Indexical Disorders and Ritual (De)Centers of Semiosis

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ABSTRACT

Focusing on Michael Silverstein's account of relationships between "microcontexts of interaction" and the "macrosociological," this article takes up his suggestion that news reporting provides particularly clear examples of such links. Examining a mundane *ABC World News* report on changing recommendations for vitamin intake, it analyzes how leading physician-journalist Richard Besser constructs a ritual center of medical semiosis, projects it as inaccessible to laypersons, and models a circulatory process that requires highly constrained forms of communication. Ethnography in newsrooms, clinical spaces, public health offices, and elsewhere suggests how notions of (1) a ritual center that produces medical knowledge, (2) a primordial space of doctor-patient interaction that affords limited, highly regulated access to laypersons, and (3) what are construed as processes of communication require the continual making of communicable models that attempt to separate projected first and second indexical orders and, just as importantly, generate *indexical disorders* that create anxiety and seem to require assistance from physician-journalist guides.

One of the principal—and thorniest—problems that Michael Silverstein has addressed over the past two decades has centered on his attempt to build an analytically adequate account of the relationship between what he refers to as "microcontexts of interaction" and the "macrosocial" or "macrosociological." He opens his influential essay on indexical orders, for example, by suggesting that "the claim of this paper is this: 'indexical order' is the concept necessary to showing us how to relate the micro-social to

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the macro-social frames of analysis of any sociolinguistic phenomenon" (2003a, 193). He further argues that examining "competing n + 1st–order presuppositions"—which he characterizes as "ethno-metapragmatic" or cultural construals of the indexical meaningfulness of a particular ("nth-order") event—helps us grasp how "politicoceconomic and other interests clash in a social system" (203). In Silverstein's essay, the analytic center seems to land on the interactional side of the equation through his insistence that the difference between an "illuminating" versus an "incomplete or inadequate" analysis rests on a scholar's ability "to take account of the dialectical plenitude of indexicality in microcontextual realtime" (227).

In "Cultural Concepts and the Language-Cultural Nexus," published the following year, Silverstein was centrally concerned with relating the poetics of interaction to "large-scale, macrosocial orders, in-effect ritual centers of semiosis" (2004, 623). Such "wider-scale institutional 'orders of interactionality'," he suggests, "come to exert a structuring, value-conferring influence on any particular event of discursive interaction with respect to the meanings and significance of the verbal and other semiotic forms used in it." Building on his indexical orders argument, he goes on to characterize the complexity of an interaction as reflecting its status "as a nodal point of a network" that is situated vis-à-vis conflicting interdiscursivities that connect macrospaces structured by political, economic, and/or other "principles and dimensionalities" (2004, 623). The ideological work of constantly creating n + 1st orders is crucial for these interactional/macrosocial connections, given that they seek to construct interdiscursivities and connections to macrospaces, sometimes in conflicting ways, at the same time that they help configure the "cultural essentializations (frequently naturalizations)" that imbue these ritual centers with value and make them "convincingly real to us" (2004, 639).

Returning to the issue nearly a decade later in "Discourse and the No-Thing-Ness of Culture," Silverstein seems to accord more analytic priority to "certain centers of value production," which he also refers to as "centers of regimentation" (2013, 329, 362). His long-term interest in interdiscursivity is here inflected through the notion of "emanation" as he suggests that what gets recognized as circulation is a reflection of "fixed and tiered structures of emanation" from centers that "anchor particular trajectories of circulation" (2013, 329). Emanation is doubly determining, given that it "defines an overall structure of tiered nodes in a network of sites of practice" through "institutionally regular trajectories." Silverstein posits that these centers possess substantial agency, referring to them as "generative" and as determining "complex cultural

forms as experienced" (2013, 363). Silverstein seems to preclude the possibility that his framework would be seen as a structural account that posits monocausal and unidirectional relations in two ways. First, he continues to locate complex forms as determined by multiple centers of emanation. Second, he echoes his previous analytic investment in interaction: "Phenomenally and epistemologically semiotic signification emerges in the first instance in events of discursive interaction" (2013, 363). Indeed, although an account of "three great macro-institutions of our society"—applied science, aesthetic connoisseurship, and retail marketing—advances the analysis of oinoglossia (wine talk) that highlights his approach to macrosociological dimensions, the essay begins with a return to his detailed analysis of the poetics of a conversation between two University of Chicago professional students.

