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ARTICLE

Doctors Without Burdens: The Neocolonial Ambivalence of White Masculinity in International Medical Aid

Jenna N. Hanchey

Department of Communication Studies, University of Nevada, Reno, Nevada, USA

ABSTRACT

Drawing from rhetorical field research at a nongovernmental aid organization in rural Tanzania, this essay investigates the relationship between U.S. hegemonic masculinity and neocolonialism in international aid work. Based on an analysis of how two different groups of U.S. medical students relate to their Tanzanian translators and patients, I demonstrate that aid provides a forum whereby hegemonic white masculinity can escape domestic crisis through a neocolonial fantasy of paternalism and control. At the same time, aid can also provide opportunities to decolonize international relationships through destabilizing hegemonic masculinities. Ultimately, I argue that international medical mission trips display an ambivalent space, inextricably caught up in both the recentering of white masculine dominance and its destabilization.

KEYWORDS

Africa; international aid; masculinity; medicine; neocolonialism; rhetorical field methods

A miraculous arrival

The medical student volunteers arrived after dark. We had expected them to pull into the dirt lot of the Tanzanian village organization around lunchtime. As they stepped out of the car, grinning and high-fiving one another, the more vocal students fought to be the first to tell us their story. Interrupting and adding details to one another, they described how there had been a miscommunication on the flight time, which led to a problem in transportation, which delayed their departure to the village and forced them to place their luggage in their laps instead of in a separate vehicle.

The delay put the medical students' vehicle on the single dirt road out from town around the same time as the local transportation. So when a small bus headed out to the village flipped over on the road, the medical students and their two attending physicians were there within minutes to help the people injured in the accident, and they luckily happened to have all of their equipment and medicine on hand. As one of the students exclaimed about how "cool" it was to watch their trip leader, Dr. Greg, stitch up a wound, others declared that *this* was why they were here. The mood was exultant. The comment that "this was why they were here" struck me: Either they were here for miraculous occurrences to happen *to* them or they were here to *be the miracle*.

Although I was glad that injured people were able to receive immediate medical care, the narration of the event discomfited me. Two days later, I wrote in my field notes,

CONTACT Jenna N. Hanchey jhanchey@unr.edu Department of Communication Studies, University of Nevada, Reno, Mail Stop 0229, 1664 N. Virginia Avenue, Reno, NV 89557, USA.

"It might be partially because of this event that I started with a semi-negative image of the medical student group. I read them as being arrogant, hegemonically masculine, and insensitive to the people and culture around them." Their behavior during the remainder of their time at the nongovernmental organization (NGO) served only to strengthen this read. However, the medical students' performance of masculine heroism cannot be separated from its context, from the histories and cultural legacies bound up together when U.S. medical students come to a Tanzanian village to treat patients for a week.

In this essay, I investigate how white masculinity relates to neocolonialism by examining the ways in which two different groups of medical student volunteers at an NGO in Tanzania interacted with their Tanzanian translators, Tanzanian patients, and Western NGO staff. Drawing on research regarding white masculine victimhood and contemporary crises of masculinity (Johnson, 2017a, 2017b; Kelly, 2016, 2018; King, 2009), I argue that aid to the so-called third world provides a forum whereby hegemonic white masculinity can escape domestic crisis through a neocolonial fantasy of paternalism and control. Yet, at the same time, aid can also provide opportunities to decolonize international relationships through destabilizing hegemonic masculinities.

Rhetorical research on masculinity has typically focused on its representations in popular culture or news media to elucidate how hegemonic masculinity is performed, (re)constructed, supported, and challenged (Ashcraft & Flores, 2003; Duerringer, 2015; Harris & Hanchey, 2014; Johnson, 2017a, 2017b; Kelly, 2012, 2016, 2018; King, 2009; Rademacher & Kelly, 2016). However, most of this research has examined interactions between masculinities and femininities in the United States. International relations research, on the other hand, has focused almost exclusively on how militarized masculinities underwrite U.S. imperial government and military affairs (Carver 2014; Enloe, 2004; Eisenstein, 2007). With the exception of Enloe (2014), such research forgoes attention to civilian relations below the state level.

Bringing these foci together allows us to draw connections between hegemonic cultural constructions of masculinity in the United States, international neocolonial relations, and subjective gender performances. In this essay, I investigate what happens when U.S. masculinities are expressed in a different national and cultural context and how this simultaneously opens pathways for toxic white masculinity to recuperate fantasies of dominance and provides avenues to challenge both hegemonic expressions of masculinity and neocolonial relations.

Hegemonic masculinity: Domestic crisis and international opportunity

In medicine, as in other male-dominated U.S. professions, adherence to certain masculine norms is not explicitly taught but rather constituted as an expectation through rituals and cultural performances. Medical workers refer to this as the "hidden curriculum," which is "used to describe the behaviors, attitudes, assumptions, and beliefs of medicine that are instilled in medical students beginning in the first year of training and becoming more salient throughout residency" (Bandini et al., 2017, p. 57). The hidden curriculum is modeled to students through the cultural context and performances of medical instruction—including attitudes, behaviors, expectations, rewards, and

punishments—that become increasingly internalized as the students progress in their medical education. Even within initial undergraduate medical training, scholars have found that students

> move from being open-minded to being fact-surfeited, from being intellectually curious to being increasingly focused on just that set of knowledge and skills that must be acquired to pass examinations, from being open-hearted and empathetic to being emotionally well-defended, from idealistic to cynical about medicine, medical practice, and the life of medicine. (Inui, qtd. in Duhl Glicken & Merenstein, 2007, p. 54)

The hidden curriculum teaches medical students to value and perform a certain type of "white/collar" masculinity (Ashcraft & Flores, 2003, p. 2). In particular, this version of masculinity centers mastery and professionalism, efficiency and time-management, and objectivity and detached concern (Bandini et al., 2017; Underman & Hirshfield, 2016). Students report that, as they progress in their medical studies, their increasing professionalism is accompanied concomitantly by increasing impatience and declining empathy (Bandini et al., 2017).

