organization) as a whole, thereby, controlling, as Eco (1990) terms it, the "otherwise uncontrollable drift of the reader" (p. 149).

This study is a part of a body of research in which the authors are pursuing the study of social interaction in various contexts, particularly health care settings, by applying rhetorical analysis to ethnographic data. The application of this approach to nonverbal language has been made possible by Eco's (1979, 1986, 1990) reconfiguration of the semiotic ontology of human language. By providing a method for the semiotic analysis of both verbal and nonverbal rhetorical language, Eco has made it possible for perspectival rhetorical analysis to take into consideration more of the semantically vibrant cotexts made available by ethnographic data.

Based on the authors' experience in pursuing the research program that includes the present study, perspectival rhetorical analysis provides important insights into language as culture. This is the case whether the discourse producing a text be dyadic, organizational, or public. Eco (1979, 1986, 1990) provides a valuable tool for improved rhetorical analysis of ethnographic data by grounding in semiotic theory the proposition that language is both verbal and nonverbal. The resulting rhetorical methodology provides a basis for research that will support the position of the communication perspective that language is the primary mechanism for creating and maintaining social realities.

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Notes

1. The term American Indian is used in this paper because it was in general use during the time of the data collection 1989-1992. Furthermore, among Native people in Oklahoma and New Mexico, the sites of the data collection, the term is more commonly used than others and is associated with the health care delivery system known as "Indian Health Service."

2. The authors wish to thank L. Brooks Hill (Ph.D., Chair of the Department of Speech and Drama, Trinity University) for suggestions on an early draft of this paper and for his idea of the term bureaucratic therapy.

3. For a more complete explanation of the documentation process of determining who is an Indian and a discussion about Indian Health Service (IHS), a federal bureaucracy under the Public Health Department, see L. (Shaver) Glenn 1990/1991).

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