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"It's all in their head!" Rhetoric in the fibromyalgia wars

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Abstract While most research on argumentation in medicine studies doctor-patient communication, this article focuses on a case of argumentation among medical professionals. Eight editorials from a well-known specialized journal, constituting a single discussion about the diagnosis of fibromyalgia (FM), are studied from a rhetorical perspective. Several rhetorical strategies are identified and commented on, illustrating how, at least outside research reports, scientists do not merely argue in a neutral way about empirical facts. In particular, I will focus on the frames used by the arguers, the appeals to common values, and the ethotic arguments that are used.

Keywords: Ethos, Fibromyalgia, Frame, Rhetoric, Values.

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0. Introduction

The kind of arguments that we find in reports of empirical research usually consist of explicit and precise claims supported by thoroughly gathered evidence and worded in a neutral and dispassionate way. Thus, it might seem odd to talk about "rhetoric" when it comes to a discussion in a medical journal (note that 'rhetoric' will not be used here as a discipline concerned merely with stylistic devices, but more broadly as «the theory and practice of persuasive communication», Perelman 1984: 129). It could be argued that communication between doctors and patients involves some tactfulness, persuasiveness and other subtleties, and therefore it merits consideration from a rhetorical or dialectical perspective (see, for example, Rubinelli & Schulz 2006), but that communication among experts in a specialized journal is another matter altogether. Nevertheless, even if we granted that research reports must be left aside, there is still material in scientific journals with interesting rhetoric features. Sometimes the available evidence is not enough and some speculation takes place, and sometimes the topic becomes controversial, in part because medical decisions have practical and economic impacts – think, for example, of the controversy surrounding the DSM-5 in psychiatry. Moreover, certain sections of journals, such as editorials or letters to the editor, afford a more informal, personal, and persuasive tone. The case that will be studied in this article contains all these elements.

Eight editorials, published in *The Journal of Rheumatology* in 2003 and 2004, will be studied here. They all are part of a discussion among experts about whether fibromyalgia (FM) should be diagnosed or not. This is an interesting case from a rhetorical perspective because the medium (the editorial section of the journal) allowed for more freedom of expression than a regular scientific article, but also because the discussion became heated and the protagonists resorted to loaded language, moral exhortations, and even ethotic attacks. In the following section I will present the background of the controversy. Then, in the next sections, I will comment on specific rhetorical features of those editorials.

1. The background

The controversial topic of the discussion that interests us here was the diagnosis of fibromyalgia (FM), a condition characterised by chronic widespread pain – as well as, very often, headaches, fatigue, sleep disorders, and problems of memory and concentration – that has no known cause. FM first appeared in the literature at the beginning of the 20th century under the name of «fibrositis» (Wolfe & Walitt 2013). In 1990, the American College of Rheumatology (ACR) recommended instead the term «fibromyalgia» and proposed a set of criteria for diagnosis, thereby providing the disease with an official recognition from a medical authority (Wolfe *et al.*, 1990). From that moment, the official diagnostic criteria were the presence of long-lasting widespread pain, and pain in at least 11 of 18 "tender points" throughout the body when pressed. This changed in 2010, when the criterion of the tender points was dropped and other criteria were included, such as fatigue, poor sleep, and cognitive problems (Wolfe *et al.*, 2010). Nevertheless, despite the fact that a large amount of research has been conducted, the cause (or causes) of fibromyalgia is still unknown, and that makes FM a disputed disease. As Wolfe and Walitt explain: «The underlying controversy, expressed repeatedly in the literature, is about whether fibromyalgia is "real", not in one's head, not psychosomatic, and not primarily a social construction or psychocultural disorder» (Wolfe, Walitt 2013: 751)

Indeed, fibromyalgia patients frequently complain that the only diagnosis they get from physicians is a belittling "it's all in your head". The lack of scientific evidence of a physical cause, together with the existence of disability compensation benefits and pressures from patients' associations for social recognition, make FM a very controversial issue with socio-economic ramifications. The dispute has become so heated that it has even been called the «fibromyalgia wars» (Wolfe 2009).