However, these masculine medical values—as with all masculine values—are neither fixed nor imperative but are constantly evolving through processes of reiteration. In addition, these values signify a standard for masculinity that can never be met or fully achieved. Given the contemporary U.S. climate of white masculine victimhood (Johnson, 2017a, 2017b; Kelly, 2016, 2018; King, 2009, 2010), it may come as no surprise that hegemonic medical masculinity also is imbued with anxiety and finds itself in a state of crisis. I argue that how the particular crisis of white U.S. medical masculinity unfolds on international aid trips demonstrates an important aspect of hegemonic masculinity: its ability to recuperate itself through a neocolonial fantasy of dominance.

White masculinity in crisis

Hegemonic masculinity is conditioned by anxiety, as performances of mastery and control—such as those in medicine—are inextricably linked to anxiety and paranoia (McClintock, 1995). Anxieties are endemic to white masculinity, which must be constantly reconstituted in reaction to its context and is always rife with contradiction (Johnson, 2017b). Yet the performativity of white masculinity acts ambivalently, as both strength and weakness. At the same time that anxiety drives white masculinity "to open up, double itself, and transgress its own boundaries" to resecure hegemony (King, 2009, p. 367), the anxious compulsion to reenact white masculinity belies its claims to natural superiority (Johnson, 2017b).

In the contemporary U.S. context, a sense of crisis imbues anxious reiterations of white masculinity. Kelly (2016) describes crises in masculinity as "responses to the perceived loss of male privilege where, nonetheless, structural inequalities continue to disadvantage women" (p. 96). The current crisis is spurred not only by movements for women's rights but also by those for the rights of people of color, immigrants, and the LGBTQ community, resulting in a peculiar cry of white masculine victimhood. That is, threats to the dominance of white masculine hegemony are felt as threats to men themselves (Johnson, 2017a), even as they retain material privilege.

Medical masculinity has not escaped this contemporary moment. Underman and Hirshfield (2016) detail many of the changes in medicine that underlie the sense of crisis. For one, what was once a bastion of white male authority now has an increasingly diverse pool of students in terms of both gender and race. In addition, patients no longer unquestioningly accept doctoral judgments, instead relying on their own research to help diagnose and treat their conditions. The rising demand for patient-centered care poses a threat to efficient time management. Finally, expectations for empathetic relation to one's patients challenge the value of detached objectivity. Doctors feel as if their (masculine) authority is under threat. Underman and Hirshfield (2016) sum up the medical masculinity crisis well: "A physician can no longer expect that his (and we do use a male pronoun deliberately) expertise alone dictates patient care" (p. 96).

International aid's neocolonial fantasies

In the United States, responses to the contemporary crisis of white masculinity often involve claims of white male victimhood and fantasies of recuperating their lost—and fictive—whole, natural, masculine dominance (Johnson, 2007; Johnson, 2017a, 2017b; Kelly, 2018). Because the threat to male domination pervades everyday life in the United States, ameliorations of the crisis depend on spaces and times where there can be a plausible "return," however false, to masculine dominance. Media present these fantasies as opportunities for men to "make masculinity great again," as it were. Fantasies act to cover lack, or "an illusory sense that the male self, or subjectivity for that matter, was ever whole" (Kelly, 2018, p. 165), by providing "a narrative of possible wholeness" that subjects may internalize as their own (Hanchey, 2018a, p. 147). U.S. fantasies of white masculine wholeness depend on distance, whether in space or time, for the masculinity on offer to escape its contemporary fragmented state and seem complete. Whether returning to the past in an imagined future (Kelly, 2016) or leaving home for the mythical ground of the "Frontier" (Johnson, 2017b), masculine fantasies require distance from contemporary U.S. life.

In this essay, I argue that international medical mission trips provide this distance for medical students, allowing them to recuperate white masculinity through neocolonial fantasies of white saviorism. White savior fantasies posit that "the U.S. American volunteer can … find wholeness, be complete … in other countries, by saving other people" (Hanchey, 2018a, p. 147). White savior fantasies allow U.S. medical students to recover masculine mastery, efficiency, and detachment abroad by treating patients and engaging with support staff who presumably will not question their authority.

International medical mission trips enable masculine recovery through a double distancing: first, geographically, and second, because the so-called third world functions in the U.S. imaginary as developmentally backward in time. As the distance between medical missions and contemporary U.S. life draws one backward in time, it opens the possibility of reusing the "racial script" offered by the history of imperialism and its mediated portrayals as a means of engaging in a neocolonial context. Molina (2014) defines racial scripts as "the ways in which the lives of racial groups are linked across time and space and thereby affect one another, even when they do not directly cross paths" (p. 6). That is, "once attitudes, practices, customs, policies, and laws are directed

at one group, they are more readily available and hence easily applied to other groups" (p. 7). This is particularly true when the racial script has been codified in the U.S. imaginary through repetition in media (Hall, 2003).

Imperial masculinity offers a particularly useful racial script for white medical masculinity to utilize as neocolonial fantasy. For one, the relationship between masculinity and imperialism leads to a gendering of physical space. In European colonial invasions, land was often feminized and sexualized, figured as virginal and "spread" for the taking (McClintock, 1995, p. 23). At the same time, the virginal figuring could also double as an erasure of indigenous peoples by painting the land as empty and clean. In this way, the feminizing of space is part of what allows for violent acts of physical colonization and cultural imposition: The weakness, lack, or perceived nonexistence of the national Other requires the guidance of white Western man to initiate development.

Today, international mission trips redeploy neocolonial relations in the form of medical assistance to those figured as unable to help themselves. During the imperial period, a sense of adventure accompanied international travels, which "became synonymous with the demonstration of the moral, social and physical mastery of the colonisers over the colonised" (Hall, 2003, p. 91). Medical mission trips also recycle this sense of adventure as a neocolonial fantasy of mastery, albeit with less spectacularly violent outcomes.