These and other essays by Silverstein's provide a provocative set of ideas for tackling issues that are central to how linguistic anthropologists use close analyses of interaction, entextualization, poetics, and indexicality to provide new insights into contemporary life. In "Discourse and the No-thing-ness of Culture," he challenges us to "consider news reportage in our media as an institutionalized route by which this process, the circulation of cultural signification, happens" (2013, 337). Television news in particular is a fascinating site, because it stages interactions that purport to be indexical icons of events that are shaping the most pressing issues of the day, shot through with what is constructed as second-order indexical discourse that promises viewers direct, privileged means of interpreting the significance of these events. Reporters and camera crews trace what are construed as processes of circulation, moving from the actors who stand in the ritual center to what is projected as the endpoint of circulation—quotes from lay-persons-in-the-street who register their surprise, pleasure, or consternation at having just been interpellated by discourse traveling this circulatory circuit. Given that each national network news broadcast traverses a spectrum of ritual centers—associated with politics, economics, sports, and so forth—Silverstein's challenge seems right on target in directing us to a locus we can use in helping his analytic rubber meet the semiotic road.

Here I focus on a ritual center that is much less explored than the political sphere, on which he has often focused (Silverstein 2003b; Lempert and Silverstein 2012). Health news forms a perfect locus of analysis, given the status of medicine as one of the most privileged and bounded centers of semiosis, one that perhaps most perfectly embodies the unequal distribution of cultural knowledge that, Silverstein suggest, is crucial to micro-macro links. I analyze a seemingly ordinary and mundane news story on a seemingly innocuous feature of

everyday health—vitamins. Seeing how journalists turn shifts in recommendations for their daily ingestion into news will, I think, suggest how we can extend Silverstein's understanding of relations between interaction, circulation, and ritual centers of semiosis. I draw on ethnographic work in exploring the analytic complexities that face us in identifying such ritual centers, scrutinizing processes of circulation, and examining what are projected as interactional endpoints, using the notion of communicability for this purpose (see Briggs 2005).

The November 30, 2010, *ABC World News* Segment "Changing Advice?"

As *ABC World News* anchor Diane Sawyer opened a health segment on the November 30, 2010, evening broadcast, her face projected anxiety and confusion. You might think that the report would focus on a new epidemic or at least a mutation that could enable an influenza virus to "jump" from chickens or monkeys to humans. Beside her, however, was a photograph of calcium and vitamin D tablets with the title of the segment, "CHANGING ADVICE?" (fig. 1). The segment was "pegged" to the release that day of a report by the Institute of Medicine (IoM) on recommendations for daily intake of calcium and vitamin D. The IoM stands at the center of the ritual center of medical semiosis. The panels it organizes consist of leading medical and public health researchers who, largely,

Figure 1. Image capture of segment of *ABC World News*, November 30, 2010

Figure 2. Image capture of Richard Besser, ABC News' chief health and medical editor

analyze studies published in professional journals and make recommendations that are designed to guide clinical practice and government policy. Beyond laying out the recommendation of 600 units of vitamin D for adults and children and 400 for infants and 1,200 mg of calcium, the news clip presented, in Sawyer's words, the "confounding" finding that guidelines designed to promote healthy bones were leading some women to take too much calcium, thereby increasing their chances of developing painful kidney stones. The story traces the circulation of knowledge from this projected point of origin in a macrosociological sphere through its assimilation by doctors to its reception by patients, both from their providers and from the physician-journalist appearing on the television broadcast.

A key feature of health and medical reporting for ABC, CBS, NBC, and CNN is the use of physicians as reporters. From 2009 to 2017, ABC News' chief health and medical editor was Richard Besser (fig. 2).[1] Trained as a pediatrician, Besser taught in a medical school and subsequently worked as an epide-

1. Hallin and I eventually succeeded in interviewing most of the physician-journalists for national network news and their producers. Among them, only Richard Besser asked us to use his name and that of his network. In order to assure anonymity among other members of this small and highly visible group, we have changed their names and do not name their networks.

miologist for the Centers for Disease Control and Prevention (CDC); he directed the CDC's Coordinating Office for Terrorism Preparedness and Emergency Response for four years before being named CDC acting director in January 2009. Besser thus played a leading role in shaping the US government's response to the H1N1 ("swine flu") pandemic of 2009 (see Briggs and Hallin 2016). During his tenure at ABC, Besser continued to practice as a physician.

The rhetorical structure of the story captures the movement between a series of staged interactions and a noninteractional voyage into the ritual center of medical semiosis. Anchor Sawyer initially seems to talk with each of us. She reaches into our own lifeworlds by projecting that the objects in question are "probably in your home right now." The discourse is highly chronotopic, with temporal deixis emphasized initially; the story is news precisely because it is new:

> **Tonight** something **new** about two nutritional supplements probably in your home right **now**, vitamin D and calcium, **long** heralded as pillars of a healthy diet. But **today** we learn that when it comes to calcium, some of those pills may not be necessary.