The discussion to be studied here took place in 2003 and 2004 on the editorial pages of *The Journal of Rheumatology* – a Canadian medical journal specialised in rheumatology that was founded in 1974[1]. The trigger was the publication, in 2003, of a report of a research study about the prevalence of fibromyalgia in an Amish community in London, Ontario (Canada), which was conducted by a research group from London (White & Thompson 2003). The aim was to address the issue of to what extent the diagnosis of fibromyalgia is motivated by disability compensation benefits. Given that Amish communities are isolated from media influences and their members do not benefit from disability compensation systems, the authors stated: «If FM is a media, litigation, or compensation-driven ailment, it should be uncommon, if present at all, in the Amish» (*ivi:* 1836). Instead, the results of the study showed that the prevalence of FM in the Amish was even greater than the prevalence in a non-Amish rural population and in an urban population. The authors concluded that those results «suggest that litigation does not have a significant augmenting effect on FM prevalence» (*ivi:* 1838). Moreover, since FM seemed to be more prevalent in the Amish, «the Amish population is ideal for assessing potential genetic or familial effects» (*ivi:* 1839).

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[1] https://www.jrheum.com/aboutus.

The tone of that article was characteristic of research reports, displaying scientific neutrality, cautious claims, and strict adherence to the facts. Our focus here will be instead on the editorials that accompanied that issue (vol. 30 issue 8) of *The Journal of Rheumatology* and on those that appeared in a later issue (vol. 31 issue 4) as a reaction to the former. Interestingly, few of those editorials mention the Amish study more than briefly. The discussion mirrors the different professionals' prior beliefs on the general issue of the status of fibromyalgia. It seems, then, that the article that triggered the debate on that occasion did not have a significant impact on the respective positions of each author.

All three editorials in the 2003 issue of the journal, where the Amish study was published, shared the opinion that physicians should not diagnose FM and that the construct of FM should be abandoned (ANTI). By contrast, the five editorials that appeared in the 2004 issue were all written in response to the previous ones and they all defended the FM construct and the importance of diagnosis (PRO). As we will see in the following sections, some of the most interesting rhetorical points are made by the latter five professionals in the form of counterarguments and attacks to the former three authors.

2. Framing: Patients' well-being vs patients' responsibility

The intended audience for the editorials is, obviously enough, the community of specialist in rheumatology in Canada and worldwide. This influences the way the authors speak about fibromyalgia patients – they are not addressing the patients. The way the authors of the editorials speak about the patients mirrors their views of what the overall problem is and therefore establishes a setting in which their arguments will be persuasive. Hence, here it is useful to see how the discussion is *framed*.

Kuypers explains what the framing of a certain issue involves: «When we frame in a particular way, we encourage others to see these facts in a particular way. Framing in this sense can be understood as taking some aspects of our reality and making them more accessible than other aspects» (Kuypers 2009: 181).

The facts of the matter can rarely be presented in a wholly neutral fashion – even less so in the case of a persuasive text. Thus, arguers organise reality around a central idea so that some aspects become more *salient*. Kuypers continues:

> Framing, then, is the process whereby communicators act – consciously or not – to construct a particular point of view that encourages the facts of a given situation to be viewed in a particular manner, with some facts made more or less noticeable (even ignored) than others (Kuypers 2009: 182).

The frame that a particular arguer is using can be seen through the themes he or she evokes, and these can be detected through the terms, metaphors, symbols, and visual images that the discourse contains. The effect of frames is «to define problems, diagnose causes, make moral judgments, and suggest remedies» (*ivi:* 195).

As an example, Entman (1991) compares the news coverage in the U.S. of two similar incidents involving the shootdown of two civilian planes by military forces. In 1983, a Soviet fighter plane shot down a Korean Air Lines (KAL) plane, killing all its 269 passengers. In 1988, a U.S. Navy ship shot down an Iran Air plane, killing all its 290 passengers. Both incidents are sufficiently similar to reasonably expect an equal treatment by the media. However, they were framed in quite different terms by the U.S. media. Entman explains that the KAL incident was portrayed as an outrageous attack while the Iran Air incident was treated as a technical problem: «For the first, the frame emphasized the moral bankruptcy and guilt of the perpetrating nation; for the second, the frame de-emphasized guilt and focused on the complex problems of operating military high technology» (*ivi:* 6).