Finally, imperial masculinity relies on a notion of masculine sovereignty, embodied in a "figure who has the power to transgress his own rules" (Gunn, 2008, p. 16). The sovereign power to operate above the law—ostensibly for the good of all or with a heroic sense of responsibility—is a type of masculinity that is reused in contemporary neocolonial contexts through the white savior industrial complex (Cole, 2012). In this complex, white Westerners create the global economic systems and policies that pull resources out of African countries and then declare themselves solely responsible for fixing such "underdeveloped" nations. U.S. fantasies of sovereign masculinity are thus notably raced and become neocolonial in international aid relations by declaring sovereign control over third-world peoples, lands, and cultures.

Doing aid otherwise

Though international medical mission trips provide an opportunity for white masculinity to remake itself through fantasy, they do not necessitate such performances. Crises in masculinity reveal the fragility of masculine hegemony. Butler (1997) claims that "the nonspace of cultural collision" (p. 383) opens the potential for reworking gendered performances and expectations. Masculinity—and aid—can always be otherwise. In this essay, I attend to the ways in which the cultural complexities of international experiences provide a space where white medical masculinity may be either recentered through neocolonial fantasies or challenged by relations with difference.

Therefore, the crisis of white medical masculinity may yet also open opportunities for destabilizing the neocolonial relations that recognize Tanzanian community members only as "passive recipients" of health interventions who are "primitive and devoid of agency" (Dutta, 2012, p. 368) and move instead toward culture-centered approaches to health that are based on dialogic relations (Dutta & Basu, 2008). Neocolonial white masculinity, in its sovereignty, rests on a notion of the subject as an autonomous

individual. When this perspective is altered and the subject is seen as radically dependent on the systems and subjects around her for her being, a type of responsibility to the Other opens up that is very different than the paternalism of sovereignty (Davis, 2010). The type of responsibility necessitated by relationality is one that no subject can ever fully meet. Subjects are thus radically indebted to those around them, predicated on the intimately political act of belonging to and with others (Carrillo Rowe, 2008). When Westerners recognize their subjective indebtedness to cultural and/or racial others, potential arises for political transformation. The same crisis in masculinity that may act to restabilize masculine hegemony through neocolonial fantasies may also allow for a greater attunement to others.

In what follows, I trace how international aid trips may function as either/both an opportunity to recuperate white masculine dominance through neocolonial fantasies or/and a space where white masculine hegemony may be contested. I do so by analyzing the differences between the experiences and interactions of two groups of medical student volunteers at a small NGO in Tanzania. The first group demonstrated how the distance between the medical mission field in Tanzania and the U.S. cultural space of masculine crisis allowed the medical students to resecure a fantasy of a white masculine dominance through interactions and attitudes of sovereignty, control, and denial of fragility. The second group, on the other hand, showed how the liminal "frontier" space of international medical missions can also disturb taken-for-granted power dynamics through enactments and behaviors of relationality, uncertainty, and care. Ultimately, I argue that international medical mission trips display an ambivalent space, inextricably caught up in both the recentering of white masculine dominance and its destabilization.

Rhetorical field research at Children's Village

The interactions, interviews, and conversations that form the basis for this essay occurred during summer 2015, when I spent two months living and working at an internationally funded NGO located in a rural Tanzanian area. Children's Village is managed by an American-Canadian couple, Sarah and Tim,[1] and the organization's staff is almost entirely Tanzanian, with the exception of a few long-term volunteers. The mission of Children's Village spans a number of community-based projects, including provision for village children whose guardians cannot care for them, educational outreach, community support-network building, and health care.

In spring 2014, medical students at a public U.S. university were told that they needed to find a new site for their groups' annual summer medical mission trip. A friend of some of the students put the two groups in contact with Sarah and Tim. In summer 2014, the first group of medical student volunteers held clinics at and around Children's Village. They enjoyed the experience so much that they promised to come back the following year, in addition to the annual new team. As a researcher in summer 2015, I was able to interact with both the returning group of now second-year medical students and the new team of first-year medical students as they worked with translators to run clinics for a week each.

The first medical group comprised the second-year students, who swept in on a heroic high of having saved a vehicle full of lives and carried that attitude through the

week with them. Two men led this group: Dr. Greg, considered an expert in medical mission trips, and a student named Hunter. The remainder of the group included five men and two women medical students, as well as two women nurses and a supporting woman doctor, Dr. Baker. Baker would then be the leading doctor for the second group. All of the participants were white, except for one Indian-American man. Most of the members of this group had come to the NGO the previous year and were further along in their medical studies than the second group. The group's two years of exposure to the hidden curriculum, along with the fact that most of the students had just taken the first part of their Medical Board exam and were awaiting their results, provided a context whereby the crisis in medical masculinity was deeply felt and conditioned their experience at Children's Village. The group's previous experience at the NGO may also have contributed to how the group recentered medical masculinity through neocolonial fantasies; because they had been there before they did not participate in any cultural awareness training or reflection over cultural dynamics. The evening debriefing sessions, which often started late as the medical students worked until dark in the village clinics, focused entirely on the medical cases they had seen that day. The Tanzanian translators did not attend because they had already worked overtime and needed to get home to their families.

The second medical student group differed from the first in significant ways. This group had just completed its first year of medical school and was not as assimilated into the expectations of medicine's masculine hidden curriculum. For many people in the group, this was their first volunteer trip abroad. Everyone in the group was white. The leaders were two women doctors, and the medical students were mostly women. Significantly, because the leader of this group, Dr. Baker, arrived with the second-year students and stayed for three weeks in between the two medical trips, the context of the second group was altered in many ways. First, Dr. Baker and I held a debriefing meeting with the Tanzanian translators and incorporated many of their concerns and suggestions into the planning for the second group. In addition, we wrote a short handbook of Tanzanian culture, the NGO context, and Swahili keywords and sent it to the medical students before their arrival. The evening debriefing sessions with this group were open to any questions or reflections the students had about the day, including medical case questions, cultural inquiries, and explanations of feelings. The students ended work in the village on time each day so that the Tanzanian translators could attend the meetings as well.