A classic news formula is the projection of conventional knowledge that is disrupted by an event that has just called it into question. By being drawn into this one-sided conversation with Sawyer, "we" enter this unsettling space between two chronotopes.

The segment continues with a quintessential example of clinical interaction: an exchange between a young, blond physician, clad symbolically in a white coat, and a balding, older male patient:

Physician:	Are you taking your vitam[in D?]	
Patient:	[Yes,] I am.	
Physician:		((breath intake))
		Beautiful!

Just as the IoM report evaluates the randomized controlled trials (RTCs) that form medicine's "evidence-based" ground zero (Adams 2013), this projection of an encounter between an individual physician and patient enacts medicine's archetypal interactional site, its "first instance" of "phenomenally and epistemologically signification." Indeed, studying "doctor-patient interaction" has created an influential industry for conversation analysts (see Heritage and Maynard 2006a, 2006b). In terms of the standardized models of "doctor-patient interaction" that have migrated from Conversation Analysis (CA)–based re-

search into the training of physicians, ABC identified a seemingly perfect interaction: here physician and patient are fully engaged with one another, smiling. The patient seems to enjoy his physician's attention and approval as much as the doctor basks in the man's "compliance" with her instructions to take vitamin D. They seem to be communicating so effectively that the patient responds even before she finishes the question, creating an interactional poetics that embodies a "beautiful" fusion of health, medicine, and communication.

When Besser provides us with a privileged look into the ritual center, the interactional frame disappears. He speaks off camera, his voice overlaid with intertexts taken from the IoM report; we see images of pills and bottles, a vitamin factory, milk and salmon in supermarkets (representing foods that contain vitamin D), and pictures of population groups (adolescent girls, elderly women) that are projected as getting respectively too little and too much calcium. Besser is interrupted by three sound bites, one from an IoM panel member and two from a Boston University Medical School professor advocating for higher vitamin D recommendations. Each constitutes a mini-monologue, where questions and questioners have been edited out.

The segment ends with another interaction, an in-studio head-to-head conversation between Sawyer and Besser, who make eye contact almost continuously. The exchange is prompted by Sawyer's appeal: "All right, help us out here, Rich, another confounding report here." Sawyer's first-person plural is key. In these dialogues, the anchor provides a synecdoche for the lay audience as she seems unable to sort through the summary of the IoM report and discern how it should guide clinical practice and patients' behavior. Besser warns that "You know, you don't want to take calcium casually," meaning in a way that bypasses the professional division of health knowledge and communicative labor. The sense that this is a real conversation—not a dual enactment of a script appearing on two teleprompters (which it is)—is enhanced by a surprised, seemingly spontaneous confession by Sawyer that interrupts Besser's final recommendation:

Besser: With any calcium you want to divide your dose, if you take it all at once it won't be absorbed very well.
Sawyer: Oh, really, I didn't know that!
Besser: Yeah, you can only take in so much at one time. And the other thing . . .

That Sawyer's exclamation was unscripted is suggested by the way she interrupts Besser just as his breath intake and opening of his mouth signal the be-

ginning of his final statement and by the camera's continued focus on Besser. This televised interaction between expert and anchor projects a poetics of inequalities of medical knowledge and its proper teleological movement toward a partial pedagogical amelioration of lay ignorance. The reflexive construction of their exchange as constituting a real time, real life interaction promising to effectively communicate medical knowledge was additionally signaled by Sawyer's deictic double marking of "here."

"Communicate Who You Are Talking As"

This story would seem to provide us with a quintessential example of how discourse emerges in a ritual center of semiosis and circulates from there to orders of interaction. The Institute of Medicine, its report, and the two physicians who provided soundbites are projected as inhabiting an institutional realm that produces first-order indexicality for medical discourse. The raison d'être of health news is precisely the sense that the density and indecipherability of the register formation and complex forms of indexicality that mark medical discourse as "evidence-based," meaning as tied to what are currently accepted as standards of care as derived from RCTs, render this arena inaccessible to persons lacking medical training. We laypersons are thus dependent on a second indexical order, one that is marked by four principal features: First, it has been stripped of medical jargon. Unlike the way that connoisseurs construct fine wines and themselves as imbued with value through oinoglossic enregisterment (Silverstein 2004, 2013), these physician-journalists mark their own privileged position through their ability to sustain referential and indexical stability as they transform medical knowledge and terminology into what they perceive as their viewers' everyday speech. Second, what is projected as first-order indexicality is contextualized vis-à-vis anatomy, pathologies, clinical trials, epidemiological statistics, and the like, formulations that by definition are detached from particular individuals. Laypersons are charged, however, with maximizing health for themselves and their family members. This process of extracting knowledge from the ritual center thus requires indexically attaching it to the medically relevant particulars of an individual patient; the privileged site for this recontextualization is an interaction between a doctor and a patient. Third, simply injecting doses of lexically stripped and individually relevant knowledge would be dangerous, because laypersons would be likely to misunderstand it. This projected process of circulation thus requires interpretation, projecting how it should reshape an individual patient's cognition, behavior, and environment. Finally, our physician-journalist