So, how do the authors of the fibromyalgia editorials frame the discussion? There seem to be two main themes. Several of the professionals frame their editorials according to the theme of *our duty towards patients*, and another one uses the theme of *patients as a socio-economic problem*. Of the three 2003 editorials that opposed diagnosis (ANTI), one of them – Ehrlich's – clearly frames the issue as a socio-economic problem, whereas in the other two – Hadler's and Wolfe's – the theme of concern for patients is more prominent. The theme of the socio-economic problem includes the central idea that the patients themselves are responsible for FM; although, as we will see, this idea also appears in an editorial with the second theme. Editorials that emphasise the doctors' duty toward patients, on the other hand, tend to regret that the patients are not getting the medical help they deserve and to blame the other side in the discussion for that – be it PRO or ANTI.

There are several clues that point to the prevalent theme in each editorial, such as the information that is selected and presented, the terms that are used, and similes. The paragraph with which Hadler begins his text is remarkable in the way he sets the frame that will characterise his approach to the issue and it is worth quoting in full:

> The burden of musculoskeletal symptomatology in the community is considerable. Regional musculoskeletal disorders predominate. If questioned closely, nearly all of us can recall low back pain last year, a third of us recall pain at the shoulder, hand or wrist, and 15% of us at the elbow. These memorable episodes last at least a week and often are recurring. Regional musculoskeletal pain is an intermittent and remittent predicament of normal life. Feeling "well" demands the sense of invincibility that we can cope with our next musculoskeletal morbidity. Being well symbolizes our triumph that we had the wherewithal to cope with the last episode for as long as it took for that episode to remit, to cope so well that the episode is barely memorable, if at all. Being well does not mean avoiding the challenges of regional musculoskeletal disorders; that is not possible. These challenges are as much a part of life as heartache, heartburn, headache, and the like. Therein lies the enigma of health (Hadler 2003: 1668).

This paragraph is a substantial portion of the two-page editorial, and yet no mention is made of fibromyalgia or the Amish study. The message that this paragraph conveys is that everybody suffers from some degree of musculoskeletal pain from time to time, so people should learn to cope with it. How is that relevant to the topic in discussion? The audience expects those remarks to be relevant and therefore they are invited to infer that temporary, regular musculoskeletal pain is all fibromyalgia is, and the problem is simply that those people cannot cope. But *that* is what is at issue, and one would expect it to be explicitly argued rather than implied.

The rest of Hadler's editorial confirms that interpretation. FM patients are portrayed as regular healthy people who simply cannot get on with their lives and *decide* to become patients. Hadler writes that «these people are choosing to be patients» and that «they are miserable and driven to seek medical care frequently» (Hadler 2003: 1668), thus placing the responsibility on the patients themselves. In the next page of the editorial, the phrase «choose to be patients» appears twice more.

Interestingly, however, the theme of Hadler's editorial is the concern for patients and the issue of how best to help them. Despite the burden of responsibility that he places on patients, he seems to be looking for a better way to treat their problem. He criticises «putatively scientific» medical treatments that rest «on the shakiest of scientific grounds» and that are «causing harm today». In his conclusion, he proposes a «dismantling of the social construction represented by FM» and he illustrates how physicians could address this kind of patients by means of a fictitious dialogue: «Then a patient can stand before a Western physician and say, "Doc, I feel awful. Could it be in my mind?" And that physician would reply, "I hope so. That's a lot better than leukemia, or renal failure, or lupus or the like"» (*ivi:* 1669).

The purpose of this dialogue may be to convey an optimistic and sensitive message. Notice, however, that here no new treatment has been proposed and the only explanation that he offers for FM symptoms is still that those people cannot "cope". That dialogue seems to amount to the "it's all in your head" message about which patients so bitterly complain. Even though Hadler's concern is the well-being of the patients, the central idea in his editorial is that medical professionals should not believe what patients say and should paternalistically redirect their complaints and needs.

The idea of the patients' responsibility for their disease is also present in Ehrlich's editorial, but now the main theme is that patients are creating a socio-economic problem. Ehrlich's tone is much less ambiguous. The theme of patients' responsibility does not appear together with a proposal to help them improve their condition but with the perhaps more coherent belief that they are a threat and should be stopped by medical professionals instead of aided and abetted.