I collected and analyzed interactions, interviews, and conversations with these two medical groups using rhetorical field methods. Middleton, Senda-Cook, and Endres (2011) define rhetorical field methods as referring to "both the rhetorical intervention into rhetorical spaces and action in which we engage when we describe and interpret insights gained through in situ rhetorical study … and to [a] focus on the processual forms of rhetorical action that are accessible only through participatory methods" (p. 387). For Middleton et al., rhetorical field methods are explicitly emancipatory in aim, working to change social structures and conditions in such a way that requires the participation of the researcher in the social realms being studied.

I draw my understanding of fieldwork from this rather than other theorizations (e.g., McKinnon, Asen, Chávez, & Howard, 2016) because my interest as a field researcher

lies in attending to—and even impacting—the political processes in and through which rhetoric is constituted. As an embodied participant in the research space, the rhetorical critic can "experience rhetorical action as it unfolds and … gather insights on how rhetoric is experienced by rhetors, audiences, and critics" (Middleton et al., 2011, p. 390), thus witnessing the political process of rhetorical construction. Yet in this understanding of field methods, the researcher is not only a witness to rhetorical construction but also a participant in it. This allows the rhetorical field researcher to act as an agent of change both within and without the lived space of the research. That is, the rhetorical critic has the opportunity both to work together with the participants of the study to question and destabilize power relations in the moment and to later write in a way that attempts to achieve similar goals within the context of research method and theory. I utilize both aspects of rhetorical field research by attempting to help the medical workers engage in decolonial relations with their translators in the field and providing a critique in writing that destabilizes hegemonic neocolonial masculinity.

Although rhetorical field methods aim for emancipatory interventions into rhetorical construction, theory, and argument, this approach does not necessarily achieve these goals. In fact, thinking that the rhetorical field researcher can unequivocally know what is required for emancipation and bring it to bear is a fantasy of mastery and certainty in much the same way as medical masculinity. My participation, though aimed toward challenging whiteness, masculinity, and neocolonialism, is nonetheless riddled with silences and gaps, suggestions unvoiced and unheeded, and interventions that miss their mark. I reflect further on this in the conclusion.

For this essay, I analyzed field notes, interviews, and conversations. The interviews included four with individual medical volunteers and four with individual translators. The conversations then include multiple group debriefings with each full medical student team, casual conversations with smaller groups of medical volunteers, and a formal meeting with the translators between the departure of the first group and the arrival of the second. Some of the interviews and conversations are in Swahili. I first transcribed these conversations in Swahili and later translated them. All told, I collected 240 single-spaced pages of transcripts and field notes regarding the two medical student groups, their translators, and my interactions with all of them. In the following section, I weave these texts together to demonstrate how international aid offers both the opportunity to resecure masculinity through neocolonial relationships and the ability to challenge masculine dominance by embracing subjective instability.

Masculinity and neocolonialism: Two cases of medical volunteers

In the two cases that follow, I explore the contextual dynamics, attitudes, behaviors, and values that the two different groups of medical students displayed through their interactions with Tanzanian translators, Tanzanian patients, and NGO staff. The first case demonstrates how the medical students were able to restabilize a fantasy of masculine dominance through neocolonial relationships and interactions of sovereignty, control, and denial of fragility. The second case, on the other hand, highlights the potential for subjective fragmentation to challenge neocolonial masculinity through relationality, uncertainty, and care.

Recuperating white masculinity through neocolonial fantasies of sovereignty, control, and denial of fragility

The first medical team primarily acted to secure neocolonial fantasies of masculine dominance. In this section, I analyze how their conduct showcased three particular aspects of masculinity—sovereignty, control, and fragility—and explain how these became forces of neocolonial relation in this particular context.

Sovereignty

At 8 a.m. on Sunday mornings, the sun is just beginning to crest the hills to the east of Children's Village. Sarah was brewing coffee while breathing deeply of the chilly June air and enjoying the quiet. Living on the NGO grounds, Sarah often had people come to her home for work requests at odd hours. Sundays offered a much-needed chance to relax. A knock at the door shattered her reverie. Dr. Greg and four medical student men had decided that they did not want to do the activity planned for the group that morning—going to church with their translators—and had come to ask Sarah to arrange a fishing outing for them, right then.

As described, masculine sovereignty functions as above or outside the laws that constrain other people (Gunn, 2008). Dr. Greg and his compatriots not only saw themselves as able to shirk the plans that had been made by the NGO for them that morning but also deemed themselves and their leisure activity important enough that those around them should forgo relaxation to provide last-minute arrangements for them. I use this event as an exemplar for attitudes, comments, and interactions displayed by the group throughout the week, but there are myriad other examples. For instance, the students often complained that their transportation did not take them directly to the clinics where they were working each day but stopped along the way to pick up Tanzanian patients who could not walk or pay for transportation themselves. Although it is common in Tanzania for transportation to never be fully private and ridesharing is expected, the medical students seemed to regard this as demeaning and grumbled about being "a shuttle service."

The masculine sovereignty embedded in this assumption that the medical group is or should be the main priority revealed itself in two particularly salient types of interaction with other people: either a paternalistic responsibility for others who ostensibly need saving or a dismissive treatment of others and their work as less important or even unimportant. A sense of responsibility toward Tanzanian others was continuously emphasized through declarations about the group's purpose. The medical volunteers were constantly repeating comments such as "I mean, that's why we're here—to give back and to help people" and "I'm here to treat more than to build relationships, really." Their words were accompanied by actions such as working through lunch and past sunset to see as many patients as possible and skipping over greetings in patient interactions to move quickly through diagnoses. Their intense focus on a perceived responsibility to treat patients may seem laudable, but it functioned as a neocolonial paternalism and excluded any other foci as interruptions to their work.

