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## ARTICLES



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## The Spanish Flu of 1918 in the Selected American Press of the Period

Epidemia grypy hiszpanki z roku 1918  
w wybranej amerykańskiej prasie epoki

### Abstract

The article examines press reports on Spanish flu in the American daily press from 1918. The name of the disease is misleading, and it was coined due to the fact that Spain, which was not involved in the military conflict at the time of the epidemic, was one from the first countries of the world reported new cases of a disturbing disease.

The press reports mainly concealed the actual state of the epidemic, as well as the number of sick and dead people. Germany, Spain and Russia were cited as countries with a high incidence rate to reassure the American public and raise morale.

### Abstrakt

Przedstawiony artykuł bada doniesienia prasowe, dotyczące zachorowań na grypę hiszpankę w amerykańskiej prasie codziennej z 1918 r. Nazwa jednostki chorobowej jest myląca, a została stworzona w związku z faktem, iż Hiszpania, która w czasie wybuchu epidemii nie była zaangażowana w działania wojenne, jako jedna z pierwszych krajów świata donosiła o nowych przypadkach niepokojącej choroby.

W związku z toczącymi się działaniami wojennymi w doniesieniach prasowych ukrywano faktyczny stan epidemii, a także liczbę chorych oraz zmarłych. Wskazywano Niemcy, Hiszpanię i Rosję jako kraje o wysokim współczynniku zachorowalności, by uspokoić społeczeństwo amerykańskie i podnieść morale.

**Keywords:** American press, history of the 20th century, world history

**Słowa kluczowe:** prasa amerykańska, historia XX wieku, historia powszechna

Recent events connected with the coronavirus pandemic, caused by SARS-CoV-2, have fueled growing discussion on the topic of epidemics. Serious illnesses transmitted by travelers have formed a persistent part of history and have accompanied mankind since antiquity. One of the first well-documented pandemics was the so called Justinianic Plague<sup>1</sup> which took its toll on the Mediterranean world between 541 and 549 A.D. It is said to have decimated the population of the time, killing 100 million people<sup>2</sup>.

The second documented disease that could be referred to as a pandemic, due to its extent, was the “Black Death”<sup>3</sup>: an epidemic that first broke out in Central Asia, probably in China, from where it spread to Crimea, and then to Europe. It was transmitted through the trade routes, reaching as far as such remote locations as Scandinavia.<sup>4</sup> Similar to the Justinianic Plague, it is believed to have been caused by *Yersinia pestis*<sup>5</sup> fleas. The disease decimated the population: “In the years 1347 to 1351, one out of every three people in Europe died”<sup>6</sup> due to it.

In the mid-19<sup>th</sup> Century, the plague appeared again in China, from where it was transmitted to North America by fleas in the fur of rodents. Fortunately, this third pandemic occurred in the times of advanced medicine, and “Once fatal to slightly more than half the people who contracted it, plague in recent decades has become routinely curable, if timely diagnosis and medical supplies permit”<sup>7</sup>, most commonly by antibiotics. Nevertheless, in spite of the more advanced Medicine of the time, the plague spread quickly, “along the commercial routes of the grain trade”<sup>8</sup>.

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<sup>1</sup> Also referred to as the “Plague of Justinian”.

<sup>2</sup> I.W. Sherman, *The Power of Plagues*, Washington DC 2020, p. 65.

<sup>3</sup> By 1800 it was called “the pestilence”, See: N.F. Cantor, *In the Wake of the Plague: The Black Death and the World It Made*, New York 2014, p. 7.

<sup>4</sup> L.K. Little, *Plague And the End of Antiquity: the Pandemic of 541-750*, Cambridge 2007, p. 5.

<sup>5</sup> R.S. Bray, *Armies of Pestilence: The Impact of Disease on History*, Cambridge 2004, p. 19.

<sup>6</sup> S. True Peters, *The Black Death*, New York 2005, p. ix.

<sup>7</sup> L.K. Little, *op. cit.*, p. 5.

<sup>8</sup> R.S. Bray, *Armies of Pestilence: The Impact of Disease on History*, Cambridge 2004, p. 84.

Not surprisingly, the plague has not been the only disease to decimate the world population. The H1N1 virus, or Spanish flu<sup>9</sup>, as it was nicknamed, caused the death of millions in the years 1918-1920. Although it is difficult to precisely determine the exact number of casualties, estimates range from 50 to 100 million<sup>10</sup>. The disease was given various names by the press: “Spanish Influenza, Russian Influenza, Lagrippe, Catarrhal Fever, Three Day Fever, and Flu, are one and the same thing”<sup>11</sup>. The outbreak of the flu coincided with the military efforts of WWI, which made the public less focused. Considered to be the most deadly disease since the Black Death, it was unique in its toll, causing mostly the death of young adults<sup>12</sup>. The mortality rate was high, ranging from 15% to 50% in adults.

The name “Spanish flu” comes from the fact that despite not being the first country to experience the disease, Spain was the first to report it.<sup>13</sup> Being neutral in WWI, Spain was not under any reporting restrictions and was hence ready to alert the public as soon as the epidemic struck. This was not the case in other countries engaged in the war: “When the epidemic first struck, most of the warring countries restricted what newspapers could print. They didn’t want their enemies to know that they were weakened by the flu”<sup>14</sup>.

The first case of Spanish flu was noted in Haskell County, Kansas as early as in January 1918<sup>15</sup>. As mentioned above, not to reveal too much to the other side, this fact was not made public. However, local physician Dr. Loring Miner, kept a record of this unusually critical illness and reported it to the US Public Health Service<sup>16</sup>. His biggest fear was the spread of influenza to a nearby Camp Funston, which eventually happened. The first symptoms were reported to the doctor by the camp cook, and soon after, a great number of other soldiers also contracted the disease<sup>17</sup>.

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<sup>9</sup> Also known as “The Spanish Lady”, See: K.C Davis, *More Deadly Than War: The Hidden History of the Spanish Flu and the First World War*, New York 2018, p. 14.

<sup>10</sup> R. Davis, *The Spanish Flu: Narrative and Cultural Identity in Spain*, 1918, New York 2013, p. 3.

<sup>11</sup> *Comments on Spanish Flue*, “Willston Graphic”, October 10, 1918, p. 1.

<sup>12</sup> S. Bonslaugh, L.-A. McNutt, *Encyclopedia of Epidemiology*, Los Angeles-London-New Delhi-Singapore 2008, p. 534.

<sup>13</sup> *Ibidem*, s. 534.

<sup>14</sup> K.C. Davis, *op. cit.*, p. 13.

<sup>15</sup> *Ibidem*, p. 126.

<sup>16</sup> C. Goldsmith, *Health Reports: Diseases and Disorders. Influenza*, Minneapolis 2011, p. 25.

<sup>17</sup> *Ibidem*.

Nevertheless, the American press remained silent in informing about the spread of the illness. One of the earliest reports of the spread of influenza was by George T. Bye, who assured the public that the disease was of a mild character: "This new Spanish enza<sup>18</sup> is not at all serious, excepting that it is causing a great many holidays in munition plants and government offices. Two deaths have been reported but these are also attributal to other causes"<sup>19</sup>. The article, signed as written in London, ridicules the malady, describing its symptoms: "Now some comical facts. Beginning with the third day you change into a comedian - and your very appreciative audience. The most foolish ideas come into your head, and if you can get anyone to listen to you, you yourself are a fountain of giggles and laughs"<sup>20</sup>. The optimistic tone of the piece was surely meant to calm the domestic readership and to confuse the enemy.

Influenza is highly contagious, and soon the disease spread not only to other regions in America, but also worldwide. The American troops brought it to France, and soon Italian and French soldiers has also been infected<sup>21</sup>. Newspapers used the malady as a means of propaganda against Germany. In August 1918, it was reported that: "The Fourth and Sixth German armies were out of fighting for weeks with the disease and great 'flu camps' have been established in Belgium and France, where the Germans were sent to receive treatment and to prevent the disease from spreading to the Hun armies"<sup>22</sup>. Unsurprisingly, the American press wrote about poor health of war enemies, neglecting to mention that the American soldiers also suffered from the malady: "In Russia both Spanish flu and cholera have claimed hundreds of victims and are both spreading"<sup>23</sup> as if the disease were a only threat to the enemy.

The flu was transmitted by American soldiers, who swarmed across Europe: "By the early summer of 1918, more than two hundred thousand British soldiers in France had been taken out of service – down with the flu"<sup>24</sup>. The American newspapers acknowledged this fact, calming the situation and assuring that

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<sup>18</sup> Influenza.

<sup>19</sup> G.T. Bye, *Look Out for Germs of the Spanish Flu*, "The Evening Missourian" (Columbia, Mo.), July 25, 1918, p. 2.

<sup>20</sup> *Ibidem*.

<sup>21</sup> C. Goldsmith, *op. cit.*, s. 26.

<sup>22</sup> *Spanish "Flu" Spreads over All of Europe*, "The Chattanooga news" (Chattanooga, Tenn.), August 5, 1918, p. 10.

<sup>23</sup> *Ibidem*.

<sup>24</sup> K.C. Davis, *op. cit.*, p. 132.

“the greatest toll, if reports are to be believed, is being taken by the epidemic in Austria, also victim of cholera and diseases arising from malnutrition”<sup>25</sup>.

It was impossible to hide the instances of sickness in America, but the press assured that no dire consequences were possible: “Treatment under direction of the physician is simple, but important, consisting principally of rest in bed, fresh air, abundant food, with Dover’s powders for the relief of pain. Every case with fever should be regarded as serious and kept in bed”<sup>26</sup>. The article mentions the Surgeon General, Rupert Blue, who “has made a telegraphic survey to determine the extent of Spanish influenza in the United States”<sup>27</sup>, and reports several instances of the disease in the US.

Further cases of the disease were reported in September 1918: “Medical officials of the first naval district reported 257 new cases of influenza today. There were ten deaths at the naval hospital”<sup>28</sup>. Even though the appearance of the epidemic in America was acknowledged, the public was told that the disease was “in mild form”<sup>29</sup> and “there was no cause for alarm over the presence of the disease”<sup>30</sup>. The paper also reported 184 new instances of the malady in New York<sup>31</sup>. The general impression was that the disease, however dangerous, could be easily cured and that American citizens were safe. It was said that “plenty of fresh air, keeping feet and body warm, sleeping warm, avoiding colds, getting ready for the Spanish influenza offensive are sensible and necessary”<sup>32</sup>.

Not even the royals were immune from the flu. A newspaper article from September 20<sup>th</sup> reported: “Prince Eric, Duke of Vestmanland, youngest son of King Gustaf<sup>33</sup> died here today of pneumonia which developed from Spanish ‘flu’ He was twenty nine years of age”<sup>34</sup>, while another noted that Wilhelm II,

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<sup>25</sup> *Grippe Kills Its Hundreds in War Inlands*, “The Washington Herald” (Washington, D.C.), August 6, 1918.

<sup>26</sup> *Steps Are Taken by Blue to Head Off Epidemic of Influenza Here*, “Albuquerque morning journal”, (Albuquerque, N.M.), September 14, 1918, p. 1.

<sup>27</sup> *Ibidem*.

<sup>28</sup> *Spanish “Flu” Gaining Grip on Eastern Cities*, “Omaha Daily Bee”, (Omaha, Neb), September 17, 1918, p. 1.

<sup>29</sup> *Ibidem*.

<sup>30</sup> *Ibidem*.

<sup>31</sup> *Ibidem*.

<sup>32</sup> *Spanish “Flu”*, “Evening Times – Republican”, (Marshalltown, Iowa), September 30, 1918, p. 4.

<sup>33</sup> Gustaf V of Sweden.

<sup>34</sup> *King’s Son Dead*, “The Bismarck Tribune” (Bismarck, N. D.), September 20, 1918, p. 1.

the Kaiser, was also sick: "The Kaiser is reported ill. A few million people could wish him nothing more devilish than Spanish flu"<sup>35</sup>.

In spite of such news, various articles assured the public that influenza was dying out. One article insisted: "The number of Spanish influenza cases reported to the health department in this city today<sup>36</sup> showed a decrease compared with the previous two days, there being 20 new victims as compared with 31 yesterday and 38 the day before. Only one death has resulted thus far"<sup>37</sup>. Spanish flu was described as mild and the American soldiers, who were infected, were said to be "able to return to duty within a short time"<sup>38</sup>.

There were numerous theories connected with the origin of the epidemic. One of them said that the malady was brought to America by a German U-boat<sup>39</sup>, as a form of biological weapon. It was also compared to medieval plague, "sweeping towards the west and south"<sup>40</sup>. The disease was present in various army camps in the US, and due to that fact, Provost Marshal, General Crowder decided to halt "the entrainment of the draft registrants"<sup>41</sup>. The sudden appearance of the malady was intriguing and heated debate over the origin of influenza began: "Is this new disease which has already killed hundreds and stricken thousands of soldiers and civilians a new German war offensive? If not, how did it happen that this epidemic appeared so suddenly and extensively in such widely scattered cities and army camps throughout the country?"<sup>42</sup>.

Later, the situation was becoming critical, with greater numbers of medical professionals being directed to helping the soldiers engaged in the war. As the access to hospitals became more limited, "People are being stricken down in the street, offices, subway, theatres and shipyards. The hospitals are crowded

<sup>35</sup> *The Kaiser Is Reported Ill*, "The Washington Herald", (Washington, D.C.), September 28, 1918, p. 6.

<sup>36</sup> New York.

<sup>37</sup> *Spanish "Flu" Is Prevalent in Navy Yards*, "Omaha Daily Bee", (Omaha, Neb.), September 22, 1918.

<sup>38</sup> *Spanish "Flu" Epidemic at Camps*, "Evening capital and Maryland Gazette", September 23, 1918.

<sup>39</sup> *Boston Panic-Stricken by Spanish Influenza*, "The Washington Herald", (Washington, D.C.), September 23, 1918, p. 2.

<sup>40</sup> *Spanish "Flu" Has Boston in Tragic Grip*, "The Seattle Star", (Seattle, Wash.), September 26, 1918, p. 8.

<sup>41</sup> *Halts Draft Calls*, "The Democratic Advocate", (Westminster, Md.), September 27, 1918, p. 1.

<sup>42</sup> *Spanish Influenza*, "The Midland Journal" (Rising Sun, Md.), October 4, 1918, p. 1.

to the limit, and under strict quarantine to visitors”<sup>43</sup>, the press began to promote a healthy lifestyle to help the citizens avoid the contraction of the disease: “You can also help the government in its fight against Spanish flu, by keeping yourself in condition to resist such germs as come your way. Civilians as well as soldiers should keep fit to fight”<sup>44</sup>. There were also attempts at finding a cure of the malady. According to the sources, a new serum was discovered to “combat the epidemic of Spanish influenza”<sup>45</sup>. The government was said to be of great help, spending one million dollars on the production and distribution of the vaccines<sup>46</sup>.

The second wave of the epidemic, which began in September 1918, was characterized by higher infection rates and consequently, a greater number of cases. A considerable number of infections were observed among soldiers due to the poor hygiene standards in military camps. Daily reports about the pandemics were horrifying: “More than 20,000 new cases of Spanish influenza were reported from army camps during the 48 hours ending at noon today. Pneumonia cases reported numbered 733 and deaths 277. The total pneumonia cases now is 5,766 and deaths 1,577”<sup>47</sup>. Towards the end of WWI, the media started to report the cases more openly. Some articles note a decrease in the number of sick soldiers, but a corresponding growth in civilian cases<sup>48</sup>.

Also, new restrictions were introduced, and public gatherings, like dances, were prohibited. For example, in October 2, 1918 it was reported that : “There will be, consequently, no dance for the men of the service given this week by the War Camp Community Service”<sup>49</sup>. Similar restrictions were put on sports:

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<sup>43</sup> *Spanish “Flu” Has Boston in Tragic Grip*, “The Seattle Star”, (Seattle, Wash.), September 26, 1918, p. 8.

<sup>44</sup> *You can also help...*, “The Oklahoma City Times”, (Oklahoma City, Okla.), September 27, 1918.

<sup>45</sup> *Spanish “Flu” to Be Fought with Vaccine*, “Omaha Daily Bee”, (Omaha, Neb.), September 29, 1918, p. 2.

<sup>46</sup> *Ibidem*.

<sup>47</sup> *Spanish “Flu” Is Making Headway in Army Camps*, “Omaha Daily Bee”, (Omaha, Neb.), October 1, 1918.

<sup>48</sup> *Spanish “Flu” Spreading Fast Over Country*, “Omaha Daily Bee”, (Omaha, Neb.), October 3, 1918.

<sup>49</sup> *Spanish “Flu” Puts Ban on Armory Dance*, “Evening Capital and Maryland Gazette”, (Annapolis, Md.), October 2, 1918, p. 1.

the schools in many regions were closed and football matches were banned<sup>50</sup>. A number of newspaper articles proposed instead of social distancing, immunity could also be gained by steering clear of alcohol. The author states: “The civilian population will also be much better able to resist the ravages of Spanish influenza because alcoholic indulgence has been greatly curtailed by Prohibition”<sup>51</sup>. However, voices blaming Prohibition for public vulnerability to the disease could be also traced: “A mere man called at the city health office Tuesday morning to relieve his system of an idea he had regarding Spanish ‘flu’. ‘I am here to state that I believe that prohibition is the cause of the Spanish ‘flu’ in Omaha,’ he began”<sup>52</sup>.

Various other ways of avoiding infection were practiced, including limiting access to entertainment: “Beginning tonight at 12 o’clock all theatres will be closed”<sup>53</sup>. Interestingly, the same press article informed that the schools in the area would continue to operate, but with windows left open: “The schools in the city proper will be allowed to run because of the fact that it is less dangerous to have the children coming in contact with each other in schoolroom, where they sit face to back, than it would be to have them come in contact in the playgrounds. All windows and doors of the schoolrooms will be left open, thereby making the spread of the disease less dangerous”<sup>54</sup>. Oddly enough, as early as one day later, a new article was published, which listed further restrictions in school activity: “The public schools throughout the city and country, as well as all other schools and colleges, are ordered closed until further notice by the board of health”<sup>55</sup>. Other locations of public gathering, such as churches, were also closed “with the exception of a very few in the country districts”<sup>56</sup>.

Another factor proposed as a cure in the media was climate. The US, with its vast territories, was able to compare the number of the ill regionally: “Cases diagnosed by competent physicians as Spanish Influenza have appeared in Al-

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<sup>50</sup> *School Squads Will Learn Today if Grid Game Will Be Continued*, “The Washington Times”, (Washington, D.C.), October 3, 1918.

<sup>51</sup> *Alcohol and Spanish “Flu”*, “The American Issue”, (Westerville, Ohio), October 4, 1918, p. 4.

<sup>52</sup> *Health Commissioner Gets Tip on Prevention of “Flu”*, “Omaha Daily Bee”, (Omaha, Neb.), October 9, 1918.

<sup>53</sup> *Close Theaters Tuesday to Stop Spread of “Flu”*, “The Chattanooga News”, (Chattanooga, Tenn.), October 7, 1918, p. 30.

<sup>54</sup> *Ibidem*.

<sup>55</sup> *All Schools Are Ordered Closed*, “The Wheeling Intelligencer”, (Wheeling, W. Va.), October 7, 1918, p. 8.

<sup>56</sup> *Ibidem*.

buquerque. This was to have been expected. Albuquerque is a tourist city<sup>57</sup>. The author continues: "We have here a climate which is highly efficacious in combating Spanish Influenza or any other kind of influenza. The sunshine of New Mexico is the best protection in the world"<sup>58</sup>. Some authors advised using salt water: "Preventative for Spanish influenza that is being used successfully in the training camps is warm salt water gargled and snuffed up the nose SEVERAL TIMES DAILY. This ought to be practiced in the homes for the next two or three weeks."<sup>59</sup> Others, proposed the use of groceries, like lemons: "Spanish Influenza doesn't like lemons. Lemons are said to be flu foes"<sup>60</sup>.

From time to time, new potential therapies for influenza were announced. One article in October 1918 reported: "Dr. George F. Baer, of the Homeopathic hospital staff here, announced this afternoon that he has found a successful cure an preventative for Spanish influenza. Dr. Baer said the preparation is not a scientific secret, but a combination of iodine and creosote"<sup>61</sup>. A new substance, nicknamed VapoRub, was produced: "Vick's VapoRub is the discovery of a North Carolina druggist, who found how to combine, in salve form, Menthol and Camphor with such volatile oils as Eucalyptus, Thyme, Cubeb, etc. so that when the salve is applied to the body heat, these ingredients are liberated in the form of vapors"<sup>62</sup>. It was believed to protect against the germs that were suspected to cause the disease.

In addition, readers were urged not to open caskets of the victims of the disease for fear of spreading the flu<sup>63</sup>. In October 1918, the press began to offer a faint hope that the disease to stop spreading. One article noted: "In contrast to the general situation, however, reports from the various army camps showed

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<sup>57</sup> *Today in The News*, "The Evening Herald", (Albuquerque, New Mexico), October 5, 1918, p. 1.

<sup>58</sup> *Ibidem*.

<sup>59</sup> *Preventative for the Flu*, "Dresden Enterprise and Sharon Tribute", (Dresden, Tenn.), October 11, 1918, p. 1.

<sup>60</sup> *Hand the Flue a Lemon*, "Deming Graphic", (Deming, N. M.), October 11, 1918.

<sup>61</sup> *Remedy for Spanish Flu is Discovered*, "Albuquerque Morning Journal", (Albuquerque, N.M.), October 12, 1918, p. 2.

<sup>62</sup> *Spanish Influenza – What It Is And How It Should Be Treated*, "The Chattanooga News", (Chattanooga, Tenn.), October 12, 1918, p. 8.

<sup>63</sup> *Orders Caskets of "Flu" Victims Sealed at Funeral*, "Omaha Daily Bee", (Omaha, Neb.), October, 5, 1918, p. 10.

a slight decrease, although pneumonia continued to increase”<sup>64</sup>. Although the first wave of the disease, that struck in spring 1918, was quite mild, the second that began towards the end of the same year was far more severe. With it came a desperate need for medical workers to treat growing numbers of patients: “An urgent need for graduate, undergraduate and assistant nurses has just been issued by Surgeon General Blue”<sup>65</sup>. The author asked all the women of Albuquerque, despite their qualifications, to help since the situation in hospitals was appalling. Social distance was advised since it was widely known that the disease spread through sneezing and coughing.

In October 1918, the disease continued to spread among civilians in the US; however, the number of cases had begun to fall among soldiers. Thus, the military officials believed that “the peak of the epidemic among the soldiers had been passed”<sup>66</sup>. Other authors also predicted that the epidemic would end soon, being “on the wane in all other districts except the South Carolina and California”<sup>67</sup>. The fall of 1918 indeed saw the retreat of the disease, and gradually the restrictions imposed on the citizens were lifted: “There is a marked improvement in Seattle and the ban will be lifted as to business tomorrow morning, when all theatres, picture shows and stores will be opened as formerly. The wearing of masks, however, must be continued for a few days longer”<sup>68</sup>. With the number of people suffering from influenza decreasing, the ban on public gatherings could be lifted: “The Spanish influenza ban which has been in force and effect in Idaho since Oct. 10 for public gatherings and Oct. 21 on for the public schools, will be lifted on Sunday, Nov. 24”. However, some restrictions were still kept<sup>69</sup>. In December 1918, short services were allowed to be held in churches on condition that people suffering from colds steer clear of the build-

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<sup>64</sup> *Spanish “Flu” on the Increase All over the Nation*, “The Public Ledger”, (Maysville, Ky.), October 8, 1918, p. 1.

<sup>65</sup> *Red Cross Calls for Nurses to Help Fight Spanish Flu*, “The Evening Herald”, (Albuquerque, New Mexico), October 9, 1918, p. 1.

<sup>66</sup> *Spanish “Flu” Still Spreading Among Civilians*, “Bisbee Daily Review”, (Bisbee, Ariz.), October 17, 1918, p. 1.

<sup>67</sup> *“Flu” Epidemic Is on the Wane*, “The Bismarck Tribune”, (Bismarck, N.D.), October 19, 1918, p. 1.

<sup>68</sup> *Spanish Flu Is Subsiding*, “The Daily Alaskan”, (Skagway, Alaska), November 12, 1918, p. 1.

<sup>69</sup> *Ban in Idaho Will Be Raised*, “Bonners Ferry Herald”, (Bonners Ferry, Idaho), November 19, 1918, p. 1.

ings<sup>70</sup>. Towards the end of the year, increasing numbers of regions were regarded as free of flu and the press could praise success: “The decline of the influenza is due to the vigilance of the health department and warning of the physicians and the observance by the public generally of the rules laid down”<sup>71</sup>.

In the US, Spanish Flu disappeared in the same mysterious way as it first appeared. There were occasional reappearances in 1919 and even 1920, fortunately the third wave was much less dangerous and far fewer people became infected. By the end of 1918, the number of new cases were already falling and it slowly became past news. Nevertheless, due to its contagious and deadly character, people still feared its reappearance, and in the fall 1919, the press reviewed the precautions against contracting influenza, claiming that “Doctors tell us that we are likely to have another epidemic of Spanish flu this winter”<sup>72</sup>.

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## What if the Black Dog Turns Out to be a Ginger Poodle? Winston Churchill and depression

Kiedy czarny pies jest w rzeczywistości rudym pudlem.  
Winston Churchill i depresja

### Abstract

The aim of this article is to analyse historical documents and biographical accounts relating to the clinical depression from which Winston Churchill, according to some sources, allegedly suffered all his life. He nicknamed his low moods “a black dog” and the phrase has become widely accepted in the English-speaking world as a personification of depression. We argue that there is scant solid evidence to prove Churchill was indeed mentally ill, even for a short period of time. He has been deliberately chosen to act as an anti-stigma icon due to his immense popularity and indisputable achievements. In an attempt to fight prejudice and lift the shame accompanying the illness, especially among males diagnosed with the disorder, Churchill’s biography has become falsified while his portrayals in film and fiction are often inaccurate.