The beginning of Ehrlich's editorial conveys the same idea as Hadler's: everybody feels pain sometimes and they should simply learn to cope with it, not call it a disease. Ehrlich, however, emphasises the economic interests: «Thus have we turned a common symptom into a remunerative industry» (Ehrlich 2003: 1666). He resorts to exaggerated claims in which he attempts to persuade by evoking catastrophic scenarios: «Without the dollar poultice, would these patients be separated from the rest of humanity and threaten to bankrupt disability compensation systems in the Western world?» (*ibidem*).

He provides no evidence for such an appeal to disastrous consequences, so it can be said that the persuasiveness of the argument lies in the *pathos* of fear that it attempts to provoke in the audience. Its role is to reinforce the frame of patients as a socio-economic problem – even a *threat*.

That picture of patients as a threat appears together with certain loaded terms and analogies that emphasise the patients' blame and make it difficult for the audience to sympathise with them. A misogynistic stereotype seems to be implied when Ehrlich says that the FM patient «focuses on herself and her discomfort (and it is mostly women who fall into this category)» (*ibidem*). Notice that *all* the medical professionals that wrote those editorials were men—and most likely the majority of readers were men as well. In this context, pointing out that the patients are mostly women may be a way of creating a distance between the audience of the editorial and FM patients, and also probably a way of evoking misogynistic prejudices, thereby making it easier to judge and blame them.

Finally, the author uses an analogy that implies a moral evaluation of FM patients as well as a suggested course of action:

> In Western cities, FM tends to be diagnosed when no other reason is found for the pain. The same pains in rural areas or developing countries go unmarked, and people get on with their lives. […] In rural areas, chronic complainers aren't well tolerated (*ibidem*).

In conclusion, the main goal of Ehrlich's editorial seems to be to inspire fear and contempt. This is not the only editorial that appeals to *pathos*, and in fact it is not the one that most conspicuously does so – as will be shown shortly. But it certainly is the editorial that most relies on loaded language, with expressions such as «chronic complainers» or «dollar poultice». For this reason, it is perhaps not surprising that Ehrlich is repeatedly accused in the PRO editorials of ignoring the available evidence and not providing cogent arguments. Emotionally loaded terms and claims are sometimes a way of triggering a value judgement in the audience while at the same time masking the fact that the arguments would not stand up to careful scrutiny (cf. Macagno 2013).

Let us move on now to the five editorials that were written as a response. Some of the 2004 editorials seem to strongly and deliberately emphasise the theme of the professionals' duty towards patients in order to counteract frames such as those used by Hadler and Ehrlich. The reinforcement of that theme through *pathos* is unreservedly manifest in White's editorial, which begins with two allusions to a Bob Dylan's song: the first, in the title – «Fibromyalgia: the answer is blowin' in the wind» – and the second, in the quote that immediately follows the title: «How many times can a man turn his head - and pretend that he just doesn't see? – Bob Dylan, "Blowing in the Wind"» (White 2004: 636).

This is a powerful rhetorical move. Dylan's song is a well-known symbol of pacifism, justice, and freedom, an artistic emblem of resistance against war and oppression. Hence by using such a symbolism, White adopts the frame of the doctors' duty towards patients and, presumably, he presents the issue as a protest against injustice and a fight for the oppressed – in this case, FM patients. And, indeed, the first paragraph of his editorial is a clear accusation in those terms:

> These immortalized words have rung true repeatedly throughout the sordid history of humankind. Yet it should seem startling that Dylan's words might apply to physicians, who recite the Hippocratic Oath, and promise to ease pain and suffering and "do no harm". Nonetheless, these words too often do apply to physicians, perhaps no more frequently than when many such physicians are asked to deal with fibromyalgia (FM) (*ibidem*).

Incidentally, notice how White appeals to a common set of values that are shared by all medical professionals: the Hippocratic Oath. He appeals to the values embodied in that symbolic text in order to emphasise the medical duty of care and help. In the following section, we will see how many of these authors appeal to other shared values, especially those related to rigour and the scientific method.

