SEARCHING FOR THE GOOD LIFE: RHETORIC, MEDICINE, AND THE SHAPING OF LIFESTYLE

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Submitted to the Graduate Faculty of

the Department of Communication

in the Kenneth P. Dietrich School of Arts & Sciences

in partial fulfillment

of the requirements for the degree of

Doctor of Philosophy in Communication

University of Pittsburgh

2012

UNIVERSITY OF PITTSBURGH

Kenneth P. Dietrich School of Arts & Sciences

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The "Chronic Care Model" (CCM), developed by Edward H. Wagner, represents a watershed attempt to address the disconnect between acute models of care and those oriented toward chronic patients for whom lifestyle changes rooted in everyday life are a central concern. To achieve the system-wide changes needed to advance the cause of patient self-care, the CCM focuses on synergizing various layers of the healthcare system, including clinical research and quality improvements, new communication technologies, and provider-patient interactions. Crucially, the conduits that connect these layers have received scant attention, especially when it comes to the methods of interaction and persuasion that enhance the prospects for healthcare innovation. This project addresses this gap drawing inspiration from Richard McKeon's claim that the art of rhetoric provides tools for synergizing complex and highly interactive human systems. Thus, it rhetorically re-imagines the CCM, arguing that rhetoric plays a role in cultivating better clinical practices through collaboration across the spectrum of activities that make up chronic care. To achieve this end, this project focuses on a CCM inspired case study: the Online Lifestyle Support System (OLSS), developed through a robust relationship between academic researchers and corporate disseminators. The OLSS translates an evidence-based lifestyle curriculum into an online platform designed to assist obese and diabetic patients in managing their weight and co-morbid conditions. This online system includes online lessons and live lifestyle coaching. In order to capture unique insights about the practices of lifestyle

management within the OLSS, this dissertation draws on three interview projects with individuals working at each layer of chronic care delivery: lifestyle coaches, participants in the study, and those tasked with advertizing and selling the OLSS to new clinical environments. Drawing on the words of these different groups provides grist for the granular development of new insights into the practices that make-up chronic care. Finally, in framing these interview projects, this dissertation draws on rhetorically-inflected terms from the ancient Greek tradition: *paideia* (education), *phronesis* (experiential learning), and *eudaimonia* (the fulfilling life), to articulate the developmental and persuasive processes involved in the preparation of practitioners, the cultivation of self-care, and the effort to disseminate new research findings.

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PREFACE

Any project of this scope is made possible by cooperative efforts, the quality of one's institutional scene, the assistance of mentors and colleagues, and the support of family and friends. In all of these areas, I have been blessed.

My advisor, Gordon Mitchell, not only pointed me in the direction of this project but also assisted me in securing the financial support and time needed to complete it. Without his sustained involvement in my development as a scholar and communicator as well as his timely interventions into my thinking and writing over the last seven years, I would never have completed this dissertation. In addition, my chances for continued success in the future would have been severely diminished without his guidance and mentorship. Of all of my scholarly mentors it is to him that I owe my greatest debt of gratitude.

The graduate program in communication at the University of Pittsburgh has provided me with the most robust learning experience of my life. While nearly every faculty member and graduate student I encountered during my formative years in the program played an important role in my scholarly life, there are several to whom I owe special consideration here. John Lyne, a committee member and frequent interlocutor, helped to cultivate my initial interest in the rhetoric of science. His course on Rhetoric and Pain showed me how to think about rhetoric and medicine as interpenetrating arts. This inspired me to join the M.A. program in bioethics at the Center for Bioethics and Health Law, the place where I started my journey into the vast and diverse arenas of medical education and research at Pitt. John Poulakos, a committee member and exceptional pedagogue, inspired my turn to the ancients. Without his influence, I would

never have discovered the words and concepts that brought this project to fruition. Barbara Warnick, chair of the department for many years during my time in the program and committee member for my M.A. comprehensive exams, gave me the tools to understand argumentation theory and the role that it might play in my work. In particular, my discussions of Stephen Toulmin's work in chapter 3 of this dissertation grew out of her influence on my reading and thinking.

So many graduate students have supported me with friendship, intellectual partnership, and the all-important need for sustained interactivity and conversation that I cannot possibly mention all of them here. However, during my first few years in the program, I benefitted from a unique concentration of graduate students with whom I shared a similar curiosity regarding the art of rhetoric and its capacious possibilities. Damien Pfister, Carly Woods, Cate Morrison, Kelly Congdon, Autumn Boyer, and Steve Llano provided mentorship and support during those precarious early years, revealing multiple pathways to scholarly rigor and success. As I started my dissertation work, Michael Vicaro spent many hours at a local coffee shop talking with me at length about the reading and writing problems I faced and how to overcome them. Joe Packer provided feedback that was helpful while revising the second chapter of this dissertation. Brent Saindon remains a great friend and interlocutor, offering his time and support in moments of greatest need. Finally, and certainly not least, Matt Brigham has been a friend, confidant, pedagogical mentor, and supporter from the first day of my graduate training. Without his presence, my experience of graduate school and my life in Pittsburgh would have been quite different and not for the better. Of all the graduate students in the program, it is to Matt that I owe my deepest and sincerest thanks.

My outside committee members, Susan Zickmund and Gary Fisher, provided expert guidance on crafting a dissertation that could speak across the gap between rhetorical theory and contemporary medical practice. Without their important contributions, this dissertation would not have as much to offer to medical researchers and practitioners and my defense would have lacked that alchemical catalyst that can only be sparked by the presence of scholars and practitioners from very different disciplines and methodological orientations inhabiting the same space.

Of course, without financial and institutional support, the time needed to cultivate my relationships with faculty and graduate students, write my dissertation, and continue my professional formation would have been severely limited. In 2010, I was selected for a pre-doctoral fellowship in clinical and translational research funded by the National Institutes of Health and offered through the Clinical and Translational Science Institute and Institute for Clinical Research Education at the University of Pittsburgh.[1] This fellowship provided me with a stipend, research and travel support, and training opportunities that complemented my already excellent foundations in rhetorical history, theory, and criticism with coursework in the ethics of research, translational science, and qualitative methods. Without this support, I would never have had the time to develop this project and fully realize it. Furthermore, this fellowship program allowed me to hire a transcriber, Jeffrey Kurr, who prepared a fantastic set of transcriptions without which my analysis and writing would have been substantially delayed. In addition, the faculty leadership for this fellowship program, Nicole Fowler, Rachel Hess, and Galen Switzer, saw my potential to contribute to translational research, supported my development in this area, and helped me to cultivate an interdisciplinary voice that will continue to serve me as I work to

[1] Grant Nos. 2TL1RR024155-05; 2TL1RR024155-06; UL1RR024153; UL1RR000005.

bridge the arts of rhetoric and medicine. Finally, my mentoring team for this fellowship, Kathleen McTigue, Susan Zickmund, and Gordon Mitchell offered their expert advice not only in terms of the dissertation work but also the early publication of one portion of the dissertation and my overall career plan. In particular, Dr. McTigue (along with Dr. Mitchell) met with me every month, helping me to troubleshoot issues as wide-ranging as the development of effective research questions, probing interview scripts, applications to the Institutional Review Board, and writing for a medical audience. Dr. McTigue's assistance in writing letters or recommendation, completing this dissertation, and forming a coherent career plan cannot be overestimated. Dr. Zickmund wrote letters of recommendation, assisted in coding and analyzing the interviews that were at the heart of the aforementioned publication and inspired me to think about my career in a much broader way than I would have otherwise.

In addition to the outstanding support of my friends, colleagues, and mentors at Pitt, I have been truly blessed with friends and family who have supported me in incalculable ways during my lengthy stay as a student in higher education. My first academic advisor and college debate coach, Kevin Cummings, initially suggested pursuing a career in rhetoric and communication. His advice and intellectual mentorship during my undergraduate career played an essential role in deciding to apply to Pitt in the first place and his willingness to play a role as confidant and mentor to this day is something for which I will never be able to repay him. John Foy, the coach who took me to unbelievable competitive heights in academic debate, has remained a friend and source of unparalleled advice. Brian Schrader, a friend since high school, college debate partner, roommate, and fellow traveler in the larger world of academia has provided emotional and intellectual support without equal. I cannot begin to express my thanks to him. Finally, without parents willing to bail me out of financial difficulties, support my

decision to move half-way across the country to attend graduate school, and furnish love and care throughout my life, none of this would have been possible. To Jim and Helen Rief, I offer thanks and love to the end of my days.

While I owe all of the individuals listed here (among many others) my thanks for their assistance in writing this document and completing my degree, I must take all of the responsibility for its final form. Any errors are of course mine. I have worked assiduously to credit those who have most directly impacted my thinking and writing style by faithfully citing them. To all those who have come before, I offer my thanks for your work and for, in a variety of small and large ways, forming the intellectual pathway that has given my intervention into the relationship between rhetoric and medicine its relevance and, I hope, vigor.

Finally, to those who took part in my interview projects, I offer my heartfelt thanks for your time, energy, and insight. Without these, my project would lack a needed connection to real world practice and to the problems and possibilities of all those involved in the medical research-to-care pipeline.

1.0 A CLINICALLY RELEVANT, DEMAND-DRIVEN RHETORIC OF MEDICINE

> Life is short, science is long; opportunity is elusive, experiment is dangerous, judgment is difficult. It is not enough for the physician to do what is necessary, but the patient and the attendants must do their part as well, and circumstances must be favourable.[1]

> The study of rhetoric, like the study of bioethics, attends to matters often shaped at the intersection of science with practical reasoning, where the constraints of time and circumstance put pressure on the possibilities for principled action. To think rhetorically is to reflect constructively on the habits of representation that position people for making judgments. Rhetoric is concerned with the invention of language that enables action, but also with the capacities of language to address and persuade. The era of biotechnology will surely test these capacities in new ways.[2]

1.1 THE SHAPING OF LIFESTYLE: A RHETORICAL ENDEAVOR

In a National Public Radio broadcast in 2007, Samr "Rocky" Tayeh recounts his story of trial and tribulation on the path to weight loss. "I really don't get myself," he says. "I know my parents feel sad for me. Who wouldn't? I'm the fattest kid in my house. I'm the fattest person on my block. I'm the fattest teenager I know."[3] This recognition had been with Samr for some time, a part of his daily efforts to make sense of his life and why he felt and acted the way he did.

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[1] Hippocratic writer, *Aphorisms* 1, in *The Medical Works of Hippocrates*, trans. John Chadwick and W. N. Mann (Oxford: Blackwell Scientific Publications, 1950), 148.

[2] John Lyne, "Contours of Intervention: How Rhetoric Matters to Biomedicine," *Journal of Medical Humanities* 22, no. 1 (2001): 13.

[3] Samr Tayeh, "Battling Obesity: The Story of Rocky's Reduction," *All Things Considered*, National Public Radio Broadcast, April 10, 2007, p. http://www.npr.org/templates/story/story.php?storyId=9499004. Parts of this broadcast were originally recorded for "Samr 'Rocky' Tayeh's Struggle with Obesity," *All Things Considered*, National Public Radio Broadcast, December 29, 2003. All transcriptions were done by the author.

During his story, he provides an account of the first time he realized that his weight was something he wanted to change:

> When I was eleven years old, I made a promise I couldn't keep. I was on vacation at my uncle's house and after a fun day of swimming, with my shirt on of course, I went into the bathroom and nervously stepped on the scale. Two hundred pounds. So I swore to Allah, something you're not supposed to do in the bathroom, that I wouldn't get any fatter. But I could never slam the door on food. My comfort for life. My best friend. Chocolate, vanilla, and strawberry . . . [4]

Samr tells of years of trying to make sense of this unfulfilled promise, of why and how he failed to achieve his goals of healthier eating and physical activity, of why and how he ultimately failed to change his life for years but finally found a path that seemed to offer some hope.

For Samr, the choices and activities needed to achieve weight loss were and continue to be far more complicated than the simple decision to do things differently. All the same, he had come to recognize that his weight was negatively impacting his life, and that he had a growing desire to lose weight and regain his health. In the end, Samr decided to undergo bariatric surgery in order to finally leave his overeating and health problems behind. During the broadcast, he discusses his experience of waiting for the surgery to begin: "It was finally time, I put on a blue gown and went into a small room to wait. Wait for my name to be called. Wait for my new life to begin."[5] It is no accident that Samr uses the words "new life" to describe this change. For many, the experience of weight loss surgery involves a profound transformation of self-conception, bodily practices, and personal relationships with others.[6]

Samr's story is not unlike that of many people who are obese. Morbid obesity is perhaps the most urgent and ubiquitous health problem in the United States and many other parts of the

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[4] Samr, "Battling Obesity."
[5] Samr, "Battling Obesity."
[6] Stephanie Sogg and Mark J. Gorman, "Interpersonal Changes and Challenges after Weight-Loss Surgery," *Primary Psychiatry* 15, no. 8 (2008): 61-66.

world.[7] The categories "overweight" and "obese" are rhetorically constructed domains, as much scientific as social, but often the context for deep emotional and health-related difficulties.[8] In Samr's case, this meant being 300 pounds overweight and losing the ability to engage in meaningful relationships and activities due to his decreased mobility. The desire to lose weight (brought about by such experiences as those recounted by Samr) is shared by many people who are experiencing the health and social problems associated with obesity. Samr, like many people, decided to undergo surgery (in his case, a band was placed around his stomach to shrink its size and reduce his appetite); however, as Samr learned, even selecting this method of weight loss, which his friends interpreted as him "taking the easy way out," meant making major changes in his lifestyle choices.[9] At one point during the broadcast, the audience hears a recording of Samr throwing up into a sink after eating more than his banded stomach could handle. Despite the surgical intervention, Samr's daily activities had not been transformed, leading to a destabilizing disconnect between his behaviors and his newly crafted biological capacities. Even for those who undergo such a surgery, medical technology is not, in the end, the primary way that they will both lose weight and sustain weight loss. Instead, lifestyle change, often called "lifestyle management" is the primary means of attaining weight loss and probably will be for the foreseeable future.

Samr's words convey the sense that weight loss, at least for him, is tied up in his conception of self, in his understanding of the social perceptions and stigmatization that surround

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[7] In fact, the number of overweight and obese individuals worldwide is growing at an accelerating rate. See Mervyn Deitel, "Overweight and Obesity Worldwide Now Estimated to Involve 1.7 Billion People," *Obesity Surgery* 13, no. 3 (June, 2003): 329-330.

[8] On the rhetorical construction of "obesity" and "body mass index" see Christine Halse, "Bio-Citizenship: Virtue Discourses and the Birth of the Bio-Citizen," in *Biopolitics and the 'Obesity Epidemic': Governing Bodies*, ed. Jan Wright and Valerie Harwood (New York: Routledge, 2009), 47; Kathleen LeBesco, *Revolting Bodies? The Struggle to Redefine Fat Identity* (Amherst/Boston: The University of Massachusetts Press, 2004).

[9] Samr, "Battling Obesity."

him, and in his sense of what his life is and what it could potentially be. All of these are important parts of the story I plan to tell about the effort to shape lifestyle in response to the growing "epidemic" of obesity.[10] Samr's sense of identity is directly tied to his narrative capacities as a person experiencing a bodily state and a series of health problems. His ability to make sense of his life, to speak about it, and to narrativize his overall experience, is fundamentally rhetorical.[11] It is an act of self-persuasion, self-(re)constitution, and "identification" with his audience (and to some extent, with himself).[12] In addition, the stigmatization that he faced, especially in school, and continues to face as he constantly fights his weight status is tied to the larger cultural understandings of and normative reactions to obese individuals.[13] The ancient Greeks, as historian Werner Jaeger points out, might call these cultural norms and beliefs, as well as the educative and propagandistic elements of these that shape action, a culture's *paideia*.[14] How a culture wrestles with central values, constructs its identity,

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[10] The notion that obesity is an epidemic has been around for some time. See, e.g., James M. Rippe, "The Obesity Epidemic: Challenges and Opportunities," *Journal of the American Dietetic Association* 98, issue 10, supplement 2 (1998): S5; Ann M. Coulston, "Obesity as an Epidemic: Facing the Challenge," *Journal of the American Dietetic Association* 98, issue 10, supplement 2 (1998): S6-S8. Regarding the contested status of obesity trends as "epidemic," see Gordon R. Mitchell and Kathleen M. McTigue, "The U.S. Obesity 'Epidemic': Metaphor, Method, or Madness," *Social Epistemology* 21, no. 4 (2007): 391-423. For a counter-argument concerning epidemic rhetoric and moral panic, see Emma Rich and John Evans, "'Fat Ethics' – The Obesity Discourse and Body Politics," *Social Theory and Health* 3 (2005): 341-358. For an account of the various layers of meaning attached to the term "epidemic" in the context of obesity, see Michael Gard and Jan Wright, *The Obesity Epidemic: Science, Morality and Ideology* (London/New York: Routledge, 2005). Finally, the term "epidemic" has invited general criticism regarding its use and abuse in medical ethics. Lisa Parker, "Breast Cancer Genetic Screening and Critical Bioethics' Gaze," *Journal of Medicine and Philosophy* 20, no. 3 (1995): 313-337.

[11] The importance of patient narratives in the construction of illness experience has received substantial attention in medical humanities and bioethics. See e.g., Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: The University of Chicago Press, 1995); Rita Charon, *Narrative Medicine: Honoring the Stories of Illness* (Oxford: Oxford University Press, 2006).

[12] For discussion of "identification" in rhetoric and narrative, see Kenneth Burke, *A Rhetoric of Motives* (Berkeley: University of California Press, 1969), 19-29 (and throughout).

[13] Regarding stigmatization and obesity, see Amy E. Farrell, *Fat Shame: Stigma and the Fat Body in American Culture* (New York: New York University Press, 2011).

[14] On the notion of *paideia* see Werner Jaeger, *Paideia: The Ideals of Greek Culture Volumes I-III*, 2nd ed., trans. Gilbert Highet (New York: Oxford University Press, 1945). According to Jaeger, *paideia* is related to the ancient Greek "process by which their character was formed and the intellectual process by which they constructed their ideal of human personality." Jaeger, *Archaic Greece*: *The Mind of Athens*, vol. 1 of *Paideia*, ix.

and manages the lives of its members are all tied to this ancient concept. Additionally, Samr's understanding of his life as somehow lacking and his need to change it are directly tied to another ancient Greek term, *eudaimonia*, or the good and fulfilling life.[15] Many, although not all, obese individuals seek a reorientation of the somatic and psychic elements of life. They are often not simply hoping to lose weight but also for the weight loss to produce an entirely different way of life, a different orientation to the world, and a transformation of the ways in which others perceive them. Finally, Samr's ongoing efforts to shape his lifestyle differently, to habituate himself to a new life, are related to another Greek concept, developed most famously by Aristotle: *phronesis*. Commonly translated as "practical wisdom," *phronesis* has to do with the cultivation of experiential wisdom, habits, and modes of decision making used by individuals in their daily existence as well as the "interpersonal dimension" within which humans learn and grow that allow the individual to lead a life of their choosing (or, for Aristotle, a more virtuous life).[16]

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[15] On *eudaimonia*, see Martha Nussbaum's definition of the term that contrasts it with mere happiness. Nussbaum argues that "*eudaimonia* means something like 'living a good life for a human being.'" Martha C. Nussbaum, *The Fragility of Goodness: Luck and Ethics in Greek Tragedy and Philosophy*, Up. ed. (Cambridge: Cambridge University Press, 2001), 6 (fn). For an updated version of her definition of *eudaimonia* as "concerned with the person's flourishing," see Martha C. Nussbaum, *Upheavals of Thought: The Intelligence of Emotions* (Cambridge: Cambridge University Press, 2001), 31-32. In addition, *eudaimonia* has been the subject of major debates in philosophy, particularly those centered on the unity versus plurality of goods or whether happiness and fulfillment have singular or diverse meanings. On this debate see Thomas Nagel, "Aristotle on *Eudaimonia*," in *Essays on Aristotle's Ethics* ed. Amélie O. Rorty (Berkeley: University of California Press, 1980), 7-14; J. L. Akrill, "Aristotle on *Eudaimonia*," in *Essays on Aristotle's Ethics*, 15-34.

[16] Aristotle *Nicomachean Ethics* VI. Regarding the "interpersonal dimension" noted above, see Joseph Dunne, *Back to the Rough Ground: Practical Judgment and the Lure of Technique* (Notre Dame: University of Notre Dame Press, 1993), 263. I am not the first to connect human striving for health and fulfillment within the medical domain to Aristotle's conception of *phronesis*. While working on this and other projects, I came across the work of Sara Rubinelli, Peter J. Schulz, and Kent Nakamoto in which they detail some of these same elements of *phronesis* in the domain of "health literacy." Importantly, they articulate a conception of *phronesis* as a mode of "self-examination" and a prompt to interact with healthcare providers that I will return to in depth in later chapters. While there is much to recommend this article, my more developmental view of *phronesis* (as well as my addition and concentration on several additional Greek terms, most notably *paideia*) substantially expands on their view. Sara Rubinelli, Peter J. Schulz, and Kent Nakamoto, "Health Literacy Beyond Knowledge and Behaviour: Letting the Patient Be a Patient," *International Journal of Public Health* 54 (2009): 309.

All of these terms (*paideia*, *eudaimonia*, and *phronesis*) play a central role in the following pages. As a rhetorician, my primary interest is in how these terms shed light on the dynamics set in motion when speakers (or "rhetors") address audiences through *logos.* A corollary of this perspective, and perhaps the most elemental of rhetoric's presuppositions, is the power of *logos* to shape experience and to respond to and transform situations.[17] *Logos* has a variety of meanings including "rationality," structure, and, its broadest sense, given to us by the Greek rhetorician, Isocrates, the medium of culture and the architecture that sutures political communities together.[18] Embracing these many meanings of the term, this dissertation pursues rhetorical understanding of the ongoing efforts of healthcare practitioners to create interventions that help individuals in their efforts to achieve weight loss. Just as rhetoric is concerned with the

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[17] This claim has been at the heart of major debates in rhetorical studies. The initial salvo in the 20th century occurred between Lloyd Bitzer and Richard Vatz. Bitzer articulated what might be called a "materialist" conception of the rhetorical situation in which actual events in the world call forth discourse. Vatz countered with a view of rhetoric as something that might transform or alter situations therefore embracing an overtly symbolic understanding of the rhetorical situation. I will tend more toward Vatz's ultimate interpretation; however, I believe that it rests on a fairly narrow reading of Bitzer that requires ongoing discussion and deliberation throughout the field in the future. Lloyd F. Bitzer, "The Rhetorical Situation," *Philosophy and Rhetoric* 25, supplement (1992/1968): 1-14; Richard E. Vatz, "The Myth of the Rhetorical Situation," *Philosophy and Rhetoric* 6, no. 3 (1973): 154-161.

[18] Dilip P. Gaonkar claims that "*logos* is the closest approximation to rationality one can find in Greek," but suggests that it has many other meanings as well. Dilip P. Gaonkar, "Aspects of Sophistic Pedagogy" (PhD diss., University of Pittsburgh, 1984), 79-80. Isocrates famously describes *logos* as that which sutures a political culture together: "Because there has been implanted in us the power to persuade each other and to make clear to each other whatever we desire . . . we have come together and founded cities and made laws and invented arts; and generally speaking, there is no institution devised by [humans] which the power of speech has not helped us to establish . . . I, myself, welcome all forms of discourse which are capable of benefiting us even in a small degree." Isocrates *Nicocles* 5-10. Takis Poulakos claims that in this, and other portions of his corpus, Isocrates, "speaking for the polis [what Poulakos identifies as his primary ethical and practical stance regarding the role of the rhetor] may still designate a way of speaking in the world that articulates speakers and audiences as social beings and discourse as the ground for binding individuals together into a potential community." Takis Poulakos, *Speaking for the Polis: Isocrates' Rhetorical Education* (Columbia, SC: University of South Carolina Press, 1997), 106. Finally, two authors have argues that *logos* may refer to a sort of organizing structure for thought and experience. Working from within the Aristotelian tradition, Jonathon Lear claims that "*Logos* is a protean word; it can also mean proportion, ratio, order. The *logos* of the essence need not be a linguistic item, it can be the order, arrangement, proportion instantiated by the essence itself." That is, according to Aristotle and Lear, *logos* may refer to the order of the world, of things, or essences. Jonathon Lear, *Aristotle: The Desire to Understand* (Cambridge: Cambridge University Press, 1988), 28-29. Finally, the rhetorician and philosopher Richard McKeon argues, "verbal rhetoric [what I call *logos*] is productive of arguments and architectonic of attitudes." I pick up this theme in chapter 2. Richard McKeon, "The Uses of Rhetoric in a Technological Age: Architectonic Productive Arts," in *The Prospect of Rhetoric: Report of the National Developmental Project*, ed. Lloyd F. Bitzer and Edwin Black (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1971), 63.

power of persuasion, the ability to gain the "adherence" of an audience to a particular idea, medicine has often concerned itself with the management of individuals and populations as a means to promote health and wellbeing, of gaining the adherence of patients to treatment regimens.[19] In this sense, medicine shares in the original ethical quandary of rhetoric, most famously posited by Gorgias: rhetoric is a powerful tool, one that can infect individuals like a drug and that can manipulate them as it did Helen of Troy, to take actions they might not otherwise take.[20] Medicine may be said to do the same, especially when its primary tool is the rhetorical therapy of a patient's lifestyle. The entwinement of these two rich traditions forms a tapestry that serves as a backdrop for the current study. The age-old debates regarding the ethics of rhetoric and medicine, their *ethos* (character, credibility, and domain), and their shared history all implicate ethical crises that emerge from the power of the rhetor's use of *logos* and the physician's use of therapy (of which one component is the use of words to persuade patients to accept the descriptions and articulations of healthcare providers and the value of health in general).[21]

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[19] On the management of bodies within the medical domain as well as the role of discourse in such management, see Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A. M. Sheridan Smith (New York: Vintage Books, 1994); Michel Foucault, *History of Madness*, ed. Jean Khalfa, trans. Jonathon Murphy and Jean Khalfa (London: Routledge, 2006). In addition, here I am pulling on a conception of rhetoric rooted in the work of Chaïm Perelman and Lucie Olbrechts-Tyteca. They argue that "the object of the theory of argumentation is the study of the discursive techniques allowing us *to induce or to increase the mind's adherence to the theses presented for its assent*." While Perelman and Olbrechts-Tyteca are writing about "the theory of argumentation" here, the title of their book suggests that they are interested in a rhetorical re-visioning of argumentation theory, one rooted, at least initially, in the classical tradition of rhetoric as developed in the Greco-Roman tradition. Chaïm Perelman and Lucie Olbrechts-Tyteca, *The New Rhetoric: A Treatise on Argumentation*, trans. John Wilkinson and Purcell Weaver (Notre Dame: University of Notre Dame Press, 1969), 4.

[20] Gorgias, *Encomium of Helen*, in *The Older Sophists: A Complete Translation by Several Hands of the Fragments in Die Fragmente Der Vorsokratiker Edited by Diels-Kranz with a New Edition of Antiphon and of Euthydemus*, ed. Rosamond Kent Sprague (Indianapolis: Hackett Publishing Company Inc., 2001), 50-54.

[21] In rhetorical studies, ethos is a concept that goes well beyond credibility into such domains as the making of homes and the crafting of culture, see Lisa Keränen, *Scientific Characters: Rhetoric, Politics, and Trust in Breast Cancer Research* (Tuscaloosa: The University of Alabama Press, 2010); Michael J. Hyde, *The Life-Giving Gift of Acknowledgement: A Philosophical and Rhetorical Inquiry* (West Lafayette, IN: Purdue University Press, 2006). For a robust discussion of the relationship between ethics and rhetoric, see Richard M. Weaver, *The Ethics of Rhetoric* (Davis, CA: Hermagoras Press, 1985). In addition, I have drawn this conception of therapy as a task of

My entrée into this sprawling literature comes via focus on the concept of "lifestyle management" or the cultivation of new habits, behaviors, and life plans in the pursuit of weight loss.[22] There are different ways to understand the project of lifestyle management. For example, some scholars (following in the same vein as the Gorgian description of rhetoric as a tool of manipulation discussed above) including, most notably, Joanna Zylinska, have suggested that lifestyle management can become a technique of domination, a way to reify the various cultural norms and beliefs about health and wellbeing (a negative or manipulative understanding of *paideia*) and remove or erase abnormal bodies through conversion, stigmatization, and intervention (thereby undermining an individualistic account of *eudaimonia* in favor of a socio-political or economic set of imperatives).[23] A different perspective frames lifestyle management as something productive and potentially empowering for the individuals who undertake it. This view highlights how the shaping process is undertaken, with what ends in mind, for what reasons, and whether the individual has freely chosen such a path (if free choice of this kind does, in fact, exist).[24] Lifestyle management, for better or worse, plays out in the domain of what

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rhetoric (and also philosophy) from Martha Nussbaum. See her *The Therapy of Desire: Theory and Practice in Hellenistic Ethics* (Princeton: Princeton University Press, 1994). See also, Julie Laskaris, *The Art is Long: On the Sacred Disease and the Scientific Tradition* (Leiden: Brill, 2002); Pedro Lain Entralgo, *The Therapy of the Word in Classical Antiquity*, ed. and trans. L. J. Rather and John M. Sharp (New Haven: Yale University Press, 1970).

[22] Of course, this term can apply more broadly to lifestyle changes that patients undergo to improve health generally but my organizing case study focuses exclusively on overweight and obese patients with co-morbid conditions such as diabetes. See section 1.5 below. For the application of *phronesis* in particular to other domains, including chronic lower back pain, smoking cessation, and the like, see Rubinelli, Schulz, and Nakamoto, "Health Literacy."

[23] In her excellent work on lifestyle management, Joanna Zylinska notes that in the same way governments manage citizen and non-citizen bodies (e.g. terrorists, enemy combatants, non-enemy combatants, and the like) due to the risk they represent to state security, so too can medicine manage the diseased, unhealthy bodies of citizen-patients, especially if these patients are constructed as a threat to the health of the body politic: "Medicine becomes one of the techniques through which power is exercised not just over individual bodies but also over bodies en masse, with increased focus on public hygiene, accidents, infirmities, and various anomalies, as well as issues connected with reproduction." See her book *Bioethics in the Age of New Media* (Cambridge/London: The MIT Press, 2009), 69. On her take and the value it has for contemporary bioethics, see my book review of *Bioethics in the Age of New Media* by Joanna Zylinska, in *JAC: Rhetoric, Writing, Culture, Politics*. 31, nos. 1-2 (2011): 381-389.

[24] This is, in a nutshell, Martha Nussbaum's response to the approach taken by Michel Foucault in his *History of Sexuality* in which he shows how efforts to manage lifestyle are in many instances modes of domination

Atul Gawande calls "practical medicine," that realm of medical practice that rejects a blind faith in science and adopts a "deep recognition of the limitations of both science and human skill."[25] While Gawande is speaking about surgery here, his insight that medicine plays out in the imperfect world of human action is just as relevant to the management of chronic disease. A rhetorical approach to medicine in the context of lifestyle management meshes well with this practical dimension, enabling a practical orientation that emphasizes training as much as production, deliberation as much as decision making, and choice as much as scientific fact.[26] In other words, a rhetorical approach to understanding the practice of medicine foregrounds the communicative relationship between different agents, especially patients, their families, and their health care providers in the cultivation of somatic and psychic health.

The next several sections situate my study as an effort to link a humanistic understanding of rhetoric (i.e., one that puts stock in the ability of humans to freely co-construct their world and make choices about how to live in it through deliberation) with a generalist and practical understanding of medicine (in which technology, procedure, communication, and the extra-

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akin to those that Zylinska warns about in her work (see above). Nussbaum claims that, especially for the philosophers of the Hellenistic era (her primary focal point), "the pursuit of logical validity, intellectual coherence, and truth delivers freedom from the tyranny of custom and convention, creating a community of beings who can take charge of their own life story and their own thought." Nussbaum doubts, "whether Foucault can even admit the possibility of such a community of freedom, given his view that knowledge and argument are themselves tools of power." It is this disconnect between postmodern/post-structural theories of discourse and power and those of the humanistic tradition that Nussbaum defends throughout her work that informs my own understanding of lifestyle management. I view the humanistic tradition as far more promising; however, one cannot deny the risks associated with asking individuals to manage their lives differently (or providing tools through which individuals might adequately control their appetites, a central concern in Western philosophy at least since Plato's attacks throughout his corpus against the unexamined life). See Nussbaum, *The Therapy of Desire*, 5. For Foucault's take, see his *The Care of the Self*, vol. 3 of *The History of Sexuality*, trans. Robert Hurley (New York: Vintage Books, 1988); Michel Foucault, *The Hermeneutics of the Subject: Lectures at the Collège De France 1981-1982*, ed. Frédéric Gros, trans. Graham Burchell (New York: Picador, 2005).

[25] Atul Gawande, *Complications: A Surgeon's Notes on an Imperfect Science* (New York: Metropolitan Books, 2002), 8.

[26] Kathryn Montgomery argues that the scientific view of medicine can and should give way to this broader conception of medicine as an art that draws on science (as well as a host of other sources) for the successful cultivation and application of its practices. Kathryn Montgomery, *How Doctors Think: Clinical Judgment and the Practice of Medicine* (Oxford: Oxford University Press, 2006).

clinical environment all have a role to play).[27] Novel insights about the communicative relationships between providers and patients, patients and their families, patients and their interpretations of their illnesses and the like not only stand to enrich rhetorical theory, but also to suggest new therapeutic possibilities for physicians and patients alike.[28]

Enhancing the understanding that rhetorical and medical scholars have regarding obesity and the effort to use lifestyle management as a therapeutic modality for its treatment may not yield the *final* breakthrough needed to address the obesity epidemic but a rapprochement between rhetoric and medicine in this arena may generate ideas that push the "unending conversation" about health, fulfillment, and human cultivation and agency forward in fruitful ways.[29] Furthermore, while I do not intend to once and for all solve the problems of medicine by gesturing to needed rhetorical correctives, I agree with the rhetorician, Judy Segal, when she argues for the "relevance of rhetorical findings for clinical practice and health policy" thus suggesting that rhetoric may help to promote better medical practices and, thus, better health

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[27] Gawande, *Complications*; Jerome Groopman, *How Doctors Think* (Boston: Houghton Mifflin Company, 2007). My use of the term "humanistic" requires some discussion here. Humanism is a complicated and contested term that is directly attached to the conception of *paideia* I draw on throughout this dissertation. As Jaeger suggests, Greco-Roman conceptions of *paideia* involved the use of "knowledge as a formative force in education, and by it to shape the living man as the potter moulds clay and the sculptor carves stone into preconceived form." This view, what Jaeger terms "humanism" is rooted in "the process of educating man into his true form, the real and genuine human nature." This understanding of humanism stands in stark contrast to contemporary notions of "individualism" which honor the individual's right and capacity to make autonomous decisions about who and what they shall be and/or become. Jaeger, *Archaic Greece*, xxii-xxiii. Balancing between these two views and following the work of Martha Nussbaum in her *Therapy of Desire*, I work to develop an understanding of practitioners and patients as co-constituted by society and their internalized modes of reasoning and desire. Thus, I argue throughout this dissertation that humanism can embrace both the socio-cultural and political coordinates of constitution and the individual's own reasoning and choice making (in the form of *phronesis*).

[28] Here, I am following Arthur W. Frank's work. In the context of medicine, Frank argues that "Those who have been objects of others' reports [i.e., patients] are now telling their own stories. As they do, they define the ethic of our times: an ethic of voice, affording each a right to speak her own truth, in her own words." Frank, *The Wounded Storyteller,* xiii.

[29] Kenneth Burke, *The Philosophy of Literary Form: Studies in Symbolic Action*, 3rd ed. (Berkeley: University of California Press, 1973), 110.

outcomes.[30] Of course, "communication" has come to play a central role in the training of physicians but "rhetoric" has not gained as much uptake. Previous work in doctor-patient communication and health communication has given us research that confirms the need for more attention to the interpersonal and transactional elements of medical care in both clinical and public domains.[31] Yet, analysis of medical phenomena drawing upon rhetorical concepts remains rare. Accordingly, that words themselves play a central role in the cultivation of health and that classical concepts from the Greek rhetorical tradition may assist in enlivening and even revising certain areas of medical practice are insufficiently developed conceptual and practical arenas. The topic area of lifestyle management presents a unique opportunity to develop this promising line of research further. The following pages show how this is the case.

1.2 A RAPPROCHEMENT OF RHETORIC AND MEDICINE: WHERE TO BEGIN?

Rhetoric has often been figured as a site for interdisciplinary translation, a nexus at which the sharing of different knowledge systems is made possible and, it is hoped, yield fruit.[32] In this sense, it appears a fertile place to begin unlocking the problems and possibilities of, for example, patient-provider interaction, because each member of this complicated partnership brings very

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[30] Judy Z. Segal, *Health and the Rhetoric of Medicine* (Carbondale: Southern Illinois University Press, 2005), 4.

[31] Work on health communication and doctor-patient communication is extensive. For several excellent examples, see Timothy Edgar, Seth M. Noar, and Vicki S. Freimuth, eds., *Communication Perspectives on HIV/AIDS for the 21st Century* (New York: Lawrence Erlbaum Associates, 2008); Stephen Rollnick, William R. Miller, and Christopher C. Butler, *Motivational Interviewing in Health Care: Helping Patients Change Behavior* (New York: The Guilford Press, 2008); Debra L. Roter and Judith A. Hall, *Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits*, 2nd ed. (Westport, CT: Praeger, 2006); Stephen Rollnick, Pip Mason, and Chris Butler, *Health Behavior Change: A Guide for Practitioners* (New York: Churchill Livingstone, 1999); Thomas Gordon and W. Sterling Edwards, *Making the Patient Your Partner: Communication Skills for Doctors and Other Caregivers* (Westport, CT: Auburn House, 1995). I detail emerging work in the rhetoric of medicine in the next section of this chapter.

[32] Julie T. Klein, *Crossing Boundaries: Knowledge, Disciplinarities, and Interdisciplinarities* (Charlottesville, VA: University Press of Virginia, 1996), 66-70.

different perspectives, accumulated forms and modes of knowledge, and communication styles to the clinical setting.[33] Rhetoric's contribution in overcoming the epistemic and practical walls separating patients and their providers is thus based on its malleable potentiality as an art that can bridge divides between different perspectives in order to find common ground for action. As such, rhetoric admits of few boundaries due to its status as situated and suasive discourse. Such discourse is happening everywhere, at all times and in all places inhabited by human beings capable of communication who face the need to make decisions in contingent circumstances, a ubiquitous feature of human existence.[34] It is in this sense that we can say rhetoric can and must occur within the clinical setting between patients and their providers.[35]

However, the fact that rhetoric is always already happening in a variety of domains does not necessarily point to its value as a theoretical perspective from which to analyze politics, law, medicine, or other professions.[36] Indeed, overzealous clarion calls for interdisciplinarity can be dangerous as they open up the possibility of miscommunication, misappropriation, and misunderstanding.[37] If rhetoric is to play an important role in our unfolding story of lifestyle

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[33] A great deal of research has been done on this topic with new paradigmatic approaches being developed to handle the roles of patients and physicians in chronic care. For example, some scholars have developed a "collaborative care [paradigm]" that "implies that while professionals are experts about diseases, patients are experts about their own lives." Thomas Bodenheimer, Kate Lorig, Halsted Holman, and Kevin Grumbach, "Patient Self-management of Chronic Disease in Primary Care," *Journal of the American Medical Association* 288 (2002): 2470. This insight is shared by many, including Rubinelli, Schulz, and Nakamoto, "Health Literacy."

[34] This view is developed thoroughly throughout Aristotle's *Rhetoric.*

[35] In fact, rhetoric as a mode of "persuasion" is an already accepted condition of doctor-patient interactions. Ruth R. Faden and Tom L. Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986), 258-262. What's more, rhetoric features prominently as a tool for analysis in at least one major text on psychotherapy. Jerome D. Frank and Julia B. Frank, *Persuasion and Healing: A Comparative Study of Psychotherapy*, 3rd ed. (Baltimore, MD: The Johns Hopkins University Press, 1961).

[36] In terms of the criticisms of the capaciousness of rhetoric described here, see Dilip P. Gaonkar, "Rhetoric and Its Double: Reflections on the Rhetorical Turn in the Human Sciences," in *The Rhetorical Turn: Invention and Persuasion in the Conduct of Inquiry*, ed. Herbert W. Simons (Chicago: The University of Chicago Press, 1990), 341-366. For a robust debate about Gaonkar's views (as well as a longer adumbration of them), see Alan G. Gross and William M. Keith, eds., *Rhetorical Hermeneutics: Invention and Interpretation in the Age of Science* (Albany: State University of New York Press, 1997).

[37] Whatever the value and position of the art of rhetoric truly *is* (or, more appropriately, whatever it *does*), the always present question regarding its rightful place in the arts and sciences has become a central element of its

management as a medical, social, and cultural activity, then it must have more to contribute than the shallow finding that persuasion is happening between physicians and their patients (or, more broadly, throughout an entire cultural context). In this sense, my effort to link medicine and rhetoric emerges from a critical issue at the heart of studying and practicing the art of rhetoric: the work of many rhetoricians to seek justifications for the continued existence of rhetoric as a scholarly perspective.[38]

But before the specific dimensions of this issue are broached, it is important to highlight that I am not the first to defend the appropriate and productive role of rhetoric in the shaping of human practices such as medicine and health care.[39] Within what can be called a "new ecology"

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existential legitimation within the halls of academe and beyond. Gaonkar, "Rhetoric and its Double"; Robert Hariman, "Status, Marginality and Rhetorical Theory," *Quarterly Journal of Speech* 72 (1986): 38-54. In addition, the history of rhetoric is replete with ongoing debates regarding its ethical praxis, its role in virtuous societies, and its place in the constitution of democratic life. In other words, one cannot begin an investigation of the sort I am working on here without at least nodding in the direction of this ongoing problem with the boundaries of rhetoric, with its gaps and fissures, with its potential manipulations and the harm that these may do. For a good example of work that engages in the reflective practice I briefly described here, see John M. Ackerman and David J. Coogan, eds., *The Public Work of Rhetoric: Citizen-Scholars and Civic Engagement* (Columbia, SC: University of South Carolina Press, 2010). See especially the "Introduction" by the editors.

[38] On the unstable ground of rhetoric among the arts, see Gaonkar, "Rhetoric and its Double"; Hariman, "Status, Marginality and Rhetorical Theory."

[39] Many scholars have argued for a wide-ranging, nearly unbounded application and deployment of rhetoric. As part of this intellectual labor over the last several decades, rhetoric has been promoted as a critical tool in the evaluation and, at times, unmasking of a variety of human modes of inquiry. The most obvious effort in this regard has been the move to understand the motivations, strategies, discursive activities, suasive appeals, and interpretive moves of scientists. The effort to establish the "rhetoric of science and inquiry" has largely played out as various iterations of this movement (e.g., the unveiling of science as deeply rhetorical, the move to understand how scientific controversies unfold) have reached fever pitch and then receded. This scholarly movement has been and continues to be invested in understanding the role that symbols, signs, tropes, metaphor, and modes of controversy play in the development and transformation of science. For some of the touchstone texts in this disciplinary arena, see e.g., Leah Ceccarelli, *Shaping Science with Rhetoric: The Cases of Dobzhansky, Schrödinger, and Wilson* (Chicago/London: The University of Chicago Press, 2001); Charles A. Taylor, *Defining Science: A Rhetoric of Demarcation* (Madison: The University of Wisconsin Press, 1996); Thomas F. Gieryn, *Cultural Boundaries of Science: Credibility on the Line* (Chicago/London: The University of Chicago Press, 1999); Gross and Keith, *Radical Hermeneutics*; Simons, *The Rhetorical Turn*; Henry Krips, J.E. McGuire, and Trevor Melia, eds., *Science, Reason, and Rhetoric* (Pittsburgh: University of Pittsburgh Press, 1995); Peter Machamer, Marcello Pera, and Aristides Baltas, eds., *Scientific Controversies: Philosophical and Historical Perspectives* (New York/Oxford: Oxford University Press, 2000); H. Tristram Engelhardt, Jr. and Arthur L. Caplan, eds., *Scientific Controversies: Case Studies in the Resolution and Closure of Disputes in Science and Technology* (Cambridge: Cambridge University Press, 1987); John S. Nelson, Allan Megill, and Donald N. McCloskey, eds., *The Rhetoric of the Human Sciences: Language and Argument in Scholarship and Public Affairs* (Madison: The University of Wisconsin Press, 1987). Over time, the grand movement to produce a new subfield (largely undertaken by the individuals listed

for the rhetoric of science and inquiry, one niche that is growing, perhaps even encountering a kind of renaissance, is the rhetorical study of medicine.[40] There are many reasons for the growth of this particular niche, most notably the increasing dominance of medicine and medical modes of thought and action in the daily lives of all human beings.[41] The movement to secure health, to be healthy, to make our health care system work, and to understand ourselves as primarily healthy bodies (and bodies in need of healthier ways of being) has been ongoing for some time.[42] While there are definitely reasons to critically interrogate the movement to secure health and produce healthy bodies, I want to suggest that as a primary mode of being, health has become a central *topos* (topic) and *exigence* (material condition calling forth discourse) in the grounded, everyday rhetorical activities of individuals well beyond the academic ecology of rhetorical studies of science.[43] As rhetoricians are often pushed and pulled by the contemporary scenery of

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above, among others) has turned into a distributed effort to understand how science and rhetoric are mutually motivated and motivating arenas of human understanding and action. In this sense, a whole ecology of rhetorical studies of science, each acting as a specific niche in a largely fragmented but still mutually supportive environment, has emerged. Rhetoricians have begun to use the term "ecology" to describe the important role that rhetoric might play in modern technological society. For instance, Robert Hariman has argued that rhetoric can be understood from the perspective of an Isocratean-inflected notion of ecology in which "prudence" as opposed to technological advancement is central to the continued survival of humans. Robert Hariman, "Civic Education, Classical Imitation, and Democratic Polity," in *Isocrates and Civic Education*, ed. Takis Poulakos and David Depew (Austin: University of Texas Press, 2004), 228. For the relationship between a revived rhetorical worldview (in response to the technological/scientific tradition) and the increasingly in vogue ecological perspective see Stephen Toulmin, *Cosmopolis: The Hidden Agenda of Modernity* (Chicago: The University of Chicago Press, 1992), 192-209.

[40] For work in the area of rhetoric of medicine in which linguistic tools are viewed as powerful in the symbolic construction of scientific understanding and dissemination to the public, see e.g. Celeste M. Condit, *The Meanings of the Gene: Public Debates about Human Heredity* (Madison: The University of Wisconsin Press, 1999); John Lyne, "Contours of Intervention"; Segal, *Health and the Rhetoric of Medicine*; Keränen, *Scientific Characters*; John Lynch, *What Are Stem Cells? Definitions at the Intersection of Science and Politics* (Tuscaloosa: The University of Alabama Press, 2011). In the same vein, see some early work on the visually symbolic appeals of the clinical setting in Burke, *A Rhetoric of Motives*, 171-172.

[41] For a discussion of the dominance of health-related thinking in contemporary society (as well as some important criticisms of "health" as a central value), see Jonathon M. Metzl and Anna Kirkland, eds., *Against Health: How Health Became the New Morality* (New York: New York University Press, 2010).

[42] Metzl and Kirkland, *Against Health*.

[43] Nikolas Rose argues that "optimization" of life (both in terms of health and beauty) is now a central aspect of human existence (and has, perhaps, been so throughout the course of human development). See Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton: Princeton University Press, 2007), 6. See also, Metzl and Kirkland, *Against Health*. In addition, Rose has argued elsewhere that "new conceptions and techniques of the self" are emergent in contemporary society and in need of

rhetorical action, it is no surprise that more and more of them are spending their time on medicine (i.e., clinical care and research) and health (i.e., a certain kind of life in which the body is "optimized" and secured, as much as it can be, from harm).[44] This, in itself, suggests one reason why rhetoricians might take an interest in medicine, but I have to go further in order to understand if this interest may in fact yield fruit beyond the development of more significant scholarship within the disciplinary domain of rhetorical studies.

Accordingly, it is useful to look at the reflexive work being done by rhetoricians to understand their increasing interest in and work on medical theory, practice, education, and experience. In this regard, rhetorical studies of medicine are now the topic of significant meta-analysis.[45] For example, Johanna Hartelius, in a recent review article, concludes by echoing the omnipresent quandary regarding the place of rhetoric in academia, one rooted in its relevance, its disciplinary coherence, and its ability to generate useful insights.[46] She suggests that rhetorical scholars must be careful that their work in medicine contributes to "sustainable scholarship" connected to internal issues related to rhetorical and communication theory.[47] In developing this argument, she suggests that scholars who engage in "hit and run" rhetorical scholarship promote a kind of "exploitative" activity (following her ecological metaphor, i.e., sustainability) that draws on experiences and modes of praxis in other intellectual, scholarly, and practical domains without contributing much to them and simultaneously failing to enhance the study of rhetoric as

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reflection and critique. I view my dissertation as an effort along these lines with a more humanist twist than that offered by Rose. Nikolas Rose, *Governing the Soul: The Shaping of the Private Self* (New York: Routledge, 1990), xii.

[44] Rose, *The Politics of Life Itself*, 6.

[45] Segal, *Health and the Rhetoric of Medicine*, especially the "Introduction," and "A Kairology of Biomedicine," 1-36.

[46] Johanna Hartelius, "Sustainable Scholarship and the Rhetoric of Medicine," *Quarterly Journal of Speech* 95, no. 4 (2009): 457-470.

[47] Hartelius, "Sustainable Scholarship and the Rhetoric of Medicine," 466.

such.[48] In other words, Hartelius' argument provides a warning for the would-be *rhetorician of medicine.* Rhetoricians may exploit medical activities, narratives, and other practices by treating them as merely rhetorical artifacts. They may, in so doing, undermine the sustainability of their own discipline as their work yields insufficient insight for rhetoricians and the practice of medicine. Such work is something that we should all, rhetoricians interested in medicine perhaps most of all, avoid.

Hartelius is, at least in part, correct. "Sustainable scholarship" within the domain of rhetorical studies of medicine is certainly an important goal. In fact, it is not merely a goal but perhaps central to the long-term viability of the arena of scholarship I plan to engage in and promote throughout my career. However, such sustainability throughout the ecological map of rhetorical studies of science and rhetoric of medicine in particular is not served simply by adding to the corpus of rhetorical work but also by the activity of sharing rhetorical insights in other arenas of human action. As rhetorical theorists and critics continue to find new ways to put the power of rhetoric on display, it behooves all of us to consider how our work functions to improve not only our internal and field specific efforts but also the promotion of rhetorical activities in professional and public spaces (in this case, medicine and public conceptions and practices surrounding health). In this sense, Hartelius' viewpoint needs some reworking. We cannot adopt a purely internalist approach however important this approach is to the initial field-specific justification of rhetorical work in medicine. In other words, moving into the various and sundry places inhabited by our objects of study may also promote sustainability by providing space for the emergence of rhetorical work. Of course, rhetoricians of medicine may be seen for a time as a kind of invasive species (again, following the ecological metaphor established by Hartelius)

[48] Hartelius, "Sustainable Scholarship and the Rhetoric of Medicine," 467.

that exploits medicine and healthcare for its own needs; however, if we truly believe that our work can promote the work of others, enhance it, and in so doing, augment our role in the world, then this risk is worth taking.

For the reasons adumbrated above, I argue here that rhetorical work that is both *clinically relevant* and also *driven by the demands* placed on situated practitioners of medicine and their patients may yield not only a sustainable model for future rhetoricians of medicine but also prepares the way for a merger of rhetoric and medicine that may pay major dividends for theorists and practitioners in both arenas. Furthermore, and perhaps even more important, the needs and concerns of medical practitioners and patients may, under these favorable conditions, loop back into the concerns of rhetorical scholars, making their work more relevant and perhaps even curative.[49] As such, rhetorical work may actually help to improve clinical outcomes, a topic that is interrogated throughout the rest of this dissertation.[50] For the reasons adumbrated above, the rest of this introduction outlines the following conceptual arenas all of which contribute to the rest of this study:

(1) A "sustainable" form of rhetorical scholarship involving medicine[51]

(2) What I mean by a *clinically relevant and "demand-driven" rhetoric of medicine* and how I believe that this model for medical scholarship can be understood as "sustainable";[52]

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[49] Segal, *Health and the Rhetoric of Medicine*, 4.
[50] Segal, *Health and the Rhetoric of Medicine*, 4.
[51] Hartelius, "Sustainable Scholarship and the Rhetoric of Medicine."
[52] Gordon Mitchell expertly develops the notion of "demand-driven" rhetorical scholarship in a recent article. He suggests that "demand-driven" rhetorical projects involve the creation of supportive networks for the advancement of work in other fields and arenas of human decision making. He also suggests that this kind of project is distinct from other attempts to "globalize" rhetoric: "This demand-driven epistemology is different in kind from the globalization project so roundly criticized by Gaonkar. Rather than rhetoric venturing out from its own academic home to proselytize about its epistemological universality for all knowers, instead here we have actors not formally trained in the rhetorical tradition articulating how their own deliberative objectives call for incorporation of rhetorical practice and even recruitment of 'strategically located allies' to assist in the process." Following his line of thinking, I suggest that a "demand-driven" and clinically relevant version of the rhetoric of medicine is a productive direction for mutually supportive work that can enhance both our understanding of the role of rhetoric in the domain of medicine and the practice of medicine itself. Gordon R. Mitchell, "Switch-Side Debating Meets

(3) Why it is that classical conceptions of rhetoric (informed by other key terms such as *phronesis*, *eudaimonia*, and *paideia*) can and should inform this study;

I conclude this introduction with a discussion of my organizing case study and my chapter designs.

These conceptual arenas indicate the extent to which my project is based on a rapprochement of rhetoric and medicine that is rooted in something more than simply scholarly interest. Instead of approaching medicine merely as an "object of study" or a thing watched from afar, I seek to inhabit the world of medicine as a rhetorician.[53] Such an approach to the rapprochement of rhetoric and medicine, as well as my own view of medicine as a domain that I have chosen to inhabit rather than merely look at and interpret, is not without controversy. Some scholars have claimed that rhetoric should be bound to a specific horizon rather than, as John Poulakos argues, a "nomadic art" that can find its way into (and is probably already present within) almost any domain.[54] For instance, Dilip Gaonkar notes that for many contemporary rhetoricians "a perfect interpretation is one in which the object of interpretation loses all of its recalcitrance and becomes transparent."[55] In other words, Gaonkar suggests that the use of rhetorical methods to elucidate the movements, transitions, and practices of other intellectual and

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Demand-Driven Rhetoric of Science," *Rhetoric and Public Affairs* 13, no. 1 (2010), 111.

[53] I mean this quite literally. For the past several years, I have been actively involved in the clinical and research domains. As a student at the Center for Bioethics and Health Law at the University of Pittsburgh, I spent over 100 hours observing physicians, nurses, and other health practitioners engaged in patient care in such diverse arenas as the intensive care unit, the primary care office, and the bariatric surgery wing of a major hospital. I have also actively engaged in cooperative research with members of a research team housed at the University of Pittsburgh. In fact, some of this research informs the current dissertation and my interaction with this team provided the foundation for my work throughout. Finally, as a fellow and trainee at the Institute for Clinical Research Education housed in the University of Pittsburgh, I have interacted with medical fellows, attended training courses in human subjects research, clinical and translational research, and qualitative research. All of these experiences have made my interest in medicine much more than a passing interest in one specific object.

[54] This conception of a "nomadic art" of rhetoric has been adopted from John Poulakos' work on sophistic rhetoric. See John Poulakos, *Sophistical Rhetoric in Classical Greece* (Columbia, SC: University of South Carolina Press, 1995); John Poulakos, "Rhetoric and Civic Education: From the Sophists to Isocrates," in *Isocrates and Civic Education*, 69-83.

[55] Gaonkar, "The Idea of Rhetoric," in *Rhetorical Hermeneutics*, 25.

practical domains renders these elements fully transparent and therefore open to rhetorical critique of an "exploitative" kind.[56] In a nutshell, Gaonkar adopts the invasive species metaphor (discussed in the context of Hartelius' work above) in his work on the rhetoric of science. Of course, the approach to rhetorical criticism that Gaonkar describes, especially one in which the notion of "recalcitrance" (the term Kenneth Burke uses to describe those material elements of the world that do not admit of symbolic intervention, re-working, or complete transcendence) is ignored, would without a doubt be problematic.[57] However, in response to this concern, I want to suggest that inhabiting another arena of human action as a rhetorician is not of necessity an attempt to render it fully transparent and ready for exploitation but rather to offer a different perspective, most importantly, one that shines a light where illumination is needed for further development. This is especially the case when the communicative practices of other fields of inquiry are up for discussion, development, and critique. Rhetoric is perfectly situated to offer insights and provide new avenues for practice when these communicative practices are on the table. In addition, much of Gaonkar's criticism has to do with the interpretive powers of rhetorical criticism as opposed to rhetorical practice outside the domain of scholarship. While this dissertation is certainly grounded as a scholarly project that engages in interpretive work, it extends beyond these activities into the productivist realm of cultivating rhetoric as a skill useful for improving the quality of clinical encounters and health outcomes (see especially, chapters 2 and 4-5).

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[56] Harterlius, "Sustainable Scholarship and the Rhetoric of Medicine," 467.

[57] Kenneth Burke argues that symbolic work often hits up against material forms of "recalcitrance" or impediments to the possibilities for symbolic transformation (e.g., one cannot simply write a story about weight loss and than make it a reality without taking action in the world to achieve this end). Kenneth Burke, *Permanence and Change: An Anatomy of Purpose*, 3rd ed. (Berkeley: University of California Press, 1984), 256. For an elaboration of Burke's notion of "recalcitrance, see J.E. McGuire and Trevor Melia, "How to Tell the Dancer from the Dance: Limits and Proportions in Argument About the Nature of Science," in *Science, Reason, and Rhetoric*, 73-93.

Beyond Gaonkar's concerns, there resides another critical limitation to this rapprochement having to do with who I am as a scholar. I am not fully within medicine nor do I have the expertise and experience of a clinical practitioner. There will always be a dividing line between what I can bring to the table and what a clinician can do and this, I believe, is a good thing. As I am not constantly doing the *thing* of medicine, I have the capacity to inhabit the medical world as a traveler with a particular vantage point quite different from (but not better than) the provider and the patient (although I have been a patient and will likely be one again).[58] In terms of my project, rhetoric is one perspective of many but it is powerful in that its perspective can innovatively contribute to the shaping of lifestyle pedagogies and practices in the clinic (without replacing the work being done in other important arenas such as medical education and health literacy).[59] It is with this perspective on my own role in the promotion of a rhetoric and medicine merger that I move on to the major claims that justify this study and provide the starting points from which it emerges.