### Abstrakt

Celem artykułu jest analiza dokumentów historycznych i tekstów biograficznych poświęconych depresji, na którą, według niektórych źródeł, miał rzekomo cierpieć przez całe życie Winston Churchill. Żartobliwie nazywał napady kiepskiego humoru „czarnym psem” i określenie to stało się rozpoznawalnym w świecie anglosaskim synonimem depresji. Autorki artykułu

utrzymują, iż nie ma prawie żadnych wiarygodnych dowodów świadczących o nawet krótkotrwałej chorobie psychicznej Churchilla. Ponieważ słynny Brytyjczyk darzony jest ogromnym szacunkiem, aktywiści działający na rzecz popularyzowania wiedzy o chorobach psychicznych i destygmatyzacji osób żyjących z diagnozą psychiatryczną, wybrali Churchilla na ikonę swoich kampanii społecznych. W tym, bez wątpienia chlubnym, celu biografia Churchilla została ostatnio zniekształcona, a jego przedstawienia w literaturze czy filmie odbiegają od rzeczywistości.

**Keywords:** black dog, depression, mental illness, Winston Churchill

**Słowa kluczowe:** choroba psychiczna, czarny pies, depresja, Winston Churchill

Posthumous diagnosing of famous people is an area of research that has achieved a permanent place in history, despite numerous protests. Putting moral issues aside, applying modern medical criteria to descriptions of symptoms is simply anachronistic. Though this critique can be fended off in the case of many physical diseases (as their symptoms remain stable across times and cultures), it is much more substantial if mental disorders are concerned. Psychiatry is, after all, a unique branch of medicine, in which cultural norms and expectations are essential in reaching a diagnosis. Though, obviously, people have always suffered from mood disorders, hallucinations or delusions, the way these complaints were voiced and treated by medical establishment varied considerably. Furthermore, organic causes such as neurosyphilis or brain tumours might give symptoms identical to what we now label as schizophrenia or paranoia – for instance, the madness of the British monarch King George III was probably caused by variegate porphyria<sup>1</sup>. Finally, the question whether a particular historical figure was really deranged or simply abusing power may appear academic if the tyrant in question is, let's say, Nero, Ivan the Terrible or Henry VIII. Recently, however, there has been a dispute about the mental condition of one of the greatest statesman and leaders Great Britain has probably ever had – Winston Churchill. The arguments used by both sides reveal hidden fears and prejudices towards mental disorders, give voice to gender disputes and cast light on the attitude to depression. Frequently, historical evidence plays a subservient role to the political and social agenda of both: those who believe Churchill suffered from depression and those who shudder at the very suggestion.

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<sup>1</sup> V. Green, *The Madness of Kings*, Phoenix Mill 2005, p. 215-216.

First of all, it is worth analysing what gave rise to the speculations that Churchill suffered from a mental disorder. Most of Churchill's contemporaries never found his mental health defective – he would not have been repeatedly entrusted with responsible positions otherwise. In his life, he was “a soldier, journalist, author, artist, sportsman, historian, orator, statesman, inventor, and a stonemason”<sup>2</sup> while people admired his “health and energy”<sup>3</sup>. Likewise, his official biographer, Martin Gilbert, hardly ever mentioned his moods. Obviously, he frequently referred to multiple hardships and professional stresses. For instance, when Churchill was a Home Secretary responsible for convicts awaiting death penalty, he considered his time there a “nightmare”, using adjectives like “distressing”, “painful” and “harassing”<sup>4</sup>. Likewise, it is widely known he was devastated after the unprecedented loss of human life during World War I, especially the Dardanelles campaign fiasco he helped to engineer. Nevertheless, it must be remembered, Churchill became the scapegoat for the failure. According to Gilbert, he was universally criticised, despite being

powerless to influence the course of events at the Dardanelles, watching and fretting and warning his colleagues, but without the executive authority to act. [...] Churchill's influence was virtually non-existent, his warnings to his colleagues seldom heeded. Again and again he spoke at the Dardanelles Committee against attacking the Turks with insufficient troops<sup>5</sup>.

So his profound grief was fully understandable – not only did he take part in one of the greatest British military mistakes but also he feared his political career would be forever marked by the failure for which he was solely, yet undeservedly, blamed. The period between 1940-45, when Churchill acted as a war-time Prime Minister, was obviously very stressful and affected his mental well-being. Roy Jenkins claims that in 1940, as soon as he accepted the premiership,

it is impossible to believe that Churchill did not in those next few weeks experience moments of almost crushing dismay, that there were not indeed mornings when he did not awake feeling that he must have been mistaken, nearly

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<sup>2</sup> J. C. Humes, *The Wit and Wisdom of Winston Churchill*, London 1994, p.16.

<sup>3</sup> P. Johnson, *Heroes. From Alexander the Great and Julius Caesar to Churchill and De Gaulle*, London 2007, p. 229.

<sup>4</sup> M. Gilbert, *Churchill. A Life*, London 2000, p. 216.

<sup>5</sup> *Ibidem*, p. 322.

insane, to have sought such a burden of supreme responsibility at a time when everything seemed more likely than not to go down into the abyss<sup>6</sup>.

He was working inhumanely long hours under enormous pressure and his co-workers initially complained of his being snappy and overbearing, which are frequent symptoms of a depressed mood. Yet, his wife gently drew his attention to “a deterioration in [his] manner” and urged him to return to his usual kindness and calm, the piece of advice Churchill took into his heart<sup>7</sup>. During the war Churchill applied himself to his duties with “boundless and frantic energy, working for more than 18 hours a day” – hardly a feat a person with severe depression would be able to perform<sup>8</sup>. He was also crestfallen when the Conservative Party lost the elections after the Second World War. He assumed the nation would choose the leader who won the war and saved Britain (and the world) from Nazism. His wife, Clementine (Clemmie), in a letter to her youngest daughter wrote that [Churchill] “is so unhappy & that makes him very difficult”<sup>9</sup>. Yet again, his deeply felt sense of injustice is easy to comprehend – there is nothing medically pathological about it.

Still, it must be kept in mind most biographers focus on Churchill the politician, statesman and soldier, not Churchill – the man. Gilbert devoted two lengthy chapters to the Gallipoli failure, and did not mention the miscarriage Clementine suffered in 1912, finding it perhaps irrelevant. It is undoubtedly a history, not herstory, to use a feminist phrase. Yet Churchill was a devoted husband, a dear friend and a tender father as well as an animal lover. These aspects of his personality not only help to perceive him as a much fuller figure, but also a more humane and likeable one. Even the biographers who focus on his non-political activities: such as writing, painting or sport seldom comment on his inner life. Undoubtedly, Churchill was not particularly analytical or prone to self-scrutiny. He was even critical of psychiatry as a quickly growing branch of science, believing thinking too much about what is in people’s heads is not

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<sup>6</sup> R. Jenkins, *Churchill*, London 2002, p. 592.

<sup>7</sup> M. Soames, ed. *Speaking for Themselves. The Personal Letters of Winston and Clementine Churchill*, London 1998, p. 454.

<sup>8</sup> E. Wakely and J. Carson, *Historical recovery heroes – Winston Churchill*, “Mental Health and Social Inclusion” 2010, v. 14, is. 4, p. 37.

<sup>9</sup> M. Soames, *op. cit.*, p. 804.

healthy<sup>10</sup>. His field was action, not pondering and hypothesising. Even his most intimate letters are filled with descriptions of meetings, actions and people – not thoughts and feelings<sup>11</sup>. Thus, it is not surprising the idea that he might have struggled with clinical depression did not occur to most biographers.

The landmark source suggesting the Greatest Briton might have had a mood disorder was the publication of Lord Moran's diaries entitled *Winston Churchill: The Struggle for Survival 1940-1965* in 1966, hardly a year after the Prime Minister's death at the ripe age of ninety-one. Charles Moran was Churchill's personal doctor so, needless to say, Churchill's family, among others, found the publication not only disturbing but also morally inappropriate. After all, it is a breach of professional etiquette and a violation of the Hippocratic Oath to reveal one's patient's secrets – whether the patient is a famous person or not is of secondary importance here. But it seems even more preposterous to do so in the case of a public figure, whose confidence the doctor gained, as it later turned out, undeservedly. Moran's defence was that he was contributing important information that would help later generations to understand fully Churchill's state of mind during the period of World War II. As he had first hand's knowledge about these matters it was even his duty to posterity to make it available. The doctor comfortably ignored to mention in the preface the generous fee he received for his diaries – and it was widely known his financial situation was not advantageous<sup>12</sup>. He received £30,000 from the *Sunday Times* for the serialised version of his book<sup>13</sup>. Needless to say, the financial gain could have been as big an incentive to publish it as his concern for accuracy of research of future history scholars.

Even the subtitle of the book is telling. "The Struggle for Survival" might be interpreted more generally – as Britain's struggle to oppose Hitler but also more narrowly, as Churchill's fight against his own mental and physical disabilities. The second interpretation is more plausible, as the dates indicated are 1940 to 1965, not 1945. Moran, in his preface, uses very charged and judgmental vocabulary, such as "distaste for life," "weakness in moral fibre," "failing powers" and "apathy and indifference"<sup>14</sup>. Thus, the reader is left under a strong

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<sup>10</sup> J. C. Humes, *op. cit.*, p. 99.

<sup>11</sup> See M. Soames, ed. *op. cit.*

<sup>12</sup> M. Gilbert, *op. cit.*, p. 887. Churchill himself made a generous contribution to Moran's family, aware of his doctor's difficulties.

<sup>13</sup> C. Moran, *Winston Churchill: The Struggle for Survival 1940-1945*, London 1968, blurb.

<sup>14</sup> *Ibidem*, p. 15.

impression that the great statesman was indeed in the state of mental collapse. It is sufficient to compare these words with the choice of subtitle for Moran's earlier book, dealing with his experiences in the trenches of the Great War – *Anatomy of Courage* (1945). Ironically, it is the First World War that produced mass conversion neurosis in British soldiers, especially recruits from the upper classes, remembered as shell-shock<sup>15</sup>. Yet the title suggests WW I was a heroic feat while Churchill's condition was disastrous.

Moran repeatedly uses the term “black dog” – a nickname Churchill himself used to refer to his darker moods. His physician interprets the term as a personification of depression. As Peter Foley and Sheilagh Quaille analyse, the phrase has its roots in British folklore, in which a dark canine figure was a harbinger of misery and death but can also be traced back to ancient mythology<sup>16</sup>. It was extensively used by Samuel Johnson, an 18<sup>th</sup> century English writer<sup>17</sup>. Yet, according to John Colville, Churchill's private secretary, the black dog for Churchill was synonymous with feeling grumpy, irritable and ill-humoured, not depressed<sup>18</sup>. It is an expression used to refer to a sulky child, not a person battling with suicidal thoughts and feelings of worthlessness. There are thus sound arguments to assume Moran misinterpreted Churchill's words.

Even if we accept Moran's account as accurate (and it may well not be the case as a few historians dispute its truthfulness and accuse the author of being dramatic and exaggerating his own importance)<sup>19</sup>, it has to be kept in mind that the doctor's opinion is, by definition, biased. Medical professionals see their patients only when they are ill so they may believe them to be in a much

<sup>15</sup> B. Shephard, *A War of Nerves. Soldiers and Psychiatrists. 1914-1994*, London 2000.

<sup>16</sup> J. Foley, ‘Black dog’ as a metaphor for depression: a brief history. [www.blackdoginstitute.org.au](http://www.blackdoginstitute.org.au). Accessed 15.01.2005 and S. Quaille, ‘The black dog that worries you at home’: The Black Dog Motif in Modern English Folklore and Literary Culture, “The Great Lakes Journal of Undergraduate History” 2013, v. I, is. 1. Notable instances of the legacy of that tradition can be seen in Sir Arthur Conan Doyle's *Hound of the Baskervilles* (1902), H. P. Lovecraft's “The Hound” (1924) and, more recently, the Grim from the *Harry Potter* series by J. K. Rowling.

<sup>17</sup> *Ibidem*.

<sup>18</sup> J. Colville, quoted in *ibidem*.

<sup>19</sup> See: J. H. Mather, *Lord Moran's book is based on his diaries*, International Churchill Society, <https://winstonchurchill.org/resources/myths/lord-morans-book-is-based-on-his-diaries/> Accessed 4.09.2020. Also Richard Holmes is dismissive of Moran's book. Furthermore there is no surviving written record of Moran's diary, so the whole book seems to be a retrospective account (W. Attenborough, Wilfred. *Churchill and the ‘Black Dog’ of Depression. Reassessing the Biographical Evidence of Psychological Disorder*, London 2014, p. 187-188).

worse state that they really are. There were undoubtedly many moments when Churchill was fine – but on these occasions he did not require Moran’s company. Churchill, who needed to keep energetic and appear resilient to others, might have allowed himself to be more vulnerable to his physician. Furthermore, Moran does not make a sufficient cause-and-effect link between Churchill’s physical complaints (a few strokes and recurrent bouts of pneumonia), which made ordinary past activities, previously pleasurable, impossible, and his mental condition. He also fails to emphasise about his famous patient that “for a man in his late sixties [and later in early seventies], his energy and stamina were astounding”<sup>20</sup>.

Another contributor to the theory that Churchill was struggling with depression was Anthony Storr, a notable British psychoanalyst and writer. Storr created, or rather invented, a psychobiography of a tormented individual, whose depression was apparently caused by premature birth and parental neglect<sup>21</sup>. He also claimed that Churchill’s hyperactivity and youthful bravado were all meant to mask his deeply hidden insecurities, fear and shyness. “His aggressiveness, his courage, and his dominance were not rooted in his inheritance,” Storr argues “but were the product of deliberate decision and iron will”<sup>22</sup>. In other words, Churchill was naturally lazy, gloomy and fearful yet forced himself to appear otherwise to avoid shame. Such a statement suggests that depression is not a real illness but a matter of willpower and determination. Storr also argues that the multiple hobbies Churchill enjoyed, such as painting or redecorating his country house at Chartwell in Kent, were also desperate measures to mask the ingrained despair and emptiness. In fact, many people would argue that the ability to enjoy life’s daily pleasures and exhibiting interest in various activities

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<sup>20</sup> P. Addison, *Churchill. The Unexpected Hero*, Oxford 2005, p. 203.

<sup>21</sup> A. Storr, *Churchill’s Black Dog and Other Phenomena of the Human Mind*, London 1998, p. 22. The psychoanalyst supports his presumptions with a controversial opinion that “a premature child is unexpected and, therefore, something of an embarrassment.” Obviously, children born too soon after their parents’ wedding may be suspected of being conceived illegitimately and only passed as premature. Yet it was never an issue in the case of Winston’s birth. Storr, like a few other biographers, exaggerate the neglect Winston apparently suffered as a child. His parents indeed did not look after him personally and sent him off to a boarding school at an early age – yet their behaviour was absolutely typical for British aristocrats of the 19<sup>th</sup>, and even 20<sup>th</sup> century – see R. Holmes, *In the Footsteps of Churchill*, London 2005, p. 27. Young Churchill received a lot of affection from his nanny, Mrs Everest. Also, his letters home suggest he was a needy child, prone to manipulative behaviour.

<sup>22</sup> A. Storr, *op. cit.*, p. 11.

is a sign of mental health. The loss of interest in them is listed as a symptom of depression. Churchill remained an active painter, avid reader of novels and frequent traveller till his death.

Storr is also responsible for starting the theory that Churchill's melancholic disposition should be seen as his asset, not weakness, an idea that will be later elaborated on by many scholars and mental health advocates.

Only a man who had known and faced despair within himself could carry conviction at such a moment [Battle of Britain]. Only a man who knew what it was to discern a gleam of hope in a hopeless situation, whose courage was beyond reason, and whose aggressive spirit burnt, at its fiercest when he was hemmed in and surrounded by enemies, could have given emotional reality to the words of defiance which rallied and sustained us [the British and their allies] in the menacing summer of 1940. Churchill was such a man: and it was because all his life, he had conducted a battle with his own despair that he could convey to other that despair can be overcome<sup>23</sup>.

Again, people diagnosed with depression are not known for their resilience and optimism. The fact that Churchill believed in victory despite the overwhelming evidence against it and could instil hope in others is yet another proof against his depression.

The fact remains Churchill's last years were indeed relatively bleak. Yet it must be remembered that he was in an advanced age, had multiple physical complaints as well as genuine reasons to worry. Three out of his four surviving children had serious personal problems, which involved alcoholism, mental illness and turbulent love lives. His second daughter Sarah was arrested for unruly behaviour while intoxicated and the news of the scandal leaked to the newspapers<sup>24</sup> while his eldest, Diana, committed suicide in 1963<sup>25</sup>. He was also saddened by the political situation in the world as well as the fall of the British Empire. Like many professionally active individuals, he did not enjoy retirement. Thus, Vivian Green's account of the last decade of the Prime Minister's life seems to be both unfair and unkind. He writes that

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<sup>23</sup> *Ibidem*, p. 5.

<sup>24</sup> M. Soames, *op. cit.*, p. 629.

<sup>25</sup> R. Holmes, *op. cit.*, p. 85.

Behind a façade he was a shadow of his former self. His speech was slurred and he walked with difficulty. He read little but novels, spent much of his time playing bezique, found it difficult to concentrate and was increasingly forgetful of names and occasions<sup>26</sup>.

Keeping in mind it is a description of an octogenarian who has had several strokes, most people would probably still envy Churchill his ability to walk, talk and read at all. He might have been a shadow of his former self, but his agility and intellectual curiosity were still impressive. That is why, his disappointment and frustration caused by aging can be labelled as clinical depression remains disputable.

Moreover, irrespective of the medical problems mentioned above, the last two decades of Churchill's life proved that he was able, even in the advanced age, to indulge in old pastimes (such as painting) and find new hobbies. All his life he was an avid reader, but he discovered the pleasures of reading novels and acquainted himself with many canonical works of Victorian literature. His youngest daughter's husband, Christopher Soames, introduced him to his last great passion – breeding race horses and horse racing<sup>27</sup>. He also made new friends and enjoyed their company. One of them was Aristotle Onassis and his first wife Tina, on whose yacht *Christina* Churchill was a frequent guest<sup>28</sup>. These are hardly the exploits of a man disabled by the grips of crippling depression.

Despite relatively scant solid historical evidence for Churchill's mood disorder, there is a growing tendency to perceive him as depressed. Encouraged by the medical account of Moran and psychoanalytic study of Storr, a few historians as well as mental health activists interpret Churchill's life through the prisms of depression. The most important of them is an American psychiatrist Nassir Ghaemi, who in his book, *A First-rate Madness. Uncovering the Links between Leadership and Mental Illness*, argued not only that the famous Briton was depressed but went further trying to convince his readers Churchill's depression was actually advantageous. His thesis, undoubtedly a highly disputable one, is that ordinary times need mentally healthy leaders while the experience of mental illness might be an asset in leaders during periods of exceptional turmoil – “in at least one vitally important circumstance insanity produces good results

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<sup>26</sup> V. Green, *op. cit.*, p. 281.

<sup>27</sup> R. Jenkins, *op. cit.*, p. 30.

<sup>28</sup> *Ibidem*, p. 906-910.

and sanity is a problem. In times of crisis, we are better of being led by mentally ill leaders than by mentally normal ones”<sup>29</sup>. Ghaemi believes “realism, resilience, empathy and creativity” are consequences of depression – though for most people these features characterise rather emotionally mature and stable individuals<sup>30</sup>. The author argues that Churchill was able not to underestimate the threat Germany posed in the 1930s because he assessed reality much more objectively as a result of his depressive episodes<sup>31</sup>. There might have been, however, other reasons for his perceptiveness – profound knowledge of history, understanding of nationalism and imperial ambitions, even sheer luck or anti-Hun prejudice, a souvenir of his few months spent in the trenches during World War I.

Arguing in favour of Churchill’s illness, many researchers draw attention to his heredity. Indeed, there have been many individuals with obvious mental health issues among both his close and distant relatives. Also three out of four of his surviving children displayed symptoms of mental illness, notably depression and alcoholism. Yet, it must be remembered that Churchill’s wife, Clementine was of weak health herself – she frequently suffered from nervous exhaustion and needed a lot of rest. She was even hospitalised because of her nerves, a euphemism which might suggest a depressive episode<sup>32</sup>. Her own mother was a gambler while her brother, also a gambler, committed suicide for no apparent reason in 1922. Thus, it is difficult to say from which parent Winston and Clemmie’s children inherited their disposition towards mental illness.

Many biographers argue that Churchill’s drinking was connected with his depressed mood and alcohol acted as self-administered medication. Obviously, Churchill was far from being an abstinent and his habit of drinking spirits at breakfast found its place in many anecdotes. Nevertheless, those who are less sensation-seeking observe that “no credible testimony of Churchill’s being drunk” exists<sup>33</sup>. He was more of a sipper than gulper, to resort to a common phrase and though he did indeed drink daily, from early hours, his whiskey and sodas were heavily diluted<sup>34</sup>. As Holmes claims “he required a steady but seldom excessive intake [...] to feel fully functional”<sup>35</sup>.

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<sup>29</sup> N. Ghaemi, *A First-rate Madness. Uncovering the Links between Leadership and Mental Illness*, New York 2011, p. 2.

<sup>30</sup> *Ibidem*, p. 3.

<sup>31</sup> *Ibidem*, p. 57.

<sup>32</sup> R. Holmes, *op. cit.*, p. 85.

<sup>33</sup> P. Addison, *op. cit.*, p. 184.

<sup>34</sup> P. Johnson, *op. cit.*, p. 216.

<sup>35</sup> R. Holmes, *op. cit.*, p. 16.

The most outspoken opponent of the theory about Churchill's depression is Wilfred Attenborough. His book, *Churchill and the 'Black Dog' of Depression. Reassessing the Biographical Evidence of Psychological Disorder*, meticulously compares historical documents with claims made by Moran, Storr and Ghaemi and finds them unfounded or even deliberately fraudulent. His main argument is that Moran mistook Churchill's occasional emotional difficulties and moral dilemmas for mental illness. For Attenborough, the black dog was a "metaphor for transient worries, anxieties and low moods consequent upon the difficulties, disappointments and setbacks inescapable in the working life of a major political figure"<sup>36</sup>. One could only add here that these are unavoidable in the life of any responsible, mature adult. He also notes that Churchill's low moods never affected his professional performance as they never led to any lasting disability. "Any mental health problem Churchill may have had," he soundly argues, "was to do with strain and worry rather than with deep depression impairing general personal and social functioning"<sup>37</sup>.

Probably the most concise text defending Churchill's sanity – but still effective in its simplicity – is the short article published on International Churchill Society website by a therapist Carol Breckenridge. She simply lists all the symptoms of depression (as well as bipolar disorder, as some historians assume it might be a better diagnosis) enumerated in *The Diagnostic and Statistical Manual of Mental Disorders*, a universally recognised diagnostic tool, in order to dismiss all of them flatly, one by one.

Despite the unresolved historical controversy, the public perception of Winston Churchill as depression sufferer has been strengthened by several things. One of them is the famous sculpture presenting Churchill in a straight-jacket commissioned by Rethink Mental Illness, a large British charity in March 2006. The statue was initially to be displayed in Trafalgar Square but it came across a public outcry. It was accused of being too offensive and ended up in The Forum, a community building in Norwich, a much less spectacular location from the originally intended. Rethink argued their intentions were "to demonstrate that mental illness is not a barrier to leadership, historic significance and popularity"<sup>38</sup>. A year later, in 2007, Rethink and Mind, another

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<sup>36</sup> W. Attenborough, *op. cit.*, p. 3.

<sup>37</sup> *Ibidem*, p. 24.

<sup>38</sup> C. London, A. Scriven and N. Lalani, *Sir Winston Churchill: Greatest Briton used as an anti-stigma icon*, "The Journal of the Royal Society for the Promotion of Health" 2006, v. 126, No 4, p. 164.

charity organisation, founded a campaign called Time to Change. They chose five famous historical figures who, allegedly, battled with mental health issues to persuade employers discrimination against people with psychiatric diagnoses is unfounded. Obviously, Churchill was included in that group, alongside Abraham Lincoln and Marie Curie<sup>39</sup>. In 2012, during Channel 4 programme, *4 Goes Mad*, a straightjacket with the words depression in block capitals was put on the statue of Churchill in Parliament Square<sup>40</sup>. Other famous Britons, such as the naturalist Charles Darwin and pioneer of modern nursing, Florence Nightingale, were also fitted with straightjacket with the names of disorders from which they had allegedly suffered. In 2011, Rebecca Hunt published her highly acclaimed debut novel entitled *Mr Chartwell*. Set in 1964, at the time when Winston resigned his membership in the Parliament, it tells a story of Mr Chartwell, a gigantic black dog, who is invisible to most people but can be clearly seen by those suffering from depression. With them he is able to engage in long discussions and they feel his physical presence and sense the odour of “an ancient thing that had been kept permanently damp; a smell of cave soil”<sup>41</sup>. The dog rents a room close to Churchill’s beloved Chartwell country house, as he wishes to live close to work – he is a freelancer and needs to visit his clients, especially Churchill, on a regular basis. The immense success of the novel can be easily explained by its ingenuity, “a marvellously subtle sense of humour” and ability to tackle difficult themes with both accuracy and tenderness<sup>42</sup>. Yet, it strengthened the myth of Churchill as a severely depressed, gloomy and irritable person even further. The assumption that Churchill lived nearly all of his adult life accompanied by acute fits of clinical depression is now generally accepted without reservation – it has been repeated so many times on so many occasions, by historians and psychiatrists alike.

Members of the general public who are not academics or mental health professionals may not be familiar with the current trends in Churchill research or agendas of health charities. Their perception of Churchill would be predomi-

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<sup>39</sup> A. Campbell and N. Jones, *A World Without: The Fantastic Five* <https://www.time-to-change.org.uk/sites/default/files/World%20Without%20report.pdf> Accessed 6.09.2020.

<sup>40</sup> E. Allen, *Outrage as Channel 4 strap a straitjacket on Winston Churchill statue to ‘highlight mental health issues’*, “Mail Online” 20<sup>th</sup> July 2012, <https://www.dailymail.co.uk/news/article-2176397/Outrage-Channel-4-strap-straitjacket-Winston-Churchill-statue-highlight-mental-health-issues.html>. Accessed 5.09.2020.

<sup>41</sup> R. Hunt, *Mr Chartwell*, London 2011, p. 7.