The most palpable example of this phenomenon is the way this group handled translator assignments. Rather than providing each individual medical worker with his or

her own translator to work with throughout the week, translators were constantly picked up and discarded for one task or another; they were related to as tools that enabled the medical students to do their work rather than as subjective partners who actively assisted in the work being done. The Tanzanians struggled with the constant change of partners. One translator named Denis described how being traded between medical students (called doctors here) was difficult:

> Because—like I met with the doctor the first day. And I need to study what he likes and what he doesn't like. So I know that this is my doctor. And we know each other, so it will be easy for me to process with this doctor. But when the time comes to change, to go to the new doctor, you're—you need to study, to start again studying each other. So that is … a challenge.

Other translators, such as Happy and Idda, explained that they had trouble understanding people who were talking too fast at first, but if they were able to get used to the style of a single speaker they could better understand what he or she was saying at a fast pace. Innocent and Damas added that spending time with one medical student was important not only to fully understand him or her but also to know how to communicate back with that individual, as certain medical students prized brevity in answers and others desired as much detailed explanation as possible.

The medical students did not notice the burden placed on the translators by the shifting assignments. Translators were sometimes detained by lunch, breaks, or patient requests for a translator of a particular gender. Because the medical students' attention was consumed by the primary goal of seeing as many patients as possible, they considered these delays a waste of time and would simply grab the nearest translator to continue their work. Some even saw the interchangeability of translators as fun, allowing them to meet new people. In this manner, the masculine imperative of time management and efficiency was reinscribed through neocolonial relationships with the Tanzanian translators that treated them like interchangeable objects.

Control

Illustrating the imperative to maintain control that is central to masculine neocolonial sovereignty, the medical workers continually demonstrated their mastery in the clinic. They performed their roles in the clinic as figures of paternalistic responsibility, acting outside of the law to save and protect others (Gunn, 2008). Of course, having control over situations and people is an unstable fiction that must be constantly bolstered. In this case, medical students' efforts to maintain control often involved disavowing Tanzanian skill or agency.

Walking into the community hall on the day of the first clinic, I noticed that the first few rows of chairs were already filled with patients; by noon, the room would hold hundreds of people from miles around. The first task when met with a large number of patients to be seen in a relatively short period of time is to triage so that they can be seen and diagnosed more quickly. On the first day of clinic, the medical workers had not started triaging immediately; they did not realize they needed to until

midday. Later that evening, in the debriefing, one of the nurses described why she started triage:

> Well, it's like, I know one thing is you've got to spell out, like, names, and I'm like, oh my gosh! I can't imagine! That takes like five minutes for somebody to just—for the translator to give you every letter of their name. I have no clue how to spell their names or even what they're saying.

Although the medical students all lauded her work and the time that she saved them, I wondered why no one thought to simply hand the notebook to a translator and let him or her write the names. Looking back, I cannot remember if I spoke up in the meeting or not. Many times I did not make suggestions to this group because they did not seem to take me seriously.

For example, later in the meeting, the doctors were planning how to communicate with one another when the team split into four groups the following day to do clinics and home visits in two different village areas. They were concerned that they only had two phones and were discussing how they could get access to a third. I interrupted and asked if they had considered that the translators also had phones. The idea that the translators could also call or text one another had not occurred to them. After nodding to acknowledge my comment, they continued their discussion as if I had not spoken at all.

In both of these examples, the medical workers had a need to maintain control of operations even when the Tanzanian translators would have been better able to perform the tasks at hand. In part, this need is connected to the sovereign aspect of masculinity and its centering of the white U.S. individual at the expense of Tanzanian knowledge; that the translators could possibly have something to offer to their work, other than the singular act of translation, threatens the masculine mastery of the medical students. The neocolonial fantasy of white masculinity requires holding control and not ceding it to cultural or racial others.

To the translators, this registered as a feeling that they were not really considered part of the team, leading to frustration at not being allowed to help to the fullest extent. Happy made this view explicit. When waiting for the transportation to arrive in the mornings and while traveling to the clinics, Happy was frustrated that the medical workers did not talk with the translators. She said, "Sometimes I feel a little angry, thinking why are they speaking just to each other when we're here as a team!" She went on to narrate that the U.S. medical workers would load the bags of supplies into the cars themselves when preparing to leave for the clinic without asking the Tanzanian translators for help. She was upset because she felt that if they were really working as a team, the medical students should include the translators in this task.

After loading supplies, the medical workers and Tanzanian translators would drive out to a different village area and hold a clinic. The U.S. students were given sack lunches with peanut butter and jelly sandwiches, hard-boiled eggs, carrots, and cookies. The translators, not caring for such Western food, were given money to find a café in the village area. This required driving ten or so minutes up the road at lunchtime, ordering the food, waiting while it was prepared, eating, and returning. The translators were often gone for an hour. They were unprepared for the animosity it bred with the medical students. As one student put it, "The Tanzanians were kind of dicking around

and stuff, and I would be a little frustrated." However, the translators did not value efficiency in the same way as the medical students. As Happy put it, "Us Tanzanians, we don't know time! … We don't know! We eat, we sit awhile, we rest, but our friends [the medical workers] go by time." The inability to control Tanzanian translators' timeliness frustrated the medical students because it highlighted the instability of neocolonial sovereignty.

Denial of fragility

Masculinity requires maintenance to stay in place, meaning it is fragile and imminently susceptible to failure (Butler, 1997). To maintain the fiction of masculine dominance, such fragility cannot be recognized or admitted. The medical students' behavior illustrates how the performance of hegemonic masculinity involves the refusal to admit to limitations and failure. The students displayed discomfort when they could not control the situation or when their sovereignty was threatened. When this happened, they attempted to deny the fragility of their masculinity. For example, the medical students sometimes refused to admit that they could not save patients from their illnesses. One evening during the debriefing session, a student described "an interesting case" of testicular cancer he had seen that day. The untreated tumor had progressed far enough that one testicle was the size of a softball. He said, "It was kind of sad to see it" as there was "just kind of nothing that we could do about it." The conversation centered on the disease as a case one might find in a textbook, abstracted to the point where the Tanzanian man whose life and body were being spoken of faded into the background—almost literally, as the student zoomed in on the man's testicles in a picture on his phone, cutting the man's face from view.

