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Christopher Peterson provides stimulating clues for the debate and analysis of physicians' metaphorical discourse and its efficacy (real or virtual) for engendering social relations, changing or maintaining ethical values in the profession itself, and creating or recreating classifications for patients and health care institutions. My comments will focus on the latter aspects.

The article, by an author-actor, stimulates the debate based on the complexity of the plot and the drama, affecting the identity and values of being-a-physician in the face of technical and social changes in medical work and practice, mediated in our society by the state.

As a profession, medicine contains a historicity and a context. As such, it cannot be analyzed outside of the conditions that engender it. Abbott (1988), among recent authors of sociological studies on the professions, contends that the key to professionalism is the fact that certain groups apply esoteric and abstract knowledge to particular cases, thereby controlling them, along with their qualifications. The medical profession is one that possesses abstract knowledge legitimizing its work. Professional medical work involves the diagnosis, theory, and therapeutics of the problem, in addition to the capacity to infer, i.e., to intervene in and recreate reality.

It is through medical societies (general or specific) and expert committees and based on ethical considerations that physicians seek to guarantee the profession's values vis-à-vis working conditions and relations both institutional and contractual, like fees, thereby preserving what they consider professional dignity. Thus, there are always conflicts and tensions between ethical values and interests, negotiations, and alliances amongst physicians as a group using its rights to guarantee the recognition and maintenance of its cognitive and corporatist structure. Professional medical relations move continuously with the structure of medical practice, with its conditioning factors, and with the maintenance or conquest of professionalism. The issue here is the dimension of the profession's jurisdiction, involving a complex cultural machinery, as suggested by Abbott.

'Medical slang' may be nothing but the tip of a very complex iceberg, circumscribed merely to word games from which [the author] extracts meanings ascribed to a group of medical specialists, or a selected set of situations. To go beyond the tip of the iceberg of word games and puns (both good – and ill – humored), and in order for them to gain greater ambiguity, diversity, and contradiction, the research needs to reach the context (both specific and general) that engenders, changes, or recreates the meanings over time. In this sense, observations by Hymes (1974) are pertinent in that he points to the limits of restricting research to linguistic forms taken as a code, or speech taken in and of itself.

Ruling out the autonomy of discursive enunciates although it is possible to perform a syntactic analysis of the words and enunciates Hymes recommends attention to context, to networks of social relations, in the investigation of communicative activities as a whole and their links and disjunctions, thus creating the possibility of penetrating the set of verbal interaction patterns, involving the uses of language, through which move the general and specific values and representations of the very existence and identity of professional social groups.

One cannot suppress verbal behaviors or analysis of the cultural system, functioning in turn as an intracommunicative structure along with other codes, allowing one to recognize or unveil the rules and structure of the very culture or subculture of specific groups (the medical profession, in this case), even when the culture may be unique in its diversity or diverse in the uniqueness of its various social and professional groups. An undertaking of this nature calls for greater involvement by the author in ethnographic research, based on knowledge of linguistic styles, in order for the result to encompass verbal behaviors and uses of language in a contextualized way.

It is thus difficult to wager only on the spontaneity of culture, although it harbors creativity, continuities, and breaks with prevailing standards. Social agents bear cultural models that are internalized, revealing themselves in their behaviors, gestures, silence, rituals, and daily work and in the verbal use of language (formal or informal). Simultaneously, as physicians, they are permeated by the historical and specific character of the social organization of medical practice and work and their jurisdictions and values, although they may be able to grasp them coming from other references and their own experience.

Thus, the analysis and search for enunciates calls for greater articulation with broader social, economic, technological, and cultural contexts and state intervention, providing both a framework of medical practice and the contexts specific to the profession itself, including the elements that articulate the identity of

physicians themselves, their jurisdictions. Such components include authority, competence, knowledge and skill, competition, and ethical values that are always articulated in an arena of conflicts, alliances, and negotiation. Institutions, as viewed by physicians, retain this set of elements, subject to opinions, evaluations, and plays on language, and within them the concrete work of doctors occurs.

Research on meaning is expanded by articulating enunciates from the different sources. These are also influenced by the different positions of social agents in the system of social relations and vis-à-vis the work market itself, in addition to gender, generation, and membership in various specialized societies and/or political parties.

Without understanding this set of elements, it would be hard to abstractly confer the exclusive power of resistance to or re-creation of language by the physicians interviewed. A reader of this article may feel the lack of a broader analysis of the multiplicity of meanings ascribed by physicians to health care institutions and which the paper limits to anesthetists, undifferentiated in terms of other attributes. With regard to other specialized medical fields, anesthetists may bear specific knowledge and skills, jurisdiction, corporatist behavior, and ethical orientation which may or may not be shared with the medical profession as a whole.

Other interviews included in the paper suggest the use of puns by members of one of the medical associations and referring to the expansion and penetration of private health insurance (domestic and transnational), serving to commodify health care and circumscribing the state's role in the provision of health services, thereby affecting some physicians' interests and identity. While medicine as business is nothing new, within a different historical context the interests and identity of physicians were also affected by attempts to make the state a more active participant in the provision of health services, with the result that it [the state] was reserved a greater share of hospital and outpatient medical care.