interviewees projected a strong affective component to physician-patient relations: laypersons want them to offer advice, to give their opinion as to what they should do.

An additional source of the semiotic power of the role of physician-journalist springs from further reifying this model of the circulation of medical knowledge by constructing "doctor-patient interaction" and televised health news as indexical twins. Dr. Ellen Cumberland noted, "I do think of my audience as a patient. Or at least somebody who might be a patient." Another physician-journalist, Dr. Richard Barnes, suggested that the process of constructing second-order indexicality is so similar in each setting that processes of metapragmatic calibration transfer in both directions:

> Over the years we realized that my being an active physician in the trenches gave me more credibility in the [journalistic] field. And while I learned to be a journalist, it gave me skills speaking to the patients. . . . Whether I'm sitting at a patient's bedside talking one-to-one, or whether I'm speaking to 11 million people at night . . . the skill set is the same. I take complicated information and I distill it—not in a condescending way but in a way that I'm a conduit and sometimes an advocate.

Besser noted that he often moved between three positionalities in a single broadcast: starting as a journalist summarizing medical findings, shifting to that of a public health professional interpreting implications for the health of populations, and ending up as a physician talking to patients. Bringing together journalism and clinical medicine places him in the position of having an entire network and its viewers as his patients:

> I serve two roles—I cover a story and I also give my opinion on the story. . . . They want my opinion here—I am not just reporting. I am ABC's doctor, and the doctor for our audience, and so if I'm doing a story on the next diet drug, they want to know not just what did the FDA do today, but what's my take on that.

Thus far, my analysis has been heavily text-centered, explicating the news broadcast and its relationship to the IoM report and medical journal articles that summarize it. My encounter with the broadcast came, however, in the midst of more than a decade's research—conducted collaboratively with media studies scholar Daniel Hallin—on health news, which included extensive study of print, radio, television, social media, and internet stories. Most significantly for present purposes, our investigation included extensive ethnographic work,

such as interviews with journalists, producers and editors, public health officials, clinicians, researchers, and others, which I have begun to use in unpacking the vitamin segment. Our work also included focus groups with audience members and ethnographic observation in a broad range of sites.[2] I want to explore how this ethnography can permit a more critical understanding of the semiotics of health news—and of ritual centers of semiosis, circulation, and interaction more broadly.

Both journalism and medicine are shaped by professional ideologies and practices, even as their practitioners frequently face accusations at present of failing to live up to them; ironically, such condemnations further reify these projections of professional guidelines. Even if objectivity, respect for truth, and established modes of producing and interpreting facts form key components of both professional ideologies,[3] how practitioners use them to position themselves in relation to knowledge production and circulation diverge significantly. In the United States, professional ideologies construct journalists as standing outside the social fields they describe and interpret, ideally without "biasing" reports by "imposing" their own values or perspectives (except in segments or columns marked as "opinion"). Doctors, on the other hand, embody medicine, seemingly speaking from within it rather than pointing in its direction; most physicians view issuing advice and opinions as a crucial part of their jobs. In our interviews, physician-journalists reflected on how they manage these competing professional orientations. Cumberland suggested:

> So I'm always reminding myself you know, as a doctor . . . I'm balancing . . . I'm a doctor, I'm a journalist, I'm a human being. . . . I'm very conscious about that line that I'm walking and . . . I ask people for advice about it sometimes. About, you know, "What do you think?" "Am I too close to this?" . . . I said, "I am personally outraged about it." Now, but I'm a journalist, you know, so how do I—am I crossing the line by saying I'm personally? . . . The advice I got was just, "communicate who you are talking as."