1.3 SOME APPROACHES TO THE RELATIONSHIP BETWEEN RHETORIC AND MEDICINE

Rhetoric and medicine emerged simultaneously and as mutually supportive domains in the intellectual history of ancient Greece. To speak of them as separate domains, as two completely different approaches to understanding and human action, as practiced and understood by different individuals, would be largely unintelligible and indefensible for many of the most

[58] This notion of traveling or touring sites other than our own while bringing our own theoretical and practical tools with us is drawn from Phaedra C. Pezzullo's, *Toxic Tourism: Rhetorics of Pollution, Travel, and Environmental Justice* (Tuscaloosa: University of Alabama Press, 2007), 21.

[59] Health literacy is a major arena in which at least one of the tools I am using in this dissertation, *phronesis*, has found a foothold. Rubinelli, Schulz, and Nakamoto, "Health Literacy."

famous and prolific Greek thinkers of the 5th and 4th centuries B.C.E. For example, Gorgias, perhaps the greatest of the Sophists (itinerant philosophers and teachers in ancient Greece), is known to have written on the subjects of rhetoric, philosophy, and metaphysics, while also claiming to be a practitioner of the art of medicine.[60] Likewise, Prodicus, another early Sophist, studied rhetoric along with many other arts including ethics and physiology.[61] However, Hippocrates, the hero of the Greek age of medicine (perhaps because the texts attributed to him were the best preserved, perhaps because those who worked to compile them were excellent rhetoricians) is the obvious place to begin unfolding the relationship between rhetoric and medicine.[62] It is, according to Chadwick and Mann, the Hippocratic tradition that informs the strand of the history of medicine that we have received in the West, the empirical and overtly rational approach to the study and practice of medicine that we now view as normative.[63] Of course, such a reading of the Hippocratic tradition might leave us thinking that medicine was bound to end up exactly where it is, as one of the most powerful institutional forces in modern

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[60] Plato *Gorgias* 456b-c; Leach, "The Art of Medicine: Valuing Communication," *The Lancet* 373 (2009): 2104-2105.

[61] In fact, Prodicus is an excellent example of the sophistic tendency to involve oneself in a variety of activities of an intellectual and practical nature. Douglas J. Stewart suggests that "Other, non-Platonic, sources do not necessarily support Plato: they give us rather an impression of a wide-ranging dilettante whose interests included ethics and physiology, cosmology and anthropology – and, of course, rhetoric, the chief preoccupation of all the sophists." Douglas J. Stewart, "84. Prodicus," in *The Older Sophists: A Complete Translation by Several Hands of the Fragments in Die Fragmente Der Vorsokratiker Edited by Diels-Kranz with a New Edition of Antiphon and of Euthydemus*, ed. Rosamond Kent Sprague (Indianapolis: Hackett Publishing Company, Inc., 2001), 70.

[62] The notion that at least some of the Hippocratic physicians were in fact rhetoricians is a central part of the argument in Joan Leach's dissertation project. See Joan Leach, "Healing and the Word: Hippocratic Medicine and Sophistical Rhetoric in Classical Antiquity" (PhD diss., University of Pittsburgh, April 1996).

[63] Chadwick and Mann, "Introduction," in *The Medical Works of Hippocrates*, 3-4. On this progress narrative of medical science and its weaknesses, see Leach, "Healing and the Word," Chapter IV. In this chapter, Leach suggests that the Hippocratic corpus was taken up as an "empiricist" account of medicine, one that questions the role of rhetoric in its formation (that is, in fact, hostile to rhetoric's role) that views the movement to an empiricist model of medicine was somehow preordained. Along with Leach, I find this version of the history of medicine both unpalatable and inaccurate.

life.[64] As with rhetoricians who have tackled this topic before me, I find this claim dubious at best and seek in this dissertation to promote a more complicated picture that lends credence to the mutability of medicine as an art as well as a form of scientific practice, one that has changed over time but not, as many would have it, progressed at all times. Despite these problems in the intellectual history of medicine, one can find more productive and, quite simply, honest reasons to engage the question of the relationship between rhetoric and medicine within the Hippocratic writings. Most importantly is the fact that Hippocrates was a student of Gorgias, that he knew the practices of rhetoric as well as medicine, and that these practices are found throughout the corpus that bears his name.[65] In this sense, one can say that Hippocratic physicians were rhetoricians, at least of a sort. They were in the business of using rhetoric not only to sell their art but also to engage in dialectical exchanges with those that would define the art of medicine differently.[66] For the Hippocratic physicians and their intellectual partners, the Sophistic pedagogues of 5th and 4th century Greece, rhetoric was seen as curative and the act of curing patients was seen as, at least in part, rhetorical.[67]

Joan Leach's dissertation, "Healing the Word: Hippocratic Medicine and Sophistical Rhetoric in Classical Antiquity," provides an excellent account of these arguments and is, thus, a

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[64] On the emergence of the institution of medicine as one of the most powerful in modern society, see Paul Starr's, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, Inc., 1982).

[65] Jody R. Pinault, *Hippocratic Lives and Legends* (Leiden, The Netherlands: E. J. Brill, 1992), 10.

[66] Leach, "Healing and the Word," 56; Adam D. Roth, "Reciprocal Influences between Rhetoric and Medicine in Ancient Greece" (PhD diss., University of Iowa, 2008); Hui-Hua Chang, "Testing the Serpent of Asclepius: The Social Mobility of Greek Physicians" (PhD diss., Indiana University, 2003). I should point out that while all of these authors entertain the notion that the Hippocratic physicians knew and utilized rhetoric in their writings, they have different theories about the reasons for this and how it ultimately played out in practice. This is a point that I return to in subsequent chapters.

[67] See Leach, "Healing and the Word"; Roth, "Reciprocal Influences between Rhetoric and Medicine in Ancient Greece"; Chang, "Testing the Serpent of Asclepius." Also, and in terms of my own view of this matter, I submit that Gorgias (at least as recorded in Plato's dialogue named for him) and the Hippocratic writer both discuss the use of rhetoric in the persuasion of patients and in the ultimate success of the medical craft. I take up this point in chapter 2.

major influence on my work. There are two other reasons to focus on this text. First, it is the only major effort I am aware of to show direct links between Sophistry (one of the earliest known strands of rhetorical pedagogy) and medical practice in the 5th and 4th centuries B.C.E. that remains directly tied to the primary sources.[68] Second, it is a dissertation completed at the University of Pittsburgh and, for this reason, indicates the connection between my work and excellent work that has been done at this institution in the past.[69] Leach argues that the Hippocratic physicians and the early Sophists were, in many cases, the same people. The reason for this was a need for articulating a new paradigm of medical practice differentiated from the mystical and magical forms of medical practice featured in the Homeric age and still healthy during the 5th and 4th centuries. Her work suggests that at the historical point of emergence for Sophistry, this new form of medicine began to use its rhetorical insights to gain dominance. In this sense, her approach values the role of rhetoric in buttressing medical approaches of an empirical form (perhaps due to a new vision of scientific method, perhaps due to the epistemological commitments of Greek Sophists and rhetoricians). Unfortunately for rhetoric, the empirical and rationalistic trends in this version of the historical narrative would come to undermine and even eviscerate the role of rhetoric in this history. Ultimately, she argues that the contemporary uptake of the Hippocratic tradition (beginning with Francis Bacon and surviving

[68] However, there are shorter and equally important scholarly contributions to the development of an intellectual history of rhetoric and medicine as interprenetrating arts. See e.g., Steven Pender, "Between Medicine and Rhetoric," *Early Science and Medicine* 10, no. 1 (2005): 36-64); Barbara Wood, "The Conjectural Method: From Ancient Medicine to Ancient Rhetorical Theory," *Western Speech* (Winter, 1967): 37-44; John Poulakos, "Philosophy and Medicine in Plato's Symposium," in *Philosophy and Medicine*, vol. II, ed. K. J. Boudouris (Samos: International Center for Greek Philosophy and Culture, 1987), 162-170. In addition, for more on Leach's arguments as summarized here, see her "Hippocratic Reason and Sophistical Rhetoric: Empiricism and Argument in Classical Antiquity," in *Philosophy and Culture*.

[69] In fact, I am willing to make the robust claim that the University of Pittsburgh has been a unique site for the innovative cultivation of rhetorical theories that animate medical practices. It is no accident that one of the largest medical centers in the United States is housed just a few blocks from our humble humanistic abode! In any case, I view my dissertation as contributing directly to this currently nascent but historically powerful tradition.

until today) has valued its rationalistic turn as a kind of progress narrative for the ascendancy of Western philosophy, technological dominance, and scientific purity.[70] Where my own work hopes to intervene is actually where Leach leaves off; in particular, with the question of whether a different kind of understanding of contemporary medicine, in which rhetoric is valued instead of progressively erased as part of the paradigm described above, may or may not find a foothold in contemporary medical practice.[71] Thus, one argument that recurs throughout this dissertation is that we have entered a liminal period in which such possibilities might be realized. I more fully develop this claim in chapter 2.

The claim that rhetoric plays a curative role, that rhetorical practice itself works as a form of therapy for the social problems that ail us has been articulated previously.[72] So has the closely related claim that philosophy, as another model of *logos*-based practice, therapeutically reconfigures incorrect beliefs and perceptions. In terms of philosophy, Friedrich Nietzsche is well known for his conception of the philosopher as cultural physician.[73] Jacques Derrida, building on Plato, has provided the most well developed account of *logos* as a kind of *pharmakon* or drug that crafts subjects, beliefs, and ways of life in particular ways.[74] Michel Foucault has argued that the bodily practices inherent in Hellenistic philosophy act as a kind of normative therapy for the body and soul that sutures it to the production and apprehension of truth.[75] Martha Nussbaum's work traces the therapeutic philosophy of Hellenistic thinkers, providing good reasons to understand philosophy as a mode of therapy for social ills, a kind of

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[70] Leach, "Healing and the Word," 103-105.

[71] Although she is much more optimistic in a more recent essay regarding the possibilities for "a Hippocratic revolution in medicine." Joan Leach, "The Art of Medicine," 2104-2105.

[72] I must thank Roth for his excellent work on this history. It has definitely informed my own. See his dissertation, "Reciprocal Influences between Rhetoric and Medicine in Ancient Greece."

[73] Roth, "Reciprocal Influences between Rhetoric and Medicine in Ancient Greece," 9.

[74] Jacques Derrida, "Plato's Pharmacy," in his *Dissemination*, trans. Barbara Johnson (Chicago: University of Chicago Press, 1983), 63-171.

[75] Here, see Michel Foucault, *Hermeneutics of the Subject* and *The Care of the Self*.

paideia.[76] Moving to overtly rhetorical accounts, Kenneth Burke argues for the cathartic nature of rhetoric in his *Rhetoric of Motives*.[77] In addition, Richard Weaver suggests that, on the Platonic reading of the role of rhetoric, rhetorical practice is aimed at guiding the soul away from harm and toward a better mode of existence (i.e., one closer to the ultimate and transcendent virtues that he defends throughout his corpus).[78] Additionally, and beyond the direct relationship between medicine and rhetoric in the authors already noted, John Durham Peters argues that for advocates of free speech, the interaction of various opinions and belief systems (especially the more offensive or radical kind) are often seen as playing a "homeopathic" role in the construction of subjects and democratic communities.[79] These authors offer only a small part of the picture. While they would find much to disagree about, their shared conceptual history resides in the power of the *word* to shape *healing*, in the therapy (either positive or negative) contained within language. I share this with all of them; however, my approach differs by arguing that medicine has not sufficiently embraced the therapeutic power of the *logos*, and that health practitioners would do well to return to the historical connections between language and healing, between rhetoric and medicine, to reframe medical practice in the context of chronic disease. That is, while practitioners of both rhetoric and philosophy have often grappled with the problems and possibilities of medicine as a framework for understanding the power of language and thought, practitioners of medicine have often (although not always) put much less emphasis on the ways in which philosophy and language might contribute to their daily professional

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[76] Nussbaum, *The Therapy of Desire*.

[77] Kenneth Burke, *A Rhetoric of Motives*, 328. On Burke's use of medicine as a way to describe the work of rhetoric, see Carly S. Woods, " 'Everything is Medicine': Burke's Master Metaphor?" *K. B. Journal* 5, issue 2 (2009): http://www.kbjournal.org/carly_woods/.

[78] On this, see Plato's *Phaedrus*; Weaver, "The *Phaedrus* and the Nature of Rhetoric," in *The Ethics of Rhetoric*, 3-26.

[79] John D. Peters, *Courting the Abyss: Free Speech and the Liberal Tradition* (Chicago: The University of Chicago Press, 2005), 6.

activities in the care of the ill. Put differently, my work engages the contemporary clinical setting, an arena that is largely beyond the scope of the authors cited above.

This section has pointed to the Hippocratic event in medical history that first announced the relationship between rhetoric and medicine. I have also shown how this event has been carried through multiple traditions and taken up by a wide variety of authors in different intellectual domains. In addition, I have suggested that this history is important but not determinative in my ongoing effort to unlock the kinds of rhetorical activity relevant to modern medicine. In this way, I have mapped a field of play that I believe may contribute to a "sustainable scholarship" in the rhetoric of medicine in two ways: (1) through an ongoing revival and discussion of historical sources in which the two arts are closely associated, and (2) through a turn to the clinical domain of today which can attune rhetorical scholars to the needs of real audiences, real patients, real human beings. Any effort to argue for a totalizing acceptance of Greek or Roman attitudes toward health, medicine, and even rhetoric would be misguided. However, as their voices have resonated throughout history, we may yet have something to learn, borrow, or recognize within their approaches that may assist in our own endeavors. This belief drives the analysis put forward in chapters 3-6.

1.4 A CLINICALLY RELEVANT, "DEMAND-DRIVEN" RHETORIC OF MEDICINE[80]

With the brief history of the relationship between rhetoric and medicine of the previous section behind us, I am now in a position to discuss the second element of my approach: attaching rhetorical insights to the needs of real human beings in the contemporary milieu, or, as I have

[80] Mitchell, "Demand-Driven Rhetoric of Science."

suggested already, the development of a *clinically relevant* and *demand-driven* conception of medicine. In order to show what a *clinically relevant and demand-driven rhetoric of medicine* looks like as well as how it might contribute to chronic care, I draw on Trevor Melia's tripartite definition of rhetoric that involves ontological ("world view"), analytical, and productive elements.[81] Rhetoric implies a normative and descriptive understanding of human knowing and doing that is not so much relativistic but rather contingent, based on the limitations of human action and the revisability of human understanding.[82] Rhetoric implies an ontological commitment to the notion that humans are embedded in a process of becoming themselves, always shifting, learning, and growing based on their relationships, their experiences, and their newly forming capacities.[83] Rhetoric also includes a critical component, what Aristotle described as an ability "to find out in each case the existing means of persuasion."[84] Finally, according to Melia, rhetoric involves the notion of production, the idea that individuals engage in invention, delivery, and reframing in the process of attempting to persuade an audience. I (and others) would add to Melia's conception the notion that rhetoric involves a deeply pedagogic orientation.[85] From its very beginning, rhetoric has been a teaching art, concerned with the

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[81] These elements are described in Trevor Melia, "Review," *Isis* 83, no. 1 (1992), 100.

[82] I draw this understanding in part from Burke and his "action/motion" dyad. On the "action/motion" dyad, see Kenneth Burke, *A Grammar of Motives* (New York: Prentice-Hall, Inc., 1952), 14-15, 64-69, 127-317; Kenneth Burke, "(Nonsymbolic) Motion / (Symbolic) Action," *Critical Inquiry* 4, no. 4 (1978): 809-838. I have drawn the notion of "action" that I use throughout this dissertation not only from Burke but also from, Hannah Arendt who discusses a notion of "action" rooted in the linguistic interactivity (speech) between human beings. She argues that "human plurality [is] the basic condition of both action and speech." Hannah Arendt, *The Human Condition* (Chicago: The University of Chicago Press, 1958), 175.

[83] On this point, see also Gorgias' "On the Nonexistent or On Nature," in *The Older Sophists*, 42-46. In this work, Gorgias is credited with saying that rhetoric or *logos* is rooted in contingency or the ongoing uncertainty that makes up the development of human life and human community. See also Isocrates *Nicocles* in which he suggests that humans overcome such uncertainty and contingency through the use of *logos*.

[84] Aristotle *Rhetoric* I.i.14.

[85] The notion of rhetoric as a kind of pedagogy emerges from its identification as a sort of *teche* (art or craft) that can be taught. For a description of this in terms of Iscorates' rhetorical theory, see Terry Papillion, "Isocrates' *techne* and Rhetorical Pedagogy," *Rhetoric Society Quarterly* 25 (1995): 149-163. See also Jaeger, *Paideia: The Ideals of Greek Culture.*

promulgation of its resources to a public that must be capable of adequate deliberation and decision-making.[86] This pedagogic element of rhetoric stands at the heart of Jaeger's description of *paideia*: "the true representatives of *paideia* were not, the Greeks believed, the voiceless artists – sculptor, painter, architect – but the poets and musicians, orators (which means statesmen) and philosophers."[87] Thus, as Jaeger argues here, rhetoric stands at the heart of socio-cultural and political development and provides a medium for the cultivation of individuals who live and act within these spheres. Accordingly, rhetoric is something that can be learned, that should be learned, by those striving to analyze and perhaps transform their socio-political milieu with an active, productive spirit.[88] This dissertation presents an opportunity to explore the extent to which medical practice could be attached to a more robust conception of pedagogy (*paideia*), both in terms of professional development as well as the patient-provider relationship. As such, this additional fourth component is a central one in the unfolding of my argument.

In each of these four ways, I contend that rhetoric can contribute to the development of medicine in a clinically relevant way. As an ontological domain (or commitment), rhetoric can contribute a great deal by way of acknowledging and revealing the gaps in medical knowledge that require contingent decision-making in the absence of well-established scientific fact, something already acknowledged by scholars of medical education.[89] In addition, the embrace of contingency is part and parcel of lifestyle change itself. In this domain, individuals must be

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[86] On the history of rhetorical pedagogy (and its emergence as a means of preparing citizens to engage in adequate public advocacy), see John Henry Freese's, "Introduction," to Aristotle's *The "Art" of Rhetoric* (Cambridge: Harvard University Press, 1926), xi-xxxiv.

[87] Jaeger, *Archaic Greece*, xxvii.

[88] According to Takis Poulakos, this is the central attribute of Isocrates' notion of rhetorical praxis, what he calls *logos politikos*. On this, see Poulakos, *Speaking for the Polis.*

[89] See e.g., Molly Cooke, David M. Irby, and Bridget C. O'Brien, *Educating Physicians: A Call for Reform of Medical School and Residency* (San Francisco, CA: Jossey-Bass, 2010).

viewed as malleable, as capable of change, as "becoming" rather than merely "being."[90] In this sense, rhetoric is directly tied to *phronesis* or the development of practical wisdom that provides the dispositional attributes needed for good and effective action in the world. As a critical tool, rhetoric can enhance the reasoning and decision making faculties of practitioners and patients who must interpret the meaning of complicated statements about healthcare goals and therapeutic modalities in time-bound circumstances. As I argue throughout the rest of this dissertation, the development of such faculties requires a strong link between rhetoric as an art and *phronesis* as a form of knowledge and action.[91] As the rhetorician, Lois Self, points out, *phronesis* is a deeply deliberative mode of thinking and acting rooted in everyday experiences.[92] As such, *phronesis* is grounded in the same experiential and communicative elements as the art of rhetoric. As she suggests, there is substantial overlap between Aristotle's conception of the good rhetorician and the *phronimos* (or person of practical wisdom).[93] However, it is useful to distinguish between them as *phronesis* relates more to the praxis needed for living well generally whereas rhetoric is attuned in particular to speech as a mode of performance and constitution. That is, *phronesis* is the performance of one's ethical and practical knowledge whereas rhetoric is the performance of such knowledge in one's speech, one's methods of communicating with and making decisions in consort with others. We will see how the two terms share similar themes and emphases but reveal different elements and tendencies in later chapters when I critically engage several

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[90] John Poulakos discusses the difference between the "actual" and the "possible" at the heart of certain conceptions of rhetoric. As he points out, this distinction largely maps onto that between "being" and "becoming" which informs rhetorical work to deal with uncertainty, contingency, and the like. I submit that patients are often pushed into the realm of being (through diagnosis) and that efforts to change lifestyle choices must rely on the more rhetorical "becoming" or a refashioning of life. John Poulaokos, "Toward a Sophistic Definition of Rhetoric," *Philosophy and Rhetoric* 16, no. 1 (1983): 44-45.

[91] A point made somewhat differently and in the context of doctor-patient communication and health literacy in Rubinelli, Schulz, and Nakamoto, "Health Literacy."

[92] Lois S. Self, "Rhetoric and *Phronesis*: The Aristotelian Ideal," *Philosophy and Rhetoric* 12, no. 2 (1979): 137-138.

[93] Self, "Rhetoric and *Phronesis*," 131.

different primary objects of study (see chapter previews section below). Furthermore, as a tool for production, rhetoric can help to inspire a more focused effort on how messages are framed and how medical knowledge is disseminated not only to medical students as they engage in the process of becoming practitioners but also to patients who must make health-related decisions for themselves. Finally, as a pedagogic art, rhetoric can help to inspire teaching as a central attribute of physicianhood and patienthood. Providers and patients have much to teach each other and, as I intend to show, some models of patient-provider communication do not emphasize or develop this crucial element. Of course, this is just a schematic understanding of the role of rhetoric in a clinically relevant domain. I must show how each of these elements works in context (a subject that takes primary importance in chapters 2 and 4-6).

Moreover, rhetoric's connection to the clinic can also be described and/or put into practice through a "demand-driven" conception of its role.[94] By this, I mean that rhetoricians who seek to apply these four areas of the art of rhetoric to the clinical environment should attend to the issues that are of current relevance to medicine. Of course, Hartelius could argue that I am now justifying the further marginalization of rhetoric as relevant only to the demands of other fields; however, three powerful arguments can be marshaled against this point of view. First, rhetoric of medicine can actually play a role in enhancing clinical outcomes.[95] Second, rhetoric should be attuned to the contingencies and exigencies facing human life, as this is central to its historical evolution and ongoing importance. Finally, to be demand-driven is to embrace the notion that rhetoric is rooted within given situations that it can challenge, transform, or reinforce.[96] Where Hartelius gets it wrong is in over-determining the value of siloing rhetorical

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[94] Mitchell, "Demand-Driven Rhetoric of Science."
[95] Segal, *Health and the Rhetoric of Medicine*, 4.
[96] Bitzer, "The Rhetorical Situation"; Vatz, "The Myth of the Rhetorical Situation"; Mitchell, "Demand-

scholarship within its own disciplinary horizons (at least insofar as its theoretic contributions are concerned). This cuts against the role of rhetoric in framing and facilitating the improvement of human society writ large (best expressed by its Greek practitioners) and under-determines the value of collaboration across disciplinary horizons.[97]

All of this is to say that rhetoric can and should be relevant to clinical care and open to the "call" of medicine, to the issues that seek resolution.[98] Of course, the rhetorical art can help to clarify, even reveal, problems that have been obscured through the calcification of medical education and tradition. In other words, it need not simply respond to the demands placed on it by situation, exigence, and discursive activity. It can also play a "constitutive" role, thus reframing and potentially transforming practices for the better.[99] However, in responding to medicine, it is the task of rhetoricians to hear, see, and carefully interpret the realm into which they are entering. To do otherwise is to attempt a sort of epistemic and practical colonization, much akin to Gaonkar's notion of a "globalizing" rhetoric.[100] As a rhetorician, I am obligated to hear the call of the patient, the physician, and other health care practitioners who are already working on the problems that I turn my attention to throughout this dissertation. As an ethical backdrop, this call provides a context for understanding my role, not so much as a scholar but as a human being who is just as concerned about the quality of clinical care as the patients and providers currently making use of it on a regular basis in the treatment of chronic disease. Another way to put this point is that we will all need the help of others, perhaps even experts, at

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Driven Rhetoric of Science."

[97] Klein, *Crossing Boundaries.*

[98] Here, I am borrowing Michael J. Hyde's terminology of "the call of conscience" or the ethical obligation to hear and respond to or "acknowledge" the needs of others. See Hyde, *The Life-Giving Gift of Acknowledgement*, 2 (and throughout).

[99] On the "constitutive" function of rhetoric, see John Lyne, "Rhetorics of Inquiry," *Quarterly Journal of Speech* 71 (1985): 68-69; Maurice Charland, "Constitutive Rhetoric: The Case of the 'Peuple Québécois,'" *Quarterly Journal of Speech* 73, no. 2 (1987): 133-150.

[100] Gaonkar, "The Idea of Rhetoric."

some point in our lives to improve health or extend life. As Robert Klitzman notes, "In the end, all of us -- including doctors -- will one day be patients."[101] In this way, seeking out the demands of such care as an object of study is not merely an effort to frame the issue of "relevance" for my academic audience. It is also a means to contribute to the human project of health and wellbeing, of *eudaimonia*, something that all of the practitioners I have encountered, even those with whom I disagree about the way to engage in lifestyle change, take very seriously.

1.5 QUALITATIVE RESEARCH ORIENTATION

Pursuit of a *clinically-relevant, demand-driven rhetoric of medicine* requires a return to the "rough ground" of experience.[102] In my case, this involves ongoing clinical work at an academic medical research center, where researchers have developed and piloted a lifestyle intervention program, hereafter referred to as the Online Lifestyle Support System or OLSS, with funding from the U.S. Department of Defense.[103] This program adapts a lifestyle intervention developed for the Diabetes Prevention Program into an online platform.[104] The pilot study included 50 primary care patients who took part in a one-year-long intervention including online lifestyle training and planning with lifestyle coaches based on this adaptation. The format of the

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[101] Robert Klitzman, *When Doctors Become Patients* (Oxford: Oxford University Press, 2008), 309.

[102] The "rough ground" is a metaphor used by the philosopher, Ludwig Wittgenstein, to describe the complexity and the contingency of lived experience, especially actual language use. See Ludwig Wittgenstein, *Philosophical Investigations*, rev. 4th ed., ed. P. M. S. Hacker and Joachim Schulte, trans. G. E. M. Anscombe and P. M. S. Hacker (Malden, MA, Wiley-Blackwell, 2009), S107. Dunne borrows this language to talk about *phronesis* as an orientation to pedagogy that has been lost due to an increasing commitment by some to a "technist" and bureaucratic view of education. See Dunne, *Back to the Rough Ground: Practical Judgment and the Lure of Technique*.

[103] This study has undergone several iterations at this point.

[104] William C. Knowler, Elizabeth Barrett-Connor, Sarah E. Fowler, Richard F. Hamman, John M. Lachin, Elizabeth A. Walker, and David M. Nathan, "Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin," *New England Journal of Medicine* 346, no. 6 (2002): 393-403.

intervention includes having patients interact with lifestyle coaches (i.e. trained health care professionals) via an online platform. This platform is meant to organize the lifestyle intervention for the patients and their coaches. It includes 16 weekly and then 8 monthly lessons that deal with everything from diet and nutrition to exercise and other habits that are meant to have a positive impact on weight loss.[105] It includes a workbook in which patients are able to interactively participate in their lessons as well as commit to an "action plan" for the week. This "action plan" is a kind of wish – a hope that certain incremental changes might transform into overall changes in health activities, clinical communication practices, and the performance of life. The web-based platform also includes an exceptional amount of information that connects the individual patient to resources in their community. Early results of the pilot study indicate that the program may have had a positive impact on weight loss for many patients; however, my focus is not on whether the pilot program actually produced weight loss but rather on how it hoped to produce it and what other dividends might be seen from engaging in such health interventions.[106]

In other words, my primary focus is on the extent to which this lifestyle intervention and by extension, other programs like it "reinforce the patient's (and family's) crucial role in managing the condition, help patients to set limited goals for improving their management of their illness, identify barriers to reaching their goals, and develop a plan to overcome the barriers."[107] This is an important issue to probe, as producing changes in the habits of life is a significant step in the right direction for health practitioners. Crafting real lifestyle changes

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[105] Kathleen M. McTigue, Molly B. Conroy, Rachel Hess, Cindy L. Bryce, Anthony B. Fiorillo, Gary S. Fischer, N. Carole Milas, and Laurey R. Simkin-Silverman, "Using the Internet to Translate an Evidence-based Lifestyle Intervention into Practice," *Telemedicine & e-Health*, 15, no. 9 (2009): 851-858.

[106] McTigue, Conroy, Hess, Bryce, Fiorillo, Fischer, Milas, Simkin-Silverman, "Using the Internet."

[107] Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action," *Health Affairs (Millwood)* 20, no. 6 (2001): 70.

(*paideia*) through the development of *phronesis* is a critical step not only toward patient health (a subject for medical researchers and public health specialists) but also toward a more robust conception of informed consent and a more active public participation in the creation of *visions of health and eudaimonia for the community* (e.g. the creation of goals, projects, and values that communities can support in their mission to produce health).[108] By focusing on this specific lifestyle intervention, I am able to ask about the issues facing actual patients and providers attempting to work on lifestyle change and weight loss. The rest of this dissertation focuses on this intervention, with some initial theoretical work that cashes out the rhetorical insights I have only glossed in the previous sections.

The qualitative rhetorical analysis I use to understand this weight loss program is informed in part by Kenneth Burke's essay "The Philosophy of Literary Form."[109] The primary critical insight of this essay is Burke's suggestion that "the symbolic act is the *dancing of an attitude*."[110] For Burke, every use of language, every choice of name, every label, even the ordering and spatial relationships between words in a given text, reveals a certain attitude or orientation to meaning. He suggests that "the 'symbolism' of a word consists in the fact that no one quite uses the word in its mere dictionary sense," indicating that this orientation to rhetorical/symbolic analysis seeks to uncover the various meanings of a word found in its actual use.[111] Beyond the meaning of terms, Burke attunes the rhetorical critic to the whole structure of the symbolic act and argues "we [should] watch, in the structural analysis of the symbolic act,

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[108] The idea that health may be a part of *eudaimonia* and that it should animate efforts to engage in patient self-management has been suggested before. Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309.

[109] Kenneth Burke, "The Philosophy of Literary Form," in his *The Philosophy of Literary Form*, 1-137.

[110] Burke, "The Philosophy of Literary Form," 9.

[111] Burke, "The Philosophy of Literary Form," 35.

not only the matter of 'what equals what,' but also the matter of 'from what to what.'"[112] The symbolic equations inhering in every text (including the use of language in conversation and other modes of public display and performance) play an important role in revealing both how words are being used as well as how they relate to one another hierarchically to form an overall synthesis of various meanings. Thus, Burke's conception of "symbolic act[s]" and their emergence within texts (imagined broadly) play a central role in my analysis as I transition from artifact to artifact in my search for the background orientations, assumptions, and rhetorical resources of the online lifestyle intervention under investigation here.[113]

Burke offers one additional insight that frames the approach to qualitative rhetorical analysis taken in this dissertation. In his own rhetorical and critical work, Burke opts for a kind of "Neo-Stoic" attitude that admits the playfulness and power of language while simultaneously remaining skeptical of and open to possibilities for change. He explains,

> To an extent, perhaps, it will be like an attitude of hypochondriasis: the attitude of a patient who makes peace with his symptoms by becoming interested in them. Yes, on the negative side, the 'Neo-Stoicism' we advocate would be an attitude of hypochondriasis. But on the positive side it would be an attitude of appreciation. And as regards our particular project, it would seek delight in meditating upon some of the many ingenuities of speech. Linguistic skepticism, in being quizzical, supplies the surest ground for the discernment and appreciation of linguistic resources.[114]

This open attitude, this acceptance of the power of linguistic resources and the ability of human actors to think critically about the language choices they make, leads to a nexus between practical and critical attitudes that allows the critic to circumvent the view that all attempts at persuasion and constitution (e.g., lifestyle management) are somehow part and parcel of

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[112] Burke, "The Philosophy of Literary Form," 38.
[113] Burke, "The Philosophy of Literary Form," 9.
[114] Burke, *A Grammar of Motives*, 443.

"disciplinary power."[115] It also indicates the need to swim in discourse, to immerse oneself in the arena of concern that one has chosen. Being obsessed with language while at the same time defusing its power over us is the key concern in this approach. Furthermore, the attitude that Burke describes leads to a method for moving forward, toward the kinds of clinical encounters that promote patient learning, "activation," and involvement in their care.[116] At the same time, such an attitude leaves open the possibility of getting things wrong, of renegotiating the linguistic and practical spheres of the clinic, in the service of not only improving health but also improving the lot of the chronically diseased individual in a highly technologized world, in a world ever more dominated by medical concerns and public health policy. This is not to indict medicine or public health policy but rather to say that they can go too far in promoting a conception of health and lifestyle change that undermines agency and activation.[117] The question of where to go from here has a lot more to do with the wider domain of human life than it does with medicine or public health on their own terms. Instead, medicine is one attribute of the broader context of human living, one that we must acknowledge and that must be part of our creation of *a good life*, or *eudaimonia* for the greatest number of people possible.

In addition to this overarching critical/analytic perspective, I bring a specific and grounded approach to data collection, thematic development, and criticism in my analysis of the

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[115] On "disciplinary" forms of power, see Michel Foucault, *Discipline & Punish: The Birth of the Prison*, trans. Alan Sheridan (New York: Vintage Books, 1995). Regarding Burke's orientation to language, Condit argues that it may be summed up as a form of "linguistic reflexivity" that "is an intellectual orientation that entails constant reflection on the forces of language as they are at work in what one hears and what one speaks." Celeste M. Condit, "Kenneth Burke and Linguistic Reflexivity: Reflection on the Scene in Philosophy of Communication in the Twentieth Century," in *Kenneth Burke and Contemporary European Thought: Rhetoric in Transition*, ed. Bernard L. Brock (Tuscaloosa: The University of Alabama Press, 1995), 209.

[116] The concept of "patient activation" has been developed widely in the literature. See e.g., Debra L. Roter, Ruth Stashefsky-Margalit, and Rima Rudd, "Current Perspectives on Patient Education in the U.S.," *Patient Education and Counseling* 44 (2001): 82, 85 (and throughout).

[117] See Metzl and Kirkland, *Against Health*. This is one of the reasons for the turn to patient *phronesis* as means to protect the individual *eudaimonia* of patients developed in Rubinelli, Schulz, and Nakamoto's, "Health Literacy."

OLSS (chapters 4-6). The data that I analyze are interviews and study documents. Interviews make up the vast majority of this data and are of three kinds. In order to understand the perspective of patients within the OLSS pilot study, I analyze patient exit interviews conducted with 35 of the original 50 pilot study participants (chapter 5). While these interviews provide great detail regarding participant experiences with the program, my interest in *paideia* as a wider educative and cultural framework catalyzed an interest not only in the participants but also in the experiences and rhetorical strategies of the lifestyle coaches who delivered the online adaptation of the lifestyle curriculum and provided asynchronous feedback to participants during the pilot study (and additional iterations). In order to capture these insights for analysis, I developed and completed an interview project with these lifestyle coaches (detailed in chapter 4). My primary reason for engaging both the participants and the coaches is to provide an overall perspective regarding the cultivation of lifestyle change, a process that, as I show, is deeply interactive and dialogic. Finally, given that this study and its participants impact only a small number of human beings working to develop lifestyle management strategies, I engaged in a third interview project with members of a dissemination team working to ensure the uptake of the OLSS in other clinical environments. Again, I developed and completed an interview project with these individuals (detailed in chapter 6) in order to understand how their rhetorical practices shape the OLSS for the wider audience of practitioners who might use it beyond its original clinical research setting. Finally, in order to augment my work on the rhetorical practices of the lifestyle coaches, I also investigate the content of various documents prepared for the study that were used to train them to work with patients in an online environment (detailed in chapter 4). Thus, my dissertation draws on unique objects of study cultivated by the original OLSS research team

(e.g., the participant exit interviews and study documents) and augmented by my own original research (e.g., interviews with the lifestyle coaches and dissemination team).

The interviews and study documents briefly described above form a rich context in which to analyze the overall *paideia* of lifestyle management, the specific role of *phronesis* in achieving lifestyle change, and the end result of achieving *eudaimonia* or a healthier and more fulfilling life for obese and overweight patients. My critical strategy for unearthing and developing these concepts within my objects of study throughout this dissertation draws on several qualitative techniques including close iterative reading, seeking thematic saturation, and attention to the particular or idiosyncratic experiences of the interviewees.[118] First, in order to identify various themes and shared concepts within the interviews and study documents, I engaged in an iterative reading process. Thus, each artifact was read multiple times. Throughout these multiple readings, a set of shared themes emerged. More than just reading a text multiple times, my approach was to look for saturation of a theme, its repetition across multiple interviews and/or documents in order to show how it plays a more than idiosyncratic role in the overall picture of lifestyle management. However, I also looked for challenges to these larger themes and concepts, thus allowing apparently idiosyncratic perspectives to augment and transform the larger and widely shared themes discovered throughout. Through close iterative reading, seeking thematic saturation, and engaging in constant reflection about the idiosyncratic

[118] This strategy is rooted in several sources and exemplars. First, my attention to the features of discourse that reveal key motivations, attitudes, and shared concepts is rooted in Kenneth Burke's, "The Philosophy of Literary Form," 1-137. In addition, the term "close reading" refers to a strategy in rhetorical studies to attend to the specific features of texts, to their structure and the words and concepts circulating throughout. For an example of this form of criticism, see Martin J. Medhurst, "Eisenhower's 'Atoms for Peace' speech: A case study in the strategic use of language," *Communication Monographs* 54 (1987): 204-220. Finally, my attention to the idiosyncrasies of texts, to their features that cannot be captured by tradition social scientific methods, is inspired by the work of Bent Flyvbjerg in *Making Social Science Matter: Why Social Inquiry Fails and How It Can Succeed Again* (Cambridge: Cambridge University Press, 2001). Interestingly, Flyvbjerg utilizes the concept of *phronesis* to ground his theoretical orientation.

challenges to shared themes as they emerged, I have crafted an overall picture of the rhetorical dynamics of lifestyle management. By adding to these strategies a concern for the historical and practical developments in medicine and chronic care, I provide a context in which to understand and use these rhetorical dynamics as resources for improving chronic care for obese and overweight individuals.

1.6 CHAPTER PREVIEWS

Each chapter unveils one layer of the rapprochement of rhetoric and medicine glossed throughout the previous sections. In addition, several focus on one of the key terms drawn from the history of rhetoric and philosophy and made apparent in the Samr's story. As such, they each provide theoretical and grounded evidence for the importance of rhetorical work on medicine and the translation of rhetoric into the domain of medicine. Thus, this chapter has provided a theoretical backdrop for the innovations yet to come in chapters 2-7.

Chapter 2 develops key insights regarding the relationship between rhetoric and medicine in the context of the chronic care crisis facing medical practitioners in the 21st century. In particular, this chapter focuses on the "Chronic Care Model" (CCM).[119] As the gold standard for chronic care, the CCM offers novel insights into the design of the overall health care system and the various roles that individual practitioners and patients play in the development and implementation of therapeutic regimens. Throughout this chapter, I develop the claim that the

[119] Edward H. Wagner, "Chronic Disease Management: What Will It Take To Improve Care for Chronic Illness?" *Effective Clinical Practice* 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action." *Health Affairs (Millwood)* 20, no. 6 (2001): 64-78. For an account that details the at times inexplicable explosion of chronic pain, see David B. Morris, *The Culture of Pain* (Berkeley: University of California Press, 1991).

CCM provides an architectural blueprint for the delivery of excellent care to patients. As rhetoric is also, following Richard McKeon, a "productive architectonic art" that frames meaning and symbolic action across a variety of domains, I suggest in this chapter that the CCM and rhetoric are interlocking architectonics that, when viewed together, provide novel insights about the role of rhetoric in medicine.[120] Following through on McKeon's work, I suggest that taking an "architectonic" approach seriously requires seeking insights that may only be gleaned through synergistic readings of my chapter findings.[121] Thus, each chapter provides its own content but they build on one another to generate insights that may only be gleaned by looking at multiple levels of the healthcare system simultaneously. Finally, I show how key elements of the Hippocratic tradition inform and augment the normative bent of the CCM toward the cultivation of mutual partnerships between providers and patients.

Chapter 3 engages in a critical reflection on *phronesis* as a mode of rhetorically-inflected knowledge that gets at the heart of the patient-provider relationship in chronic care.[122] Drawing on its original expositor, Aristotle, as well as Isocrates and a host of contemporary philosophers and medical researchers, this chapter attempts to elucidate the development of a specific kind of rhetorical knowledge that makes sense of the experiences and activities of patients as they engage in their own care. In doing this, I build on work already done by Sara Rubinelli, Peter J. Schulz, and Kent Nakamoto to trace connections between Aristotle's conception of *phronesis*

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[120] Richard McKeon, "The Uses of Rhetoric in a Technological Age," 48.

[121] McKeon, "The Uses of Rhetoric."

[122] This chapter is a major revision of an initial attempt to identify critical elements of patient *phronesis* in rhetorical theory, most explicitly in Aristotle's *Nicomachean Ethics*. In this work, I substantially expand upon the view of patient *phronesis* developed by Rubinelli, Schulz, and Nakamoto's, "Health Literacy." For more on this, see chapters 3 and 5. John J. Rief, "Widening Applications of Phronesis in the Clinic and Beyond: Patients as Decision Makers," in the proceedings of the *7th Conference on Argumentation of the International Society for the Study of Argumentation (ISSA)*, 2011, CD-ROM.

and patient self-care.[123] This development continues throughout chapters 4 and 5 and provides, in my estimation, a more robust discussion of the concept and a more grounded and sustained application of it to the activities of patients engaged in lifestyle change. As such, chapters 2 and 3 (along with the work done during the first part of this chapter) provide a robust theoretical framework that I use to drive the content featured in the middle chapters.

Chapter 4 investigates the coaching protocol developed organically throughout the original OLSS pilot study.[124] The coach training protocol emerged out of an earlier version developed for the Diabetes Prevention Program.[125] According to the coaching protocol notes, "It [the lifestyle intervention] is designed for delivery in coordination with outpatient medical care, and teaches patients about healthy eating and physical activity patterns, along with tips as to how best fit them into their lives."[126] As part of this coordinated information dissemination and teaching program, the coaches have an important role to play "in behavioral intervention delivery."[127] Both of these passages indicate two important overarching tendencies of the coaching protocol: to include co-clinical coaching from health care professionals, and to view information delivery as part of a pedagogy (*paideia*), not merely as a means of transferring information to patients. This program is, in other words, an interactive one meant to operationalize changes in the patient's life, not merely give them information that they can chose

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[123] Rubinelli, Schulz, and Nakamoto's, "Health Literacy."

[124] An initial version of this chapter was presented at a bioethics conference. The chapter has, of course, been expanded to accommodate new findings, interviews done by the author, and theoretical insights unknown to the author at the time of presentation. See, John J. Rief, "Lifestyle Coaching in the Context of Obesity: A Practical Pedagogical Approach" (paper presented at the *Nineteenth Annual Meeting of the Association for Practical and Professional Ethics*, Cincinnati, Ohio, March 4-7, 2010).

[125] Several iterations of the coaching protocol have been made available to me by the Online Lifestyle Support System (OLSS) research and writing group: "Summary of lifestyle coaching advice compiled from FY06 pilot through 9/1/09 (draft)," the original coaching protocol, "[OLSS] Lifestyle Coach Training," Copyright 2008, University of Pittsburgh, a power point presentation, "[OLSS] Lifestyle Coach Training," and some supplemental coaching tips prepared for specific lessons on the virtual portal, "[OLSS] Lifestyle Coaching Guide" both of which are internally circulating documents in the OLSS research and writing group.

[126] OLSS Lifestyle Coach Training, 1.

[127] OLSS Lifestyle Coach Training, 1.

to simply ignore. My discussion of the coaching protocol focuses on three interrelated domains of rhetorical analysis: (1) rhetoric as a teaching discipline (pedagogy), (2) the relationship between rhetorical theory and praxis, and (3) the development of *topoi* (topics that might help lifestyle coaches with the inventional process). The research for this chapter includes an interview project with lifestyle coaches and members of the team that put together the coaching protocol for the intervention pilot study completed in Fall, 2010. Such context provides an essential backdrop for describing the process of invention and dissemination of the coaching materials to lifestyle coaches. Finally, in terms of *phronesis*, this chapter indicates how and to what extent the coaching protocol enhanced opportunities for the development of experiential and rhetorical knowledge through the interpersonal, transactional, and constitutive mode of interaction that sutures the professional development of the lifestyle coaches to the cultivation of patient skills in self-care. My choice to engage the words and experiences of practitioners in this chapter in tandem with those of the study participants (in chapter 5) yields a holistic perspective regarding the clinical delivery of care. Most studies focus on patients or practitioners, leaving the middle ground of interactivity and mutual cultivation untouched.[128] Seeing the whole process of lifestyle management from both vantage points yields a rare perspective that may point to the importance of my "architectonic" approach to breaking down the role of rhetoric in medicine (chapter 2).[129]

Chapter 5 focuses on the analysis of recently transcribed interviews completed with 36 patients enrolled in the OLSS lifestyle intervention study following their 16-week involvement

[128] This is certainly the case with the only other study to take on patient *phronesis* of which I am aware. In that case, the words of several patients are analyzed but practitioners' experiences are not detailed. See Rubinelli, Schulz, and Nakamoto, "Health Literacy."

[129] McKeon, "The Uses of Rhetoric."

with the program.[130] An analysis of these interviews gives substance to the ways in which *phronesis* gets at the heart of patient self-care as well as how the program impacted their health and rhetorical capacities. In this chapter, I am primarily concerned with unearthing the development of *phronesis* and other elements of self-care on the part of patients by analyzing their language choices and how these reveal their experiential development of new capacities and insights. In other words, I seek to understand how their words reveal the extent to which they have augmented their knowledge, and rhetorical skills by seeking out the relationships between various words and concepts utilized by the interviewees and drawing connections between these and the larger concepts circulating throughout this dissertation (in particular *phronesis* and *paideia*).

Chapter 6 investigates the commercial distribution of the OLSS. It focuses primarily on the dissemination campaign initiated by the proprietor of the program, referred to as the Corporate Dissemination Team (CDT) throughout this dissertation. It makes make use of interviews with members of the CDT that provide more context for understanding the strategies behind the dissemination campaign. In addition, this chapter considers organizational/institutional communication as it looks at how marketing strategies are developed to deal with the needs of contemporary medicine (e.g. in hospitals, the clinical setting, medical

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[130] An initial version of this project has been presented at several conferences and is now part of a forthcoming essay. The following conference presentations offered various iterations: John J. Rief, Kathleen McTigue, Gordon R. Mitchell, Susan Zickmund, and Tina Bhargava "Promoting Practical Wisdom: Communication Patterns in the [OLSS] Program" (panel presentation at the *18th Annual LHAS Medical Ethics Update Conference* at the University of Pittsburgh Medical School, Pittsburgh, Pennsylvania, April 6, 2009); John Rief, "Promoting Patient *Phronesis* in an Online Lifestyle Program" (oral presentation at the *2011 National Predoctoral Clinical Research Training Program Meeting*, University of Washington in St. Louis, School of Medicine, St. Louis, Missouri, May 11-13, 2011). For the qualitative coding of these interviews that provides a starting point for my rhetorical work in this dissertation, see John J. Rief, Gordon R. Mitchell, Susan L. Zickmund, Tina D. Bhargava, Cindy L. Bryce, Gary S. Fischer, Rachel Hess, N. Randall Kolb, Laurey R. Simin-Silverman, and Kathleen M. McTigue, "Promoting Patient *Phronesis*: Communication Patterns in an Online Lifestyle Program Coordinated with Primary Care," *Health Education & Behavior*, forthcoming.

schools, etc). This transition from the narratives of individual medical researchers and study participants (upstream) to the rhetoric of dissemination to larger medical institutions (downstream) allows me to engage the development of the OLSS in the larger context of its circulation to end-users.[131] In doing so, this chapter draws on the Sophistic tradition as one site in the history of rhetoric where the dissemination of rhetorical practices to a larger public takes center stage. In drawing such connections, I show how rhetoric plays a "productive architectonic" role not only in the construction of clinical sites for lifestyle management but also for the circulation of grounded practices and modes of knowledge developed at these sites to a wider net of practitioners and patients.[132]

Chapter 7 draws on Kenneth Burke's conceptions of "permanence and change" in order to suggest how the work done throughout this dissertation reconnects medicine with the practical art of rhetoric – a union that should never have been disjoined in the first place and should be continually rebuilt for specific moments, cultural configurations, and social needs that arise in the future.[133] It poses questions about the appropriate role of medicine in the management of life. It also investigates the extent to which a generalist orientation to the rhetoric-medicine nexus contributes to patient autonomy, a more robust conception of informed consent, and a pushback against the power of expert knowledge through the acceptance of patient *phronesis* in the context of their own health care.[134] Finally, the conclusion points to a variety of problems facing health

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[131] The development of my perspective on upstream and downstream rhetorics of science emerges from the works of Gieryn and Taylor. Gieryn, *Cultural Boundaries of Science.* In this text, Gieryn introduces the conception of upstream and downstream science to conceptualize public uptake of new scientific knowledge. See also, Charles Alan Taylor, *Defining Science.* He shows a real concern for public conceptions of science and the public face that scientists must utilize in attracting support for their theories and projects.

[132] McKeon, "The Uses of Rhetoric," 48.

[133] On Burke's notion of "permanence and change," see Kenneth Burke, *Permanence and Change.*

[134] A normative point that forms the fundamental basis for the arguments made by Rubinelli, Schulz, and Nakamoto in their discussion of patient *phronesis* in their "Health Literacy."

care including budgetary constraints and an over-reliance on technology that might undermine an ethically sound and rhetorically savvy conception of lifestyle management.

Each of these chapters develops at least one element of the four-part understanding of rhetoric described earlier in this introduction. Chapter 2 takes on every element as it analyzes the overall structure of chronic care from systemic orientation (ontology) to the analysis of specific contingencies faced by particular patients and the production of therapeutic modalities to deal with these contingencies and improve health. In this way, the CCM is focused directly on providing the right training and knowledge to all of the stakeholders working to improve chronic care. Likewise, chapter 3 unfolds all four elements under the term *phronesis* (an experiential form of knowledge) that is rooted in the event of clinical care. *Phronesis* is directly linked with the four elements of the rhetorical arts and is, in fact, the one form of knowledge that is appropriately fitted to rhetorical action. Chapters 4-6 each focus on specific elements of rhetorical activity. Chapter 4 indicates how rhetoric can aid in the promotion of *phronesis* in the teaching relationship between providers and their patients as well as how *eudaimonia* might be enhanced through this teaching relationship. Chapter 5 indicates how patients develop the various rhetorical skills of production and analysis in their daily activities of self-care. Chapter 6 reveals how rhetoric is used in the circulation of teaching and healing practices to clinical practitioners and other end-users. As such, this dissertation provides insights into the many ways that rhetoric interacts with medical activity through the four-part lens I have provided. By the end, it should be clear that the CCM, the rhetorical conception of knowledge inhering in *phronesis*, and the lifestyle intervention under investigation point to solutions to the problems facing all providers and patients dealing with chronic disease in the 21st century. Finally, this dissertation is an effort to promote greater depth and clarity about the rhetoric/medicine merger

that, I believe, is central to the development of rhetorically oriented medical praxis and therapeutic modes of rhetoric that might contribute to the overall health and well being of society.

2.0 THE "CHRONIC CARE MODEL": AN "ARCHITECTONIC"[1]

> From Hippocrates to now, reasoning about the living, suffering body depends upon analogy, exemplarity, and probable sign-inference, all of which find their home in the history of rhetoric. Then, as now, medicine cannot be immured from the pressures and pulsions of rhetorical inquiry.[2]
>
> Philosophers of rhetorical theory are medical theorists.[3]

2.1 THE CHRONIC DISEASE CRISIS

Chapter 1 details a variety of arguments that support a more robust connection between rhetoric and medicine, two arts that share an intellectual history but are too often separated, both spatially and in terms of practice, in the biomedical age.[4] In this chapter, I provide more specific substance to the relationship between rhetoric and medicine rooted in a set of "exigencies" ("imperfection[s] marked by urgency") now facing healthcare researchers and practitioners.[5]

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[1] Edward H. Wagner, "Chronic Disease Management: What Will It Take To Improve Care for Chronic Illness?" *Effective Clinical Practice* 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action." *Health Affairs (Millwood)* 20, no. 6 (2001): 64-78. For an account that details the at times inexplicable explosion of chronic pain, see David B. Morris, *The Culture of Pain* (Berkeley: University of California Press, 1991). I am using the term "architectonic" in the same way that Richard McKeon famously develops the term in his work. See Richard McKeon, "The Uses of Rhetoric in a Technological Age: Architectonic Productive Arts," in *The Prospect of Rhetoric: Report of the National Developmental Project*, edited by Lloyd F. Bitzer and Edwin Black (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1971), 44-63.

[2] Stephen Pender, "Between Medicine and Rhetoric," *Early Science and Medicine* 10, no. 1 (2005): 64.

[3] Barbara Wood, "The Conjectural Method: From Ancient Medicine to Ancient Rhetorical Theory," *Western Speech* (Winter, 1967): 41.

[4] Joan Leach, "The Art of Medicine: Valuing Communication," *The Lancet* 373 (2009): 2104-2105. Leach argues for increasing attention to the art of communication, as understood by the Hippocratic physicians, as a means to resolve the lack of interaction between medical researchers, practicing clinicians, and broader publics.

[5] As Lloyd Bitzer points out, the world presents us with various "exigences" which he defines as "an imperfection marked by urgency; it is a defect, an obstacle, something waiting to be done." He suggests that these imperfections provide context and direction for rhetorical activity. Lloyd F. Bitzer, "The Rhetorical Situation," *Philosophy and Rhetoric* 1 (1968): 6.

These exigencies circulate around the increasing prevalence and incidence of chronic disease. As the Centers for Disease Control states,

> Our nation faces a crisis due to the burden of chronic disease. Today, 7 of the 10 leading causes of death in the United States are chronic diseases, and nearly 50% of Americans live with at least one chronic illness. People who suffer from chronic conditions such as heart disease, stroke, diabetes, cancer, obesity, and arthritis experience limitations to function, health, activity, and work. These limitations affect the quality of their lives, as well as the lives of their families.[6]

The extensive nature of the modern chronic disease crisis, the sheer number of patients who suffer from diseases with long timeframes and few quick fixes, has created the need for reconsidering the roles of healthcare practitioners, patients, and the overall healthcare system in the promotion of health and, more broadly, *eudaimonia*.[7]

One major barrier to dealing with chronicity is the unfortunate focus in modern healthcare on acute conditions. As Hassan Soubbi points out, "The essential attributes of the structure and delivery of primary care continue to be defined in terms of acute conditions and disease specific approaches . . . Encounters for chronic care are still treated as if they were unique events rather than a continual process of care."[8] In addition, unlike in acute health crises (e.g., epidemics rooted in the transmission of viruses, bacteria, or unhealthy environmental conditions), the chronic disease crisis, far from being resolved through major technological breakthroughs (e.g., vaccines, new drugs), has instead seemed to be, at least in part, augmented by them. That is, the contemporary prevalence of chronic disease is partly the result of the many

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[6] Centers for Disease Control, *Healthy Communities: Preventing Chronic Disease By Activating Grassroots Change At a Glance 2011*, April 6, 2011, http://www.cdc.gov/chronicdisease/resources/publications/aag/healthy_communities.htm [Accessed September 2, 2012].

[7] Wagner, "Chronic Disease Management: Illness?"; Wagner, Austin, Davis Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action." For an account that details the at times inexplicable explosion of chronic pain, see David B. Morris, *The Culture of Pain* (Berkeley: University of California Press, 1991).

[8] Hassan Soubbi, "Toward an Ecosystemic Approach to Chronic Care Design and Practice in Primary Care," *Annals of Family Medicine* 5, no. 3 (2007): 263.

solutions used to stave off what were at one time acute illnesses. Arthur Frank discusses this turn of events in the context of cancer and the rise of what he terms the "remission society" or those individuals who suffer from the ongoing recurrence of cancer and the side effects of drugs used to manage it.[9] In addition, Chris Feudtner details the use of insulin to stave off acute cases of diabetes and deliver long-term management strategies to individuals who, less than a century ago, would have died relatively quickly.[10] What's more, our increasing scientific capacity to link certain styles of life to the increased likelihood of disease and death has created an exigence for the medicalization of bodily states and practices that, not long ago, were beyond the realm of medicine's concern (e.g., obesity).[11] Thus, an entire arsenal of medical practice oriented toward the quick resolution of acute threats to health is now faced with patients for whom death is not the most immediate concern and whose health problems require long-term therapeutic modalities rooted as much in the expertise of medical science as in the daily activities of patients.

Multiple institutional, systematic, and practice-based solutions have been developed to deal with this disconnect between the acute and chronic approaches to care and to enhance the central role played by patients and their relational networks (e.g., families, friends, and healthcare providers) in the successful implementation of therapy.[12] In this chapter, I look at one

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[9] Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: University of Chicago Press, 1995), 8 (and throughout).

[10] Chris Feudtner, *Bittersweet: Diabetes, Insulin, and the Transformation of Illness* (Chapel Hill: The University of North Carolina Press, 2003). See especially "Chapter 2: A Disease in Motion: The Cycles of Diabetic Transmutation" and "Chapter 4: Getting to the Point: The Daily Work of Diabetes."

[11] Jeffrey Sobal, "The Medicalization and Demedicalization of Obesity," in *Eating Agendas: Food and Nutrition as Social Problems*, edited by Donna Maurer and Jeffrey Sobal (Hawthorne, NY: Aldine De Gruyter, 1995), 67-90. On medicalization as a general process and its ethical consequences, see John Z. Sadler, Fabrice Jotterand, Simon Craddock Lee, and Stephen Inrig, "Can Medicalization Be Good? Situating Medicalization within Bioethics," *Theoretical Medicine & Bioethics* 30 (2009): 411-425.