Sarah interjected and asked the student directly, "Did you tell him that he has cancer?" He responded:

> I told him that we thought he had a tumor and that we are planning on bringing a surgeon back next year, and that we would like to take a picture so we can show the surgeon so that when we come back next year we could hopefully take care of it.

He quietly added, "He won't make it a year." Even though the student knew that the patient could not last a year, he denied the fragility of his masculine power to save by extending it into the (fictive) future: It *will* happen, next year. At the same time, the medical student paternalistically made a decision on behalf of this Tanzanian man about what knowledge he should or should not have about his own body. By not telling the man that he had cancer, the medical student presumed that the Tanzanian man would not be equipped to handle his diagnosis and thus should be protected from it.

This example is one case of many over the week where the medical students were afraid or unwilling to tell patients that they had untreatable diseases. They voiced concern to a U.S. college student volunteer that the Tanzanian patients would be angry or might blame the medical workers for their conditions, concluding it was better not to tell them. Neocolonial paternalism underlies these attitudes; withholding information from Tanzanians about their own bodies necessitates an assumption of cultural superiority to make those decisions on their behalf.

On the final evening of their stay, the medical workers, Sarah and Tim, and the other U.S. volunteers currently staying at the NGO put on our fanciest Tanzanian clothing and rode up the hill to the nearby expatriate retreat lodge for drinks and dinner. After dining, we gathered by the fireplace so the medical students could discuss which patients would be receiving referrals for advanced treatment in a city hospital or, in dire cases, transport to the capital of Dar es Salaam. The medical students had worked throughout the school year raising funds to distribute, but there were not enough for everyone who needed help. Decisions would have to be made. To the chagrin of the medical students, some patients who had been given money for treatment the previous year needed referrals again. They learned that many patients had arrived at hospitals only to be turned away; others discovered the requisite surgeon had moved; and more had been unable to leave their families for so long a time. The medical students were deflated; ostensibly, they had failed to fully enact their roles as white saviors the year before. Yet tonight, the air was again jovial. They had more money to give and another chance to leave with a clean slate—returning to the United States under the illusion that this time their masculinity was final and secure; this time the patients would be saved. By placing their masculine security in a future to come, they not only denied its fragility but also reinforced a perpetual neocolonial cycle of Tanzanian dependence on Western medical aid.

Divesting from White masculinity to embrace subjective relationality, uncertainty, and care

Diverging from the behavior of the first group, the second group of medical students related with the Tanzanian translators and patients in ways that divested from the neocolonial fantasies of securing masculine dominance. Through performances of relationality, uncertainty, and care, these medical volunteers created space to do medical care otherwise.

Relationality: Challenging sovereignty

Dr. Baker stayed for two weeks in Children's Village when the first group left and remained to lead the second group of students when they arrived. On the evening after the first day of clinic, she facilitated a debriefing session including all of the medical students and translators, Sarah and Tim, Mustafa (the NGO's chief medical officer), and myself. Rather than asking what "interesting cases" the medical workers had seen that day, Dr. Baker asked, quite simply, "Does anyone have something they want to share?" Although some students asked medical questions, many of the students shared their feelings, celebrated their translators' hard work, and asked Mustafa about cultural issues. These responses portrayed the day's work as a partnership utilizing the skills of the medical students, translators, and NGO staff.

Kelly, the first medical student to speak, explained that she was surprised by "how uncomfortable [she] could be while helping at the same time." She performed her first vaginal exam on a patient that morning and described the connection she experienced with her patient: "But I also—the same lady—got to talk to about getting HIV testing.

And I feel like after that, like, intimate moment we *shared* something. So we were in a weird way bonded, and we had a long talk." Kelly concluded, "It was terrifying and wonderful at the same time." Whereas the first medical group regarded time speaking with patients as wasteful or distracting from "real" work, Kelly provided a relational perspective on medical work. By seeing the intimacy of connection as "terrifying and wonderful," Kelly located herself in the thick of relational complexity.

In a second reflection time later in the week, another medical student echoed this approach. Carrie, detailing her challenge of the day, explained, "I had this lady who had HIV, and there wasn't really much wrong with her, but she was just very sad at the test. And she just wanted to sit there and talk to me." Carrie took the time to talk with the patient even though there was nothing she could do because she recognized that medical work is more than attention to physical ailments.

The medical group wove this assumption throughout their experiences, treating language and cultural concerns as an important part of the work being done and thereby relying heavily on the translators for advice and assistance. In the following exchange at the first debriefing, the medical students professed their dependence on the translators and Mustafa to provide ethical and quality care to patients:

> Dr. Baker: Was everyone okay with the level of independence we gave you today? Was it surprising? Was it scary?
>
> Samantha: I was surprised by it. Um, I thought that … it was a lot more independence than that—than we would have. […]
>
> Dr. Lewis: Do you wish you had more supervision during it? Did you feel uncomfortable with it?
>
> Samantha: Um, no. I felt good about it. Because I felt like I had kind of a built-in supervisor in my translator. You know? Like, somebody's there to help. […]
>
> Kelly: I was really worried that like our inexperience would give like lower-level care. But it ended up being like our input, and you guys' input, and the translators, sometimes Dr. Mustafa. I felt like we were working more together and had more ideas than most patients would ever get. Like having different perspectives on the problem.

This group addressed the translators as their partners in providing quality care. Having the input of the translators enabled the students to feel more confident that they were treating patients ethically: No saving could be done without their Tanzanian counterparts.

Uncertainty: Losing control

By embracing a relational perspective on medical care, the second medical group was also more willing to relinquish some control over their circumstances. Facing uncertainty head-on allowed the second medical group to create more equitable partnerships with their Tanzanian translators. As a result, the team was able to triage much more quickly and efficiently. The U.S. students immediately realized that they were hopeless at writing unfamiliar Tanzanian names, so Francis was assigned triage duty. He handled it with aplomb—instructing patients where to sit, letting them know when they would

be seen, and taking down their introductory information. That evening in the debriefing, Musa congratulated his fellow translator on a job well done:

> Francis was very good today at like the management of patients … . Last time we met this challenge that in the reception part, people would come, then they [the medical workers] would use … Western writing style. *Long* time there. And, you know, arranging everybody … I have to give my big ups to Mr. Francis for always doing it!