<sup>42</sup> S. Bissell, *Review of R. Hunt’s Mr. Chartwell*, “Library Journal” 2010, November, p. 55.

nantly influenced by popular culture portrayals, such as films or TV series – and there have been countless of films in which the famous Briton appeared as an episodic, supporting or even main character. The most recent ones include Netflix original series *The Crown* (2016-2021) with John Lithgow as Churchill and two biographical films made in 2017: *Darkest Hour* and *Churchill*.

The most inaccurate and harmful is undoubtedly *Churchill* directed by Jonathan Teplitzky. In a humorous travesty of Churchill's words about the Battle of Britain, Andrew Roberts dismisses the innumerable factual errors deliberately committed by the filmmakers: "Never in the course of movie-making have so many specious errors been made in so long a film by so few writers"<sup>43</sup>. In the film, the Prime Minister is a "petulant, ill-tempered, sarcastic, unpleasant, decrepit, oafish drunken has-been"<sup>44</sup>. He is a truly detestable, deluded character, out of touch with reality, haunted by guilt over the failure of the Gallipoli campaign – the film opens with a scene of a hallucination in which Churchill on the beach sees waves of human blood. It strengthens the misconception that Churchill was and felt responsible for that bloodshed – a double mistake. Moreover, his relationship with Clemmie is tense and devoid of tenderness – she has little patience, support and warmth towards her husband. Furthermore, the choice of Brian Cox also raises several controversies. The first association most viewers have seeing the actor is with his previous roles in which he played a Marvel arch villain in the *X-men* series or the dishonest CIA official in the *Bourne* series. Thus, the atmosphere of corruption and deceit surround him, casting a shadow on the character of Churchill he impersonates.

However, it must be noted, that the film portrayal of Churchill in Joe Wright's Oscar-winning *Darkest Hour* (2017) might have positively affected the public perception of the Prime Minister's mental stability. The British statesman is presented as an eccentric often ignoring good manners or social norms. He is also often vulnerable and overwhelmed by his enormous responsibility yet the features that are highlighted are his wit, courage, determination and compassion. There is no hint in the film that Churchill might have been an alcoholic or depressive. The choice of Gary Oldman for the leading role also contributed to the warm reception of Churchill as a character as the actor's boyish charm can be still noticed despite the heavy make-up and silicon rubber.

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<sup>43</sup> A. Roberts, *Fake History in Churchill starring Brian Cox*. The Churchill Project. Hillsdale College. <https://winstonchurchill.hillsdale.edu/fake-history-in-churchill-starring-brian-cox/> Accessed 8.09.2020.

<sup>44</sup> *Ibidem*.

Since Churchill, in his youth, used to be a slender man with very delicate facial features, it was a good casting decision. Moreover, a lot of attention in the film was placed on the presentation of Churchill's marriage. His relationship with his wife, which lasted over half a century, was indeed his source of strength. Clementine was a woman of great intelligence and wisdom and was immensely supportive of her husband. The inclusion in the film of his intimate conversations with Clemmie makes the audience familiar with the Prime Minister's private persona, not just the official resilient bulldog image.

In *The Crown* Churchill is, obviously, not one of the main characters and he appears mainly in the first series. Although worn by advanced age, he retains his wit and political shrewdness. He is presented, on the whole, as a likeable character and a great statesman. His relationship with his wife, close co-workers as well as the constant company of Rufus II (his second ginger poodle) make him come across as a warm human being.

The agenda between establishing Churchill as an anti-stigma hero is fuelled by the common perception of depression as a female malady, magnifying traits traditionally seen as feminine: moodiness, dependency, vulnerability. Indeed, the great majority of individuals diagnosed with depression are women, yet the reasons behind it are complex and caused, probably, a mixture of biological factors and cultural/social/economic ones<sup>45</sup>. Also, many scholars assume depression goes undiagnosed in males as it is differently channelled and masked by substance abuse, especially alcoholism<sup>46</sup>. Still, receiving the diagnosis of depression is damaging to male identity, which is based on independence, strength, rationality and agency<sup>47</sup> – battling depression is synonymous with restoration of masculinity<sup>48</sup>. Thus, arguing Churchill suffered from depression yet was a great statesman, successful politician and fearless leader acts as a proof that there is nothing effeminate about the illness and one can lead a fulfilling, active life with it.

Churchill's name for his affliction, the black dog, is also meaningful in the context of masculinisation of depression. As Kimberly Emmons observes, "domestic pets suggest resilience rather than dominance" – a dog should be muz-

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<sup>45</sup> P. Prior, *Gender and Mental Health*, New York 1999.

<sup>46</sup> *Ibidem*.

<sup>47</sup> D. Galasiński, *Men's Discourses of Depression*, London 2008.

<sup>48</sup> K. Emmons, *Black Dogs and Blue Words. Depression and Gender in the Age of Self-Care*, New Brunswick 2014, p. 88.

zled, obedient to its master, domesticated<sup>49</sup>. It brings to mind a tough masculine image of a macho Cesar Millan-type character, whose dominant personality brings the canine companion to helpless submission as it recognises the leader of the pack and yields to his will. This connotation is evoked, for instance, in an online self-help book *Leashing the Black Dog: A Guidebook to Understanding and Managing Male Depression* by Brett McKay, which promises the prospective male buyers they will learn how to master their illness<sup>50</sup>.

Following the arguments of both sides, one may get the uncanny impression that factual evidence, both medical and historical accuracy, are completely irrelevant to them. What matters most is the potential application of their theories to the common perception of depression as an illness, especially its gender connotations. The motivation of the believers in Churchill's depression is undeniably noble. Obviously, no mental illness should be seen as shameful and making the public aware that many of the most cherished members of the community, great leaders, artists and thinkers suffered from mental disorders helps to lift the stigma. Furthermore, de-gendering depression and questioning the debilitating effects of narrow gender roles that negatively influence men's and women's psychological welfare is also a worthwhile task. Yet, the question whether a lie should be propagated because it serves the right cause cannot be avoided here.

In conclusion, Winston Churchill's long life was indeed filled with moments of profound sadness or even despair but never without tangible, external reasons. He carried on his shoulders a tremendous responsibility and was aware that his mistakes may cause, with no exaggeration, the fall of the Western world. He also had more than a fair share of personal problems. Nevertheless, the slightly humorous phrase he gave to his darker moods, the black dog, in all likelihood refer to "worry and mental overstrain", not clinical depression<sup>51</sup>. Thus, the notorious black dog, the beast that only the bravest can leash and subordinate, turns out to be a benign ginger poodle, Rufus. Churchill was an ardent animal lover and innumerable dogs and cats accompanied him, often living in Downing Street. Rufus had the honour of being his loyal companion during the tempestuous period of World War II. Much can probably be said about him, but he was definitely not black and not at all ferocious.

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<sup>49</sup> *Ibidem*, p. 106.

<sup>50</sup> <https://store.artofmanliness.com/products/leashing-the-black-dog-a-guidebook-to-understanding-and-managing-male-depression> Accessed 5.09.2020.

<sup>51</sup> W. Attenborough, *op. cit.*, p. 74.

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## Medicine in the Service of Nazism and other Silesian Stories – Reconstructing “Memory Shot Through with Holes” in Anna Dziewit-Meller’s *Góra Tajget*

Medycyna w służbie nazizmu i inne śląskie historie – rekonstrukcja „pamięci podziurawionej” w *Górze Tajget* Anny Dziewitt-Meller

### Abstract

The article discusses the literary reconstruction of the “memory shot through with holes” (H. Raczymow) in Anna Dziewit-Meller’s *Góra Tajget* (*Mount Taygetus*). The author analyses how this moral treatise set against the backdrop of the tale about three generations of a Silesian family as well as German eugenic operations fills the empty spaces in history and memory. In this process, the category of the body plays a unique role – one that is supervised by Nazi medicine, as well that which serves as a medium of what has been repressed from consciousness. Another key element of the text is the multiplied figure of the child, which binds together all the stories and accentuates the role of autobiographical factors in postmemorial discourse. Finally, the author examines how the anomalies of the discourse present in the book destroy the comfort of reading, and the literature, presented in an ethical perspective, becomes one of the most important discourses on responsibility, ethics (also medical) and human condition.

### Abstrakt

Artykuł poświęcony jest omówieniu literackich sposobów rekonstrukcji „pamięci podziurawionej” (H. Raczymow) w *Górze Tajget* Anny Dziewit-Meller. Autorka artykułu analizuje, w jaki sposób ten moralny traktat wpisany w trójpokoleniową historię śląskiej rodziny i niemieckich akcji eugenicznych wypełnia

puste miejsca w historii i pamięci. Szczególną rolę w tym procesie pełni kategoria ciała – zarówno tego pod nadzorem hitlerowskiej medycyny, jak i ciała jako nośnika tego, co wyparte ze świadomości. Drugim kluczowym elementem tekstu jest multiplikowana figura dziecka, spajająca wszystkie opowieści i akcentująca role czynników autobiograficznych w dyskursie postmemorialnym. Wreszcie autorka śledzi, jak obecne w książce anomalie dyskursu burzą komfort lekturowy, a literatura ujmowana w perspektywie etycznej staje się jednym z ważniejszych dyskursów na temat odpowiedzialności, etyki (także lekarskiej) i kondycji ludzkiej.

**Keywords:** empty spaces in memory, body as a medium of postmemory, literature and Nazi medicine, postmemorial discourse

**Słowa kluczowe:** „pamięć podziurawiona”, ciało jako nośnik postpamięci, literatura wobec medycyny hitlerowskiej, dyskurs tożsamościowy i postmemorialny

For history teaches us that those who do not remember the past  
are condemned to repeating it in the future<sup>1</sup>

In one of the opening pages of the chapter titled *Adik*, which concludes *Góra Tajget* (“Mount Taygetus”) by Anna Dziewit-Meller, we find the following passage:

Theoretically, they were only supposed to visit the area around Frankfurt, where Karlchen’s family had moved, but on the way there – as the online guidebook describes – there is so much splendour! Nuremberg, for example. Such a lovely place! Those tenements with Gothic vaults, those shops with local products, those restaurants full of happy people! [...] Karolina reads about the Nuremberg Toy Museum in her guidebook. “Let’s go with the child! Nuremberg is the city of toys! The whole world used to know about it, until it forgot.”<sup>2</sup>

The story of young parents enjoying the tourist attractions of Nuremberg several decades after the war is an ironic reminder of the cultural amnesia associated with the events of World War Two (the world used to know, until it forgot), and

<sup>1</sup> S. Sterkowicz, *Nieludzka medycyna. Lekarze w służbie nazizmu*, Warsaw 2007, p. 11.

<sup>2</sup> A. Dziewit-Meller, *Góra Tajget*, Warsaw 2016, p. 116 (e-book).

at the same time a telling commentary on the stories we learn in Dziewit-Meller's book. Nuremberg – a city which, after Hitler's rise to power, gradually turns into a utopian city of the future, on 15 September 1935 is the arena of the Nuremberg Laws, and later houses the International Military Tribunal, which tried Nazi war criminals in 1945–46 – on the pages of the novel becomes, literally and metaphorically, the stage of a spectacle in which the sinister giggle of history is particularly haunting. At the toy museum, amidst horrifying porcelain dolls with vacant eyes, replicas of bourgeois houses or railway tracks models, there is also a collection of World War Two figurines. It includes grotesque puppets in Nazi uniforms, which, somewhere on the sidelines, away from the visitors' attention, are conducting a meeting concerning the euthanasia of children, which became a prelude to the Holocaust before World War Two.

As Meller writes,

The toy museum is visited by children on a school trip. It gets loud and crowded. The leader and his entourage immediately take strategic positions, on and around the lectern. Tea cools down in microscopic cups on the table at the Grand Hotel apartment by the Baltic Sea. Children with black faces, with slanted eyes, in yarmulkes and scarves on their heads, peer at subsequent displays [...]. They talk to one another in German, laughing and pushing.<sup>3</sup>

The clash between the grotesque theatre of the Nazi puppets and a group of multiracial German children is an ironic encounter between the past and the present, but it is underpinned by the fear that at any time, at some seaside hotel, the tea at a meeting might not be actually getting cold, and that history is not just a puppet theatre. The story of Adolf Hitler, saved from drowning in the Danube by a childhood friend, carries a similar counter-factual meaning. "Then there would have been no *ein Reich, ein Führer*, no crematorium in Auschwitz, no Luminal in a hospital in Lubliniec, no ghosts in Muranów. *Perhaps*."<sup>4</sup> The author seems to follow alternative paths – the past seen in the museum is blurred under the pressure of current events. The experiences of children and their parents from the time of the Second World War cannot be compared to the tired parents of little Małgosia. However, in the final sentence of the book, they become infused with new meanings in the context of history, although it is possible to take away their authenticity: "Karolina, Sebastian and Małgosia,

<sup>3</sup> *Ibidem*, p. 130.

<sup>4</sup> *Ibidem*, p. 125. Emphasis A.G.

who is crying once again, are walking towards the hotel, maybe the little one will fall asleep, maybe when she sleeps, she will be in a better mood, because now, looking at her performance, having children is the last thing you would want.”<sup>5</sup> As a difficult child, little Karolina would probably have been positively verified in a eugenic programme, but now, several decades after the war, her whining provokes dislike at most. That is why we need to remind and remember. Dziewit-Meller herself admits that the scale of the denial and silence about the uncomfortable aspects of history was one of the most important incentives for writing the book.<sup>6</sup> In this inspiration, historical themes are closely linked to family history – and History turns into a drama of individuals, not figures in a mock-up. And although the book does not say more than would have been written in historical studies from that period, it serves as a moving reminder, as it is strongly marked by a postmemory trace and an overall moral message that cannot be overlooked in interpretation. As one of the reviewers wrote, “This is a story that brings us closer to the truths that we would not have had the strength to bear without the help of an artist.”<sup>7</sup> It is easy to distance oneself from life experience, while Dziewit-Meller’s story seems more true than reality itself. This is not because the author makes exceptionally meticulous use of historical sources; instead, she builds a fictitious world that moves and touches us as if we were co-participants, without giving up references to historical facts that we are unable to challenge. This conglomeration of truth and fiction, of great History and the history of individual people touches us and destroys the comfort of reading, constantly reminding us that, even if it is a truism, history likes to repeat itself.

The key category that makes it possible for the interpretative framework to cover all the themes and characters presented in the book is the category of

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<sup>5</sup> *Ibidem*, p. 130.

<sup>6</sup> In one of the interviews, the author admits to being inspired by the story of Anna Rosmus and her book *Out of Passau. Leaving a city Hitler called Home*. For Meller, it was particularly shocking that the inhabitants of Passau, a city on the border between Germany and Austria, were so successful in repressing the awareness that Hitler’s family had once lived there, that upon learning of the book on the subject they nearly lynched the author. As a result, Rosmus was forced to emigrate from Germany and now lives in the USA. See P. Reiter, *Zbrodnie na chorych psychicznie byly preludeum do Holocaustu*; interview with A. Dziewit-Meller, <https://www.wysokieobcasy.pl/wysokie-obcasy/1,53662,19613666,zbrodnie-na-chorych-psychicznie-byly-swoistym-preludeum-do-holocaustu.html> (accessed 10 August 2020).

<sup>7</sup> P. Bravo, *Cialo swoje, ciało obce. O „Górze Tajget” Anny Dziewit-Meller*; <https://kulturaliberalna.pl/2016/04/05/pawel-bravo-recenzja-gora-tajget/> (accessed 31 July 2020)

‘memory shot through with holes’. Its essence is – as Anna Ciarkowska writes – the relationship between the “untold” and the “told”, including the process of disappearance of the story, which becomes emptiness and turns into silence. It is around it that the postmemory structure develops, forcing us to answer the question of what used to be there and now is empty.<sup>8</sup> According to Henri Raczymow, this kind of postmemory emptiness feeds itself, tames underdefined places, and by projecting what it cannot remember, it makes the relation to the object or source of the story mediated not by memory, but by imagination. This half-heard or half-read, half-imagined memory is an overwhelming force shaping the identity and attitude of subsequent generations towards the past. This is the case with the author of *Góra Tajget*, who in her book sets the history of Silesian families, including her own, within the history of German eugenic operations. The author dedicates the book to her grandparents and her children – the generation that remembers and the generation that should carry that memory on, thus building the foundation of its own identity. Filling in the blank spaces of family and collective history is a necessary condition for this process and warrants the understanding of today’s social and political processes.

The factor that binds all five stories together is the denunciation of the criminal, distorted role of medicine in human history and the reflection on the role of the body, which becomes a carrier of postmemory. A separate cohesive element of the presented world is the figure of the child, which in various ways is crucial for each story, also referring to the author’s autobiographical experience. Dziewit-Meller admitted that the experience of motherhood, including her profound fear for her children and their future, was one of the most important incentives for this book.<sup>9</sup> The key role of the child’s figure in the narrative is already suggested by the title itself – Mount Taygetus, a place where, according to legend, weak or crippled newborns, unfit for the harsh lives in the *polis*, were thrown into the abyss. That primordial selection returns in the era of crematoria, although this time it does not take place on the edge of a cliff, but with the assistance of doctors and behind hospital walls.

The narrative axis of the novel is the euthanasia programme for mentally disabled people, also known as *Aktion T4*.<sup>10</sup> It was closely linked to racist theo-

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<sup>8</sup> A. Ciarkowska, *Kto ma pamięć podziurawioną? O koncepcji postpamięci według Henriego Raczymowa*, „Politeja” 2015, no. 3, p. 189–199.

<sup>9</sup> P. Reiter, *op. cit.*

<sup>10</sup> The operation was named after the street in Berlin, Tiergarten 4, where its headquarters were located. See: S. Serkowicz, *op. cit.*, p. 47–69.

ries, according to which “racially defective” individuals stood in the way of the racial perfection of the German nation. This was the first and main type of argument preceding the “euthanasia campaign” that was raised after Hitler came to power. Another cited economic reasons, emphasising the ‘burden’ that the state has to bear in maintaining disabled individuals. While the first type of argument was reflected in programme statements (e.g. in *Mein Kampf*), the second type of justification was used when it came to laying the psychological ground work for *Aktion T4*. Propaganda campaign involved attempts to sway public opinion by means of films and various educational materials. For example, one of the tasks of a mathematics textbook by Adolf Borner (published in 1935) was: “The construction of a madhouse costs RM 6 million. How many new flats can be built for this sum if one flat costs RM 15,000?”<sup>11</sup> And although discussions on the admissibility of euthanasia for mentally ill people continued to divide the medical community, at the beginning of 1939 there was a case which strengthened this project significantly. Hitler’s office received a letter in which the father of a crippled newborn requested that he be granted official consent to kill his son. Hitler had the matter handled by Karl Brandt, who was in charge of the euthanasia campaign. The child was killed with sleeping pills, and that first death officially launched *Aktion T4*, that is to say the organised euthanasia of so-called superfluous “bread-eaters”, people who did not contribute any benefits to the Reich, mainly the mentally and terminally ill, both adults and children. The antedating of Hitler’s regulation on this subject, in fact passed October but signed on 1 September 1939, was intended to highlight the special circumstances of the state of war, making it possible to kill all those who, for racial, health or even political reasons, were considered “undesirable”. In 1940, the programme was institutionalised with the establishment of the Reich Commission for the Scientific Analysis of Serious Hereditary and Congenital Diseases, which decided whether a sick child would live or be euthanised. Sick and handicapped children were sent to special centres, one of which was a hospital in Lubliniec.<sup>12</sup>

Dziewit-Meller’s attempt to fill in the empty places of “memory shot through with bullets” opens with a bracket of contemporary times, in which the main character, Sebastian Kowolik, a well-to-do Silesian who runs his own hospital pharmacy, has just become a father. With the birth of his daughter, Małgosia, Sebastian’s peaceful everyday life is disturbed by a strong, even para-

<sup>11</sup> J. Mikulski, *Medycyna hitlerowska w służbie III Rzeszy*, Warsaw 1981, p. 37.

<sup>12</sup> See: S. Serkowicz, *op.cit.*, J. Mikulski, *op. cit.*

noid fear for the child's life. His obsession deepens when he learns that the hospital, a place which for years has been for him an object of sexual fantasies about shapely nurses and a synonym for recovered physicality, suddenly turns out to be part of the hellish Lubliniec facility for children as part of *Aktion T4*. That crime is all the more heart-breaking for him because he himself, as a pharmacy owner, is involved with the healthcare system: "Sebastian likes his work because he feels he is part of that community whose work has a profound social sense. He treats people, he saves lives, he does not create unnecessary entities – that is how he thinks about himself..."<sup>13</sup> However, faith in the salvific power of medical science, which until now has accompanied Sebastian, is gradually being undermined. The first alarming signal comes when the doctor suggests a caesarean section to his pregnant wife. At the time, Sebastian assuages Karolina's doubts as follows: "Well, the doctor said so.' Sebastian firmly believes that. Who to trust, if not the healthcare system?"<sup>14</sup> When it turns out that the procedure was unnecessary, doubts arise. In the second case, Sebastian loses faith in the missionary power of healthcare when, after several months, little Małgosia's parents are forced to bring their daughter to hospital.

A children's hospital, a place full of undeserved misery. Mothers and fathers, lying on the ground, on inflatable mattresses and thin foam pads, unwashed and distressed, slinking along the walls like shadows, so as not to be noticed by the all-powerful gaze of the staff. But what else can they do if the child is so young and doesn't want to understand that it would be better for the nurse if he or she stayed there alone, without the hysterical mother wandering around stealthily.<sup>15</sup>

What shocks the hero, however, is the crime committed against two hundred defenceless children, which took place in the Lubliniec hospital. Although the knowledge about it is not precisely concealed, the protagonist extracts it by force. It is only when he meets an elderly teacher – a father, who himself experienced the loss of his child – that Sebastian can come closer to the memory of what happened. Fear and understanding comes at the moment of identification, when what is abstract and forgotten becomes his, i.e. close and personal.

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<sup>13</sup> A. Dziewit-Meller, *op. cit.*, p. 12.

<sup>14</sup> *Ibidem*, p. 7.

<sup>15</sup> *Ibidem*, p. 17. Hospital reality is, in this case, one of the many social comments that we find in the book. In this case, it is an appeal for adequate conditions for hospitalised children and their parents, which, unfortunately, is still not the standard in Polish hospitals.

He wonders why it hits him so hard, this knowledge that the place where he works today used to be a site of execution. And that in the old brick pavilion at the back of the hospital, now being converted into a hotel, dying children once laid on cold stone floors. And again, an uninvited lightning comes, pierces his brain with an electric impulse and lightens up in his head – because here, on the dirty stone floor, his daughter lies, in torn clothes, screaming out of fear, cold and pain. She can't get up and run away by herself yet, she only turns from her back to her stomach and back again, her eyes filled with animal-like terror, pushed to act by her survival instinct. He wants to run up to her and take her in his arms, warm her with his body, his breath, calm her down, feed her, but the closer he wants to get, the further away she goes, as if some secret force pushed her into the never-ending hospital corridor, which Sebastian has walked so many times, tapping the soles of his shoes against the cold floorboards. He wakes up screaming.<sup>16</sup>

The nightmares that haunt Sebastian are filled with shame for the lack of empathy and the evils of this world aimed against the smallest and most defenceless. In the history of the city, the memory of children systematically killed with Luminal remains at the far end of commercial needs, historical duties and human conscience. “A person must have a grave with their name on it,” says Zgierski, the teacher, during a conversation with the Mayor. “Not a monument, not a mass grave where they are buried anonymously, as if they had never existed. A person must be given the dignity they were deprived of before their death. Let us give these children their names”. In response to his request, the official inundates him with words:

Ah, Mr Zgierski, well, it is not that simple, it is not our area, it is not our business, it is not possible, it is not appropriate, the private investor, former owners, reprivatisation, claims, damages, a mountain of money, city investments, budget support, the Institute of National Remembrance, serious heroes, accursed soldiers, the Home Army and the anniversary of the Warsaw Uprising. Crazy, minors, might not be good for the city, there is going to be a SPA, the clients (also from Germany!), negative image, cash outflow. Property taxes, various obligations, local government elections, promises. We look into the future, we do not look back, the skeletons in the closets. There are important graves and there are less important graves. Right of state, weighing the pros and cons. Social conflicts, dissatisfaction of influential groups, unnecessary

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<sup>16</sup> *Ibidem*, p. 23.

reopening long healed wounds. In addition, there is a lack of funds, this year has been frozen for a long time, and the new one is still a mystery. A visit from the head of the province, EU subsidies, fiscal control. Food in canteens, living children, today's children, our children. Unemployment, the Coal Company, protests. This is a marginal issue, however, try with the civic budget, although there are speed bumps on the roadways and the paver stones in the square, and flowers for the city's flower beds and the black sausage festival in August.<sup>17</sup>

In Sebastian's consciousness, intergenerational fears are transmitted and the traumas of the past are combined with those of the present, the familiar becomes global. Dreams of war overlap with images of drunken mothers, molested and abandoned children, the wartime tragedies of children in Syria or Iraq, and the bodies of small refugees washed away on the Mediterranean shore. When he tries to find out more about what happened in the Lubliniec hospital, he hears: "That's abstraction, Sebek," adds Mirka, who also knows something about that from her grandmother. "This is a complete abstraction for me. No use getting upset by such stories if there are even worse around you every day."<sup>18</sup> But he "knows, he feels that it is not an abstraction at all. After all, Sebastian is afraid that one day, together with the gas bill and the Lidl supermarket advertisement, he might find a leaflet on how to behave when the war comes in the mailbox. After all, why not? They are already distributing those in Vilnius."<sup>19</sup> His maturity involves the acceptance that the present is always a reminder of the past, a warning that must not be underestimated.

What Sebastian shares with the central character of the following story is shame and fear, although in the context of her biography these concepts take on completely different meanings. The protagonist, Gertrude Luben, who was visited by a German journalist several decades after the war, is based on Elisabeth Hecker. In 1942–44, together with Ernest Buchalik, she ran a psychiatric hospital in Lubliniec and was responsible for selecting children for the so-called B Ward, where they were killed with regular doses of Luminal. Today, Luben is a valued, respected and distinguished professor of child psychiatry and nobody wants to remember her hospital "mission". Officially acquitted, she does not feel culpable. As she puts it, "We were only scientists, our role was and is to transcend the borders of the unknown for the sake of humanity. A scientist must always move

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<sup>17</sup> *Ibidem*, p. 39.