[12] The "Socio-Ecological Model," popular among researchers who work in the area of health disparities, attempts to link the patient's biology with their family life, the institutions in which they participate, the cultural coordinates that define their identity, and the vast array of environmental and technological features that surround them. For the first exposition of this model, see Kenneth R. McLeroy, Daniel Bibeau, Allan Steckler, and Karen Glanz, "An Ecological Perspective on Health Promotion Programs," *Health Education Quarterly* 15, no. 4 (Winter,

such model, Edward H. Wagner's "Chronic Care Model" (CCM), and the ways that it presents the problems of chronic care and attempts to resolve them through widespread and structural changes to the production and delivery of life-saving therapeutic interventions.[13] The CCM engages in this process by portraying the healthcare system as a structure with discrete parts that must be transformed in a synergistic way. Thus, this chapter interrogates and develops the notion that the CCM acts as a sort of integrative architecture for the kinds of changes that may be needed to make healthcare more relevant and effective for the chronically ill.

While the CCM effectively delineates what most researchers and practitioners would view as the essential elements of healthcare improvement and delivery, this chapter argues that the rhetorical conduits linking researchers to clinicians and their patients are not given enough attention (this is true not only of the CCM but also other models and discussions of linking research findings to improvements in care). Thus, my hypothesis in this chapter is that the glue

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1988): 351-377. The "Biocultural Model," developed by David B. Morris, focuses on the ways in which cultural narratives function to make sense of the origin and experience of illness. David B. Morris, *Illness and Culture in the Postmodern Age* (Berkeley: University of California Press, 1998): 12, 70-77 (and throughout). "Metabiosis," described by Chris Feudtner in his work on the history of diabetes care, focuses attention on the ways in which medicine and lifeworld interpenetrate in the lives of patients living with chronic disease in 19th and early 20th century clinics. Feudtner, *Bittersweet*, 40. Finally, in a vein quite similar to "metabiosis," Arthur Frank argues for a model of patients as "wounded storytellers" who engage in the practice of reporting their illness to physicians and reorienting themselves to their illness over time. Frank, *The Wounded Storyteller*. All of these models and approaches emphasize the gaps not only in the various kinds of knowledge available to medical practitioners but also between medicine and forms of knowledge (e.g. experiential, narratival, and social) that might contribute important insights about the adequate treatment of disease. In such models, the patient, policy-makers, family-members, and even the systems in which humans live (environmental, social, cultural, political, economic, etc.) are given roles in the adequate unification and systematization of knowledge and application of therapy. Such models imagine medical practitioners as inhabiting a broader world than the clinic and, therefore, synergizing their medical expertise with forms of knowledge held by patients, shared within their communities, and emergent from their larger environmental locale. Several of these models fill in major holes in the CCM, most notably a more nuanced conception of the environment in which the health care system (its various practitioners, patients, and institutions) exists; however, only the CCM re-envisions the entire health care system from top to bottom in a way that moves beyond aspiration and into policy actualization. Wagner, Austin, Davis, Hindmarsch, Shaefer, and Bonomi, "Improving Chronic Illness Care," 64-65. In addition, the CCM has achieved major uptake in the realm of chronic care. It is now one of the most widely used models for re-designing systems of care to achieve enhanced patient self-management in the United States. On the growth of the CCM and its widening acceptance (as well as research that supports its use in the improved delivery of chronic care), see Sara A. Kreindler, "Lifting the Burden of Chronic Disease: What Has Worked? What Hasn't? What's Next?" *Healthcare Quarterly* 12, no. 2 (2009): 30-40.

[13] Wagner, "Chronic Disease Management"; Wagner, Austin, Davis Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action."

which holds the many pieces of CCM together and that provides answers to some of the most pressing questions in medical practice is the art of rhetoric and, in particular, its role in constituting starting points for action and interactivity among the various individuals tasked with the daily management of chronic conditions. In developing this claim, I draw on a view advanced by Richard McKeon that rhetoric is a sort of "productive architectonic art" which structures meaning, interaction, and practice.[14] That is, rhetoric is more than the study and production of speech. According to McKeon, rhetoric may also provide pathways for linking disparate actors and ways of knowing. For this reason, rhetoric may have a structuring and connective role to play in the cultivation of better approaches to chronic care in the 21st century.

The first half of this chapter discusses several elements of the CCM approach to dealing with chronicity, in particular its focus on the provider-patient relationship, the cultivation of self-care, and the effective delivery of evidence-based interventions in the treatment of chronic disease. Throughout, I argue, following Wagner and those that have commented on his model, that the CCM is a sort of architecture, with corresponding elements for changing the entire system of chronic care in the 21st century. In the second half of the chapter, I link the CCM to the rhetorical tradition and show how the ancient art of rhetoric might complement the CCM architecture by providing connective tissue between its disparate parts and the inventional energy needed to address the improvement of chronic care. This argument unfolds in two primary stages. First, I show how the CCM architecture provides a context for the use of rhetoric as a critical and productive tool in elucidating the interconnections between the various problems of chronic care. Second, following Joan Leach, I argue that a "Hippocratic revolution in medicine," one that draws explicitly on the interrelationships between rhetoric and medicine in the ancient

[14] McKeon, "The Uses of Rhetoric," 48.

Greek tradition, is made possible through the alignment of the CCM with key inflections of ancient Greek rhetorical and medical theory.[15]

In addition, by developing this architectural context for understanding the rhetorical elements of the CCM and its connection to more ancient conceptions of the relationship between rhetoric and medicine, I introduce a map for the kind of research and arguments yet to come in subsequent chapters. That is, the rest of this dissertation is organized around the various layers of the healthcare system discussed in this chapter (especially the role of practitioners, patients, and those tasked with delivering new evidence and interventions to clinical sites where they can impact health outcomes – chapters 4, 5, and 6), providing specific case studies regarding the role of rhetoric in the cultivation of an overall healthcare architecture needed to successfully implement lifestyle management. Finally, in focusing both on the discrete elements of chronic care and on their architectural interactions, I extend on McKeon's arguments by showing how his approach provides grist for a method of rhetorical criticism that links all of my chapters together, one based on seeing broader interconnections between objects of study, that may yield different and, in some cases, more robust and useful findings than narrower and single-object focused efforts.[16]

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[15] Joan Leach, "The Art of Medicine," 2104-2105.

[16] In short, studies that seek to illuminate the needed changes in chronic care that focus on element (e.g., patient self-care), may end up eliding the connections between that element and others (e.g., practitioner training and the delivery of new evidence-based interventions that might improve the possibilities for patient self-care).

2.2 AN "ARCHITECTONIC" APPROACH TO CONTEMPORARY CHRONIC CARE[17]

In this section, I highlight three elements of Wagner's "Chronic Care Model" (CCM) that I believe act as "commonplaces" for the development of chronic care in the 21st century.[18] The notion of "commonplace" utilized throughout this section is drawn from the Greek tradition. In a general way, "commonplaces" act as sites for shared discovery, meaning making, and interactivity. Furthermore, as Richard McKeon argues, "commonplaces" do not simply mark off specific areas of knowledge and do more than give rhetors the capacity to determine what ground they must cover and in what order when giving a speech.[19] Instead, he argues that commonplaces can, if adequately understood, developed, and deployed, become, "places of invention and of memory . . . places of things, thoughts, actions, and words."[20] Thus, in marking off these sites for shared action that are important for any knowledge or practice domain, one can get a sense not only for the necessary areas to be covered in decision making processes but also the context of discovery or invention in which new insights are gleaned and new practices developed. McKeon writes,

> If there is a philosophy of discovery and creativity, it cannot be a philosophy established by consensus concerning the nature of things, the powers or faculties of thought, the devices of arts, or the meanings or warrants of statements. It must be a pluralistic philosophy which establishes a creative interplay of philosophies inventing their facts, their data, their methods, their universes. It must be a rediscovery of the commonplaces of invention and memory for innovation rather

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[17] McKeon, "The Uses of Rhetoric," 48.

[18] Wagner, "Effective Clinical Practice"; Wagner, Austin, Davis Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action." On the rhetorical constitution of "commonplaces" or sites for shared meaning-making and action, see also Chaïm Perelman, "Philosophy, Rhetoric, Commonplaces," in his *The New Rhetoric and the Humanities: Essays on Rhetoric and Its Applications* (Boston: D. Reidel Publishing Company), 52-61.

[19] Richard McKeon, "Creativity and the Commonplace," *Philosophy & Rhetoric* 6, no. 4 (Fall, 1973): 199.

[20] McKeon, "Creativity and the Commonplace," 207.

> than the establishment of a doctrine for proselytizing and conversion among marked-off heresies and dogmas.[21]

Thus, McKeon suggests that part of the inventional and creative process in any knowledge domain is the articulation of commonplaces in which a plurality of different viewpoints and knowledge practices are synergized. Furthermore, the use of such commonplaces not only provides for the possibility of pluralistic approaches to discovery, invention, and transformation. Such commonplaces may also, according to McKeon, act as "places both of memory and invention."[22] Thus, the use of commonplaces assists individuals seeking to engage in any particular practice with a set of short-hand reminders, the structures for memorization and remembering, that might be needed when making specific decisions rooted in the uncertainty and contingency of the moment (a central concern for rhetoric).

I believe the CCM provides a set of commonplaces that can function in a similar way to that suggested by McKeon. Following this insight, I deploy his concept of "commonplace" to consider how the CCM engages in the cultivation of memory and invention.[23] In so doing, I argue that the CCM provides a framework for, as McKeon suggests of the use of commonplaces in the rhetorical tradition, "exploring the old and constructing the new" in chronic care delivery.[24] Furthermore, this section suggests that the CCM rhetorically configures the commonplaces of chronic care as interlocking aspects of overall systemic change. It accomplishes this task through the invocation of an architectural metaphor, one that is

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[21] McKeon, "Creativity and the Commonplace," 207.

[22] McKeon, "Creativity and the Commonplace," 205.

[23] It is also important to keep in mind that McKeon intends his analysis to move beyond the arena of rhetorical activity into the broader spheres of human experience and discovery: "the commonplaces of creativity operate in the interpretation of texts as well as in the writing of texts, in the interpretation and formation of character, thought, actions, and things." McKeon, "Creativity and the Commonplace," 209.

[24] McKeon, "Creativity and the Commonplace," 208.

structurally related to the notion of "arrangement" in the ancient Greek rhetorical tradition.[25] In other words, just as excellent speeches utilize the powers of arrangement to craft a comprehensible and persuasive speech, the CCM provides an architectural system for unlocking important aspects of chronic care. In drawing this connection between the architectural metaphor of the CCM and the ancient conception of arrangement, I begin the process of showing how rhetoric and medicine may become interlocking arts in modern chronic care delivery. The second half of this chapter builds on this nascent connection.

2.2.1 The CCM Architecture

The CCM represents a watershed shift in approach to medicine, prompted by the increasing prevalence of chronic disease.[26] It is a paradigm that seeks to unravel the core assumptions of acute care in the context of risk factors for disease such as obesity, poor diet, smoking, environmental pollutants, and the like. The model focuses on the effective delivery of healthcare to chronic patients as members of their community. This approach de-centers clinical medicine, shifting emphasis to: (1) the "activation" of patients in their own care, and (2) empowering patients with information through improved interactions with healthcare practitioners.[27] The CCM incorporates what is known as the "health care team" which includes doctors, nurses, and

[25] "Arrangement" is one of the original canons of rhetoric, those organizing skills upon which the production and analysis of speech has been built for thousands of years. On these five "canons" of rhetoric and the brief definitions I offer throughout this paragraph, see Edward P. J. Corbett and Robert J. Connors, *Classical Rhetoric for the Modern Student*, 4th ed. (Oxford: Oxford University Press, 1999), 17-23. Corbett and Connors derive the "canon" from Aristotle and the Roman rhetorical scholar, Cicero.

[26] Wagner, "Chronic Disease Management."

[27] The model is described by Wagner in several articles. For its original manifestation, see Wagner, "Chronic Disease Management." For its further elaboration and development, see Wagner, Austin, Davis, Hindmarsch, Shaefer, and Bonomi, "Improving Chronic Illness Care." On the development of the concept of activation elsewhere, see Debra L. Roter., Ruth Stashefsky-Margalit, and Rima Rudd, "Current Perspectives on Patient Education in the U.S," *Patient Education and Counseling* 44 (2001): 79-86.

other healthcare professionals.[28] Unlike in previous conceptions, the CCM conception of the healthcare team includes patients as part of the care network. Thus, they are expected to work on a daily basis to improve their health.[29] Perhaps more appropriately, patients are not required but probably need to engage in self-care when it comes to chronic disease (a point I develop throughout this dissertation). Most importantly, the CCM provides a way to move beyond the divisions between particular specialties and between patients and their care providers through the use of technological and practice-based innovations.

Moreover, Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi suggest that "the CCM depicts the health system as part of the larger community and the practice as a part of the health organization."[30] Thus, the CCM moves beyond the clinical site into the various and sundry locales in which chronic disease is experienced and managed. In addition, the CCM has been developed in line with the recognition that "the longer time horizon and fluctuating course of many chronic diseases requires regular interaction between caregivers and patients."[31] By bringing both spheres (e.g. community and health system) into alignment, Wagner believes that patients are "informed" and "activated" and more likely to engage in "Productive Interactions" with their "Prepared, Proactive Practice Team."[32]

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[28] Wagner, "Chronic Disease Management"; Wagner, Austin, Davis, Hindmarsch, Shaefer, and Bonomi, "Improving Chronic Illness Care." The "health care team" is now a central feature of patient care, especially in terms of chronic disease. For this reason, pedagogical approaches to cooperative care and communication are now being developed. For an example, see Inge B. Corless, Theresa H. Michel, Marjorie Nicholas, Deborah Jameson, Ruth Purtilo, and Angelique M. A. Durkes, "Educating Health Professions Students about the Issues in Communicating Effectively: A Novel Approach," *The Journal of Nursing Education* 48, no. 7 (2009): 367-373; E. McKinlay, L. McBain, and B. Gray, "Teaching and Learning about Chronic Conditions Management for Undergraduate Medical Students: Utilizing the Patient as Teacher Approach," *Chronic Illness* 5, no. 3 (2009): 209-218.

[29] Wagner, "Chronic Disease Management."

[30] Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care."

[31] Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care," 70.

[32] Wagner, "Chronic Disease Management," 3.

Such interactions rely on many elements, each of which provides not only a specific arena for the improvement of chronic care but also a site for discussion and interrogation regarding the connections between the various levels of the model. For example, Wagner's team isolates the following layers (among others) as important and interrelated conduits for the improvement of chronic care:

> (1) "delivery system"
> (2) "complementary community resources"
> (3) "activate and inform patients"
> (4) "traditional patient education"
> (5) "confidence and skills in managing their [patient's] condition"[33]

The concern with providing an adequate "delivery system" for information, evidence-based interventions, and care involves the accumulation of research, technological innovations, and the need for communication. Thus, the CCM breaks out of the biomedical laboratory and clinic in its search for "complementary community resources" and, in this way, enters the domain of public uptake of biomedical and behavioral discoveries. In addition, the CCM shows a concern with the role of patients in their own care, including: (1) the goal to "activate and inform patients" which involves a transformation of the patient from a fleshy object into a fully-fledged human being, (2) the notion of "activation" through interactivity between different elements of the system, and (3) "traditional patient education" which brings with it the entailment that physicians cannot merely tell patients what to do but must rather involve themselves in the creation of health competence on a broad scale.[34] Moreover, the idea that patients might "develop confidence and skills in managing their condition" indicates the importance of translating medical knowledge

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[33] Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care," 69-70.

[34] A view held by many authors. See, e.g., Sara Rubinelli, Peter J. Schulz, and Kent Nakamoto, "Health Literacy Beyond Knowledge and Behaviour: Letting the Patient Be a Patient," *International Journal of Public Health* 54 (2009): 307-311; Thomas Bodenheimer, Kate Lorig, Halsted Holman, and Kevin Grumbach. "Patient Self-management of Chronic Disease in Primary Care." *Journal of the American Medical Association* 288 (2002): 2469-2475.

and advice into direct patient action. Importantly, Wagner and his team imagine all of these elements as something very close to the rhetorical conception of commonplace introduced at the beginning of this section. That is, each is meant to mark off a sphere of discovery and practice that is needed in the ongoing effort to fight chronic disease.[35] In addition, the model indicates the degree to which each element acts as an important link in an overall synergistic chain of research and quality improvements, practice-based improvements and training, and the integration of patients in their own care.

Given all of this, it should not surprise us that the CCM has been described through a highly visual metaphor, one that hints at how the model is meant to function in healthcare improvement efforts: architecture. Janet Colwell refers to Wagner as the "chief *architect*" of the model, implying that this model is more than simply a list of various initiatives but is rather an overall structure, built by Wagner and his fellow researchers, to provide a blueprint for action.[36] Stephen L. Isaacs and James R. Knickman, suggest that while many efforts to improve chronic care have "focused on specific illnesses such as asthma, diabetes, or depression . . . the chronic care model developed by Wagner . . . applies to a broad range of chronic illnesses and serves as a *roadmap* for physicians to organize their practices to meet the often complex needs of chronically ill people."[37] They go on to suggest that "the chronic care model calls for a structural change in the way people with illnesses are cared for, and the participation of nurses, social

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[35] McKeon, "Creativity and the Commonplace."

[36] Janet Colwell, "Key 'Medical Home' Model Elements Hit the Market," *ACP Internist* (of the American College of Physicians), 2012, http://www.acpinternist.org/archives/2006/04/medhome.htm [Accessed September 3, 2012]. Emphasis added.

[37] Stephen L. Isaacs and James R. Knickman, "Editor's Introduction," in Irene M. Wielawski's "Improving Chronic Illness Care," chapter 3 of *The Robert Wood Johnson Foundation Anthology: To Improve Health and Health Care X*, ed. Stephen L. Isaacs and James R. Knickman (The Robert Wood Johnson Foundation, 2006), http://www.improvingchroniccare.org/index.php?p=Reports&s=163 [Accessed September 3, 2012]. Emphasis added.

workers and patients themselves."[38] Thus, this "roadmap" (a metaphor closely associated with architecture) is rooted in the interactivity of a wide-ranging group of practitioners and patients requiring changes not only in their activities but the entire structure of care. Furthermore, Irene M. Wielawski suggests that the CCM, "offers a process for changing [medical] *architecture* so that clinicians and patients can work as partners in managing disease and preventing complications."[39]

The deployment of this metaphor in the context of the CCM shows the extent to which the model is not merely a set of goals but an overall structure, not merely a descriptive model but also a normative conception of how research and care may be synergized to improve outcomes for chronic patients. Much like a building, the CCM is constructed with interlocking pieces that cannot be dealt with in isolation but work to create an overall approach. Following the rhetorical tradition, we might say that the architectural model used in the passages quoted above is directly related to the term "arrangement," one used to make sense of the structural attributes of speeches that make them comprehensible and persuasive.[40] Thus, what the CCM implies is that any chronic care intervention must attend to what rhetoricians might call the arrangement of chronic care, to the ways in which, just like a speech or a written work must have structure to be effective, interventions addressing chronic disease must attend to the overall structural problems that undermine chronic care at every level. Ignoring this complex arrangement and its many parts may yield unsatisfactory care.

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[38] Isaacs and Knickman, "Editor's Introduction," http://www.improvingchroniccare.org/index.php?p=Reports&s=163.

[39] Wielawski, "Improving Chronic Illness Care," http://www.improvingchroniccare.org/index.php?p=Reports&s=163. Emphasis added.

[40] Corbett and Connors, *Classical Rhetoric for the Modern Student*, 17-23.

Thus, the CCM is designed through the lens of the architectural metaphor in order to address how the interconnection between the various elements implicates their effective improvement. This metaphor enriches my rhetorical reading of the CCM, in particular by showing how the organizational structure of the model is artfully arranged to produce a strategy for dealing with chronic disease. In short, for patients and practitioners to interact well requires not merely interventions and improvements aimed at these individuals but also at how the structure of healthcare and research might play a role in making them possible. Taking this problem from the opposite direction, improving healthcare research and practice requires not merely the generation of hypotheses by clinical scientists but also their understanding of the on-the-ground problems facing patients and practitioners in realizing their partnership to address chronic care. That is, just as each screw, girder, and panel assists in holding an entire building together, each commonplace covered by the CCM plays an essential and interconnected role with the others.

In the next three sub-sections, I look at the three commonplaces drawn from the CCM: (1) the "Prepared, Proactive Practice Team," (2) the "Informed, Activated Patient," (both connected by the cultivation of "Productive Interactions") and (3) the dissemination and translation of research from the lab to the clinical site.[41] I take these as the most critical elements of the model because they broadly cover the three problem areas for chronic care identified throughout the medical literature (see below). In addition, by showcasing these three commonplaces, I have made my own architectural choice, one grounded in the arrangement of my own research project (chapter 3-5 cover each commonplace in turn).[42] Finally, in giving

[41] Wagner, "Chronic Disease Management."

[42] The only element that I do not cover with these three focal points is the problem of producing "community resources," (see Figure 1) which are separate from the clinical setting that is the focus of this

these commonplaces more context and content, I reveal how "commonplaces" may become "places both of memory and invention," zones of creative transformation and energetic practice.[43]

2.2.2 "Prepared, Proactive Practice Team"[44]

The CCM is based on the notion that only through coordination of patient and provider roles in the context of chronic care, as well as the development of patient self-care, can chronic disease be more effectively managed in the clinical setting and beyond. For example, Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi suggest that "interactions are more likely to be productive if patients are active, informed participants in their care."[45] In addition, they argue that "effective self-management support and links to patient-oriented community resources help to activate and inform patients and families to better cope with the challenges of living with and treating chronic illness."[46] These insights, based on new developments in clinical research across the U.S. suggest two primary systems-level changes that are needed to make chronic care more effective: (1) the development of providers (and networks of providers) who can adequately deal with the complexities of chronic disease while also training patients to more effectively engage in their own care, and (2) the development of patients who can care for themselves.

The first problem, the development of providers capable of promoting patient self-care, is related to a sort of cognitive and practical "overload" that can occur among physicians and other

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dissertation. Far from an oversight, I view this exclusion as a potential area for further development in future research projects after the dissertation is complete.

[43] McKeon, "Creativity and the Commonplace," 205.

[44] Wagner, "Chronic Disease Management."

[45] Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care," 68.

[46] Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care," 69.

healthcare practitioners during their training.[47] In short, physicians and other healthcare providers are often faced with new scientific developments and practice-based approaches to patient education that may outstrip their capacities to adequately incorporate knowledge and make it useful for patients in the context of care. The emergence of team-based care has been due, in large part, to this problem and it is a central value in the CCM.[48] Synergizing the work of many different professionals is now considered cutting-edge medical practice and is the subject of multiple innovations in medical theory and research. In addition, the move to team-based work may require even more fundamental changes in pedagogy that are based on the necessity to produce collective action between providers and their patients. The CCM designers have recognized this need; however, research on how to actually achieve this kind of pedagogical approach has only recently been gaining ground.[49]

Of course, the notion that providers must improve their capacities to assist chronic patients in achieving their goals is one that has been developed in a variety of domains; however, the CCM's approach is to view this problem as directly related to the other commonplaces under discussion in this section. That is, providers cannot improve their daily practices if they are not aware of the kinds of challenges facing their patients or the major improvements in care yielded at the research level. Thus, Wagner and his coauthors argue, "chronically ill persons wrestle with the physical, psychological, and social demands of their illness without much help or support from medical care. More often, the help received, while well intentioned, fails to afford optimal

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[47] On the general problem of "overload" in medical education, see Molly Cooke, David M. Irby, and Bridget C. O'Brien, *Educating Physicians: A Call for Reform of Medical School and Residency* (San Francisco, CA: Jossey-Bass, 2010), 77.

[48] Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care," 68.

[49] Debra L. Roter, Ruth Stashefsky-Margalit, and Rima Rudd, "Current Perspectives on Patient Education in the U.S.," *Patient Education and Counseling* 44 (2001): 79-86.

clinical care or meet persons' needs to be effective self-managers of their illness."[50] For this reason, the CCM is designed to address these gaps through the improvement of interactivity between various practitioners and the cultivation of strategies rooted in evidence and patient needs. They continue,

> We assume that every chronically ill person has a primary care practice team that organizes and coordinates their care. Whether led by a generalist physician, a nurse practitioner, or a medical subspecialist, this team tries to optimize patient outcomes through a series of interactions during which they (1) elicit and review data concerning patients' perspectives and other critical information about the course and management of the condition(s); (2) help patients to set goals and solve problems for improved self-management; (3) apply clinical and behavioral interventions that prevent complications and optimize disease control and patient well-being; and (4) ensure continuous follow-up.[51]

Note how the architectural metaphor is at work in this passage. Instead of taking one element of the problem of patient self-management and the preparation of providers as the central problem, the list recounted here suggests that, if chronic care is to be successful, the provider role is to synergize research, specific knowledge about patient needs, and the interactions needed to support continuity of care and self-management. In other words, what the CCM inspires is attention to how all of these disparate elements are managed by a healthcare team. Instead of viewing these as unrelated issues or problems for one practitioner rather than another (or worse, something for the patient to worry about on their own), the CCM approach is to understand how all of these fit together and require one another for the cultivation of success. Thus, the preparation of providers requires sound education about new interventions and their own ongoing work to understand the needs of their patients and keep in touch with them over the long term. It is the artful arrangement of these elements and their ongoing integration within the healthcare team that, according to the comments above, will yield fruitful results.

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[50] Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care," 65.
[51] Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care," 68.

2.2.3 "Informed, Activated Patients"[52]

The "informed, activated patient" capable of "self-management" is a central feature of the CCM.[53] As one research team suggests, "Patients with chronic conditions self-manage their illness. This fact is inescapable."[54] This is due to the fact that chronic conditions require management beyond the clinical domain in the daily lives of patients. Of course, the problem of crafting patients capable of engaging in their own care is not a new one. Over the course of the last century, beginning with diabetes care, and now pervasive, the chronic patient as caregiver of and for the self has become more and more central.[55] Despite the major breakthroughs in medical technology and know-how throughout the last century that have enhanced the role of medical experts in the treatment of a vast number of illnesses, a paradoxical swing back toward self-care has grown out of the "transmutation" of illness (its movement from acute to chronic) and the inability of medical practitioners to deal with the lived experiences and needs of every individual patient.[56] Feudtner's work on diabetes indicates the degree to which this transition took place during the first part of the twentieth century. He argues while medical science was making leaps and bounds in staving off acute conditions, in particular diabetes, it was preparing the way for the emergence of chronically ill populations who could not be fully cared for in the clinic.[57] Unfortunately, teaching patients how to care for themselves is not a simple process, one to be resolved through the transfer of information from healthcare practitioner to patient. Combine this fact with a society, at the beginning of the 21st century, that is increasingly savvy about its own

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[52] Wagner, "Chronic Disease Management."
[53] Wagner, "Chronic Disease Management," 3.
[54] Bodenheimer, Lorig, Holman, and Grumbach, "Patient Self-management of Chronic Disease in Primary Care," 2470.
[55] On this, see Feudtner, *Bittersweet.*
[56] Feudtner, *Bittersweet*, 214.
[57] Feudtner, *Bittersweet*.

medical care and interested in taking more control over healthcare decision making and you have the makings of a crisis in self-care.[58]

The CCM addresses these issues by suggesting that the health care system and providers must work together with patients on a consistent basis if they are to become "pilots" of their own care:

> The patient must be the pilot, because the other possible pilot, the health care professional, is only in the plane a few hours every year, and this plane rarely touches ground. If chronically ill patients must pilot their planes, then the role of health care is to ensure skilled pilots, safe planes, flight plans that safely get the pilots to their destinations, and air traffic control surveillance to prevent mishaps and keep them on course. Medical care then must assure that persons with chronic illness have the confidence and skills to manage their condition; the most appropriate treatments to assure optimal disease control and prevention of complications; a mutually understood care plan; and careful, continuous follow-up. Well-designed interactions between practice team and patient will be needed to complete the important clinical and behavioral work of modern chronic illness care. Evidence suggests that the typical acute problem–oriented visit is a barrier to such care.[59]

Here, patients are viewed as the primary providers of their own care. This is due in large part to the fact that chronic conditions are ongoing and that their treatment does not take place in the clinical setting, one designed primarily to handle acute cases. In addition, patients and providers are seen as partners in realizing the goal of self-care. Neither can act alone in realizing this goal. In staking out these claims, this passage utilizes a piloting metaphor to describe the interconnections between patients, their providers, and the healthcare system. Yet, one can immediately grasp the connection between the arts of flying and building, thus bringing us back to the primary metaphor of this chapter: architecture. As Wagner and his co-authors elucidate here, the pilot relies on a variety of other practitioners (e.g. air traffic controllers) and an overall

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[58] Bodenheimer, Lorig, Holman, and Grumbach, "Patient Self-management of Chronic Disease in Primary Care," 2469.

[59] Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care," 66.

system (air traffic control surveillance) to safely reach their destinations. Thus, just as architects rely on teams of other artisans and technically skilled builders to realize their designs, so too do pilots rely on systems and teams of others to fly their planes. This passage argues that the same is true for patients. Arguing that patients must care for themselves or telling them to do so with only minimal support will not work. Finally, this passage ends with the claim that the "acute problem-oriented visit is a barrier to such care [chronic care, patient centered care, etc.]."[60] Again, the system itself must be adequately designed or the specific changes and practices utilized by providers and patients may not adequately address chronic disease. As I argue in the previous section in terms of preparing providers to adequately interact with and care for patients, here patients are viewed as deeply embedded in a variety of processes that require working with a multitude of different practitioners and an overall system of care. Making these processes function requires synergy and interactivity for success as well as a system designed to make such interactions more effective.

2.2.4 Translation and Dissemination

Perhaps the most complicated commonplace associated with the CCM is embedded in one of the titles of an important CCM article: "Translating Evidence into Action."[61] The need to connect evidence and interventions produced in the laboratory or as part of clinical research efforts to changes in clinical practice does not have its own discrete space in the model. However, the CCM is grounded in the notion that the best evidence must make its way from researchers to healthcare organizations and communities and finally to the providers and patients who will make use of them. In addition, the CCM itself is rooted in an effort to bring together all of the

[60] Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care," 66.
[61] Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care."

best available evidence on how to conduct chronic care effectively and synthesize it into commonplaces for improvement and transformation. As Wagner and his co-authors argue, "The chronic care model is like an evidence-based guideline: a synthesis of system changes to be used to guide quality improvement."[62] In addition, as other researchers have suggested (following the architectural model), the CCM provides a "blueprint" for future research efforts: "The CCM directs improvement efforts to a population-based, proactive, and planned approach to chronic care delivery. Various trials provide substantial evidence that application of elements of the CCM . . . will improve care for individuals with diabetes."[63] Thus, and in line with the architectural metaphor, the CCM offers a "blueprint" for researchers that indicates key areas of need and the overarching point that these areas must be synergized with one another.[64] In short, the CCM itself is a "blueprint" for how to effectively engage in research and quality improvement efforts as well as how to make these relevant to everyday clinical care.[65]

The commonplace under consideration here, making research and evidence relevant in action, has recently become a focal point of the National Institutes of Health (NIH) under the term "translational research." For clinical researchers, "translation" refers to the process of making available, accessible, and useful the findings produced within a clinical research setting.[66] Simply put, when a particular drug, intervention, or practice is shown to yield positive results for patients, it does not, according to the NIH, leap from the research setting into the

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[62] Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care," 76.

[63] Paul A. Nutting, W. Perry Dickinson, L. Miriam Dickinson, Candace C. Nelson, Diane K. King, Benjamin F. Crabtree, Russell E. Glasgow, "Use of Chronic Care Model Elements is Associated With Higher-Quality Care for Diabetes," *Annals of Family Medicine* 5, no.1 (2007): 15.

[64] Nutting, Dickinson, Dickinson, Nelson, King, Crabtree, Glasgow, "Use of Chronic Care Model Elements," 15.

[65] Nutting, Dickinson, Dickinson, Nelson, King, Crabtree, Glasgow, "Use of Chronic Care Model Elements," 15.

[66] On the technical definition of "translation," see the United States National Institutes of Health, "Glossary and Acronym List," http://grants.nih.gov/grants/glossary.htm#T [Accessed September 4, 2012].

various and sundry locales of clinical care. Instead, a process of persuasively reporting such findings and discovering ways to incorporate them into situated clinical settings is needed. Dissemination is the process through which such findings, once they are made portable in this way, are marketed and delivered to new clinical environments. The NIH has reorganized its research promotion efforts around the issues of translation and dissemination in its "Roadmap" and has initiated major grants for scholars working in translational domains.[67] There are now journals committed to the development of translational methods of research.[68] Moreover, the interest in translation now extends far beyond the U.S. For example, European nations are now engaged in the development of translational research.[69] The Canadian Institutes of Health Research funds what they call "knowledge translation" in the hopes of expanding their work to connect research to care.[70] While some have raised important questions about the advisability

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[67] On the National Institutes of Health Roadmap, see Elias A. Zerhouni, "The NIH Roadmap," *Science* 302, no. 5642 (2003): 63-64, 72; Jocelyn Kaiser and Jennifer Couzin, "Speeding Up Delivery: NIH Aims to Push for Clinical Results," *Science* 302, no. 5642 (2003): 28-29; Elias A. Zerhouni, "Translational and Clinical Science – Time for a New Vision," *The New England Journal of Medicine* 353, no. 15 (2005): 1621-1623; Arthur M. Feldman, "Does Academic Culture Support Translational Research?" *Clinical and Translational Science* 1, issue 2 (2008): 87; Alexander A. Kon, "The Clinical and Translational Science Award (CTSA) Consortium and the Translational Research Model," *The American Journal of Bioethics* 8, no. 3 (2008): (author manuscript, available online); Stephen H. Woolf, "The Meaning of Translational Research and Why It Matters," *Journal of the American Medical Association* 299, no. 2 (2008): 211; Gordon R. Mitchell and Kathleen M. McTigue, "Translation Through Argumentation in Medical Research and Physician-Citizenship," *Journal of Medical Humanities* 33, no. 2 (2012): 84.

[68] Woolf, "The Meaning of Translational Research and Why It Matters," 211. Woolf cites two of these journals – *Translational Medicine* and the *Journal of Translational Medicine*.

[69] Woolf, "The Meaning of Translational Research and Why It Matters," 211. Woolf cites the work of the European Commission and the United Kingdom.

[70] On "end of grant knowledge translation" and "integrated knowledge translation" as part of the Canadian framework for translational research, see Ian D. Graham and Jacqueline Tetroe, "Nomenclature in Translational research: To the Editor," *Journal of the American Medical Association* 299, no. 18 (2008): 2149. For more on the Canadian model and its uptake of the term "knowledge translation," see e.g., Jonathon Lomas, "Using 'Linkage and Exchange' to Move Research into Policy at a Canadian Foundation," *Health Affairs* 19, no. 3 (2000): 236-240; Jon F. Kerner, "Knowledge Translation Versus Knowledge Integration: A 'Funder's' Perspective," *The Journal of Continuing Education in the Health Professions* 26, no. 1 (2006): 72-80; Jacqueline Tetroe, "Knowledge Translation at the Canadian Institutes of Health Research: A Primer," *National Center for the Dissemination of Disability Research* (Technical Brief) 18 (2007): http://www.ncddr.org/kt/products/focus/focus18/Focus18.pdf [Accessed September 4, 2012]; Ian D. Graham and Jacqueline Tetroe, "How to Translate Health Research Knowledge into Effective Healthcare Action," *Healthcare Quarterly* 10, no. 3 (2007): 20-22; Barbara Campbell, "Applying Knowledge to Generate Action: A Community-Based Knowledge Translation Framework," *Journal of Continuing*

and ethics of translational research, in particular its emphasis on increasing the speed of research and the use of research findings in clinical care, it is now one of the main areas of concern for the worldwide effort to improve health.[71]

Crucially, the CCM provides a map for how to engage in such translational activities. That is, according to Wagner and his co-authors, research on chronic care must address the problems facing patients and their providers as they enter into the healthcare system to seek care. As a "blueprint," for researchers and organizations, the CCM offers a structural method for understanding the research process, one based on the notion that new evidence and interventions should be developed through careful attention to the demands and needs of actual patients and practitioners.[72] In addition, as I have already discussed earlier, the designers and researchers involved in the promulgation of the CCM consistently argue that new interventions will not filter down to practitioners without major efforts to make them relevant, engage in adequate training and preparation, and specify them to the particular needs of diverse clinical environments and patients.

These sub-sections have shown how the three commonplaces I have elected to focus on in this dissertation are linked to one another and to broader discussions in contemporary healthcare. Thus, each one shows how my selected focal points are both "demand-driven" and

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Education in the Health Professions 30, no. 1 (2010): 65-71; Janet A. Curran, Jeremy M. Grimshaw, Jill A. Hayden, and Barbara Campbell, "Knowledge Translation Research: The Science of Moving Research Into Policy and Practice," *Journal of Continuing Education in the Health Professions* 31, no. 3 (2011): 174-180.

[71] One of the only articles I have discovered that offers any criticism of the move to translational research suggests that "we need to consider carefully what implications the translational model of research has for scientific research in the laboratory as well as for all aspects of the research-medical-industrial enterprise. It is, after all, quite possible that much will be lost in translation." Jane Maienschein, Mary Sunderland, Rachel A. Ankeny, and Jason Scott Robert, "The Ethos and Ethics of Translational Research," *The American Journal of Bioethics* 8, no. 3 (2008): 43-51. They make a variety of arguments about the risks associated with translational research; however, many of them have to do with design issues that can be addressed through improvements in practice. I take up these arguments in the conclusion of this chapter.

[72] Nutting, Dickinson, Dickinson, Nelson, King, Crabtree, Glasgow, "Use of Chronic Care Model Elements," 15.

"clinically relevant."[73] In addition, my discussion of each in turn (the development of prepared practitioners, the activation of patients in their own care, and the translation and dissemination of research to clinical sites) has shown how they are interconnected with one another and the extent to which the CCM is designed to synergize the various elements that make up contemporary chronic care. Moreover, my analysis shows how each of these areas provides not only inventional energy (by posing problems and the arrangement of elements needed to solve them) but also a set of principles to be remembered and deployed in the artful improvement of chronic care. Thus, the commonplaces of chronic care represented in the CCM, following McKeon, act "as instruments for the perception, creation, arrangement, and establishment of the new in existence, experience, discursive exploration, and inclusive organization."[74] In short, the commonplaces I have investigated here may be viewed as "instruments" that catalyze creative, system-wide, and grounded solutions to the problems facing contemporary chronic care.[75] Finally, as McKeon suggests, as commonplaces, each one has to do not merely with the construction of better research practices and clinical policies for the advancement of effective interactivity among practitioners and their patients but also their rhetorical arrangement into an overall whole.[76] Thus, the CCM, and all of its associated articles and discussions, is as much a rhetorical act as a model for the improvement of care. In the next section, we shall see how the rhetorical work within the CCM might be combined with an architectural view of rhetoric to enliven the current study and provide a methodological backdrop for my approach to criticism and the generation of findings in future chapters.

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[73] Gordon R. Mitchell, "Switch-Side Debating Meets Demand-Driven Rhetoric of Science," *Rhetoric and Public Affairs* 13, no. 1 (2010), 111.
[74] McKeon, "Creativity and the Commonplace," 210.
[75] McKeon, "Creativity and the Commonplace," 210.
[76] McKeon, "Creativity and the Commonplace."

2.3 RHETORIC AND THE CCM: DUAL ARCHITECTONICS

Following McKeon and the words of CCM designers and practitioners, I have shown in the last section that the CCM is not merely an architecture for healthcare reform and quality improvement. As a model, it is a rhetorical act, one that structures and arranges the disparate elements of healthcare into an easily grasped framework of interrelated commonplaces. Building on this argument, in this section, I show how rhetoric can play a more than descriptive role in unlocking how the CCM functions. That is, beyond showing how rhetoric can make sense of the structural features of the CCM (as I did above), in this section, I show how rhetoric can aid in the process of invention and discovery across the disparate parts of the model. In short, I turn here from engaging in a rhetorical analysis of the CCM as a model to an interrogation of how rhetoric might add to the processes of invention, discovery, and interactivity that CCM practitioners imagine as central to the improvement of chronic care.

McKeon famously advances the claim that rhetoric is a "productive architectonic art."[77] In so doing, he challenges the view, held by many rhetorical critics of the twentieth century, that rhetoric is largely an interpretative art, one best animated by the study of speeches, or as McKeon puts it, "the semantic analysis of what somebody else has said."[78] Instead, McKeon suggests, rhetoric involves both the critical and productive functions needed to address complex problems in a highly technological and scientific age. These functions allow rhetoric to act architectonically as "an art of structuring all principles and products of knowing, doing, and

[77] McKeon, "The Uses of Rhetoric," 48. On McKeon's use of the term "architectonic" and its importance to understanding how rhetoric functions to organize, systematize, and provide inventional resources for multiple knowledge domains, see, e.g., Gerard A. Hauser and Donald P. Cushman, "McKeon's Philosophy of Communication: The Architectonic and Interdisciplinary Arts," *Philosophy and Rhetoric* 6, no. 4 (1973): 211-234; Carl B. Holmberg, "The Pedagogy of Invention as the Architectonic Production of Communication and Humanness," *Communication Education* 30 (1981): 229-237.

[78] McKeon, "The Uses of Rhetoric," 63.

making."[79] In so doing, rhetoric as "architectonic" may work to address the connections between, "knowledge, action, and production," and "contribut[e] to innovation and growth in theory, practice, and production."[80] Thus, what McKeon terms a "new rhetoric" for a "Technological Age" should be "constructed as a productive art and schematized as an architectonic art . . . [that] can be used to reorganize the subject-matter and arts of education and life. What rhetoric should be and to what conditions it is adapted are not separate theoretic questions."[81] In other words, the "architectonic" or structuring possibilities of rhetoric are not just a matter for historical analysis or theoretical discussion.[82] Instead, and following in line with my "demand-driven" and grounded approach in this dissertation, rhetorical work is made relevant and given its power through an application of its general tools to specific needs and circumstances.[83]

McKeon's claims would come off as too generic and abstract if not for his historical analysis of the evolution of rhetoric and his schematic map of the various general ways in which rhetoric may play this "architectonic" or structuring role in the development of human societies, the arts, and various knowledge domains.[84] He begins with Aristotle, the grand systematizer, for whom the discovery of the interconnections between and differences among the various arts was a central concern.[85] According to McKeon's reading of Aristotle, the two primary architectonic arts are "Prudence [*phronesis*]" which "is architectonic with respect to doing" and "Rhetoric" which is "the architectonic art of making."[86] Thus, McKeon's reading of the connection between

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[79] McKeon, "The Uses of Rhetoric," 45.
[80] McKeon, "The Uses of Rhetoric," 44-45.
[81] McKeon, "The Uses of Rhetoric," 45.
[82] McKeon, "The Uses of Rhetoric."
[83] Mitchell, "Demand-Driven Rhetoric of Science," 111.
[84] McKeon, "The Uses of Rhetoric."
[85] McKeon, "The Uses of Rhetoric," 45-46.
[86] McKeon, "The Uses of Rhetoric," 46.

phronesis and rhetoric is much akin to the way I treat these terms in chapter 1. *Phronesis* is a way of learning by doing, of engaging the world through the application of one's experiential repertoire, thus exhibiting wisdom. Rhetoric, on the other hand, has to do with making or producing, performing through the use of speech in everyday life. Of course, as Lois Self argues, these two arts intermingle at the level of combining experiential learning with sound rhetorical performance.[87] McKeon does not ignore this connection. In fact, his overall project is to show how rhetoric, fashioned by Aristotle long ago as the "'universal art' limited to no one subject-matter but applicable to all" might be used "to reunite eloquence and wisdom in action."[88] It is in staking out this claim that McKeon hints at the direct connection between rhetorical skill and wisdom, between making and doing, and between words and actions. All of these pairs link human speech with the practices and arts that make up the world, including our focus in this chapter – chronic care.

The historical problem, one that still haunts rhetorical theorists and the various arts that rely on speech as a medium for production and discovery, is that this conception of rhetoric as the great systematic and structuring art has been lost. McKeon suggests that the Roman reception of rhetoric led to its narrowing as an art: "with the institution of the Roman Empire, political deliberative rhetoric ceased to play an important part in political deliberation and action, and the old dichotomy reappeared between eloquence and wisdom, between language and action, words and deeds."[89] He goes on to point out that another key turn in history, largely centered in the

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[87] Lois S. Self, "Rhetoric and *Phronesis*: The Aristotelian Ideal," *Philosophy and Rhetoric* 12, no. 2 (1979): 137-138.

[88] McKeon, "The Uses of Rhetoric," 47-48.

[89] McKeon, "The Uses of Rhetoric," 49. Although, McKeon does point out that Cicero was one of the great rhetorical theorists of the age who attempted to defend "rhetoric as a productive architectonic art [that] laid down the structure of a program of education and culture designed to reunite eloquence and wisdom in action." McKeon, "The Uses of Rhetoric," 48. McKeon attributes the loss of the Ciceronian vision of rhetorical education to the emergence of the Emperors who replaced political deliberation with proclamation. McKeon, "The Uses of Rhetoric," 49.

emergence of modern science in the nineteenth century, caused a "'fragmentation' of knowledge, community, and communication" and the emergence of disparate and specific "subject-matters."[90] Thus,

> Rhetoric ceased to operate as the productive architectonic art initiating and guiding these processes [knowledge, community, and communication]. It was replaced by numerous arts of making and disposing which prepared for and produced a technological age, and rhetoric itself became technical: it turned from applications in other subject matters . . . except as they could be treated as instances of . . . the art of speech.[91]

The problem with this narrowing of the art of rhetoric, according to McKeon, is the now vast number of subjects, arts, and modes of life that have little or no coordination. If knowledge is primarily technical and specific, divided from the broader context of human life and its problems as well as from the performative and productive uses of communication (rhetoric), then there is little hope for interdisciplinary work or for structured efforts to overcome the problems of the day. That is, the role of rhetoric as a means of coordinating knowledge and words in action is more than just an idealistic vision of the rhetorical theorists. It is something that assists in the cultivation of practices that not only coordinate the disparate affairs of human beings but also improves these practices by providing the necessary tools for overcoming complexity, confusion, frustration, and lack of inspiration.

Now, one may ask, what is it about rhetoric that allows it to play such a central role and that makes it an architectural medium for the cultivation of any art or the coordination of disparate arts when such coordination is called for? In order to answer this question, McKeon draws on rhetorical history and theory again, arguing that rhetoric has always had tools that, if properly translated to the problems of a technological society, might aid in assaulting the

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[90] McKeon, "The Uses of Rhetoric," 51.
[91] McKeon, "The Uses of Rhetoric," 51.

complexity facing so many different fields of human knowing and doing today. In particular, he argues that "The sciences have become, more and more, sources of production, of new matters and new forms, in need of organizing methods and principles."[92] McKeon suggests that there are four primary ways in which rhetoric might assist in developing such organizing methods and principles. First, he argues that rhetoric has always been an inventional art, one animated by the discovery of means of proof and persuasion. Thus, rhetoric's inventional focus may be helpful to scientists and other practitioners seeking to develop hypotheses, test them, and appropriately interpret their discoveries: "A reconstituted verbal art of invention . . . might be used to shadow forth the methods and principles of an architectonic productive art generalized from invention in language to discovery in existence."[93] Second, he argues that rhetoric is fundamentally tied to judgment, what I have called, following Melia, its "analytic" function.[94] This function, according to McKeon, might be adapted to assist a variety of practitioners to appropriately judge "hypotheses and facts in experience."[95] Third, McKeon suggests that "A universalized verbal art of making, and modifying, connections could be used to relate the separated fields of the arts and sciences and to trace themes as they move in variations from field to field."[96] Thus, the art of rhetoric, which has its roots in the tracing of themes and structures in texts, may be modified and applied to interdisciplinary work among the different sciences and different practitioners. Fourth and finally, McKeon contends that rhetoric may play a role in understanding "the compositions of things, constitutions of communities, and constructs of communications."[97] This fourth element draws on an earlier point made in his essay regarding "the absence of interdisciplinary

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[92] McKeon, "The Uses of Rhetoric," 54.
[93] McKeon, "The Uses of Rhetoric," 55.
[94] Trevor Melia, "Review," *Isis* 83, no. 1 (1992), 100.
[95] McKeon, "The Uses of Rhetoric," 56.
[96] McKeon, "The Uses of Rhetoric," 56-57.
[97] McKeon, "The Uses of Rhetoric," 57.

connection and . . . the breakdown of interpersonal, inter-group, and intercultural communication."[98] Thus, rhetoric may play a role in charting why the breakdowns of community, and "inter" modes of communication, have occurred and how to address these problems. Throughout all of these four arenas, and in his concluding remarks, McKeon makes the case that "verbal rhetoric" is both the model and tool for addressing the age-old division between knowing, doing, and speech.[99]

I have recounted McKeon's arguments at length for a reason. Just as Wagner and other CCM practitioners have made the case that their architecture is needed for the adequate resolution of crises in chronic care (and medicine more generally), McKeon's work suggests that, in a general way, rhetoric is the necessary organizing art for overcoming "fragmentation" and complexity in technological societies.[100] Furthermore, McKeon's four interlocking points about the role of rhetoric as a sort of architecture for interdisciplinary and coordinated work in a technological society directly address what I view as the primary gap in the CCM, that is, the ways in which verbal speech and interactivity may play a key role in linking the various parts of the CCM architecture and addressing how new discoveries will move from the laboratory to the clinical site and finally to the patient. Thus, the four elements of rhetoric as "architectonic" described by McKeon might highlight the critical and productive functions of rhetoric in unlocking the healthcare improvements that Wagner imagines.[101]

In other words, while the previous section suggests that the CCM is itself a rhetorical act, one that coordinates the various commonplaces of chronic care into a visual whole, here I am

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[98] McKeon, "The Uses of Rhetoric," 52.
[99] McKeon, "The Uses of Rhetoric," 63.
[100] McKeon, "The Uses of Rhetoric," 51. On the role of rhetoric in addressing fragmentation, see also Michael Calvin McGee, "Text, Context, and the Fragmentation of Contemporary Culture," *Western Journal of Speech Communication* 54 (1990): 274-289.
[101] McKeon, "The Uses of Rhetoric."

suggesting that rhetoric may play a role in generating new knowledge and practices in the interdisciplinary and coordinated activities of providers and patients as they address chronic disease. First, rhetoric as an inventional art may provide resources for chronic care researchers as they craft hypotheses from the visual and verbal cues gleaned during provider-patient interaction. Recall that for Wagner and his model, generating research that is relevant to specific needs and that coordinates action between providers and patients is essential to effective chronic care delivery. Thus, just as rhetors must size up their audience and find ways to persuade them so to must healthcare researchers and practitioners size up the problems they are facing and generate relevant hypotheses and practice changes to address the uncertainties and contingencies of the clinical setting.

Second, rhetoric as a mode of judgment may be directly linked to the cultivation of better decision making by providers, patients, and researchers. In other words, just as rhetoric is related to the practice of analyzing and judging in the cultivation of verbal performance, the generation of research findings and the delivery of adequate care to chronic patients are rooted in the process of making judgments in particular cases and with the idiosyncratic needs of particular patients and providers in mind. Thus, McKeon's notion of rhetoric as an art of judgment links already well-defined modalities of research and care currently being utilized by CCM practitioners with a concern for how these modalities are made relevant to specific situations and how they may need to be changed in moments of uncertainty and contingency, an element of medical practice that takes center stage in my work in chapters 3-6.

Third, rhetoric may, following McKeon, provide the tools of interactivity and translation that are necessary for disparate actors and practitioners from a variety of disciplines to work together in the generation of new solutions. As McKeon points out, the various knowledge

domains of technological society are, to a certain extent, fragmented. This claim bears marked similarity to the view of CCM practitioners that the various health disciplines as well as providers and patients lead fragmentary and disconnected lives. Coordinating their activities through the creation of teams is the CCM approach to solving this problem. However, the ways in which these teams interact, how they arrange their knowledge claims and practices, and how they coordinate their activities with those of patients who are engaged in self-care is an understudied element of the CCM that, McKeon's arguments suggest, rhetoric is geared to address directly.

Finally, McKeon's insight that rhetoric is the constitutive building block of community suggests that it may play a crucial role in realizing "productive interactions" between healthcare providers and patients.[102] That is, rhetoric is the process through which identities are constructed, knowledge practices are revealed and disseminated, and communities are called into existence. In terms of Wagner's model, rhetoric may provide needed insights into the process of cultivating practitioners who can speak across interdisciplinary divides, think of themselves as assisting patients in caring for themselves rather than controlling the therapeutic process, and engage in the coordination of evidence based in research with their daily experiences in the clinical setting. Likewise, patients must, following this constitutive line of thinking, be prepared to care for themselves. In short, patients are no less embedded in a process of becoming capable to handle chronic disease than their trusted providers. Rhetoric is thus the medium through which the cultivation of providers and patients may be achieved (chapters 4-5).

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[102] Wagner, "Chronic Disease Management." Additionally, others have recognized this constitutive function of rhetoric. See John Lyne, "Rhetorics of Inquiry," *Quarterly Journal of Speech* 71 (1985): 65-73; Maurice Charland, "Constitutive Rhetoric: The Case of the 'Peuple Québécois,'" *Quarterly Journal of Speech* 73, no. 2 (1987): 133-150.

This section argues that McKeon's notion of rhetoric as a "productive architectonic art" provides grist for my claim that rhetoric may play a more than descriptive role in understanding the commonplaces of chronic care represented in the CCM.[103] While the CCM is itself a rhetorical act, one that is visually constructed to coordinate and synergize various commonplaces of care into an overall strategy for improving health outcomes for patients, what I argue is that rhetoric may also be a tool synergizing healthcare delivery. In the following chapters, I chart how rhetorical practices not only describe the activities of providers, patients, and healthcare research and dissemination teams but also play a central role in their cultivation and success. My arguments in this section are laid out in a provisional way in order to suggest that the evidence is yet to come. Only though the careful analysis of interviews and research documents prepared for a CCM style intervention can I begin to produce evidence of the claims I have made here regarding the interconnections between rhetoric and the CCM; however, I have provided initial thematic connections between McKeon's notion of rhetoric and the CCM construction of the commonplaces of chronic care that will be of use in this endeavor. Thus, I am prepared to prove in the chapters ahead that rhetoric and the CCM are dual architectonics that help to both elucidate the problems facing chronic care, and when utilized in tandem, reveal the sorts of communicative and persuasive activities needed to solve these problems. Finally, given my investment in the "architectonic" elements of rhetoric, my critical method in the chapters ahead will seek not only to treat my various objects of study (interviews rooted in the experiences of providers, patients, and research disseminators respectively) in isolation but also as mutually informing.[104] Thus, I utilize McKeon's work not only as a way to realize rhetoric as a "demand-

[103] McKeon, "The Uses of Rhetoric," 48.
[104] McKeon, "The Uses of Rhetoric."

driven" and "clinically relevant" art but also as an analytical tool that can draw connections between discoveries in different knowledge and practice domains.[105]

2.4 HIPPOCRATES AND GORGIAS: TWO MODELS OF THE RHETORIC/MEDICINE MERGER

In this section, I investigate two ways of thinking about rhetoric and medicine as related and overlapping arts rooted in the ancient Greek tradition and drawn from the works of the Hippocratic writer and the words of the Sophist, Gorgias.[106] My move to the Greek tradition here is in keeping with my work in chapter 1 to return to sites in the intellectual history of rhetoric and medicine where these arts have been closely related and mutually informing. These sites function as aspirational locations in intellectual history for the elaboration of contemporary practices in chronic care. With this in mind, and following Joan Leach, I contend that the Hippocratic approach to the overlap between rhetoric and medicine is preferable to the more manipulative and "pessimistic" approach developed by Gorgias.[107] Thus, I develop the claim that the *Hippocratic Corpus* utilizes the artistic powers of rhetoric to create mutually supportive partnerships between medical researchers, clinicians, and patients. As Leach contends in this regard: "In addition to urging physicians to 'do no harm', the Hippocratics realised that knowledge was of little good if it was not disseminated. Many of their writings exhort physicians as they travel to take on students who show aptitude for communication as well as potential technical competence."[108] She goes on to suggest that in addition to showing a concern for knowledge dissemination, the Hippocratic tradition moves in the direction of mutual partnership between physicians and patients: "This broadly Hippocratic view has found favour in medical

[105] Mitchell, "Demand-Driven Rhetoric of Science," 111.
[106] This section is heavily indebted to the work of Joan Leach in her "The Art of Medicine."
[107] Leach, "The Art of Medicine."
[108] Leach, "The Art of Medicine," 2104.

training in the latter half of the 20th century with an emphasis on communication skills in various curricula and the emergence of an entire field that studies and tries to improve doctor–patient communication."[109] As we shall see, the CCM actually draws on concepts that can be traced to this Hippocratic approach to medicine. In particular, the normative conception of rhetoric as a method of interaction and shared decision making at the heart of many Hippocratic passages is in keeping with the CCM's goal to produce supportive and equitable interactions between providers and patients as well as researchers and clinicians; however, this is not the only way to think about the deployment of rhetoric in the realm of medicine.

Importantly, Leach argues that the Greek tradition offers competing visions of the connection between rhetoric and medicine providing contemporary scholars the opportunity to compare, contrast, and select the most useful and applicable concepts for further elaboration and development.[110] For example, Gorgias and his student Hippocrates offer different but highly instructive views on the role that rhetoric might play in the medical arts. This difference emerges from a complicated terrain of metaphysical ponderings, contrasting conceptions of the rhetorical, and distinct understandings of the doctor-patient relationship. Gorgias' life and teachings indicate the extent to which the firm distinctions between medicine, rhetoric, and other arts were simply not part of early Greek conceptions of intellectual and practical life. In describing the power of rhetoric to persuade (or even violently manipulate), Gorgias turns to the notion of *pharmakon* (drugs) to make his point. In his *Encomium of Helen*, Gorgias suggests that rhetoric is often manipulative and is deeply implicated in the quest for power. Acting like a drug, rhetoric can affect the senses and change our perceptions of the real through the mere use of words.[111] In

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[109] Leach, 'The Art of Medicine," 2104.
[110] Leach, "The Art of Communication," 2104-2105.
[111] Gorgias, "*Gorgias' Encomium of Helen*," in *The Older Sophists,* 50-54.

thematically similar remarks made in his titular Platonic dialogue, Gorgias suggests that rhetoric is "the ability to persuade with speeches either judges in the law courts or statesmen in the council-chamber or the commons in the Assembly or an audience at any other meeting that may be held on public affairs. And I tell you that by virtue of this power you will have the doctor as your slave."[112]

While these remarks indicates the potential power of rhetoric to control members of the various professions, to take over their arenas of practice and colonize them (recall Gaonkar's argument from the introduction here), in other arguments attributed to him, Gorgias offers a slightly more complicated approach to this merger.[113] At one point in Plato's dialogue named for him, Gorgias claims that only through the use of suasive language can a doctor convince patients to take their advice and act accordingly.[114] Here, rhetoric is viewed as part and parcel of medical practice. It is this sense of medical rhetoric (or rhetorically-inflected medicine) offered by Gorgias that is most salient for modern concerns about medicine as a communicative, pedagogical, and fundamentally rhetorical activity. As Leach notes of this turn in Gorgias' thinking: "In a less pessimistic mood, Gorgias was rumoured to have taught classical physicians rhetorical skills including the ability to persuade their patients to pay for their services in a timely manner, methods of communication to advertise the physician's prowess, and techniques to encourage patients to particular regimens."[115] It is this part of Gorgias' approach to rhetoric that Leach suggests comes closest to the Hippocratic tradition.[116]

Unfortunately, Gorgias' commitment to the power of rhetoric comes with a price. He also

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[112] Plato *Gorgias* 452e

[113] See Dilip Gaonkar, "The Idea of Rhetoric in the Rhetoric of Science," in *Rhetorical Hermeneutics: Invention and Interpretation in the Age of Science*, ed. by Alan G. Gross and William M. Keith (Albany: State University of New York Press, 1997), 25-85.