How do physician-journalists mark these speaking positions? How does Besser signal shifts between talking as journalist, public health practitioner, and phy-

2. See Briggs and Hallin (2016) for detailed exposition of the larger study.

3. For examples of the vast literature on the professional ideologies of journalists, see Gans (1979); Hallin (1986, 1994); Schudson (1995, 2003); Hannerz (2004); and Boyer (2005, 2013). With respect to at least as extensive research on professional ideologies in medicine and public health, see Lock and Gordon (1988); Waitzkin (1991, 2000); Good (1994); Lupton (1995); Anderson (2006); Menéndez (2009); and Krieger (2011).

sician? Given the power of medical and public health register figurations, one might suspect that physician-journalists would index these shifts lexically. As I noted, however, televised performances of densely enregistered medical lexical items are unusual for these individuals; interestingly, health journalists who lack medical training more commonly enregister their stories with medical, public health, and other scientific jargon.

A concept from science and technology studies (STS), Thomas Gieryn's (1983) notion of boundary work, can assist us here: STS scholars reject the sense that there are institutions that directly embody differentiated social fields. They rather suggest that it takes a great deal of semiotic labor to construct boundaries and use them in containing objects, concepts, people, and forms of knowledge. Drawing on this concept and my ethnographic work, I now want to shift the analytic lens. Positing a ritual center of medical semiosis and projecting the circulation of discourse through communicative processes is precisely the work that is undertaken by health journalists. Like the vitamin example, stories begin as anchors project a lay "us"—including themselves and their viewers—in need of someone who is specially qualified to enable "us" to enter what is constructed as a ritual center. Anchor Sawyer ended her initial voicing of lay confusion by handing over the discursive baton: "and medical editor Dr. Richard Besser checked out the facts." Her look of anxiety and her head shakes and tilts disappeared as she gave a pronounced nod and increase volume in uttering "the facts." We need a special ticket to enter this foreign realm, and we must expect to be "confounded" by knowledge that reaches us from within it.

After our guide takes us on a tour of the ritual center and warns that confusion on the part of laypersons may lead us to take too much or too little of these vitamins, anchor Sawyer implores Besser to "help us out here." If we think of centers as institutionally demarcated, we might miss the way that projecting circulation is actually doing a lot of the work of making the center and its ritually constructed borders. The ritual center of medical semiosis is constructed as constituted by the making of "facts," by researching vitamin consumption, mortality, and the distribution of diseases. For laypersons, gaining provisional access to this domain requires a different process, one that has a different metapragmatic logic: it is called *communication*. Doctors have access to facts; we laypersons need to wait until communicative processes begin, hoping that we can find doctors—in their offices or on television—who are skilled in interpreting facts for us. Lest we think that getting provisional entrance to what is constructed as the ritual center authorizes us to access medical knowl-

edge on our own, physician-journalist guides constantly do boundary work that keeps the borders and their viewers in their place. They warn us that watching the segment does not render us competent to decide what is best for our bodies: we still need to consult our doctor and pharmacist. Given that millions in the United States lack health insurance and efforts by conservative politicians to repeal the Affordable Care Act that greatly reduced the ranks of the uninsured, the presupposition that all of "us" have a doctor that we can easily consult is of no small political significance. Being interpellated as a legitimate receiver of health information through these televised "doctor-patient interactions" seems to require possession not only of a television but of the sort of health coverage that affords access to a personal physician.

Recall that Sawyer frames the story in pedagogical terms: "today we learn. . . ." What exactly are we supposed to learn? The ostensive referent, of course, is the "medical facts" about calcium and vitamin D that Besser is checking for us. At the same time, this story—like the other thousands of stories Hallin and I have examined—purports to teach us valuable lessons about issues that have recently worried linguistic anthropologists: about chronotopes, scales, and agency (see, e.g., Blommaert 2015; Carr and Lempert 2016). "Medicine" and "communication" are relationally and chronotopically defined as occupying opposing spaces across a spatial and temporal divide. We learn that medicine revolves around a ritual center of semiosis, which is constantly creating knowledge that is accessible to health professionals but reaches us only through clearly defined processes of circulation. We laypersons get information, not knowledge, and it comes at the price of foregoing claims to agency, even over the very communicative processes in which we are engaged. We learn not to access such knowledge "casually," such as by making our own, unsupervised forays into the center (such as by reading a medical journal online), or attempting to circumvent "centers of value production that anchor" this locus of "particular trajectories of circulation" (Silverstein 2013, 329).