<sup>18</sup> *Ibidem*, p. 26.

<sup>19</sup> *Ibidem*.

forward.”<sup>20</sup> She explains the crimes committed against children by the rational logic of medicine, which, however, does not withstand the confrontation the real response – the response of her body. Pressed by subsequent questions, Luben vomits and sweats, and her sweat smells of fear. She knows that fear – that is how children used to smell when she leaned over and injected them with another lethal dose of Luminal. Just like Sebastian, the body of the characters is the most important medium of memory. It cannot be deceived. Luben, who explains her actions during the war by the need to perform her duties, without any moral reflection on what was being done, effectively denied the crimes she committed.<sup>21</sup> “I have not dreamt of anything for years. And I am very happy about that. Great nothingness. A small death.”<sup>22</sup> What is noteworthy in her first-person narrative, however, is not just her body language but also childhood memories, including a strict upbringing in a rich house full of physical, cold violence on the part of parents. “It was a different time,” comments the heroine. “I am not complaining. We were brought up to be decent people. And tough people. Weak ones would not have survived all that happened afterwards.”<sup>23</sup> Therefore, is Luben, once a murderess in a doctors uniform and now a lover of classical music, a product of Prussian discipline? The author often introduces us into the sphere of moral dilemmas, also in this case, seemingly without any doubts as to the moral assessment of Luben’s conduct. This discourse is perfectly reflected not only in the monologue form of this chapter, in which what is being thought escapes from underneath what is being said. Dziewit-Meller introduces the theme of settling accounts with the past in the form of a journalist who asks the doctor the already famous question: *How have you been the doing?* This is a reference to the masterpiece of non-fiction literature by Krzysztof Kąkolewski, *Co u pana słychać?* [How have you been the doing?]. Thirteen after the war, Kąkolewski found and interrogated ten Germans responsible for the Nazi crimes, who had not been brought to justice and who, like Luben, were respected members of society after the war. He asked each one of them the

<sup>20</sup> *Ibidem*, p. 58.

<sup>21</sup> One of the last statements made by K. Brandt, who was responsible for the euthanasia programme, before the announcement of the Military Court’s judgment, was: “It is immaterial for the experiment whether it is done with or against the will of the person concerned... The meaning is the motive – devotion to the community... Ethics of every form are decided by an order or obedience”; cited in: V. Spitz, *Doctors from Hell: The Horrific Account of Nazi Experiments on Humans*, Boulder 2005, p. 258.

<sup>22</sup> *Ibidem*, p. 64.

<sup>23</sup> *Ibidem*, p. 45.

same question that made the heroine so angry. By initiating a conversation with Dr. Luben, the author unveils and fills with dilemmas such area of “memory shot through with bullets” which speaks of guilt that has become blurred and punishment that has never been adequate, and whose memory pulsates under the skin. This phrase also touches on the tragedy resulting from the tension “between a being reduced to a suffering, chafing body wrapped in a minimal layer of self-reflection, and the pure, discursive rationality of the medical profession, which pushes physicality away from the human being, [...]”<sup>24</sup> Such tension cannot be relieved permanently. That is why in the memory of future generations the building of the hospital in Lubliniec will remain as a centre of euthanasia horror, and at the same time, as a hospital, it will be associated with a place of hope that people can be freed from their physical afflictions.

While in the chapter *Gertruda* the reader receives a psychological study of the suppression of the crime by one of the perpetrators, chapter titled *Ryszard* brings us closer to the centre of the Lubliniec tragedy. It is the story of a boy, ten-year-old Rysiu, brought to the hospital in Lubliniec by his stepfather, an SS officer, with his mother’s consent. The second-person narrative tells the story of Rysiu from the viewpoint of someone who empathically penetrates the boy’s emotional states and situation. The recurring phrases “you remember” evoke empty spaces, which have escaped the memory or which the boy would like to forget. It is as if using the second-person narrative, the author rejects the social strategy of suppressing that story from the posterity’s consciousness. Through the narrative “you”, we are gradually included in someone else’s experience and it is as if we participate in it, which brings about the effect of emotional involvement, both in the mental and physical sphere of the presented space-time. Through such an approach, we learn the history of an abandoned child, his struggle with loneliness and the physical trauma of a hospital “treatment”. Through Rysiu, who returns to the hospital in Lubliniec for a moment (all the more so because the narrative “you” sometimes resembles the masked “I” of a monologue), we also know how Dr. Luben qualified children for euthanasia – most often it was not even a serious illness, but so-called “social” considerations. Often, children who were simply disobedient, lively, with minor physical defects, were killed and death certificates were falsified. We also find out how little Rysiu managed to flee from the ward during bombing with the help of a nurse, who recognised a distant relative in him. The second-person

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<sup>24</sup> P. Bravo, *op. cit.*

narrative is a multifaceted figure in this case – the protagonist is not just Rysiu, but all the children whose fate he shared during his stay in hospital. What is more, as Magdalena Rembowska-Pluciennik wrote, “the phrase ‘you’ forces the reader – even if it is only temporary and reversible – to feel an impulse for self-reference, i.e. to cross the borders between the world of the text and reality.”<sup>25</sup> Thus, the story of Rysiu is both fictional and true, and the ethical aspect of those events acquires the power of judgement. Such moral judgment is part of all the stories in Dziewit-Meller’s book. Here, the accusation of the abuse of medical ethics resonates particularly strongly – we are reminded of this by the words of the Hippocratic oath spoken in trembling voice by the doubtful nurse. However, fragments of Rysiu’s story, sometimes stylised as a court trial, and equally evoking the arguments of perpetrators who escaped punishment, correspond to the accusations not only against people, but also against science, systems and institutions whose development and success have been built on the trauma of victims.

However, Dr. Luben was not afraid of what she was supposed to fear. You see, Rysiu, she did scientific work. Everything she did, she did on behalf of science, for higher purposes and to improve the fate of humanity. See here – it was in this very room that she cut your little bodies, rigid after death. Autopsies of corpses to find out what killed you made no sense, because you were killed by someone else’s hatred, but Dr. Luben would take your precious brains out of your little heads and then, immersed in formalin, in huge jars, send them all the way to Wrocław, to Professor Weizsäcker, a collector and head hunter from the Institute of Neurology. Your epilepsy, underdevelopment, antisocial behaviour, any deviation from the norm, your artistic abilities – all of this the professor drew to the light of day of science with the help of microscopes, Petri dishes, boards and diagrams. What would psychosomatic medicine be without your contribution? Where, dear Rysiu, would the world be without the sacrifice of all the victims of such numerous experiments? In just five years of the war the progress was made as if an entire era had passed. How many German medical students, at the Max Planck Institute, for example, have learnt how human body is built on human body parts collected for such purposes in camps, hospitals and God knows where. Victims’ remains were used for learning years after the war, in Tübingen, Heidelberg, Vienna, where only recently

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<sup>25</sup> M. Rembowska-Pluciennik, *O przechodzeniu na ty... narracja diadyczna wśród literackich reprezentacji świadomości bohatera*, [in:] *(W) sieci modernizmu. Historia literatury – poetyka – krytyka*, eds. A. Kluba, M. Rembowska-Pluciennik, Warszawa 2017, p. 253.

it has been admitted that the brains of four hundred Holocaust victims are still stored at the Institute of Neurobiology. Ah, Rysiu, if it had not been for that war, where would IBM, Bauer and Volkswagen be today, where would IG Farben be, where would Audi, Krupp and Deutsche Bahn be? (When you, Rysiu, were not yet even planned, and your mother had only just welcomed your eldest sister, Marysia, Willy Heidinger, head of IBM's German subsidiary, gave a wonderful speech at the opening of the company's factory, in which he spoke with incredible, contagious enthusiasm about the excellent prospects that IBM technology offers for the biological future of the German people – population statistics is a reliable method of eliminating unhealthy, inferior elements from German society.<sup>26</sup>

The little boy who managed to avoid the tragic fate of his peers grew up in a foster home, became a miner and started a family. And as the narrator writes, employing Silesian dialect:

You never said anything to yer bairns or yer wife, nuthin' t' talk 'bout, b'gones are b'gones. No use blabberin', yesterday is yesterday, t'day is t'day and tha'sit. Sometimes you are just as surprised yourself that ye're not back in that hospital wi' th' loonies, because sometimes you are reminded of all that, the images come, and then something tenses in your gut and you feel like your head is about to break. Then you press your fingers into the table top or backrest of the chair and hold on, as if you were afraid that if you let go, you might fall back into that well with no bottom, from which so many never came out. But you did come out. You and a few more.<sup>27</sup>

Trauma, trivialised and pushed into oblivion, also in this case speaks through the body that never forgets. Again, the author poses the question – why does the father and grandfather never speak to his loved ones about his past? Why it was only in the 1960s that Jerzy Redlich, who was the prototype of the character of Rysiu, decided to tell us in *Trybuna Ludu* daily what had happened in the hospital in Lubliniec?<sup>28</sup> The author uses these source texts to fill in numerous holes in “memory shot through with bullets,” painful enough that they are hidden even from those who are the closest to us.

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<sup>26</sup> A. Dziewit-Meller, *op. cit.*, p. 110–112.

<sup>27</sup> *Ibidem*, p. 112.

<sup>28</sup> <https://czestochowa.wyborcza.pl/czestochowa/1,150461,20759903,mroczna-historia-szpitala.html> (accessed: 7 August 2020).

One of the most dramatic, silenced stories of borderland Silesia is that of Zefka. When we meet her, she is an eighty-year-old old woman dying of cancer, visited by pregnant Karolina, the mother of little Małgosia. The women are bound by family ties and symbolic opposites. One is young, waiting for a new life, the other is saying goodbye to the world. The conversation about the past is initiated by the “presence” of the child. When Zefka touches the pregnant woman’s belly, for a moment she becomes a teenager again – not yet destroyed by evil, still dreaming of a better life. “‘Give the lil’ un a good name,’ says the aunt, who now has a habit of falling into lengthy moments of lethargy. She looks then as if she was already elsewhere. On such occasions I am afraid to look into her eyes. I smile. ‘Good, meaning what?’ ‘Not Russky.’”<sup>29</sup> This scene initiates a return to the past. We get to know Aunt Zefa’s life: from childhood, through adolescence and war time, which brutally forced her to grow up faster. Also in this story, Dziewit-Meller emphasises unobvious moral qualifications, both at the level of family and social life. Throughout her life, Aunt Zefa avoids answering the question of her childlessness, but her secret is the fate of many women in borderland Silesia and is linked to the mass rapes that the Russians committed during the offensive. On the night of 31 January to 1 February 1945, Wildenhagen, today’s Lubin, witnessed dramatic events rarely recorded in historical chronicles. Again, Dziewit-Meller constructs the character of Zefka by mixing memory and imagination. The book follows an account of a German woman, Adelheid Nagel, who was one of the few to survive that night.<sup>30</sup> She was several years old at the time, a witness to the brutal mass rape of local women and girls and part of a mass suicide that was committed by German women and whole families before the Russians entered the city. On the one hand, we are therefore witnessing the drama of the raped women, the contempt and the instrumental treatment of their bodies by Soviet victors:

When it comes to fertilisation, the gene carousel is spinning like crazy. It is impossible to judge which one has just become a dad. Maybe when the child grows up, when it turns out whether he or she has more slanted eyes or less, whether he or she is tall or short, thick or eloquent – then maybe everything will be revealed. Zefka lies in the backyard of her house, naked, in minus twenty degrees, her mother, who did not want her to come back, lies on the stairs of

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<sup>29</sup> A. Dziewit-Meller, *op. cit.*, p. 66.

<sup>30</sup> This story was described by W. Nowak and A. Kuźniak in their reportage *Noc w Wildenhagen* (2000), included in the collection: W. Nowak, *Obwód głowy*, Warsaw 2015, p. 23–45.

the house. In the basement there is a father who has been shot, who will very much want to recover from his wounds, but nobody knows how successfully. Next to him, Magda, who pissed herself in fear, and Aniela, quivering in some kind of attack.<sup>31</sup>

Zefka becomes pregnant but the baby dies during premature birth: “There is nothing worse than when your baby’s body, still wet from your blood, grows cold on your breast.”<sup>32</sup> On the other hand, the memory of the body that marked her fate is also linked to the tragedy of the one who survived the attempted extended suicide:

Daughter, wife, mother, there is only one way out for us – to die by our own hand. By our gentle hand. Before we can see how hell consumes us all. Here is a rope, daughter, a rope, the same we used to hang laundry on summer days, to dry in the warm wind. Your white dresses and my black ones used to on it. Bed linen from your sisters’ beds and your father’s shirts, still smelling of soap. I am now clenching it around my neck, look, listen, when your mother speaks to you, look, because this is a one-time instruction, see? When you squat, this rope will tighten and you will only hear a dry crack. It’s going to be that quick death that we pray for before bedtime and after waking up.<sup>33</sup>

Dziewit-Meller reconstructs traumatic scenes, combining historical facts with literary fiction. However, she succeeds in bringing to light something that has been ejected from public awareness. Until recently, the Germans were reluctant to admit that as a result of the collective hysteria that preceded the Red Army mothers cut their daughters’ veins, hanged them and persuaded their children to commit suicide. Historians say that the women of Wildenhagen suffered the Nemmersdorf syndrome, which not long after seized the imagination of thousands of Germans. Nemmersdorf, a small village in East Prussia, today Mayakovskoye in the Kaliningrad district, fell into Russian hands as early as October 1944. The Wehrmacht took it back several hours later, but what soldiers saw surpassed their worst expectations: women with their clothes rolled up, a clear sign of rape, crucified on the barn door, the massacre of seventy-two women, children and one man, children with broken skulls and a woman with her head split with an axe or a shovel. German women became victims of Göeb-

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<sup>31</sup> A. Dziewit-Meller, *op. cit.*, p. 85.

<sup>32</sup> *Ibidem*, p. 87.

<sup>33</sup> *Ibidem*, p. 83.

bels' propaganda, which depicted the Red Army as a dangerous horde, prone to extreme brutality and murder on unprecedented scale. At the same time, many historians confirm that men who hailed from the steppe peoples who served as reserve troops brutalised and raped their victims. What is more, such behaviour was even "justified": "Joseph Stalin takes a drag from his pipe and says: and what is so disgusting about a man having some fun with a woman after such horrors? You have to understand that the Red Army is not perfect. It is important that they fight the Germans – and they fight well, so nothing else matters."<sup>34</sup> When describing the tragedy of women, Dziewit-Meller not only evoked and condemned the rape, which has only been on the list of war crimes since 2008. She also revealed the ideological foundations behind the notion of 'Freitod' (good death), which occurred on the border between Poland and Germany.

One of the crucial features of the events described above are the unobvious qualifications and identity shifts characteristic of Silesia residents. When little Zefka goes to Germany to work, she does not expect to find there a home and a mother who would love her more than her biological one, although of course she is not aware that *Lebensborn* plays out in the background. In her eyes, Germany is an idyllic, fairy-tale land, filled with kindness and unconditional parental love she does not know from her own home. "And what did ye come back for? Nobody call'd ye here," says the mother when she sees her daughter back at the threshold of the family home. Years later, Zefka's foster brother, Karlchen, arrives at her funeral and brings with him a handful of soil that he throws into her grave with words: "She wanted to be buried in our soil. That is all I could do for her."<sup>35</sup> By employing the micrological perspective, the author nullifies simple antinomial qualifications: good-wrong, family-foreign, self-existent. This identity rioting affects the inhabitants of Silesia many times. When the offensive approaches, Zefka's father does not decide to run away, saying:

'And where is we t' go? We is fro' here! And we is no Germans, we is Silesians, fer fooksake, quit yer blatherin', lassies, ask me no more or ah'll smack yer,' father says and goes outside to the yard to watch what is happening. The children, who have been learning *Ich bin klein, mein Herz is rein*[7] since they were little, diligently repeat 'Angel of God, my guardian dear, to whom God's love commits me here,' try to remember counting to a hundred and Polish

<sup>34</sup> *Ibidem*. The quoted excerpt is a fictionalised version of J. Stalin's statement in talks with M. Jilas in 1962. See: W. Nowak, *op.cit.*, p. 39–40.

<sup>35</sup> A. Dziewit-Meller, *op. cit.*, p. 92.

declination. Teach your child the language in three days, go on. It's a pity that nothing can be burned here, burn that the gurgling speech out of their throats once and for all. 'First they beat us fer speakin' Polish, now they is gonna beat us fer German!' whines some bairn bawlin' in the square.<sup>36</sup>

Alfons, Zefka's brother, first forcibly conscripted into the Wehrmacht, returns home, but is immediately taken by the NKVD and conscripted into the camp in Łambinowice, where the existing infrastructure built by the Germans is used for the brutal "re-education" of Silesians. He returns ten months later, on the verge of exhaustion: "After a week, Alfons sits on his bed. Next to him sits a skinny Zefka, who immediately jumped out of the chair and calls out to her family. 'Lassie, what 'ave they done t' ye!' Alfons looks into his sister's eyes, and she notes with horror that her brother's gaze is empty, as if there was nothing left in him except the desire for revenge."<sup>37</sup>

The fluid identity, which the author emphasises through the ambiguous fate of her characters, is also manifested in language. For it is in this chapter that the question of who the Silesians are and what historical legacy the inhabitants of the region have come to face is particularly clear. Dziewit-Meller stresses such identity (non)attachment in the language, because it is the language that is the source of self-knowledge – the Silesian dialect defines the characters and best expresses their original feelings and fears. Language – also treated as an element of bodily experience – best reflects the pain and experience deeply hidden in individual and intergenerational memory. The fact that Zefka wanted to be buried in German soil does not complicate anything, but rather highlights that there is no need for unambiguous qualifications.

Similarly ambiguous assessments are generated in the last chapter of the book, which, like a bracket, closes the stories linked through the tragedy of the war trauma and the awareness that brutality against the weakest is judged with particular severity. What about little Hitler saved from drowning by a friend? Is the curse that an organist from Passau throws against the priest that rescued Hitler from the river years earlier excusable? If Johann Kuehberg had known how his act of courage would change the world, would he have done it? Of course, the author asks us this question and never answers it directly. The latter can only be gleaned, as in this case, from paratextual suggestions. Why is the name of Rysiu written like the name of an adult even though the character is

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<sup>36</sup> *Ibidem*, p. 81.

<sup>37</sup> *Ibidem*, p. 89.

a child, while little Adolf remains Adik? It seems that this is deliberate on the part of the author, for every adult, even Hitler – she seems to be saying – was once someone else’s child, just as Adik was Klara’s beloved son. Not without a reason, it is his theme that both opens and closes the book. It is related to the already-cited “perhaps” – if Hitler had drowned, “perhaps” there would have been no Auschwitz, no crematoria... The act of criminal euthanasia of children would not have had to happen. Perhaps. This conditional form is also a certain ethical suggestion. The past, if we know it, can be a source of knowledge and a lesson for the future. But only if we see people in history as flesh and bone – as the author does by building a micrology of characters by giving them (eponymous) names and emphasising their physical and sensual condition vulnerable to injury. Human ignorance, lack of imagination and empathy, followed by violence, starts when we stop seeing the other as a human being. When humanity is replaced by an idea, science and politics, Sebastian, Zefka and Rysiu disappear from sight. This is when the time of great History begins, when carnality and medicine break off from the chain of moral constraints. The author, granddaughter of doctors, admits that such kind of betrayal of the doctor’s ethos and abuse of the Hippocratic oath seemed unfathomable to her.<sup>38</sup> However, she is capable of more than simple condemnation and brings us into the sphere of ethical dilemmas, which are the greatest strength of this book. As one critic writes, “somewhere in the area of this rationality, which makes one’s body foreign in order to be able to control its illness and deterioration, there is a line that divides the doctor from the torturer. A line, by the way, which is completely conventional and cannot be drawn once and for all.”<sup>39</sup> The same convention and ironic view of reality dynamise the plot and the moral message of the story: the father, who takes over the cultural role attributed to mothers in the atavistic fear for the child’s life; the mother who does not show any feelings to her daughter, but who, watching a propaganda film, feels an inner opposition to the so-called “good death”; the girl who accepts a child conceived out of rape; forced labour as an Arcadian home experience; grotesque figures of dolls making decisions about the life and death of others; Nuremberg – the city of toys and the Military Tribunal for Nazi criminals. This ironic reversal is a peculiar anomaly of discourse, an element of an ethically motivated literary strategy, which avoids pure facts and literalism by negating unambiguous qualifications: identity, moral, but also those resulting from reading experience. As

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<sup>38</sup> *Ibidem*, p. 131.

<sup>39</sup> P. Bravo, *op. cit.*

Michał Paweł Markowski wrote, literature understood in such a way “makes us aware, in a unique and revealing way, of the nature of our obligations towards reality and broadens our social sensitivity.”<sup>40</sup> Filling in the blank spaces of the “memory shot through with bullets” is one of the most important elements of that reading strategy.

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<sup>40</sup> P. Markowski, *Przed prawem. Interpretacja, literatura, etyka*, “Teksty Drugie” 2002, nr 1/2, p. 32.

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## Historical and Cultural Aspects of Politeness in Constructing Narrative Coherence in Patient and Doctor Communication

Historyczno-kulturowe aspekty grzeczności i ich rola  
w konstruowaniu spójności narracyjnej w komunikacji  
między pacjentem a lekarzem

### Abstract

This paper aims at showing a study on how doctors as well as patients try to negotiate in the process of communication with special attention to the aspect of narrative in the medical interactions and the concept of politeness that is culturally and historically shaped. The study also analyzes the approach of Narrative Medicine (NM) which proposes patients the “space” in which to create their narratives. The findings show that both patients as well as doctors try to create narrative coherence based on cultural and partially historical expectations. Generally, the analysis indicates that narrative and historically and culturally determined politeness plays an essential part in forming relevant meanings in medical interactions between the doctor and the patient.

### Abstrakt

Celem artykułu jest stanu wiedzy dotyczącego tego, jak lekarze i pacjenci próbują kształtować interakcję na wspólnej płaszczyźnie komunikacyjnej ze szczególnym uwzględnieniem historycznego oraz współczesnego zarysu kształtowania komunikacji w obrębie teorii grzeczności. Badanie ma na celu ukazanie, że podejście medycyny narracyjnej może stanowić istotny wkład w pogłębianie tego rodzaju badań. Przeprowadzone badanie empiryczne wskazuje, że narracyjna oraz historycznie i kulturowo uwarunkowana grzeczność odgrywa istotną rolę w kształtowaniu istotnych znaczeń komunikacyjnych w dyskur-

sie medycznym, a tym samym w znaczącym stopniu wpływają na budowanie pozytywnych interakcji w relacji lekarz-pacjent.

**Key words:** medical discourse, narrative medicine, patient-doctor communication

**Słowa kluczowe:** dyskurs medyczny, medycyna narracyjna, komunikacja lekarz-pacjent

The most significant characteristic of language seems to be communication, particularly when interlocutors are doctors and patients. Patients, because of their illnesses, experience a mental burden and they require professional help to relieve themselves physically as well as psychologically. The type of behavior which is anticipated from doctors is ‘behaving well’, or rather ‘politeness’. As Gino Eelen<sup>1</sup> proposes, the idea of politeness recalls Penelope Brown and Steven Levinson’s<sup>2</sup> politeness theory, which has been exploited in many studies<sup>3</sup>. Moreover, many researchers have examined medical communication, particularly from the viewpoint of discourse as well as conversation analysis, considering the aspect of politeness as well<sup>4</sup>.

In Polish studies on medical communication, there are some descriptions of doctor-patient interactions<sup>5</sup> that discuss various aspects concerning medical narrative. However, more research is needed to offer more complex viewpoint on the aspect of medical communication. The research of interactions between doctors and patients from the viewpoint of discourse pragmatics will not only add to current studies concerning medical communication in Poland but will

<sup>1</sup> G. Eelen, *A Critique of Politeness Theories*, Manchester, 2001.

<sup>2</sup> P. Brown, S. Levinson, *Politeness: Some universals in language usage*, Cambridge 1987.

<sup>3</sup> M. Nevala, *Assessing Politeness Axes: Forms of address and terms of reference in early English correspondence*, “Journal of Pragmatics” 2004, v. 36, pp. 2125–2160; M. Bazzocchi, *Doctor-patient communication in radiology: a great opportunity for future radiology*, “Radio med” 2012, no. 117, pp. 339–353.

<sup>4</sup> R. Wodak, *Critical discourse analysis and doctor-patients’ interaction*, [in:] *The construction of professional discourse*, ed. B. Gunnarson, P. Limmell and B. Nordberg, London 1997, pp. 173–200.

<sup>5</sup> M. Nowina Konopka, *Komunikacja lekarz – pacjent Teoria i praktyka*, Kraków 2016; A. Zembala, *Modele komunikacyjne w relacjach lekarz – pacjent*, „Zeszyty Naukowe Towarzystwa Doktorantów UJ. Nauki Ścisłe” 2015, v. 11, pp. 35–50; K. Stefaniak, *Władza i tożsamość w komunikacji lekarz – pacjent*, Wrocław 2011; *Jak rozmawiać z pacjentem? Anatomia komunikacji w relacji w praktyce lekarskiej*, red. A. Ostrowska, Warszawa 2017.

also explain discourse as well as pragmatic aspects with the use of data collected from the conversations by native speakers of Polish.