[114] Socrates *Gorgias* 456b

[115] Leach, "The Art of Medicine," 2104.

[116] Leach, "The Art of Medicine," 2104.

argues that communication between human beings is fraught with incommensurabilities and so defends a notion of rhetoric as the power to *control* through persuasion those individuals with whom we disagree.[117] As Leach suggests, Gorgias offers an incomplete vision of the role that rhetoric might play in the interaction between medical practitioners and patients, one imbued with a deep "pessimis[m]."[118] To this, I add that another entailment of Gorgias' views is an abiding paternalism that would certainly not work in a contemporary clinical setting constituted by the bioethical concerns of autonomy, respect for persons, and informed consent.[119] It also stands in direct contrast to the views of Wagner and his research cohort. For them, "productive interactions" cannot occur unless patients and providers engage in mutually supportive and equitable conversations that draw as much on medical knowledge as the specific and often idiosyncratic needs of patients.[120]

Gorgias' student, Hippocrates, offers us a slightly different picture.[121] Throughout the medical works attributed to him, the Hippocratic writer argues that doctor-patient communication must involve dialectical equity and a concern for the "commonplaces" of the given cultural milieu.[122] Effective communication in such circumstances also depends upon the *ethos* (credibility) of the physician, established through the adequate diagnosis and prognosis of

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[117] Gorgias famously rejects the power of logos (words) to manifest the "majority of substances." Gorgias, "Gorgias' *On the Nonexistent or on Nature*," in *The Older Sophists*, 46. On this point, see Leach, "The Art of Medicine," 2104. She uses this argument from Gorgias as a springboard into a commentary on the role of communication in the dissemination of medical research.

[118] Leach, "The Art of Medicine," 2104.

[119] On this, see Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 6th ed. (Oxford: Oxford University Press, 2009); Ruth R. Faden and Tom L. Beauchamp, *A History and Theory of Informed Consent* (Oxford: Oxford University Press, 1986).

[120] Wagner, "Chronic Disease Management"; Wagner, Austin, Davis, Hindmarsch, Shaefer, and Bonomi, "Improving Chronic Illness Care."

[121] Pinault, *Hippocratic Lives and Legends*, 10.

[122] Leach, "The Art of Medicine," 2105; McKeon, "Creativity and the Commonplace"; Perelman, "Philosophy, Rhetoric, Commonplaces."

patients.[123] In the work, *Tradition in Medicine*, the Hippocratic writer remarks that "if anyone departs from what is popular knowledge and does not make himself intelligible to his audience, he is not being practical. For such reasons, we have no need of hypothesis."[124] The Hippocratic writer also suggests throughout the corpus that adequate prognosis is central to the promotion of the physician's credibility among his patients.[125] Accordingly, the Hippocratic writer is not so much interested in rhetoric as a mode of power and control, but rather its potentially beneficial role in the give-and-take relations between physician-researchers and the public.[126] These brief inflections of the Hippocratic tradition support Leach's claim that the Hippocratic tradition embraces an "optimism that at least some strategic communication could work to get medical knowledge out to broader audiences as well as to other practitioners and investigators who need to know."[127] Taking this context as a backdrop, this section is an effort to recover some elements of the Hippocratic rhetorical approach to medicine highlighted above. As such, it brings to the fore elements of Hippocratic medicine beyond the "do no harm" conception of his oath, the primary element of his work that receives attention in modern bioethics and clinical practice.[128] In fact, at least in part, this section questions the original *Hippocratic Oath* as an orientation to medical knowledge as the distinct province of the practitioner.[129] Instead, I argue, following the

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[123] Lisa Kieranen has recently argued that *ethos*, persona, and voice are central to public understandings of scientific professionals and their discourse. Her re-interpretation of *ethos* "as the widely shared cultural values or implied norms that characterize a group of people" allows for a broader reading of *ethos* than the commonly understood notion of "credibility." As such, it opens the door for understanding how, as she puts it, "ethos derives from a rhetor's inventional choices but resides in audience assessments of the speaker's character." See Lisa Kieranen, *Scientific Characters: Rhetoric, Politics, and Trust in Breast Cancer Research* (Tuscaloosa: University of Alabama Press, 2010), 26.

[124] Hippocratic writer, *Tradition in Medicine*, in *The Medical Works of Hippocrates*, trans. by John Chadwick and W.N. Mann (Oxford: Blackwell Scientific Publications), 13.

[125] Hippocratic writer, *Prognosis*, 112.

[126] Leach, "The Art of Medicine."

[127] Leach, "The Art of Medicine," 2105.

[128] Hippocratic writer, *The Oath*, 9.

[129] On this, see Chadwick and Mann, *The Medical Works of Hippocrates*, 9; Vivian Nutton, "Medicine in the Greek World, 800-50 BC," in *The Western Medical Tradition,* 19. Here, Nutton also mentions that while the

CCM practitioners described in earlier sections of this chapter, that medical knowledge and practice, due to the emergence of epidemic chronic disease, must be made available and accessible to patients as caregivers of and for themselves. Such a view militates against the Gorgian conception of medical rhetoric as a form of control and domination and the *Oath's* concern with controlling the medical arts within a small professional guild.

Returning to the context of ancient Greece, we have found two models of medicine that rely on particular views of rhetoric. Following Leach, I argue that the Hippocratic view, with its less parternalistic and more cooperative bent, is the better of the two for handling chronic disease; however, we should keep the Gorgian model in mind as we go along, primarily because it allows us to consider the role of rhetoric in medicine from a normative standpoint. By this, I mean that the Gorgias' view reveals the potential power of *logos* as a tool of persuasion, domination, and control.[130] As rhetoric is the primary art for the use (and abuse) of *logos*, it behooves us to proceed carefully lest we unleash rhetoric in ways that are exploitive, that, for example, might occlude the possibilities for enhanced provider-patient dialogue, a central value of the CCM. In the next few paragraphs, I unpack key inflections of the Hippocratic tradition in terms of the three primary commonplaces of chronic care detailed in section 2.2: the cultivation of providers, the preparation of patients to engage in self-care, and the translation and dissemination of research into the clinical setting.

The first commonplace discussed in the previous section, patients as capable of self-care, is directly tied to the second, the rhetorical activities of physicians, in the ancient Greek tradition. For the sake of clarity, I thus treat the first two commonplaces together. In terms of

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Oath seems to place limits on who may possess medical knowledge, the likelihood is that anyone willing to pay for training could receive it. However, as I will show, this notion of protecting medical knowledge has found new support in some contemporary accounts of patient autonomy and self-care.

[130] Leach, "The Art of Medicine."

contemporary medical practice, there is a problem of power residing at the heart of patients acting as caregivers of the self in 21st century medicine. For many physicians, some subscribing to the more paternalistic notion of medicine represented by the Gorgian tradition, the notion of patients developing expertise in self-care is both a necessity and a potential catastrophe.[131] As patients seek out more information regarding their health and incorporate medical advice into their daily lives, they are likely to make mistakes, to assume too much, or to argue with their physicians. Primarily emanating from the relatively new disciplinary domain of bioethics, research on the hallowed principle of respect for persons and the notion of patient autonomy tends to focus on a balancing of the relationship in which the health care professional holds most of the epistemic cards. Creating a mutual partnership with patients is valued but only if patients are not said to hold medical knowledge but, rather, to employ the expertise of their physician.[132] Some have even argued that autonomy has gone too far, echoing the concerns raised by the Hippocratic writer that knowledge must be protected and that physicians should play the primary role in diagnosing and offering a variety of prognoses and treatment plans for the diseases experienced by their patients.

The concerns adumbrated above regarding the role of patients and society as a whole in the cultivation of self-care echoes what Donald Ainslie has called a "managerialist approach" to bioethics and medical praxis.[133] As bioethics is the primary domain through which the ethics of care and the importance of patient autonomy is defined and incorporated into medical activity, bioethicists tend to "manage" controversial spaces, such as the degree to which individuals can

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[131] D. H. Smith, "Ethics in the Doctor-Patient Relationship," *Critical Care Clinics*, 12, no. 1 (1996): 179-197.

[132] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 307-311.

[133] Donald Cameron Ainslie, *Redefining Bioethics in the Age of AIDS* (Masters Thesis, Center for Bioethics and Health Law, University of Pittsburgh, 1996). Ainslie uses the term "managerialism" throughout his work.

or should care for themselves, without accounting for the "bioethics of everyday life."[134] This notion of bioethics, described and defended throughout Ainslie's work, places emphasis on the needs and concerns of patients and their communities as a critical counter-part to the concerns of medical science. We may find that patients have different solutions to the problems they face with the chronic diseases than the newly fashioned medical teams with which they interact. As such, the move to deal with patient knowledge, the epistemology of illness, and the kinds of skills needed for self-care must be made part of the concern for medicine as it approaches the crisis in knowledge production, dissemination, unification, and systematization wrought by chronic disease.

When viewed through a Hippocratic lens, the problem of self-care may be understood as the difference between on the one hand, facing a great wave in a small dinghy, with only your own two arms to paddle, and on the other, the same wave in a large ship with motor engines. As the Hippocratic writer suggests, "Most doctors seem to me to be in the position of poor navigators. In calm weather they can conceal their mistakes, but when overtaken by a mighty storm or a violent gale, it is evident to all that it is their ignorance and error which is the ruin of the ship."[135] If we continue to ask physicians (or individual patients for that matter) to withstand the gale force winds and tidal waves of new medical technology and new information about their conditions, they may find themselves drowning. What solutions would a CCM practitioner offer to these problems? Networked communication, shared responsibility and action, etc.; however, the CCM only points the way. It does not provide the actual substance to apply these ideas. As I suggest in section 2.3, filling out and applying these ideas requires direct attention to rhetoric and its productive and critical possibilities.

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[134] Ainslie, *Redefining Bioethics in the Age of AIDS*, 23.
[135] The Hippocratic writer, *Tradition in Medicine*, 17.

In addition, and in contradistinction to the *Oath*, the Hippocratic writer also suggests that medicine requires a relationship between physicians and patients in which persuasion and learning occurs. The Hippocratic writer argues in *Epidemics I* that "There are three factors in the practice of medicine: the disease, the patient and the physician. The physician is the servant of the science, and the patient must do what he can to fight the disease with the assistance of the physician."[136] In the same text, the Hippocratic writer suggests that "we must consider the nature of man in general and of each individual and the characteristics of each disease. Then we must consider the patient."[137] For the Hippocratic writer and the CCM practitioner alike, the move to understand the specific case, to deal with the complexities of chronic disease on a case-by-case basis through analysis and appropriate communication with patients, provides a rhetorical context in which to generate knowledge of the particular case and the therapeutic tools to deliver such care. Of course, the ability to size up a situation correctly and communicate this information to others and use it as a springboard for innovation are all rhetorical activities, defined originally in Aristotle's *Rhetoric*. As such, the Hippocratic insights adumbrated above and directly connected to the concerns of CCM practitioners in the context of provider-patient cooperation indicate the degree to which rhetoric fulfills McKeon's promise as an art that can structure and improve the activities of other knowledge domains.

The third commonplace described in section 2.2 has to do with the translation and dissemination of research to the clinical setting. Following the work of Joan Leach, the CCM is in many ways a real instantiation of her "Hippocratic revolution in medicine," due to its focus on

[136] The Hippocratic writer, *Epidemics, Book I*, 36.
[137] The Hippocratic writer, *Epidemics, Book I*, 42.

the "Translat[ion of] Evidence into Action."[138] Leach suggests that researchers and practitioners often do not interact effectively, thereby undermining the movement of new findings into the domain of practice.[139] I agree with her, and her point that the Hippocratic writer makes the pedagogical role of the medical researcher paramount, especially in the *Aphorisms*.[140] Leach's understanding of the "Hippocratic revolution" focuses on the dissemination of research findings. Her suggestion is that, from a Hippocratic point of view, creating useful knowledge and then making it available through the composition of easily digested texts (*Aphorisms*) is necessary to dissemination.[141] The CCM engages in a practice very similar to the one under investigation by Leach. Recall that my reading of the CCM shows how it organizes the various commonplaces of chronic care into sites for creativity and the generation of new findings and practices. It is thus a model for how to create new medical knowledge and move it from one point to another in the overall structure of chronic care delivery. In this way, the Hippocratic tradition provides additional evidence for my claim that rhetoric and medicine can and should function as dual architectonics.

In this section, following Leach, I suggest that the relationship between rhetoric and medicine emerged in a synthetic and mutually informing way in the Greek tradition (as represented by Gorgias and the Hippocratic writer). Furthermore, I indicate that the *Hippocratic Corpus* offers a more holistic terrain and a broader conception of the physician and patient in providing for health than the Gorgian approach, yet both offer a view of rhetoric and medicine as

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[138] Leach, "The Art of Medicine," 2105; Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care."

[139] Leach, "The Art of Medicine," 2104-2105.

[140] Leach, "The Art of Medicine," 2105.

[141] Leach makes this point while arguing that Gorgias himself denied the possibility of effectively communicating knowledge. For her, and I agree, this viewpoint undermines the adequate development and delivery of new healthcare findings and should be replaced by the Hippocratic approach in the *Aphorisms*. On Gorgias' claim that knowledge cannot be communicated, see Gorgias, "Gorgias' On the Nonexistent or On Nature" (fragments taken from Sextus Against the Schoolmasters VII 65) in *The Older Sophists*, 42.

interpenetrating in a way that modern medicine has yet to fully appreciate.[142] In this regard, the Hippocratic writer's conception of medicine might usefully be called a generalist orientation to the medical arts, one that values the role of rhetoric, the importance of healing (construed broadly), and the need to educate future practitioners in both scientific and artistic approaches to caring for patients.[143] The Hippocratic tradition thus pushes us to see connections between the disciplines of rhetoric and medicine obscured by our contemporary concerns with disciplinarity and professional distinctiveness. Finally, the Hippocratic perspective is fitted to the new problems facing medical theory and practice in ways that the Gorgian tradition (and its modern counter-part, physician paternalism) simply is not. Chronic disease calls for a different set of skills than those normally taught at our medical schools. Again, following Leach, persuasion, recognition of the everydayness of illness, real empathy for patients, and many related arenas of training are crucial to dealing with the increased prevalence and incidence of chronic disease and have not received sufficient attention. As aspirational (as well as instructional) texts, the works of the Hippocratic writer (although imperfect in many ways) point to some of these elements and could become the foundation for a revival of rhetorical work in medicine.[144] I have also directly linked these Hippocratic ideas with key commonplaces in the CCM, thus showing that the CCM and rhetoric are already conceptually joined when viewed from the perspective of the Hippocratic tradition. Finally, this section has shown how all of the elements of the CCM may draw on the normative view of the Hippocratic tradition, primarily that communication is a central element not only in the cultivation of partnerships between patients and their providers but also, following Joan Leach, in the dissemination of research findings.

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[142] Leach, "The Art of Medicine," 2104-2105.
[143] Leach, 'The Art of Medicine," 2104-2105.
[144] Leach, 'The Art of Medicine," 2104-2105.

2.5 CONCLUSION

In this chapter, I advance four primary claims. First, I argue that the CCM is an architectural model that combines the various commonplaces of chronic care into a systemic whole. In this regard, the CCM points to an important insight, one gleaned from my rhetorical analysis of how the various commonplaces fit together. That insight, that every commonplace is both a site for invention and memory (drawn from McKeon's work) and that each in turn is connected in some important way to the others, indicates how much work the architecture of the CCM is able to do in reorienting the research and clinical practices needed for improving chronic care delivery.[145] In short, the CCM indicates the degree to which the preparation of providers, the cultivation of patient self-care, and the translation and dissemination of research and new interventions to the clinical sites in which they may improve health outcomes, all depend upon one another for success.

Second, while the CCM acts as a powerful architectural framework for the arrangement of the various commonplaces of chronic care, it is not as strong on how the various elements might be connected. Following McKeon, I argue that rhetoric may be viewed as "a productive architectonic art," one that might reveal the power of *logos* as a conduit to connect the various commonplaces of the CCM and to improve upon the skill sets needed for success in each of them.[146] I also develop McKeon's four primary elements that make up the architectonic features of rhetoric: invention, judgment, interactivity across disciplines, and constitution. I argue that rhetoric's inventional role in the discovery of various methods of persuasion for different

[145] McKeon, "Creativity and the Commonplace."
[146] McKeon, "The Uses of Rhetoric," 48.

audiences might be adapted to the practices of chronic care research. In addition, I suggest that rhetoric's reliance on judgment rooted in the particular might help to explain and improve upon the provider-patient relationship in the context of chronic care. As chronic conditions are often complex and experienced in idiosyncratic ways, the faculty of judgment that McKeon makes central to the art of rhetoric may be the needed tool in improving chronic care delivery and making it relevant to the needs of individual patients. Furthermore, I point out that McKeon's view of rhetoric as an art designed to enhance interactivity across various knowledge domains may help to establish new connections between disparate actors and fields in the creation of new approaches to chronic care. As such, following McKeon, it may provide the needed tools for enhancing interdisciplinarity across the allied health disciplines, cultivating needed tools for the arrangement and application of disparate knowledge and practice domains within healthcare teams, and establishing approaches that overcome the epistemic divide between providers and patients. Finally, I argue that McKeon's view of rhetoric as an art useful in drawing communities together may contribute to our understanding of how practitioners develop their professional capacities to deal with chronic care and how patients are constituted as capable of self-care through interaction with their providers and the healthcare system. I still need to show how each of these arguments works in the course of a real, grounded health intervention. Only in such a context can the role of rhetoric be fully investigated and developed in each of these domains. I turn to just such an intervention in chapters 3-5.

Third, following the excellent work of Joan Leach, I investigate nascent linkages between rhetoric and medicine within the CCM by drawing on the ancient Greek tradition. Thus, I have shown not only how rhetoric may play a role in energizing the commonplaces of chronic care but also that there are deep ties between my selected theoretical frame for this dissertation, the

ancient Greek tradition, and the CCM. Moreover, I argue that the paternalism of Gorgias is softened by what Leach has identified as the Hippocratic concern with persuasion and the development of mutual relationships between practitioners and their patients as well as researchers and practitioners.[147] Finally, I argue that the Hippocratic tradition has more salience for the development of patient-centered approaches grounded in the development of self-care than the paternalistic bent of Gorgias. In all, the ancient Greek tradition and its close alignment of rhetoric and medicine shows how CCM practitioners might engage in the process of building ties between the dual architectonics of chronic care and rhetoric.

Fourth, in detailing the three primary commonplaces of chronic care within the CCM, I have laid the groundwork for my analysis in future chapters. Chapter 4 investigates the cultivation of practitioners as members of a team in the delivery of chronic care to obese patients. Chapter 5 investigates how patients engage in the cultivation of practices needed to engage in self-care. Finally, chapter 6 investigates how rhetoric plays a central role in the translation and dissemination of research findings from the academic research setting into other clinical locations. Furthermore, I have hinted that McKeon's "architectonic" view of rhetoric not only indicates the extent to which rhetoric may play a role in improving chronic care delivery but may also provide a critical resource for framing the findings in each of these chapters.[148] That is, in taking an "architectonic" view, I may discover that the findings of each chapter overlap in important ways that generate insights which non-architectonic, single-object focused projects might not.[149]

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[147] Leach, 'The Art of Medicine," 2104-2105.
[148] McKeon, "The Uses of Rhetoric."
[149] McKeon, "The Uses of Rhetoric."

In the next chapter, I initiate my turn into the first commonplace of the CCM: the preparation of providers for the ongoing and deeply interactive practices of chronic care. I do this by investigating a concept that many researchers and scholars view as central to professional development in medical education: *phronesis* (practical wisdom). Recall here that McKeon discusses the need to synergize rhetoric and *phronesis* so as "to reunite eloquence and wisdom in action."[150] Thus, I argue in the next chapter that *phronesis* is deeply tied to the rhetorical tradition and provides a way to understand how the practices of chronic care delivery and patient self-care may be improved. I then turn to chapters 4 and 5 in which I investigate the experiences of providers and patients as they work through an intervention rooted in the commonplaces of the CCM described in this chapter.

[150] McKeon, "The Uses of Rhetoric," 48.

3.0 WIDENING APPLICATIONS OF *PHRONESIS* IN CONTEMPORARY CHRONIC CARE

> A wise man ought to realize that health is his most valuable possession and learn how to treat his illnesses by his own judgment.[1]

> The best illustration of what I hold is that of a *cable* which is made up of a number of separate threads, each feeble, yet together as sufficient as an iron rod. An iron rod represents mathematical or strict demonstration; a cable represents moral demonstration, which is an assemblage of probabilities, separately insufficient for certainty, but, when put together, irrefragable . . . A man who said 'I cannot trust a cable, I must have an iron bar,' would *in a certain given case*, be irrational and unreasonable.[2]

> What I propose, therefore, is very simple: it is nothing more than to think what we are doing.[3]

3.1 THE CONCEPTUAL DEVELOPMENT OF *PHRONESIS*

In this chapter, I engage in the conceptual development of a key term introduced in chapter 1: *phronesis* (practical wisdom). As I suggest in that chapter, the sort of knowledge and skills needed to attend to chronic patients are rooted in their experiential repertoire. That is, because chronic diseases require individuals to engage in self-care, they must draw on their own illness experiences (and the learning process embedded in experience) in order to succeed. As the following sections delineate, *phronesis* is the mode of knowledge most closely associated with

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[1] The Hippocratic writer, *A Regimen for Health* in John Chadwick and W. N. Mann, *The Medical Works of Hippocrates* (Oxford: Blackwell Scientific Publications, 1950), 218.

[2] John Henry Newman as quoted in Joseph Dunne, *Back to the Rough Ground: Practical Judgment and the Lure of Technique* (Notre Dame: University of Notre Dame Press, 1993), 45. See John H. Newman, *Letters and Diaries of John Henry Newman*, ed. C. S. Dessain, T. Gornall, and I. T. Ker (Oxford: Clarenden Press, 1961), XXI: 146. I am deeply indebted to Dunne's work, primarily his revival of Newman, Arendt, and Aristotle in the scholarly history and development of the concept of *phronesis.* For detailed comparisons of the views of these different authors (among others) see his *Back to the Rough Ground*.

[3] Hannah Arendt, *The Human Condition* (Chicago: The University of Chicago Press, 1958), 5.

experience in the Greek tradition. It is, according to Aristotle and Isocrates, a model for learning through the practice of doing, of performing activities based on the dispositional cultivation of capability. While most discussions of *phronesis* in the realm of medicine focus on its usefulness in capturing the experiential learning of healthcare professionals, I develop the concept in a way that directly addresses the interconnection between patients and their providers (the first two commonplaces of the "Chronic Care Model" discussed in chapter 2), thus expanding the concept to cover the practical activities of every actor engaged in the cultivation of chronic care.[4]

While completing the work for this dissertation, I became aware of two sources that develop the concept of *phronesis*, drawn primarily from the Aristotelian tradition, in the context of patient self-care. First, Sara Rubinelli, Peter J. Schulz, and Kent Nakamoto suggest that while *phronesis* has been applied to healthcare professionals and their clinical activities, it has not been expanded into the realm of the patient.[5] They go on to argue that in order to deal with the increasing incidence of chronic disease, a new approach that values the "individual's existential experience" as one factor in their overall lifeworld that can contribute to more effective self-management strategies and more realistic interactions between healthcare practitioners and their patients.[6] For them, *phronesis* refers directly to the necessary practice of patient "self-examination" in the cultivation of goals and the capability to engage in "asking the right questions," during healthcare encounters.[7] Second, Bryan Vartabedian, a pediatric gastroenterologist, has developed a simple but important conception of patient *phronesis*. He

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[4] Edward H. Wagner, "Chronic Disease Management: What Will It Take To Improve Care for Chronic Illness?" *Effective Clinical Practice* 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action." *Health Affairs (Millwood)* 20, no. 6 (2001): 64-78.

[5] Sara Rubinelli, Peter J. Schulz, and Kent Nakamoto, "Health Literacy Beyond Knowledge and Behaviour: Letting the Patient Be a Patient," *International Journal of Public Health* 54 (2009): 308.

[6] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 308.

[7] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309-310.

writes, “Patients have practical judgment. We often can tell when something’s amiss with our own body. Things feel different or look different. Taking action on these observations is how we exercise judgment as patients.”[8] Thus, he views patient *phronesis* as the method patients utilize to read the signs and symptoms in their own bodies. Both of these viewpoints, that *phronesis* involves “self-examination” and that it is also related to the patient’s capacity to think critically about what their body is telling them, are part of the story I plan to tell about the application of *phronesis* to the patient experience of illness. However, they leave parts of the story of *phronesis* untold, in particular, its application as a method for experiential learning and cultivation.[9]

Furthermore, while Rubinelli, Schulz, and Nakamoto as well as Vartabedian move in the direction of widening the application of *phronesis* by suggesting its connection to patient experience and critical thinking, my approach in this chapter is to interrogate how the concept has worked in the medical literature, where its drawbacks have emerged, and the extent to which medical activity of any sort can rightfully be understood through the lens of *phronesis*. In other words, there are rich debates regarding both the meaning of *phronesis* as well as whether Aristotle ever imagined it as covering the sorts of activities involved in achieving health, that previous scholarship in this area has failed to adequately address. In addition, many accounts of *phronesis* in medicine rely on the Aristotelian tradition, in particular, his conception of *phronesis* as a mode of “deliberative excellence,” leaving another key inflection of the concept in Greek sources largely untouched: its rootedness in the developmental process of experience. Aristotle argues throughout the *Nicomachean Ethics* that *phronesis* is rooted in experience. In addition,

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[8] Bryan Vartabedian, “Do Patients Have Clinical Judgment?” *33 Charts: medicine. Health. (social) media*, posted January 11, 2011, http://33charts.com/2011/01/patients-clinical-judgment.html [accessed August 22, 2012].

[9] An argument I have made elsewhere. John J. Rief, Gordon R. Mitchell, Susan L. Zickmund, Tina D. Bhargava, Cindy L. Bryce, Gary S. Fischer, Rachel Hess, N. Randall Kolb, Laurey R. Simin-Silverman, and Kathleen M. McTigue, “Promoting Patient *Phronesis*: Communication Patterns in an Online Lifestyle Program Coordinated with Primary Care,” *Health Education & Behavior*, forthcoming.

Isocrates provides a richly developed account of *phronesis* as a mode of experiential learning and performance that, when fully realized, provides a wider picture of the role of *phronesis* in medical practice, one that finds expression in contemporary accounts of professional formation.[10]

In developing these arguments, I engage in two broad movements in this chapter. First, I use a narrative exemplar to launch a discussion regarding the epistemic and practical gaps between physicians and their patients and between knowledge and action. This sets the context for a description of the importance of the concept of *phronesis* as a means to address gaps in current medical education and patient-provider interactions. I then argue that Aristotle and Isocrates, when viewed together, provide a wider conception of the term *phronesis* than has gained uptake in much of the medical literature. To prove this claim and defend the concept of *phronesis* against detractors, I then engage in a critical narrative review of the medical scholarship relating to this term. By the end of this chapter, the stage is set for the further development of *phronesis*, both in terms of practice (through the analysis of interviews with practitioners and patients in chapters 4 and 5) and theory (when I more fully develop a conception of patient *phronesis* in chapter 5).[11]

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[10] An argument developed most notably by Steven Schwarze in his "Performing *Phronesis*: The Case of Isocrates' *Helen*." *Philosophy and Rhetoric* 32, no. 1 (1999): 78-95.

[11] There are, of course, other ways in which the term *phronesis* has been developed. For example, Susan Zickmund's work investigates the use of the term in Martin Heidegger's philosophy. Susan Zickmund, "Deliberation, Phronesis, and Authenticity: Heidegger's Early Conception of Rhetoric," *Philosophy and Rhetoric* 40, no. 4 (2007): 406-415.

3.2 THE PATIENT-PROVIDER RELATIONSHIP

3.2.1 Mary's Story

Mary, an overweight and diabetic patient suffering from hypertension, enters her primary care physician's (PCP) office. She has spent the last six months trying to deal with her newly initiated diet and exercise plan, working to make sure that she takes the right medications at the right times of day, and maintaining her contact with her PCP, Dr. Taylor.[12] Of course, these medical attributes of her life are not all that Mary has to contend with on a daily basis.[13] She is a 45-year-old mother of three children with a full time job as a special education instructor at the local high school.[14] She works 9-10 hour days, takes care of many of the household chores, and provides care and support for her 75-year-old mother with Alzheimer's. All of these details make her life busy, not unlike the lives of many middle-aged women.[15] While she has been relatively

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[12] Lifestyle management often involves both diet and exercise. See my description of the Online Lifestyle Support System's (OLSS) curriculum and regimen for more details on this (chapter 4).

[13] Many scholars have pointed to the fact that patients are not merely patients but also human beings living in a complex world in which a variety of factors interfere with health decision-making. Rubinelli, Schulz, and Nakamoto, "Health Literacy," 308.

[14] I have personal experience with such a way of life from my mother, Helen Rief. While these details are not identical to hers, I have drawn from her life experiences as a way to think about the problems that the fictional character, Mary, is experiencing here. She is one of the strongest people I know.

[15] Arthur Kleinman has done excellent work on the implications of lifestyle and context on appropriate care, especially for those facing chronic conditions. Many of the narratives he recounts throughout his work suggest a direct connection between the life experiences of patients and their ability to engage in healthy ways of life. He utilizes these experiential narratives to develop an overall orientation to the relationship between physicians and their patients. In this regard, he notes that a major problem for clinicians, one taken up in the following pages of this dissertation, is the lack of a "rhetoric" which might bind patients and physicians together in a real partnership. He opines, "No doctor is taught how to explain the biomedical account to patients. Yet this is an essential task in the work of doctoring, and one which patients, in the West at least, increasingly expect to be well handled. Presenting the biomedical model is an act of translation for the practitioner. When the presentation is well done, the physician has the great advantage of collaborating with accurately informed patients and families who can contribute to the therapeutic process. When it is poorly done, however, the stage is set for clinical communication to have serious problems, which can unsettle the therapeutic relationship and thereby undermine care. Skill in explaining correlates with the practitioner's sensitivity to the patient's level of understanding and desire to know, along with an aptitude for speaking, plain and simple, the patient's language. The masters of this tradecraft are talented in using the patient's metaphors and even his model to clarify biomedical information and render biomedical judgment

consistent with her medication, there are days when her diet and exercise regimen are just too overwhelming.[16] She is also unsure of how best to balance her work life with her personal and social obligations given the many demands on her time.[17] Eating the right food is time consuming, and she often forgets some of the elements of her overall plan. When Dr. Taylor set up this regular meeting for screening and counseling, Mary became nervous. She knew at the time that her glucose levels were higher than Dr. Taylor wanted and that she was not losing weight.[18] She was asked to stop by the clinic for some basic blood tests just a few days ago in order to prepare for this regular check-up. Now, sitting in the waiting room of the clinic, Mary is worried that she may have disappointed Dr. Taylor. What's more, she is increasingly disappointed with herself.[19]

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convincing. There is, then, a rhetoric of explaining to patients, and physicians differ greatly in their aptitude and skill in making clinical judgments convincing to patients and their intimate social circle." In other words, his work both confirms the studies of medical education and practice detailed in chapter 2 of this dissertation and also calls for a reinvigoration of the role of rhetoric in the patient/provider relationship. Importantly, Kleinman focuses here on the role of the physician in learning the "tradecraft" of rhetoric so as to "convince" patients to accept and work within the biomedical model. I shall have more to say on this issue later. Arthur Kleinman, *The Illness Narratives: Suffering, Healing & The Human Condition* (New York: Basic Books, 1988), 240.

[16] There is now growing evidence that patients face many barriers that could easily overwhelm their efforts to engage in and achieve effective lifestyle management, weight loss, and control of various co-morbidities. These barriers are often divided into several categories including "cognitive," "social," and "environmental." In other words, individuals face problems with their own thinking and acting, their social obligations, and other factors of their context that impede lifestyle change. See e.g., Robin Whittemore, Patricia S. Bak, Gail D'Eramo Melkus, and Margaret Grey, "Promoting Lifestyle Change in the Prevention and Management of Type 2 Diabetes," *Journal of the American Academy of Nurse Practitioners* 15, issue 8 (August, 2003): 343.

[17] Rubinelli, Schulz, and Nakamoto suggest that balancing such goals is an element of what they call *phronesis* as a form of "self-examination." They write, "self-examination is an essential component of health literacy as it is a process that helps the person whose goal is health to attain it." Rubinelli, Schulz, and Nakamoto, "Health Literacy," 310. That is, the individual interested in attaining better health must engage in a process of "self-examination" that involves balancing their life goals with their goal of health.

[18] For the important role of blood glucose levels in diagnosing and monitoring diabetes, see the National Institute of Diabetes and Digestive and Kidney Diseases, "Diabetes Overview," *National Diabetes Information Clearing House*, updated April 4, 2012, http://diabetes.niddk.nih.gov/dm/pubs/overview/#diagnosis [accessed August 21, 2012].

[19] Research on the efforts of patients to abide by complicated changes in lifestyle has indicated that there are major risks of disappozintment and therapeutic failure for both patients and physicians, especially when the expectations of either party (especially patients) are too high or unrealistic. See e.g., Fiona Jones, Peter Harris, Hilary Waller, and Adrian Coggins, "Adherence to an Exercise Prescription Scheme: The Role of Expectations, Self-Efficacy, Stage of Change and Psychosocial Well-Being," *British Journal of Health Psychology* 10, issue 3 (2005): 359-378. On the related problem of obese patients avoiding physicians and their physicians lacking essential

Dr. Taylor enters, smiles, and sits down at his workstation. He pulls up Mary's blood results and reviews her blood pressure reading taken just after her arrival at the clinic. Then the discussion begins[20]:

Dr. Taylor: "Mary, have you been eating right, walking every day, you know, and using the basic strategies from our diabetes manual?"[21]

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skills in dealing with conversations about their weight and related lifestyle issues, see e.g., Christina Zarcadoolas, Yvette Sealy, Joslyn Levy, Michelle Dresser, Diego Ponieman, Shiu May Young, Lisa Littman, Kelly Larson, and Lynn Silver, "Health Literacy at Work to Address Overweight and Obesity in Adults: The Development of the Obesity Action Kit," *Journal of Communication in Healthcare* 4, no. 2 (2011): 88-101. Self-blame (often an outcome of stigmatization and other negative social feedback) is a common feature of the experience of obesity and can negatively impact the ability of patients to lose weight and deal with other psychological repercussions of weight problems. On this, see e.g., Kelly D. Brownell, Rebecca M. Puhl, Marlene B. Schwartz, and Leslie Rudd, eds., *Weight Bias: Nature, Consequences, and Remedies* (New York: The Guilford Press, 2005).

[20] At the outset of this fictional narrative example, I should share my reasons for not bringing a "real" narrative into this discussion. As I note in the first chapter of this dissertation, I have spent over 100 hours in the clinical setting observing patient/provider interactions; however, I was not covered by an IRB protocol at the time and was merely observing. I imagine possible future trajectories of this work in which I utilize actual patient/provider interactions (observed within the clinical setting) but am not able to provide these in the current instantiation of this chapter. I beg the reader's confidence that the above example is drawn from insights gleaned through research and experience even if they are not drawn from any specific interaction I witnessed as a clinical observer or researcher. Furthermore, the interviews that I analyze in chapters 4-6 suggest many of these same themes and provide experiential evidence that the above narrative bears out themes that have been experienced by actual providers and patients. Moreover, the use of this narrative is in keeping with the casuistic tradition (described later in this chapter) and the effort to come up with cases (even fictionalized ones) that assist in clarifying ethical and practical problems in need of solutions. Finally, in utilizing this fictional narrative, I borrow a strategy from Martha Nussbaum who often uses fictional characters in her works to determine the value of the various philosophical traditions and schools under investigation. In her *Therapy of Desire*, Nussbaum utilizes "Nikidion" to test the educational platforms of Aristotle, Plato, the Skeptics, the Stoics, and the Epicureans. In another work, Nussbaum utilizes the characters of "Marcel" and "Albertine" to test various approaches to the erotic and love. See Martha Nussbaum, *Upheavals of Thought: The Intelligence of Emotions* (Cambridge: Cambridge University Press, 2008). Because I have found this to be a hugely beneficial narrative device in unfolding various philosophical approaches, I take it up here with Mary and utilize her experiences throughout this chapter to unveil my view of the patient as *phronimos*.

[21] Manuals are a common way for health professionals to disseminate weight loss and diabetes management materials. A great deal of research has been done on this topic. For example, one research cohort looks at the use of manuals in promoting self-monitoring: Elaine C. Moreland, Lisa K. Volkening, Margaret T. Lawlor, Karen A. Chalmers, Barbara J. Anderson, and Lori M. B. Laffel, "Use of a Blood Glucose Monitoring Manual to Enhance Monitoring Adherence in Adults with Diabetes," *Archives of Internal Medicine* 166 (2006): 689-695. This study found that manuals that prompt self-monitoring are effective at improving patient outcomes. Other research confirms one of my hypotheses, primarily that the use of manuals and education alone is insufficient and that additional modes of therapeutic intervention aimed at actual skills and attention to the specificity of the individual case may be important as well. See e.g., Rubinelli, Schulz, and Nakamoto, "Health Literacy"; Thomas Bodenheimer, Kate Lorig, Halsted Holman, and Kevin Grumbach, "Patient Self-management of Chronic Disease in Primary Care," *Journal of the American Medical Association* 288 (2002): 2474. Of course, the research on these issues is quite large so I will return to it in additional iterations of this argument. Interestingly, by using manuals, health care practitioners offer basic skills in the form of "how-to" guides much like the ancient rhetorical educators in Greece

Mary: [Sighs] "Well . . . yes, that is, as best I can . . ."

Dr. Taylor: "What about the meds? Have you been taking everything on time, based on the schedule we set up?"[22]

Mary: "Well, most days. You know, I sometimes have so little time. I'm so busy at school. We have one kid, Devon; he has so much trouble with writing I have to sit there with him for an hour to get a sentence out of him. And my youngest, Trevor, he has been in some trouble at school lately. I've been going up there, well, seems like almost every week to deal with some new issue . . ."

Dr. Taylor: [Interrupting] "Yes, I know you have a difficult job and the family, well, that can be another full time job; however, the meds will keep you healthy. So will eating right. Make sure you review the manual. I'll set up another consult with our dietician for you. How about walking to work?"

Mary: "Yes, I have thought about that . . . but it's just so hard. I have to get Katie and Eric out the door for school with lunches in hand and then I have to drive Trevor to school before I can even get to my office. Then I have to make sure I'm ready to go. I have a lot of early meetings. Walking to work might force me to get up by 4am and that doesn't even begin to

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did. I show in chapter 4 that this model may not be the best approach in the context of chronic disease by articulating debates about the content and form of rhetorical education.

[22] On the importance of appropriately timing medication and the need for medication adherence in appropriately managing chronic disease, see e.g., Rajesh Balkrishnan, "The Importance of Medication Adherence in Improving Chronic-Disease Related Outcomes: What We Know and What We Need to Further Know," *Medical Care* 43, no. 6 (2005): 517-520. Time, or *kairos* is also a critical element of rhetorical education, one noted by the sophists and commonly asserted in the Hippocratic corpus. In terms of the Hippocratic tradition and *kairos*, see Adam D. Roth, "Reciprocal Influences Between Rhetoric and Medicine in Ancient Greece" (PhD diss., University of Iowa, 2008), 87-92. On the role of *kairos* in rhetoric theory, see e.g., Phillip Sipiora and James S. Baumlin, eds., *Rhetoric and Kairos: Essays in History, Theory, and Praxis* (Albany: State University of New York Press, 2002).

manage the time crunch of getting all of the kids to school. Then, there's mom . . . she just isn't getting any better. I'm tired and stressed as it is."[23]

Dr. Taylor: "Yes, of course you are. But these numbers just aren't looking good. We really need to work on this together, Mary."[24]

Mary: "Oh, I know! You have been so helpful and I just feel horrible about my tests. What can I do?"

Dr. Taylor: "Well, you can meet with the dietician and really start using the manual we gave you. It contains almost everything you need to know. Do you have any questions about it?"

Mary: "No, not that I can think of . . . I mean, I read it a few months ago and did my best to follow through on everything but the diet was just so hard to handle and . . ."

Dr. Taylor: [Interrupting] "Yes, of course. I know you are trying. Please, I do not mean to judge. I'm just concerned about you. If we don't start seeing improvements, you may have complications."

Mary: "Oh yes, I'm concerned about that. I'll do whatever I can to turn things around."

Dr. Taylor: "Well, we could set up a meeting with a physical trainer, maybe at a local gym. Do you have a gym nearby, perhaps one you could get to on your lunch hour?"

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[23] Research suggests that stress may in fact be related to weight gain and other chronic ailments. In this sense, Mary is reporting not merely on an attribute of her life that effects her ability to engage in the regimen set up by Dr. Taylor but also on a potential causal pathway for at least some of her conditions and symptoms. On the relationship between stress and obesity, see Mary F. Dallman, Norman Pecoraro, Susan F. Akana, Susanne E. la Fleur, Francisca Gomez, Hani Houshyar, M. E. Bell, Seema Bhatnazar, Kevin D. Laugero, and Sotara Manalo, "Chronic Stress and Obesity: A New View of 'Comfort Food,'" *Proceedings of the National Academy of Sciences of the United States of America* 100, no. 20 (2003): 11696-11701.

[24] Such tests are an essential element of diagnosis; however, tests in themselves do not provide sufficient detail to determine the health and well being of patients. For example, Jerome Groopman argues that tests are important in that they "coalesce into a pattern that the physician identifies as a specific disease or condition"; however, he also notes that despite the important role of tests, "language is still the bedrock of clinical practice." In other words, throughout his work, Groopman argues that tests play a critical role, can be fallible, and are not the only crucial element of the patient/provider interaction. They are only one piece, of which language is the more important and central to the holistic enterprise of clinical care. Jerome Groopman, *How Doctors Think* (New York: Houghton-Mifflin Company, 2007), 34, 8. See also Atul Gawande, *Complications: A Surgeon's Notes on an Imperfect Science* (New York: Metropolitan Books, 2002).

Mary: “Hmm . . . I think so, although getting there during lunch might be difficult. I’m generally returning phone calls to parents during lunch, or grading.”

Dr. Taylor: “I understand. But you need to remember that work is only possible if you have your health. We need to start talking about priorities: how to set them and what to do to make sure you stick with them.”

Mary: “I know. I wish I could get around all of this. What do you recommend?”

Dr. Taylor: “Scale back your work as much as you can. Let them know that you need time to care for yourself. You can’t be everything to everyone.”

Mary: “Okay, I’ll do that. And I will start making more time for exercise.”

Dr. Taylor: “Good, so, when can you meet with the dietician? Oh, and let’s check to see what meds need refilling.”

Mary: “Thanks, Dr. Taylor.”

After this brief conversation, Mary is given a refill prescription for her blood pressure medication and then goes to the nurse at the front to set up a diet counseling session with Brad, the clinic’s dietician. Even as she sets up the meeting, Mary is unsure if it will help. Brad just does not seem to understand Mary’s situation or the severity of the diet she had been asked to undertake. She already knows what will happen at their meeting. He will give her recipes, calorie counts, and motivational texts, much like the last time. Would this help? Mary has never actually incorporated most of these things into her life despite her previous meetings with Brad.[25] Despite her ongoing efforts to pull the various strands of her life together (e.g., diet, exercise, family, job)

[25] Rubinelli, Schulz, and Nakamoto point out a fairly well-worn but useful axiom in this regard: “This critical reflection is an essential step for the application to concrete action of any health knowledge that would otherwise be ‘‘external’’ to the person and of any skill that would otherwise remain in its potentiality (e.g. I can be skilful in writing and never write).” Rubinelli, Schulz, and Nakamoto, “Health Literacy,” 309. I encapsulate the same insight, that individuals may have information and even skills but not act on these in their daily life, in Arendt’s language of thinking while doing. Arendt, *The Human Condition*, 5 (and throughout).

she has yet to develop the overall disposition that might allow her to adequately care for herself. Maybe this time would be better . . . [26]

3.2.2 Narrative, Rhetoric, and the Experiential Context of Care

Every narrative involves tendencies, biases, and strategies for crafting an interpretive lens through which to understand the rocky contours of experience.[27] As Kenneth Burke argues, narratives are a kind of "equipment for living" that reveal the underlying motivations of their authors as well as those they want their audience to incorporate into their own symbolic work to frame the world around them.[28] In addition, Burke argues that symbolic resources play a role in understanding the sociology of various phenomena, in unlocking the aspects of actual experience: "the kind of observation from this perspective should apply beyond literature to life in general (thus helping to take literature out of its separate bin and give it a place in a general 'sociological' picture)."[29] Burke goes on to point out that such a link between literature and life cannot fully embrace a relativistic viewpoint. That is, "one must also, to develop a full strategy, be *realistic*. One must *size things up* properly."[30] Narratives are also rhetorical, they engage in suasive appeals directed toward action that addresses shared problems.[31] Finally, narratives are

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[26] I should note at the end of this first account of Mary's situation that I do not mean it as a thoroughgoing assault on medical professionals and related health care practitioners. I recognize that most of these individuals work very hard to treat their patients well and provide them with the most up-to-date treatment modalities for their conditions. Instead, one possible lesson here could be that Dr. Taylor lacks the critical support mechanisms and the training (a topic of chapter 1) to adequately address Mary's situation. This is a topic to which I return later in this chapter and in chapter 4.

[27] Or what Joseph Dunne, following Wittgenstein, calls the "rough ground." See Joseph Dunne, *Back to the Rough Ground*; Ludwig Wittgenstein, *Philosophical Investigations*, rev. 4th ed., ed. P. M. S. Hacker and Joachim Schulte, trans. G. E. M. Anscombe and P. M. S. Hacker (Malden, MA, Wiley-Blackwell, 2009), S107.

[28] Kenneth Burke, "Literature as Equipment for Living," in his *The Philosophy of Literary Form: Studies in Symbolic Action*, 3rd ed. (Berkeley: University of California Press, 1973), 293-304.

[29] Burke, "Literature as Equipment for Living," 296.

[30] Burke, "Literature as Equipment for Living," 298.

[31] Wayne C. Booth ruminates on the rhetorical function of stories in his *The Rhetoric of Fiction*, 2nd ed. (Chicago: University of Chicago Press, 1983). Walter R. Fisher is well known for his view that narrative frames

therapeutic, providing instructions concerning how to live one's life, how to reconfigure the values and skills one utilizes to navigate worldly affairs.[32]

Mary's story is no different. I wrote it with a certain idea in mind, one based on research, experiential and observational learning, and some of the best evidence out there concerning the kinds of experiences people have when they enter their PCP's office for lifestyle counseling.[33] While it is not descriptive of every encounter between patients and their PCPs, it does indicate the basic contours of a set of problems noted by many of the most respected experts in medicine: the communicative and experiential gap between providers and patients in the clinical setting.[34]

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communication and rhetorical strategies, that it informs worldviews and functions persuasively in his "Narration as a Human Communication Paradigm: The Case of Public Moral Argument," *Communication Monographs* 51 (1984): 1-22. For a more robust account, see Walter R. Fisher, *Human Communication as Narration: Toward a Philosophy of Reason, Value, and Action* (Columbia: University of South Carolina Press, 1987). Finally, Kenneth Burke's work provides what may be the most direct link between the ancient arts of rhetoric or suasive discourse and narrative (or rhetoric and poetics). On this, see especially his *Counter-Statement* (Berkeley: University of California Press, 1931). In this text, Burke proffers one of his most famous definitions of symbolic form as a matter of both rhetorical action and poetic fulfillment: "*Form* in literature is an arousing and fulfillment of desires. A work has form in so far as one part of it lead the reader to anticipate another part, to be gratified by the sequence." Burke, *Counter-Statement*, 124. On this move in Burke's work, see especially Andrew C. Hansen, "The Stasis in *Counter-Statement*: 'Applications of the Terminology' as Attempted Reconciliation of the Formal and the Rhetorical, *Rhetoric Review* 20, nos. 3/4 (2001), 293-313.

[32] This is one point addressed in Nussbaum's discussion of the Greco-Roman philosophical schools and their pedagogical methods. She argues that for the Greeks, the therapeutic and educative power of language as well as the important role played not only be philosophical arguments but also poetic writing and dramatic performance, see Martha C. Nussbaum, *The Therapy of Desire: Theory and Practice in Hellenistic Ethics* (Princeton: Princeton University Press, 1994); Martha C. Nussbaum, *The Fragility of Goodness: Luck and Ethics in Greek Tragedy and Philosophy*, Up. ed. (Cambridge: Cambridge University Press, 2001).

[33] The important role of lifestyle management in contemporary chronic care is addressed in recent medical literature, e.g., James M. Rippe, Suellyn Crossley, and Rhona Ringer, "Obesity as a Chronic Disease: Modern Medical and Lifestyle Management," *Journal of the American Dietetic Association* 98, issue 10, supplement 2 (1998): S9-S15; Deborah J. Toobert, Russell E. Glasgow, Linda A Nettekoven, and Jane E. Brown, "Behavioral and Psychosocial Effects of Intensive Lifestyle Management for Women with Coronary Heart Disease," *Patient Education & Counseling* 35 (1998): 177-188; William C. Knowler, Elizabeth Barrett-Connor, Sarah E. Fowler, Richard F. Hamman, John M. Lachin, Elizabeth A. Walker, and David M. Nathan, "Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin," *New England Journal of Medicine* 346, no. 6 (2002): 393-403; Jaakko Tuomilehto, "Counterpoint: Evidence-Based Prevention of Type 2 Diabetes: The Power of Lifestyle Management," *Diabetes Care* 3, no. 2 (2007): 435-438. Also, recall my discussion from chapter 1 regarding my own personal experiences observing in clinical settings as part of my curriculum for a Masters degree in bioethics.

[34] Here, I have in mind a wide variety of works by medical doctors and others on the erosion of the provider/patient relationship, especially its communicative aspects. See e.g., Groopman, *How Doctors Think*; Gawanda, *Complications*; Kleinman, *The Illness Narratives*; and Bernard Lown, *The Lost Art of Healing* (Boston:

Mary's story also raises questions about the relationship between providers and patients as they negotiate major lifestyle changes in order to stave off the worst consequences of chronic disease: e.g., How does a patient enact lifestyle changes? By what process, using what art, through what kind(s) of praxis, is this made possible?[35] We will follow Mary's story throughout this chapter utilizing her experiences, her needs, and her potential responses to various theoretical and practical considerations in self-care in order to frame the larger question of how patients in general might approach these problems. Mary's story enters the conversation as a constant reminder that I am not speaking in the abstract here. I am speaking about the actual practices needed to cultivate self-care as well as why the practices of the modern clinical domain have lacked sufficiency in this regard.

Mary struggles with something that faces many diabetic patients in the "general 'sociological' picture": multiple co-morbidities.[36] Such patients are often asked to engage in multi-layered transitions in lifestyle including changes in diet, physical activity, and medication.[37] Even the simplest things like whether to take the stairs or the elevator, whether to eat this candy bar or walk to the supermarket for some fruit, and whether you took the right pill this morning become deeply important, at times, overwhelming for overweight and obese

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Houghton Mifflin Company, 1996). See also Molly Cooke, David M. Irby, and Bridget C. O'Brien, *Educating Physicians: A Call for Reform of Medical School and Residency* (San Francisco, CA: Jossey-Bass, 2010).

[35] We have seen these questions before, notably in Samr "Rocky" Tayeh's story recounted in chapter 1 of this dissertation.

[36] Burke, "Literature as Equipment for Living," 296. Patients with diabetes and other chronic conditions often suffer from additional co-morbidities that require complicated "priority setting" and integration of care. On this, see e.g., Jacqueline A. Pugh, "Priority Setting for Patients with Multiple Comorbidities: Diabetes May Not End Up Number One," *Journal of General Internal Medicine* 22, no. 12 (2007): 1783-1784.

[37] Multiple studies have indicated the importance of diet, physical activity, and other sustained lifestyle changes as critical elements in the management of obesity and its associated co-morbidities, e.g., Knowler, Barrett-Connor, Fowler, Hamman, Lachin, Walker, and Nathan, "Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin." Other researchers have suggested that such elements need more attention given a widespread lack of public uptake. See e.g., Ali H. Mokdad, Barbara A. Bowman, Earl S. Ford, Frank Vinicor, James S. Marks, and Jeffrey P. Koplan, "The Continuing Epidemics of Obesity and Diabetes in the United States," *The Journal of the American Medical Association* 286, no. 10 (2001): 1195-1200.

patients who have multiple, associated morbidities.[38] This process does not require the mere act of deciding but rather a whole set of thoughts and actions that must become habitual (even dispositional) if individuals are to succeed in ameliorating the health problems they are experiencing. Whether patients actually complete the lifestyle transformations recommended by their provider(s) is determined based on how well they perform the activities required by their regimen and by the unique circumstances that help to define their illness conditions and their roadblocks to success.[39]

Of course, it is not simply the plans of provider(s) that are engaged here. Patients have many reasons to engage in lifestyle change, including the desire for health and wellness.[40] In other words, many chronic patients are in search of the "fulfilling" and "good life," what many Greek philosophers, most especially Aristotle, call *eudaimonia*, but often face difficulties in translating their desire into a curative pathway in the ongoing effort to shape their lifestyles in healthier ways.[41] Moreover, because of the high likelihood of failure in achieving weight loss and related health goals, many individuals simply give up or begin to feel that they are incapable

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[38] Multiple factors impact the choice and capacity to effectively lose weight. Consider here the issue of the built environment (e.g. no sidewalks, no public transit) and its relationship to obesity. On this point, see Melissa C. Nelson, Penny Gordon-Larsen, Yan Song, and Barry M. Popkin, "Built and Social Environments: Associates with Adolescent Overweight and Activity," *American Journal of Preventive Medicine* 31, no. 2 (2006): 109-117. For a related discussion of environment in urban and minority communities, see Katherine N. Bent, "Culturally Interpreting Environment as Determinant and Experience of Health," *Journal of Transcultural Nursing* 14, no. 4 (2003): 305-312. For an extension of this discussion to rural health, see Janice C. Probst, Charity G. Moore, Saundra H. Glover, and Michael E. Samuels, "Person and Place: The Compounding Effects of Race/Ethnicity and Rurality on Health," *American Journal of Public Health* 94, no. 10 (2004): 1695-1703. Finally, for a related discussion of the built environment and geographic space in terms of dietary habits and food availability, see Kimberly Morland, Steve Wing, Ana Diez Roux, and Charles Poole, "Neighborhood Characteristics Associated with the Location of Food Stores and Food Service Places," in *Race, Ethnicity, and Health: A Public Health Reader*, ed. T.A. Laveist (San Francisco: Jossey-Bass, 2002): 448-462. Finally the economic conditions of specific neighborhoods (e.g. stores that do not stock healthy foods or charge too much for them) can create a context for increased rates of obesity. See Robert Albritton, *Let Them Eat Junk: How Capitalism Creates Hunger and Obesity* (London: Pluto Press, 2009).

[39] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 310.

[40] As pointed out repeatedly by Rubinelli, Schulz, and Nakamoto in their "Health Literacy."

[41] Nussbaum, *Upheavals of Thought*, 31-32; Nussbaum, *The Fragility of Goodness*, 6(fn). On the role of *eudaimonia* as synonymous with reaching health-related goals, see Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309.

of producing the changes they want to make.[42] In other words, the *eudaimonistic* wish that patients have regarding their health and weight loss goals requires some form of *paideia* or educational activity that might transform the diffuse and complex problems they face in achieving their desired weight loss and other health-related goals.[43] However, the content, context, and timing of such education are complicated matters. Additionally, the question of whether physicians are actually capable of delivering such education to patients is certainly an open one.

Recent research about physicians and their understanding of lifestyle change indicates the degree to which many of them do not understand the difficulties their patients face or the need for more than adequate information delivery in the maintenance of lifestyle change.[44] Research into the amount of time that PCPs actually spend with patients discussing lifestyle change indicates that many often say nothing or engage in brief interactions like the one Mary experienced.[45] Moreover, while patient-provider communication is now an important element in the health care practitioner's armamentarium, it is unclear whether communication skills are effectively taught (in medical schools or through clinical and experiential learning) and whether providers truly can communicate with patients when they cannot fully empathize with them.[46]

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[42] Kate Harding and Marianne Kirby, *Lessons from the Fat-o-sphere: Quit Dieting and Declare a Truce with Your Body* [New York: Penguin Group (USA), Inc., 2009].

[43] Rubinelli, Schulz, and Nakamoto, "Health Literacy."

[44] Recall from chapter 2 that this is a central concern of the "Chronic Care Model" (CCM). See Edward H. Wagner, "Chronic Disease Management: What Will It Take To Improve Care for Chronic Illness?" *Effective Clinical Practice* 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action," *Health Affairs* 20, no. 6 (2001): 64-78. Other scholars have noted the degree to which information-only approaches are lacking. See Rubinelli, Schulz, and Nakamoto, "Health Literacy"; Bodenheimer, Lorig, Holman, and Grumbach, "Patient Self-management of Chronic Disease in Primary Care," 2474.

[45] U.S. Preventive Services Task Force, "Screening for Obesity in Adults: Recommendations and Rationale," 2003, www.uspreventiveservicestaskforce.org/.../obesity/obesrr.pdf [accessed August 22, 2012].

[46] For an excellent survey of work concerning the problems with provider-patient communication, see Timothy Edgar, Seth M. Noar, and Vicki S. Freimuth, eds., *Communication Perspectives on HIV/AIDS for the 21st Century* (New York: Lawrence Erlbaum Associates, 2008); Stephen Rollnick, William R. Miller, and Christopher C.