By emulating "doctor-patient interactions," news stories teach us valuable lessons about scales. Physicians can grasp knowledge that applies to millions of bodies; us laypersons will be confounded until a scalar project has been put in place that reduces the knowledge to our size, the level of a specific patient. That a television story might not be precisely equivalent in this regard to a real "doctor-patient interaction" is signaled by Sawyer's closing words: "And if everybody out there wants to ask a question of Dr. Besser, or check out your personal Vitamin D and calcium intake, head to abcnews.com/worldnews." Beyond linking "traditional media" to "social media," a survival strategy these

days in media markets, her statement acknowledges a remaining scalar gap between projecting viewers as individual patients and reaching the projected endpoint of having a doctor match your body to general guidelines, just as it simultaneously promises to close the gap through an e-mail exchange with "Dr. Besser"—probably written in his name by one of the four medical residents then working under him at ABC.

Pragmatic Complexities in the Ritual Center

Once again, ethnography can help push the analysis here. The status of medicine as a demarcated ritual center of semiosis and the ideological relegation of "communication" to "information" that is exported outside it is complicated by the degree to which practices associated with "the media" enter into medicine's day-to-day activities. In the United States, nearly all health institutions—from small clinics and hospitals to pharmaceutical corporations and healthcare provider networks—employ persons trained in media and journalism. Rather than simply helping "to communicate" medical knowledge generated by health professionals, they play a fundamental role in shaping "the facts." Not only does the CDC have legions of media consultants, but county and other public health officials tell me that they often spend as much as half of their time devoted to responding to reporters, launching "media campaigns," and the like, a time commitment expands when a media controversy creates a political firestorm. Either in-house employees or consultants with media backgrounds train top administrators, researchers, clinicians, financial officers, and others in "how to speak with the media." When I asked a media consultant whose firm is contracted by small biotechnology and pharmaceutical corporations in the San Diego area how he helped his clients get news coverage, he followed a how-could-you-be-so-naive look with a description of how he works closely with scientists from the start: in creating (what will be perceived as) a new disease, identifying molecules for research, organizing clinical trials (including shaping their parameters and recruiting participants), and commissioning medical writers and approaching journal editors. Although he stages "background" conversations between the firm's researchers and health journalists during the entire lifetime of the project, issuing press releases and pitching stories are only a small part in the process and begin only late in the game.

As I noted, "doctor-patient interaction" is continually reified as the privileged site of clinical medicine. In the vitamin story, we get a clip of a doctor and patient, Besser and Sawyer simulating a physician-patient exchange, and

the two of them exhorting viewers to consult their doctor and pharmacist in order "to do it right," not "casually." Skeptical readers will likely think that such clinical interactions are staged, and they would be correct. One of the producers told us that in reporting newly published studies:

> We always reach out to the researchers first to see if they can talk, right? And if they're articulate enough to put on television, then we say, "Well, do you have people involved in the study?" "Yes," and then . . . our partners, our unofficial partners are the PR at these medical centers around the country. They know what we're going to need.

Particular clinicians, like the young blond physician, are selected by their organizations to be trained by their media staff or a consultant; they develop a sense as to which patients will perform well on camera or provide a good radio, print, or social media sound bite. Recall that our model patient responds before his doctor has supplied the name of the substance ingested, suggesting a significant degree of rehearsal. To be sure, it would be easy to turn the common disparagement of journalists, particularly those who work on television, into a haughty dismissal of such televised exchanges as mere fabrications. Turning such skepticism into a narrow interpretation of motives and practices would, however, foreclose a host of analytic insights just as we are getting started.

Let us leave behind these TV physician-journalists and their 11 million viewers for a moment and think about other physicians and other patients. My ethnography with clinicians suggests that their examining rooms interface just as actively with "the media." All spoke of patients bringing printouts of news stories, social media, material available from websites, summaries of medical journals, and other sources; patients sometimes present them as first-order indexical medical discourse, text-artifacts extracted from the medical institutions, implying or even demanding that they should script the ensuing doctor-patient interaction. As Dumit (2012), Healy (2006), and others have documented, physicians now find it difficult to evade the demands of patients who arrive with the name of a pharmaceutical they saw on television, sometimes with their symptoms checked off on lists appearing on the corporation's website. Indeed, advertisements, websites, and news stories all instruct patients on how to interact with their clinicians (tell your doctor X, ask your doctor Y). My ethnography suggests that clinicians' responses are diverse: my primary care physician reported that he enjoyed such interactions, believing that they made for more informed patients and more productive encounters. My dentist, on the other hand, grumbled that he had to spend half of his time reeducating patients who

had been "misinformed" by "the media."[4] This example—amplified by many interviews and ethnographic observations—suggests that there is no domain of "medicine" that exist apart from what is deemed to be "communication" and that clinicians connect these constructed domains in very different ways.