Everyone seconded Musa's praise, and many clapped Francis on the back. The medical students were not only unperturbed to have a Tanzanian doing a job other than direct translation, they were thankful for the help and appreciative of his skill.

The group was also willing to admit that they were uncertain about some of the medical issues that their patients faced. The students often met with situations that they found frustrating or even inconceivable under a Western frame; however, they were open to listening to other interpretations. During one debriefing session the students were asked to present a highlight, challenge, and learning moment from the day. David related that his challenge was dealing with HIV-positive patients who did not have proper medical record information with them. "They just didn't seem to care!" he interpreted.

Dr. Baker reframed the situation by noting the large divide between HIV care and regular medical care in Tanzania: "They don't connect that those two things are put together because they're treated totally differently by the health care system."

I offered a third interpretation, mentioning that oftentimes the machine testing the progression of the disease is out of order at the local treatment center and that their shipments of medicine do not always arrive. "It might be that they're lackadaisical because sometimes their medicine just doesn't come in when it's supposed to."

David sat thoughtfully for a moment before deciding that his "learning moment" of the day was this very exchange, as it made him face that he was "not really thinking about the extenuating circumstances for all the people." As the exchanges with David illustrate, this second group of medical students allowed for their own uncertainty and recognized that they could be wrong. Their willingness to embrace the realization that they may not be able to fully understand their patients broke from neocolonial masculine logics that assume U.S. dominance over Tanzanian culture.

Care: Embracing fragility

The second group of medical students demonstrated an ethic of care in engaging with their Tanzanian patients. This group took care to investigate how their work fit into complex circumstances. To be attentive to the feelings and perspectives of their patients, the second group had a number of discussions about how to avoid dismissing patients too quickly because their symptoms look—on the surface—like things the medical student knew to be common problems in the area.

On the first day debriefing, Dr. Lewis challenged the medical students, saying: "You're going to see a lot of swelling, the arthritis, but don't … say, 'Oh, another leg pain!' And say 'Motrin.' Take a look at the toenail, and say, 'Oh, we can remove the toenail. It's not just leg pain.'" Dr. Lewis wanted to make sure that the medical students put patient care in front of expediency or efficiency. When dealing with more than 100

patients in a day, medical workers can easily resort to a quantity-over-quality means of valuing their work. Instead, this group labored under the assumption that even though they might not be able to see all the patients, the Tanzanians who came to the clinic deserved the best care they could give.

The second medical group also treated their struggle to understand their patients' health concerns as an ethical dilemma, something to be carefully worked out with their patients. David described his approach to patients as "treading lightly" and making sure to ask "Is it okay if I do this?" before attempting any tests or procedures. His surprise that the patients were continually obliging did not alter his approach: He continued to treat each one with care. David saw his solicitous approach as mitigating the possibility that he might be giving them substandard treatment.

Amy, on the other hand, found that the question of whether the treatment given was ethical could not be decisively settled. She reflected:

> I feel like everyone [in the group] has this … idea of "I want to help people." But at the same time, like, I probably think this experience is more valuable for us—our learning and development, more than we're actually helping people. But … it's a conflicting—moral conundrum. Whether what we're doing is actually helpful or [not].

Amy never came to a conclusion. She allowed herself to be uncomfortable with the service she provided in the village. Later, during an interview, she added, "I think this is a good thing to experience now, as like an eye-opening experience, and then like, with more knowledge and more ability, like I think it would be better to come back in a few years, once that is there."

As Amy's comment indicates, the second medical group did not consider their interactions with the Tanzanian villagers as isolated interactions during a particular week. Thinking relationally, they recognized that the relationships they formed would continue to have reverberating effects. This perspective allowed Amy to think beyond her immediate trip and to recognize that the ethicality of her work hinges on a future return when she can give back from the wealth of cultural learning gained in this initial experience.

The ambivalence of medical mission trips

The preceding analysis illustrates how two groups of medical aid workers hailing from the same U.S. university demonstrated vastly different ways of conceptualizing medical aid work and interacting with Tanzanian counterparts and patients. For the first group, more heavily conditioned by the hidden curriculum of medical expectations of masculine authority, the international aid trip presented an opportunity to recapture a fictive past where white medical masculinity could be whole and unchallenged. This group recentered white masculine dominance through neocolonial relations to their translators and patients. For the second group, only recently introduced to both medical school and international experience, the medical mission trip offered a means to better understand their interrelatedness with and dependence on others. However, even though I have presented these two international responses to the contemporary crisis in U.S. white masculinity as distinct, they cannot ever be fully disentangled. For white masculinity can never secure "permanent answers to the recurring crisis of the male self"

(Kelly, 2016, p. 110), much as it tries, and thus there can be no masculine subjectivity that is fully sovereign or individual—even the most overt masculinity is reliant upon the Otherness it ostensibly seeks to eject (King, 2009).

For example, there were moments in the first group's visit that balked masculine standards and expectations. Consider Ken, who I earlier quoted as saying, "I'm here to treat more than to build relationships, really." Later, during an interview, he admitted, "Like I said, I came here not really with the intention of building relationships, but it just kind of is what happens over time, and I guess maybe I should have been trying harder from day one to do that." As he continued talking about the relationships he had been building with the translators, he expressed frustration with how he had seen them "dicking around" and returned to the premise that he was here "to work one hundred percent of the time, like, as much as possible." Ken's attempt to consider a relational perspective toward his work was commandeered by the masculine imperative toward efficiency and expediency, curtailed before it could have much impact.