Additionally, even if certain communication techniques are shown to be effective and in use, the issue of whether adequate communication between provider and patient actually produces improved chances of productive and effective lifestyle changes is in need of additional research.[47] Ultimately, the problem of providers failing to augment and reinforce the health activities of their chronic patients revolves around knowledge and communicative competence, both of which are meant to apply not only to providers but also their patients. Having the right sort of knowledge "ready to hand" is one aspect of clinical care for chronic diseases; however, the capacity to speak about this knowledge and share it with other practitioners and patients is also important, especially in the context of chronic disease.[48] In other words, only a knowledge of the terrain of chronic disease and a capacity to speak about it can promote a praxis capable of in some way handling it in the effort to discover a more fulfilling life.[49] As I suggest in chapter 2, such conditions have long timeframes, require long-term cooperation between patients and their providers, and are not healed so much as they are managed.[50] All of these elements provide

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Butler, *Motivational Interviewing in Health Care: Helping Patients Change Behavior* (New York: The Guilford Press, 2008); Debra L. Roter and Judith A. Hall, *Doctors Talking with Patients/Patients Talking with Doctors: Improving Communication in Medical Visits*, 2nd ed. (Westport, CT: Praeger, 2006); Stephen Rollnick, Pip Mason, and Chris Butler, *Health Behavior Change: A Guide for Practitioners* (New York: Churchill Livingstone, 1999); Thomas Gordon and W. Sterling Edwards, *Making the Patient Your Partner: Communication Skills for Doctors and Other Caregivers* (Westport, CT: Auburn House, 1995).

[47] For example, Robert Klitzman notes that the concept of "dignity" has not yet received enough attention. While this chapter does not focus on dignity, I believe that the overall argument will tend toward a more dignified role for patients in the clinical setting. See his *When Doctors Become Patients* (Oxford: Oxford University Press, 2008), 306-308. In addition, I view this chapter as adding to the call for more research noted above by developing the contributions of rhetorical theory to the issue of provider/patient interaction in the clinical setting and beyond.

[48] Michel Foucault makes much of this notion of having certain ideas or techniques of life "ready to hand," a translation of the Greek term *prokheiron ekhien.* See Michel Foucault, *The Hermeneutics of the Subject: Lectures at the Collège De France 1981-1982*, ed. Frédéric Gros, trans. Graham Burchell (New York: Picador, 2005), 499. I will have more to say about this when I discuss the Stoic approach to *phronesis* or practical wisdom later in this chapter and in chapter 6.

[49] I have made this claim elsewhere. See John J. Rief, Gordon R. Mitchell, Susan L. Zickmund, Tina D. Bhargava, Cindy L. Bryce, Gary S. Fischer, Rachel Hess, N. Randall Kolb, Laurey R. Simin-Silverman, and Kathleen M. McTigue, "Promoting Patient *Phronesis*: Communication Patterns in an Online Lifestyle Program Coordinated with Primary Care," *Health Education & Behavior*, forthcoming.

[50] On these various problems facing chronic illness care as well as the specific issue of "management," see Wagner, "Chronic disease management." For a historical perspective on the management of chronic disease, see

some insight into the complex nature of chronic disease but do not get us closer to an answer or a solution. What may be needed in the physician context is cultivation of the right kind of knowledge, the implementation of more effective training, and/or an enhanced facility with communication.[51] One way to unravel the complexity of the problems facing physicians is to discover how physicians themselves think about disease, how they experience it, and how they might think about managing their own lifestyles. After all, if physicians, for whom knowledge about the consequences of unhealthy activities has been ingrained through years of training and experience with ill patients, cannot effectively engage in healthy behaviors on their own, patients face an even more Sisyphean task. Additionally, if physicians must deal with the same sorts of problems facing their patients when making health-related decisions in daily life, then it becomes clear that knowledge on its own (even the knowledge doled out in the very best medical schools) does not count for much when it comes to the daily treatment of chronic disease.

In his extensive and groundbreaking study of physician experiences with illness, Robert Klitzman opines that in the effort to, "improv[e] doctor-patient relationships and communication, and the health care system as a whole, knowledge alone is not enough. Attitudes of physicians need to shift as well."[52] As he worked through the many narratives about illness shared with him by physicians, Klitzman began to realize that this insight eluded individual physicians until they actually experienced disease, in many cases terminal.[53] Addressing this problem, Klitzman suggests that "*Physicians should at least be made more aware of the limitations they confront – from patients' perspectives*. Healers need to realize the impact of their constrained time and

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Chris Feudtner, *Bittersweet: Diabetes, Insulin, and the Transformation of Illness* (Chapel Hill: The University of North Carolina Press, 2003).

[51] On these elements of physician pedagogy, especially in terms of contemporary medical education, see Cooke, Irby, and O'Brien, *Educating Physicians.* I discuss many of these issues in more detail in chapter 1.

[52] Klitzman, *When Doctors Become Patients*, 307-308.

[53] Klitzman, *When Doctors Become Patients*, 294-296.

resources – how patients at the other end of the stethoscope see their treatments and providers."[54] That is, physicians are often not provided with the tools needed to understand how their diagnoses, prognostications, and treatments actually impact their patients' lives. Such perceptions, Klitzman seems to suggest, play an important role in the overall context of care and the extent to which patients feel their needs are being met and that they can in fact deal with their disease conditions.

In a more specific way, Klitzman's study suggests that healthcare providers are not always thinking about how they deploy their medical knowledge (or fail to do so) in their everyday lives. He argues that "Many doctors did not practice what they preached, particularly regarding diet, treatment adherence, and preventive care. Changing unhealthy behavior proved hard. These physicians tended to feel invulnerable, and the demands of medical training facilitated poor health behavior."[55] That is, much like Mary's life makes treatment adherence difficult, physicians and other healthcare providers face similar challenges and yet, often do not make this connection when dealing with their patients.[56] It was not until the physicians he interviewed experienced illness that they began to understand these issues. For instance, Klitzman recounts the story told by one physician he interviewed who transformed his approach to patient adherence by acknowledging every good action that his patients took, instead of seeking "100%" success.[57] This realization came from actually trying to change his own lifestyle, his own daily behaviors. He realized just how hard this could be.[58]

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[54] Klitzman, *When Doctors Become Patients*, 296.
[55] Klitzman, *When Doctors Become Patients*, 82.
[56] For an excellent discussion of how the personal health behaviors of providers do not always match the advice and expectations they have for their own patients, see Rubinelli, Schulz, and Nakomoto, "Health Literacy," 308.
[57] Klitzman, *When Doctors Become Patients*, 285-286.
[58] Klitzman, *When Doctors Become Patients*, 285-286.

Klitzman is certainly not the first to note such a divide between patients and physicians.[59] However, he is one of the first to study this problem through direct interviews with sick physicians and with a pedagogical focus in hand. Additionally, Klitzman's work is important in the main because he turns to the perspective of the "wounded healer," one developed by Carl Jung to describe the ways in which healers draw on their own wounds, their own pain, and their own diseases in the construction of their healing practices.[60] His work to uncover the ways that "wounds" can improve the healer's perspective indicates the powerful role of *experience* in shaping understanding, even for physicians. Put simply, such changes are hard and require more than the adequate transfer of information from medical experts to non-expert patients.[61] This is true because information, even medical knowledge (*episteme*) and procedural skill (*techne*), do not guarantee success in every given situation.[62] For this reason, physicians may require a deeper sense of empathy with patients and a better understanding of what it is they go through. Such knowledge is not something easily distributed or learned; in the case of Klitzman's research participants, it took grave illness to initiate the learning process. As such, it is a major problem for medical education. Medical schools cannot provide illness experiences to trainees nor would anyone ever want this to be a condition of medical training.

Importantly, Klitzman's work provides a realistic appraisal of medical education and an alternative way of viewing the issue of adequate medical pedagogy, one that does not rely on

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[59] See e.g., Arthur W. Frank, *The Wounded Storyteller: Body, Illness, and Ethics* (Chicago: The University of Chicago Press, 1995); Kleinman, *The Illness Narratives.*

[60] Klitzman, *When Doctors Become Patients*, 4-5. Klitzman uses Jung to introduce the concept. For more on the "wounded healer," see Carl Jung, *The Practice of Psychotherapy: Essays on the Psychology of the Transference and Other Subjects*, 2nd ed., trans. Gerhard Adler and R. F. C. Hull (Princeton: Princeton University Press, 1985).

[61] Wagner, Austin, Davis, Hindmarsch, Shaefer, and Bonomi, "Improving Chronic Illness Care," 69-70. Bodenheimer, Lorig, Holman, and Grumbach, "Patient Self-management of Chronic Disease in Primary Care,"; Rubinelli, Schulz, and Nakamoto, "Health Literacy."

[62] F. Daniel Davis, "*Phronesis*, Clinical Reasoning, and Pellegrino's Philosophy of Medicine," *Theoretical Medicine and Bioethics* 18 (1997): 191. See also Rubinelli, Schulz, and Nakamoto, "Health Literacy," 310.

physicians or other practitioners actually becoming ill. At one point in his study, Klitzman suggests,

> These doctors [his interviewees] illuminate, too, how and why book and experiential learning differ. As patients, these doctors learned much that they had not fully realized before. Not until now did they truly see and learn what it was like to be in the opposite role. *Illness taught them what books failed to*. Thus, these doctors limned the divide between intellectual and experiential knowledge, and the extent to which experience involves emotions and deeper layers of self. The discrepancies can be vast. Yet awareness of this gap can help bridge it.[63]

Following Klitzman, I too believe that one of the primary elements of the divide between physicians and their patients has to do with the distinction between book learning and "experience" as ways of forming professional and patient roles. What many call the "partnership" between chronic patients and their providers cannot be produced through a more refined explanation of chronic care in a textbook or more time spent simply talking about these issues during rounds.[64] It is also not something that chronic patients can come to on their own through the use of manuals and paying close attention to the instructions of their many providers. Simply put, and as Socrates suggests in Plato's dialogue, the *Phaedrus*, we are not in a position to learn, especially about practical matters such as how to live one's life, from a text or from the dissemination of information as text. The most effective learning, Plato suggests, comes from the give and take experience of conversation, from the shared effort at coming to knowledge, from the dialectical exchange of teachers and students.[65] While Plato's corpus never defends

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[63] Klitzman, *When Doctors Become Patients*, 274.

[64] See e.g., Bodenheimer, Lorig, Holman, and Grumbach, "Patient Self-management of Chronic Disease in Primary Care," 2469.

[65] For an extensive defense of Socratic dialectic (the give and take method of face-to-face argumentation favored by Socrates throughout Plato's dialogues) and its relationship to rhetoric, see Plato's *Phaedrus* 271c-279c. I view dialectic as the interpersonal domain of rhetoric and, thus, the two overlap in my account throughout this dissertation. I base this in part on Aristotle's claim that "Rhetoric is a counterpart of Dialectic; for both have to do with matters that are in a manner within the cognizance of all men and not confined to any special science." Aristotle *Rhetoric* I.i.1. In other words, both are arts that involve communicative and reasoning skills. While Plato might suggest that dialectic is a philosophical art, one rooted in correct reasoning which occurs before persuasion, I

experience as the ultimate guide for learning and wisdom, the character Socrates places a high degree of value in an educational platform that valorizes the agonistic relationship between mutually engaged agents committed to their collective moral and intellectual development.[66] As such, Socrates provides part of the argument that I wish to make in this chapter, that is, we may not learn as much from texts and from calcified principles as we do from people, from our shared worlds. In the *Phaedrus,* Socrates initiates his critique of "book-learning" early when he cajoles Phaedrus for enticing him away from the people and into the country, away from those with whom he might learn through conversation (dialectic):

> Forgive me, my good man. You see, I'm a lover of learning, and country places and trees won't teach me anything, which the good people of the city will. But you seem to have found the prescription to get me to go out. Just like people who lead hungry animals on by waving a branch or some kind of vegetable in front of them, so you seem to me to be going to lead me round all of Attica and wherever else you please by doing as you are now and proffering me speeches in books. In

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argue that persuasion is always already a part of the argumentative exchange and deliberation involved in apprehending reality and coming to decisions. Plato *Phaedrus*. Thus, I treat the arts of rhetoric and dialectic as direct and overlapping counterparts here and elsewhere. Moreover, Martha Nussbaum describes dialectic as a pedagogical paradigm, one central to the cultivation of students who can actively interrogate the words and actions of their teachers, other students, and individuals beyond the classroom. As she suggests, "Liberal education in our universities is, and should be, Socratic, committed to the activation of each student's independent mind and to the production of a community that can genuinely reason together about a problem, not simply trade claims and counterclaims." It is this kind of activated pedagogy that will play a key role in my understanding of the provider-patient relationship. Martha C. Nussbaum, *Cultivating Humanity: A Classical Defense of Reform in Liberal Education* (Cambridge: Harvard University Press, 1997), 19. Furthermore, Jacques Derrida discusses Plato's *Phaedrus* as a paradigm for the problematic relationship between the writer and the text, the speaker and the written word, and the ultimate problem of gaining knowledge from a dead text. While his argument is far more complicated than this, his deconstruction of the *Phaedrus* provides yet more evidence that the written word may not bring us any closer to knowledge, to the thing itself, to experience, and to experiential learning. He demonstrates this problem by unpacking the many meanings contained within the term *pharmakon* as used by Plato in the *Phaedrus*. Given the complexity of the term, one cannot fully grasp its meaning in its original context. In a similar way, I argue (following Klitzman's sociological evidence) that physicians cannot learn about chronicity (the experience of chronic illness or the ways in which this experience implicates treatment options) from written accounts. Of course, the performative contradiction inherent in Plato's critique of writing within a written text is not lost on any of the dialogue's commentators. See Jacques Derrida, "Plato's Pharmacy," in his *Dissemination*, trans. Barbara Johnson (Chicago: University of Chicago Press, 1983), 63-171. Finally, other healthcare researchers have linked the Socratic method to the clinical encounter in the context of lifestyle change, e.g., Stephen Rollnick, William R. Miller, and Christopher C. Butler, *Motivational Interviewing in Health Care: Helping Patients Change Behavior* (New York: The Guilford Press, 2008), 54.

[66] Rubinelli, Schulz, and Nakomoto mention the importance of seeking counsel from expert providers but not of the mutual negotiation of meaning and collaborative learning that may accrue from the provider – patient relationship. Rubinelli, Schulz, and Nakomoto, "Health Literacy," 310-311.

> any case, now that I've got here, I think I'm going to lie down for the present, and you chose whatever pose you think easiest for reading, and read.[67]

Of course, any reader of this dialogue knows that Socrates does not really want to listen to Phaedrus read from a book. He actually wants to engage him in conversation, in an experientially rich process of give-and-take argument. Self-care and the emotional and experiential elements that inform this care are a central but often elided element of training practitioners and, more importantly, patients and, furthermore, they cannot be contained in a single counseling session, a single manual, or on the page of any text or pamphlet.

Klitzman's ill physicians learned Socrates' lesson well.[68] Yet physicians need not experience illness in order to gain the kind of practical and grounded knowledge they need to assist with chronic patient care. What some physicians lack in terms of experience of illness, they may find in the experiences of their patients (in other words, it is literally the dialectical exchange between physicians and patients that makes possible the experiential learning needed for adequate chronic care). Revaluation of the kind of knowledge patients have of their own conditions should form the basis of any strategy to rework the roles, modes of learning, and overall orientation of efforts to achieve lifestyle change.[69] Physicians, especially the healthy ones, need something like Arthur Frank's vision of the patient as "wounded storyteller" who is capable of providing experiential wisdom about their disease and their life plan in the formation of adequate treatment.[70] In other words, patients should be given space to tell their stories and to have these stories impact both their own conception of their illness and the kinds of therapeutic interventions they and their physicians use throughout the course of an illness. As Frank

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[67] Plato *Phaedrus* 230d4-e4.
[68] Klitzman, *When Doctors Become Patients*, 294-296.
[69] A normative view that I share with Rubinelli, Schulz, and Nakomoto, "Health Literacy," 308.
[70] Frank, *The Wounded Storyteller*.

suggests, "Because stories can heal, the wounded healer and the wounded storyteller are not separate, but are different aspects of the same figure."[71]

However, something even more fundamental is at stake here. Patients certainly can provide critical health-related information and contextual details that may improve the diagnostic and prognostic activities of their physicians.[72] In this sense, they act as "data point[s]" in the construction of individualized care.[73] But, they can and should to do more. Telling stories is important but so is action. Patients may find themselves in the situation of not just providing narrative resources to physicians, but also becoming caregivers for and of themselves.[74] This realization takes us to the "realm of rhetoric," to the sites of human interactivity that call for more than narrative but the direct and urgent connection of narrative to action.[75] As Aristotle opines in his *Rhetoric*, a rhetor's goal is always to promote some form of action guided by practical reason and the good.[76] Such rhetorically inspired action, I shall argue, may be found, following Frank, in the fusion of the "wounded healer" and the "wounded storyteller" as well as in the fusion of narrative and action in the ancient art of rhetoric.[77]

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[71] Frank, *The Wounded Storyteller*, xii.

[72] On this point, see Jerome Groopman, *How Doctor's Think*. In particular, see the story of "Anne Dodge" that begins on the first page and continues throughout the book. Her experience confirms the need for extensive and accurate storytelling by patients and attention to these stories by physicians in order to produce workable diagnoses and treatment plans.

[73] Kathryn Montgomery uses this language to describe the role of patients in the cultivation of physician *phronesis*. Kathryn Montgomery, "Thinking about Thinking: Implications for Patient Safety," *Healthcare Quarterly* 12, special issue (2009): e194. She develops her argument regarding the importance of patient narratives in the construction of clinical knowledge and judgment in her *Doctor's Stories: The Narrative Structure of Medical Knowledge* (Princeton: Princeton University Press, 1991).

[74] Michel Foucault's work charts the broader issue of self-care under the rubric of "the care of the self" providing a critical and historical account of ancient Greek and Roman texts regarding human sexuality and philosophical education. On this, see especially, Foucault, *The Hermeneutics of the Subject*; Michel Foucault, *The Care of the Self*, vol. 3 of *The History of Sexuality*, trans. Robert Hurley (New York: Vintage Books, 1988).

[75] Here, I am borrowing Chaïm Perelman's phrase "the realm of rhetoric." See his *The Realm of Rhetoric*, trans. William Kluback (Notre Dame: University of Notre Dame Press, 1982).

[76] On this element of Aristotle's *Rhetoric*, see Lois Self, "Rhetoric and *Phronesis*: The Aristotelian Ideal," *Philosophy and Rhetoric* 12, no. 2 (1979): 130-145.

[77] Frank, *The Wounded Storyteller*, xii.

In developing this argument, I suggest, following the work of Bernt Gustavvson and F. Daniel Davis, that there are different forms of knowledge that might be applied to clinical education and praxis.[78] The first, *episteme*, has to do with the scientific knowledge of the provider. The second, *techne*, has to do with the technical skills of providers as they engage in various procedural interventions to improve patients' health. The third, and in my estimation most important, *phronesis*, has to do with the application of *episteme* and *techne* to the specific needs of an individual patient.[79] Now, I pick up this line of reasoning again to explore a revised conceptualization of health care practitioners as the primary knowledge producers and users in the clinical setting, one that adapts to the changes being wrought by chronic care on the boundaries of the clinic and the overlapping arenas of patienthood and physicianhood. Chronic care (following my arguments in chapter 2) requires a practical integration of the activities of providers and patients, each playing a substantial role in the process. The experiential and practical activities of patients can best be summed up by a reconceptualization of *phronesis* along the lines of a praxis-based, action-oriented account of human growth, development, and change. This, in turn, requires a rhetorically-inflected conception of *phronesis*, one that attaches symbolic recourses to the promotion and actualization of health-related activities.[80]

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[78] Bernt Gustavsson, "Three Forms of Knowledge," in *Challenges and Development: Adult Education Research in Nordic Countries*, ed. Sigvart Tøsse, Pia Falkencrone, Arja Puurula, and Bosse Bergstedt (Trondheim, Norway: Tapir Academic Press, 1999), 169-185; Davis, "*Phronesis*, Clinical Reasoning, and Pellegrino's Philosophy of Medicine."

[79] Please keep in mind that these definitions are fitted to contemporary medical practice and are not necessarily the same as the definitions proffered by the ancient Greeks. For my account of the translation from the Greek understanding of these terms into the modern clinical setting, see chapter 2. In addition, I share the view that the scientific and clinical know-how of physicians must be made relevant to particular individuals (an element associated with *phronesis* as a form of "self-examination") with Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309.

[80] This is where my approach differs from that proffered by Rubinelli, Schulz, and Nakamoto. Where they focus on *phronesis* as a sort of "self-examination" that patients undergo to actualize health-related decisions and practices, my view of *phronesis* engages the larger question of learning through experience, through the act of doing, and reflecting and deliberating on this process in consort with others. Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309. While there may be some overlap between these different notions of *phronesis*, I believe

Moreover, I use the narrative exemplar of Mary provided above as a launching point for several layers of analysis that will bring my synergistic conception of provider and patient *phronesis* to life. First, I account for the life of *phronesis* within medicine. Its life in this regard has largely revolved around the practical work of physicians summed up by casuistic forms of thinking that inform clinical judgments at the level of individual patients.[81] This view of *phronesis* has yielded major debates over its appropriate application to medicine, its role as a method for overcoming controversy, and its place in the development of critical thinking skills for physicians. Second, I recover of a more complicated and patient-oriented conception of *phronesis* drawn primarily from the works of Aristotle and Isocrates, who spent their careers wondering about the forms of knowledge most applicable to rhetorical activity and practical decision making.[82] In this regard, I augment the already healthy rapprochement of rhetoric and *phronesis* in communication studies by showing how it may also apply in the context of medicine. I also expand upon the work of Rubinelli, Schulz, and Nakamoto as well as Vartabedian as part of this recovery project.[83] Third, I draw out the implications of an Aristotelian/Isocratic merger on the question of *phronesis* and respond to several objections that might be raised against my account, and the general application of *phronesis* to the activities of

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that the experiential learning element is elided in their article and requires additional development. On the distinctions being drawn here, see Rief, Mitchell, Zickmund, Bhargava, Bryce, Fischer, Hess, Kolb, Simin-Silverman, McTigue, "Promoting Patient *Phronesis*: Communication Patterns in an Online Lifestyle Intervention Coordinate with Primary Care."

[81] Albert R. Jonsen and Stephen Toulmin discuss *phronesis* as a mode of casuistic thinking, linking it to the Jesuit tradition of moral philosophy. See Albert R. Jonsen and Stephen Toulmin, *The Abuse of Casuistry: A History of Moral Reasoning* (Berkeley: University of California Press, 1988).

[82] In later chapters, I add to this source material by seeking more elaboration of *phronesis* and Socratic dialectic in Stoic philosophy, primarily the works of Epictetus.

[83] Rubienlli, Schulz, and Nakamoto, "Health Literacy,"; Vartabedian, "Do Patients Have Clinical Judgment?"

medicine.[84] In the end, the reader should have a clear view of how *phronesis* might function as a model for the everyday activities of practitioners and for the development of patient self-care as well as how it informs a philosophy of *praxis* that is sorely needed in the ongoing development of chronic care.[85]

3.3 WIDENING *PHRONESIS*: MUTUALLY INFORMING THEORIES OF *PHRONESIS* IN ARISTOTLE AND ISOCRATES

The relationship between *phronesis* and medicine is an old and complicated one. In his *Nicomachean Ethics* Aristotle draws an analogy between the kind of reasoning involved in being healthy and the kind of practical activity involved in living a life well (i.e., ethically).[86] Of course, as many have pointed out, this analogical relationship in Aristotle's work does not mean that he considers medical practice to be a perfect exemplar of *phronesis*.[87] Instead, throughout most of his corpus, Aristotle argues that medicine is a kind of *techne* or a set of skills that compose an overall art rather than the practical activities that result from a virtuous disposition.[88]

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[84] In this chapter, I seek to respond to the primary criticisms that might be raised from within the tradition of scholarship seeking to understand and utilize *phronesis* as it emerges from the Greco-Roman period. This is another innovation of my approach as compared to those mentioned elsewhere.

[85] The rest of my arguments in this chapter should be read as fulfilling the call made in chapter 2 to better understand the patient role in the context of chronic care, to fill in the Latourian "black box" between the education of patients and their actual engagement in self-care activities. Bruno Latour, *Science in Action: How to Follow Scientists and Engineers Through Society* (Cambridge: Harvard University Press, 1987), 2.

[86] In fact, the "medical analogy" is a central element of what Martha Nussbaum has called a "therapy of desire" which she convincingly argues is central to Greco-Roman philosophy. She writes that "the medical analogy is not simply a decorative metaphor; it is an important tool both of discovery and justification . . . The rival schools debate with one another in terms organized by the analogy, commending themselves to prospective pupils as doctors belonging to rival schools of medicine would debate, proclaiming the merits of their differing conceptions of the art." In addition, she notes that "They [the Greco-Roman schools] saw the philosopher as a compassionate physician whose arts could heal many pervasive types of human suffering." Nussbaum, *The Therapy of Desire*, 14, 3.

[87] See, e.g., Duff Waring, "Why the Practice of Medicine Is Not a Phronetic Activity," *Theoretical Medicine and Bioethics* 21 (2000): 139-151.

[88] On the medical analogy and medicine as a *techne*, see Aristotle *The Nicomachean Ethics* V.ix.15-16; Joseph Dunne, "Aristotle after Gadamer: An Analysis of the Distinction between the Concepts of Phronesis and Techne," *Irish Philosophical Journal* 2, issue 2 (1985): 105-123; Werner Jaeger, "Aristotle's Use of Medicine as a

On this view, medicine is a mode of study and a kind of practice that aims at improving health but does not by its very practice create health (in the way that having *phronesis* actually brings about virtuous action). As Aristotle remarks in chapter VI of the *Nicomachean Ethics*:

> We have now discussed the nature and respective spheres of Prudence [*phronesis*] and Wisdom, and have shown that each is the virtue of a different part of the soul.
>
> But the further question may be raised, What is the use of these intellectual virtues? Wisdom does not consider the means to human happiness at all, for it does not ask how anything comes into existence. Prudence [*phronesis*], it must be granted, does do this; but what do we need it for? seeing that it studies that which is just and noble and good for man, but these are the things that a good man does by nature. Knowing about them does not make us any more capable of doing them, since the virtues are qualities of character; just as is the case with the knowledge of what is healthy and vigorous – using these words to mean not productive of health and vigour but resulting from them: we are not rendered any more capable of healthy and vigorous action by knowing the science of medicine or of physical training.
>
> If on the other hand we are to say that Prudence [*phronesis*] is useful not in helping us to act virtuously but in helping us to become virtuous, then it is of no use to those who are virtuous already. Nor is it of any use either to those who are not, since we may just as well take the advice of others who possess Prudence [*phronesis*] as possess Prudence [*phronesis*] ourselves. We may be content to do as we do in regard to our health; we want to be healthy, yet we do not learn medicine. Moreover it would seem strange if Prudence [*phronesis*], which is inferior to Wisdom, is nevertheless to have greater authority than Wisdom: yet the faculty that creates a thing governs and gives orders to it.
>
> Let us now therefore discuss these difficulties which so far have only been stated. First then let us assert that Wisdom and Prudence [*phronesis*], being as they are the virtues of the two parts of the intellect respectively, are necessarily desirable in themselves, even if neither produces any effect.
>
> Secondly, they do in fact produce an effect: Wisdom produces happiness, not in the sense in which medicine produces health, but in the sense in which healthiness is the cause of health. For Wisdom is part of Virtue as a whole, and therefore by its possession, or rather by its exercise, renders a man happy.
>
> Also Prudence [*phronesis*] as well as Moral Virtue determines the complete performance of man's proper function. Virtue ensures the rightness of the end we aim at, Prudence [*phronesis*] ensures the rightness of the means we adopt to gain that end.[89]

Model of Method in His Ethics," *The Journal of Hellenic Studies* LXXVII (1957) 54-61; Michael J. Seidler, "The Medical Paradigm in Aristotelian Ethics," *The Thomist* 42 (1978): 401-433; Waring, "Why the Practice of Medicine Is Not a Phronetic Activity."

[89] Aristotle *Nicomachean Ethics* VI.xii.1-6.

Phronesis is, for Aristotle, a central element of ethics, a way of engaging in the fulfilling life energized by the desire to be good or for the highest good. We cannot say, following Aristotle's definitional work in this segment of the *Nicomachean Ethics*, that medicine is grounded in *phronesis*. In fact, medicine, as understood by Aristotle, is merely knowledge concerning how to promote health in others.[90] Simply having this knowledge does not grant one health. However, and this strikes many modern readers as a sort of tautology, having *phronesis* (or, having ethical knowledge) is the same as being ethical. One cannot be a *phronimos* (or person of practical wisdom) and fail to act in accordance with virtue and the good.

Most of the scholars who question the relationship between medicine and *phronesis* stake their position on two claims that emerge from the long passage drawn from the *Nicomachean Ethics* quoted above. The first is that medicine aims at an external good, that being the promotion of health, while *phronesis* is aimed at the internal good, the good of the individual expressed or embodied as the ethical and virtuous life.[91] Aristotle's definition of *phronesis* implies that it promotes the internal good of virtue while his notion of *techne* highlights the production of external things such as health, ships, and buildings.[92] Second, the connection between *phronesis*

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[90] In fact, even if the physician were to produce her own health, this might not count as *phronesis* in this passage of the *Nicomachean Ethics* as health is still external to character. The reason for this is the non-instrumental character of *phronesis* (i.e., its inability, according to some accounts, to make sense of behaviors that are aimed at the production of some thing or some state of affairs). Joseph Dunne opines that "The point I am making about phronesis is that it does not stand outside or above this temporal dispersion of our lives. And this is an important part of the reason why it cannot be instrumentalized . . . In what I have just been saying, phronesis has been bound up in the kind of person that one is." Dunne, "Aristotle After Gadamer," 111.

[91] This is the central argument made by Duff Waring in his polemical critique of the move to incorporate *phronesis* into medical theory and praxis. Waring, "Why the Practice of Medicine Is Not a Phronetic Activity."

[92] As Dunne argues, "phronesis is not a cognitive capacity that one has at one's disposal but is, rather, very closely bound up with the kind of person that one is." Dunne, *Back to the Rough Ground*, 273. In other words, having the capacity to build a building is a form of *techne*, a skill that one can utilize to achieve a certain external end such as the production of a house, and not *phronesis* which is a disposition or state of character. While this reading of *phronesis* presents problems for the demand-driven rhetorician of medicine and the search for rhetoric's role in improving health outcomes for chronic patients (as I describe below), it is one that I endorse. This view of *phronesis* also differentiates my approach to *phronesis* from that proffered by others, that is, as a particular skill or goal orientation, e.g., Rubinelli, Schulz, and Nakamoto, "Health Literacy."

and virtue, between practical wisdom and living the ethical life, is often used to disqualify medicine as a "phronetic activity."[93] In other words, *phronesis* is a concept that arises, at least for Aristotle, in the context of ethics and not the other arts such as rhetoric, medicine, the law, etc. For this reason, it is said, we do not have the license to extend *phronesis* into these domains.[94]

I believe that these arguments (whether they completely capture the thrust of Aristotle's philosophy or not) are unfortunate and misguided primarily because the term *phronesis* captures a practical and unsystematic view of ethics (one based on the broad issues of living life well generally as opposed to many contemporary conceptions of ethics that focus on specific kinds of obligations, principles, or weighing mechanisms for adequate decision making). In addition, *phronesis* captures something that cannot be explained or promoted from within the horizon of *episteme* or *techne*-based accounts of action, primarily, that action emerges not just from skills, training, and habituation, but also from individual, imperfect, constantly revisable, and always human experience.[95] This view might address many problems residing at the heart of contemporary ethical and medical theory and praxis, most notably, the deeply complex and individuated elements of living a healthy life (or, at least, healthier) with a chronic condition. As Martha Nussbaum points out regarding the ancient Greco-Roman schools of philosophy,

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[93] Waring, "What the Practice of Medicine Is Not a Phronetic Activity."

[94] As Waring suggests, "These differences are again the limits to the medical analogy which avoid the conflation of medical *technai* with *phronesis*. Aristotle does not include health in the virtues of character which permeate *phronesis* . . . A *phronimos* can be a physician, but a conscientious and effective physician is not, by any definition of Aristotle's, necessarily a *phronimos*." Waring, "Why the Practice of Medicine Is Not a Phronetic Activity," 147-148.

[95] Of course, this view of an imperfect, plural, and revisable version of *phronesis* is not one commonly associated with Aristotle. It emerges primarily in Martha Nussbaum's attempt to show that Aristotle is, in fact, an "anthropocentr[ic]" philosopher, a thinker animated by the complexities of human existence rather than their ultimate resolution. She argues, "Aristotle emphatically asserts that the goodness of *lives* is, and must be, a species-relative matter." She then goes on to discuss what this goodness means for humans: "values that are constitutive of a good human life are plural and incommensurable; and that a perception of particular cases takes precedence, in ethical judgment, over general rules and accounts." Nussbaum, *The Fragility of Goodness*, 238, 292, 294.

> First and centrally, one must, I think, point to the *new attention to questions of need and motivation* that we see in the schools' attempts to grapple medically with concrete human lives. Ancient Greek and Roman philosophy tends to be more sensitive to these questions than contemporary moral philosophy in any case; for asking how to live is never, in the Greek traditions, a merely academic exercise, nor philosophy a merely academic subject. It is prompted by real human perplexities and it must address these in the end. But the Hellenistic schools move well beyond Aristotle, and even beyond Socrates and Plato, in their fine-tuned attention to the interlocutor's concrete needs and motives for philosophizing. They design their procedures so as to engage those deepest motivations and speak to those needs. The different schools do this in different ways, with rather different conceptions of the diseases that lead the pupil to seek the philosophical doctor. Yet from all of these attempts contemporary moral philosophy has much to learn, if it wishes to move beyond the academy to take its place in the daily lives of human beings.[96]

I take Nussbaum's words as a call to engage the discrete and grounded activities of individuals who seek the assistance not only of philosophical doctors but also physicians, who are seeking a path to an ethical and healthy life, and who are engaged in the ongoing attempt to interpret their experiences and fold them into their practices. In addition, despite this distinction between the medical art and the art of living a virtuous in the *Nicomachean Ethics*, Aristotle does offer an insight very close to Klitzman's (Section 3.2.2). There is a gap between information and wisdom on the one hand and wisdom and right action on the other. The leap needed to transform knowledge into action can be found in Aristotle's conception of *phronesis* in which being, becoming, knowledge, and virtue are all realized simultaneously in the moment or event of a single act. Put another way, the ontological, epistemological, and performative elements of living a virtuous life are one in the same according to Aristotle's notion of *phronesis*. In a similar way, I shall argue, being healthy and engaging in the activities that lead to health are one in the same for patients and physicians. The fact that Aristotle does not view medicine as sharing in the grounded, practical, virtuous, and experiential elements of *phronesis* ultimately says more about

[96] Martha Nussbaum, *The Therapy of Desire*, 485-486.

his view of medicine than ours, more about the goals of his philosophical pursuits than the goals of contemporary medical practice, and more about his focus on those who fit his definition of the good and the virtuous than our understanding of these terms. All of this is not to say that Aristotle's view should be rejected. Instead, I believe it contains seeds that, when properly tended, may lead us down a productive path. Finally, while Aristotle does defend a conception of dialectical engagement with others (and with phenomena) much akin to Socrates view (Section 3.2.2), he is willing to take an additional step, one with which Plato would heartily disagree. Instead of vesting true ethical wisdom at the "rim of heaven," Aristotle offers ethics as something that emerges far below the clouds, on the ground, in the interactions between human beings and between human beings and their environment.[97]

Moreover, accounts of *phronesis* often ignore (or at least under-develop) the important and mutually constructive notion of the concept developed by one of Aristotle's contemporaries, Isocrates.[98] For Isocrates, *phronesis* emerges from attention to public affairs and the performance of civic duties. This point becomes clearest in his work when he openly criticizes other rhetoricians for their obsessive attention to mere verbal wordplay: "It is their 'philosophy' applied to eristic disputations that effectively produces this result; for these rhetoricians, who care nothing at all for either private or public affairs, take most pleasure in those discourses which are of no practical service in any particular."[99] Isocrates also suggests that practical

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[97] Regarding Plato's search for ethics and true knowledge at "the rim of heaven" see Nussbaum, *The Therapy of Desire*, 17. The notion that humans dialectically engage with the world and thereby learn about themselves is a central element of Aristotelian philosophy. For example, Jonathon Lear argues, following Aristotle, that "the world presents itself as puzzling to beings like us. But as soon as we formulate questions about the world, philosophy (at least in embryonic form) is already under way. By posing and answering questions we do what we can to render the world intelligible to us: and rendering the world intelligible is what, for Aristotle, philosophical activity is." Jonathon Lear, *Aristotle: The Desire to Understand* (Cambridge: Cambridge University Press, 1988), 5.

[98] The great exception being the now expanding group of scholars attending to Isocrates' work in rhetorical studies.

[99] Isocrates *Helen* 5.

reasoning and good judgment are made manifest in good speech: "for the power to speak well is taken as the surest index of a sound understanding, and discourse which is true and lawful and just is the outward image of a good and faithful soul."[100] He adds to this an overall endorsement of the role of virtuous rhetoric by stating that we should "welcome all forms of discourse which are capable of benefitting us even in a small degree" and that those discourses "which give directions on good morals and good government" should be seen as the most critical to civic life.[101]

For Isocrates, good speech and good reasoning are bound to one another in the production of the good life. Thus, the Isocratean notion of *phronesis* is fundamentally rooted in right speech leading to the virtuous performance of life. This performance is aided by habits of mind that are learned though *mimesis* (i.e. imitation).[102] Drawing on Isocrates' work *Against the Sophists*, Robert Hariman contends that Isocrates "imitative method" (*mimesis*) is key to understanding the difference between those who merely engage in repetitive processes and those that can learn through imitation to take on the gritty and complex problems that require the translation of skills into new contexts:

> Low-level professionals (like Sophists or hairdressers) are provided models for imitation [e.g., speeches given by others] which they reproduce exactly. High-level professionals (like Isocrates and his students) also work with exact instruction and the imitation . . . of patterns . . . but they become proficient in a number of discourses and are judged successful when they excel in performative virtues . . . in other words, in civic education the successful reproduction of the teacher's instruction cannot occur without being somewhat different from the teacher's own example. Successful imitation includes judgments of which verbal

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[100] Isocrates *Nicocles* 7.
[101] Isocrates *Nicocles* 10.
[102] For an analysis of this view of *mimesis* in Isocrates, see Robert Hariman, "Civic Education, Classic Imitation, and Democratic Polity," in *Isocrates and Civic Education*, ed. Takis Poulakos and David Depew (Austin: University of Texas Press, 2004), 217-234. Also, see Schwarze, "Performing *Phronesis*," 78-95. Schwarze offers a dual reading of Aristotle and Isocrates that sees them as developing relatively compatible notions of *phronesis.* He adds the notion that Isocrates performative understanding of the term is what is needed to appropriately enact *phronesis* in day-to-day life.

> means to use in previously unspecified situations, as well as qualities of usage that can succeed only if fitted to the distinctive features of the speaker in the specific situation. Because a process of literal imitation is not useful, students have to not only acquire expertise but also learn to use it according to standards of opportunity, propriety, and originality . . . which in turn are resources for civic leadership.[103]

In other words, according to Isocrates' pedagogical approach, the imitation of good practices (experiential learning) and their fitting to new situations and circumstances (thus changing them to deal with the contours of experience) allow for the cultivation of better civic practices and approaches to rhetorical production. Thus, Isocrates' pedagogical method implies that the individual, in order to adequately grasp the knowledge necessary for action in the world, must be persuaded that a certain viewpoint, concept, or practice of everyday life will have the desired effect. This persuasion occurs through the active engagement in right habits and right speech, through the learning that can only come from experience. This view is certainly not at odds with Aristotle who suggests that "*phronesis* is derived from experience, which a young man does not posses; for experience is the fruit of years."[104] The passage shows the degree to which Aristotle views *phronesis* as something "derived from experience" rather than a process of experiential learning. Thus, one can see that Aristotle seems to focus on "*phronesis* as an intrinsic good, an excellence for its own sake" rather than a larger experiential process of learning through performance.[105]

According to some scholars, Aristotle's view takes practical reasoning to be a cognitive faculty whereas Isocrates views it as a performative endeavor.[106] While this distinction may be analytically useful, I see Aristotle and Isocrates as offering largely overlapping, or at least

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[103] Hariman, "Civic Education," 222-223.
[104] Aristotle *Nicomachean Ethics* VI.viii.5-6.
[105] Poulakos, "Isocrates' Civic Education and the Question of *Doxa*," 61.
[106] Schwarze, "Performing *Phronesis*"; Takis Poulakos, "Isocrates' Civic Education and the Question of *Doxa*," in *Isocrates and Civic Education*, 44-65.

mutually beneficial, conceptions of *phronesis*. That is, Aristotle argues for a kind of *phronesis* linked directly with good deliberation both in public and within one's own process of thinking through needed solutions to specific problems.[107] As Rubinelli, Schulz, and Nakamoto put it, the Aristotelian conception of *phronesis*, especially when applied to the context of healthcare, deals with the development of excellence in "self-examination."[108] This insight is not at odds with Isocrates' understanding of *phronesis*. Takis Poulakos argues that when developing his conception of *phronesis*, "Isocrates is . . . suggesting the kind of insight or judgment necessary for orators to deal with the uncertainties of the deliberating situation."[109] However, as Steve Schwarze suggests, Isocrates' rhetorical works, especially his *Helen* move away from this deliberative focus, instead, "enacting a performative, rather than strictly deliberative, version of *phronesis*."[110]

For these reasons, in this chapter and those that follow, I argue that the concept of *phronesis* may benefit from its expansion into the performative domain and into the domain of experiential learning. That is, while Aristotle gives us an excellent account of *phronesis* as a sort of deliberative skill (a view that has received substantial development in the medical literature), Isocrates clarifies how it is that *phronesis* acts as a form of *paideia*, as a mode of education, that is bound to experience and imitation. Thus, *phronesis* is not just a skill or set of skills, not just the ability to deliberate well, but also the process of making such skills part of the performance of life. Thus, the central nugget I draw from this nexus between Isocrates and Aristotle is that

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[107] In his *Nichomachean Ethics*, Aristotle argues that "the prudent [*phronematic*] man in general will be the man who is good at deliberating in general." Aristotle *Nicomachean Ethics* VI.iv.2.

[108] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309.

[109] Takis Poulakos, *Speaking for the Polis: Isocrates' Rhetorical Education* (Columbia: University of South Carolina Press, 1997), 79.

[110] Schwarze, "Performing *Phronesis*," 79.

phronesis can and should be understood as a process of learning by doing, one that allows other elements of *phronesis* described in the literature discussed throughout this dissertation to emerge.

3.4 THE LIFE OF *PHRONESIS* IN MEDICINE

This section unpacks the view of *phronesis* currently circulating in the medical literature (and in closely associated scholarly venues) by showing how the concept has been utilized to make sense of ethical controversies and to broaden our conception of medical education in the effort to improve "clinical judgment."[111] In both of these ways, *phronesis* has found a life in medicine that is rich and that has transformed the theory and praxis of the clinic. At the same time, we shall see that the current life of *phronesis* in medicine has largely ignored two critical points that require articulation and augmentation in this dissertation in order to reach the goal of promoting a *clinically relevant and demand-driven rhetoric of medicine* aimed at improving efforts to resolve the chronic disease crisis described in detail in chapter 2. These are (1) the role of patients in their own care (introduced by Rubinelli, Schulz, and Nakamoto as well as Vartabedian), and (2) the unsystematic and deeply complex relationship between knowledge, rhetoric, illness, and therapy.

Moreover, this section proceeds in a fashion designed to clear space for conceptual innovation, particularly in the context of patient knowledge and action. The aim of this "critical narrative review" is not only to illuminate the literature available in the medical use of the term *phronesis* but also to critically interrogate this work in order to point to my own theoretical inclinations. In order to accomplish this task, I utilize two foundational texts that provide a

[111] The term "clinical judgment" has been used since the mid-20th century to describe the mode of judgment utilized by physicians to diagnose and prognosticate in the clinical setting utilizing both their training and their accumulated experiences. For an early and excellent work on this topic, see Alvan R. Feinstein, *Clinical Judgment* (Baltimore: Williams and Wilkins, 1967).

context for understanding the emergence and continued relevance of *phronesis* in 20th and 21st century medicine. The first, Albert R. Jonsen and Stephen Toulmin's *The Abuse of Casuistry*, has to do with the resolution of ethical disputes. Importantly, their work on this issue originally emerged out of the medical domain at a time when the ethics of medical research and clinical care were objects of major public deliberations. The second, Kathryn Montgomery's *How Doctors Think: Clinical Judgment and the Practice of Medicine,* has to do with the development of a concept of the physician as a professional, engaging in the use of *phronesis* to determine the appropriate diagnosis and therapeutic interventions for *this* patient as opposed to patients in general.[112] These two texts inform the two primary trajectories of *phronesis* in the current medical literature and also bring into the foreground the need for more work on the role of patients in their own care.[113]

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[112] Kathryn Montgomery, *How Doctors Think: Clinical Judgment and the Practice of Medicine* (Oxford: Oxford University Press, 2006). While I have chosen to focus on Montgomery's work, other scholars, most notably Edmund Pellegrino, have worked on the concept of *phronesis* as a way to understand medical theory and praxis, especially in terms of the ethical obligations and activities of physicians in the clinical setting. Where his work differs from Montgomery's is in the direct focus on the ethical comportment and virtuous action of physicians as opposed to the broader experiential context of professional development in Montgomery's account, one with which I largely agree. As Edmund Pellegrino and his long-time collaborator, David Thomasma, suggest, *phronesis* is related to the "intimate dialogue between the clinical facts and the moral principles, values, or virtues" at play in any given case. Edmund D. Pellegrino and David C. Thomasma, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993), 90. I plan to delve into Pellegrino's work more fully in my MA thesis for the Center for Bioethics and Health Law. On Pellegrino's use of *phronesis* throughout his corpus, see Davis, "*Phronesis*, Clinical Reasoning, and Pellegrino's Philosophy of Medicine." Finally, one other contemporary intellectual and scholarly domain has developed a conception of practical reasoning and prioritizing individual cases as a means for professional formation. The education theorist, Donald A. Schön is perhaps the most famous expositor of this vein of scholarship in his *The Reflective Practitioner: How Professionals Think in Action* (Basic Books, 1983).

[113] See John Rief, "Widening Applications of *Phronesis* in the Clinic and Beyond," *Proceedings of the 7th Conference on Argumentation of the International Society for the Study of Argumentation* (The Netherlands: Sic Sat, 2011), CD-ROM. It has also been made in collaborative work on the development of *phronesis* in the clinical setting. Rief, Mitchell, Zickmund, Bhargava, Bryce, Fischer, Hess, Kolb, Simin-Silverman, and McTigue, "Promoting Patient *Phronesis*."

3.4.1 *Phronesis* and Casuistry: Resolving Ethical Disputes

Perhaps the best-known 20th century effort to rescue *phronesis* and place it in the service of medicine can be found in the works of Albert R. Jonsen and Stephen Toulmin. In fact, one can see throughout Toulmin's work in particular an ongoing desire for a return to the practical from the heights of analytical philosophy, a return to the grounded elements of human interaction from the overly philosophical terrain of logic (all elements of his understanding of *phronesis* as a form of practical wisdom). For example, in the new preface to his *The Place of Reason in Ethics* (the book published from his dissertation project), Toulmin opines, "my argument [in *Reason in Ethics*] had placed limits on the universalizability of moral concepts and arguments, and so opened up the possibility of reviving older traditions of practical moral reasoning; especially, the much despised tradition of 'casuistry,' or case morality."[114] These limits would find use not only in the domain of ethics but also in the broader domain of argumentation theory. At the end of his germinal work (at least for my colleagues in argumentation studies), *The Uses of Argument*, Toulmin poses an important question: "Having thrown out the old 'logic' and 'epistemology' sections from the catalogue of our intellectual library, how are we to set about replacing the scattered volumes in a new and more *practical* arrangement?"[115] Toulmin offers several suggestions in his answer to this question including the need to combine logical analysis with an epistemological perspective, the need for a "comparative method" that does not value "arguments in one field [as] superior to those in another," and the need to consider "historical," "empirical," and "anthropological" work in the construction and judgment of arguments.[116] All

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[114] Stephen Toulmin, *The Place of Reason in Ethics* (Chicago: The University of Chicago Press, 1986), xiv.

[115] Stephen Toulmin, *The Uses of Argument* (Cambridge: Cambridge University Press, 1964), 254. Italics are mine.

[116] Toulmin, *The Uses of Argument*, 254.

of these remarks suggest the need for a practical philosophy aimed at the contingent world of human affairs rather than the dusty shelves of analyticity. Finally, even in his critical-historical work, *Cosmopolis: The Hidden Agenda of Modernity*, Toulmin states that practical philosophy is his scholarly goal: "This revival of 'case ethics' is not the only sign of recognition by contemporary philosophers of the need to avoid concentrating exclusively on abstract and universal issues, and to reconsider particular concrete problems arising, not generally, but in specific types of situations."[117] A theme running throughout Toulmin's work, then, is the revival of "case ethics" or "casuistry" in response to the inadequate efforts of philosophy to capture the features of argument and decision making in contingent situations, at least as he experienced it during the 20th century.[118]

I have mentioned these works by Toulmin at the outset of this section primarily because his work has informed major transitions in my own disciplinary homes of rhetoric and argumentation studies.[119] However, Toulmin's embrace of practical ways of knowing, casuistry, and *phronesis* finds its strongest and most sustained defense in his collaborative work with Albert R. Jonsen in the broader domain of the history of philosophy and ethical theory. In their *The Abuse of Casuistry*, Jonsen and Toulmin argue that *phronesis* (or practical wisdom) and its closely associated method for resolving moral disputes, casuistry (or reasoning based on the specific parameters of the given case rather than from universal principles) developed out of an Aristotelian tradition that reached fruition in the work of Jesuit ethicists in the 16th century.[120]

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[117] Stephen Toulmin, *Cosmopolis: The Hidden Agenda of Modernity* (Chicago: The University of Chicago Press, 1990), 188.

[118] These terms run throughout the texts cited here from Toulmin. See above.

[119] On Toulmin's importance to argumentation theory in the United States, see e.g., Wayne Brockriede and Douglas Ehninger, "Toulmin on Argument: An Interpretation and Application," *Quarterly Journal of Speech* 46, no. 1 (1960): 44-53.

[120] Jonsen and Toulmin, *The Abuse of Casuistry*, 139-151. Many authors have developed contemporary approaches to casuistic ethics rooted, either directly or at least in spirit, in this intellectual tradition. See e.g., Carson

According to their historical work, major criticisms of this method of ethical analysis and dispute resolution, primarily voiced by Blaise Pascal in the 17th century, led to the eventual decline and disrepute of this approach to moral reasoning.[121] However, for both Jonsen and Toulmin, it is *phronesis* that can and should enliven and enrich the life of ethics and medicine and so, they undertake its defense through a sweeping historical and critical work that tours the ancient Greco-Roman period, the middle ages, the Enlightenment, and contemporary problems with moral deliberation.[122] Their work plays a primary role in this review primarily because their resuscitation of *phronesis* as a concept relevant to medical ethics framed much of the 20th century use of the term in the realm of medicine. It has also proved highly controversial, producing a debate over the application of *phronesis* to the resolution of moral disputes in medicine and bioethics.

Jonsen and Toulmin's work has been taken up in medicine and bioethics primarily due to their discussion in *The Abuse of Casuistry* of medical institutions as the main site at which case ethics and *phronesis* might be revived.[123] As they argue, "renewal [of casuistry] calls for more

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Strong, "Justification in Ethics," in *Moral Theory and Moral Judgments in Medical Ethics*, ed. Baruch A. Brody (Norwell, MA: Kluwer Academic Publishers, 1988), 193-211; Carson Strong, "Critiques of Casuistry and Why They Are Mistaken," *Theoretical Medicine and Bioethics* 20 (1999): 395-411; Baruch A. Brody, *Taking Issue: Pluralism and Casuistry in Bioethics* (Washington, D.C.: Georgetown University Press, 2003); Richard B. Miller, *Casuistry and Modern Ethics: A Poetics of Practical Reasoning* (Chicago: The University of Chicago Press, 1996); and, a text noted by Jonsen and Toulmin as displaying insights very close to their own, John Mahoney, *The Making of Moral Theology: A Study of the Roman Catholic Tradition* (Oxford: Clarendon Press, 1987).

[121] Jonsen and Toulmin, *The Abuse of Casuistry*, 231-249.

[122] Jonsen and Toulmin, *The Abuse of Casuistry*.

[123] Jonsen has also made direct contributions to bioethical theory in his defense of case ethics. See Albert R. Jonsen, "Casuistry and Clinical Ethics," *Theoretical Medicine and Bioethics* 7, no. 1 (1986): 65-74. Also, Toulmin has done exceptional work relating his theory of casuistry and his understanding of practical decision making to medicine. See, Stephen Toulmin, "How Medicine Saved the Life of Ethics," *Perspectives in Biology and Medicine* 25, no. 4 (1982): 736-750. Furthermore, in understanding the link between their work and medical ethics, it is useful to note that Jonsen and Toulmin's text begins with an moral controversy directly related to medicine: Geraldine Ferraro's support during her 1984 vice-presidential campaign for "the rights of women to make their own decisions" in terms of abortion. Jonsen and Toulmin, *The Abuse of Casuistry*, 1. Jonsen and Toulmin also point out that "The occasion that led to the writing of this book exemplifies its thesis. From 1975 to 1978 the authors collaborated in the work of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, which was set up by the United States Congress in 1974. One outcome of this work was a casuistry (or moral

than a grasp of the intellectual methods of casuistry; it requires institutions that provide the locus for and lend support to the uniquely casuistical way of approaching moral problems."[124] For Jonsen and Toulmin, such institutions have largely come into existence in the realm of "medicine and health care."[125] These arguments emerge from their own experiences working with the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. Regarding this experience and how it brought *phronesis* to the foreground of their thinking and inspired the writing of *The Abuse of Casuistry*, they write,

> In the opening pages of this book we described the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, and suggested that the methods of that Commission were, in fact and unknown to itself, a 'casuistry' of human experimentation. That Commission had a successor, the President's Commission for the Study of Ethical Problems in Medicine and in Biomedical and Behavioral Research, which has studied such problems as the definition of human death by brain criteria, the withholding or withdrawing of life supporting medical technology, and screening for genetic defects. Several other bodies have been established by various Federal agencies of the Untied States government to make recommendations about the ethical problems posed by modern medicine and health care.[126]

They go on to suggest that this model of casuistry is not simply a matter of deliberating about moral issues based on case analysis but is a fully realized acceptance of the tenets of Aristotle's notion of *phronesis*: "Practical reasoning in ethics is not a matter of drawing formal deductions from invariable axioms, but of exercising judgment – that is, weighing considerations against one another. It is a task not for clever arguers but for the *phronimos* (or 'sensible practical

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taxonomy) for distinguishing acceptable from unacceptable ways of involving humans as subjects in medical or behavioral research. As the commission's work approached its end we compared notes, and found that we were independently struck by aspects of its methods and results that were hard to account for in terms of current ethical theory. The time had come (it seemed to us) to reconsider the older 'case methods' of confessional and pastoral theology, which relied on Aristotle's analysis of moral practice in the *Nicomachean Ethics* and which have their parallels in the moral practice of Judaism and Islam." Jonsen and Toulmin, *The Abuse of Casuistry*, vii.

[124] Jonsen and Toulmin, *The Abuse of Casuistry*, 338.

[125] Jonsen and Toulmin, *The Abuse of Casuistry*, 338.

[126] Jonsen and Toulmin, *The Abuse of Casuistry*, 338.

person') and the *anthropos megalopsychos* (or 'large spirited human being')."[127] This understanding of casuistry, its relationship to *phronesis,* and its seemingly unacknowledged application in the deliberations of various bioethics commissions in the 20th century, informed the historical recovery project at the heart of Jonsen and Toulmin's work. It has also led to no small amount of controversy among bioethicists and medical practitioners.

This controversy circulates around two related sets of arguments, one normative and one descriptive, that challenge the perspective offered by Jonsen and Toulmin.[128] First, Eric B. Beresford's argument in opposition to Jonsen and Toulmin's revival of *phronesis* in the context of medicine and bioethics involves two normative arguments concerning the problems of expertise and consensus. He rightly points out that Jonsen and Toulmin participate in extending the paternalism of previous medical traditions by imbuing *only* medical and ethical experts with the power to make ethical and practical decisions in the medical domain.[129] In other words, in the account offered by Jonsen and Toulmin, the individuals utilizing *phronesis* and engaging in casuistic ethics are ethical and medical experts, not larger publics that would be impacted by their decisions. This, for Beresford, indicates a kind of paternalism at the heart of their project that needs to be interrogated and ultimately challenged. Another normative problem Beresford notes has to do with finding consensus in the context of deep and abiding moral controversy: "The task of ethics [according to Jonsen and Toulmin] was to be construed from now on as an attempt to generate the sort of taxonomy of cases that might facilitate the development of

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[127] Jonsen and Toulmin, *The Abuse of Casuistry*, 341.

[128] The next few paragraphs rehearse and argument that I have already made in previous instantiations of this text. See Rief, "Widening Applications of *Phronesis* in the Clinic and Beyond."

[129] See Jonsen and Toulmin, *The Abuse of Casuistry*, 313-314; Eric B. Beresford, "Can *Phronesis* Save the Life of Medical Ethics?" *Theoretical Medicine and Bioethics* 17 (1996): 222-223. I should note that in the earlier version of this argument, published in the ISSA proceedings, I attributed this argument to Duff Waring. While Waring mentions this argument, he faithfully cites Beresford as I now realize I should have.

consensus on new problems and new issues as they arose."[130] In other words, on Beresford's reading, Jonsen and Toulmin argue in favor of a casuistic account of ethics rooted in *phronesis* that is meant to: (1) resolve moral disputes and craft the "conditions of consensus in ethical policy formation," and (2) enlist the service of "*phronimoi*" (i.e., medical doctors and policy makers) in this process.[131] Beresford's point is not to fully reject the move to *phronesis* but rather to question the way in which Jonsen and Toulmin enlist their newly enlivened conception of *phronesis* in the context of medical controversies involving ethical dimensions. Accordingly, he agrees that *phronesis* should play a role in medical ethics, just not quite the role that Jonsen and Toulmin defend: "phronesis cannot provide us with the sort of consensus and moral certainty that governments and other agencies are seeking . . . But it may still help to save the life of medical ethics if it is able to deliver us from the tyranny of the quest to elide the ambiguity and uncertainty that must be part of all practical decision-making."[132] So, the normative arguments against the revival of *phronesis* in the context of casuistic ethics and at the service of medicine have to do with the power held by those defined as *phronimoi* (a point to which I shall return in my discussion of patient *phronesis*) and the goal of casuistry itself, at least from Jonsen and Toulmin's perspective (i.e., the resolution of moral disputes). As Beresford rightly points out, *phronesis* may not resolve large-scale disputes because it has to do with the contingency and individuality of human knowing and decision making. Utilizing *phronesis* to deliver moral consensus in this way disarticulates it from its original purpose in damaging ways.