In this study, special attention will be given to interaction between doctor and patient in Polish, which is examined from the perspective of the pragmatics, discourse and aims at enhancing register studies of the Polish language taking into consideration observations proposed by Susie M. Barone<sup>6</sup>. Familiarizing oneself with the pragmalinguistics as well as sociolinguistics of medical interaction appears to be a part of the obligation of communicative competence in the given language. Standard doctor-patient communication involves three parts, namely: interview (sometimes in the form of diagnosis), treatment as well as follow-up<sup>7</sup>. Every part has its own structure and distinguishing characteristics that can be seen and examined also as distinct or as part of a longer discourse. This research will be restricted to the diagnostic facet as it is the most important part of the interaction that completely develops the usage of conversation. This paper discusses the aspect of politeness in doctor-patient interactions in Polish in certain hospitals in Poland<sup>8</sup>. It tries to examine the contextual beliefs regarding the doctor and the patient. The attention is also given to the linguistic forms used in the conversations and the pragmatic acts completed in them. Furthermore, special attention will be given to understand the doctor-patient communication in a private outpatient clinic, focusing on the patient's age and gender and their effect on the politeness strategies employed by the doctor. Some studies focused on interactants' reception of politeness in the hospital. The number of studies that concentrated on the aspects were not been given enough attention to. The limited number of studies, only in the specific context of a Polish hospital, has concentrated on how the cultural, historical, and institutional orientations of customers and doctors<sup>9</sup> clash at the specific stage taking into account the aspect of face and politeness. The results of the research are anticipated to add to current work on discourse analysis, register studies, pragmatics and medical communication in Poland.

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<sup>6</sup> S.M. Barone, *Seeking narrative coherence: Doctors' elicitations and patients' narratives in medical encounters*. Ph.D thesis 2012, <https://core.ac.uk/download/pdf/41337614.pdf>.

<sup>7</sup> R. Wodak, *Critical discourse analysis and doctor-patients' interaction...*, pp.173–200.

<sup>8</sup> The data was obtained from private clinics in Poland (dolnoslaskie region). The process of data collection started on the 10<sup>th</sup> March 2017 and finished on the 30<sup>th</sup> June 2018. All the doctors took part in a special course aiming at improving their communicative skills.

<sup>9</sup> S. L. Graham, *Hospitaltalk: Politeness and hierarchical structures in interdisciplinary discharge rounds*, "Journal of Politeness Research. Language, Behaviour, Culture", 2009, v. 5, is. 1, pp. 11–31.

This paper also aims at exploring how narratives offered with narrative medicine (NM<sup>10</sup>) approach<sup>11</sup> can shape the process of communication within medical interactions, concentrating on how patients use linguistic processes which show agency as they administer their health conditions. The investigation tries to comprehend the connection between doctors' elicitations and narratives that are offered by patients to add to awareness of communicative events in various clinical settings in Polish hospitals aimed at discovering how discourse analysis could be exploited in applied linguistics research concentrating on medical discourse. John Creswell<sup>12</sup> indicates that more comprehensive narratives result in better patient contentment and more precise diagnosis. Obtaining understanding into aspects of narrative as well as identity that is historically and culturally determined within the process of creating medical interactions seems to be also crucial to understanding how to fulfill patient needs more efficiently.

The assumption of this examination is that there appear to be a narrative that is either implicitly or explicitly recommended by the patient in contact with the doctor as well as that this narrative occurs to be prompted by the health care provider<sup>13</sup>. Narrative within the NM context is described as stories told in words, gestures, silences, tracings, images, and physical manifestations recognizing that 'any phenomenon has to be contextualized in order to be understood'<sup>14</sup>. The method employed in this research is established on the identical assumption; specifically, that the patient proposes a narrative, and it is the responsibility of sources to offer the prompts, 'space', and considerate person needed for the narrative to be reported by the patients.

### Theoretical framework

Doctor-patient communication tends to be an example of institutional talk, as it is strictly connected with the 'institutions', i.e. with the settings in which it takes place. These institutions and organizations, such as hospitals or clinics, appear to determine Norman Fairclough's social context<sup>15</sup>. In his opin-

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<sup>10</sup> NM (abbreviation) narrative medicine – it will be used in the following text to refer to the concept of narrative medicine.

<sup>11</sup> R. Charon, *Narrative medicine: Honoring the stories of illness*, New York 2006.

<sup>12</sup> J. Creswell, *Narrative, pain, and suffering*. [Review of the book *Progress in pain research and management*], "New England Journal of Medicine" 2005, no. 353 (15), p. 1637.

<sup>13</sup> R. Charon, *Narrative medicine: Honoring the stories of illness...*, passim.

<sup>14</sup> *Ibidem*.

<sup>15</sup> N. Fairclough, *Language and power*, London 1989.

ion, all forms of discourse are formed by these organizations which are in turn formed by wider power relations. Joanna Thornborrow<sup>16</sup> states that institutional discourse can be considered as (1) goal oriented, (2) having differentiated, pre-inscribed participant roles, and (3) asymmetrical. These features may be incomplete, but they propose an indispensable insight into what institutional discourse is and how it can affect the process of communication. The doctor and the patient meet to offer the doctor a chance to gain necessary information, make a diagnosis and help (or try to help) the patient. This goal orientation determines most aspects of the interactions. The reason is that patients provide their doctors with information about their lives – sometimes, it may be information of a very intimate character – whereas doctors usually do not reciprocate. The institution establishes roles for both doctors and patients. It is the role of the doctor to collect the essential information and help the patient, and it appears to be the role of the patient to offer the information with the intention of getting a diagnosis and treatment. Furthermore, doctors are typically those who initiate as well as terminate the process of interviews<sup>17</sup>. Offering information and information withholding appear to be significant from the viewpoint of the patient and doctor. Patients nearly always want to obtain as much data as possible, doctors occasionally tend to withhold it<sup>18</sup>, and the doctors' ability to control information generates an elementary asymmetry in the relationship between doctors and patients. Nonetheless, it seems clear that doctor-patient communication is in many respects asymmetric, with doctors wielding more power and patients less. As stated by John Heritage<sup>19</sup>, participants in institutional confronts employ a sequence of linguistic as well as interaction resources specific to the situation and consistent with the linguistic and cultural competence concerning all participants. Heritage added that the features of institutional interaction, namely<sup>20</sup>: "(i) the participants [hold] some specific roles, (ii) a series of constrictions characteristic of the institutional context are [significant] and (iii) inference marks and specific procedures [related]

<sup>16</sup> J. Thornborrow, *Language and interaction in institutional discourse*, Harlow 2002.

<sup>17</sup> J. Beran, *Doctor-patient communication: Part I – Introduction*, Prague 1999.

<sup>18</sup> H. Waitzkin, *Information giving in medical care*, "Journal of Health and Social Behavior" 1985, v. 2 (2), pp. 81–101.

<sup>19</sup> J. Heritage, *Conversation analysis and institutional talk*, [in:] *Quantitative research: theory, method and practice*, ed. D. Silverman, Sage 1977, pp. 161–182.

<sup>20</sup> C. Valero-Garces, *Interaction and conversational constrictions in the relationships between suppliers of services and immigrant users*, "Pragmatics", 2002, v. 12, is. 4, pp. 469–495.

to each institution [occur].” The features above are accompanied by the following elements: “(i) assignment of the participants’ roles, (ii) general structure, (iii) sequential organization, (iv) lexical choice, as well as (v) asymmetrical relationships.” (ibid.) With respect to doctor-patient communication, scholars have made extensive remarks in their studies. Malcolm Coulthard and Margaret Ashby<sup>21</sup> noticed the reappearance of doctor-instigated exchanges in diagnostic communication between the doctor and patients. As stated by them, if an individual tries to begin conversation, the doctor does not think he/she has a duty to reply. They notice that the communication is based on transfer swaps, in which data is transmitted from the responding patient to the eliciting doctor, along with matching exchanges, in which the patient offers the doctor some information to be approved. The negotiation of a mutual orientation between doctor and patient arises through series (sequences) of interactions in order, up until the doctor is completely able to match a medical diagnosis with the patient’s predicament. Moreover, Moira Chimombo and Robert Roseberry<sup>22</sup> state that medical communication seems to be a goal-oriented process that reflects participants, medium, strategies, and setting as well as theme.

It should also be noticed that doctor-patient communication can be described, besides the above stated, by a high level of formality and detachment. The formality and detachment are noticeable in employing the concept of politeness. The idea of politeness and face concur. Politeness, which is noticeable in conditions of social distance or intimacy, is how individuals demonstrate awareness of another person’s face, the face being technically identified as the ‘public self-image of a person’<sup>23</sup>. Academics have recommended numerous maxims of politeness<sup>24</sup>, particularly the subsequent ones suggested by Geoffrey Leech<sup>25</sup> have been given wide consideration: tact, generosity, approbation, modesty, agreement, sympathy and Pollyanna. Leech’s input to this view of

<sup>21</sup> M. Coulthard, M. Ashby, *A linguistic description of doctor-patient interviews*, [in:] *Studies in everyday medical life*, ed. M. Wadsworth and D. Robinson, London 1976.

<sup>22</sup> M. Chimombo, Robert L. Roseberry, *The power of discourse: An introduction to discourse analysis*, London 1998.

<sup>23</sup> E. Goffman, *Interaction ritual: essays on face-to-face behavior*, New York, Garden City 1967; P. Brown, St. Levinson, *Politeness: Some universals in language usage*, Cambridge 1987; J. Thomas, *Cross-cultural pragmatics failure*, “Applied linguistics” 1995, v. 4, is. 2, pp. 91–112.

<sup>24</sup> R.T. Lakoff, *The logic of politeness; or, minding your p’s and q’s*, Chicago 1973; G. Leech, *Principles of pragmatics*, London 1983; B. Fraser, *Perspectives on politeness*, “Journal of pragmatics” 1990, pp. 219–236.

<sup>25</sup> B. Fraser, *op. cit.*, pp. 219–236.

politeness was to offer explanations for the factors which guide and constrain conversations by elaborating on Grice's Maxims. Limitations recognized with Leech's approach comprise the fact that the maxims do not address the expressive aspects of language<sup>26</sup>, or the way in which language is employed to address interpersonal issues<sup>27</sup>.

Fundamental to Penelope Brown and Stephen Levinson's<sup>28</sup> comprehensive theory of politeness is the management of cooperative relations through considering positive and negative face. Brown and Levinson's theory of politeness is based on Erving Goffman's<sup>29</sup> observation that when individuals cooperate, they continuously take care of maintaining a commodity called face<sup>30</sup>. As Judith Spiers<sup>31</sup> remarks, it is significant to comprehend that although face can be associated with the concept of "self", the comparison is of restricted utility, since face does not imply something that is inherent in the person, but rather is demonstrated through interactions with others. However, as Brown and Levinson<sup>32</sup> clarify, face-needs and the performance of facework are not something that one is inevitably aware of. Because of this dependence on others for the satisfaction of face-needs, identified as *mutual vulnerability*<sup>33</sup>, it seems to be in everyone's interests to take part in each other's face-needs. One's mutual face-needs are accomplished and protected through facework and the employment of politeness strategies. Positive face is improved by offering and getting affection, solidarity, positive evaluations, appreciation of individual qualities and by displaying understanding<sup>34</sup>. On the other hand, negative face is engendered by imposing the individual's need for autonomy, territoriality and independence in thought and action. Negative face is alleviated by respecting the individual's desire for privacy and independence, giving the option of not acting/getting involved, respecting hierarchical changes and being conventionally polite. Any utterance

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<sup>26</sup> J. Spiers, *The use of facework and politeness theory*, "Qualitative Health Research" 1998, v. 8, is. 1, pp. 25–47.

<sup>27</sup> M. Sifianou, *Politeness phenomena in England and Greece*, Oxford 1992.

<sup>28</sup> P. Brown, S. Levinson, *Politeness: Some universals in language usage*, Cambridge 1987.

<sup>29</sup> E. Goffman, *Interaction ritual: essays on face-to-face behavior...*

<sup>30</sup> S. Pinker, *Indirect speech, politeness, deniability, and relationship negotiation: Comment on Marina Terkourafi's The Puzzle of Indirect Speech*, "Journal of Pragmatics", 2011, v. 43, is. 11, pp. 2866–2868.

<sup>31</sup> J. Spiers, *The use of facework and politeness theory...*, pp. 25–47.

<sup>32</sup> P. Brown, S. Levinson, *Politeness: Some universals in language usage...*, p. 58.

<sup>33</sup> *Ibidem*, p. 61.

<sup>34</sup> J. Spiers, *The use of facework and politeness theory...*, pp. 25–47.

has the possibility to threaten face, to be a face threatening act (FTA)<sup>35</sup>. Brown and Levinson<sup>36</sup> recognized five politeness strategies included in the management of face, namely:

- ‘Bald on record’ – referring to efficient utterances (in terms of Grice’s quantity maxim) that do not comprise any mitigation, e.g. the utterance “deep breaths”;
- ‘Positive politeness’ – protecting and attending to an individual’s positive face;
- ‘Negative politeness’ – concerning the maintenance of the individual’s (either the speaker’s or hearer’s) negative face, i.e. maintaining their autonomy, avoiding imposition and maintaining appropriate social dissonance;
- ‘Indirect, off-record’ – strategies denote utterances that do not make the illocutionary intent explicit, but rather, in order to protect face and provide the listener with the option of replying or not, the intention is only hinted at;
- ‘Not doing the FTA’ – the individual perceives the speech act to be too threatening, so chooses not to perform it..

The strategy names indicate the degree of mitigation used (whether consciously or unconsciously) to soften utterances with the first, ‘Bald on record’ involving the least mitigation and the last, ‘Not doing the FTA’ containing the most. Brown and Levinson continue to elaborate, clarifying how the diverse components of one’s utterances can be comprehended and understood concerning face management. At this micro level they denote the utterances which attend to face as outputs<sup>37</sup>. Brown and Levinson offer a limited explanation concerning the hierarchy of these charts, placing super-strategies at the “highest level” and “output strategies” as “the final choices of linguistic means to realize the high[er order] goals”<sup>38</sup>. They also clarify that they employ the word ‘strategy’ to denote a plan at any of these levels, depending on the context to make clear which hierarchical level is [being] talked about<sup>39</sup>. To this end, they frequently employ the terms strategy, mechanism and output interchangeably. Brown and Levinson do not make clear whether these “final choices” are the words that individuals say or whether what is at stake is what individuals say plus their intention when saying it. Specifically, they do not obviously state

<sup>35</sup> P. Brown, S. Levinson, *Politeness: Some universals in language usage...*, p. 61.

<sup>36</sup> *Ibidem*, p. 61.

<sup>37</sup> *Ibidem*, p. 58.

<sup>38</sup> *Ibidem*, p. 92.

<sup>39</sup> *Ibidem*, p. 93.

whether locutionary or illocutionary force is the focus. Yet, the outputs listed appear generally to be intentional in nature and this interpretation is strengthened in their intricate description of the various super-strategies, mechanisms and outputs. Utterances can involve the employment of a mixture of strategies, i.e. outputs from more than one of the super-strategies<sup>40</sup>. Brown and Levinson<sup>41</sup> believe that the leading strategy within the discourse allows one to determine the level of threat that the speaker perceives the speech act to hold.

There seems to be a range of principles controlling language exploitation which competent users may or may not be explicitly aware of. Patients nowadays are frequently treated as consumers with specific expectations of service providers such as medical health care providers. Furthermore, they are encouraged to express themselves and make choices concerning the management of their own health. At the same time, as these factors try to raise the status of the patient within the consultation, many other ongoing matters can constrain patient involvement. These include fear, pre-existing expectations regarding social norms, emotional or physiological problems affecting sense of control, and their inferior position as layperson. Sequentially, cooperation hinges on the maintenance of friendly relations, a significant aspect of doctor-patient communication<sup>42</sup> and the one which can be endangered by breaches to contextual norms. Brown and Levinson's (1987) theory of politeness and facework offers a useful device with which one may explore the linguistic strategies employed to obtain cooperation and to manage FTAs. Considering the theoretical aspects presented above, the following research question is investigated in this paper: Do the patient's age and gender influence the politeness strategies used by the doctors?

Taking into account the aforementioned aspects, one should be aware that the concept of politeness can contribute to creating coherence within NM as it exploits various discursive strategies to make the text cohesive and coherent. The most prominent pioneering work linked to NM has been conducted by Charon<sup>43</sup>. She created the idea and invented the concept "Narrative Medicine" (NM). NM developed from the medical as well as comparative literature per-

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<sup>40</sup> *Ibidem*, pp. 17–21, pp. 230–232.

<sup>41</sup> *Ibidem*, pp. 74–84.

<sup>42</sup> P. Ranjan, A. Kumari, A. Chakrawarty, *How can Doctors Improve their Communication Skills?*, "Journal of clinical and diagnostic research: JCDR" 2015, no. 9(3), JE01–JE4.

<sup>43</sup> R. Charon, *Narrative medicine. Litsite*. Retrieved September 2018, from <http://litsite.alaska.edu/healing/medicine.html>

ceptions, and is therefore, grounded in narrative theory. The NM approach tries to see a person as an individual rather than only concentrating on signs and disease. It also attempts to cultivate empathy among healthcare staff for their patients.

One has to be aware that recognizing historically distinctive patterns, especially when one takes into account the aspect of politeness, seems to be crucial. Brooks<sup>44</sup> underlines the fact that every social history of common cultural traditions predefined all important figures as well as events that tends to shape imminent activities in the course of history. The same seems to hold for the approach of politeness and constructing narratives in the doctor-patient interaction. As Hofstede<sup>45</sup> mentions all linguistic aspects take into consideration historical and cultural aspects that are later transformed into altered norms and principles that are widely adopted in genuine cultural practices. While analyzing the patterns of politeness, one can see that the reality that is a sociocultural construct based on past experiences and verbal-interactional elements have been passed down to contemporary society through the actual text record that is a sum of all cultural and linguistic exchanges that evaluated through the time. What is clearly visible is the that there are challenging aspects that need to be analyzed taking into account the fact that all doctor-patient interactions are results not only of doctor-patient interactions but also historical and cultural predetermined outcomes of mental structures participants bring into the process of communication.

Results in this paper show that the scope of coherence in medical confronts may also involve less serious, chronic cases of illness, where the absence of coherence itself may tell portion of the patient's story and indicate that patients take for granted some aspects that are not conveyed in the process of communication to the doctors. It also underlines that the concept of politeness can contribute to achieve the desired coherence while shaping various narratives. Moreover, this discussion indicates that NM appears to be a clinical approach which permits for, but also supports, the broad scope of narrative coherence. It shows that the attention is given to narrative skills which doctors can create with the aim of "reading" these complex, and frequently, less coherent patient narratives.

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<sup>44</sup> T. Brooks, *The Confusions of Pleasure: Commerce and Culture in Ming China*, Berkeley, University of California

<sup>45</sup> G. Hofstede, *Culture's Consequences: Comparing Values, Behaviors, Institutions, and Organizations across Nations*, Sage 2001.

### Methodology

The current research employs a methodology that reflects the patients' gender, age and some parts of their interaction with doctor and uses the written account of observation of the patients. The observation sheet is constructed in a way that splits patients into groups of males and females who are younger or older than the doctor. Furthermore, after requesting the essential consent from both groups, the doctor and patients' conversation was documented and transcribed. Some parts of the conversation were taken down to make the transcription phase easier in terms of recognizing which voice belongs to a patient, considering his/her age. As the observer wanted to maintain the patients' privacy, he/she did not ask their name. After that, as stated by Brown and Levinson's politeness theory, the strategies employed by the doctor are assessed. Also, the researcher put some questions to doctor at the ending of the research to classify the doctor's ideas about doctor-patient interaction. The participants in this study involved 50 patients (25 male with 13 younger and 12 older, and 25 females with 12 younger and 13 older), patients in a clinic, and the doctors have been practicing about 10-20 years as specialists.

The motivations for selecting various specialists among doctors and patients are the following: (1) as the clinic is a diagnostic ward and this branch copes with a higher number of patients, other clinics ask some of their patients to contact this clinic for diagnostic reasons. Consequently, the number of observations rises; and (2) as Massimo Bazzocchi<sup>46</sup> proposes, speech has a crucial role in a doctor's profession; likewise, the politeness issue seems to be a very delicate one, and there would be communication in detail to describe the relationship between doctor and patient, e.g. addressing as well as sharing talks about everyday life, so again clinics would be a better place to examine this rapport in the medical area.

Taking into consideration this framework, narratives are also seen as a way in which patients encounter ill health, promote empathy that can be shown in the form of various politeness forms as well as understanding between doctor and patient, help in the construction of meaning<sup>47</sup> and may provide valuable analytical clues and categories<sup>48</sup>. Narrative competence within the NM approach

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<sup>46</sup> M. Bazzocchi, *Doctor-patient communication in radiology: a great opportunity for future radiology*, "Radio med" 2012, v. 117, pp. 339–353.

<sup>47</sup> C. Riessman, *Narrative methods in the social sciences*, Sage 2008.

<sup>48</sup> T. Greenhalgh, B.Hurwitz, *Ethics and narrative*, "British Medical Journal" 1999, no. 318, pp. 48–50.

is expected to build a higher level of doctor empathy toward the patient, it can also be achieved by means of politeness, even it is not openly stated that the NM approach can take advantage of that. This empathy is established as doctors evaluate their own experiences with life, illness as well as other patients' illnesses. Taking into account the narrative competence, the doctor may then better determine what is salient to an illness and what is not<sup>49</sup>. The patient's narrative is critical to the doctor's capability to comprehend how each medical event is situated in a patient's life.

### Results

In Table 1, presented below, politeness strategies are examined through four categories, considering the aspects of patients' age and gender. The results display how many times each strategy was employed.

Table 1. Exploited politeness strategies

	Younger/ Female	Younger/ Male	Older/ Female	Older/Male
Bald on Record	9	12	8	10
Positive Politeness	4	2	0	2
Negative Politeness	1	0	7	3
Off-Record	0	0	0	0

It is evident from the figure that 'Bald on Record' seems to be the most frequently chosen approach. For example, the doctor instructed a twenty-nine-year-old, female patient to „hold your breath for a minute!”, correspondingly, he said to a forty- six-year-old male patient “take a deep breath and hold”. These examples demonstrate that the patients are younger than doctor and the gender did not affect the message as the number of 'Bald on Record' is the same for both genders thus the approach of doctor is direct communication, whether to female or male. It is less likely for the doctor to select 'Bald on Record' while

<sup>49</sup> R. Charon, *Narrative Medicine: Honoring the Stories of Illness...*

speaking to older/female patients. Conversely, the highest value of 'Bald on Record' is showed with male patients, who are older than doctor; it seems to be astounding as talking to old people involves respect and indirect speech but here, doctor reduces the distance and employs direct sentences – this holds for both male and female doctors.

The other strategy is 'Positive Politeness' which is typically employed by female patients who are younger than the doctor. Employing inclusive forms such as "we" or "let's" specifies positive politeness<sup>50</sup> which is face saving, rather than 'Bald on Record'. For example, the doctor told a twenty-five-year-old female (pregnant) patient "we're going to apply three-stepped diagnostic procedure to..." even though it is only the doctor who will conduct this procedure. In younger/male, 'Positive' and 'Negative Politeness' strategies were not applied; as the patient is younger than doctor and of the same gender, more direct speech might have been favored. In older/female category which as anticipated contains the highest occurrence of 'Negative Politeness', the doctor did not employ 'positive politeness' at all.

The doctor interacts with female and male patients who are older than him/her with more respect and detachment, so the occurrence of phrases such as "please" or "could/can you" demonstrate the higher rate of exploiting 'negative politeness'. In the categories where doctors and patients are of opposite genders, we observe the lowest frequency of 'negative politeness'. It might be stated that as the patients are younger than the doctor, so she/he perceives no necessity to use distant manners.

The zero frequency of 'off-record' and 'don't do the FTAs' signifies a normal and anticipated distribution, as the doctor-patient communication involves a kind of transparent relationship and patients should share their problems rather than employ implications or signs, and the doctor should feel comfortable requesting information without difficulty with his/her patients.

Taking into account the aspect of the solidarity and politeness criteria with four groups that are examined where the age and the gender of patients constitute the independent variables, one can observe in female patients who are younger than doctor, the smallest amount of solidarity was chosen but the most well-mannered formulations were employed. For example, while doctor was interviewing a twenty-nine-year-old female patient: "Have you just had

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<sup>50</sup> D. A. Morand, *Language and power: an empirical analysis of linguistic strategies used in superior-subordinate communication*, "Journal of Organizational Behavior" 2000, v. 21, pp. 235–248.

a surgery?” he employed singular ‘you’, which indicates sincerity or solidarity; yet, it occurred only once. Conversely, the use of addressing phrases plural ‘you’ might show politeness.

In male patients who are younger than doctor, the state of affairs is vice versa as the doctor employed mostly singular ‘you’ like “Just take off your shirt”. It is obviously grounded in the fact that both interlocutors are of the same gender and the doctor feels no need to set a distance between himself/herself and the patient; they take advantage of some kind of man-talk with more honest behaviors. Therefore, linked to the higher level of solidarity, politeness is less detected in terms of the above revealed explanations.

In female patients who are older than the doctor, both solidarity and politeness are balanced. While the doctor uses singular ‘you’, he/she increases the solidarity as a means of sincerity, using such phrases as ‘my dear’, ‘my sweetie’ to raise politeness.

In male patients who are older than doctor, the doctor frequently uses singular ‘you’. For example, the doctor informs a fifty-eight-year-old male patient “Now, you clean...” hence, the distance between doctor and patient reduces and sounds more like a sincere talk. Conversely, with addressing phrases like “man, you know”, the level of politeness rises, since the doctor shows his respect to patient but once more because of a kind of man-talk, solidarity is higher than politeness. In this figure, the most noticeable result is that the doctor makes no concession to age and gender with all groups except for younger/female in which she/he behaves politely and on the other hand chooses solidarity with the same frequency in other three categories.

While taking into consideration NM, one can observe that doctors appreciate and promote open-ended narratives because this is a natural element of conversation, which is the most likely means for conveying unsolved and problematic life events<sup>51</sup>. As one can observe, it employs various strategies that are present within the politeness concept. Within the medical encounter, doctors may need to adapt the open-endedness of patients’ narratives as patients communicate and seek to construct meaning of their unsolved health conditions even without comprehending what has happened and why.