White presents a large amount of evidence and a battery of arguments against the ANTI claim. During his argumentation, some of his remarks emphasise the main theme of his text: «What is important is that all such patients are in distress, and that physicians can help (or hinder) if they so choose» (*ivi:* 637). The focus, then, is no longer on the patients' choices, but on the physicians' responsibility. Against those who oppose the diagnosis of FM, White uses expressions such as «verbal and destructive», «ire», «zealous anti-FM movement», «hateful disregard for RM», «venomous responses», «venomous attacks», and «violent FM-beaters». The Amish study – conducted by White himself, together with another colleague – is described as «an antidote against such venom» (*ivi:* 638). Again, the language is that of a frame in which medical professionals are seen as enemies of FM patients – thereby betraying their duty of care.

The last paragraphs of White's editorial present the discussion as a battle between truth and malice, and the editorial opportunely ends with another allusion to Dylan:

> Let FM not be another tragic example of letting ill-informed, malicious logic derail conscientious, methodical attempts to gradually discover the truth.
> To quote Bob Dylan again: "How many ears can one man have before he can hear people cry?" (*ivi:* 639).

Admittedly, the frames in the rest of the editorials are not as conspicuous as in Hadler's, Ehrlich's and White's, and that is why I have focused on those. The main idea in most of the five PRO editorials published in 2004 is an emphasis on the importance of empirical evidence and an accusation that the 2003 ANTI editorials ignore that evidence, as will be shown in the next section. In some of them, we can still find signs of the theme of the medical professionals' duty, for instance when Nielson and Harth point out that «as health care professionals we have an obligation to reduce pain and suffering» (Nielson, Harth 2004: 631). But it is no longer a central idea that frames the whole text.

3. Professional values: Mere rhetoric vs empirical research

The fact that both the communicators and the audience of the editorials consist of medical specialists also influences the system of values that is presupposed and used for argumentative purposes. Indeed, the authors can appeal to certain values precisely because they are addressing their editorials to a particular audience: fellow members of the same scientific community. Here, values function as objects of agreement, as a common ground on the basis of which arguments and criticisms can be put forward (Perelman, Olbrechts-Tyteca 1969: 74).

Undoubtedly, the system of values of modern medicine includes the importance of data and empirical research against the unreliability of abstract speculation and the vacuity of unsupported claims, as well as the value of respect for the facts against the disvalue of political agendas. This system of values and disvalues becomes manifest in this discussion partly due to the socio-political impact of FM and to the explicitly socio-political character of the hypothesis tested by the Amish study – whether diagnosis of FM is motivated by disability compensation benefits.

Indeed, one of the authors explicitly criticises the Amish study, not on the basis of methodological flaws but simply because it has a political character:

> The White and Thompson study, finding increased rates of FM in the Amish, was undertaken for a political reason, to show that FM could be found in settings where litigation does not occur. However, it illustrates instead the central problem of FM, i.e., that diagnosis has become a social and political issue. It also may remind us that palpating patients in open studies where the goal is to make a political point is not good science and may make just the opposite point (Wolfe 2003: 1672).

However, the appeal to the common value of respect for empirical evidence is mostly present in the 2004 editorials, and it is used as a criticism against the previous ANTI editorials. The three ANTI authors are accused of ignoring the evidence and making unsupported claims, resorting instead to "rhetoric", "speculation", and "armchair philosophizing". At the same time, the PRO authors portray themselves as advocates of evidence-based medicine whose judgements rely on empirical data. This is a powerful attack precisely because it frames the issue in terms of a simple dichotomy between "evidence" and "speculation", and there is little doubt that, when put in those terms, most medical professionals would rather be associated with the former than with the latter.

Thus, Nielson and Harth title their editorial *Fibromyalgia: beyond the rhetoric*. They defend the Amish study on the basis that it is a genuine piece of scientific research – as opposed to the vacuity of ANTI editorials:

> White and Thompson should be given credit for adopting a scientific approach to this question rather than engaging in the type of armchair philosophizing that has become all too common in discussions of FM. The literature is replete with commentaries such as those by Hadler, Ehrlich, and Wolfe; they do nothing to advance our understanding of FM or resolve issues that can, without research, be debated *ad nauseam* (Nielson, Harth 2004: 631).