These normative arguments against the use of *phronesis* in the context of medicine and medical ethics have been coupled with an equally powerful set of descriptive arguments focusing

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[130] Beresford, "Can *Phronesis* Save the Life of Medical Ethics," 210.
[131] Beresford "Can *Phronesis* Save the Life of Medical Ethics," 218, 222-223.
[132] Beresford, "Can *Phronesis* Save the Life of Medical Ethics," 211.

on Aristotle's intended meaning of the term *phronesis* and its misappropriation by Jonsen and Toulmin. Duff Waring, in his aptly titled essay "Why Medicine is Not a *Phronetic* Activity," relies on the claim that Aristotle's conception of *phronesis* describes the attributes of the good person (*phronimos*) as opposed to the good physician.[133] He is correct on this point. As I have already noted (Section 3.3). Even a basic reading of the *Nicomachean Ethics* reveals that, for Aristotle, medical practice and the physician may in some ways be analogous with ethics and the disposition and actions of the *phronimos*, but they are not isomorphic with them. However, in unraveling Waring's point, we would do well to remember that Aristotle is not directly concerned with medical ethics in his work. In fact, such a concept of profession-specific ethics is not at all mentioned in his *Nicomachean Ethics* and this should not surprise us. The notion that medicine might have a specific ethical content or set of ethical concerns and precepts is largely a 20th century construction.[134]

In addition, while Waring's arguments may be correct if our concern is primarily what Aristotle understood *phronesis* to be, an Aristotelian notion of *phronesis* fitted to the modern clinical setting might offer important insights that we should not expect Aristotle himself to provide. As F. Daniel Davis points out we may be able to understand, "*phronesis* [as] critical to the appropriate exercise of medicine's moral virtues in the concrete circumstances of the clinical encounter with a particular patient" in our current construction of the fiduciary relationship of the clinic.[135] In other words, the contemporary notion of medicine always already includes ethical

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[133] Waring, "Why the Practice of Medicine Is Not a Phronetic Activity," 142 (and throughout).

[134] However, it is important to note that the Hippocratic writer, especially in the *Oath* does initiate a conversation of about medical ethics that remains valuable to this day. On this point, see Steven H. Miles, *The Hippocratic Writer and the Ethics of Medicine* (Oxford: Oxford University Press, 2004). In addition, for a modern take on the foundations of ethics specific to medicine, see the special issue of *The Journal of Medicine & Philosophy* 26, issue 6 (2001): 555-662, on the internal morality of medicine edited and introduced by Robert M. Veatch and Franklin G. Miller.

[135] F. Daniel Davis, "*Phronesis*, Clinical Reasoning, and Pellegrino's Philosophy of Medicine," 187.

action within the choices made by particular physicians and for particular patients, something that Aristotle does not emphasize in his discussion of *phronesis* perhaps because the form of medicine with which he was familiar did not involve the major moral disputes and ethically principled forms of action that are now legally and morally required of medical practitioners.[136]

Following Davis, it seems that Waring might be caught in a kind of double anachronism. First, Waring seems to believe that the vision of *phronesis* developed by an ancient Greek mind for a specific cultural context should be understood and utilized by contemporary practitioners and philosophers without any translation. In other words, where Waring might claim that Davis' (and, by extension, my own) approach to *phronesis* is anachronistic because it takes a 5th/4th century Greek concept and applies it to medical ethics in the 20th century, I argue quite the opposite. Waring adopts Aristotle's language, definitions, and analysis as if they were appropriate to our own conceptions of ethics. He sees no room for a discussion of practical wisdom (of course inspired by the Aristotelian move in the *Nicomachean Ethics*) that might transform it into something useful in today's language. Second, and in a related way, Waring seems to acknowledge an analogy between medicine and ethics but then utilizes the version of medicine popular in Aristotle's time (or simply central to Aristotle's own thinking) in order to prove that contemporary medicine must also remain a merely paternalistic *techne*, one done by physicians and enacted through the appropriate knowledge of the craft without a concern for the larger good or the ethical formation of physicians. New trends in medicine indicate the extent to which we must have a wider conception of medicine that goes beyond "general biological

[136] On the current legal and moral consensus regarding informed consent, see e.g., Ruth R. Faden and Tom L. Beauchamp, *A History and Theory of Informed Consent* (New York: Oxford University Press, 1986). For a general take on contemporary medical ethics, see Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 6th ed. (New York: Oxford University Press, 2009).

theories" and deals with the ethics as well as the science of the clinical encounter.[137] Theoretical innovation in the biomedical age must, following Jonsen and Toulmin, move beyond narrow disciplinary divides. The translation of new concepts and approaches requires ongoing work to link various disciplinary tendencies and approaches rather than finding ways to erect barriers to their cooperation. This argument dovetails with the primary thrust of the "architectonic" view of the CCM and rhetoric in chapter 2.[138] That is, one way that rhetoric and larger models of chronic care address the problem of disciplinarity is through the translation of concepts (a rhetorical affair) from one domain into another. Therefore, Waring's arguments may have some purchase for ethical philosophers and those bound to narrowly interpreting the intended meaning of Aristotle's texts but not for 21st century medical practitioners for whom interdisciplinary concepts and dialogue may allow for otherwise impossible transformations in care delivery.

Furthermore, in staking out his claim, Waring relies on a definition of *techne* in terms of external goods (products) as opposed to character, disposition, and good living or the internal goods associated with *phronesis*.[139] However, reading Joseph Dunne's work on *phronesis* against Waring (and, ultimately, against himself as he disagrees with the view of *phronesis* articulated in this chapter), we might say that the medical agent (*phronimos*), "can never possess himself in the way that the craftsman possesses the form of his product; rather than his having any definite 'what' as blueprint for his actions or his life, he becomes and discovers 'who' he is through these actions."[140] Contemporary discussions of the "professional formation" of

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[137] Jonsen and Toulmin, *The Abuse of Casuistry*, 285.

[138] Richard McKeon, "The Uses of Rhetoric in a Technological Age: Architectonic Productive Arts," in *The Prospect of Rhetoric: Report of the National Developmental Project*, eds. Lloyd F. Bitzer and Edwin Black (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1971), 44-63.

[139] Waring, "Why Medicine is Not A Phronetic Activity," 140, 143. He quotes Beresford on this issue. See Beresford, "Can Phronesis Save the Life of Medical Ethics," 219-220. On this issue, see also, Dunne, "Aristotle after Gadamer," 107.

[140] Dunne, "Aristotle after Gadamer," 108.

physicians indicate that there is some irreducible element of physicianhood that is or should be incorporated into the trainee through which she becomes a physician. As Molly Cooke, David M. Irby, and Bridget C. O'Brien argue,

> Professional formation is a synthetic process that occurs along with learning and development in all other domains: conceptual understanding, practice and performance, and inquiry, innovation, and improvement. This is not to say, however, that specific pedagogies to support professional formation are unnecessary. Instead, it is important that they be understood in the broader context of students' learning and experience. Creating caring, compassionate, resilient, and altruistic physicians in training is part of the process of medical education.[141]

Following this line of reasoning, I argue, contra Waring and Dunne, that physicians do not "possess" their physicianhood but in an important sense become physicians, are transformed and enact their physicianhood, through scientific, technical, and ethical decision making, and most importantly, the Isocratean notion of learning by doing. It is in this way that physicians might be said to own or "possess" a character of physicianhood.[142]

In addition, as Jonsen and Toulmin point out, philosophical concepts arise out of the particular socio-cultural milieu and social scientific understandings of the era in question:

> If general, abstract theories in moral philosophy are read against their historical and social backgrounds, they will need to be understood not as making *comprehensive and mutually exclusive* claims but, rather, as offering us *limited and complementary* perspectives on the whole broad complex of human conduct and moral experience, personal relations, and ethical reflection. So interpreted, none of these theories tells us the whole truth (even the only fundamental truth) about ethical thought and moral conduct. Instead, each of them gives us part of the larger picture we require, if we are to recognize the proper place of moral reflection and discussion, ideas and rules, in the world of human interactions and in our relations to the larger scheme of things.[143]

Jonsen and Toulmin go on to suggest, in line with my rhetorical revival of *phronesis* in this dissertation, that "those who rake a *rhetorical view* of moral reasoning see general rules and

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[141] See Cooke, Irby, and O'Brien, *Educating Physicians*, 100.
[142] Dunne, "Aristotle after Gadamer," 108.
[143] Jonsen and Toulmin, *The Abuse of Casuistry*, 293.

principles as bearing on limited classes of problems and cases alone. They do not assume that moral reasoning relies for its force on single chains of unbreakable deductions which link present cases back to some common starting point."[144] It may be that the medicine of ancient Greece did not require or demand a conception of medical knowledge best summed up by the term *phronesis*; however, as I will continue to argue throughout this chapter our age is certainly in need of just such a concept. *Phronesis* involves, at least in part, making ethical, goal-oriented, and experience-based decisions in actualizing a healthy life.[145] Simply because Aristotle finds reason to differentiate between health as a product and the overall good life as constitutive of the agent does not mean that we must do the same. Instead, we might come to the understanding that health is at least one part of this constitutive drive for *a good life* (and perhaps one of the more important parts in our biotechnological age).[146]

My defense of Jonsen and Toulmin in this section should not be read as a wholesale acceptance of their point of view. I believe their detractors (especially Waring) are wrong to disqualify their arguments based on close readings of Aristotle when their point is not to get Aristotle right but to find a concept that might have some use in the formation of policy and consensus in deeply divided, pluralistic societies. *Phronesis* does have a role to play in this regard; however, the notion that *phronesis* may lead us to some kind of consensus-based casuistical model of moral deliberation strikes me as both utopian and misguided. If one thing is true of the concept of *phronesis*, it is unsystematic and incapable of delivering on such a promise

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[144] Jonsen and Toulmin, *The Abuse of Casuistry*, 293.
[145] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309-310.
[146] Or, as Rubinelli, Schulz, and Nakamoto argue regarding *eudaimonia* when translated into a medical domain, "the goal is health enhancement and the practical wisdom is the ability to identify the best possible route to this goal." Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309.

given its valuation of experience and contingency (something it shares in common with rhetoric, see section 3.3).[147]

Furthermore, we may ask whether the view championed by Jonsen and Toulmin is at all helpful for our fictional character, Mary (3.2.1). Of course, the need to resolve deep and abiding moral controversies will always be with us, especially as our technology continues to challenge who and what we are as human beings. But, if *phronesis* primarily points us to a form of more effective (or at least more honest) moral deliberation, what can it do for Mary. Mary is facing ethical, practical, medical, and social problems that are not so much part of large-scale moral disputes (at least from her perspective) but are rather tied to her inability to fully engage in her health regimen. If she were to seek guidance on how to deal with these problems by consulting the view of *phronesis* promulgated by Jonsen and Toulmin, she would find very little assistance. More to the point, she would find that Jonsen and Toulmin place far more emphasis on the needs of physicians and policy-makers to start getting deliberation right rather than assisting the diffuse publics impacted by their decisions to become experts in their own ethical care. In this sense, she would face a version of *phronesis* that is paternalistic in its orientation, one that focuses on practitioners, professionals, and policy-makers rather than the individuals who matter most in chronic care management, patients. Mary would find very little help from this application of *phronesis* in the medical literature. Finally, while I largely agree with the sentiments of Jonsen and Toulmin, particularly their rejection of analytical modes of philosophy that would reduce human moral controversies to bare deductions from principles, and with their embrace of

[147] Or, as Dunne points out, *phronesis* "is the notion through which he [Aristotle] allows into knowledge, as well as into the proper ordering of human affairs, the greatest degree of flexibility, openness, and improvisation." Thus, Dunne argues, *phronesis* "might almost be regarded as a 'deviant' concept," in the Aristotelian framework when considered against other more developed and comprehensive concepts. Dunne, *Back to the Rough Ground*, 245.

deliberation as a method for resolving disputes, the formulation of *phronesis* I defend throughout this dissertation diverges from their view by involving discrete decision making practices of agents in their everyday circumstances and the process of learning by doing involved in cultivating such decisions. As Aristotle opines in the *Nicomachean Ethics*, "Prudence [*phronesis*] also is commonly understood to mean especially that kind of wisdom which is with oneself, the individual."[148] I mention this not to dismiss Jonsen and Toulmin's account but to point to an alternative inflection of the concept that can be found in Aristotle's work, one that I believe has important implications on how medicine can and should incorporate the concept: the individual engaged in deliberation with herself (and her closely associated friends, family, and health providers) in the project of realizing self-care.[149] I now turn to a view of *phronesis* that features the cultivation of the individual (complementing the broader concern with public deliberation) within the medical literature, one that comes closer to the Isocratean concern with *mimesis* or learning by doing. Unfortunately, as I will point out, this view of *phronesis* also succumbs to the form of paternalism that I have criticized in this section, namely, a focus on health practitioners as opposed to patients.

3.4.2 *Phronesis* as a Model for Professional Formation

The second trajectory of *phronesis* in the medical literature, and the one that is perhaps most familiar to physicians, is its application to the hallowed conception of "clinical judgment."[150] Clinical judgment represents that form or mode of judgment utilized by physicians to treat a

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[148] Aristotle *Nicomachean Ethics* VI.viii.3.

[149] The view of *phronesis* espoused by Rubinelli, Schulz, and Nakamoto in "Health Literacy."

[150] Feinstein, *Clinical Judgment*; Montgomery, *How Doctors Think*; Montgomery, "Thinking about thinking"; Eric B. Beresford, "Uncertainty and the Shaping of Medical Decisions," *The Hastings Center Report* 21, no. 4 (1991): 6-11; R. Jane MacNaughton, "Evidence and Clinical Judgment," *Journal of Evaluation in Clinical Practice* 4, no. 2 (1998): 89-92.

particular patient. Many scholars argue that clinical judgment is developed not so much through learning the *episteme* or scientific concepts central to medicine in the classroom or even in the simulated environment used by many medical schools for training physicians in various *techne* or procedures used in patient care but rather through actual clinical experience.[151] In this sense, *phronesis* is taken to be that form of experiential learning and deliberative praxis deployed by physicians in specific circumstances, facing particular patients, and utilizing their experiences (in combination with their professional knowledge) to determine what is best at this time and in this place. It is, following this view, an expression of "professional formation."[152] This view links up directly with the Isocratic notion of *phronesis*, one that involves learning through engagement with experience and with the everyday practices that are bound up in the promotion and perfection of a truly civic life.

Kathryn Montgomery utilizes this understanding of *phronesis* in her groundbreaking work *How Doctors Think*.[153] Montgomery brings an interdisciplinary perspective to the study of

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[151] Cooke, Irby, and O'Brien, *Educating Physicians*; Montgomery, *How Doctors Think*.

[152] See e.g., Jeffrey P. Bishop and Charlotte E. Rees, "Hero or Has-been: Is There a Future for Altruism in Medical Education?" *Advances in Health Sciences Education: Theory and Practice* 12 (2007): 391-399; Al Dowie, "*Phronesis* or 'Practical Wisdom' in Medical Education," *Medical Teacher* 22, no. 3 (2000): 240-241; Sean R. Hilton and Henry B. Slotnick, "Proto-Professionalism: How Professionalization Occurs Across the Continuum of Medical Education," *Medical Education* 39 (2005): 58-65; Warren A. Kinghorn, "Medical Education as Moral Formation: An Aristotelian Account of Medical Professionalism," *Perspectives in Biology and Medicine* 53, no. 1 (2010): 87-105; Charlotte Rees, "Proto-professionalism and the Three Questions of Development," *Medical Education* 39 (2005): 7-11; Margaret J. Conner, "The Practical Discourse in Philosophy and Nursing: An Exploration of Linkages and Shifts in the Evolution of Praxis," *Nursing Philosophy* 5 (2004): 54-66; Inger James, Birgitta Andershed, Bernt Gustavsson, and Britt-Marie Ternestedt, "Knowledge Constructions in Nursing Practice: Understanding and Integrating Different Forms of Knowledge," *Qualitative Health Research* 20, no. 11 (2010): 1500-1518.

[153] I should also note here that many authors share the intuition in favor of experience and practical judgment found in Montgomery's work. Jerome Groopman and Atul Gawande in particular offer very similar conceptions of the role of the physician in making decisions about the diagnoses and therapeutic interventions needed in particular cases. Groopman uses the term "pattern recognition" and Gawande articulates these elements as part of his conception of "practical medicine." See Groopman, *How Doctors Think*; Gawande, *Complications*. Finally, cooperative work between an argumentation theorist and a physician has yielded interesting work on the issue of *phronesis* as well. Milos Jenicek and David L. Hitchcock define *phronesis* as, "A label given by some authors to the process of knowing and doing, experiencing and acting, undertaken by a physician on behalf of a particular patient in a specific clinical situation and setting." This definition comes very close to my own

medicine (much akin to my own) that is at once highly instructive for this study and also deeply critical of certain conceptions of medicine, particularly those that rely on a scientific explanation for the modes of thinking and praxis used by medical practitioners. In fact, she argues, focusing on the scientific attributes of medicine has caused many medical practitioners to misunderstand the nature of their *art* by overemphasizing research and denigrating the more human, contingent, and uncertain elements of clinical care:

> There is no question that medicine is scientific or that the benefits of biomedicine are enormous. Once doomed lives are now routinely saved, and the sense of human possibility has been profoundly altered. Yet medicine is not itself a science. Despite its reliance on a well-stocked fund of scientific knowledge and its use of technology, it is still a practice: the care of sick people and the prevention of disease. The recent emphasis on evidence-based medicine grounds that practice more firmly in clinical research and aims to refine and extend clinical judgment, but it will not alter the character of medicine or its rationality. Physicians draw on their diagnostic skills and clinical experience as well as scientific information and clinical research when they exercise clinical judgment. Bodies are regarded as rule-governed entities and diseases as invading forces or guerrillas biding their time. But neither is true. Patients with the same diagnosis can differ unpredictably, and maladies, even those firmly identified with bacteria or tumors or genetic mutations, are never quite *things*. Thus, although scientific and technological advances refine clinical problems and provide solutions, physicians still work in situations of inescapable uncertainty. New diseases like human immunodeficiency virus (HIV) or severe acute respiratory syndrome (SARS) are the extreme examples, but everyday cases are uncertain, too. Useful information is available in overwhelming quantities, and physicians have the daily task of sorting through it and deciding how some part applies to an individual patient in a given circumstance.[154]

In other words, Montgomery (and others who follow this line of reasoning including Jerome Groopman, Atul Gawande, Edmund Pellegrino, and David Thomasma) argues that medicine is best understood as an art or a practice that is governed not by the rules of science or even by the

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rhetorically-inflected conception of *phronesis* however it still roots it directly in the decision-making process as opposed to the formative processes under discussion in this section and elsewhere in this dissertation. However, they end up rejecting the term within their overall perspective given its rootedness in virtue-based ethics. Milos Jenicek and David L. Hitchcock, *Evidence-Based Practice: Logic and Critical Thinking in Medicine* (American Medical Association Press, 2005), 273, 203.

[154] Montgomery, *How Doctors Think*, 3.

evidence produced by science as much as the "inescapable uncertainty" of human life, illness, and death. It focuses on the "individual patient in a given circumstance" rather than the larger and more generalized findings of medical researchers. This is not to say, as Montgomery points out, that medicine does not rely on science. Medical practitioners must know the science in order to apply it to the specific cases they encounter in the clinical setting; however, they must also be able to avoid the error of allowing general rules to cloud out the specific attributes facing *this* patient at *this* moment in time with *these* symptoms.

In order to flesh out her conception of medicine as a "practice", Montgomery relies on Aristotle's conception of *phronesis* not so much as a method of resolving ethical disputes (as in the work of Jonsen and Toulmin) but rather as a method for understanding and unpacking the specific and situated experiences of individual patients.[155] In her rendering, *phronesis* becomes the mode of reasoning whereby physicians are able to understand the needs of their patients and engage in their care:

> What characterizes the care of patients, however, is contingency. It requires practical reasoning, or *phronesis*, which Aristotle described as the flexible, interpretive capacity that enables moral reasoners (and the physicians and navigators that he compares with them) to determine the best action to take when knowledge depends on circumstance. Today we might add engineers and meteorologists and even Xerox copier technicians to the list. In medicine that interpretive capacity is clinical judgment, and this book attempts to describe that intelligence: how it differs from the rationality of science that medicine idealizes, how it displaces or contravenes science in practice, how it is taught, and how recognizing its importance might reduce some of the adverse side effects of the belief that medicine is itself a science.[156]

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[155] This use of the term "practice" is one alternative way of referring to the development of situated skills much like those implied by *phronesis*. It is developed most fully in Alasdair MacIntyre's work. See Alasdair MacIntyre, *After Virtue: A Study in Moral Theory*, 2nd ed. (Notre Dame: University of Notre Dame Press, 1984). For a lucid application of MacIntyre's theory to the actions of patients engaged in self-care, see Andrew Edgar, "The Expert Patient: Illness as Practice," *Medicine, Health Care and Philosophy* 8 (2005): 165-171.

[156] Montgomery, *How Doctors Think*, 4-5.

For Montgomery, professional practices (including everything from medicine to engineering and even copy machine technicians) are themselves expressions of *phronesis*. In this sense, she refuses the arguments that might be raised regarding problems with the medical analogy described earlier in this chapter. Instead of relying on Aristotle's specific definition of *phronesis* that is related to but not precisely the same as medical practice (or any practice) because it is only truly applicable to ethical decision making, Montgomery offers a modern reading of *phronesis* that roots it in practices that have ethical and practical inflections well beyond those imagined by Aristotle. In other words, on this rendering, *phronesis* has a more general or generic scope. It involves the sort of knowledge that one deploys in the specific circumstances encountered when engaging in one's job. This is not to say that *techne* and *episteme* play no role at all in any number of professions. One must know how various tools and materials work synergistically in order to engineer a mechanism or build a functional structure (chapter 2). One must understand how a copier works before one can actually fix it. However, and this is the element of the above quotation that is most critical, this knowledge is not enough and the belief that scientific knowledge (or organized knowledge in a general sense) is enough to complete tasks in the everyday world of any number of professions is itself dangerous and may have "adverse side effects."[157] The rest of Montgomery's text highlights these adverse side effects in terms of medical practice including poor patient outcomes, bad diagnostics, and unethical practices that might be performed by physicians who believe that the core of their craft is merely the science (*episteme*) or just the various clinical procedures they have been trained to complete (*techne*).

[157] Montgomery, *How Doctors Think*, 4-5.

Of course, just as with Jonsen and Toulmin, Montgomery could potentially fall into the trap of the detractors, especially Waring and Dunne, who view *phronesis* as primarily attached to ethics and as dealing with the internal development of the individual rather than the external outcomes of their actions. I have already responded to these problems by noting that Aristotle's originary distinction between internal and external goods need not be viewed as absolute in the health care context. Certainly, the good of health for patients is in some sense external to the moral and practical development of the physician. The physician, in other words, is not made healthy by making others healthy; however, we might argue, contra Aristotle, that the very act of improving someone else's health is made possible only through the adequate formation of a professional disposition (following Isocrates) which can adequately bring such a state of affairs about. It is in this way that the larger debates about the true meaning of *phronesis* for Aristotle in his particular moment and for his purposes seem less critical when we are considering the application of the term to medical practice in the 21st century. Montgomery's work convincingly argues that medical practice cannot and should not be seen as primarily scientific, that it cannot and should not be seen as somehow distinct from the ethical and practical fashioning of physicians in the everyday context of their clinical environment, and that it must, therefore, be understood as an amalgam of the scientific, practical, experiential, and deeply communicative aspects of physician training and clinical practice. This is, for Montgomery, the meaning of "clinical judgment" and it is, on her view, central to the adequate delivery of patient care.

Up until this point, I am fully on board with Montgomery's take on the role of *phronesis* in unlocking critical elements of professional formation and clinical judgment. It seems undeniable that medicine is not merely science, although we may not want to go so far as Montgomery does in denying the scientific elements of the story. However, she makes a striking

comment in a brief article on patient safety written after her book that indicates a shade of paternalism in her account. In this article, she refers to patients as "data points" for physicians who are seeking to make use of their clinical experience and render diagnostic and treatment decisions.[158] I have already pointed to this conception of patients in the introduction to this chapter and, I believe, it goes beyond Montgomery's work. In fact, the work of most of the philosophers and physicians cited in this chapter echo Montgomery in saying that patients provide evidence (through their words and bodily signs) that is then used by practitioners to formulate a medical judgment. On this rendering, patients are literally "storytellers" and not caregivers. They provide the evidence that, when combined with the appropriate use of *phronesis* by physicians, produces effective and ethical care. While I do not think that Montgomery (or, for that matter, any of the authors cited throughout this chapter) is motivated by a paternalistic impulse, the way that she utilizes the concept of *phronesis* might itself be classified as paternalistic, primarily because she invests clinicians and researchers with this mode of reasoning rather than patients. This paternalistic bent is to be expected from authors whose primary focus is on the development of the practitioner. It is as old as the Hippocratic writer who viewed patients as partners with physicians and yet viewed the actual practice of medicine as centrally controlled by the professional physician (chapter 2).[159]

At this point, Mary's story becomes relevant for us yet again. Of course Mary wants a physician who thinks about her specific situation, one who understands and even acknowledges uncertainty when making diagnosis and advising various therapeutic interventions, and embraces her needs and her problems as something more complex than anything that might be stated in a textbook or summarized in a research article. In fact, Montgomery's work provides one half of

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[158] Montgomery, "Thinking about Thinking," e194.
[159] One can, as I have already noted, find this impulse in the Hippocratic *Oath*.

the solution that Mary is seeking – a caregiver who can deal with her specific needs. Her physician in the fictional narrative in 3.2, Dr. Taylor, seems unable or unwilling to deal with Mary on her own terms. He repeats various evidence-based solutions to Mary's problems (something that he should do) but when it comes to her specific needs, her problems, and the fact that she must care for herself, Dr. Taylor has little to offer. Perhaps if he could embrace the notion of *phronesis* adumbrated throughout Montgomery's work, he might place a greater amount of emphasis on the attributes of Mary's specific case. Unfortunately, due to gaps in his training and due to the demands placed on his time, he is unable to practice the art of medicine in a way that might change Mary's situation for the better. What's more, even if he engaged in the use of *phronesis* in his healing relationship with Mary, this might not give Mary everything she needs to enhance her own skills as a caregiver for and of herself. This predicament highlights the central reason that extant elaborations of *phronesis* in the medical literature remain inadequate to support a conception of patient knowledge and action: a focus on physicians rather than patients.[160] The following two content chapters present an opportunity to address this gap in the literature by developing a third sense of *phronesis,* one that is geared specifically to cultivate the role of the patient as caregiver, built on the merger between Aristotle and Isocrates described earlier.

[160] Rubinelli, Schulz, and Nakamoto, "Health Literacy."

3.5 CONCLUSION

The next chapter shifts theoretical discussion of *phronesis* in the practice of medicine into the grounded practices of one type of practitioner: the lifestyle coach.[161] In doing so, I expand upon the already prevalent scholarly discussions of *phronesis* (i.e., experiential, performative, and situational praxis) as a model for the professional practices of medical practitioners. My account is innovative in three senses. First, I deal with the practices of a new type of medical practitioner, one focused on lifestyle management and the cultivation of patients who must care for themselves. Other work has focused primarily on the role of the physician and on the use of *phronesis* as a model for clinical forms of knowing.[162] As lifestyle coaches span the gulf between the clinic and the external world of the chronic patient, describing their practices through the lens of *phronesis* opens the door to a different inflection of the meaning of this term that includes teaching patients, what I will call *paideia*, to engage in their own pursuit of a good and fulfilling life, or *eudaimonia*. Second, most of the scholarly discussion of *phronesis* in medicine has focused on its connection to ethical comportment. While Aristotle develops the term in the context of the *Nicomachean Ethics*, the concept has broader applicability and, when specified through a careful analysis of one type of professional praxis, gains substance and meaning in the wider domain of human action. Third, most of the work on *phronesis* in rhetorical studies focuses on its role in political methods of invention, delivery, and style.[163] I argue that the

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[161] The moniker "lifestyle coach" is one that I have taken from my work with members of the OLSS research team. It is used to describe those practitioners who use the online platform to interact with participants and assist them in completing their lessons.

[162] See e.g., Kathryn Montgomery, *How Doctors Think*; Pellegrino and Thomasma, *The Virtues in Medical Practice*; F. Daniel Davis, "*Phronesis*, Clinical Reasoning, and Pellegrino's Philosophy of Medicine."

[163] See e.g., Robert Hariman, ed., *Prudence: Classical Virtue, Postmodern Practice* (University Park, PA: The Pennsylvania State University Press, 2003); Robert Hariman, "Prudence/Performance," *Rhetoric Society Quarterly* 21, no. 2 (1991): 26-35; M. Lane Bruner, "The Rhetorical *Phronimos*: Political Wisdom in

professional practices of lifestyle coaching provide a context for understanding the role of *phronesis* as a pedagogical method in medicine, an approach to rhetorical analysis, and a way to capture the form of knowing and acting that is central to lifestyle change. In this way, I expand the relevance of *phronesis* in rhetorical studies and offer it as a scholarly, professional, and rhetorical concept that animates discussions of medical practice.

Postmodernity," *Controversia: an international journal of debate and democratic renewal* 2 (May, 2003): 82-102; Self, "Rhetoric and *Phronesis*."

4.0 RHETORICAL DYNAMICS OF LIFESTYLE COACHING

> Complexity, instability, and uncertainty are not removed or resolved by applying specialized knowledge to well-defined tasks. If anything, the effective use of specialized knowledge depends on a prior restructuring of situations that are complex and uncertain. An artful practice of the unique case appears anomalous when professional competence is modeled in terms of application of established techniques to recurrent events. Problem setting has no place in a body of professional knowledge concerned exclusively with problem solving. The task of choosing among competing paradigms of practice is not amenable to professional expertise.[1]

4.1 LIFESTYLE COACHING AND RHETORIC: THERAPY AS CONSTITUTIVE

4.1.1 The scope of lifestyle coaching: A public and professional practice

The figure of the lifestyle coach and the practice of "lifestyle management" are prevalent in popular culture as is the normative conception of cultivating the self in the pursuit of health.[2] Physicians have taken part in this explosion of popular concern for the prevention of disease and promotion of health. Many daytime talk shows now feature the physician-turned-health-advocate and lifestyle counselor who provides necessary information to a large population of health consumers.[3] The lifestyle coach can also be found as a textual figure on the bookshelves of multiple stores where self-help, exercise, fitness, and holistic health manuals are ready-to-hand

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[1] Donald A. Schön, *The Reflective Practitioner: How Professionals Think in Action* (Basic Books, 1983), 19.

[2] On this point, see Joanna Zylinska, *Bioethics in the Age of New Media* (Cambridge: MIT Press, 2009); Jonathan M. Metzl and Anna Kirkland, eds., *Against Health: How Health Became the New Morality* (New York: New York University Press, 2010).

[3] For example, Dr. Mehmet Oz, host of "The Dr. Oz Show" has made a career of doling out health advice on almost every topic to large television audiences. The very fact that he has generated so much interest and continues to be the voice of self-help in the performance of health speaks to the widespread existence of "lifestyle management." See his show's website, http://www.doctoroz.com/.

for eager shoppers.[4] All of these examples of popular conceptions of lifestyle coaching are important from a rhetorical perspective as they point to the needs, fears, aspirations, and hopes of a mass public. That such programs, items, and plans sell indicates that we live in a time and in a place where weight and its relationship to health status are primary concerns.[5] As Dana L. Cloud notes in her study of therapeutic rhetorics in the United States, we live in a world infused with a concern for self-care, personal responsibility, and the management of lifestyle.[6] Unpacking the various rhetorical devices used to solicit money and attention from a mass consumer audience whose constituent individuals are interested in their own health (and rhetorically generating this interest in the first place) is a worthy endeavor, one that should take center stage in the rhetoric of health and medicine in coming years. Scholars from health, advertizing, public relations, and organizational communication backgrounds along with rhetorical scholars of medicine can and should direct their attention toward these elements of contemporary consumer culture in order to reveal the manipulations and potentially productive transformations that are already emergent and may yet come to fruition. Substantial scholarly attention has been paid to the specific

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[4] On the history of what she calls "the self-help movement" and its implications on consumption and social movement, see Dana L. Cloud, *Control and Consolation in American Culture and Politics*: *Rhetorics of Therapy* (Thousand Oaks: Sage Publications, 1998), 29-35. For another account of such self oriented therapies in American society, see Nikolas Rose, *Governing the Soul: The Shaping of the Private Self* (New York: Routledge, 1990).

[5] In fact, health in general has become a sort of "new morality" that seems to dominate public conversation in productive and somewhat less productive ways. See Metzl and Kirkland, *Against Health*. As Jonathon M. Metzl proclaims in his introduction to this text, "Health is a desired state, but it is also a prescribed state and an ideological position . . . An the definition of our own health depends in part on our value judgments about others. We see them – the smokers, the overeaters, the activists, and the bottle-feeders – and realize our own health in the process." Later he goes on to suggest that "this book's stand against health is not a stand against the authenticity of people's attempts to ward off suffering. We instead claim that individual strivings for health are, in some instances, rendered more difficult by the ways in which health is culturally configured and socially sustained." Thus, "articulating the disparate valences of 'health' can lead to deeper, more productive, and indeed more health interactions about embodied expectations and inter-subjective desires." Metzl, "Introduction: *Why Against Health*?, 2, 9. In other words, one element under consideration in this chapter is the extent to which the term and idea of health plays a role in managing the plural desires of health care providers and patients (as well as the wider political, social, cultural, and other arenas of human action in which health becomes a problem to be managed).

[6] Cloud, *Control and Consolation*; Chris Feudtner, *Bittersweet: Diabetes, Insulin, and the Transformation of Illness* (Chapel Hill: The University of North Carolina Press, 2003). In the context of obesity in particular, see Abigail C. Saguy and Kevin W. Riley, "Weighing both Sides: Morality, Mortality, and Framing Contests Over Obesity," *Journal of Health Politics, Policy, and Law* 30, no. 5 (2005): 869-921.

professional needs, tasks, and dispositions of the traditional health professions.[7] Here, I focus on the specific task of training already skilled healthcare workers in the practice of supporting patients in weight loss, exercise, and lifestyle management. Unpacking the emergent professionalization of weight loss practitioners is critical as it involves both a new trajectory of medicalization (i.e., lifestyle coaching has long been in the hands of non-clinical practitioners but is now entering the clinical domain) as well as a new site for communicative and, more specifically, rhetorical interaction between patients and the professionals who inhabit their larger clinical context.[8] In short, my task over the course of this chapter is to highlight the praxis-based

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[7] For example, Kathryn Montgomery's, *How Doctors Think: Clinical Judgment and the Practice of Medicine* (Oxford: Oxford University Press, 2006), is just one of many texts that attempt to understand the professional and practical elements of actually becoming and being a physician. This process has been the subject of major policy documents produced to challenge prevailing pedagogical practices and methods of professionalization for physicians. See, e.g., Molly Cooke, David M. Irby, and Bridget C. O'Brien, *Educating Physicians: A Call for Reform of Medical School and Residency* (San Fransisco: Jossey-Bass, 2010). It has also played a key role in bioethics discussions of the patient-provider dyad, most notably in Edmund D. Pellegrino and David C. Thomasma's, *The Virtues in Medical Practice* (New York: Oxford University Press, 1993). In addition, nursing has been the subject of a great deal of work on professionalization. See e.g., Nancy Crigger and Nelda Godfrey, *The Making of Nurse Professionals: A Transformational, Ethical Approach* (Sudburry, MA: Jones & Bartlett Learning, LLC, 2011). Finally, Donald A. Schön provided grist for a now enduring reflection on professional practices in his *The Reflective Practitioner.* This text introduces many issues that play a role below and in chapter 5, primarily the difference between what I have been calling "*techne*-based" accounts of professional and personal practices and Hannah Arendt's notion of thinking coordinated with doing. Hannah Arendt, *The Human Condition* (Chicago: University of Chicago Press, 1958), 5. Schön acknowledges Arendt's contributions in this debate (278-280). He describes these elements in his dichotomy between "technical rationality" and "reflection-in-action." He also provides an excellent description (very much in line with the Aristotelian notion of *phronesis*) of the importance of particular situations and how they drive the need for "reflection-in-action." See his Chapters 2 and 3 for the most robust discussion of these elements of his argument. Thus, much of my analysis is indebted to Schön's, as are the works of many of the philosophers I have cited on these issues previously, in particular Joseph Dunne in his *Back to the Rough Ground: Practical Judgment and the Lure of Technique* (Notre Dame: University of Notre Dame Press, 1993). In fact, Dunne cites Schön on the very first page of his preface, suggesting that it is his *Reflective Practitioner* that eloquently poses the question regarding knowledge and action, and the lack of coordination between them, in professional practice (xv). In all, Schön is something of an intellectual grandfather to many late twentieth and early twenty-first century theorists of what I call *phronesis*.

[8] On the issue of "medicalization" or the redefinition of health-related problems as "medical" and therefore open to medical surveillance, intervention and management, see e.g., Jeffrey Sobal, "The Medicalization and Demedicalization of Obesity," in *Eating Agendas: Food and Nutrition as Social Problems,* ed. Donna Maurer and Jeffrey Sobal (Hawthorne, NY: Aldine De Gruyter, 1995), 67-90. John Z. Sadler, Fabrice Jotterand, Simon Craddock Lee, and Stephen Inrig define "medicalization" as "a process by which human problems come to be defined and treated as medical problems," in their "Can Medicalization Be Good? Situating Medicalization within Bioethics," *Theoretical Medicine & Bioethics* 30 (2009): 412. I largely agree with this definition and pose a similar question regarding the benefits and disadvantages of medicalization in the context of lifestyle coaching throughout this chapter.

and rhetorical features of the emergence of the lifestyle coach as healthcare practitioner, something that has received scant attention in medical and rhetorical scholarship.

4.1.2 *Phronesis, Paideia,* and the Constitutive Function of *Logos*

Lifestyle coaching, when viewed through the lens of rhetoric and therapy, gives rise to a critical concern—the relationship of *logos* (language or discourse) to the therapeutic strategies aimed at changing the habits, activities, and even dispositions of others.[9] This avenue of inquiry is not a new one. Its emergence in the Greco-Roman tradition has been ably (re)constructed by Martha C. Nussbaum in her *Therapy of Desire* in which she charts various "therapeutic arguments," the philosophical and often dialectical efforts of Hellenistic teachers of philosophy, aimed at reorienting the beliefs, values, and practices of their pupils.[10] In making her argument, Nussbaum refurbishes the medical analogy to philosophical training, suggesting that these philosophical and ethical teachers thought of themselves as doctors of the soul. She writes,

> When a doctor treats a patient, the patient's body is ill; but it is from the patient's beliefs, judgments, and desires that the account of symptoms is elicited: and these are not the seat of the disease. Medical moral philosophy, by contrast, deals with people whose beliefs, desires, and preferences are themselves the problem. For according to the Hellenistic philosophers, society is not in order as it is; and, as the source of most of their pupils' beliefs and even of their emotional repertory, it has infected them with its sicknesses. The upbringing of young people is held to be deformed in various ways by false views about what matters: by excessive emphasis, for example, on money, competition, and status. These corruptions often go deep; and they will in this way influence any self-description the patient gives the teacher/doctor. Nor, since the diseases are internal, is there even the possibility of an independent examination by the physician: everything depends on the pupil's unreliable report. The philosophical doctor must, then, be even more skeptical than the medical doctor about any report made by the pupil based

[9] The therapeutic strategies under consideration here are central to the works of Martha Nussbaum. For her major contributions to this area, see e.g., Martha C. Nussbaum, *Cultivating Humanity: A Classical Defense of Reform in Liberal Education* (Cambridge: Harvard University Press, 1997) and *The Therapy of Desire: Theory and Practice in Hellenistic Ethics* (Princeton: Princeton University Press, 1994).

[10] Nussbaum, *The Therapy of Desire*, xi.

> on her own immediate judgments and perceptions, knowing that the very same parts that produce the report are the ones that are, or may be, diseased. And yet how can the teacher know them, except by asking them to *speak*.[11]

Lifestyle coaching spans the gulf between the two forms of *medicine* that circulate in this passage. It is animated by a desire to improve the bodily health and wellbeing of obese and diabetic patients, and yet, its aim must be the transformation of "the patient's beliefs, judgments, and desires," the patient's "preferences" and practices. It is for this reason that I view lifestyle coaching as a new form of professional practice in healthcare. It is not oriented toward the cultivation of better technological interventions or more precise modes of clinical judgment but is instead focused on ways to promote the health of the patient through her cultivation as a healthy person. It involves, in particular, a conception of training and behavior change that I believe is best summed up in one word: *phronesis*. Lifestyle coaching is a mode of training that focuses on a practical reorientation of the patient through her own experiential learning and through a dialectical interaction with her coach.

Understanding how *phronesis* captures the practical, health-oriented, and rhetorical practices of lifestyle coaching requires a new framing of the concept itself. A theory of how individuals come to be and how this version of them might be transformed requires an account behavior formation and behavior change. In order to develop this account, I draw on another term from rhetorical history: *paideia*. As Werner Jaeger points out, the Greeks (and later the Romans) were invested in the cultivation of character, in the ongoing development and evolution of their culture, and in the processes needed to achieve these ends. For the Greeks, the term *paideia*, translated as "culture" or "education" by Jaeger, is a philosophy of such

[11] Nussbaum, *The Therapy of Desire*, 26. Emphasis added.

intergenerational cultural transmission.[12] It is rooted in the idea that "the community is the source of all behaviour."[13] Following from this, *paideia* is generally understood to be the often diffuse and always circulating education that one receives by virtue of residing within a particular cultural milieu. The project of community is the cultivation of the person, their character, and their capacity to act virtuously in the world. It is for this reason that the Greeks viewed, "*paideia* [as] active energy" or as the transmission of the means for action, not merely disposition.[14] Most importantly, *paideia* involves both action and speech, both doing and speaking as a member of one's culture and for the good of the whole.[15] This Greco-Roman ideal of *paideia* is bound up with normative assumptions surrounding the nurture v. nature debate that is so central to moral psychology, philosophy, and contemporary theories of behavior change. As Jaeger points out, in the Greek context, *paideia* tends more toward the philosophy of nurturing as a means to produce good citizens capable of action in the direction of the general good, or, in other words, of *arête* or excellence of character.[16] Individuals are not born good but, rather, have the capacity for such excellence as members of a community. As such, *paideia* is promoted through life training, a deeply rhetorical affair in which the individual is immersed in the *logos* (including the language, structure, and modes of reasoning) of her culture.[17] Important for our purposes here, Jaeger suggests, "that the Greek ideal of culture was the ideal of Health."[18] Of course, Jaeger is pointing to the idea that, for the ancient Greeks, the formation of a culture

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[12] Werner Jaeger, *Archaic Greece: The Mind of Athens,* vol. 1 of *Paideia: the Ideals of Greek Culture*, 2nd ed., trans. Gilbert Highet (New York: Oxford University Press, 1945), xvii.

[13] Jaeger, *Archaic Greece*, xiv.

[14] Jaeger, *Archaic Greece*, xxvii.

[15] Jaeger, *Archaic Greece*, 8. This is also a central feature of Isocrates' notion of *logos politikos* or the training of individuals in the philosophies, cultural norms and vales, and rhetorical practices of their particular milieu. On this, see Takis Poulakos, *Speaking for the Polis: Isocrates' Rhetorical Education* (Columbia: University of South Carolina Press, 1997).

[16] Jaeger, *Archaic Greece*, 8 (and throughout)

[17] Jaeger, *Archaic Greece*, xxii.

[18] Jaeger, *The Conflict of Cultural Ideals in the Age of Plato,* vol. 3 of *Paideia*, 45.

implies a concern for health in all its guises including ethics, political stability, mental and bodily excellence and the like. This is in keeping with Nussbaum's conception of therapy discussed above.

There are three major problems confronting this application of *paideia* to contemporary lifestyle coaching. Most importantly, the basis of *paideia* in culture and community is not consonant with the more individualistic and autonomous model of the liberal subject in contemporary U.S. culture.[19] The idea that the *logos* of a culture, or of medicine, might somehow impact the development of the individual opposes the commonly understood meaning of several "ultimate terms" in our democratic imaginary (e.g., freedom, liberty, autonomy, etc.).[20] In this regard, a skeptic might say that the notion of *paideia* is far too conservative in its account of the reification of social values and its rootedness in community. My response is simple: the role of *paideia* in the pages ahead is to underscore the ways in which our self-conception is framed by our culture and how this framing might be interrupted through the close relationship between teacher and student or lifestyle coach and patient. This is in keeping with Nussbaum's conception of "therapeutic arguments" in Hellenistic philosophy.[21] In part, the task of such arguments is to undermine the dominance of cultural beliefs and practices (for my purposes here, things like over-consumption and sedentary lifestyle) through a valuation of different "desires."[22] In other words, "ultimate terms" (health being the most relevant to the current discussion) are themselves open to critique, therapy, and contestation. As Richard Weaver suggests,

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[19] On contemporary liberal subjectivity, especially in the arena of education, see e.g., Patricia Roberts-Miller, *Deliberate Conflict: Argument, Political Theory, and Composition Classes* (Carbondale: Southern Illinois University Press, 2004), 58-97. For a broader discussion and critique of the concept, see John D. Peters, *Courting the Abyss: Free Speech and the Liberal Tradition* (Chicago: University of Chicago Press, 2005).

[20] On "ultimate terms" see Richard M. Weaver, "Ultimate Terms in Contemporary Rhetoric," in his *The Ethics of Rhetoric* (Davis, CA: Hermagoras Press, 1985), 211-232.

[21] Nussbaum, *The Therapy of Desire*, xi.

[22] Nussbaum, *The Therapy of Desire*, 11.

> An ethics of rhetoric requires that ultimate terms be ultimate in some rational sense. The only way to achieve that objective is through an ordering of our own minds and our own passions . . . It is especially easy to pick up a tone without realizing its trend. Perhaps the best that any of us can do is to hold a dialectic with himself to see what the wider circumferences of his terms of persuasion are.[23]

That is, part of the project of *paideia* is the act of reflection, both self and (I would add) other, in an attempt to understand how the elements that constitute a particular culture (including its "terms of persuasion") support or enervate *eudaimonia*.

In this regard, I argue in the sections that follow that *paideia* can be understood as both a task and result of the therapeutic efforts of lifestyle pedagogy. On the one hand, lifestyle coaches are, in the most general sense, tasked with changing the ways of life of individuals dealing with obesity and diabetes (among other co-morbidities). In this sense, lifestyle coaching is aimed at ameliorating what Martha Nussbaum calls "antecedent *paideia*" or modes of enculturation that have caused the health problems faced by their patients.[24] In addition, *paideia* is a result of lifestyle coaching if we accept that such coaching aims at the cultivation of a new identity, one that is healthy or health-oriented, over and against an older self-conception, an antecedent way of being and doing. In some ways, this use of *paideia* is not in keeping with its Greek roots. *Paideia* is not a state but a process, a cultural architecture that breeds the cultivation of an identity. However, my use of the term is meant to signal that lifestyle coaching is in actuality an ongoing process; that subject-formation or identity-formation is itself an ongoing process, never complete and never fully-formed. Lifestyle pedagogy, when practiced well is not mechanistic, instrumental, or reductionist. If practiced ethically, especially with the notion of autonomy in mind, lifestyle coaching cannot and should not produce bodies that simply go about exercising and eating correctly as if these activities were automatic. It is not a process involving the

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[23] Weaver, "Ultimate Terms in Contemporary Rhetoric," 232.
[24] On "antecedent paideia" see Nussbaum, *The Therapy of Desire*, 97.

accretion of habits and a subsequent calcification of character. Instead, lifestyle coaching provides a context for revising one's life over and over again in the pursuit of health (health being defined through the lens of individual goals and aspirations). As such, it delivers not one identity but a process of identification that is best understood, I believe, through the lens of *paideia* as a rhetorical process of identity-formation.

The second problem at the heart of articulating *phronesis* as a sort of rhetorical *paideia* is grounded in the concern with patient autonomy in medical ethics. Nussbaum argues that the medical model of philosophical training she investigates can at times lend itself to, "an asymmetrical model of the relationship between teacher and pupil, doctor and patient."[25] For 21st century practitioners and patients, the use of *logos* and its inflection through the rhetorical arts as a means of therapy (*paideia*) brings this asymmetry to the fore in the dialectical tension between paternalism and autonomy.[26] Balancing the goals and commitments of medicine (which can be applied paternalistically) with the aspirations and life plans of patients (their autonomy) is a central concern, one born out of the abuses of medical research and care in the 20th century.[27] One could argue that, as healthcare practitioners begin to use their skills to help patients *manage* their lifestyles, the concern with paternalism is ramified. This sort of activity opens up the possibility of substituting the goals and aspirations of medicine for the life plans, beliefs, values, and goals of patients. It may even justify the constitution of completely new individuals with subjectivities that are wrapped around and infused with the values of medicine. On the one hand, and in keeping with the dialectical arrangement described above, medical practitioners might say

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[25] Nussbaum, *The Therapy of Desire*, 27.

[26] On this point, see Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 6th ed. (New York: Oxford University Press, 2009), 99-148.

[27] On the history of research-based abuses of human rights and their role in the eventual emergence of "autonomy" and other contemporary principles of medical ethics, see Stephen Toulmin, "Preface, 1986," in his *The Place of Reason in Ethics* (Chicago: The University of Chicago Press, 1986), vii-xx; Robert Jay Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (New York: Basic Books, Inc., Publishers, 1986).

that this is exactly the point. Patients come to their physicians to learn how to lead healthy lives, regain health, and avoid death.[28] They should follow the advice of physicians if they want to achieve such goals. On the other hand, those who are leery of expanding the net of medical concern might retort that the goal of medicine is to provide solutions to health problems, not to change the very nature of the individual patient such that they are unrecognizable to themselves and others. Managing this dialectical tension is one of the permanent features and philosophical problems inhering in teacher/student and doctor/patient relationships. No conceptual theorizing can fully ameliorate it. Instead, I approach it through the grounded analysis of practices in order to discover how it is managed and how this management might be improved. In this way, I follow the excellent work of bioethicists David H. Smith and Loyd S. Pettegrew who support a "mutual persuasion" model for the provider-patient relationship.[29] In their essay, they directly interrogate the "classical distinction between rhetoric and sophistic" in the ancient Greek tradition suggesting that rhetoric implies a notion of "mutuality" that allows for shared persuasion whereas Sophistic implies "manipulation" and power.[30] In the end, they embrace an ethical and rhetorical stance (one with which I heartily agree) in which "both parties [provider and patient] are active choice-makers, [so that] neither can be truly said to be manipulated by the other so long as the influence process employed is persuasive discourse, not coercion, hidden psychological process, or group pressure."[31] Of course, there is some idealism in this model that

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[28] David H. Smith and Loyd S. Pettegrew suggest a shared decision-making model that moves beyond the dialectic between "physician paternalism" and "patient sovereignty." David H. Smith and Loyd S. Pettegrew, "Mutual Persuasion as a Model for Doctor-Patient Communication," *Theoretical Medicine and Bioethics* 7, no. 2 (1986): 127-146. On the problems associated with unchecked patient autonomy and an early version of the arguments more fully developed in the essay cited above, see David H. Smith, "Ethics in the Doctor-Patient Relationship," *Critical Care Clinics* 12, no. 1 (1996): 179-197.

[29] Smith and Pettegrew, "Mutual Perusasion as a Model for Doctor-Patient Communication."

[30] Smith and Pettegrew, "Mutual Perusasion as a Model for Doctor-Patient Communication," 141.

[31] Smith and Pettegrew, "Mutual Persuasion as a Model for Doctor-Patient Communication," 141.

only a grounded approach in which the activities of real patients and providers are analyzed can fully temper (thus, the second half of this chapter).

The third problem confronting the notion of *paideia* developed in this section is rooted in a contemporary debate over the function of rhetoric. During the 1980s, and at a time when continental philosophy was beginning to influence rhetorical theory and criticism, a transition from the humanist tradition (i.e., one that viewed rhetoric as primarily a persuasive art, intentionally aimed at actors with a capacity for reflective judgment) to a postmodern concern with the "constitutive" features of discourse rocked the foundations of the field.[32] One of the scholars at the heart of this transition, Maurice Charland, argues in his germinal 1987 essay "Constitutive Rhetoric: The Case of the *Peuple Quebecois*," that audiences are constituted by rhetoric, perhaps even by diffuse ideological commitments that they are not even aware of, and thus are not always free to think openly and reflectively about the arguments made to and for them as well as in their name.[33] He writes that "attempts to elucidate ideological or identity-forming discourses as persuasive are trapped in a contradiction: persuasive discourse requires a

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[32] John Lyne offers one of the first accounts of the "constitutive" function of rhetoric (at least in terms of 20th century rhetorical theory), one that transcends a simple transmission model of persuasion and that underscores the importance of *logos* as a feature of human sociality that works to produce and constrain rhetorical possibilities: "This constitutive function of rhetoric is one that should probably get more attention in our literature than it does, since it helps explain why the study of discourse is important independent of whether it can be demonstrated to have 'caused' events . . . Rhetoric, seen in this light, exceeds the merely instrumental and seems to constitute parts of our world . . . Communities as well as practices can be constituted rhetorically." John Lyne, "Rhetorics of Inquiry," *Quarterly Journal of Speech* 71 (1985): 68. Of course, this understanding of the role of rhetoric has a lineage in the Burkean corpus as well where the term "identification" has joined persuasion as a primary element of rhetorical activity. Identification is, in part, a constitutive process much like the one described here by Lyne. It involves the use of language in crafting identity, in producing a sense of who and what we are that, by implication, effects our practices, our understandings, our interpretations, our habits, our motivations, and our actions. Of course Lyne and others who write about the constitutive function of *logos* have already recognized this connection to the Burkean corpus. Kenneth Burke, *A Rhetoric of Motives* (Berkeley: University of California Press, 1969): 19-23 (and throughout). Finally, this move to understand how language, and more specifically textuality, plays a role in socialization and identification has been developed in other scholarly arenas. On the role of language in the constitution of nationalism, see Benedict Anderson, *Imagined Communities: Reflections on the Origin and Spread of Nationalism*, Rev. ed. (London: Verso, 2006). On the role of language in the cultivation of various identities through the circulation of text, see Michael Warner, *Publics and Counterpublics* (New York: Zone Books, 2002).

[33] Maurice Charland, "Constitutive Rhetoric: The Case of the 'Peuple Québécois,'" *Quarterly Journal of Speeh* 73 (1987): 133-150.

subject-as-audience who is already constituted with an identity and within an ideology."[34] Charland suggests here that persuasion cannot occur without the existence of an already constituted audience for whom rhetorical work is produced in the first place. In a broader sense, Charland's perspective implies that we are all to some extent constituted by cultural norms, beliefs, and discourses and that often, we are unaware of these processes given their direct influence on who and what we believe ourselves to be. Charland's turn to the "constitutive" features of *logos* is directly related to the paternalism vs. autonomy dilemma described above as well as the meaning of rhetoric as a therapeutic *paideia*. It poses the question of whether an individual patient can *choose* to change her lifestyle or whether it is always already formed through the ideological functions of larger discourses.

I believe there are ways to transcend the divides between: (1) the overly utopian vision of humanist agents and cynical notions of postmodern subjects, (2) the possibility of persuasion and reflective judgment and the "constitutive" or even ideological features of *logos*, and (3) the existence and ineradicable nature of power and the possibility of individual reflection and opposition to power. In contradistinction to Charland's take on constitutive rhetoric, in this chapter I suggest that we are sometimes asked to actively engage in this process of constitution, to reflect upon it, to in some sense choose it. Whether we are merely tricked into believing that we are exercising choice or not seems to me an issue best resolved through grounded rhetorical analysis, through experiential discussion, through the close investigation of practices. While Charland's case study may support his ideological and anti-humanist read, others might challenge it, providing a richer conception of constitutive rhetoric with multifaceted connections to identity, identification, and identity-formation.

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[34] Charland, "Constitutive Rhetoric," 134.

Finally, this chapter is focused on the cultivation of practitioners who can rightfully be said to use *phronesis* as part of their approach to lifestyle management within a larger conception of *paideia* as a mode of rhetorical pedagogy. The role of patients in this process is a concern, but I focus most of my energy on specific methods of training lifestyle coaches who can then perform *paideia*, a performance that assists patients in their efforts to lose weight and manage co-morbid conditions. As such, I will direct my analysis at the therapeutic and constitutive features of training regimens for lifestyle coaches as well as the forms of training they engage in with patients. The case studies that follow develop grounded interpretations of various documents and interviews related to the practice of lifestyle coaching with a focus on the dialectical tensions between and among constitutive rhetoric, *paideia*, and *phronesis*. The first of these unpacks a training protocol developed to assist lifestyle coaches in the performance of their professional role. The second involves interviews I completed with Online Lifestyle Support System (OLSS) lifestyle coaches in the fall of 2008.