The following example is derived from interaction 1, echoed for the reader’s convenience, and presents an example of how doctors and patients seem to move through a narrative even when the story may not be fully solved. In the

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<sup>51</sup> R. Charon, *Narrative Medicine: Honoring the Stories of Illness...*

example below the doctor's feedback, *OK*, tends to suggest that he understands what the patient has stated thus far and is expecting the next part of the patient's story. In this same quotation, the patient communicates a lack of understanding of what essentially caused her to fall by assuming that her foot *must have slipped*:

Example 1 (patient – female, doctor – male):

*D (doctor): OK. Could you tell me what brought you here?*

*P (patient): You know, I was walking [...] and I went to cross the street at the curb [...] and **my foot has slipped**.*

*D: OK. I fully understand you...<sup>52</sup>*

Even though this patient's narrative is not entirely resolved regarding why the event she defines has taken place, it can be distinguished from interaction in the example 2, where the patient's narrative appears to leave much of the meaning of the events without resolution even if a lot of linguistic support is offered in the form of polite expressions:

Example 2 (patient – male, doctor – male):

*D: Nice to see you again. I hope you feel better. Would you like to tell me how you feel?*

*P: [...] about the past two weeks [...] I don't think the XXXX is working anymore and I don't think I need to go on with it.*

*D: I completely understand you. Would you like to suggest a solution?*

*P: Really? I would be incredibly open to stay on the XXXX, but it would be much better if you could replace it with another XXXX drug.*

This example shows the type of open-endedness the doctor might encounter in proposing the patient "space" in which to speak without presenting elicitation to lead to a more completed narrative. By proposing the patient "space" without the guidance of more regular elicitation, the patient may or may not be able to present a concise, more complete narrative. That open-endedness can happen as the doctor offers a polite opening to the patient, encouraging the patient to state his/her point of view at the same time.

Another example shows that additional staff members seem to be also an integral part of the interaction as they help the healthcare staff to make some

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<sup>52</sup> Translation from Polish into English – A.K.

decisions. As Susan Ehrlich<sup>53</sup> suggests, “participants who are not directly and actively involved in an interaction can nonetheless influence the meanings and understandings that are assigned to that interaction”:

Example 3 (patient – female, doctor – female):

*D: Excuse me, there’s staff there and I need to go out.*

*P: You always go out there and have a look.*

*D: I understand that you may not feel comfortable with me leaving the room, but I try to keep up to date records and I will have to ask you some extra questions. Would it be OK with you?*

The significance of these extra staff members in this part of the interaction is that they did not offer the patient any information, the patient was requested to supply information about her medical history. Even though the extra staff are not adding to the interaction through words, their role and accountability for patient charting add to the development of the patient’s narrative. As it can be seen from the example above, the doctor tries to stick to politeness principles to give the patient a chance to decide about the process of treatment.

### Discussion

Taking into consideration the research question that aimed at finding whether the patient’s age and gender influence the politeness strategies exploited by the doctors, the results showed that the patient’s age and gender can affect the doctor-patient interaction. Considering the younger/female patients, all the obtained data confirms that doctor’s attitude toward those patients was quite direct with ‘Bald on Record’ utterances, since at the same time, those patients have the second highest number of ‘Positive Politeness’ strategies used by the doctor. Correspondingly, the ‘Negative Politeness’ strategy used with this group comprises the third place among all four categories, which indicates a low frequency. Since the patients are younger than the doctor, the strategies showing distance are not exploited.

In addition, from a general perspective the doctor’s interaction with male patients, whether younger or older, is nearly always direct. When a younger/male patient is examined, the doctor (male) employed a less distant attitude, in

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<sup>53</sup> S.Ehrlich, *Trial discourse and judicial decision-making: Constraining, the boundaries of gendered identities*, [in:] T. Van Dijk, *Discourse Studies*, London-Sage 2007, p. 196.

other words, favored direct utterances. Still, it was astonishing that the highest number of 'Bald on Record' appears in older/male patients, as it was anticipated that direct sentences would not be used, but rather polite manners with old people. Conversely, bearing in mind the use of 'Positive Politeness' and 'Negative Politeness' with the older/male group, the significance of age is observed again. Furthermore, in the interview, the doctor talked about the older/male patients feeling more uncomfortable. This indicates the doctor's creating a balance between the age and gender factors.

The doctor is also balanced in terms of results with older/female patients, since 'Bald on Record' and 'Negative Politeness' strategies share the same numbers. Yet again, the doctor has tried to display both respect and create sympathy and solidarity with this group. It can be determined that in this research, the age and gender are significant issues in doctor-patient interactions. Cultural values are of vital significance in defining the strategy exploited. For example, in both female and male older groups, more 'Negative Politeness' strategies are used more frequently in comparison to the younger group of both genders. In Polish culture, people who are old are valued, so the direct speech with imperative sentences which specifies the 'Bald-on-Record' strategy is not exploited but more polite behaviors are favored. Similarly, within the group of the same age but different genders (i.e. younger/male & younger/female and older/male & older/female), the female gender is also appreciated more, which indicates another aspect of cultural values. Generally, the groups to which the most direct (impolite) to most indirect (polite) strategies have been used are ordered in the following way: 1) younger/male, 2) younger/female, 3) older/male, and 4) older/female. Both female groups (both younger and older) are treated with less solidarity and more politeness in comparison with male groups (both younger and older) who are treated with more solidarity and less politeness. This study shows that the doctor-patient communication has its own standards but is still culture-oriented. This study was conducted in Poland, so the same outcomes might not have been obtained if the examination were conducted in a country which has different cultural features. Moira Stewart, Ian McWhinney, and Carol Buck<sup>54</sup> described the doctor-patient relationship "as reflected by the doctor's knowledge of the patient's problems, psychological and social

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<sup>54</sup> M.A. Stewart, I.R. McWhinney, Carol W. Buck, *The doctor/patient relationship and its effect upon outcome*, "Journal of the Royal College of General Practitioners" 1979, no. 29(199), pp. 77-82. Retrieved on September, 25, 2018 from: <http://pubmedcentralcanada.ca/pmcc/articles/PMC2159129/>.

as well as physical”; however, the doctor’s awareness did not “significantly affect the patient’s satisfaction”. This is a power-related interaction, where doctors hold the higher status. Yet it can also be observed that some doctors’ practice is rejected by patients only because of a lack of healthy communication between them and doctors, even if the doctor holds a highly valued medical knowledge. Thus, cultural medical awareness training might be included in medical education. As Evelyn Verlinde, Nele Laender, Stephanie Maesschalck, Myriam Deveugele, and Sara Willems<sup>55</sup> state, there is a “growing interest in patient’s perception of doctor-patient communication and doctors’ medical knowledge should be enriched with empowering verbal communicative skills”. It is worth including an education program which contains both medical and cultural norms to improve the process of communication between doctor and patient. Consequently, the better they communicate with patients, the better the outcomes of medical treatments.

These samples that were selected to display how the NM concept and politeness interrelate with the procedure of generating a narrative designate offering “space” aspect of the NM approach to the degree that the patient’s narrative is accomplished completely in spite of the great question occurrence and the restricted amount of “space” in which the patient was offered a chance to speak in relation to the length of the medical appointment. This might indicate that there are additional tactics which might prompt a more complete patient narrative, providing the particular condition of a patient. Furthermore, the NM approach has a tendency to allow for narratives which are more or less coherent by offering patients “space” in which to speak with minimum feedback and disruption from the doctor, at the same time conform the underlying regulations of politeness in language.

What is shown in this interaction through the framework of NM is the doctor recommending the patient space through evocations as well as feedback which tend to suggest that the doctor offers himself/herself to listen to the patient and to be of service. In summary, the doctor is challenged to generate narrative coherence from the abundance of data the patient presents in a less-than-coherent manner. That information can be obtained counting on a variety of politeness techniques that can be incorporated in the process of generating discourse that often have cultural and historical basis..

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<sup>55</sup> E.Verlinde, N. De Laender, S. De Maesschalck, M. Deveugele, S. Willems, *The social gradient in doctor-patient communication*, “International Journal for Equity in Health” 2012, v. 11, is. 12, pp. 1–14.

Consensus is not achievable without adequate knowledge concerning the patient's situation. Though patients' narratives are shaped by doctors' elicitation and the sort of reporting fear, they also seem to be affected by several factors that go beyond the range of the medical set, doctor's elicitation as well as discursive strategies, e.g. politeness. These intricacies impact and shape the advancement of patient narratives, which frequently lack typical, explicitly depicted narrative structure and coherence, despite efforts by both participants.

### **Recommendations for future research**

There is much possibility here for further research. There are no reports in the literature that any of the claims suggested above have been combined into healthcare practitioners' communications skills training elsewhere. Examination in this area and implementation as part of a well-designed trial would permit more specific recommendations. Studies collecting patients' feedback would also be valuable and would add some rationality to the results here. Another area for examination could be that of the relationship between positive politeness and rapport structuring. Additional research in this area concentrating on the ability to manage facework flexibly, i.e. to recognize the essential variation in individual wants for attention to positive and negative face, has the potential to be most informative. Moreover, there are also some reasons for further discovering the position of narrative in consultations as it may affect the communication process involving the doctor and the patient.

### **Conclusion**

From a linguistic perspective, generating a cooperative environment within the consultation encourages friendly relations and collaboration. Yet, the way in which suggestions are essentially framed with the aim of achieving this kind of environment does not create chances for alternative ideas to be articulated. Comprehending politeness strategies would simplify reflection on why people say what they say and raise awareness of the range of functions as well as effects of speech. From the evidence offered here, these would also comprise the possible effects of ambiguity in relation to decision-making that results from the use of indirectness, and the importance of the role of small talk in helping some patients to find a way of contributing. Appreciation of this latter element may make practitioners more aware that such talk can act as a medium for offering additional information that might otherwise remain unspoken.

This research contributes to the work of politeness theory by presenting a unique example of the way in which politeness strategies have been noticed in a group of Poles, in primary care consultations and emphasizes areas in which the teaching of such theories could be presented. Its attention to face threat and the way in which positive politeness can raise it offers a platform for better communication of the problems inherent in invitations to agree and consultation styles focused on cooperation. To fully comprehend the implications of these results for clinical practice further research is required. A significant starting point might be to analyze how practitioners can maximize positive politeness as a means of rapport to encourage contribution without generating an environment oriented toward agreement.

The most valuable outcome from this study was indication that doctors and patients tend to constantly attempt to create narrative coherence throughout medical interactions by exploiting various discursive devices, especially the concept of politeness. This finding offers a discourse analytic frame from which provides the information how these participants co-construct patient narratives and identities, especially in interactions relating to chronic illnesses. This understanding makes an essential impact on the area of discourse analysis of medical interactions by establishing the framework for analysis, which improves the comprehension of how patients' narratives as well as identities are co-constructed. The research offered insight into how, through this process, doctors and patients represent crucial aspects of their identities as participants placed in medical encounters. It also underlines the aspect of historical and cultural dimension that is present in creating the narrative and politeness in doctor-patient interactions that cannot be forgotten.

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## Diversification of English Medical Terminology: social and historical determinants

Zróźnicowanie angielskiej terminologii medycznej:  
czynniki społeczne i historyczne

### Abstract

The present article focuses on English medical terminology and its easily noticeable division into formal and informal terms. Numerous factors which may account for the observed diversification are discussed. The dichotomy formality-informality, however, seems to be related primarily to the history of the English language. Informal terms are predominantly of Anglo-Saxon, French, Germanic or Scandinavian origins, while formal terms are mainly borrowings from Latin and Greek.

### Abstrakt

Przedmiotem analizy dokonanej w niniejszym artykule jest angielska terminologia medyczna i zauważalny w jej obrębie podział na terminy formalne i nieformalne. Wiele czynników może odpowiadać za omawianą różnorodność nomenklatury medycznej. Dychotomia formalność-nieformalność zdaje się jednak przede wszystkim być powiązaną z historią języka angielskiego. Terminy nieformalne są pochodzenia anglosaskiego, francuskiego, germańskiego czy skandynawskiego, podczas gdy terminy formalne mają swe źródło w łacinie i grece.

**Keywords:** medical terminology, etymology, formal and informal terms, diachronic changes

**Słowa kluczowe:** terminologia medyczna, etymologia, formalne i nieformalne terminy, zmiany diachroniczne

This article concerns an intriguing characteristic feature of the English language used in medical discourse. In English, there is a clear division of medical terms into those specialized – specific for a certain profession, and colloquial expressions typical for the language of people from outside the medical profession. Obviously, in any other language, including Polish, there are both formal and informal terms referring to diseases, ailments or human anatomy and physiological processes. However, the scale of this division is not so notable. In the present paper an attempt is made to identify possible causes of the observed dichotomy.

### Medical language defined

There is an increasing interest in medical language as a means of specialist communication, its metaphoricity (metaphorical understanding and description of physiological processes [human body and its functioning, death, birth]), diachronic development, etc. There has been released a substantial body of literature focusing on various aspects of medical language. One area of the scholarly concern is translation of medical terminology and mistakes made by translators<sup>1</sup>. Besides, a great number of works are published to guide doctors and nurses through special strategies of correct communication with patients and their families (the so-called bedside manners, breaking bad news, handling complaints and dealing with conflicts, and the like).

Witold Doroszewski characterizes medical language in the following way<sup>2</sup>:

I. It is concrete; it avoids abstractness or ambiguity;

II. It is a professional variant of natural language enriched with elements of languages used in various fields of science;

III. It intersects related areas of science - biology, chemistry, psychology, etc.;

IV. It refers to both healthy and sick individuals;

V. It supports scientific communication that focuses on objective daily decisions and their implementation;

VI. It is used for both scientific and universal communication.

Similarly, Keith Brown (2005) asserts that *the most obvious characteristics of medical English is its extensive use of words related to the subject matter (...)*.

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<sup>1</sup> C.f. W. Karwecka, *Przekład tekstów medycznych*, Gdańsk 2016.

<sup>2</sup> W. Doroszewski, *Polski język medyczny*, [in:] *Polszczyzna 2000: Orędzie o stanie języka na przełomie tysiącleci*, ed. W. Pisarek, Kraków 1999.

*Apart from the medical jargon, medical communicators also favour a passive and impersonal styles that focus on objective and measurable phenomena<sup>3</sup>.*

### **Medical terminology – diversification and levels of formality<sup>4</sup>**

Tables (1) and (2) exemplify formal and informal (specialist and non-specialist) terms used in medical discourse. Their etymology is presented to demonstrate foreign influences which substantially affected development of medical terminology. Obviously, only a selection of terms has been made, since this division of medical terminology is not limited to a dozen or several dozen words. One can quote tens, if not hundreds, of similar terms, and any subsequent example would only confirm the dichotomy noted. These terms are grouped according to the general thematic areas in which they function.

Significantly, all the terms listed in Table 1 refer to the general anatomy of the human being, not the detailed one. A clear division into professional and non-specialist terminology has developed, despite the general applicability of these terms (a general description of the anatomical structure of a human body).

Table 2 exemplifies terms referring to diseases and their symptoms. What ought to be emphasized, the terms in question are used to describe common and well known diseases.

As easily seen, each of the informal terms mentioned, as used in non-specialist discourse, has its formal equivalent. As already stated, the observed tendency does not concern solely the English language. After all, in Polish we say *wyrwać ząb* (to pull a tooth out) and *dokonać ekstrakcji zęba* (to extract a tooth) or *opryszczka wargowa* (lip herpes) and the so-called *zimno* (cold sores), yet the scale of the formality-informality dichotomy (medical specialist language – colloquial language) characteristic of the Polish medical discourse is definitely less noticeable. Then, again, one cannot definitely say that formal terms are completely unknown to people who lack medical knowledge. Nevertheless, although they refer to common diseases or basic anatomical structures, many of the terms may be completely unknown to non-specialists.

<sup>3</sup> K. Brown, *Encyclopedia of Language and Linguistics*, Amsterdam 2005, p. 328.

<sup>4</sup> It should be emphasized that when writing about informal terms we do not mean offensive language. The terminology discussed in the body of the present paper is commonly used by non-specialists in everyday communication.

### A brief outline of the history of medical English

Let us take a closer look at the development of medical English from a historical perspective. It should be pointed out that the history of the language of medicine obviously parallels the history of the English language itself, but also parallels the history of medicine in Europe. Henrik R. Wulf observes that the oldest written sources of western medicine are the Hippocratic writings from the 5th and 4th centuries BC<sup>5</sup>. They concern all aspects of medicine at that time and include numerous medical terms. The Greek era of the language of medicine continued even after the Roman conquest as the Romans adopted Greek medical tradition. The doctors practicing in the Roman Empire were mainly Greeks. Numerous terms originated during the Greek era – *catarrh*, *diarrhoea*, *dyspnoea*, *melancholic*, *podagra*, to mention but a few.

Greek words were imported directly into Latin, as done by Aulus Cornelius Celsus, who compiled an encyclopedic overview of medical knowledge entitled *De Medicina*. In some cases he latinized Greek terms by using Latin suffixes or adding some letters to the original orthographic form.

Before the Roman conquest, the native inhabitants of Britain spoke Celtic dialects, which later developed into the modern Gaelic and Welsh. The invaders intended to establish Latin as the official language, which could have led to Celtic-Latin bilingualism. As far as medical language is concerned, we can even speak of Celtic-Latin-Greek trilingualism<sup>6</sup>.

When the Romans left Britain in 410 AD, the country became a target for new invasions from Europe. The Celtic population was forced to move into the mountain regions of Wales and Scotland pushed by German tribes of Angles, Saxons, and Jutes. The newcomers progressively transformed into a new nation with its own languages, which ultimately led to the development of four main dialects, out of which the West-Saxon dialect, because of political reasons, gained prominence. The oldest texts of that time were written in West-Saxon dialect. The period named Old English, or Anglo-Saxon alternatively, constitutes a foundation for contemporary English. As estimated by Edmund Andrews, the modern colloquial language preserved one third of Anglo-Saxon

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<sup>5</sup> H.R Wulff, *The language of medicine*, "Journal of Royal Society of Medicine" 2004, v. 97, pp. 187-188.

<sup>6</sup> B. Dżuganowa, *A brief outline of the development of medical English*, "Bratislavské Lekárske Listy" 2002. v. 103, 223-227.

lexis<sup>7</sup>. As regards medical English, it is only five percent of words. It is noteworthy, however, that the terms denote very basic anatomical structures. The words with Anglo-Saxon origins are, for instance, *arm, chin, finger, foot, gut, hair, head, hip, liver, mouth, wrists, heart, lung, bone, foot, neck*.

The subsequent invasions of Vikings from Scandinavia (789-1066) and the settlement of the people undoubtedly affected the language. Significantly, just a few Scandinavian words entered medical vocabulary (e.g. *ill, leg, kidney, skin, skull*). Simultaneously, it must be stressed that Latin still remained the language of science<sup>8</sup>.

The 7th and 8th century marked decline of Classical Latin, which split into several languages like Spanish, Italian, and French. The last of the listed ones here had a great impact on both colloquial and specialist language due to the conquest of England by the Normans in 1066. French terms penetrated medical discourse to a remarkable extent. It should be pointed out that numerous French terms had been previously adopted from Latin. As exemplified by Andrews, French words which enriched the language of medicine are: *superior, inferior, male, female, face, leper, gout, migraine, nature, nourish, nurse, odour, ointment, pain, venom, voice*.

The next centuries are marked by a strong position of Latin, which did not lose its status as the language of specialist communication. A great number of Latin terms entered the language in the original or altered forms. In the 16th century *cerebellum, delirium, virus, cadaver, cornea, vertigo, albumen, sinus, appendix, pus, abdomen, digit, ligament, saliva* were assimilated.

As asserted by Wulff, *then followed the era of the national medical languages, such as medical English, medical French, medical German, medical Italian and many others*<sup>9</sup>. Simultaneously, *medical scientists continued to develop new concepts that had to be named, and our classically schooled predecessors coined a multitude of new terms, most of which were composed of Greek rather than Latin roots, since Latin did not permit, to the same extent, the formation of composite words (e.g. nephrectomy, ophthalmoscopy, erythrocyte)*. As easily seen, classical languages continuously affected lexicalization of new concepts.

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<sup>7</sup> E. Andrews, *A History of Scientific English. The Story of its Evolution Based on a Study of Biomedical Terminology*, New York 1947.

<sup>8</sup> H.R Wulff, *op. cit.*, p. 188.

<sup>9</sup> *Ibidem*, p. 188.

### The possible sources of the dichotomy

Having discussed the development of medical English, in this section let us attempt to identify the sources of the observed diversification of English medical terms. First, sociolinguistic factors are focused on. However, they do not seem to be most significant. In the case of the English language historical facts should be foregrounded.

Since ancient times, people dabbling in medical practices have held a special position in their communities. It could have been a shaman, a country woman - a whisperer, a folk healer, a feldsher or finally a doctor. These people were respected because they tried, effectively or not, to relieve suffering. When outlining the beginnings of medicine, Władysław Szumowski emphasizes the importance of empathy and compassion in shaping the social position of a doctor: *Some people are trusted by a sick person when he or she feels their compassion. A suffering man wants and seeks help, wants to talk about the suffering. Whoever approaches him or her with compassion, creates an invisible thread of sympathy by this sole action (...)* (trans. D.G.)<sup>10</sup>. Moreover, it had often been widely believed that the one providing treatment had knowledge unavailable to others or was endowed with supernatural powers. People such as those were trusted but at the same time approached with some apprehensions. In consequence, a specific way of perceiving a doctor was formed. Although doctor's work required a close contact with the human being, the knowledge he or she possessed (real or only attributed) caused a feeling of inaccessibility. Economic factors also strengthened this special, social position of a doctor – not every patient could afford the services of a professional doctor. The doctors themselves, aware of the respect they were given, often being very wealthy people, deliberately distanced themselves from those regarded as uneducated and destitute. One of the ways of emphasizing a social position is to use distinctive language forms. This sociolinguistic phenomenon is analyzed e.g. by Howard Giles, who describes two opposing communication strategies – *convergence* and *divergence*. To minimize the social distance between us and the interlocutor, we use the language spoken by our interlocutor (we modify our own style, vocabulary, etc.). However, when we intend to accentuate our cultural and social difference, we deliberately use phrases that may be incomprehensible to the interlocutor, for example, because of his or her lack of education<sup>11</sup>.

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<sup>10</sup> W. Szumowski, *Historia medycyny historycznie ujęta*, Białystok 2005, p. 29.

<sup>11</sup> H. Giles, *Language: Contexts and Consequences*, London 1991.

Lexicographers, as it can be assumed, also contributed to the phenomenon discussed. For centuries the recorded linguistic facts have not been described as they are, but as they should be. In other words, while taking a prescriptive approach, lexicographers made subjective choices (they performed a kind of language purification)<sup>12</sup>. All kinds of glossaries, dictionaries and encyclopedias were addressed to literate people, therefore those educated who knew Latin and Greek. It is not surprising that borrowings from Greek and Latin have entered the so-called *high* language thanks to lexicographers, as well as authors of textbooks on medical subjects – medical doctors, anatomists.

Although, the national languages gradually gained ground at the expense of Latin and a numerous glossaries, dictionaries and encyclopedias published in British started to be written in English, they still were unavailable and incomprehensible to ordinary, usually illiterate people (e.g. *Mirror of the World*, a study that was a translation from French, published by William Caxton in 1481, *Monipulus Vocabulorum* by Peter Levins from 1570, who made a specific purification of the English language, marking some words as *barbarous*, *The New World of English Words* 1658 by Edward Phillips).

Language is used for communication. On the one hand, the emergence of certain sociolects limits the efficient information transfer within the entire community, on the other hand, it improves communication among members of a particular group, in this case professional one. As previously mentioned, the formal terminology used in medical discourse predominantly comes from Latin and Greek. Interestingly, colloquial terms are of Anglo-Saxon, French, German or Scandinavian origin. Some of the informal coinages are based on associations (cause-effect), reflect metaphorical patterns of reasoning, result from folk knowledge and understanding of the functioning of the human body and healing processes or even they have their roots in superstitions.

Let us illustrate the issue with the etymology of a few terms. *Elbow* is commonly referred to as *funny bone*, since, as elucidated by John Ayto, we experience a strange feeling during the injury to this part of the limb<sup>13</sup>. *Malleus* has its colloquial equivalent - *a hammer*. The underlying motivation for this coinage was an observed similarity between this anatomical structure and a tool (metaphorical extension of the meaning of the noun *hammer* meaning a tool). Similarly, *kneecap*, denoting the bone at the front of the knee joint, looks like a protective cover with a domed shape.

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<sup>12</sup> See: H. Béjoint, *The Lexicography of English*, Oxford 2010; D. Crystal, *The Stories of English*, New York 2010.

<sup>13</sup> J. Ayto, *Oxford School Dictionary of Word Origins*, Oxford 2002, p. 201.

It is not argued that, unlike English, the development of the Polish language was a less complex process, which could translate into limited diversification of the medical language. There are also numerous borrowings in Polish as a result of cultural contacts or long-lasting occupation. In the latter case, however, Polish society rather did not assimilate with the invaders, showing clear opposition instead, for example, to Germanization or Russification during the partitions<sup>14</sup>. Moreover, the British written culture seems to have had a longer tradition than the Polish one, which may indicate more advanced development of medical sciences (e.g. the influence of medical knowledge of Ancient Rome and Greece).

### **Diversification of medical terminology and communication problems**

The division into formal and informal medical terminology may cause problems with communication between the patient and the doctor, especially when the specialist, for some reasons (lack of empathy, willingness to stress his or her social position) uses specialist language only. However, without empirical research, we are unable to clearly state whether, in fact, British patients have problems in communicating their problems and needs to doctors –speakers of a different language. Neither do the doctors know if the patients understand the diagnosis and the doctors' instructions. However, there is a noticeable number of literature on the book market – guides addressed both to medical professionals and patients, aimed at improving communication between the specialist and non-specialist, which make such a communication efficient, e.g. *How to Communicate Basically Brilliantly with Patients*, *Mastering Communications with Seriously Ill Patients: Balancing Honesty with Empathy and Hope*, *Skills for Communicating with Patients*, *Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits*, etc.

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<sup>14</sup> Z. Klemensiewicz, *Historia języka polskiego*, Warszawa 2010.