Let's go back to thinking about why a massive scalar leap between a scripted conversation between an anchor and a physician-journalist and what is projected as everyday, ordinary "doctor-patient interaction" seems to make sense to producers, physician-journalists, and viewers. The reason, I would suggest, is that both are highly complex arenas of performance from the get-go. In recent decades, a major focus in medical school has been on quasi-theatrical training in "doctor-patient interaction," using other medical students and people paid to act like patients. CA-based research plays a crucial role here. Researchers use videotaped interactions to analyze the "overall structure of the primary care visit," including the opening, presenting complaint, examination, diagnosis, treatment, and closing (Heritage and Maynard 2006a, 13–14). These results then shape acting lessons in medical school, such that students must learn how to adequately perform the role of doctor in each of these phases. Not only do students view video recordings of dramatized and "real" reenactments of "good" and "bad" communicative practices, they are generally videotaped interacting with fellow students, actors, and patients, helping them to calibrate their ability to replicate accepted models and their professors to assess and correct them.[5]

Learning to play the role of patient in these dramas is no less complex or consequential. As T. S. Harvey (2008) has argued, lacking socialization in how to act the part of the patient can jeopardize access to health care. On the other hand, learning to perform a complex balance between attending to physicians' discourse and avoiding any signs of "noncompliance" yet simultaneously asking questions that demonstrate engagement and comprehension can confer the status of expert patient (Dumit 2012). Another IoM report suggested that physicians' assessments of the communicative competence of their patients—projections of their ability to understand what physicians say and transform their utterances into prescribed bodily and behavior outcomes—significantly affects the quality of care they receive (Smedley et al. 2002).[6] Voila! Watching televised

4. To forestall any hasty generalizations, they were of the same generation (in their sixties) and served roughly the same multiracial and cross-class patient population.

5. If you are interested, YouTube offers plenty of examples.

6. The study reports that African Americans and Latinos are often stereotyped as bad medical communicators, suggesting that such perceptions by physicians affect the quality of care they receive.

enactments of "doctor-patient interaction" makes perfect sense, given how thoroughly we have been trained to recognize it as the natural, necessary locus of clinical medicine and the reward for being good doctors and good patients. Not only do news stories often reproduce these model interactions, but some focus explicitly on research that identifies good and bad interactions and assesses their medical consequences. Fascinatingly, CA students of "doctor-patient interaction" now study the very object that they helped create!

Communicability and Indexical Disorder

I began by mapping how the vitamin story constructs a ritual center of medical semiosis, positions it as first indexical order, identifies a point of origin for newly minted knowledge, and projects a newly unfolding act of communication. The story builds tension—as reflected in Sawyer's anxious face and intonation—through disclosing a communicative gap opened by the report, between what "you've been hearing for years" and the "new" findings. The story seems to construct the proper remedial process right before our eyes, as physician Besser gives us "the facts" and provides a simulated interaction with us as patients, all the while reminding us that proper circulation must be supervised by health professionals. Thus, the ritual center, processes of circulation, and the interactions that form their projected endpoints are central to what we are learning in the story. I refer to this ideological work of constructing how knowledge is produced and becomes mobile in particular ways as *communicable models*. The notion points to the chronotopic and scalar dimensions that emerge in the second-order indexicality modeled in such events, the way they naturalize particular forms and processes of discursive mobility, define other circulatory modalities as problematic, and render others unthinkable. Given the power of the referential reductionism that so frequently emerge when "communication" is constructed, this process can be, in Ralph Ellison's (1972) words, hidden right out in the open through the purported focus on a specific referent, in this case, vitamins. Communicable models are scalar projects, both constructing opposing scales—here research studies and general guidelines versus doctor-patient interactions—and projecting both legitimate and illegitimate ways of moving between them. They comfortingly tell us where first-order indexicality resides, and they model how perfect second orders should be constructed. They purport to be second-order indexical projections of how this particular first-order event is unfolding, even as they evoke familiar types.

This communicable modeling produces reassuring forms of indexical order. Besser models physicians who can reach into first-order indexicality, find "the