4.2 THE ONLINE LIFESTYLE SUPPORT SYSTEM COACHING PROTOCOL: TRACES OF A DEVELOPMENTAL AND CONSTITUTIVE PROCESS

The Online Lifestyle Support System (OLSS) is a lifestyle management tool designed as a clinical plug-in for chronic care practitioners who work with obese and diabetic patients. Members of a research team developed the program with generous financial support from the Department of Defense and other grant organizations. The program involves three primary elements. The first is an online platform that includes a 1-year long lifestyle curriculum. This curriculum is composed of 16 weekly and 8 monthly lessons that cover topics ranging for good nutrition to physical activity, managing stress, and dealing with barriers to change. Participants

in the program utilize the online platform to work through lessons represented visually and through a voice recording that walks them through key insights. It also includes a workbook function that allows participants to record answers to prompts in the lessons and a tool for asynchronous communication with trained lifestyle coaches. That is, participants contact lifestyle coaches through the online platform and receive responses later. I discuss these coaching notes and the various ways in which they are delivered to participants later in this chapter. Second, the OLSS is coordinated with primary care. That is, participants are selected by their primary care physicians to take part in the program and, at least in some cases, play a role in helping patients monitor their progress. In addition, primary care physicians are provided with regular reports on their patients who have elected to participate in the program. Third and finally, the OLSS involves the use of real lifestyle coaches who interact with participants through the online platform, and, in some cases, on the phone. These coaches are trained nurses, physical therapists, and other healthcare practitioners with specialties related to obesity and diabetes care. They not only assist participants in working through their lessons but also provide help when participants face mental and physical problems that require referral to other trained professionals. The OLSS has undergone several iterations. In this chapter, I primarily investigate the pilot study.

In the OLSS pilot study, a coaching protocol was developed to assist coaches in the cultivation of skills needed for the promotion of lifestyle change. To achieve this end, a Coaching Protocol Development Team (CPDT) worked to: (1) understand the state-of-the-art in lifestyle coaching and, (2) deliver this knowledge to lifestyle coaches who would be working with the participant cohort. The CPDT created a protocol (i.e., a list of principles and best practices) and a coaching guide to train the coaches and assist them in the performance of their

role on a daily basis.[35] *Lifestyle Coach Training* and the *Lifestyle Coaching Guide* are documents that form the heart of the original OLSS pilot program's coaching protocol.[36] *Lifestyle Coach Training* provides both a general overview of the principles that should guide lifestyle coaching practice, as well as a more specific discussion of a primary obligation of lifestyle coaches: crafting notes to study participants. These notes are meant to provide feedback to participant questions as well as to their overall progress in the lifestyle curriculum. *The Lifestyle Coaching Guide* provides specific guidance regarding how these notes should be written based on the content of specific lessons in this curriculum.

These documents are handbooks, much like the handbooks that the ancients used to teach the rhetorical arts, especially invention and delivery.[37] They provide a basic map, a set of principles for effective action, and in particular, an inventional guide for crafting rhetorical products (i.e., notes) and delivering them to participants. An initial version of the protocol was prepared for the coaches at the outset of the OLSS pilot study; however, it was and remains a living document, ultimately revisable based on the experiences of the coaches as they work with participants. I did not participate in *Lifestyle Coach Training* and the *Lifestyle Coaching Guide's* organic, iterative production and cannot offer a detailed account of their creation from experience. However, as I imply in the title of this section, *Lifestyle Coach Training* and the *Lifestyle Coaching Guide* indicate various *traces* of a developmental process with constitutive

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[35] I should note that the individuals who worked on this team did not use the moniker "Coaching Protocol Development Team." I have crafted this term to reference those individuals who helped to design the coaching protocol and may not have actively engaged in coaching participants.

[36] The training protocol (Lifestyle Coach Training) was made available to the author by the OLSS working group. Its working title is, "[. . .]: Lifestyle Coach Training," Copyright University of Pittsburgh, 2008. The guide (Lifestyle Coaching Guide) was made available in the same way and its working title is "[. . .]: Lifestyle Coaching Guide," Copyright University of Pittsburgh, 2008. The proprietary names of the training document and the guide have been omitted here as is customary in medical research. Both documents and other training materials are currently retained by the author and the OLSS study group.

[37] On this handbook tradition, see John Henry Freese, "Introduction," in his translation of *Aristotle: The "Art" of Rhetoric* (Cambridge: Harvard University Press, 2000), xi-xxxiv.

and therapeutic entailments, and with a specific conception of *paideia* as well. As such, they are both critical starting points for thinking about what it means to be a lifestyle coach, how this activity is rhetorical (both in terms of learning how to be a lifestyle coach and then engaging in coaching), and the instabilities inherent in the kind of *phronesis* utilized in their construction. To say that these pedagogical, rhetorical, therapeutic, and constitutive documents are grounded in *phronesis* is to call attention to their contingent emergence (i.e., the fact that they were written *in situ* as the pilot study was beginning and then consistently revised), to suggest that what we may find within it is grounded in experience as opposed to theory. However, their attributes linked with *phronesis*, just as with their constitutive and therapeutic attributes, remain as *traces* of that process that can now, in hindsight, only be partially recovered. They cannot fully reveal themselves (not even the interviews discussed in the next section can achieve this); but they can point us to some important remaining bits of the process from which they emerged.

The following section uncovers the various ways in which *Lifestyle Coach Training*, and to a lesser extent *Lifestyle Coaching Guide*: (1) manage tensions in the constitution of lifestyle coaching, (2) construct a *kairotic* imperative for the timely delivery of advice, and (3) utilize general topics to frame the needs of specific situations. In each of these ways, the coaching protocol reveals a concern for *paideia* and with the unreflective reproduction of principles. Thus, the protocol shows how *paideia* may not of necessity engage in the conservative reification of ideology or the seductive interpellation of subjects.[38] Finally, I utilize *Lifestyle Coach Training* as a primer for the deeper layer of rhetorical-critical work initiated in my analysis of the

[38] Charland actually uses the term "seduced" to describe the rhetorical and interpellative work of the constitutive discourses he is analyzing. See Charland, "Constitutive Rhetoric," 138.

interviews I conducted with the lifestyle coaches from the pilot OLSS study.[39] In short, I use several critical rhetorical tools as well as the conception of *phronesis* as developed in the chapter 3 to reveal the pedagogical tendencies and strategies of *Lifestyle Coach Training.*

4.2.1 Managing Tensions in Lifestyle Coaching

Lifestyle Coach Training carefully stitches together a picture of the lifestyle coach as medical professional. This stitching involves the delicate rhetorical management of complicated tensions. The first of these tensions involves the emergence of the lifestyle coach as a *medical* professional, with a discrete and important role to play in lifestyle management. The second works through the paternalism vs. autonomy dilemma briefly touched on in section 4.2. The last has to do with the conflicting values and roles that are bound up within the character of the lifestyle coach, in particular the balancing act between the goals of promoting the health and wellbeing of the participants on the one hand and ensuring the credibility and integrity of the ongoing research study on the other.

Lifestyle Coach Training opens with a rhetorical gesture that marks it as part of a clinical study within the parameters of a larger effort to test the effectiveness of lifestyle management: "The [OLSS] is an online translation of the lifestyle intervention developed for the Diabetes Prevention Program."[40] It also points out that the Diabetes Prevention Program (DPP), "was

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[39] The *Lifestyle Coaching Guide* does not receive as much attention as *Lifestyle Coach Training* in this section. I do this in part because the *Lifestyle Coaching Guide* does not have the same constitutive features as Lifestyle Coach Training but also because the *Lifestyle Coaching Guide* is another project, one better left for after the completion and defense of this dissertation. This new project will deal with technical writing and the crafting of coaching notes and will utilize the text of the actual notes written by coaches during the protocol, something that I do not have access to at this point. A more robust discussion of the interviews mentioned here along with my strategies for setting them up including the selection of interviewees, interpretive strategies, and the like are discussed at the beginning of section 5.3.

[40] This document, along with the others in this chapter, is open to revision. The version I am using here was last revised on February 21, 2008. Lifestyle Coach Training, 1.

tested with a large randomized, controlled trial, and found to promote clinically significant weight loss."[41] When viewed through a constitutive lens, and with the background of clinical research trials and their increasing importance at hand, these early moves in the document take on major rhetorical importance. The act of constituting *Lifestyle Coach Training* through its relationship with a clinical trial promotes a certain *ethos* (i.e., scientifically sound and rigorous medical research) and implies that the coaches involved in the study should base their activities on supporting and embodying this *ethos*.[42] This is of no small importance. As the OLSS is a pilot study meant to initiate a series of larger clinical trials it must emerge from sound, evidence-based research questions and hypotheses; however, I argue that this move accomplishes much more. As I note in the introduction to this chapter, lifestyle coaching is undergoing a process of medicalization. Constituting lifestyle coaching as a rigorously tested practice based in the methodology of the clinical trial accomplishes the goal of crafting the coach as a legitimate healthcare practitioner, one supported by the *ethos* and constitutive features of clinical research. In this instance, by "constitutive features," I mean those building blocks in the protocol that highlight how one is to become a lifestyle coach; a sort of becoming that requires careful attention to detail and to the modes of praxis and, following Lisa Keränen's work, "characterization" needed to achieve it.[43]

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[41] *Lifestyle Coach Training*, 1.

[42] Lisa Keränen's describes the history and development of the clinical trial as a central element of the "scientific *ethos*," throughout her work on the controversy surrounding breast cancer research in the 20th century. Lisa Keränen, *Scientific Characters: Rhetoric, Politics, and Trust in Breast Cancer Research* (Tuscaloosa: The University of Alabama Press, 2010), 24, 33-44. Colleen Derkatch discusses this issue as well, arguing that the rules of clinical trials and other methods currently grouped under the heading of evidence-based medicine, act as "epideictic" appeals that work "to draw professional and epistemic boundary lines." Colleen Derkatch, "Method as Argument: Boundary Work In Evidence-Based Medicine," *Social Epistemology: A Journal of Knowledge, Culture and Policy* 22, no. 4 (2008): 372 and 384 respectively.

[43] Again, I am drawing here on Keränen's work. That scientists and medical practitioners must engage in a "process of characterization" in which they simultaneously constitute themselves and craft images of themselves for their patients and the broader public is a major contribution of her study regarding breast cancer research. Keränen, *Scientific Characters*, 4-8, 33-36 (and throughout). For more on this, see John Lynch, *What Are Stem Cells?*

Crucially, this move manages the tension between popular conceptions of lifestyle change and the newly fashioned clinical model that will provide legitimacy and effectiveness to this practice.[44] As *Lifestyle Coach Training* argues, the OLSS is based on a trial that was "found to promote clinically significant weight loss and a 58% reduction in Type 2 diabetes among adults at high risk for diabetes onset."[45] Of course, it does not hurt that the findings of this trial have been published in one of the most prestigious journals in American medicine: the *New England Journal of Medicine*.[46] Furthermore, these details provide a powerful warrant to adopt the general features of the OLSS program, all of which, *Lifestyle Coach Training* claims, have the backing of clinical research: "dietary and physical activity advice; frequent participant contact, particularly early in the intervention; and behavioral techniques to help people modify their established habits."[47] As part of their participation in the OLSS study, coaches are also asked to engage in an additional training program: "the Group Lifestyle Balance training offered by the Diabetes Prevention Support Center," or at least something "equivalent."[48] This move adds to the overall constitutive effort of the document, reinforcing the idea that clinically proficient coaches should receive substantial training and orientation in order to accomplish their

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Definitions at the Intersection of Science and Politics (Tuscaloosa: The University of Alabama Press, 2011); Derkatch, "Method as Argument."

[44] In staking out this claim, I do not mean to suggest that the public conception of the lifestyle coach was somehow in the minds of the CPDT when they wrote these lines. Instead, what I mean to suggest is that the document provides a rhetorical resource for considering lifestyle coaching as a form of healthcare practice, something not to be taken for granted and separate from the more public models of lifestyle change, for instance, those one can find on WeightWatchers.com.

[45] *Lifestyle Coach Training*, 1.

[46] On the DPP, see http://diabetes.niddk.nih.gov/dm/pubs/preventionprogram/index.htm. For the research outcomes of the DPP, see William C. Knowler, Elizabeth Barrett-Connor, Sarah E. Fowler, Richard F. Hamman, John M. Lachin, Elizabeth A. Walker, and David M. Nathan, Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin," *The New England Journal of Medicine* 356, no. 6 (2002): 393-403.

[47] *Lifestyle Coach Training*, 1.

[48] *Lifestyle Coach Training*, 1.

task.[49] Training is the hallmark of professional development in medicine making this request as well as the significance of the training materials under investigation here all the more important.[50] Again, they provide *ethos* to this emergent practitioner role, as well as rigor and standardization of practice.[51] Only a practitioner aware of the background research and practices will be persuaded and able to engage in the practices outlined in this document.

After articulating the clinical research that suggests lifestyle coaching is a legitimate and effective *clinical* practice, *Lifestyle Coach Training* then moves on to the issue of practitioner paternalism vs. participant autonomy: "[The OLSS curriculum] is designed for delivery in coordination with outpatient medical care, and teaches patients about healthy eating and physical activity patterns, along with tips as to how best fit them into their lives."[52] According to *Lifestyle Coach Training*, the point of the OLSS is to provide information, knowledge, and basic skills regarding physical activity and weight loss to participants in a way that allows for the integration of these into the specific attributes of their lives. Moreover, *Lifestyle Coach Training* argues, the role of the lifestyle coach is defined in terms of his or her relationship to the participant: "participants work closely with a lifestyle coach who should be skilled in behavioral intervention delivery."[53] These passages accomplish two goals, both of which manage the tension between paternalism and autonomy: (1) it places the onus on participants as the primary actors in managing lifestyle change, and (2) suggests that the participants' role is accomplished through close coordination with the coaches. In other words, by placing participants first in the sentence

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[49] This is in some ways akin to the process of constitution preceding persuasion outlined by Charland. See Charland, "Constitutive Rhetoric," 141 and throughout.

[50] On the importance of properly training medical professionals in their craft, see chapters 1-3.

[51] And, as Keränen points out, this *ethos* of medicine stands as a backdrop for further moments of constitution and "characterization." She suggests that individuals may then select various "personae" that they "voice" in an effort to individually take on the *ethos* of the practices they hope to embody and engage in, to literally become the embodiment and point of articulation for these practices. Lisa Keränen, *Scientific Characters,* 24-33.

[52] *Lifestyle Coach Training*, 1.

[53] *Lifestyle Coach Training*, 1.

and attributing responsibility to them, this passage suggests that the coaches are to provide support and guidance for participants in their effort to transform their own lifestyles.

As such, while the goal of the OLSS is to achieve lifestyle change, this change is made possible through the action of participants who are assisted (rather than paternalistically coerced) into making the changes they need to make to lose weight and manage their diabetes. *Lifestyle Coach Training* continues: "Coaches must be conscientious about delivering their advice in a timely manner, and alert for any signs of participant frustration, distress, or physical health issues that may influence appropriate dietary and physical activity goals."[54] Here, the coach is constituted as a catalyst for change as well as support structure for problem-solving. While participants must make changes to their lifestyles on their own (assisted by the coach), the coach may in fact intervene with advice, dialectically reinforcing the changes that the participant has chosen to make. Ideally, the participants have decided, based on their own health goals and life plans, that they need to change their diet and physical activity so as to achieve enhanced health. In all, these moves are suggestive of the tension between healthcare practitioners and their patients. What they point to is a patient-centered "partnership" rooted in the notion that the end outcome of lifestyle management should be autonomous changes made by the patient, not enforced by the coach; however, this does not release the coach from his or her responsibility to "guide" and reinforce such activities.[55] The language of the *Lifestyle Coaching Guide* provides

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[54] *Lifestyle Coach Training*, 1.

[55] On "partnership" with patients, see Thomas Bodenheimer, Kate Lorig, Halsted Holman, and Kevin Grumbach, "Patient Self-management of Chronic Disease in Primary Care," *Journal of the American Medical Association* 288 (2002): 2469. On "guiding," see Stephen Rollnick, William R. Miller, and Christopher C. Butler, *Motivational Interviewing in Health Care: Helping Patients Change Behavior* (New York: The Guilford Press, 2008), 7, 11 and throughout.

even more evidence of this by reminding coaches to offer "positive comment[s]", "compliment" and "encourage the participant," and "provide suggestions" to the participant.[56]

There are, of course, limits to this balancing act between paternalism and autonomy, expressed most clearly in the goals established for the DPP and emblazoned at the bottom of the first page of *Lifestyle Coach Training* in a bold text box. Here, *Lifestyle Coach Training* transitions into the rhetorical management of the simultaneously reinforcing and conflicting goals of promoting the health of the participants and engaging in sound research practices. The first principle in the text box has to do with establishing "Clearly defined study goals":

> All participants receive a study goal for weight loss and physical activity at the start of the intervention. Later, calorie goals are added as well. From the beginning of the intervention, you [lifestyle coaches] should state these goals without equivocation and set high expectations for achieving and maintaining them, in order to improve the participants' health."[57]

As with any health intervention, the primary goal of the healthcare practitioners involved is to improve the health of their patients. However, as the training of coaches in the OLSS is done in order to provide support for a clinical pilot study, there must be certain baselines for exercise, physical activity, and potential weight loss established. Without these, the intervention might not yield insight into the effectiveness of lifestyle change as a means to accomplish weight loss and manage co-morbidities. Given the parameters of the study within which *Lifestyle Coach Training* was prepared and continues to be developed, there is, therefore, a tension between on the one hand promoting autonomous action in the service of health and on the other achieving the research goals of the study. A similar tension exists for all practitioners and patients who participate in medical research (as opposed to normal clinical care). While one of the goals of this study (and innumerable others) is to promote the health of the participants, this goal is

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[56] *Lifestyle Coaching Guide* 2, 4, 8 and throughout.
[57] *Lifestyle Coach Training*, 1.

secondary to helping the much larger group of potential patients who might use the lifestyle program in the future if it is proven effective.[58] That some paternalism, here in the form of study goals, creeps into any medical intervention is a fact, one that cannot be wished away and that, at least in this document, is rigorously managed. What makes the management of the tensions between paternalism and autonomy on the one hand and the practitioner-research on the other more complex in the context of lifestyle management is that the goal is to constitute patients, through ongoing contact and counseling, as autonomous agents who can care for themselves. This idea is established in the second principle in the text box already mentioned, namely, "Participant Self-Management":

> Each participant makes personal choices about how to achieve the goals. This allows for flexibility and reinforces the ability of the participants to shape and evaluate their own progress by self-monitoring, developing personal goals and action plans, and problem solving. Your [the lifestyle coach] role is to guide and support the participants in self-management.[59]

Here, another extremely important constitutive and therapeutic tension emerges. The goal of the intervention is the constitution of patients who can care for themselves. For the study to effectively engage in research regarding the possibility of participant self-management, the study goals must be front and center in the interactions between coaches and participants; however, at the end of the protocol, the true test of effectiveness is whether the goals crafted by the researchers can be implemented by autonomous agents. As such, *Lifestyle Coach Training* provides a variety of cues to manage this tension, to encourage coaches to fulfill their professional obligations as researchers and health practitioners while also providing space for the

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[58] This is a central dilemma in 21st century clinical trials. On this dilemma and how it is managed by researcher-physicians, see Keränen, *Scientific Characters*, Introduction, Chapters 1-2. See also, Rebecca Dresser, *When Science Offers Salvation: Patient Advocacy and Research Ethics* (Oxford: Oxford University Press, 2001); Rebecca Skloot, *The Immoral Life of Henrietta Lacks* (New York: Crown Publishers, 2010).

[59] *Lifestyle Coach Training*, 1.

participants to develop lifestyle skills that are rooted in their own health goals and that they continue to exercise after completing the lifestyle curriculum.

There is no need to resolve these tensions here. Instead, the fact that these issues remain irresolvable points to the fact that the *paideia* established in the coaching protocol is itself revisable, rooted in the multiplicative contingencies of specific moments and particular needs. Paternalism and autonomy, the paradoxical identity-formation and practical activities of researchers engaged in the provision of care, are all permanent features of the medical arts and cannot be wished away through increased professionalization. In short, these tensions point to the *phronesis* inhering in medical practice (when done well) and the need for ongoing revision instead of unreflective reification of practices. As Kenneth Burke suggests, "People may be unfitted by being fit in an unfit fitness."[60] For this reason, *Lifestyle Coach Training* furnishes multiple opportunities for lifestyle coach trainees to investigate the competing demands of their role as well as the need to reinforce rather than enforce lifestyle change.

4.2.2 The *Kairotic* Imperative

In addition to the various role-based tensions described above, *Lifestyle Coach Training* also provides several arguments in favor of the time-bound and situated character of lifestyle coaching. For instance, *Lifestyle Coach Training* argues for the importance of "delivering . . . advice in a timely manner" indicating the situated nature of the advice to be given, a crucial element in the story I have been telling about *phronesis* throughout this dissertation.[61] In order for the deliberative function of *phronesis* to work in the way that Aristotle envisions, it is

[60] Kenneth Burke, *Permanence and Change: An Anatomy of Purpose*, 3rd ed. (Berkeley: University of California Press, 1984), 10.

[61] *Lifestyle Coach Training*, 1.

necessary for *phronimoi* to engage in situated rhetorical acts, to make decisions rooted in time and for particular purposes. The ancient Greek notion of *kairos* (timeliness) sums up this time-bound character of rhetoric.[62] In his landmark essay on Sophistic rhetoric, John Poulakos notes, "Clearly the notion of *kairos* points out that speech exists in time; but more important, it constitutes a prompting toward speaking and a criterion of the value of speech. In short, *kairos* dictates that what is said must be said at the right time."[63] In other words, rhetoric is rooted in the moment that calls it forth. Ideally, there is a match between the skills of the rhetor (knowing the right moment) and the actual existence of this moment in time (and likewise, the skills of the practitioner and the needs of the patient). *Kairos* may also be used to judge the rhetorical acts utilized by practitioners to address such moments. As Steven Schwarze points out, "the basis for critical judgment is better cast in terms of *kairos*: to what extent does a particular rhetorical intervention operate as a timely and opportune response to contingent circumstances and particular audiences?"[64] This temporal dimension of judgment, so central to rhetorical and deliberative skill, has not been emphasized enough in the literature surrounding *phronesis*, and yet it points to an important critical function needed for action and central to understanding how particular situations are *particularized* – through the ongoing march of time, wrecking havoc on our ability to engage the same way in every instances. Further, *kairos* plays a constitutive role in that it highlights material and symbolic resources, rooted in a particular moment, that the rhetorically savvy practitioner might use to constitute their own rhetorical activities. Ultimately, the delivery of timely advice to participants, mentioned several times in *Lifestyle Coach*

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[62] For one of the most substantial contributions, see Phillip Sipiora and James S. Baumlin, eds., *Rhetoric and Kairos: Essays in History, Theory, and Praxis* (Albany: University of New York Press, 2002).

[63] John Poulakos, "Toward A Sophistic Definition of Rhetoric," *Philosophy and Rhetoric* 16, no. 1 (1983): 40-41.

[64] Steven Schwarze, "Environmental Melodrama," *Quarterly Journal of Speech* 92, no. 3 (2006): 257.

Training, is in keeping with the goals of the lifestyle change practitioner, to provide help and support, to balance between the goals of health and wellness and the particular needs of the participant in question.[65]

In particular, *Lifestyle Coach Training* suggests that "coaches should monitor participants in a time-frame that is appropriate for their underlying health and safety concerns."[66] The terms "time-frame" and "appropriate" in this passage point to the crucial status of time in the creation and delivery of health care messages.[67] According to *Lifestyle Coach Training*, if coaching notes are not delivered in a timely way, in response to the needs of the participants at that moment in time, then they may lose their therapeutic, constitutive, and suasive affect. Participants in the OLSS are in the process of (re)constituting their lives and they are, according to *Lifestyle Coach Training* and the OLSS lesson plan, on a schedule. Interrupting this schedule or crafting untimely messages may have negative consequences for the participant as well as the relational and cooperative interaction between participants and coaches.

In addition, "tailoring lifestyle coaching to an online setting," requires some attention to time.[68] Coaching notes are provided on a timed schedule but also in response to specific queries; however, they are sent asynchronously. That is, participants may receive feedback but it is not

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[65] This is something achieved in the *Lifestyle Coaching Guide* which provides lessons and specific advice.

[66] *Lifestyle Coach Training*, 2.

[67] *Lifestyle Coach Training*, 2. Contemporary scholars working to understand the Hippocratic approach to medicine have noted that rhetoric and medicine draw on the concept of kairos in similar ways: Adam D. Roth, "Reciprocal Influences between Rhetoric and Medicine in Ancient Greece" (PhD diss., University of Iowa, 2008), 86-91. Also see (cited by Roth), Catherine R. Eskin, "Hippocrates, Kairos, and Writing in the Sciences," *Rhetoric and Kairos*, 97-113. In addition, Judy Z. Segal notes that "as rhetoric is plastic, there is a medical rhetoric of the moment that both responds to and helps to materialize a new sort of patient and a new relation between patient and physician." She names her approach to studying this "rhetoric of the moment" in medicine "A Kairology of Biomedicine." Judy Z. Segal, *Health and the Rhetoric of Medicine* (Carbondale: Southern Illinois University Press, 2005), 28, 21-36.

[68] *Lifestyle Coach Training*, 5.

instantaneous. This makes the issue of *kairos* all the more complicated for online (as opposed to live) lifestyle coaches because they cannot respond to the questions and problems of participants in the moment they are being experienced. Alternatively, the online environment collapses the spatial division between the participant and lifestyle coach thereby increasing accessibility and reducing the turn-around time for feedback (imagine waiting for a scheduled meeting rather than simply emailing your healthcare provider for feedback). All of this is to say that *kairos* directly relates to the problem of online coaching and to providing coaching notes to participants in a way that is therapeutically sound.

In short, the role of *kairos* in the coaching protocol provides an additional layer of evidence to support my claim that the constitutive rhetorics involved here are rooted in *phronesis*. There is no attempt to hold to principles unreflectively or to approach each participant in the same exact way. Of course, the study goals and the well-established practices of lifestyle coaching are not simply erased in each moment but are rather particularized. Therefore, one could argue that the ideological presuppositions of medicine are reified in each passing moment, for each coach and each participant. On the other hand, embracing the constitutive role of *kairos* in calling forth particular kinds of rhetorical work, suggests that constitutive rhetorics are themselves revisable through the kinds of reflection that only experience provides. That the coaching protocol attunes the OLSS lifestyle coaches to these sorts of experiences and provides them with interpretive and inventional tools to deal with them indicates the extent to which lifestyle management itself is not a fundamentally paternalistic process. Instead, according to the protocol, coaches should engage in co-constructing timely solutions in partnership with the participants.

4.2.3 Negotiating Between the General and the Particular

In addition to the problem of time, *Lifestyle Coach Training* also manages the issue of moving between general and specific forms of advice with participants, especially when crafting notes. For this reason, *Lifestyle Coach Training* argues that writing coaching notes requires knowledge of the most important topics needed to achieve productive lifestyle change, or, more to the point, therapeutically and rhetorically inspire such changes. Of course, knowledge of relevant and general topics is a critical element in rhetorical invention (chapter 2). Throughout his corpus, Aristotle suggests that one of the most important elements of a sound rhetorical education involves learning the topics needed to invent suasive discourse for a particular audience.[69] Aristotle's system includes many topics, most importantly, as Sharon Crowley and Debra Hawhee point out, the "common topics" or "*koina*" and the "special topics" or "*eide.*"[70] The *koina* allow rhetors to deal with the general features of rhetorical production, the kinds of issues that recur over and over again and are so general that they may be of very little assistance in particular moments other than to point in the direction of a structure for argument.[71] The *eide* or specific topics are rooted in particular kinds of obligations and activities, such as "war-making."[72] As Crowley and Hawhee point out, "one who would discuss war and peace, for example, must be able to assess the strength of his country's defenses and that of supposed enemies; must know the history of relations between the two countries; and must study the war-

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[69] See the numerous discussions of the use of "topics" in his *Rhetoric* and *Topica*. As Aristotle notes in his *Topica*, "The purpose of the present treatise is to discover a method by which we shall be able to reason from generally accepted opinions about any problem set before us and shall ourselves, when sustaining an argument, avoid saying anything self-contradictory." *Topica* I.i.1.

[70] Sharon Crowley and Debra Hawhee, *Ancient Rhetorics for Contemporary Students*, 4th ed. (New York: Pearson/Longman, 2009), 120.

[71] For several examples, including "Whether a thing has (or has not) occurred or will (or will not) occur)," as well as the traditional genres of epideictic, forensic, and deliberative, see Crowley and Hawhee, *Ancient Rhetorics*, 119-120.

[72] Crowley and Hawhee, *Ancient Rhetorics*, 121.

making capabilities of [others]."[73] The same is true for any sort of rhetorical practice, even the kind of invention involved in crafting notes in response to participant needs in the context of lifestyle management.

For Aristotle, the knowledge of the various topics relevant to a particular rhetorical act is important to robust conception of *phroensis*; however, knowledge of these topics provides only limited guidance. As Schwarze points out, "Often articulated as a concern with 'the general and the specific' or 'the rule and the case,' Aristotle's distinction suggests that something about the realm of the practical [*phronesis*] precludes easy subsumption of a particular case under a universal rule."[74] Aristotle puts very little purchase in the knowledge of general rules or principles for the activities of the *phronimos*; however, he does not deny that they play a role in the interpretive process. To do so would render reflection moot as individuals would simply engage in the ongoing apperception of the particular case without reference to anything else, rendering any kind of consistency or predictability impossible. Accordingly, *phronesis* involves uncovering the various layers of a rhetorical situation – what issues are at hand? What kinds of information will be needed ready-to-hand in order to deal with the situation in question? These issues ultimately reveal the connection between rhetoric and *phronesis*. Knowing what to talk about is central to rhetorical invention while knowing how to appropriately craft this "what" into a message that deals with the relevant content and knowledge (either theoretical or experiential) is central to *phronesis*.

This insight has not been lost on the authors of *Lifestyle Coach Training*. According to *Lifestyle Coach Training*, there are several "topics" common to the creation of a scheduled note

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[73] Crowley and Hawhee, *Ancient Rhetorics*, 121.

[74] Steve Schwarze, "Performing *Phronesis*: The Case of Isocrates' *Helen*," *Philosophy and Rhetoric* 32, no. 1 (1999): 82.

or a note that is written with the express purpose of catching up with the participant and checking in on their status: "1. Overall Progress," "2. Lesson Completion Status," "3. Action Plan and Worksheet Statements," "4. Tracking Status," "5. Fat Consumption," "6. Calorie Consumption," "7. Physical Activity Level," and "8. Any Other Open Issues."[75] That these topics are listed indicates the extent to which the crafting of scheduled notes is rooted in a concern for the ongoing effectiveness of the intervention and the tracking of participant progress, all of which contributes to the timeliness of the feedback offered here as well as keying coaches into the problems that participants might be having.

Moreover, given that online lifestyle coaching is an emergent professional activity, the authors of the protocol have seen fit to engage in the cultivation of a set of principles that should be followed in the construction of notes on any of the topics listed in the previous paragraph (as well as unscheduled notes in which the coach is dealing with the particular problems of an individual participant). These principles are *eide* of a sort. They act as "*maxims*" or "precepts, proverbs, famous sayings, epigrammatic pronouncements, self-evident truths, sententious generalizations – all kinds of charismatic statements that people introduce into an argument."[76] These maxims, called "practical tips" in *Lifestyle Coach Training*, can be seen as a kind of *Hippocratic Oath* suited for lifestyle coaches.[77] They act as a constitutive "oath," a set of obligations in need of particularization, as well as a therapeutic construct for the cultivation of the right *ethos* in the context of lifestyle coaching. They are sententious and normative, but also

[75] *Lifestyle Coach Training*, 5.
[76] Edward P. J. Corbett and Robert J. Connors, *Classical Rhetoric for the Modern Student*, 4th ed. (New York: Oxford University Press, 1999), 116.
[77] *Lifestyle Coach Training*, 4.

general and vague, allowing for the interpretation and application of them in particular moments:[78]

Tip 1 – "Express support & acceptance for the participant regardless of their progress toward their lifestyle goals."[79] This tip indicates the importance of building rapport with the patient. Building such rapport is closely associated with the conception of *ethos* glossed in the previous section. By not blaming the patient and by showing an awareness of their current condition without judging them, the coach shows kindness, builds credibility, and solidifies their relationship with the patient. This is an important element of rhetorical training. Contemporary rhetorical theorists are now well aware of the need to build cooperative and even intimate relationships between interlocutors in order to produce sustained persuasion and behavioral changes.[80]

Tip 2 – "Look for success & build on it, no matter how small or gradual." This tip largely reaffirms the first. It indicates that recognition of even small successes for the patient can yield positive dividends in the long run. Such recognition builds on the notions of support and autonomy developed in the first tip.

Tip 3 – "Maintain the highest standards and expectations." This is a crucial tip in that it shows a concern with the goals of medicine, originally defined in the *Hippocratic Oath* and later theorized for contemporary medicine by Edmund Pellegrino. Pellegrino suggests that the primary

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[78] That these principles might act as a sort of oath that allows for the cultivation of a particular *ethos* should come as no surprise. The foundational account of medical professionalism and ethics, *The Hippocratic Oath*, continues to play what has been called an "*epideictic*" role in the cultivation of the medical *ethos.* On the "*epideictic*" role of *The Hippocratic Oath* see Lisa Keränen, "The Hippocratic Oath as Epideictic Rhetoric: Reanimating Medicine's Past for Its Future," *Journal of Medical Humanities* 22, no. 1 (2001): 55-68.

[79] *Lifestyle Coach Training,* 4. All of the quotes in the remainder of this section are taken from page 4 of the document.

[80] Contemporary rhetorical theorist, Wayne Brockriede, suggests that rhetoric can be viewed in terms of varying relationships, one being that of the lover and the loved. When messages are crafted in such a way as to create comfort and a certain kind of intimacy between to interlocutors, the relationship is solidified and cooperative. See Wayne Brockriede, "Arguers as Lovers," *Philosophy and Rhetoric* 5, no. 1 (1972): 5-8.

goal of modern medicine is improving the quality of life of the patient: "The medical good aims at the return of physiological function of mind and body, the relief of pain and suffering by medication, surgical interventions, psychotherapy, etc."[81] On this interpretation, the goal of medicine is to provide a higher quality of life for the patient. Giving up, reducing our expectations, and remaining rooted only in the status quo of the patient's life and choices would fundamentally undermine this goal of medicine. The coaching protocol continues its discussion of this tip by suggesting that "expectations are often self-fulfilling. If expected to do poorly, participants are more likely to do poorly; if expected to do well, many will rise to the occasion." In other words, while the coaching protocol maintains that coaches should fit their advice to the patient, this does not mean that such fitness precludes changing the patient and their own expectations of success. There is a powerful ethical and rhetorical point being made here: if medicine completely conforms with the current beliefs and expectations of the individual and gives no care to potential transformations and changing contexts, then patient care may be seriously degraded.

Tip 4 – "Do not assume that a barrier to the study goals exists until it is evident (for example) that a participant who has a lower level of education will be unable to calculate fat grams when self-monitoring). Such assumptions are often based on hidden biases that may prove false." This tip brings up another set of rhetorical, ethical, and pedagogical concerns. First, it indicates that when we craft messages for the individual, we may sometimes assume certain things about them that are false. This is something health care professionals should work hard to avoid. Remaining open to the possibilities that lifestyle coaches have incorrectly understood the

[81] Edmund D. Pellegrino, "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions," *Journal of Medicine and Philosophy* 26, no. 6 (2001): 569. It is the case that Pellegrino limits his analysis to the clinical encounter rather than also including such circumstances as co-clinical or extra-clinical communication; however, for my purposes, the definition is applied to these broader contexts.

capacities of a patient shows concern for the changing dynamics of human communication. Second, it deals with the ethics of first impressions and filling in the goals, life plans, and mental capacities of patients. To do this is to allow our assumptions to affect the quality of care that is delivered. Third, it deals with the pedagogical problem of training educators to believe in the power of education to transform the student. The OLSS program was designed to challenge the barriers to weight loss and management, not reify them. This tip generates important insights for coaches in this regard as it prods them to continue the process of education, thereby revising what is possible for the patient in their weight management regimen.

Tip 5 – "Involve the participant as much as possible." This tip largely reaffirms the last and places emphasis on the role of the patient in his or her own care. It also indicates that experimentation on a daily basis is a necessary component of pedagogy: "evidence of a barrier is not a sign of failure on the part of the coach or the participant but rather is a valuable piece of information to be used to design and test a better experiment together." This advice also reaffirms the need for ongoing revision of the coach-patient interaction and of the methods of care being applied to the patient in their everyday experience of obesity and weight management.

Tip 6 – "Be the expert." This is an important caveat to the patient-centered approach being described above. It indicates that while there needs to be give-and-take between the coach and the patient, there is still a power imbalance in terms of knowledge. The OLSS is not designed to turn obese patients into experts but rather to activate them in their own care. Health professionals still have important knowledge that must remain part of the give-and-take communication they engage in with their patients. What is most important is the recognition that "information and behavioral strategies are included in the intervention because of their likelihood of enhancing achievement and maintenance of the goals, not as ends in themselves." This is a

crucial acknowledgement of the limits of information and of expert knowledge but a simultaneous acknowledgement of the importance of these things in the coach-patient relationship. Expertise must be translated and fitted to the needs of specific audiences and patients, a clearly ethical and rhetorical insight.

Tip 7 – "Tailor the intervention to participant lifestyle, learning style, and culture." This tip largely recapitulates many of the rhetorical, ethical, and pedagogical lessons I have detailed throughout this essay. It indicates a concern for the fitness of medical advice (to situation and patient), the need for patient autonomy, and the need to deal with different learning styles as part of any robust pedagogical encounter.

Finally, and as I shall point out in my analysis of interviews conducted with the CPDT and lifestyle coaches in the second half of this chapter, all of these tips act as aphorisms (in the Hippocratic style) based in experience and experimentation but providing key insights for the coach.[82] They provide a starting point for action but do not fill out the content of this action primarily because doing so would undermine the necessity of fitting advice to the particular needs of the participant. That is, each tip acts as a tool of invention, giving the coach a site at which to generate specific content for participants. They do not assume a mere training by rote but rather build on experiences developed during the initial pilot study in order to provide a context for coaching. However, it would do some good to remember Schwarze's warning that general principles are not easily translated into specific situations, that they can stand in the way of or in contrast with particular principles that drive the development and use of *phronesis*. The *Lifestyle Coaching Guide* recognizes this problem and suggests that: "The best coaching notes

[82] I have already discussed the aphoristic style of the Hippocratic writings as a means for translating and disseminating research findings in chapter 2. Here, I am suggesting that these tips act as aphorisms that then must be situated, explored, and engaged in particular situations. On the Hippocratic aphoristic style, see Joan Leach, "The Art of Medicine: Valuing Communication," *The Lancet* 373 (2009): 2104-2105.

are based on the coach's knowledge of and history with a participant. Feedback to the participant should be individualized and should be based on his or her workbook entries, comments, and level of program participation."[83] Managing this tension between the general and the particular is a key theme in the interviews and one that will help in the exploration of this central feature of Aristotle's theory of *phronesis*. Ultimately, the topics and maxims discussed here provide a map for action that is incomplete, that can only be read through experience. As such, they once again indicate the extent to which the *paideia* being developed here is itself revisable. Even in its constitutive moments, it calls forth *phronesis* as reflection, as the following section explores in further detail.

4.2.4 A Framework for the Cultivation of a Healthy *Paideia*

Lifestyle Coach Training ends on a note that brings *phronesis* front and center, one rooted in the instability, revisability, and contextuality of rhetorical practice: "The contents of these training materials are meant as general guidelines. Specific advice must be tailored to the health and safety concerns of each individual participant."[84] This statement provides an interpretive inflection point in the overall protocol that opens the door to individualized development and constitution. This rhetoric of individualization and particularity is, as Martha Nussbaum notes, central to Aristotle's conception of reasoning. She argues that he thoroughly rejects "pseudo-scientific pictures of rationality" and harbors distaste for "the insistence that rational choice can be captured in a system of general rules or principles which can then simply be applied to each

[83] *Lifestyle Coaching Guide*, 1.
[84] *Lifestyle Coach Training*, 7.

new case."[85] Nussbaum continues with Aristotle's alternative: "Aristotle's defense of the priority of 'perception,' together with his insistence that practical wisdom cannot be a systematic science concerned throughout with universal and general principles, is evidently a defense of the priority of concrete situational judgments of a more informal and intuitive kind to any such system."[86] These Aristotelian insights point to the paradox implied by the term "framework" in my title. Despite this potential paradox, one can also read this line as an attempt to manage the relationship between generalized knowledge and particularity, to appreciate both as constitutive features in the production of lifestyle change as *paideia*.

Furthermore, *Lifestyle Coach Training* provides not only this sentiment in favor of particularity but also a method for achieving it. This method involves professional communication and collaboration of a sort that harkens back to my discussion of rhetoric as "a productive architectonic art" in chapter 2, particularly in terms of the role of rhetoric in suturing various types of expertise and disciplinary distinctiveness into a team capable of synergized activity.[87] *Lifestyle Coach Training* suggests,

> A coaching team should have access to people with expertise in nutrition, exercise physiology and behavioral medicine, as well as a physician. The coach should be a health professional with skill in making clinical decisions. The behavioral medicine specialist should provide oversight as needed to ensure that coaching practices adhere to the recommendations in this document. Coaches should monitor participants in a time-frame that is appropriate for their underlying health and safety concerns. The team's physicians should contribute input on the appropriate monitoring interval.[88]

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[85] Martha C. Nussbaum, "The Discernment of Perception: an Aristotelian Conception of Private and Public Rationality," in her *Love's Knowledge: Essays on Philosophy and Literature* (New York: Oxford University Press, 1990), 66.

[86] Nussbaum, "The Discernment of Perception," 66.

[87] Richard McKeon, "The Uses of Rhetoric in a Technological Age: Architectonic Productive Arts," In *The Prospect of Rhetoric: Report of the National Developmental Project*, edited by Lloyd F. Bitzer and Edwin Black (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1971), 48.

[88] *Lifestyle Coach Training*, 2.

This passage pursues collaborative knowledge production so as to promote the overall health and well being of participants. In the case of this protocol, the mechanisms through which such collaboration might occur are not spelled out. The team is left to synergize its activities without a map for how the rhetorical attributes of this synergy (deliberation, dialogue, discussion, and ultimately problem-solving and decision-making) are to be achieved. This may be a missed opportunity, one that, according to my work in chapter 2, requires attention in future iterations of the OLSS and any efforts to coordinate teams of professionals in the care of patients. Put simply, the protocol provides extensive guidance on how to engage with participants but leaves the substance of professional communication nearly untouched. However, the interviews I conducted with the CPDT and lifestyle coaches in the OLSS provide extensive detail on this point, filling in this gap and suggesting ways in which the protocol might be enhanced in the future.

Finally, throughout the coaching protocol, I have uncovered multiple layers of constitution, multiple rhetorical moments through which lifestyle coaches are rhetorically crafted. Through appeals to the background *ethos* of scientific method, coaches are attuned to their role as specialists and healthcare practitioners. Through multiple attempts to manage the dialectical tension between patient autonomy and paternalism, *Lifestyle Coach Training* suggests that the constitutive and therapeutic rhetorics deployed in the *paideia* surrounding lifestyle change are wrought with risk and instability. Constant renegotiation and balancing must occur throughout the co-constitutive process of lifestyle management. At multiple points, *Lifestyle Coach Training* utilizes the ancient conception of *kairos* to describe how particular situations and moments in time constitute the goals and activities of participants and lifestyle coaches. Finally, the topics, maxims, and principles of enshrined in *Lifestyle Coach Training* provide general constitutive features that inform action but that must be inflected through experience and

situational constraints if they are to be used effectively. All of this suggests that here we have a reflective constitutive process, one rooted in experience and open to renegotiation. In simple terms, we have the beginnings of an alternative to the ideological model of constitution proffered by Charland. While one may argue that the ideological commitments of medicine and healthcare inhere in all of the constitutive acts enumerated above, I argue that the force of these ideological commitments is rendered soft by the concern with renegotiation and reflection. I now turn to the experiences of the coaches in articulating, engaging in, and revising this process.

4.3 THE COACHES SPEAK: RHETORICAL ELEMENTS OF LIFESTYLE PEDAGOGY

4.3.1 The Interview Process

In the summer of 2010, in preparation for the completion of this chapter, I submitted a project to the University of Pittsburgh's Institutional Review Board (IRB) titled "Development of the Coaching Protocol for the [OLSS]."[89] The findings of this research project are presented in this section. The project was designed to provide me with grounded and experiential content in the form of interviews with individuals who worked on the production of the OLSS coaching protocol including members of the Coaching Protocol Development Team (CPDT) and lifestyle coaches.[90] The project proposal included two sets of questions (one for lifestyle coaches and the

[89] It was submitted for exempt review and received approval from the IRB. University of Pittsburgh IRB # PRO10060173.

[90] Following Bent Flyvbjerg's conception as described in chapter 1, this project was the beginning of my effort to cultivate an approach rooted in the experiences of practitioners becoming experts. Bent Flyvbjerg, *Making*

other for members of the CPDT) aimed at deciphering the meaning of lifestyle coaching, the various practices involved in effectively engaging in lifestyle coaching, the role of Lifestyle Coach Training and the Lifestyle Coaching Guide in the OLSS pilot study (in particular, how the coaches used these documents and how the documents were developed in the first place), and the problems of moving lifestyle coaching online (Table 1). My investigation of each of these issues in dialogue with the interviewees provides a textured map of the experiences of those who participated in the OLSS pilot study.[91] As such the interviews and their analysis below form an experiential account of the documents examined in the first half of this chapter. In addition, they provide a grounded context through which to recover some of the rhetorical, dialectical, and deliberative processes utilized in the cultivation of lifestyle coaching for this study.

Table 1. Interview Questions by Category (Lifestyle Coaching)

Interview Questions (Lifestyle Coaches)	**Interview Questions (Coaching Protocol Development Team)**
• How would you define the role of the lifestyle coach in the [OLSS] program? • As a lifestyle coach, what are the greatest challenges you faced in adapting your face-to-face counseling skills to an online setting? • When did you first become aware of the need for a lifestyle coaching protocol as part of the [OLSS] pilot study and what was the catalyst for this awareness? • How was the coaching protocol prepared and made available to you?	• How would you characterize the process of changing and adapting the lifestyle protocol through its different iterations? • Why is lifestyle coaching important? • Why did you decide you need a lifestyle coaching protocol? • How did the protocol change over time? • What were the key pieces of advice you were trying to convey to the coaches?

Social Science Matter: Why Social Inquiry Fails and How It Can Succeed Again (Cambridge: Cambridge University Press, 2001), 129-140.

[91] In a couple of cases, interviewees were part of the second iteration of the OLSS study. As the coaching protocol remained consistent (at least in design), this is not something that I believe would hinder their insights into this process or make them any less relevant to the task of this chapter.

Table 1 (continued).

• Did you play a role in the development of the coaching protocol? If so, what was this role and what was the nature of your contribution? • How did you integrate the coaching tips and guidelines into your own coaching practices? • What did you think about the presentation of the coaching protocol? Was the method of training effective in your mind? If so, why? If not, why not? • What are the most important elements of the coaching protocol for you? What are the least important? • If you were to add anything to the coaching protocol to aid future lifestyle coaches, what would it be? • How did the coaching instructions and your discussions with the [OLSS] investigators about how to structure lifestyle coaching contribute to your development as a lifestyle coach in the [OLSS] pilot study? • As the [OLSS] research has evolved, how has your perception of the lifestyle coaching task and your approach to coaching challenges changed over time? • Is there anything else you would like to add?	• In what way did the coaches help in the development of the coaching protocol created for the [OLSS] pilot study, if at all? • What, if any, pedagogical theories or practices were consulted during the creation of the coaching protocol for the [OLSS] pilot study? • How would you define the role of the lifestyle coach in the [OLSS] program? • Who should be involved in training future lifestyle coaches for the program? • How are lifestyle coaches selected for participation in [OLSS] research? • What changes would you consider making, if any, to the current coaching protocol for future [OLSS] studies and/or programs? • Is there anything else you would like to add?

The interviews analyzed in this chapter were conducted in the fall of 2010.[92] Three lifestyle coaches and two members of the CPDT agreed to take part.[93] Each individual was informed about the goals of the interview study, apprised that specific identifying information about them would be omitted from any published materials, and asked if they wanted to proceed (Appendix A). As mentioned above, two sets of questions were developed aimed at dealing with any experiential differences between the coaches and the CPDT. While I used the same questions

[92] The principal investigator (PI) of the OLSS pilot study, Kathleen M. McTigue, graciously provided access to conference rooms at McKee Place for the interviewees and put me in touch with potential interviewees.

[93] During the interviewee recruitment process, I determined that it might be easier to expand my search to include lifestyle coaches who were hired to work on the OLSS's second iteration as some of the original coaches were not available. I completed a modification to the project described above and received approval from the IRB on September 29, 2010.

as a backdrop in each set of interviews, I at times moved beyond the scripted questions in order to probe individual interviewees regarding answers that seemed to move in fruitful directions. Given that the interviewees must remain anonymous (aside from the fact that they took part in this study as coaches or members of the CPDT) I refer to them as respondents (in general), coaches, or CPDT members throughout this chapter. Any information provided by the interviewees that might provide clues as to their specific identity or the identities of the individuals they are speaking about have also been omitted. The interviews lasted between 20 and 40 minutes, generating over thirty-eight pages of single-spaced, standard-format text.[94]

The following analysis of the interviews is grounded in the words of the interviewees. Over the course of reading and thematically mapping the interviews in the fall of 2011 and spring of 2012, I developed four overarching themes (and a variety of sub-themes), all of which emerged from the rhetorical and narrative choices of the interviewees discovered through my strategy of close reading as described in chapter 1 (Table 2).[95] These four areas, although grounded within and emergent from the text of the interviews are also related to critical themes that have already come up throughout this dissertation, in particular, the role of dialectic in the formation of *paideia*, the notion of collaboratively developed knowledge that transcends *techne* and *episteme*, the notion that *phronesis* is rooted in "the priority of the particular," and the problem of moving rhetorical and dialectical therapeutic practices online (with associated

[94] The interviews were recorded by me and transcribed by a research assistant, Jeffrey Kurr, who was reimbursed through funds generously provided by the ICRE/CTSI fellowship and mentioned in the acknowledgements of this dissertation. The author retains full transcripts of these interviews.

[95] Kenneth Burke, "The Philosophy of Literary Form," in *The Philosophy of Literary Form: Studies in Symbolic Action*, 3rd ed. (Berkeley: University of California Press, 1973), 1-137; Martin J. Medhurst, "Eisenhower's 'Atoms for Peace' speech: A case study in the strategic use of language," *Communication Monographs* 54 (1987): 204-220; Bent Flyvbjerg, *Making Social Science Matter*.

questions regarding invention and tone).[96] As such, my analysis here moves forward from the critical work done earlier adding quality and substance, a more fully formed yet still granular vocabulary, and an overall picture of lifestyle management situated somewhere between theory and practice. In this way, the interviewees provide a context for dialectically and collaboratively producing knowledge about the fabric of chronic care in the context of delivering lifestyle management tools to diabetic and overweight patients.[97]

Table 2. Interview Sub-Theme Map (Lifestyle Coaching)

Themes	**Sub-Themes**
Dialectical Engagement	Dialectic *Paideia* Guide/Guiding The Coach as Professional *Phronesis* Encouraging Supporting Confidence Knowledge Expertise Non-Judgmental Information Reinforcement Reflecting Back Steering *Eudaimonia* Tailoring Motivation Avoiding the Negative Spiral

[96] Martha C. Nussbaum, "The Discernment of Perception," 66. I was made aware of Nussbaum's language here by Bent Flyvbjerg who discusses "the priority of the particular" in his work. See Flyvbjerg, *Making Social Science Matter*, 57-60. Of course, her language matches with other discussions of *phronesis*, notably by Sara Rubinelli, Peter J. Schulz, and Kent Nakamoto, "Health Literacy Beyond Knowledge and Behaviour: Letting the Patient Be a Patient," *International Journal of Public Health* 54 (2009): 307-311.

[97] Further, I believe that these insights provide tools that may be of use beyond the immediate context of lifestyle change, providing a map for best practices, understood rhetorically and pedagogically, in healthcare overall.

Table 2 (continued).

Collaborative Knowledge Production	Roadblocks Standardization Weight Plateaus Interdisciplinarity Meetings Ad Hoc Feedback Patient feedback Filling in Gaps Collaboration Avoiding Fear of Change Avoiding Assumptions Addressing Inactivity Replicability Avoiding Starting from Scratch Action
Moving Lifestyle Coaching Online	The Newness of the Online Environment Invention Tone Technical Breakdowns The Problem of Rapport The Importance of Wording Rigorous Revision
"The Priority of the Particular"	Coaches as Liaisons Dialectic General vs. Particular Ramping Up Intensive and Experiential Training Protocol as Evolving Document *Kairos* Topic Selection

Before moving into my analysis, I offer a brief assessment of the limitations of my approach as well as the strategy of presentation I have selected. The primary limitation of the following analysis is the number of interviewees. I cannot say that five interviews are sufficient to understand all of the elements of contemporary lifestyle coaching. The knowledge generated from these interviews is necessarily contingent. However, my goal is not to provide the final epistemic and technical certainties for the effective use of lifestyle coaching. Instead, what I

provide is a situated account of lifestyle coaching, one that can give us insights into the process that, when shared with the work of others, may yield rhetorical insights with implications for practice. In addition, as these interviews deal with the rather novel problem of lifestyle coaching online, they contribute critical information and insight into a new process that has not been around long enough to study sufficiently. As such, the interviews provide material that may help set the agenda for future research into online lifestyle coaching.[98] Finally, I see this project and my analysis as one that can shed unique, highly textured, and substantive insights into the workings of lifestyle coaching, insights that would not be possible with a larger cohort of interviewees but can only be achieved through careful attention to the particular insights of this small group of coaches and developers.[99]

4.3.2 Dialectical *Paideia*: The Lifestyle Coach as 'Guide'

> *There's a difference between knowing something and doing it. I think what our coaches are there to do, or what we hope to do with people with coaching is to coax them . . . We're sort of pushing them along to say . . . , 'We're not just thinking about this. We're not just desiring a change. We're doing it and we're feeling successful.'* -- CPDT Member

Lifestyle change is a difficult thing to accomplish. There are gaps that exist between what we know we want to do, what we know we should do, and then actually doing it.[100] Aristotle's conception of *phronesis,* in all its various iterations across times and disciplines, addresses these gaps between knowing and doing. In this vein, Hannah Arendt has declared that we must "think what we are doing" in an effort to move human social development away from mechanistic and

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[98] On the problems and possibilities of the currently limited amount of research on this topic, see Kathleen M. McTigue, Molly B. Conroy, Rachel Hess, Cindy L. Bryce, Anthony B. Fiorillo, Gary S. Fischer, N. Carole Milas, and Laurey Simkin-Silverman, "Using the Internet to Translate an Evidence-based Lifestyle Intervention into Practice," *Telemedicine & eHealth* 15, no. 9 (2009): 852.

[99] Flyvbjerg, *Making Social Science Matter,* 129-140.

[100] Rubinellis, Schulz, and Nakamoto, "Health Literacy," 309.

behaviorist notions of activity and toward a more philosophically rich and practically grounded sense of what it means to live as a human being.[101] The words quoted at the outset of this section regarding the meaning and content of lifestyle coaching are attuned to this perennial problem. Moving from thinking to doing, from understanding to practice, is something not only faced by the participants in the OLSS but, as we shall see, the coaches themselves. Thus, these words stand at the outset of this section because they point to the central problem facing lifestyle coaches in the pursuit of action rooted in knowledge.

The respondents speak about this problem in various ways, giving it a variety of inflections. What I have called "dialectical *paideia*" in the title of this section is meant to attune the reader to the problem of coaching individuals (*paideia*) in becoming something new, in (re)constituting themselves as beings that can effectively lose weight and regain health. By combining dialectic and *paideia* here, I mean to point us in the direction of the respondents' comments, primarily toward a notion of pedagogy rooted in the back-and-forth questioning and steering that can be found in Plato's dialogues and in the figure of the teacher, Socrates. One of Socrates' Roman descendants, the great Stoic philosopher Epictetus adopted his dialectical method and formed a kind of philosophical training based on it that he calls *elenchus*. On his *elentic* method, Epictetus writes,

> (4) The person who can show an individual the conflict responsible for his error and clearly make him see how he is not doing what he wants to do and is doing what he does not want to do -- that is the person who combines expertise in

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[101] Hannah Arendt, *The Human Condition* (Chicago: The University of Chicago Press, 1958), 5. Joseph Dunne rightly places Arendt within the tradition of *phronesis*, in particular because of her rejection of *techne* as a metaphor for human work and labor. See Dunne, *Back to the Rough Ground*, 89-103. Others have taken up this call as well, including Hubert L. Dreyfus and Stuart E. Dreyfus and their theory of expertise and Kenneth Burke whose corpus attempts to deal with questions of motivation, change, and the knowledge-action gap. On expertise, see Hubert L. Dreyfus and Stuart E. Dreyfus, *Mind Over Machine: The Power of Human Intuition and Expertise in the Era of the Computer* (New York: The Free Press, 1986). On Kenneth Burke's theory of human motivation (as opposed to behavioristic action) see his *A Grammar of Motives* (New York: Prentice-Hall, Inc., 1952), esp. 64-69; Kenneth Burke, "(Nonsymbolic) Motion/(Symbolic) Action," *Critical Inquiry* 4, no. 4 (1978): 809-838.

> argument, exhortation [*protreptikos*], and refutation [*elenktikos*]. (5) For if a person can show this, the erring individual will concede of his own accord; but as long as you fail to show it, don't be surprised if the other persists, because he is acting under the impression that he is right.[102]

In other words, Epictetus' understanding of Socratic dialectic as *elenchus*, as a form of *paideia* is rooted in the ongoing, at times agonistic, relationship between teachers and students through which error is revealed over time. Only through such challenges from an interlocutor can change occur. As A. A. Long suggests in his extensive study of Epictetus,

> I have already noted the importance Epictetus attaches to the Socratic injunction on the worthlessness of living an 'unexamined life'. Both in Plato and in Epictetus *elenctic* discussion is a methodology that gets its participants to examine their beliefs by exposing unrecognized inconsistencies and involuntary ignorance. Plato's Socrates regularly asks his opinionated interlocutors to answer questions about `what' some moral concept (piety or courage, for instance) `is', with a view to subjecting their responses to *elenctic* examination.[103]

This form of "*elentic* examination" in Epictetus' works, modeled on the Socratic writings, is rooted in the effort to challenge the wrong opinions, errors in thinking, problematic habituations and the like that get in the way of *eudaimonia*. As such, it is focused on removing or resolving "antecedent *paideia*" or those elements of thinking and doing that stand in the way of the fulfilling life.[104] The rest of this section unpacks the dialectical *paideia*, this *elenchus*, through two inflection points in the narratives of the interviewees: (1) the coach as "*guide*", and (2) the role of the lifestyle coach as a distinct form of professional practice.