Table 1.<sup>15</sup> Anatomy

Informal term	Etymology	Its formal equivalent	Etymology
Funny bone	It is named after the odd sensation one gets when it is struck	Elbow	c. 1200, <i>elbowe</i> , from a contraction of Old English <i>elmboga</i> „elbow,” from Proto-Germanic * <i>elino-bugon</i> , literally „bend of the forearm”
Kneecap	1650s, from knee (n.) + cap (n.), from Old English <i>cneo</i> , <i>cneow</i> „knee,” from Proto-Germanic * <i>knewa-</i> and late Old English <i>cæppe</i> „hood, head-covering, cape,” a general Germanic borrowing (compare Old Frisian and Middle Dutch <i>kappe</i> , Old High German <i>chappa</i> ) from Late Latin <i>cappa</i> „a cape, hooded cloak” (source of Spanish <i>capa</i> , Old North French <i>cape</i> , French <i>chape</i> )	Patella	1690s, from Latin <i>patella</i> „small pan or dish; kneecap” diminutive of <i>patina</i> „pan”
Upper jaw	late 14c., <i>jowe</i> , <i>joue</i> , „the bones of the mouth,” „A word of difficult etymology” [OED]. Probably from Old French <i>joue</i> „cheek,” originally <i>jode</i> , from Gallo-Romance * <i>gauta</i> or directly from Gaulish * <i>gabata</i>	Maxilla	1670s, from Latin <i>maxilla</i> „upper jaw,” diminutive of <i>mala</i> „jaw, cheekbone.”

<sup>15</sup> Compiled on the basis of: R. Fortuine, *The Words of Medicine. Sources, Meanings, and Delights*, Springfield 2000 and W. S. Haubrich, *Medical Meanings: A Glossary of Word Origins*, New York 2003.

Lower jaw	See <i>upper jaw</i>	Mandible	late 14c., from Late Latin <i>mandibula</i> „jaw,” from Latin <i>mandere</i> „to chew,” which is perhaps from PIE root <i>*mendh-</i> „to chew” (source also of Greek <i>mastax</i> „the mouth, that with which one chews; morsel, that which is chewed,” <i>masasthai</i> „to chew,” <i>mastikhan</i> „to gnash the teeth”).
Belly button	1877, colloquial, from <i>belly</i> + <i>button</i> ; <i>belly</i> from a general Germanic word for „leather bag, pouch, pod” that in English has evolved to mean a part of the body; from Old English <i>belg</i> , <i>bylig</i> (West Saxon), <i>bælg</i> (Anglian) „leather bag, purse, pouch, pod, husk, bellows,” from Proto-Germanic <i>*balgiz</i> „bag”; <i>button</i> comes from c. 1300, „knob or ball attached to another body,” especially as used to hold together different parts of a garment by being passed through a slit or loop (surname <i>Botouner</i> „button-maker” attested from mid-13c.), from Old French <i>boton</i> „a button”	Navel	From Middle English <i>navele</i> , from Old English <i>nafela</i> , <i>nabula</i> , from Proto-Germanic <i>nabalan</i>
		umbilicus	1540s, from Medieval Latin <i>umbilicalis</i> „of the navel,” from Latin <i>umbilicus</i> „navel”
		omphalos	1850, from Greek <i>omphalos</i> , literally „navel,” later also „hub” (as the central point)

Bell	from Old English <i>belg</i> , <i>bylig</i> (West Saxon), <i>bælg</i> (Anglian) „leather bag, purse, pouch, pod, husk, bellows,” from Proto-Germanic * <i>balgiz</i> „bag” (source also of Old Norse <i>belgr</i> „bag, bellows,” <i>bylgja</i> „billow,” Gothic <i>balgs</i> „wine-skin”)	Abdomen	1540s, from Latin <i>abdomen</i>
Stomach	from Old French <i>stomaque</i> , <i>estomac</i> „stomach,” from Latin <i>stomachus</i> „throat, gullet; stomach,”		
Throat	From Old English <i>þrote</i> (implied in <i>þrotbolla</i> „the Adam’s apple, larynx,” literally „throat boll”), related to <i>þrutian</i> „to swell,” from Proto-Germanic * <i>thrut-</i>	Pharynx	1690s, from Greek <i>pharynx</i> (genitive <i>pharyngos</i> )
Windpipe	From Old English <i>wind</i> „wind,” and Old English <i>pipe</i> „simple tubular musical wind instrument,” also „tube for conveying water,” from Vulgar Latin * <i>pipa</i> „a pipe, tube-shaped musical instrument”	Trachea	late 14c., from Medieval Latin <i>trachea</i> (13c.), as in <i>trachea arteria</i> , from Late Latin <i>trachia</i> , from Greek <i>trakheia</i>
Bowels	from late 14c. specifically as „human intestines,” from Old French <i>boele</i> „intestines, bowels, innards” (12c., Modern French <i>boyau</i> ), from Medieval Latin <i>botellus</i> „small intestine,” originally „sausage,” diminutive of <i>botulus</i> „sausage,” a word borrowed from Oscan-Umbrian.	Intestines	early 15c., from Middle French <i>intestin</i> (14c.) or directly from Latin <i>intestinum</i> „a gut,” in plural ( <i>intestina</i> ), „intestines, bowels,” noun use of neuter of adjective <i>intestinalis</i> „inward, internal,” from <i>intus</i> „within, on the inside,”

Gullet	c. 1300 from Old French golet „neck (of a bottle); gutter; bay, creek,” diminutive of gole „throat, neck” (Modern French gueule), from Latin gula „throat,” also „appetite,” which is related to gluttire „to gulp down, devour,” glutto „a glutton.”	Oesophagus	late 14c., from Greek oisophagos „gullet, passage for food,” literally „what carries and eats,” from oisein, future infinitive of pherein „to carry”
Spine	c. 1400, „backbone,” later „thornlike part” (early 15c.), from Old French espine „thorn, prickle; backbone, spine” (12c., Modern French épine), from Latin spina „backbone,” originally „thorn, prickle” (figuratively, in plural, „difficulties, perplexities”)	Spinal column, vertebral column	early 15c., from Latin vertebra „joint or articulation of the body, joint of the spine” (plural vertebræ), perhaps from vertere „to turn”
Skull	c. 1200, probably from Old Norse skalli „a bald head, skull,” a general Scandinavian word (compare Swedish skulle, Norwegian skult), probably related to Old English scealu „husk”	Cranium	early 15c., craneum, from Medieval Latin cranium „skull,” from Greek kranion „skull, upper part of the head,” related to kara (poetic kras) „head,”
Womb	Old English wamb, womb „belly, bowels, heart, uterus,” from Proto-Germanic *wambo (source also of Old Norse vomb, Old Frisian wambe, Middle Dutch wamme, Dutch wam, Old High German wamba, German Wamme „belly, paunch,” Gothic wamba „belly, womb,” Old English umbor „child”), of unknown origin.	Uterus	late 14c., from Latin uterus „womb, belly”

Table 2. Conditions and symptoms

Informal term	Etymology	Its formal equivalent	Etymology
Fever – blisters	Compound of fever + blister; fever from Middle English fever, fevere, from Old English fefer, fefor (“fever”), from Latin febris (“a fever”) bliser from From Old French blestre, from a Germanic source. Compare Middle Dutch blyster (“swelling”), Old Norse blastr (“a blowing”).	Labial/ oral herpes	late 14c., „any inflammatory, spreading skin condition” (used of shingles, gangrene, etc.), from Latin herpes „a spreading skin eruption,” from Greek herpes, the name for the disease shingles, literally „creeping,” from herpein „to creep, move slowly”
Running nose	Coined to described in a suggestive way the symptom	Rhinitis	1829, medical Latin, from rhino- „nose” + -itis „inflammation
		Nasal catarrh	late 14c., from Medieval Latin catarrus, from Late Latin catarrhus, from Greek katarrhus „a catarrh, a head cold,” literally „a flowing down,”
Whooping cough	mid-14c. from Old French huper, houer „to cry out, shout,” and Old English coughen (onomatopoeic)	Pertussis	1670s, from Modern Latin pertussis, from per- „thoroughly,” or here perhaps with intensive force (see per), + tussis „cough,” a word of unknown origin
Mumps	c. 1600, from plural of mump „a grimace” (1590s), originally a verb, „to whine or mutter like a beggar” (1580s), from Dutch mompen „to cheat, deceive,” originally probably „to mumble, whine” and of imitative origin (compare mum (interj.), mumble).	Parotitis	From Greek παρωτίτις (νόσος), parōtītis (nósos) : (disease of the) parotid gland < παρωτίς (stem παρωτιδ-) : (gland) behind the ear < παρά - pará : behind, and οὖς, ous (stem ὠτ-, ὀτ-) - ear

Flu	shortening of influenza. Spelling flu attested from 1893 (previously flue).	Influenza	from Italian influenza „influenza, epidemic,” originally „visitation, influence (of the stars),” from Medieval Latin influenza in the astrological sense
Chickenpox	c. 1730, from chicken (n.) + pox. Perhaps so called for its mildness compared to smallpox, or its generally appearing in children, or its resemblance to chick-peas.	Varicella	From medical Latin, 1764, irregular diminutive of variola
(Common) Cold	from 1530s, so called because the symptoms resemble those of exposure to cold; cold from Old English <i>cald</i> (Anglian), <i>ceald</i> (West Saxon) „producing strongly the sensation which results when the temperature of the skin is lowered,” also „having a low temperature,” from Proto-Germanic <i>*kaldjon</i>	Coryza	1630s, medical Latin, from Latinized form of Greek <i>koryza</i> „running at the nose,”
German measles	early 14c., plural of Middle English <i>masel</i> „little spot,” which is perhaps from Middle Dutch <i>masel</i> „blemish” (in plural „measles”) or Middle Low German <i>masele</i> , both from Proto-Germanic <i>*mas-</i> „spot, blemish” (source also of Old High German <i>masla</i> „blood-blister,” German <i>Masern</i> „measles”)	Rubella	1883, Modern Latin, literally „rash,” from neuter plural of Latin <i>rubellus</i> „reddish,” diminutive of <i>ruber</i> „red”

Hay fever	1825, from hay + fever; hay from „grass mown,” Old English heg (Anglian), hieg, hig (West Saxon) „grass cut or mown for fodder,” from Proto-Germanic *haujam (source also of Old Norse hey, Old Frisian ha, Middle Dutch hoy, German Heu, Gothic hawi „hay”), fever from late Old English fefor, fefer „fever, temperature of the body higher than normal,” from Latin febris „fever,” related to fovere „to warm, heat,”	Allergic rhinitis	1829, from medical Latin, from rhino- „nose” + -itis „inflammation.”
Heavy bleeding	From Old English bledan, „to cause to lose blood, to let blood” (in Middle English and after, especially „to let blood from surgically”), also (intrans.) „to emit blood,” from Proto-Germanic *blodjan „emit blood” (source also of Old Norse blæða, Dutch bloeden, German bluten).	Haemorrhage	c. 1400, from Latin haemorrhagia, from Greek haimorrhagia, from haimorrhages „bleeding violently,” from haima „blood” (see -emia) + rhagē „a breaking, gap, cleft,” from rhēgnynai „to break, burst,”
Balding	by 1938, from bald (n.) from rom Celtic bal „white patch, blaze” especially on the head of a horse or other animal (from PIE root *bhel- (1) „to shine, flash, gleam”)	Alopecia	The term alopecia is from the Classical Greek ἀλωπηξ, alōpēx, meaning „fox”

### Conclusions

There is a clear division between specialist and colloquial terminology in the English medical language. There may be numerous reasons for the observed division into formal and informal terms. However, the diversification of medical terminology seems to be related primarily to the history of the English language. Informal terms are predominantly of Anglo-Saxon, French, Germanic

or Scandinavian origin, while formal terms are mainly borrowings from Latin and Greek. We can observe an interesting linguistic phenomenon which consists in the functioning of two systems of terms with the same object of reference, but a different contextual application (a different sphere of social reality), which evolved as a consequence of diachronic development of the language.

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## **Disease as an Act of Evil Spirit: Vision of John Wimber, the Founder of the Vineyard Fellowship**

Choroba jako działanie złego ducha.

Perspektywa założyciela Vineyard Fellowship Johna Wimbera

### **Abstract**

The theoretical proposition of John Wimber, the founder of the Vineyard Fellowship, in relation to the disease is a product of several factors. On the one hand, the changes that took place in evangelical theology in the second half of the 20th century under the influence of pentecostalism, and on the other, the socio-cultural transformations of American society, which did not remain indifferent to the functioning of religious communities. The denomination, led by Wimber, was created under the influence of the counterculture. Wimber himself combined his evangelical experiences with the theology of dynamically developing pentecostalism. An important part of it is demonology and the theology of healing. Wimber synthesized these two theological subdisciplines, showing the strong connections between demonological aspects and the etiology of the disease.

### **Abstrakt**

John Wimber był jednym z założycieli neocharyzmatycznej denominacji ewangelikalnej. Jako religijny przywódca zaproponował postrzeganie choroby, odwołujące się do fideistycznych podstaw teoretycznych. Nie odrzucał rozumienia biomedycznego, ale dostosował je do własnego rozumienia Biblii i

wiary. Jego konceptualizacja opiera się w szczególności na dwóch zasadach. Z jednej strony na założeniach hamartologicznych (związanych z ideą grzechu), z drugiej zaś na przesłankach demonologicznych, które w etiologii choroby upatrują działania złych duchów. Jego model jest supranaturalistyczny, dynamiczny i animistyczny, to znaczy odwołuje się do czynników nieweryfikowalnych i transcendentalnych, które mają charakter pozasomatyczny, nieorganiczny i pozamaterialistyczny.

**Keywords:** John Wimber, disease, religion, evangelical movements

**Słowa kluczowe:** John Wimber, choroba, religia, ruchy ewangelikalne

“**T**he Jesus People movement of the 1960s was a spiritual awakening within hippie culture in the United States, as thousands of young people found themselves on a desperate search to experience God. Not finding Him through drugs, sex, or rock’n’roll, the hippies were one of the subcultures powerfully impacted by ministries such as Calvary Chapel (Costa Mesa, CA) that arose during this move of God across America”<sup>1</sup>. This is how the Association of Vineyard Churches, an American neocharismatic evangelical denomination founded on the West Coast of the USA in the 1970s, describes its origins. Kenn Gulliksen (b. 1945) started the first church in West Los Angeles as a group who studied the Bible. They met at Larry Norman’s (1947–2008), a People! musician, and Chuck Girard’s (b. 1943), who are both regarded as the pioneers of Christian rock music. At that time Bob Dylan (b. 1941) experienced his conversion and Gulliksen became his first pastor. The fellowship soon began connecting actors, musicians, and artists. T-Bone Burnett (b. 1948), a musician, songwriter and record producer, or Keith Green (1953–1982), a Christian musician, may serve as examples<sup>2</sup>. Soon the fellowship included John Wimber (1934–1997), a keyboardist playing in Las Vegas and in a blue-eyed soul band called The Par-amours, as well as a co-founder of The Righteous Brothers<sup>3</sup>. In 1963 Wimber became a Christian in Evangelical Friends Church International, which was

<sup>1</sup> *History & Legacy: Reaching This Generation with the Power of the Gospel*, <<https://vineyardusa.org/about/history/>> [16.08.2020].

<sup>2</sup> See B. Jackson, *A Short History of the Association of Vineyard Churches*, [in:] *Church, Identity, and Change: Theology and Denominational Structures in Unsettled Times*, ed. D.A. Roozen, J.R. Nieman, Grand Rapids-Cambridge 2005, p. 132–140.

<sup>3</sup> B. Medley, M. Marino, *The Time of My Life: A Righteous Brother’s Memoir*, foreword B. Joel, Boston 2014, p. 10–13.

a Quakerish denomination. It was where he became a pastor in 1970. Along with C. Peter Wagner (1930–2016), a theologian and missiologist from the Fuller Theological Seminary, he was the founder of the Charles E. Fuller Institute of Evangelism and Church Growth at the Fuller Theological Seminary's Fuller School of World Missions, which is considered to be "probably the most influential seminar in America"<sup>4</sup>. It was where his theological opinions on healing and deliverance from demons were shaped.

As he wrote in his books, in 1977 he began to pray for the sick in his congregation. That activity was influenced by Carol, his wife, who was inspired by Pentecostal ideas and her own experience<sup>5</sup>. Initially he was skeptical of miracles and charismata (especially of healing) due to his theological principles. At the time Evangelicalism represented a cessationist position, i.e. it assumed that miracles and spiritual gifts ceased with the apostolic age or right after it. The matters of personal evil and demons also raise issues. American Quakerism speaks more of sin and sinful nature than personal evil; the former being structural injustice that causes "bad things", which reproduce further "bad things" (according to the "sin leads to another sin" principle). Liberal Quakers reject the existence of a personal devil<sup>6</sup>. Wimber had a conservative approach; therefore, the missionaries who had come across the belief in the real existence of demons outside the Euro-Atlantic area had a noticeable effect on his opinions. Eventually Wimber adopted Pentecostal-Charismatic demonology. One of the missionaries who influenced Wimber's opinions was Charles H. Kraft (b. 1932), an evangelical apologist, anthropologist, linguist, as well as a Brethren missionary in northern Nigeria<sup>7</sup>. Once Kraft approached African religiousness, he "rebuilt" his approach to evil spirits, from the initial individual acceptance of a Christian doctrine concerning demons to running a deliverance ministry. He argued that his academic background as a cultural anthropologist and theological preparation were insufficient after the "encounter" with Africans' experience. To be a successful missionary, he has to take a "complementary" approach, which

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<sup>4</sup> G.M. Marsden, *Reforming Fundamentalism: Fuller Seminary and the New Evangelicalism*, Grand Rapids 1987, p. 292.

<sup>5</sup> See J. Wimber, K. Springer, *Power Healing*, introduction by R.J. Foster, San Francisco 1991 (1987<sup>1</sup>).

<sup>6</sup> See more *Good and Evil: Quaker Perspectives*, ed. J. Leach Scully, P. Dandelion, London-New York 2016.

<sup>7</sup> This is a denomination that derives from the Mennonites, which is called the Church of the United Brethren in Christ in the USA. It is distinct from the Churches of Brethren of the Czech and Moravian (Hussite) Reformation from the 15th c.

considers the local culture approach. In other words, he has to incorporate inculturation<sup>8</sup>. C. Peter Wagner, who served as a missionary in South America, was Wimber's personal friend, and was employed at the same seminar, took a similar path. Based on his own experience, he rebuilt his theology from strongly Dispensationalist, which represented the position of pessimistic Premillennialism<sup>9</sup>, i.e. Christians should withdraw from the social sphere, to Dominionist, which advocates the involvement in a social, even political, transformation<sup>10</sup>. The seminary they both worked for represented a position that may be called "activist". In other words, it advocated the confrontation of Christianity with the contemporary society, ergo a certain "dialectical" relationship. At that time the Fuller Theological Seminary did not accept the attitude of being a passive observer, who would sometimes address a specific issue, of social and cultural changes in progress. This may also be one of the reasons for the seminar success and influence<sup>11</sup>.

Wimber's approach to the model of healing and disease perception combines many social and cultural, historical and political, and personal factors. It should be remembered what conditions affect the creation of beliefs of a new religious movement, and therefore a new denomination, but also entire Evangelicalism at the time, and, more widely, American Protestantism. To grasp the changes to the awareness and mentality of Americans, the following events may be indicated: The Vietnam War (1962–1975), Cuban Missile Crisis (1962), the first fission weapon test by the People's Republic of China (1964), John F. Kennedy's (1963) and Martin Luther King's (1968) assassination, or the Six-Day War (1967) between Israel and Egypt, Jordan, and Syria, which was interpreted as the beginning of Armageddon by some Protestant fundamentalist communities. As a result, a new broad counterculture movement was shaped that questions the social and political solutions suggested by the country. Indeed, it also questions the epistemic *status quo*. The Jesus Movement mentioned at the beginning of the article was associated with the counterculture. Its disci-

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<sup>8</sup> See Ch.H. Kraft, *Christianity in Culture: A Study in Dynamic Biblical Theologizing in Cross-Cultural Perspective*, foreword by B. Ramm, Maryknoll 1995 (1979<sup>1</sup>); idem, *Defeating Dark Angels: Breaking Demonic Oppression in the Believer's Life*, Ventura 2014 (1992<sup>1</sup>).

<sup>9</sup> It is a theological belief that Jesus will physically return to the earth, which will fully initiate the kingdom of God.

<sup>10</sup> See C.P. Wagner, *Dominion!: How Kingdom Action Can Change the World*, Grand Rapids 2008.

<sup>11</sup> See G.M. Marsden, *op. cit.*, *passim*.

ples were called Jesus People. Apart from the so-called sexual revolution, which was introduced and advocated by the hippie movement, the Jesus Movement was a representative of many similar counterculture lines and ideological solutions, which were critical of the social, political, and economic problems at that time. Brotherly love and mutual respect were expressed by the spread of pacifism and emancipation ideas, which was common about the entire counterculture<sup>12</sup>. Both counterculture movements advocated the return to spirituality, but they varied in where the its roots were located. The Jesus Movement may be described as a “religious Christian ministry” for hippies<sup>13</sup>. It was a type of “subcultural” Christianity, which began to use an inclusive language and adapt the form and method of its message to the needs of an “alternative” receiver. The Vineyard Church, which the movement laid the foundation for, also “re-built” Evangelicalism at the time, as Pentecostalism did at the beginning of the 20th c. with American Protestantism. The Church introduced popular music (including rock, metal, electro) in the Pentecostal-Charismatic liturgy<sup>14</sup>, and then in the evangelical. It also introduced prayers for the sick as a fixed part of the church service from Pentecostalism. It was incorporated in the so-called “power evangelism” concept<sup>15</sup>, built on the theology of George Eldon Ladd (1911–1982), a Baptist minister and professor of New Testament exegesis. He had a major impact on conservative evangelical theologian communities<sup>16</sup>.

Ladd advocated the restoration of Kingdom theology in Evangelicalism. He understood it in a “processualistic” dimension – “already now and not yet”, which referred to *Kingdom theology* advocated at the beginning of the 20th

<sup>12</sup> See more *Kontrkultura. Co nam z tamtych lat?*, ed. W.J. Burszta, M. Czubaj, M. Rychlewski, Warszawa 2005 [book in Polish: *Counterculture: What Are We From That Time?*]; J. Heath, A. Potter, *Nation of Rebels: Why Counterculture Became Consumer Culture*, New York 2004; Th. Roszak, *The Making of a Counter Culture: Reflections on the Technocratic Society and Its Youthful Opposition*, Berkeley 1969; S. Tokarski, *Orient i kontrkultura*, Warszawa 1984 [book in Polish: *Orient and Countercultures*].

<sup>13</sup> See more R. Bustraan, *The Jesus People Movement: A Story of Spiritual Revolution among the Hippies*, Eugene 2014; R.M. Enroth, E.E. Ericson, C. Breckenridge Peters, *Jesus People: Old Time Religion in the Age of Aquarius*, Grand Rapids 1972.

<sup>14</sup> Music already was an important part of a church service in these denominations; however, in this case it only involves popular music, which, to a large extent, replaced the previous canon of liturgical music involving *gospel* and *soul* music, as well as *spirituals*.

<sup>15</sup> See J. Wimber, *Signs and Wonders and Church Growth*, Placentia 1984; J. Wimber, K. Springer, *Power Evangelism*, San Francisco 1986.

<sup>16</sup> B. Jackson, *The Quest for the Radical Middle: A History of the Vineyard*, foreword by T. Hunter, Cape Town 1999, p. 53.

c. by Geerhardus Vos (1862–1949), a Calvinist theologian from Princeton. Salvation mattered in the latter theology, while the kingdom mattered in the former theology. Both theological concepts in the proposed approaches should be understood in two dimensions – “worldly” and “eschatological”. On one hand, they should already be present in a Christian (or on the earth); on the other hand, they would “complement” each other in the eschatological future. The existence of the kingdom (“already now”) was to be fulfilled in “manifestations of power of the kingdom”, including healing and demon exorcising, in Wimber’s extensions, which was supposed to refer to and be confirmed in the following evangelical passage: “And as you go, preach, saying, ‘The kingdom of heaven is at hand.’ Heal the sick, cleanse the lepers, raise the dead, cast out demons. Freely you have received, freely give.” (Matthew 10, 7 NKJV)<sup>17</sup>. The following implication was the result of Wimber’s approach — if the kingdom of heaven is already on the earth, miraculous events are possible, as in the case of the ministry of Jesus. Therefore, healing and casting out demons should be a fixed part of Christian ministry, and, therefore, of every Christian meeting (service). The “establishment” of the healing model in the context of Kingdom theology is also a safe approach. It shows that even though the kingdom (and salvation) is “already now”, there is still a “not yet” dimension. Thus, a belief that God “already now” heals people does not imply the situation where all people are “given” healing since there are some people who are not healed. This is how the “not yet” dimension is carried out. Wimber indicates that they are examples of people from the New Testament who were not to be healed by God (Epaphroditus, Paul, Trophimus, Timothy). Therefore, unlike Pentecostal healing preachers, the author indicates and preaches that if a Christian does not “experience” the healing of God from a given disease, such a situation does not result from lack of, or problems with faith, but it is a concealed dimension of “not yet” of the kingdom of God<sup>18</sup>.

In the Wimber’s model, prayer for the deliverance from demons is part/type of prayer for healing. Wimber has a complementary approach to the issue of disease, and places it in the hamartiological-demonological contexts. Thus, disease is supposed to be the result of sin inspired by Satan. Healing is a specific shift from this order — it is a shift from sin and “entering” a conflict with Satan.

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<sup>17</sup> See G.E. Ladd, *The Gospel of the Kingdom: Scriptural Studies in the Kingdom of God*, Grand Rapids 1959; more *The Princeton Theology 1812–1921: Scripture, Science, and Theological Method from Archibald Alexander to Benjamin Breckinridge Warfield*, ed. M.A. Noll, Grand Rapids 2001, *passim*.

<sup>18</sup> J. Wimber, K. Springer, *Power Healing...*, p. 157.