facts," and select the ones that are relevant for us laypersons; he can then construct a second-order indexicality that can perfectly match first-order indexicality, be grasped by laypersons, and guide us with respect to what we should do. It seems, to quote Silverstein, to provide a striking example of how "*ritual centers* of semiosis come to exert a structuring, value-conferring influence on any particular event of discursive interaction" (2004, 623). Just as importantly, however, I would argue that the story creates *indexical disorders*. We need Besser's help because "the facts" are "confounding," because the advice that doctors have been touting and that we have been "hearing for years" about these vitamins turn out to be inaccurate—and possibly to be leading postmenopausal women down a path paved by kidney stones. An ABC News story of October 12, 2011, is more striking in this regard. A news segment broadcast earlier that week had reported that daily ingestion of a multivitamin might not only be unnecessary but "that for older women, some multi-vitamins might actually be harmful," leading to a "slight increased risk of death." Anchor David Muir voices this "growing controversy and confusion" through panicked Skyped soundbites from two women. In the common frame of journalistic "balance," the segment places Dr. Oz and coauthor Dr. Michael Roizen on the side of promoting multivitamins and brings in several clinicians who discourage their use. Here second-order indexicality reveals disorder within a first indexical order, generating an alarming sense that perhaps second-order indexicality can never reliably provide a guide to shifting and contradictory medical first orders. Muir turns, of course, to Besser "for the bottom line on all this." Besser generally discounts the value of multivitamins: "No, I don't take a multivitamin, and I generally don't recommend them for my patients," only to exhort viewers that "if your doctor tells you to take a vitamin, take one, because there's many groups for whom they are beneficial." Muir thanks him for "clearing things up."

I deliberately chose for my inquiry one of the most privileged and prestigious ritual centers, one that guards its borders and points of access particularly carefully. Claims to go outside its borders in producing knowledge about health or through practices not authorized by professional medical associations and bodies like the Institute of Medicine—that is, unauthorized claims to first-order indexicality—can be punished with lawsuits or even prison time. Medicine goes to impressive lengths to structure what are recognized as modes of circulation, who controls them, and the forms of agency they confer and—for laypersons—restrict. The 1960s and 1970s witnessed critical engagements with the idea that doctors constitute the only reliable sources of medical information for laypersons; conservatives opposed to the idea that "the state" should ensure ac-

cess to medical services—a debate raging yet again in the United States as I write—and challenges by feminist, social movement, and consumer rights organizations to medical authority both contributed, ironically, in this regard. More recently, the proliferation of health journalism, the vast accessibility of medical discourse on websites and through social media, and electronic access to medical journals might seem to similarly question the reification of encounters between patients and doctors as the privileged site for legitimately gaining medical information.

Into this mix marches the figure of the physician-journalist, reinscribing dominant models of medical semiosis and reassuring us that someone who can clear things up, ascertain the facts, and give us the bottom line appears most evenings on our television screens. Nevertheless, offering positive affect through indexical orderings requires creating anxiety-producing indexical disorder, warning us that what we take to be second-order medical indexicality may never reliably map its first-order counterpart or that the latter is really not as ordered, regimented, and bounded as "you've been hearing for years." In other words, keeping people tuned in involves both offering access to the ritual center of medical semiosis and generating the anxiety that perhaps there really isn't a center at all—at least as defined by agreed-upon principles and definitive guidelines that are based on a secure body of "unbiased" evidence that faithfully structures each visit to the doctor and hospital stay.

There are, I think, some broader lessons here, both about the value of Silverstein's framework and the complexities that arise as we employ them. Notions of first and second orders of indexicality, the poetics of interaction, ritual centers of semiosis, and circulation were extremely valuable in capturing the features of the remarkably complex semiotic labor that was packed into a two-minute-and-forty-five-second broadcast about a fairly mundane topic. Using ethnography undertaken in a host of sites within and far beyond both news rooms and clinical spaces to critically extend analysis of the story, I have tried to demonstrate that all of these domains are products of the indexical work undertaken collaboratively by people cast as researchers, physicians, journalists, and viewers. Close ethnographic scrutiny of this collective metapragmatic work reveals how the illusion that "*ritual centers* of semiosis come to exert a structuring, value-conferring influence on any particular event of discursive interaction" (Silverstein 2004, 623) and how they shape our fundamental understandings of things like diseases, doctors, treatments, bodies, knowledge, and agency—or prestige goods, politics, or "the market"—require being seduced by the boundary work and other essentializations. Such projections enable us to separate ritual centers from interactions, to identify first orders of indexicality and their pro-

jected priority vis-à-vis what are constructed as their second and subsequent construals. Interaction is crucial, but it is hardly natural or primordial; it rather emerges as a definitional endpoint of a scalar project, a site of performance continually constructed in a variety of sites and crucial for essentializing what seem to be distinct scales, institutions, and professional visions (Goodwin 1994). It is precisely the power of this mode of analysis that should prompt us to develop practices of critical reflexivity that remind us that building our own scholarly indexical orders forces us to enter into the semiotic processes that we seek to elucidate. By drawing attention to the indexical disordering that makes indexical orders both powerful and precarious, I hope to have introduced an important resource for keeping our own claims to produce intellectual order in check.

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