In fact, Nielson and Harth admit that the construct of FM is problematic and that its usefulness is open to discussion. However, they insist that this should be a discussion guided by empirical research – and they mention the inappropriateness of resorting to «polemical editorials» and loaded language: «Whether, in the final analysis, the construct continues to be used should be determined not by polemical editorials about "chronic complainers" who can't get on with their lives, but by research» (*ibidem*).

The expression «armchair philosophizing», as opposed to evidence-based claims, also appears in White's editorial when he criticises «the endless armchair philosophizing of so many who have claimed, while making no attempt to gather any evidence to support their contentions, that FM is a compensation-driven illness» (White 2004: 638). White is perhaps the author that puts the strongest emphasis on the importance of data and research. His four-page long editorial (one of the longest) is full of references to empirical studies that, he argues, the ANTI authors have overlooked or ignored. He insists that any arguments put forward in the discussion about FM should take into account those studies:

> The list of scientifically demonstrated physiologic abnormalities in FM patients goes on and on. Detailing them all is far beyond the scope of this editorial. Nonetheless, this research exists and no critic should verbalize his or her opinions without performing an educated and unbiased review of it (*ivi:* 637).

White's accusations against his opponents for failing to support their arguments with empirical data sometimes take the form of direct attacks:

> Some authors, such as Ehrlich, Hadler, and A.S. Russell, seem to have made a career out of writing opinion papers chastising FM, while publishing virtually no research at all to support any of their claims. Why? Why do those who belittle the concept of FM offer virtually nothing more of an argument than their own feeble versions of "common sense", while repeatedly ignoring a huge and ever-growing body of evidence supporting its legitimacy? (*ivi:* p. 638).

In a similar vein, Smythe accuses the three ANTI editorials of failing to address «either the science of the [Amish] paper or the inferences» (Smythe 2004: 627). He criticises «the rhetorical skills of Ehrlich and Hadler», and he concludes that «we would prefer more data and fewer words» (*ibidem*). Again, the term "rhetoric" is used here with a negative connotation, as opposed to "data" or "evidence".

Wallace's brief editorial characterises Ehrlich's claims as «to pontificate», and ends with an exhortation that makes an interesting reference to one of the main ways that good scientific work is acknowledged: «Show me the evidence and you will be cited!» (Wallace 2004: 632). As it is well known, being cited is the reward for publishing a good piece of academic writing. It is the signal that other scholars acknowledge and respect one's work.

Finally, in a more calm language, Goldenberg also points out: «Hadler's argument that FM is simply a social construct ignores 25 years of clinical observations and research» (Goldenberg 2004: 634).

In sum, as has been shown in this section, the editorials are situated in a framework which establishes a dichotomy between two sets of contrasted terms or expressions. Each of those sets possesses a positive and a negative connotation respectively, according to the system of values of the scientific community. Table 1 summarises the expressions that appear.

Value	**Disvalue**
clinical observations evidence data research scientific approach	armchair philosophizing common sense polemical editorials political pontificate rhetoric

Table 1

4. Ethotic arguments: Authority and *ad hominem* accusations

The previous section has already hinted at another rhetorical strategy that was used in several of the editorials: *ad hominem* arguments. These ethotic attacks are closely related to the issue of whether the authors live up to the values of the scientific community, but we will also find circumstantial *ad hominem* arguments that refer to hidden motives. There is even a joke that could be interpreted as undermining the authority of the entire medical profession – perhaps as a way of acknowledging their own limitations: «When doctors don't know, they speak Latin. When they really don't know, they use Greek» (Smythe 2004: 627).

But, first of all, why would scientists, who purport to be objective and to argue only about the facts, resort to *ad hominem* argumentation? Actually, the epistemologist John Hardwig (1991) convincingly argued that, even in science, the role of trust in the acquisition of knowledge is indispensable – and therefore the scientists' ethos do matter, at least to some extent. No scientist can check every piece of data gathered and analysed by other scientists. They work in teams and must rely on each other's testimony to a certain extent. The whole body of scientific knowledge depends in part on these relationships of trust among scientists. Hence, considerations of character are relevant even in the objective, evidence-based world of science. As Hardwig explained: «Scientific propositions often must be accepted on the basis of evidence that only others have. Consequently, much scientific knowledge rests on the moral and epistemic character of scientists» (Hardwig 1991: 706).