Abed also illustrates how the first group's behavior was not monolithic. In his side project, he partnered with NGO workers to train them how to treat a particular disease endemic to the area. Abed's project was dependent on the NGO workers' ability to implement the treatment plans once the medical group had left. He was the only volunteer in the first group who consistently represented his work as a partnership with Tanzanians. Describing how the partnerships came together, he exclaimed, "It's so many cogs in the wheel coming together to form something incredible!" Abed suggested that he had a different perspective than the rest of the group because his project allowed him to relate to the translators and staff in a more intimate way than those students who saw only patients in clinic. Abed and Ken demonstrate that there is a latent ambivalence in medical mission trips. The response of medical workers to the contemporary crisis of U.S. white masculinity functions as an entangled both/and; neither groups nor individuals can perform medical masculinity perfectly, no matter their neocolonial fantasies, but they also cannot completely disentangle from it either.

The second group also demonstrated ambivalence in their more relational approach to providing medical care. They still expressed impulses to think of the Tanzanian patients as remarkably ignorant or even nonsensical. The neocolonial paternalism built into U.S. American identity over the course of centuries cannot be easily overcome and neither can medical imperatives of masculine mastery and control. What makes the second group notable is that even when the medical students began to center masculine dominance or neocolonial views, they were still open to alternative interpretations and reframings of their experiences.

International aid practitioners can learn from the relational ethic of the second group, which demonstrates the anticolonial tactic Spivak (1990) calls "un-learning our privilege as our loss" (p. 9). The recuperation of masculine privilege should be seen as a loss for the first group, cutting off opportunities for cultural learning and partnership through neocolonial relations of sovereignty and control. The second group recognized the loss inherent in privilege and attempted to abdicate masculine privilege in favor of Tanzanian agency. Carrillo Rowe (2008) tells us that "deep connections across lines of difference are a transformative source" (p. 4). In this case, relations that connect

Western medical volunteers and Tanzanian patients and translators through a sense of subjective dependence on and belonging to and with each other hold the potential to transform the power relations underlying medical aid.

For rhetorical scholars, this study helps us see how mediated masculine ideologies affect lived experience. For the men—and women—conditioned under the auspices of medical masculinity, this medical mission trip provided an opportunity to act on a fantasy of neocolonial and masculine dominance to the detriment, in many ways, of the Tanzanians with whom they worked. As the domestic crisis of white masculinity continues, rhetoricians should pay particular attention to the attempts to ameliorate white masculine victimhood through neocolonial or colonial fantasies, not all of which will be as nonviolent as the medical masculine imperative to save.

Facing the ambivalence of our own frontiers

Rhetoric today faces a very similar crisis to that of white masculinity in medicine. As a predominantly U.S.-centered field, we cannot help but feel the reverberations of contemporary cultural conditions in our work as well. The racial and colonial bases of our theory and publishing are ever-increasing sites of struggle within rhetoric (Chakravartty, Kuo, Grubbs, & McIlwain, 2018; Flores, 2016; Hanchey, 2018b; Wanzer-Serrano, 2015), challenging the white masculine hegemony that has marked our field for centuries. I do not think it a coincidence that rhetorical field methods have risen in popularity during the crisis of white colonial masculinity in rhetorical studies. Rhetorical field methods offer a space that seems *distant* from that of traditional rhetorical study—that far-off place called "the field." Though it may in actuality be no farther than one's backyard, the concept of the field provides the same distance to rhetorical masculinity that international aid does to medical masculinity—enough that rhetorical field methods could be used as a way to resecure white colonial masculinity in rhetoric. Although rhetorical field methods arise out of a desire to participate in social change aimed at emancipation, they tempt a scholarly persona of mastery—someone who knows what that change should look like and exactly what must be done to get there—and if not objectivity, then a clean cut between right and wrong that allows for certain judgment.

Rhetorical field methods may be seen as an ambivalent response to the crisis of rhetorical masculinity, one that encompasses both a fantasy of achievable ends and the absolute uncertainty of lived interaction. To some extent, these are impossible to untie. During my fieldwork, I felt the temptation to mastery, to claim that I knew better than the first group of students how they should be interacting with Tanzanians. In part, this was a response to their dismissal of my work—that it was unimportant compared to theirs, that they did not have time to waste sitting for interviews, that the feminized work of communication is no match for clear, hard data. Sometimes I did not speak out because their (anticipated) refusal to listen stung too deeply. And yet Abed agreed to an interview, and he spoke passionately about the relationships he formed in his work. Ken felt caught between the values of the hidden curriculum and those derived from experience. To claim that my read on this group is final would be to claim a sovereignty as problematic as that of neocolonial fantasy. However, the demands of our field to write with a certain detachment from emotionality, to present a clear and well-

bounded argument, can also make this difficult to avoid. Let us as rhetorical scholars accept the invitation this study extends to attend not only to the ways that white masculinity attempts to resecure hegemony in our society, but in our field as well.

As this essay demonstrates, the liminal space of the (methodological or geographical) "frontier" functions as a space where white masculine dominance can be resecured *and simultaneously* as a space where it can be challenged—or even dismantled. To focus on one of these aspects while relegating the other does a theoretical and political disservice. Frontier space may indeed be feminized as eminently conquerable, recentering both white masculine dominance and neocolonial relations (McClintock, 1995). But the distance the frontier provides from U.S. gender relations also opens space for a refiguring of gender norms within this liminal cultural space. On the frontier, "material structures are open to restructuration and reinterpretation" (Kelly, 2009, p. 227), affording agency to institute alternative genderings and anticolonial relations.

Examining how these two medical groups approached the liminal space of the NGO differently provides a valuable lesson: that these intertwined processes of re/destabilizing white masculinity do not simply occur but are *enacted*. The liminal space of the frontier—whether in rhetorical field methods or medical missions—is a place where agency may be exercised to perform and institute gender and international relations differently (Kelly, 2009). As the second group of medical students demonstrates, the way we approach liminality can constitute tangible transformations in power relations. By engaging with frontier spaces, whether methodological or geographical, through relationality, uncertainty, and care, we open opportunities for decentering white masculinity and neocolonialism. We cannot ever fully disentangle from neocolonial systems or attempts to resecure white masculine dominance, but there is much to be gained by trying.

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Note

1. To protect the anonymity of participants, all names provided in this essay are pseudonyms.

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