The preacher argues that „health is frequently determined by individual righteousness or sin”<sup>19</sup>. He refers to the following biblical references: Mark 2:1-12; John 5:1-11; James 5:14-16. Thus, he believes that disease is a consequence of human actions and refers to human morality and the concept of sin. Further, it may be corporate in character. In other words, sin or disobedience are supposed to lead to disease or death and thus have social implications: “Western Christians live in an individualistic, fragmented society. Few people think sin committed by one person can affect the well-being, even the health, of an entire group. In this regard, private sin has corporate implications.”<sup>20</sup> More importantly, the author spots the change in the theological conceptualisation of collective responsibility in ancient Judaism; therefore, he indicates that sin is not the cause of every disease. However, Satan may be. Still, this idea is obscure in the literature of the Old Testament where the concept of “New Testament” Satan (devil) is not even adumbrated<sup>21</sup>. Furthermore, the last constatation does not seem to be conclusive for communities that engage in fundamentalist hermeneutics, i.e. literal. Wimber claims that Jesus explains the meaning of the *Book of Job* in his evangelical word (John 9:3) by showing no relationship or its “loosening” in terms of the idea of disobedience/sin and disease through the example of the blind person<sup>22</sup>. As can be seen, it is not an absolute relationship. Although the preacher’s approach does not seem to be consistent, it is in reality. The author adopts a certain principle from the Old Testament, but he does not render it complete in character, i.e. he determines its certain action boundaries and places them in the context of the conflict with Satan. In fact, a conclusion may be reached: every war involves victims, and the above-mentioned conflict is no exception<sup>23</sup>. However, the conclusions does not explain the scope of divine responsibility in a theodical sense. It indicates that all are subject to suffering (including disease), while the healing of God is a response to it<sup>24</sup>.

<sup>19</sup> *Ibidem*, p. 39.

<sup>20</sup> *Ibidem*.

<sup>21</sup> See K. Kościelniak, *Złe duchy w Biblii i Koranie. Wpływ demonologii biblijnej na koraniczne koncepcje szatana w kontekście oddziaływań religii starożytnych*, Kraków 1999 [book in Polish: *Evil Spirits in the Bible and the Quran: The Influence of Biblical Demonology on the Quranic Concepts of Satan in the Context of the Interaction of Ancient Religions*]; more on the changes in: J.B. Russell, *The Devil: Perceptions of Evil from Antiquity to Primitive Christianity*, Ithaca–London 1977; idem, *Satan: The Early Christian Tradition*, Ithaca–London 1987.

<sup>22</sup> J. Wimber, K. Springer, *Power Healing...*, p. 39.

<sup>23</sup> *Ibidem*.

<sup>24</sup> More on the perception of suffering in Wimber’s books: G. Wiktorowski, *Uzdrowianie według założyciela Vineyard Fellowship Johna Wimbera*, [in:] *Medycyna i religia*, v. II, ed.

In his publications, Wimber represents the position of a person who regards the existence of Satan and demons as indisputable. He perceives them in the context of the so-called spiritual warfare. He places Jesus Christ, who is to be the conqueror of Satan, on the other side. In fact, his power over demons, disease, nature, and death may serve as a proof<sup>25</sup>. According to Wimber, Jesus was sent by God the Father to “destroy the kingdom of Satan” and “establish the kingdom of God”<sup>26</sup>. Therefore, he formulates four principles of his doctrine concerning the kingdom of God in the context of the doctrine concerning spiritual warfare: 1) God’s reign began on the earth in the person of Jesus (“intrusion” onto an enemy territory concept); 2) conversion and faith in Jesus Christ bring forth redemption from the world, flesh, and devil (“interception of captives” concept); 3) the kingdom of God destroys the kingdom of Satan (“destruction of enemy infrastructure” concept) and 4) the final destruction of Satan when Christ returns and fully establishes the kingdom of God (“new order” concept)<sup>27</sup>. The militaristic rhetoric indicates that there is a warfare conceptualisation of the extraterrestrial conflict, which refers to the Manichaeism-Gnosticism approaches representing a conflict between two (almost) equal adversaries. The two dualistic and antithetic “elements” — God who represents good, light and salvation and Satan who represents evil, darkness and damnation (destruction) — are not conceptualised as equal, especially in ontological terms, by Wimber. The Author makes a rather clear “diversification”, differentiation and leans towards the triumphalism of the ontologically good side, i.e. God. Thus, it does not essentially swerve from the classical (“traditional”) ideas of Christian theologies, which indicate lack of equity, or similarity, between God and Satan. This approach claims that God is the highest and absolute being who creates all that exist. On the other hand, Satan is to be a “creature” that was created and limited by, subservient to, as well as dependent upon God’s will. Satan is temporary, gains an advantage over human beings “for a while”, and is to be ultimately destroyed. These subjects are especially entered on in Pentecos-

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B. Płonka-Syroka, M. Dąsal, Warszawa–Bellerive-sur-Allier 2017, p. 287–323 [article in Polish with English abstract: *Healing According to John Wimber, Founder of Vineyard Fellowship*, in: *Medicine and Religion*, v. II].

<sup>25</sup> J. Wimber, K. Springer, *Power Evangelism...*, p. 161–180.

<sup>26</sup> *Ibidem*, p. 100.

<sup>27</sup> *Ibidem*, p. 100–101.

tal-Charismatic demonologies<sup>28</sup>. Wimber perceives Jesus as a “divine invader”, which still introduces an element of warfare: „Jesus came as a divine invader to destroy demons and release men and women to eternal life, which explains why the Lord’s presence caused demons to tremble and fear”<sup>29</sup>. Furthermore, he indicates that demons were and are afraid of the “presence” of Jesus, which is evocative of the images of a dualistic conflict in fairy tale stories and pieces of work by Clive S. Lewis (1898-1963) or John R.R. Tolkien (1892-1973)<sup>30</sup>. So, Jesus comes to the Earth to establish the kingdom through his public mission, which would be run by his followers afterwards. The mission is based on two elements: proclamation of good news (Gospel) and demonstration of power by casting out demons, healing the sick, and raising the dead. Therefore, Jesus enters into continual conflict with the current “wardens” of the area (the Earth), i.e. with Satan and demons. Wimber would say clearly: „Jesus’ ministry was marked by continual conflict with Satan and demons for the purpose of establishing God’s reign on earth”<sup>31</sup>.

<sup>28</sup> See more N. Scotland, *The Charismatic Devil: Demonology in Charismatic Christianity*, [in:] *Angels and Demons: Perspectives and Practice in Diverse Religious Traditions*, ed. P.G. Riddell, B. Smith Riddell, Nottingham 2007, p. 84–105; G. Wiktorowski, *Demony jako epifanie zła egzystencjalnego. Demonologia religii niechrześcijańskich, kultury ludowej oraz jej nawiązania w psychoanalizie. Zarys ogólny problematyki*, [in:] *Socjologia i antropologia medycyny w działaniu*, ed. W. Piątkowski, B. Płonka-Syroka, Wrocław 2008, p. 243–291 [article in Polish: *Demons as Epiphanies of Existential Evil: Demonology of Non-Christian Religions and Folk Culture, and Its References in Psychoanalysis. A General Outline of Problems*, [in:] *Sociology and Anthropology of Medicine in Action*]; idem, *Egzorcyzm jako sakralna terapia antydemoniczna. Relacja lekarz-pacjent na przykładzie stosunku egzorcysty i opętanego w radykalnych nurtach pentekostalizmu „Trzeciej Fali”*, [in:] *Leczyć, uzdrawiać, pomagać*, ed. B. Płonka-Syroka (Studia z Dziejów Kultury Medycznej, v. XI), ed. B. Płonka-Syroka, A. Syroka, Wrocław 2007, p. 337–377 [article in Polish: *Exorcism as Sacred Anti-Demonic Therapy: The Doctor-Patient Relationship on the Example of the Relationship between Exorcist and Possessed in the Radical Streams of the “Third Wave” Pentecostalism*, [in:] *Cure, Heal, Help*, (Studia z Dziejów Kultury Medycznej, v. XI); idem, *„W imieniu moim demony wyganiać będą...” — egzorcyzm (uwolnienie) jako rodzaj „terapii behawioralnej” w pentekostalizmie „Trzeciej Fali” (Third Wave) w USA i Kanadzie*, [in:] *Medycyna i religia*, v. I, ed. B. Płonka-Syroka, M. Dąsal, Warszawa-Bellerive-sur-Allier 2017, p. 249–276 [article in Polish with English abstract: *“In My Name They Will Cast Out Demons...” — Exorcism (Deliverance) as a Kind of “Behavioral Therapy” in a “Third Wave” Pentecostalism in the USA and Canada*, in: *Medicine and Religion*, v. I].

<sup>29</sup> J. Wimber, K. Springer, *Power Healing...*, p. 101.

<sup>30</sup> On another note, it may be indicated that both writers based the plot of their novels on the Christian concept of a dualistic conflict (Protestant and Catholic).

<sup>31</sup> *Ibidem*.

The above implies that the Earth is seen as a peculiar battlefield between unequal subjects, armies. However, unlike e.g. representatives of the Pentecostal Word of Faith movement, Wimber does not debase the completely different meaning of the “kingdom of Satan”, but approaches the problem seriously and does not underestimate the “enemy”: “(...) the kingdom of Satan is powerful, well organized, and it can affect men and women in many ways (...)”<sup>32</sup>. He believes that this activity is related to “chronic problems” experienced by many people, which cannot be solved via medicine, psychology or psychotherapy. The author is convinced that demons are the cause of these problems. Correct identification (diagnosis) of the cause is therefore essential for effective “therapy”. Wimber believes that there are diseases which should undoubtedly be classified as demonopathy, meaning that they have a “demonological basis”, that is directly caused by demons. They include dumbness and blindness, epilepsy, high fever or crippling<sup>33</sup>. However, he does not present any arguments, even of theological nature, supporting this claim. Instead, as is common for a scripturalist, he cites biblical references (Matthew 9:32; 12:22; Mark 9:14-29; Luke 4:38-39; 13:10-17), although he does not explain their contextual meaning. This kind of demonologization of diseases can lead to strong stigmatization of people with these diseases, particularly in the context of these religious groups. Demonopathy<sup>34</sup> is also said to cause problems of psychological nature, such as anxiety, fear, phobias, uneasiness, depression, and problems of psychosexual nature, such as homosexuality<sup>35</sup>, excessive sexual drive (hypersexuality) as well as various fetishes and “deviations” of a much wider range compared to the

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<sup>32</sup> *Ibidem*, p. 106.

<sup>33</sup> *Ibidem*, p. 108.

<sup>34</sup> Here as a technical term.

<sup>35</sup> Even though author’s publications come from the 1980s and the beginning of the 1990s, the position of most (if not all) evangelical denominations, including Pentecostal-Charismatic, is against homosexuality, often referring to it as a “deviation” or “perversion”. The Association of Vineyard Churches does not assume a favourable position, but it emphasises respect towards homosexuals and expresses its attrition, grief, as well as renounces intolerance, hostility or persecutions, which occurred in relation to homosexuals in the history of the church. It also states that the Association is open to such people on the condition that they exercise abstinence or enter a heterosexual relationship. See more The Vineyard USA Executive Team, *Pastoring LGBT Persons: Position Paper*, 2014, <[https://pulpitandpen.org/wp-content/uploads/2016/05/PositionPaper-Pastoring\\_LGBT\\_Persons.pdf](https://pulpitandpen.org/wp-content/uploads/2016/05/PositionPaper-Pastoring_LGBT_Persons.pdf)> [16.08.2020].

approach of contemporary clinical sexology or sexual pathology (e.g. transvestism, the aforementioned homosexuality, bestiality<sup>36</sup>, or sodomy<sup>37</sup>)<sup>38</sup>.

Wimber notices extra-demonological causes of etiopathogenesis of diseases. Therefore, unlike e.g. “faith healers” from the early history of 20th century Pentecostalism, he does not reject the achievements and findings of contemporary medicine and psychiatry. At the same time, he performs a peculiar anachronization and cultural imputation<sup>39</sup> through indicating that the Holy Scripture differentiates between “natural” and demonic causes of diseases<sup>40</sup>. The preacher believes that the biblical text, when it describes occurrences of diseases, differentiates between people who are “demonized” and those who are simply “sick”. He refers to biblical texts to prove this statement (Matthew 4:24; 8:16; 10:1.8; Mark 1:32-34; 3:10-11; 6:13; 16:17-18; Luke 4:40-41; 6:18-19; 7:21;

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<sup>36</sup> The author uses this term as a synonym for the term zoophilia. Still, it may be differently understood. Polish translators rendered the term *bestiality* as “being cruel in a sexual act”, which would indicate BDSM-type sexuality. It is not the case here, however. Such sexuality is not accepted in evangelical and fundamentalist communities, including Pentecostal-Charismatic, either. See G. Wiktorowski, *Model rodziny i relacji małżeńskich w amerykańskim fundamentalizmie protestanckim*, [in:] *Problem kontroli urodzeń i antykoncepcji. Krytyczno-porównawcza analiza dyskursów*, ed. B. Płonka-Syroka, A. Szlagowska, Wrocław 2013 (Studia Humanistyczne Wydziału Farmaceutycznego Uniwersytetu Medycznego we Wrocławiu, v. VII.), p. 45–78 [article in Polish: *Model of Family and Marital Relations in American Protestant Fundamentalism*, in: *Birth Control and Contraception Problem: Critically-Comparative Analysis of Discourses*, “Humanities Studies of the Faculty of Pharmacy, Medical University of Wrocław”, v. VII].

<sup>37</sup> The author understands this term as all anal, including heterosexual, intercourses. He does not wrongly refer to it (although it is ingrained culturally and historically) as homosexuality or zoophilia. See J. Boswell, *Chrześcijaństwo, tolerancja społeczna i homoseksualność. Geje i lesbijki w Europie Zachodniej od początku ery chrześcijańskiej do XIV wieku*, transl. J. Krzyszpień, Kraków 2006, p. 96–101 [translation from English: *Christianity, Social Tolerance, and Homosexuality: Gay People in Western Europe from the Beginning of the Christian Era to the Fourteenth Century*, Chicago 1980].

<sup>38</sup> J. Wimber, K. Springer, *Power Healing...*, p. 108, 118; see G. Wiktorowski, *Egzorcyzm...*, *passim*; idem, *Model...*, *passim*.

<sup>39</sup> I take and understand this term as meaning transfer of a way of thinking characteristic for a given culture and historical period into a different cultural and historical context. See W. Wrzosek, *The Problem of Cultural Imputation in History: Relations Between Cultures Versus History*, [in:] *Historiography Between Modernism and Postmodernism: Contributions to the Methodology of the Historical Research*, (Poznań Studies in the Philosophy of Sciences and Humanities, v. XLI), ed. J. Topolski, Amsterdam-Atlanta 1994, p. 135–144.

<sup>40</sup> The author does not point only to the New Testament, but to the entire Holy Scripture, including the Old Testament, which in this interpretive context constitutes a double abuse.

8:2; 9:1; 13:32; Acts 5:16; 8:6-7; 19:11-12). Moreover, he writes about mental illnesses and their “natural” causes (understood as organic, biological), which is completely unfounded, as such understanding of aetiology of psychological disorders begins in the 18th-19th century. Wimber believes that Jesus and his disciples undertake different actions depending on identified (diagnosed) cause of a disease (demons or “natural” causes). In case of physical and mental diseases caused by demons, the latter were supposedly “cast out”. On the other hand, in cases where diseases had a physical basis, “casting out” of evil spirits was not performed<sup>41</sup>.

The preacher points out that the Greek terms used in the New Testament to describe people who “had demons” are rather imprecise. Due to that the English translations of the Bible are supposedly misleading by describing people who “had a demon” as “demon-possessed”. This latter term is said to introduce semantic confusion by suggesting that demons are able to completely possess and take over a human being, with which the author disagrees. He writes the following on that topic: “But I do not believe that demons may own people absolutely while they still live on earth; even when demons gain a high degree of control, people are able to exercise a degree of free will that may lead to deliverance and salvation.”<sup>42</sup> He then points out that the Greek work *daimonizomai* (δαιμονίζομαι<sup>43</sup>) which means “having a demon” could be more literally rendered as “demonized”, which would mean “to be influenced”, “to be afflicted” or “to be tormented”<sup>44</sup>. Wimber therefore “shifts” from a classic (also among the so-called traditional, tribal societies) understanding of “possession” as “embodiment of evil spirit” to a wider understanding of influence. Through that, the author differentiates between “being under demonic influence” or “having a demon” and being possessed. It would seem that the aspect of a possibility of a demon completely taking over control of a human being is essential, and that is something that Wimber is reluctant to agree with. He also distinguishes, like many other Pentecostal-Charismatic demonologists, several degrees of “demonic influence”, which are characterized elsewhere. For our deliberations, this distinction holds no particular importance, also due to its lack of precision, clarity and definite separation of each phase/stage. This does not mean, however, that Wimber completely rejects the possibility of possession in the

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<sup>41</sup> J. Wimber, K. Springer, *Power Healing...*, p. 108.

<sup>42</sup> *Ibidem*, p. 109.

<sup>43</sup> All additions in Greek by the author.

<sup>44</sup> *Ibidem*.

classic sense. However, this is supposed to be an extremely rare occurrence and constitutes the final distinct phase/stage<sup>45</sup>. Such approach translates to “ease” of “therapeutic” procedure. Immediate release (and therefore recovery) occurs in cases of being “demonized”. This is also when a mental illness is supposed to “subside” immediately. Further, the author writes: “Those whose mental illness is other in origin must go through a long and costly process of psychological healing.”<sup>46</sup> From this statement, it can be inferred that there is a whole spectrum of “mild” psychological disorders caused by demons. There are also disorders more “difficult” and requiring a longer period of a more professional “psychological healing”.

The preacher also proposes a list of mental illnesses whose occurrence often takes the form of psychosomatic disorders. They are said to be often caused, induced by demons. According to him they include:

1) schizophrenic disorders (ICD-10: F20)<sup>47</sup>, including language and communication disorders, delusions, hallucinations or loss of contact with the outside world;

2) paranoid disorders (ICD-10: F20.0; F22.0; F60.0), including persecutory delusions or “extreme and unjustified jealousy” (sic!);

3) affective disorders, including mood disorders (ICD-10: F30-39) such as depression (ICD-10: F32; F33) or mania (ICD-10: F30);

4) anxiety disorders (ICD-10: F40-42), including phobias (ICD-10: F40) and obsessive-compulsive disorders (ICD-10: F42);

5) somatic symptom disorders (ICD-10: F45) of unknown aetiology (“somatoform disorders”)<sup>48</sup>, which are supposed to include any disorders with an unknown cause which cause loss of motor function, paralysis, blindness, severe pain (persistent somatoform pain disorder; ICD-10: 45.4);

6) dissociative disorders (ICD-10: F44), including amnesia (ICD-10: F44.0), fugue state (ICD-10: F44.1) or multiple personality disorder (ICD-10: F44.81).

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<sup>45</sup> More G. Wiktorowski, *W imieniu moim...*, p. 281–284.

<sup>46</sup> J. Wimber, K. Springer, *Power Healing...*, p. 112.

<sup>47</sup> For the purpose of maintaining order I added the equivalent from the International Classification of Diseases ICD-10. See World Health Organization, *The ICD-10 Classification of Mental and Behavioural Disorders: Diagnostic Criteria for Research*, Geneva 2003.

<sup>48</sup> Persons with these disorders feel like they have a somatic disorder even though there is no organic basis for this disorder.

To create the above list<sup>49</sup>, Wimber used works related to clinical psychiatry<sup>50</sup>. It is clear that he did not neglect academic science; however, he was selective about it and adapted its conclusions to a “space” strongly characterized by fideism, supernaturalism and dynamism.

John Wimber was a preacher, a pastor and a religious leader who clearly represented a fideistic position. However, in his model of healing and definition of disease he coupled etiopathogenetic factors well-recognized by academic science (organic, chemical, psychological, emotional) with unverifiable factors related to religion, such as demons or spiritual factors associated with sin. He therefore proposed a complementary, holistic model based on two principal theoretical foundations — scientific, insofar as it did not directly conflict with religious faith or literary exegesis of the Bible, and fideistic, which rooted its conceptualization of aetiology of diseases particularly in demonological and hamartiological aspects. The care which Wimber provided to his faithful patients was of a pastoral nature; he always tried to make them feel comfortable, safe and cared for<sup>51</sup>. This may have led to positive effects in patients who sought them, especially in cases of disorders of psychological and emotional nature. Wimber also proposed a cohesive vision of the world, wherein triumphalistic elements oriented towards success, hope and ultimate victory have been emphasized. This was integrally related to the American approach, which could be classified as dominionistic and which began to take shape particularly during the 1970s and 1980s, when the United States was a major world power with even greater perspectives (the pinnacle of this approach was seen during the 1990s). This amalgamation of religion, “medicine” and politics is quite visible in Wimber’s theology of the Kingdom of God, which is supposed to already be present here on Earth. Therefore the “powers and manifestations of the Kingdom”, referred to by Wimber specifically as “signs and wonders”, should be revealed not only within the sphere of the Christian’s inner experience, as was the case in many American Protestant movements (particularly Wesleyan-Holiness or Pentecostal-Charismatic), but also on a somatic (related to body,

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<sup>49</sup> J. Wimber, K. Springer, *Power Healing...*, p. 135.

<sup>50</sup> See J.C. Coleman, J.N. Butcher, R.C. Carson, *Abnormal Psychology and Modern Life*, 7th ed., Glenview 1984, p. 231; G.C. Davison, J.M. Neale, *Abnormal Psychology: An Experimental Clinical Approach*, 3rd ed., New York 1982, p. 70–72.

<sup>51</sup> J. Wimber, K. Springer, *Power Healing...*, p. 169–235.

health, well-being, orientation towards success) as well as political level; as for the latter, Christian Right began to implement it in practice during the 1980s<sup>52</sup>.

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<sup>52</sup> See more S.D. Johnson, J.B. Tamney, *The Christian Right and the 1984 Presidential Election*, "Review of Religious Research" 1985, v. XXVII, no. 2, p. 124–133; W. Martin, *With God on Our Side: The Rise of the Religious Right in America*, New York, N.Y. 1996; *The New Christian Right: Mobilization and Legitimation*, Ed. R.C. Liebman, R. Wuthnow, New York, N.Y. 1983; G. Wiktorowski, *Przewyciężyć „świat”. Elementy transgresyjne w amerykańskim protestantyzmie fundamentalistycznym*, [in:] *Perspektywy poznawcze w kulturze europejskiej. Studium porównawcze*, ed. B. Płonka-Syroka, E.I. Rudolf, (Orbis Exterior — Orbis Interior, v. V), Wrocław 2012, p. 105–155 [article in Polish: *Overcome the "World". Transgressive Elements in American Fundamentalist Protestantism*, in: *Epistemic Perspectives in European Culture. Comparative Study*, (Orbis Exterior — Orbis Interior, v. V).

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**REVIEWS**  
**AND BIBLIOGRAPHICAL NOTICES**



Zygfryd Rymaszewski, *Obrót prawny nieruchomościami w Krakowie i podkrakowskim Kazimierzu w średniowieczu*, Wydawnictwo Uniwersytetu Łódzkiego, Łódź 2020, ss. 351

The issue of real estate transactions in medieval cities located in Poland has long been waiting for exploration. The scientific community impatiently waited for the realisation of the promise of Professor Zygfryd Rymaszewski, who had already declared to take up this important research topic a few years ago.

The book is divided into four chapters. The author has provided it with an extensive “Introduction”, which perfectly introduces the reader to the complex matter of urban relations. It presents, inter alia, the authorities before which individual legal actions in the field of real estate trade were performed. It also shows the attitude of the authorities towards the transaction, especially the city’s desire to control the turnover.

The first chapter describes the parties of the contract (for example the monarch, city, church and clergy, nobility, brotherhoods, guilds and others) and their representatives. The second chapter shows the subject of trading and its great diversity. In the third chapter, entitled “Types of property transactions”, the author emphasizes that municipal real estate was often the subject of perpetual purchase and sale, and much less often donation, exchange or lease. They were also often the subject of security for claims. Additionally, chapter four describes the activities accompanying the activities performed.

The choice of topic should be considered as appropriate. This is because the monograph partially fills the research gap, covering the application of German law systems in Polish lands in the Middle Ages. Previous studies on this extensive subject have dealt only with certain narrow issues, such as the purchase of an annuity. However, there were no comprehensive works. The analysis of two cities: Kraków and Kazimierz near Kraków is also justified. Firstly, they had the

same legal system (Saxon-Magdeburg law), and otherwise they constituted an economic whole. Also, the chronological framework indicated by the sources, i.e. essentially the years 1300-1442, should be considered proper.

The author used numerous printed sources, in particular magistrate's books (*acta scabinalia*), the records of the Cracow city council (*acta consularia*), and additionally the books of the head of the Supreme Court of German Law at the Kraków Castle, diplomatic codes (*Codex diplomaticus*), Kraków urban statutes based on Magdeburg Law, collections of Saxon and Magdeburg law, records of judgements (ortyle, Urteile) of the Higher Court of German Law and works of old Polish lawyers.

At the same time, the writer notices gaps in the sources he invokes, and therefore approaches them with great caution. The problems in the research on court books are mainly due to the fact that they lack the texts of the contracts. It should be emphasized that the analysis of the researched sources was very difficult, laborious and required a huge amount of time. What is more, the author presents a new research field, which is the query of handwritten documents. However, their further analysis would require the appointment of a whole research team.

A huge merit of the work is a detailed description of the adopted research method, which can be considered an exemplary one. It can be treated as a type of textbook for learners taking their first steps in scientific work.

Undoubtedly, another benefit of the work is also the list of sources with abbreviations included. It makes it easier for the reader to follow complex issues. The author's annex, containing as many as 31 tables, is also very useful. Presenting them collectively in a separate annex was a good move, because it allows for quick data comparison. Providing the tables with a separate list also makes navigating the book easier.

The subject matter that Professor Zygfryd Rymaszewski took up has long been waiting for elaboration. The author shows that in Kraków and Kazimierz real estate was traded on a very large scale. The conclusions drawn are not general in nature, but are confirmed and supported by detailed, reliable data indicated in the tables.

Also interesting conclusions are drawn. First of all, contrary to what one might expect, there was no increased interference by the ruler in Krakow (the seat of the ruler's court). The ruler rarely participated in the trade, and in addition, he acted according to the norms of municipal law. Also, the large share

of women in property transactions may be thought provoking. In some of the years depicted, they accounted for more than half of the contractors. Interestingly, among them there were not only widows, but also married women as well.

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