This is why, for instance, we find the following comment in Wolfe's editorial before he rejects the Amish study: «The London group is a well known and respected research group» (Wolfe 2003: 1672). This can be relevant if it is interpreted as a caveat that his rejection of the research study should not be taken as a criticism of the researchers. Hardwig argued that it will be justified to believe a scientist's testimony when such a scientist is truthful, competent, conscientious, and has an «adequate epistemic self-assessment» (Hardwig 1991: 700). Therefore, all these aspects will be relevant when evaluating whether to believe a scientist's judgement.

In the FM discussion that is being analysed here, the audience of the editorials is, let us not forget, mostly medical professionals. My contention is that, in the case of the *ad hominem* arguments in some of the PRO editorials against certain ANTI authors, what we see is an attempt to undermine those authors' authority by casting doubt on their truthfulness, their competence, or their conscientiousness. It is clear that the victims of the *ad hominem* accusations will not be convinced by such a rhetorical strategy. The aim is to undermine the *ethos* of those ANTI authors in the eyes of the professionals that read that journal. Let us see how.

Wallace's editorial contains one of the most direct and clear *ad hominem* accusations. Here, there is no doubt that the author attempts to question his opponent's competence in the FM discussion: «Dr. Ehrlich has written numerous opinion pieces and reviews, but according to PubMed has not been an author or coauthor of a peer-reviewed, published clinical trial or survey since 1986» (Wallace 2004: 632).

Similar remarks are made by White against ANTI authors in general: «Why are those who oppose the FM concept so verbal and destructive, many going out of their way to write position papers about an area in which they have done no research, and seem so oblivious and impervious to the research of others?» (White 2004: 636).

The implication is that those authors are not competent or contentious enough to judge on the issue of fibromyalgia. Of course, the accusations that were mentioned in the last section about reliance on "rhetoric" instead of "data" can also be seen as undermining the authority of those accused.

However, there are also remarks that suggest that the opponents are not truthful – or, perhaps more accurately, that they are not *honest*. It is claimed or implied that the opponents' view on the FM issue is motivated by hidden motives – either economical or purely practical. The most damaging implication of this kind is expressed by White in a comment between parentheses: «It takes no imagination at all to see how this anti-FM agenda might be pushed aggressively by those health care providers among us whose incomes come largely from performing independent medical evaluations for insurance companies» (*ivi:* 638).

Smythe uses a similar kind of attack against Wolfe. He reminds us that Wolfe was one of the researchers that proposed the use of the tender point criteria in the 1990 article, even though he now rejects them: «Why did Dr. Wolfe disown his offspring? Because now he must do without tender point counts» (Smythe 2004: 629). And he goes on to explain: «Reliable tender point counts can be expensive in dollars and time, if one includes the costs of training new (preferably independent) assessors, of collecting and analyzing the data, and of responding clinically to the findings» (*ibidem*). That is, Wolfe now purportedly opposes the use of tender points as "a matter of principle", even though, according to Smythe, the real reason is that the criterion is difficult to implement in practice.

These remarks suggesting that there are hidden motives behind certain author's positions can be seen as accusations of *bias*. They are contentions that «an advocate has a hidden agenda, a conflict of interest, a stake in the outcome that affects their ability to be an unbiased authority on the subject» (Schiappa, Nordin 2014: 166). As such, they are attempts to undermine those authors' authority.

Conclusion

The modest goal of this paper was to study the rhetorical elements in a particular set of editorials that appeared in a medical journal. We have seen that the discussion contained rhetorical elements such as analogies, loaded language, appeals to *pathos*, allusions to popular music, appeals to values shared by the medical community, and *ad hominem* arguments. To be sure, all the editorials make references to plenty of empirical studies in order to support their claims; but, as we have seen, their claims are framed in a specific way and sometimes go beyond what can be ascertained on the basis of empirical evidence.

Of course, as it was pointed out in the introduction, what we have seen is not the way arguments are presented in research reports. Quotations of Dylan's songs and *ad hominem* arguments are very unlikely to be found in a peer-reviewed published report. However, editorials such as those that have been studied here are part of scientific argumentation as well. Analysing them from a rhetorical perspective can shed light on, among other things, the role of frames, values, and *ethos* in the scientific community.

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