We are aware that the public and private configuration of health services has always involved state intervention in health policy and relations with corporatist interests, an analysis of which is beyond the scope of these comments. *Trambliclínicas*, *mulambulatórios*, and *pilantrópicos* may also involve values pertaining to the degree of incorporation of technologies in medical acts, possibilities for or limitations imposed on specialized work by practitioners, fragmentation of their work (increasingly shared with other health professionals), types of organizational control of medical practice, wage policies, business practices, and greater exploitation, involving higher profit margins, including the early exploitation of medical students as labor.

A greater diversity in the interviews might have allowed for less speculation as well as a meeting between the multiple meanings, relations, and conditions in the production of and contradictions and links within metaphorical discourse with other forms of verbal behavior by physicians in their relations with health care institutions.

Peterson's study opens up prospects for analyzing ethical and moral valuational dimensions in the medical profession, and quite appropriately he provides us with clues as to their possible links with the constitutive dimensions of medical practice. Yet he restricts the reader's ability to grasp the way by which doctors translate into verbal behaviors and practices the values, permanence, changes, structures, relations, and conflicts that constitute the medical profession and their conditioning factors according to representations by physicians, which should be the subject of reflection by the researcher.

Studies such as that of Donnangelo (1975) analyzing professional ideologies along with changes in medical practice and work vis-à-vis the market, and Campos (1988) focusing on the contents of discourses and strategies of medical associations vis-à-vis health policy, have shown the articulation between the profession's ethical orientation and defense of its corporatist interests. These may move, change, or institute themselves in terms of behaviors and representations according to how relations have been structured between the state and society, with the historicity of these relations in Brazilian society as reference. And certainly, although not all medical practitioners act as negotiators of professional interests vis-à-vis the state, they do not fail to reflect on such relations.

Steffen (1987) refers to the dialectic relations between public and private medicine in French health policy, observing an ideological impact in the confrontation between the two sectors. Thus, on the physicians' rhetorical plane, there is no relationship to the system's dualistic context. Two ideas or values are directed for or against the state. One emphasizes autonomous undertakings, guaranteeing individual freedom. The other sees the state as server and guarantor of public interests.

Without meaning to transport these ideas to the Brazilian situation, one notes that Peterson, like other researchers of the professions (Ma-

chado, 1997), does not deny the conflicts vis-à-vis the ideal of autonomy that physicians seek to preserve. What remains to be seen is whether, by defending autonomy together with or separately from the service ideal (at the valuational level), physicians continue to view the state and its service-providing institutions as servers of private or public interests, or both at the same time. And with regard to the private sector, it remains to be seen which segment of private health insurance continues to be rejected, as was in the past the segment linked to corporations rather than medical cooperatives, which are also undergoing changes today, along with what used to be philanthropic hospitals.

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The article by Christopher Peterson is highly stimulating. The author gradually introduces us to Carioca medical talk and invites us to reflect systematically on its meaning and constructive process. The analysis of slang and puns currently used by physicians in three specific areas (acquisition of knowledge, physician-patient relationship, and the health system) draws out a network of meanings linking scientific medical discourse, Hippocratic ethics, and medical practice in the current Brazilian context.

Associations, contradictions, and breaks characterize the author's coming and going between the text and the context evoked by it, and which, paradoxically, it helps to create. On the one hand, citizens' universal right to health care and the duties of a non-discriminatory medical practice, and on the other, the scarcity and poor distribution of resources for health, generating contradictions permeating the context of medical training and practice.

The invasion of medical practice by technology fosters the development of a private, entrepreneurial medicine. The dismantling of public health care services aggravates inequality and reinforces the subordination of health care professionals to health plans. Disparate access to health services, physicians' deprofessionalization, and transgression of professional ethics emerge in the gap established between theory and practice. Autonomy, duties, and responsibilities become the attributes of a model for ideal practice which is increasingly estranged from the model made possible in practice.

The question raised so often by medical students concerning the type of doctors they want, should, or can become vanishes in the context of learning the kind of medical practice that is possible in reality. To refuse such practice means to refuse reality, to exclude oneself from the learning process, from integration into health care services and the exercise of medicine. To accept it is to infringe on professional ethics, to lose one's rights, to compromise. Confronted with the contradictory demands of theory and practice governing the profession, the future physician not without conflict, of course must learn to strike a balance. Contradictions, tension, and discomfort accompany this learning process and subsequent medical practice. The confrontation between the ideal model dictated by the code of ethics and the possible model dictated by reality creates an impasse.

Metaphor, says the author, condenses the irreconcilable and fosters the creation of new meanings. Its use in the construction of a kind of anti-language widely used by physicians allows them to reveal the unsayable and express this impasse: challenge and irreverence establish rules and mark the impossibility of complying with them. The author asks about the implications of this linguistic register for medical ethics might it be the sign of an ethical metamorphosis? Equally relevant here is to ask about the implications of this register for medical practice might it reflect the standardization of a new practice we could call an anti-ethic?