Many of the respondents describe the role of the lifestyle coach as a form of "guiding," a method for encouraging action by the participants, and a way to keep the participants on track.[105]

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[102] Epictetus, *Discourses*, 2.26.4-5. As qtd. and trans. by A. A. Long in his *Epictetus: A Stoic and Socratic Guide to Life* (Oxford: Clarendon Press, 2002), 74.

[103] Long, *Epictetus*, 84.

[104] Nussbaum, *The Therapy of Desire*, 97.

[105] As lifestyle coaching is rooted in the ongoing discussion with and counseling of patients, the CPDT relied on the strategies that have been developed under the general heading of motivational interviewing (MI). As one research cohort suggests, MI involves the related skills of "asking, listening, and informing" all in the exercise

Using a variety of related terms, including "guiding," "encouraging," "supporting" and the like, the interviewees point to the general features of an approach to lifestyle coaching that is aimed at achieving *paideia* and combating "antecedent *paideia*."[106] For example, one lifestyle coach suggests that,

> *I would say that, first and foremost, [lifestyle coaches] have to engage the participants. After engaging the participants, they have the ... confidence and knowledge, expertise . . . Lifestyle coaching is a broad term, so . . . understanding folk's behavior enough to help in terms of motivating, following through, supporting, those kind of things . . . it is non-judgmental.*

Engaging and motivating are central elements of this coach's conception of lifestyle coaching. In accomplishing these tasks, this coach lists several important skills. The cluster of terms "confidence, knowledge, expertise" suggests that lifestyle coaching is, after all, a professional practice. In addition, the choice of the word "expertise" here hearkens back to one of the key tips offered in Lifestyle Coach Training: "Be The Expert."[107] Here, this respondent is constituted as a coach through language, providing details as to the constitutive move underway in to form of a claim to *ethos*, to professional credibility. This coach discusses expertise in the context of developing relationships with study participants. Expertise is posed as part of this dialectical partnership and as central to its success. In addition, this coach argues that lifestyle coaching must not become "judgmental" indicating that the role of the coach is not to stand in judgment and dole out punishment but rather to act as a professional, one with knowledge and expertise, but not with deeply "asymmetrical" power vis a vis the participants.[108]

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of "guiding" patients toward change. On the basic elements of "motivational interviewing" see Rollnick, Miller, and Butler, *Motivational Interviewing in Health Care*. On the terms used above, see 7 and 11 in particular.

[106] Nussbaum, *The Therapy of Desire*, 97.

[107] Lifestyle Coach Training, 4.

[108] On "asymmetry" in the teacher/student or doctor/patient relationship, see Nussbaum, *The Therapy of Desire*, 27.

In addition, another coach provides a complex picture of the process of lifestyle coaching and a set of cognate terms that point to the various activities it involves. This coach begins with the metaphor that stands at the heart of the interviews for describing the activities of lifestyle coaches, that of the guide:

> *I think of myself as somebody who is a guide. I offer support, I certainly offer information, encouragement, reinforcement. I'm somebody who reflects what somebody has shared with me to help them learn to move towards healthier lifestyle behaviors. And, of course, I function somewhat as an expert . . . [The process is] Educational, but also very much support, encouragement. I listen, I sympathize, I empathize when its appropriate and fits in um so to motivate them, to continue, hopefully retain them for the study but also for their own purposes and needs . . . I would say its more than just educating.*

These words should key us into a tension that exists in the role of the lifestyle coach. The terms "support", "information", "encouragement", and "reinforcement" as well as the notion of reflecting back on the words of another all fit within the dialectical model of coaching. In a sense, these terms figure the coach as a sounding board for the ideas, problems, and concerns of the participants. But the coach is also an active agent, one who interprets these and offers guidance in response. The comments discussed in the last two paragraphs point out that coaches are experts and their expertise is essential to the success of the participants no matter how much situational translation and reflection takes place.

A CPDT member continues this line of thinking, fully articulating a conception of the lifestyle coach as professional:

> *I mean we just want coaches to be ... we want them to be accurate, we want them to give people, ... as I've said there's so much bad information floating out around there. We'd like them to give people really concrete factual good information. I know that sounds so basic, but I think that's one of the most important things. In one of the documents . . . it says "Be the Expert," we are the expert.*

In other words, part of the process of coaching involves the provision of information that the participants do not have, strategies of which they may be unaware that might assist in losing weight. Of course, this knowledge is given with the express purpose of helping the participants to reach their goals. One of the coaches recounts a similar understanding of the coaching role in the OLSS: "*what we're doing is . . . guiding them in the right direction so that they're doing . . . what we want but also that its their goals. And we're encouraging their goals*." Simply put, a critical element of guiding as dialectical *paideia* for the coaches is rooted in the cultivation of *eudaimonia* for the participants, a good and fulfilling life rooted in their experiences, their hopes, and their conceptions of health as much as in those offered by the coaches.

Ultimately, guiding involves more than encouragement and reflective response. It places a burden on the coaches to actively steer the conversation in more fruitful directions, to dialectically interrupt, as Epictetus suggests, and point to a different path (or point back to the right path as the case may be). For example, one coach suggests,

> *Some of these participants can go off and you can go off and then you're not focusing on the lesson. And, I think focusing on the lesson is important because this is what we're here for and this is what we're trying to train them. So yes, they do have other questions, but we still have to focus on the protocol. So, I value the guideline. I really do, I value the tips and I value . . . the structure and that we should try to keep them within that structure . . . we're telling them this and how to avoid negative thoughts. Well, we should be talking, 'Well, you did a great job on your negative thoughts with positive thoughts,' and then, down the road, you can refer back to the lessons, and I do that, like 'Well remember when you were in lesson 4. Remember we were looking at the balanced plan, look back at that one.' So, yes the language is very good, and I do value those.*

What this coach describes here is more than simply encouraging or motivating the participant. This coach is setting the agenda, pulling the participant back to the lesson, back to the tips and guidelines in *Lifestyle Coach Training*, the *Lifestyle Coaching Guide*, and online curriculum. Simultaneously, this coach is engaged in self-reflection in order to balance the goals of the study

with the activities and goals of the participants – weight loss and health. Finally, this coach emphasizes the important role of language in this process, as it is the critical link between the participant and coach. It sutures them together in a dialectical exchange that succeeds or fails based on how well the coach and participant can cooperate on dealing with the situational demands of lifestyle management.

Moreover, the comment above adds another layer to the dialectic, the coaching protocol and participant curriculum. As living documents used in the training of the coaches and in setting up their approach to the lifestyle curriculum in the OLSS, *Lifestyle Coach Training* and the *Lifestyle Coaching Guide* act as constant reminders, as principles in need of reflective engagement and situational expression (much like the commonplaces of chronic care discussed in chapter 2). They are the outcomes of dialectical and collaborative knowledge production (see the next section for more on this) that are pillars within the complex rhetorical structure of the OLSS platform. Through dialogue with the participants, the coaches come to find the value of the coaching documents, as well as the value of experience in challenging and retooling these documents so that they work within the particular constrains of particular situations. As one CPDT member points out,

> *People can do things on their own, but you need a good solid professional person who knows how to give this type of advice. Helping people to tailor it to their own lifestyle. I think we see this as one of the best components of this program, being able to have this resource. I think it's really important to provide a top-notch program for people to try to manage their lifestyle this way*.

This process of reflective dialectic between coach and participant and between them and the protocol and curriculum crafted to guide the study are critical parts of the exchange being described here. This strategy is critical to the process of (re)constituting oneself and one's practices. Understanding may not be achieved through the neutral and at times overtly positive

and optimistic exchanges that might be described as "*support*," "*motivation*," and "*encouragement.*" These are certainly important rhetorical gestures, elemental in the construction of trust and building relationships that work, but they are not, according to the respondents, enough. By turning to the protocol and curriculum in the comment above, this coach is engaging in a constitutive process. Recall from the comment above that, at times, coaches fall off the mark. The protocol and curriculum act as beacons, pulling coaches back to a center of gravity as guides. This CPDT member offers the added layer of "*tailoring*" these elements to the specific needs of the coaches and the participants as they address particular problems. In this sense, the process of coaching is doubly, and as we shall see, perhaps triply constitutive. It involves the coach, participant, and even the rhetorical products of collaborative knowledge production – *Lifestyle Coach Training, Lifestyle Coaching Guide*, and lifestyle curriculum.

Furthermore, and related to the problem of keeping the participants focused, the respondents consistently describe the need to deal with their lack of control over the activities of the participants. Despite their role as guides, and the necessary tool of dialectic, the coaches must at some point stop short and accept that they do not control the process. As one coach points out,

> *Its like folks who . . . log on . . . and don't do anything, you know, we have those people, and to me . . . there is something going on there. You know, they are just looking. And they are engaged ever so slightly [more] than the person who comes to orientation and never signs on again. So, something is happening in this person's thought process . . . we don't control that.*

Were coaches to take these things personally or react negatively, they might undermine the goals of the study while simultaneously undermining the goals of the caring relationship – to promote health and well being. In addition, this element of the constitutive move of lifestyle coaches further complicates the dialectical relationship inherent in lifestyle management. Teaching someone else, engaging in the cultivation of *paideia* in others requires some level of self-

preservation. Descending fully into the "*negative spiral*" described earlier would undermine the study goals and render coaching deeply unproductive.

By looking at these responses through the lens of dialectical *paideia* or *elenchus*, we can see that these respondents are engaged in something much more complex and robust than simply "*guiding*" or, worse, "*cheerleading*." As one CPDT member points out, "*We wanted it to be more than just 'Ra Ra Go Go' you know supportive cheerleading. It really is a lot more than that*." The respondents consistently articulate this transcendence of mere cheerleading, offering insights into the complex constitutive and therapeutic processes underway. This effort at transcending "*cheerleading*" is a deeply rhetorical move, one invested in a particular self-presentation as well as a normative conception of the task at hand. It is one that continues when the respondents talk about what I have termed the process of collaborative knowledge production.

4.3.3 Collaborative Knowledge Production: Breaking Through 'Roadblocks' and Working Past 'Plateaus'

> *I think that is what we're doing now as we're . . . learning and with the four of us working together, you know, we have two nurses, we have a nutritionist, and we have an exercise physiologist. So, we have a lot of different areas that we can work from and we can look at it from different aspects and different angles . . . So we put this all together and you're sitting there going, 'Oh, wow, that triggers this person. I'm going to try it this way and see what we can do.' And, when you're first starting out, especially you're looking at it going, 'I've hit a roadblock, how can I break this roadblock with this person?' And if you have different ideas, you can throw that out and see if it makes a difference.* -- Lifestyle Coach

> *I think we developed things as we went along, saw what needs were, how to refine, and how to standardize it. I think that was a huge thing we worked on. If you're going to help train additional coaches, you want to be able to say this is what you need to do, which I think is a huge asset there. So, you know we [made] changes as [we] went along, we then kind of fine-tuned I think the actual content that the coaches had to focus on . . . also making sure they can do this in the*

> *clinical care, primary care setting. That was a huge factor as well.* -- CPDT Member

Another major theme that emerges from the comments of the respondents has to do with the highly collaborative and iterative process utilized in the creation of *Lifestyle Coach Training* and the *Lifestyle Coaching Guide* as well as the cultivation of best practices for lifestyle coaches. While the coaching protocol documents contain many of the lessons that the practitioners of the OLSS learned across time, some of the elements that are most central to the success of the coaches are made available socially, passed dialogically between the coaches as part of the process of engaging in the work of lifestyle management. In fact, the comments discussed below suggest that this process was and continues to be an example of *phronesis*, rooted in experience and realized through the communicative and deliberative practices of the coaches and developers. In this instance, *phronesis* is also used to refer to the capacity of the coaches and the protocol itself to deal with what one lifestyle coach refers to as the "*roadblocks*" experienced by participants in the study, such as the oft-discussed problem of weight "*plateaus*." I will return to the problem of plateaus as well as other roadblocks experienced by the respondents as this section unfolds.

The collaborative knowledge production theme under investigation here also brings to the foreground the revisable, "mutable," and altogether social elements of Aristotle's concept of *phronesis.*[109] While there are those who view *phronesis* as a deeply internal affair, it is only when the concept is attached to the broader claims of *paideia* (i.e., cultural education) and *eudaimonia* (i.e., the individual and collective good either in tandem or competition) that it reaches fruition. In other words, an unstated premise in Aristotle's theory of *phronesis* is the

[109] Nussbaum uses the term "mutability" to describe Aristotle's notion of *phronesis* and his focus on the uniquely human aspects of knowledge production. See Martha C. Nussbaum, *The Fragility of Goodness: Luck and Ethics in Greek tragedy and Philosophy*, Up. ed. (Cambridge: Cambridge University Press, 2001), 302-305.

recognition that individuals develop experiential wisdom *in community* with one another rather than as separate, isolated minds simply imbibing sense perceptions and crafting calculated outputs through a rarefied form of ratiocination.[110] As Robert Hariman points out, "As a program for reasoning, prudence [phronesis] emphasizes situational constraints, social knowledge, and enthymematic appeals."[111] In short, this theme, emergent from the words of the respondents, is suggestive of an "arational" process that involves the dialectical pairing of individual experience inflected through collective dialectical engagement.[112] It is not deductive or based on the simple accumulation of evidence but is rather interpretive, revisable, and contingent. This is not to say that the protocol used by the coaches and the lessons undertaken by the participants were and are not evidence-based. Instead, what I suggest here is that once an evidence-based, clinically proven method is put to use, it can be revised and this process of revision does not unfold neatly but rather through fits and starts, driven by anecdotes and insights gleaned from experiential learning. The rest of this section accounts for this process using the words of the respondents by addressing several related sub-themes: (1) the interdisciplinary make-up of the team, (2) the various modes of feedback and meetings used to capture experiential insights, and (3) the incorporation of patient feedback. Thus, this theme brings to the foreground the "architectonic" features of rhetoric utilized by the lifestyle coaches and CPDT.[113] That is, in the comments recounted below, the interviewees provide content and substance to the claim that ongoing

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[110] As Robert Hariman points out, there is a calculative and individualistic model of *phronesis* in the rhetorical tradition, one that stands at the heart of the enlightenment understanding of subjectivity. As he and M. Lane Bruner point out, however, this model needs revision if it is to be useful in contemporary contexts. On this, see Robert Hariman, "Prudence/Performance," *Rhetoric Society Quarterly* 21, no. 2 (1991): 28-29; M. Lane Bruner, "The Rhetorical *Phronimos*: Political Wisdom in Postmodernity,"*Controversia: an international journal of debate and democratic renewal* 2 (May, 2003): 82-102.

[111] Hariman, "Prudence/Performance," 27.

[112] Flyvbjerg, *Making Social Science Matter*, 22. He culls this concept from Dreyfus and Dreyfus. See Dreyfus and Dreyfus, *Mind Over Machine*, 36.

[113] McKeon, "The Uses of Rhetoric."

interactivity and cooperation between practitioners from very different backgrounds and orientations may yield the sort of knowledge needed to address complex problems emerging in the highly technological realm of the OLSS online platform and the electronic delivery of notes to participants.

As one of the coaches points out in the first quotation at the outset of this section, the OLSS coaching and development team is highly interdisciplinary. A CPDT member keys into this insight as well: "*we all come from different backgrounds, and I think that from each of our own areas of expertise [we are] contributing ideas to the group about how to handle that particular area*." Another coach provides additional context, suggesting that collaboration between different members of the team allowed for revisions to the DPP guidelines and curriculum based on new research findings and the particular problems faced by the participants:

> *It could be something as mundane as, 'What margarine would you recommend' there is somebody asking something like that, very practical . . . I made recommendations . . . about 'be more consistent in vitamin and mineral supplements, calcium and vitamin D,' that they hadn't noticed, well it just wasn't in the DPP protocol, some concerns I've had about the amount of carbohydrates versus the amount of fat and how things have changed since DPP . . . there's new research so things have been slightly modified . . . shifting the emphasis of how we think about the macro nutrients and those are just because of my training. My bias comes to mind in a different way that I notice more than an exercise physiologist or a nurse or a behaviorist or even a physician would notice, and they in turn obviously do the same in their respective areas of expertise. So it's a nice complement in terms of the team.*

The observations in the comment above regarding gaps in the DPP as well as the insightful discussion about the different biases (rooted in different professional experiences and kinds of expertise) balanced out through teamwork are essential to unlocking the attributes of successful collaborative research and chronic care delivery. And yet, this ideal of the healthcare team is often just that, an ideal. For groups of individuals to work seamlessly in the collaborative production of knowledge is not something to be taken for granted and is one of the critical

elements under investigation in this section. As I pointed out in my discussion of *Lifestyle Coach Training* earlier in this chapter, the strategies utilized in forming a team that can work as a unit are not always clearly spelled out. Ultimately, one of my primary goals is to learn how the notion of collaboration expressed in the interviews and the coaching documents was and is actually realized.

Aside from the numerous accounts of the highly interdisciplinary nature of the team, every respondent describes the complicated and often ad hoc moments of feedback and revision utilized in tandem with regular meetings that allowed for the ongoing process of refinement. As one of the coaches points out, the notion that the protocol might need to be changed to deal with a variety of situational constraints and the unique issues faced by different participants seems to have been a shared assumption among the various team members:

> *I think if you keep in mind what the goal is, . . . [to] . . . help these folk lose weight . . . any changes or any comments about taking an idea that I have and changing it is not something that makes me feel as though I'm not doing a good job . . . and I feel very comfortable going to everyone and I'm not afraid to voice my opinion and its [sic, recte reception]. That's all you can ask for.*

Here, the spirit of collaboration that inheres throughout the interviews is voiced as an acceptance that change is an expected, perhaps even laudatory, goal of the OLSS study. Fearing change or feeling that revising one's practices in some ways undermines his or her professional *ethos* is not consistent with the collaborative model described here. Instead, the comment above, and those of many of the other team members, indicates that the coaching team views their role as complicated and varied. They must, of course, attempt to help the participants in their pursuit (*paideia*) of a healthier and more fulfilling life (*eudaimonia*); however, this is only a part of the process. Improving the praxis of coaching involves dealing with problems as they come up, making necessary changes, and rejecting the feeling of fear that might creep into the minds of

healthcare practitioners when they have been doing something that is not effective for the participants. In short, given the fact that lifestyle coaching is a newly emergent professional practice, one should not, following the comment above, view it as fully formed but rather as revisable, mutable, and changeable, all hallmarks of *phronesis*.

Other interviewees key into this as well. For example, one CPDT member discusses the importance of the experience-based feedback of the coaches:

> *They're out there coaching and can give us feedback certainly on the protocol. I believe they were helpful . . . their input was very valuable. We always kind of worked as a team, so it wasn't always just us telling them what to do. Looking to their experience ... their suggestions . . . they definitely were very helpful . . . Inactive status was something we all worked on . . . it was one of the trouble areas of this type of study. You e-mail a participant and you're asking them questions, and they're not replying, they don't message back. That was very frustrating for these coaches because normally . . . [when] . . . you have an individual meeting with somebody, they'll answer your question, they're not going to sit there in silence. I know that was a very big issue . . . where the coaches would say, 'I don't know what to do. They don't email me back. They don't answer my questions. I don't know what to say.' That was a big issue too with me . . . 'Don't make assumptions about what their situation is. You have to stay neutral and understand.' This is the very challenging part about this. So that's an example of how the coaches were giving me feedback on their experience, you know coaching, when you had someone not adhering, we had a lot of those people. So then, we developed, I forgot to mention, we did go over and have a reasonable strategy to help deal with inactive status. The coaches did help a lot with, 'Here's what I'm experiencing. Here's what we need to do.'*

This account is instructive in two senses. This CPDT member points out that coach feedback was and remains a critical element of the OLSS. Their experiences, their problems, and their questions set the agenda for problem-solving and for training coaches *in situ* how to deal with the variety of problems their participants inevitably bring to the table. However, this comment suggests that coaches would bring problems to the CPDT and would then receive solutions. This is not, of course, the only model of feedback mentioned in the interviews but it does indicate that at times, experience may not yield answers. The fact that the coaches were experiencing the

problem of "*inactive status*" (i.e., participants not responding to coaches through the online platform of the OLSS) presented an issue in need of a response, a "rhetorical situation" demanding collaborative problem-solving.[114] It is useful to keep this limitation in mind. Aristotle's conception of *phronesis* is not grounded in the notion that experience *of necessity* translates into knowledge. Internal reflection and external deliberation are the next step and these too were part of the feedback process. Importantly, this CPDT member points to the fact that the experiences of the coaches were setting the agenda for these kinds of deliberation and, as we shall see, contributed to improvements to the praxis of coaching in the context of the OLSS. In this way, the experiences of the coaches were and are at times generative of knowledge rather than the substance of knowledge itself.

The experiential knowledge of the coaches in the OLSS has been collected and preserved in yet another way, in the form of coaching notes. Recall from chapter 4 and the previous sections of this chapter that one of the practices required of the coaches involved delivering feedback to participants in the form of notes. As one CPDT member points out, these notes are themselves a reservoir of collective, experiential knowledge that assist in ongoing revisions to the OLSS approach to lifestyle coaching:

> *The coaches who did the first iteration of the pilot, we've archived all their notes. We have referred to them and learned a lot from the coaches' notes. So that's one way . . . of reviewing the material. We have a protocol for supervising the coaching notes . . . That's one way the coaches really help with the development of the protocol is they write these notes, they create this document or archive and we look at it and learn from what is going on with their coaching. They also obviously speak to us directly about issues that are coming up with participants.*

The concept of an "*archive*" provides a way of framing the accumulation of knowledge about not only lifestyle coaching but also healthcare practice writ large. Of course, what we have in this

[114] Lloyd F. Bitzer, "The Rhetorical Situation," "The Rhetorical Situation." *Philosophy and Rhetoric* 1 (1968): 1-14.

"*archive*" is not just wisdom accumulated over time by a single individual but a resource that contains the collective experiences of a large number of people.[115] Finally as this comment suggests, this resource is not useful in and of itself but only through interpretation and contextualization, through *phronesis.*

In order to achieve a more robust understanding of the feedback process described variously above, I now turn to one example that came up across the interviews and that provides more detail about how collaborative problem-solving was and is woven into the ongoing development of the OLSS protocol: "*weight plateaus*." In the context of "*weight plateaus,*" one CPDT member describes the process of collaborative knowledge production as it moves beyond the mere reporting of problems into the collective construction of grounded solutions:

> *So, we come together in person every week, which is fairly frequent if I think about other studies I've been on, having the intervention team come together every week is very frequent, but I think those frequent meetings are important because that way we're constantly hearing about issues as they come up, we're staying on top of our study and most importantly of our participants. So, at our meeting last week, we talked about the issue of weight plateaus, the fact that often in weight loss programs . . . people will hit . . . a plateau . . . This means someone who wants to lose thirty pounds has only lost five or ten and they're just stuck week after week. So last week, we made an observation both that plateaus were common and that people hitting a plateau seemed to be a risk for them becoming less interested in the program and becoming frustrated. Then what will happen in an online program is people stop logging on . . . So, looking at those retention patterns, or use patterns, we talked about . . . common reasons why people might be at risk for stopping their participation in the program, people who at one time were participating enthusiastically. Then we came on the idea of weight plateaus, then we took it a step further and said, 'Okay, let's talk about how to engage people who have hit a weight plateau' 'When is the right time to engage them?', 'What kind of things can we talk to them about?' . . . So I think that's . . . an example of . . . how we work as a team. We identify a problem, in this case people*

[115] Cass Sunstein, a modern legal and cultural scholar, has discussed this type of knowledge production, the coalescing of "many minds," and how it has become a central feature of contemporary, internet-based knowledge accumulation and delivery. Of course, there are debates to be had over the relevance and use-value of the knowledge produced by non-professionals in the somewhat anarchic domain of the internet. Here, what we have is a resource containing the accumulated experiences of several professionals, all working on the same goal – effective and ethical lifestyle management. Cass R. Sunstein, *Infotopia: How Many Minds Produce Knowledge* (Oxford: Oxford University Press, 2006).

> *not logging on or people hitting weight plateaus. Then, we push the conversation further into . . . . 'What can we do about that', 'What are the resources we have as a team', 'What are resources we can make available to our participants', and 'What kind of messages should we be sending people at what time points when we notice that they're . . . hitting this point when they're not making progress with their weight and they're getting frustrated.'*

The description of this meeting includes multiple points of contact with the various themes I have been discussing throughout this chapter. First, this CPDT member argues that the meeting structure for the team is rooted in determining what problems the participants and coaches are having and addressing them as practical issues in need of solutions. This is in line with the structure of knowledge production and situational praxis described as *phronesis* in chapter 3 of this dissertation. Second, the metaphor of guiding is used here to frame the problem-solving strategy used by the team. This CPDT member suggests that the primary concern of the team at this moment was to find new ways to "*engage*" the participants who, after having hit a plateau in their weight loss effort begin to fall away from the program, failing to log on and complete additional lessons and tracking. Finally the comment above points to the various critical questions asked by the team members, all of which are animated by dialectically guiding the participants back to the program and their weight loss regimen.

One of the lifestyle coaches provides support for the vision of team-based work described above. This coach adds the issue of tone or, in other words, how messages should be worded to participants who have started moving toward inactivity:

> *That's what we are doing at our meetings. As we're going along, we're saying, 'Ok, this person has hit a plateau.' Plateau is a very big thing for the participants, 'What do you do?', 'How do you break the plateau?'. So we sat there, and we all collaborated on different ideas and suggestions, and we typed them up and now, they're part of our coaching so we can go back and say 'oh look at this, let's trying saying it this way or saying it this way.' I value that because when you get somebody that is not ... there's something off and you don't know what it is. They could be recording it wrong or they are in a plateau and they are falling.*

Providing the means to avoid "*falling*" out of the program is one of the key issues discussed by the respondents as they ruminate on the various meetings and moments of ad hoc feedback and dialogue they have experienced as members of the OLSS team. Ultimately, "*weight plateaus"* are just one of the problems that the team has addressed but the detail provided in the comments over the last several pages adds substance to the claim that collaboration has been and remains a constitutive feature of the team-based work of the OLSS lifestyle coaches and CPDT. In other words, in these passages, we have a substantive understanding of collaboration, one shared by a CPDT member and a lifestyle coach. Simply put, collaborative problem-solving is what allows this team to effectively manage problems with the evidence-based curriculum they are using on a daily basis. It is not a deductive and rationalistic process but one grounded in *phronesis*.

Overall, these comments and the larger theme of collaborative knowledge production are rooted in the idea that the OLSS should be replicable, that it should be useful to a large number of researchers, practitioners, and patients. This is the move to generalized knowledge production and practice change that stands at the heart of all medical research. However, the comments recorded in this section do not fall heavily on the side of medicine as a science. Instead, the form of knowledge production undertaken here entails cultivation of practices from experience, something that most physicians experience as they develop clinical judgment during their internships and residencies.[116] While it cannot be characterized as strictly scientific, or even quantifiable, as experience builds into an archive, some elements become more general and more predictive but nearly always revisable. As Aristotle suggests, "things whose fundamental principles are variable are not capable of demonstration, because everything about them is

[116] This is in line with Kathryn Montgomery's claim that medicine is artistic as opposed to scientific in its application. See Kathryn Montgomery, *How Doctors Think: Clinical Judgment and the Practice of Medicine* (Oxford: Oxford University Press, 2006). For more detail, see my discussion of her work in chapter 3.

variable, and inasmuch as one cannot deliberate about things that are of necessity, it follows that Prudence [*phronesis*] is not the same as Science."[117]

The goal of the OLSS study is, of course, to provide a means to engage in lifestyle management that can be used by others; however, the program is not transferable as information. It is only transferable through the process of collective experience, eventually gaining wisdom, and then sharing it with others who have the talent and resolve to use it responsibly. This is precisely what one CPDT member argues when considering the use-value of the protocol for future coaches:

> *I think the biggest reason we need a protocol is so that others can do what we have done and won't have to start from scratch especially because they're not going to have the team of researchers or this combination of the coaching staff as well as the researcher here, which is kind of probably one of the more talented in terms of breadth and depth in experience. It's a pretty impressive group. I think that's why.*

"*Start[ing] from scratch*" is of course difficult and time consuming. Collaborative knowledge production rooted in the rhetorical relationships between members of a group, can reach a point of transferability, assisting future practitioners in their work. Thomas B. Farrell calls this form of shared knowledge "social knowledge" and argues that it moves from points of stability to instability, that it frames situational modes of decision making (i.e., rhetorical modes of decision making), and that it is revisable.[118]

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[117] Aristotle *Nicomachean Ethics* VI.v.3. We ought to read this passage with all due caution. Of course, Aristotle differentiates *phronesis* from art here as well but we would do well to remember that Aristotle had very narrow understandings of these terms. Science was invariable, deductive knowledge for him. Art was the making of things and would not have been used in the context of action. However, the general point that *phronesis* does not mimic or even come close to approaching scientific certitude is one that we can usefully draw from his analysis in this passage.

[118] Thomas B. Farrell, "Knowledge, Consensus, and Rhetorical Theory," *The Quarterly Journal of Speech* 62, no. 1 (1976): 1-14.

Finally, Hannah Arendt provides a way to frame the collaborative knowledge production described in this section. Her work engages the possibility and necessity of relational knowledge production and coordinated action. She writes,

> Since action acts upon beings who are capable of their own actions, reaction, apart from beings a response, is always a new action that strikes out on its own and affects others. Thus action and reaction among men never move in a closed circle and can never be reliably confined to two partners. This boundlessness is characteristic not of political action alone, in the narrower sense of the word, as though boundlessness of human interrelatedness were only the result of the boundless multitude of people involved, which could be escaped by resigning oneself to action within a limited, graspable framework of circumstances; the smallest act in the most limited circumstances bears the seed of the same boundlessness, because one deed, and sometimes one word, suffices to change every constellation.[119]

This boundlessness of human action (i.e., humans reflecting about what they are doing) is at the heart of the collaborative process being described here as well as its *telos* – being shared with others. What the CPDT member suggests above is the idea that small shifts and changes in language, when they become elements of collaborative action, can ripple across the wide-ranging activities of humanity. What the respondents describe in the comments discussed in this section is a process through which their experiences were taken up, synthesized, and reproduced as text and as new practices. It is this combination between text and practice, between the individual and the group, and between the group and the larger community in which they exist that truly gets at what Arendt means by action. It also provides a very different notion of how practitioners might be trained, one that gets around the problem of "book learning" or learning by rote criticized in Plato's *Phaedrus* (chapter 3).[120]

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[119] Arendt, *The Human Condition*, 190.

[120] Plato *Phaedrus*; Robert Klitzman, *When Doctors Become Patients* (Oxford: Oxford University Press, 2008), 274.

4.3.4 "The Priority of the Particular"[121]

> *[The lifestyle coaches are] on the frontline with the participants, they're our liaison to the participants, and they're often the first one['s] to know when things are working well or things aren't working well. We sit down every week and look at data, you know like how many people are logging on, and how much weight people are losing, but the coaches . . . have a sense of that because they're interacting with the participants constantly, and they know in general what's going on. I really feel like for all the theory and research design you want to talk about, the coaches are the one who really know what's going on with the participants.* -- CPDT Member

> *The process started out small and then we kind of as we learned more about what would be helpful, things like came to mind, for instance, making sure that the coach utilized the actual curriculum in their coaching to better guide the participant, used the same language behavioral language was another area that I can think of we talked a lot about that.* -- CPDT Member

> Nor is Prudence [*phronesis*] a knowledge of general principles only: it must also take account of particular facts, since it is concerned with action, and action deals with particular things. This is why men who are ignorant of general principles are sometimes more successful in action than others who know them: for instance, if a man knows that light meat is easily digested and therefore wholesome, but does not know what kinds of meat are light, he will not be so likely to restore you to health as a man who merely knows that chicken is wholesome; and in other matters men of experience are more successful than theorists. And Prudence [*phronesis*] is concerned with action, so one requires both forms of it, or indeed knowledge of particular facts even more than knowledge of general principles Here too however there must be some supreme directing faculty. – Aristotle, *Nicomachean Ethics*[122]

The centerpiece of Aristotle's conception of *phronesis* is its grounded nature, its rootedness in everyday decision making. The first comment by a CPDT member at the outset of this section suggests that the lifestyle coaches, as "*liaisons*" to the participants have access to the most relevant, timely, and accurate knowledge regarding the effectiveness of the coaching protocol and the lifestyle curriculum. As they are truly engaged in the practice of lifestyle coaching, they have access to the experiential wisdom that designers and theorists do not. I have coupled this

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[121] Nussbaum, "The Discernment of Perception," 66; Flyvbjerg, *Making Social Science Matter*, 57-60.
[122] Aristotle *Nicomachean Ethics* VI.vii.7.

comment with a passage from Aristotle that gets at this notion of the particularity of knowledge, the fact that knowledge about how to engage in everyday praxis is rooted not in theory or general principles but rather in the actual doing of things. However, and this is crucial to unpacking the comments discussed in this section, Aristotle does leave room for the application of general principles. They may sometimes get in the way of sound advice and decision making that can only be the product of experience (although who could possibly be confused about the fact that chicken is one of the healthier meats!); however, and especially when these general principles are themselves guided by the endeavor to engage in action in the world, they can help to support the individual agent in framing problems and coming to grips with necessary solutions. The second quote from a CPDT member above describes the importance of the protocol, explaining how it works as a guide, a way to keep everyone on the same track despite the differential experiences they may encounter. All of us are faced with difficult decisions demanding urgent actions; however, we also carry with us a store of socio-cultural knowledge (a sense of *paideia*) that may assist in these moments.

The respondents describe this process, variously championing the coaching protocol (general principles), experience (the particular), and a mixture of the two as central to the practice of lifestyle coaching. The coaches engage in a dialectical back-and-forth with themselves and each other as they pursue better principles, more experience, and a fusion of the two. In other words, there are two levels of dialectic at play here. The first is concept-based and has to do with the use of general principles as a backdrop for the cultivation of particular solutions to grounded problems. The other is interaction-based and is rooted in the back-and-forth between coaches and participants. Critically, this dual dialectic provides excellent evidence for the usefulness of conceptualizing rhetoric as "a productive architectonic art" and utilizing it

to uncover productive processes and critically interrogate them.[123] Recall for my discussion in chapter 2 that chronic care may benefit from synergy between different actors as well as between general commonplaces and the needs of particular patients with specific problems. The coaches and CPDT members describe just such a process here providing unique content that delivers on the promise of rhetoric in not only revealing how collaborative processes draw on rhetorical tools but how rhetoric itself is a constitutive medium connecting different conceptual layers and actors together in the generation of innovative solutions. Here, rhetoric acts as an inventional tool, one in which general knowledge is combined with particular cases and various actors combine their talents to interpret experience and draw lessons from it.[124] The rest of this section unpacks these different, highly generative, processes as voiced by the respondents.

Most of the respondents make reference to the protocol as a guide, a way to deal with complexity, and a means for "*ramping up*" for lifestyle coaching. For example, one lifestyle coach details the importance of the protocol as a guide:

> *I use the . . . coaching manual all the time because it gives me the guidance of staying within the protocol lines . . . I worry that I go over and start to talk outside of the box and what we need to do with the participants. But, I . . . try to get to know them and then use what they tell me and keep referring to that when I'm coaching them . . . the manual is wonderful. Its a wonderful protocol, and also it is very cut and dry 'You do this, you talk to them once a week. If this happens, you do this.' So, its very succinct that you know where you're standing and there's really no fine, you know where to go and you know what to do. I like that.*

Part of the concern that lifestyle coaches face, according to this coach, is keeping on track, remaining within the guidelines of the study, the coaching protocol, and the lifestyle curriculum. Having a document ready to hand that provides answers to pressing questions is in some sense necessary to the daily activity of coaching. Without it, the coaches would have to "*start from*

[123] McKeon, "The Uses of Rhetoric," 48.
[124] McKeon, "The Uses of Rhetoric," 55.

scratch" from moment to moment. This insight draws out the implications of McKeon's arguments regarding the use of commonplaces as tools of memory introduced in chapter 2. Here, the protocol acts as a tool of invention and remembering that allows for the generation of hypotheses and grounded solutions in the delivery of care. [125]

Another critical reason for the existence of the protocol and its use value to the coaches (related to the issue of having commonplaces from which to develop solutions discussed above) has to do with one of the problems described in chapter 2: cognitive overload and complexity. Chronic care is a deeply complex process and lifestyle coaching represents one of the most interactive and multi-faceted forms of contemporary care animated toward addressing chronicity. One of the lifestyle coaches voices this problem in the following way:

> *I really value this, the book is with me when I do all my coaching. I don't do any coaching without my book because there are tips in there. There are so many different things. I mean we have 16, how many 18 lessons plus maintenance. There are ... there's a lot of information and while I'm listening to them, it doesn't mean I know every single thing about it. And, you know, the tips are there. The only thing I would say is add more tips.*

The "*book*" mentioned here is the coaching protocol (*Lifestyle Coach Training* and the *Lifestyle Coaching Guide*) and it is clear that, at least for this coach, it plays a central role in dealing with the highly complex process of synergizing professional skills with the needs of the study and those of the participants. In fact, this coach mentions the need for even more "*tips*" that might help to navigate new problems as they come up, thus providing an added warrant for the model of collaborative knowledge production described in the previous section.

In addition, this complexity is not addressed solely through the use of the coaching protocol. Complexity and cognitive overload are also good reasons for intensive training and

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[125] Richard McKeon, "Creativity and the Commonplace," *Philosophy & Rhetoric* 6, no. 4 (Fall, 1973): 199-210.

experiential learning, all in the service of understanding how the coaching protocol can be translated into the realm of the particular. One of the lifestyle coaches notes that,

> *There's so much that there's no way you can retain it when you have all of that coming at you and what has been much more helpful is to meet with [. . .] on a weekly basis. Things come up, so you address things, and I consider that part of our . . . training that comes up ... as a result of the protocol or you know when you hit that lesson or something happens and I don't understand it, what's that all about it, that teaching, that training is ongoing. I think until we cycle through the entire um lesson plan, all 24 that will be difficult.*

As this coach suggests, all of the lifestyle coaches see training as a sort of ongoing process, one through which specific problems, moments of cognitive overload, and complex issues in need of new solutions are work-shopped by the group, either through meetings or through discussions about the coaching protocol and what it has to offer. Another coach notes that this process of "*ramping up*" for coaching was an essential element of the introduction to the program: "*When I started my job certainly I had information and training and the manual given to me actually even before I started, given some of those materials to start looking over and begin ramping up. Obviously that became more intense when I officially started my work here.*" Again, this coach makes note of the important role of the coaching protocol and other materials in helping her to begin the constitutive process of becoming a lifestyle coach; however, this coach also indicates that the process of training does not begin and end with the manual. In fact, as this coach describes it, training became more "*intense*" when moving from the introductory lessons and manuals and into the real world of working with participants.

So, while the coaching protocol is an essential piece of the puzzle, a set of general guidelines to which all of the interviewees say they refer on a normal basis, the "*training*" of lifestyle coaches involves much more. It is experience that gives meaning and content to the coaching protocol. While reflecting on the role of the coaches in the OLSS, another coach notes,

> *I'm somebody who reflects what somebody has shared with me to help them learn to move towards healthier lifestyle behaviors . . . I listen, I sympathize, I empathize when its appropriate and fits in um so to motivate them, to continue, hopefully retain them for the study but also for their own purposes and needs.*

This coach's self-conception suggests that the daily activities involved in working with participants include listening to participants, reflecting back on what they have said, empathizing with them, and providing grounded and specific forms of motivation. Striking a balance between the coaching protocol and this much more experientially based conception of lifestyle coaching plays a major role in the stories told by the respondents about their training and their daily praxis as lifestyle coaches.

For example, another coach notes that the protocol, combined with experience, is central to the daily practice of working with participants:

> *I use the coaching guide all the time. I use it all the time, so whenever I get to it, and it says Lesson One, I look at their suggestions and then I go to the meetings and I listen to what the other interventionists are saying and then I start to formulate 'Well, ok, this didn't work for them or this worked' then I try to piece what the participants like I write something about every single participant, I have a little box that I fill it in so that it triggers. When you're dealing with a lot of participants, you're going to end up forgetting somebody. So, I try to remember something about them so I can say 'ok, their personality, they're going to want to be saying 'No, don't do that.'' Or the other ones, 'Maybe you could try, let me know what you think.'*

This coach indicates that the *Lifestyle Coaching Guide* plays a major role in engaging in the grounded activities of lifestyle coaching, but is not in itself sufficient. Only through interacting with others on the team and actually learning from their experiences can individual coaches find solutions that are workable and that seem to fit the particular situations of different participants. This is the reason that the *Lifestyle Coaching Guide* cannot remain stable but is instead a mutable, always changing document, continuously refitted to the needs of the particular situations faced by the lifestyle coaches. As one coach points out, "*So, as opposed to most*

protocols where you read it, you know it, you take it with you, and that's that, the protocol stays the protocol, this is more to me an evolving . . . kind of document within certain standards . . . and it has wonderful ideas if you're working with someone who is non-responsive, where do you go from there.'" This notion of the protocol as an "*evolving . . . document*" gets to the core of the relationship between general principles and the "priority of the particular" in Aristotle's conception of *phronesis*.[126] While there must be guiding concerns, a framework for action, there must also be an experientially rooted faculty through which individuals come to challenge preconceived notions (when necessary). This coach suggests that this is what makes the OLSS protocol unique – its evolving character, its fitness, its situatedness, and its timeliness.

Of course, the "priority of the particular" comes to the fore in the interviews in many ways beyond the issue of training and professional practice.[127] The most important of these, and the one that takes up the last part of this section, is related to the ways in which the coaching protocol is fitted to the particular needs of particular patients. The respondents have many examples of how well this drive toward particularity works for them. One coach argues that the problem of cognitive overload is not just faced by the lifestyle coaches; the participants are also bombarded with information and need the guiding hand of coaches to assist in making it relevant to them:

> *I've been getting better at it, and discerning . . . what are the key things you want to . . . choose to address . . . knowing that people can only learn and remember and process only so much at one time and so . . . working to always take all this motivation and you want to help and do all these things, bring it down to this, and gel it, synthesize it . . . it almost makes me think of sound bites. That's challenging, and . . . so, I think its even harder than I anticipated it would be*.

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[126] Nussbaum, "The Discernment of Perception," 66.
[127] Nussbaum, "The Discernment of Perception," 66.

This process of selection is one that brings lifestyle coaching very close to the rhetorical tradition. In fact, it makes the practice of lifestyle coaching itself a rhetorical skill. Knowing what to say and when, making advice timely (*kairos*), and delivering it in a way that people can digest has been a central rhetorical skill from the time of its founding as a discipline. This is because rhetoric is a deeply intertwined with *phronesis*. It is rooted in the moment, crafted for the situation, with the capacities of the audience (cognitive or otherwise) always in mind. One member of the CPDT provides even more detail on this point, suggesting that lifestyle coaching is, at least in one sense, a method of guiding individuals through the morass of information wrought by new communication technologies:

> *Our coaches provide people with helpful information. There's a lot of weight loss stuff out there. You can log onto the internet, there's a lot of crazy stuff out there as well as some good information like how do you help people sort that out. We have a standardized evidence-based curriculum that help people sort it out, but also our coaches provide answers to question that timely and accurate and scientifically based.*

While this CPDT member describes the coaching protocol as "*scientifically based*" the overall comment also emphasizes the sorting role played by coaches. Again, rhetoric enters as "a productive architectonic art," one through which the vast amounts of information available to participants is sorted and tied back to the evidence-based concerns of clinical medicine.[128] This indicates the extent to which McKeon's insights regarding the complexity and fragmentation of technological societies requires a sorting out, an arrangement (and even hierarchization) of different layers of information.[129] In addition, the fact that new information technology plays such a major role in producing complexity and fragmentation (e.g., through countless online websites providing weight loss information) and resolving them when human actors connect with

[128] McKeon, "The Uses of Rhetoric," 48.
[129] McKeon, "The Uses of Rhetoric," 51, 56-57.

each other virtually (as the coaches and participants do) should not go without notice here.[130] McKeon's solution to this problem is the use of "verbal rhetoric" (represented in this case through the online conversations between coaches and participants) to cut through the mess and reconnect actors with one another in coordinated and shared action. Through coordinated action, various modes of knowing (e.g., scientific and non-scientific) may come together to form sound judgments.[131] Additionally, the science that backs the protocol and the sorts of answers being given by the lifestyle coaches in the OLSS is rooted in experiential knowledge, gathered through robust and ongoing clinical trials. Ultimately, for the respondents discussed on the last two pages, dealing with the particular, making it a priority, requires scientific knowledge on the one hand and a capacity for rhetorical action (*kairos*, sorting, agenda-setting, and specific feedback) on the other.

In fact, one CPDT member argues that what sets the OLSS protocol and lifestyle curriculum apart from others currently under investigation is its refusal to provide algorithmic models for problem-solving:

> *Every time . . . I see another group that does online lifestyle coaching present their work, it . . . seems like sometimes a lot of the other studies have more formulaic advice that they give to patients, if you answer X, Y, and Z, you get an automated message that says why (Y). I think we really take pride in the fact that our protocol is very individualized and our coaching is very personal. We spend a lot of time not just talking about the protocol but the participants who are in our studies.*

So, despite its basis in scientific (clinical) research, the fact that it is evidence-based, the fact that a "protocol" with generalized tips and guidelines has been crafted, and the fact that the study goals are always in mind, the thing that makes the OLSS protocol so unique, for all the

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[130] On the role of rhetoric in addressing fragmentation, see McKeon, "The Uses of Rhetoric," and Michael Calvin McGee, "Text, Context, and the Fragmentation of Contemporary Culture," *Western Journal of Speech Communication* 54 (1990): 274-289.

[131] McKeon, "The Uses of Rhetoric," 63.

respondents, is its capacity to deal with the specific problems faced by the participants. This focus on the particular needs of the participants and its role in both the collaborative knowledge production used in crafting the protocol as well as the form of dialectical *padeia* (or *elenchus*) used by the coaches to work with the participants, suggests that the particular certainly is a priority for the OLSS. The comments discussed over the last several pages also suggest the extent to which the OLSS relies on the "architectonic" features of rhetoric to address fragmentation between various types of knowledge (practitioner and patient) and different conceptual layers (general and particular) in the delivery of care.[132]

Despite all of this, there are times when translating skills, knowledge, and advice into a particular setting, or even working from situational constraints to generate new modes of action, may fail. One coach describes this risk of failure (akin to the lack of control sub-theme in section 4.3.2) through the lens of a case -- a participant with hyperthyroidism: "*I have one person I find extremely difficult. [This participant] has [hyperthyroidism]. And even with [hyperthyroidism] . . . should be on medication that stabilizes, and . . . I can't figure out ... why [this participant is] not losing weight. [This participant is] persevering, and I suspect there's other medical problems, but I don't know that.*" Rhetorical scholars have long noted that when it comes to the use of *logos* to frame, interpret, troubleshoot, and solve problems in the world, there can be no error-proof method. Similarly, Aristotle's conception of *phronesis* leaves room for error, for mistakes, and for revisions to habits, dispositions, and skills that might improve ameliorate error in the future. Ultimately, there can be no final answer to every problem, situational constraint, and particular participant. Instead, there can only be a focus on the particular (at times assisted

[132] McKeon, "The Uses of Rhetoric.

by general principles built up over time through experiential learning) and an ongoing effort to improve.

4.3.5 Invention and Tone in the Age of Electronic Lifestyle Coaching

> *You can't read a person. Its very difficult to read a person online, and its also . . . you can't project your own, face to face either, but it seems to me that it can turn up a lot easier in the written word . . . because your own mood or whatever. People can interpret your words, you know they don't hear your voice, they don't see the smile, they don't, you know all those things that . . . can happen in a face to face. In face to face too, you can also assess and evaluate physically much easier . . . so that's difficult. And so . . . when things happen that aren't ... accounted . . . you can't see . . . why this person lost five pounds in one week or why did they gain five pounds in one week or is it. So there's a lot of surmising*. -- Lifestyle Coach

> With written words: you might think that they spoke as if they had some thought in their heads, but if you ever ask them about any of the things they say out of a desire to learn, they point to just one thing, the same each time. And when once it is written, every composition trundles about everywhere in the same way, in the presence both of those who know about the subject and of those who have nothing at all to do with it and it does not know how to address those it should address and not those it should not. When it is ill treated and unjustly abused, it always needs its father to help it; for it is incapable of either defending or helping itself . . . But I think it is far finer if one is in earnest about those subjects: when one makes use of the science of dialectic and, taking a fitting soul, plant and sows in it words accompanied by knowledge, which are sufficient to help themselves and the one who planted them, and are not without fruit but contain a seed from which others grow in other soils, capable of rendering that seed for ever immortal, and making the one who has it as happy as it is possible for a man to be. – Socrates[133]

The coach's words at the outset of this section echo one of the largest concerns for 21st century healthcare practitioners – how to deliver health information, skills, knowledge, and even some behavioral interventions in an online setting. Socrates' famous attack against the written word, recorded by Plato, provides a useful reference point for understanding this comment. Socrates was also facing a major technological revolution, the transition from an oral to a written

[133] Plato *Phaedrus* 275d7-277a4.

culture.[134] For him, the permanence of written words, as well as the absence of the author, undermines the meaning making and learning process. Only dialectic, styled as back-and-forth conversation and related to the version of pedagogy defended in section 4.3.2 above, is appropriate for Socrates' effort to train students in the good and fulfilling life. The idea that written words cannot clarify themselves, that they become trapped in their own permanence, is something that the coach quoted above discusses in terms of the notes written for OLSS participants: "*in basically an e-mail situation, an electronic situation, once you write something down, that's it.*" Managing this tension between, on the one hand, giving feedback to participants in a highly accessible manner (i.e., through an online portal) and on the other, the concern with clarity and tone in the pedagogical process, is mentioned throughout the interviews as central to the ongoing effort to improve the OLSS. The rest of this section unpacks this tension, focusing on key inflection points in the interviews, including: (1) shifting the rhetorical and therapeutic terrain from face-to-face encounters into the online setting, (2) the impact of the online setting on rhetorical invention and tone, (3) the temporal and spatial dynamics of accessibility in lifestyle counseling, and (4) the problem of technical breakdowns. Each of these sub-themes provides substance to the claim that online lifestyle counseling is crucially different from the face-to-face model, that it has problems and possibilities that can only be addressed through specific attention to the rhetorical dynamism of online interactivity, and that technology can breakdown, it can fail us. However, despite these crucial differences, there are similarities as well that allow for the translation of counseling skills into the online domain. In all of these ways, the respondents provide unique insights into this new feature of healthcare for those dealing with obesity and diabetes.

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[134] For more on this transition, see Walter J. Ong, *Orality and Literacy: The Technologizing of the Word* (New York: Routledge, 1982).

All of the respondents make reference to the major differences between their new online platform and their previous experiences with face-to-face (and times, by telephone) counseling. For example, one coach describes the problem of soliciting responses from people in an online setting. Much like Socrates, this coach views the back-and-forth with participants as essential but also recognizes the limitations of doing so online where your interlocutors are not pressed by your physical presence and expectation to respond: "*it's hard . . . for someone not to respond to you sitting face-to-face so that's another major difference . . . one of the things for us is knowing whether or not someone has read our messages and we're working on getting that resolved*." This coach provides more evidence in support of Socrates' claim that written words do not necessarily produce a response (at least not the one that the author is hoping for). While the OLSS has a strategy in place to deal with "inactive" participants, this is still a central feature of the experience of online counseling that cannot be wished away but may in fact be a permanent feature. On the other hand, the asynchronicity of the interaction may exacerbate this difficulty indicating that synchronous online communication may be one solution. Recall that one element that makes the OLSS different from other interventions (especially face-to-face counseling) is that coaches and participants do not speak with one another directly, that is, in real time. Participants receive scheduled notes on a regular basis that are largely automated and can submit queries that coaches reply to later.

In addition to the problem of actually getting a response, other respondents note that words are not the only, or even primary, way in which communication occurs between coaches and participants. In fact, physical symptoms, tone, expressions, and the like are filled with bits of important information that cannot be assessed in the absence of someone's body, face, and voice. As one coach suggests, not being able to *hear* the participants has major implications on the

ability to offer care and support: "*That was a hard thing for me to do because when I was on the phone with them, I didn't have to do that as much, I could hear what they were saying, so I had to read between the lines and ask them to give me more information. And then you have to wait, and that's the frustrating part because you're waiting for them to answer back.*" At least on the telephone, one can hear the voice of the other person and fill in some of the missing links in the chain of meaning. This is much more difficult online, as is the problem of waiting for a reply and not knowing how to interpret it.

Furthermore, and beyond the problems already noted, another coach suggests that developing trust and rapport with the participants is much harder in the online setting:

> *On the other hand, the obvious things that happen when you talk to somebody: visual cues, body language; there's probably more of a rapport, a different kind of rapport that can develop . . . when you talk with somebody one-on-one that is harder to develop . . . attributes like warmth things that are less tangible, they're hard to convey when you are typing than when you're talking . . . some of the things that might be misconstrued when one is talking one-on-one in person or misread, that doesn't happen online . . . let's say I look at the way you moved your eyes and I might feel or notice or decide to project something that can't happen if I'm not looking at you. So in that regard, that's a benefit. On the other hand, I also can't detect those things.*

This coach views the problem of building rapport in the online setting as a double-edged sword. On the one hand, not being able to see, hear, or directly speak with the participant means that it is harder to develop a professional and pedagogical relationship with them. On the other hand, this coach points out that the highly textured communication that occurs in the face-to-face setting can lead to misunderstanding, misinterpretation, and the like. For example, one of the CPDT members suggests that there are benefits to the online setting, most notably the fact that some participants are actually more forthcoming with information, concerns, and the like: "*Because of the journal, they write things that I'm not quite sure they would say face-to-face.*" This CPDT member is talking about the online journal used by participants to track their own progress,

report problems they are having, and work through the online curriculum. According to this respondent, this feature allows individuals to write down their deepest concerns, feelings, and problems suggesting that such revelations in the online setting are sometimes more robust than they are in the face-to-face context. What these respondents offer is a way around the technophobia of Socrates' argument, as well as the more contemporary concerns voiced by scholars about the erosion of face-to-face communication with others.[135] Simply put, there are problems and possibilities with both forms of communication, and for this reason, both rely on particular practices of interpretation and response that need to be developed experientially. It is to these practices, as understood by the respondents, that I now turn.

It should come as no surprise that the online setting presents rhetors with new inventional quandaries. What the respondents offer is a substantive account of these quandaries in the specific context of lifestyle coaching. The most important problem caused by the shift to an online environment, mentioned time and again by the interviewees, is that of tone. For example, one coach describes the difficult writing and revision process the coaches goes through in the production of notes for participants:

> *I had to . . . figure out how to get my intonation [right] and to word things so that they knew that I was supporting them. I was not overly sugaring, but I was also being strict . . . I took a lot of time in wording how I was going to be talking to them, and I reread and reread and reread and I used a lot of the coaching tips and also going to the meetings and having the other interventionists' thoughts and ideas helped me formulate my plan on how I was going to deal with the participants.*

This description of the inventional process needed to craft notes provides essential insight into the way that the coaches work through the problem of counseling in an online setting. This coach

[135] For example, Michael Keren argues that the "blogosphere" has often become a space in which the "melancholy" of isolation in the technological age is voiced. See Michael Keren, *Blogosphere: The New Political Arena* (Lanham: Lexington Books, 2006).

suggests that "*intonation*" and "*wording*" are critical to the production of the "guiding" form of pedagogy at the heart of the OLSS program. This coach also suggests that the right mixture of "*sugaring*" and being "*strict*" is a key concern, hearkening back to my discussion of dialectical *paideia* in section 4.3.2. Managing all of these concerns became, for this coach, an issue for collaboration and situational praxis. Only through ongoing interaction with other members of the team and the rigorous process of revision is this coach able to find the words, the tone, and the message needed to interact with a particular participant.

The CPDT members acknowledge these difficulties and suggest in their responses that they are central to effective lifestyle coach training. One CPDT member suggests that the problem of tone has been and continues to be addressed through the iterative revision of the protocol: "*what's the appropriate tone for a coaching note to be very supportive, to ask open ended questions, to frame things positively rather than negatively . . . we just learned over time and that's how the protocol keeps changing*." The rhetorical concern with tone, therefore, has become a central theme in crafting a more effective approach to coach training. In addition, another CPDT member adds more detail to this process, suggesting that the issue of tone is directly related to the problem of making sure that coaches are promulgating a version of lifestyle coaching that fits with the goals of the study (i.e., dialectical *paideia*, guiding, and the like): "*A particular example would be the tone of your note, keeping it positive, keeping it professional . . . That became very important . . . you just can't take it for granted that coaches are going to know how to communicate to maximize that relationship with the participant*." Here, the issue of tone is sutured directly to the cultivation of trust, of a healing partnership with the participant. In this regard, this CPDT member also mentions that tone has been a major problem for new coaches:

> *We had coaches that maybe not meaningfully but just word things in a more negative way . . . because every word choice is so important. You have to be really careful about how you word things so we talk a lot about that too. Trying to include a tone that is positive, professional, to the point, specific . . . You know ... its hard to think about that level of how you are coming across in an email versus in person . . . They took it the wrong way. It's so easy to make assumptions about what's happening with them or judging, you know again you have to be really careful. I feel like you do anyway. The worst to do is to alienate a person or make them feel like they didn't understand me at all.*

Tone is figured here as central to the creation of meaning. How you word something has direct consequences for the horizon of potential interpretations you deliver to your interlocutor. What this comment emphasizes is the need for a positive and professional tone, one that avoids alienation and provides context for sharing the difficulties of lifestyle change between coaches and participants. That some coaches had difficulties emulating this sort of tone and that the CPDT took actions to address this problem indicates just how central the rhetoric of note writing is to the process of online lifestyle coaching.

In addition, the comments quoted in the previous paragraph indicate the elements of tone relevant to *phronesis*.[136] The idea that it is easy "*to make assumptions*" about participants keys into the problem of applying generalized knowledge to the specific problems faced by individual participants. One CPDT member discusses one possible solution to this problem:

> *I think another big chunk that came up was the personalization of the note . . . What I felt was that you could write a note and say, 'Hey you lost five pounds. You're doing a great job,' but that could be automated. What [coaches] could do is then look at the journal notes, look at the notebook, take something the participant has given you, and throw it back into the note and personalize it. Not that you need to say anything so personal to them, but just tailor it to their situation.*

This comment should bring us back to Plato's concern with the written word. There is a sense in which writing something indicates its suitability for a large number or people, its capacity to be

[136] Hariman refers to tone as one of the key elements of *phronesis* in the rhetorical domain. Hariman, "Prudence/Performance," 28.

preserved both in substance and in applicability. The problem is that this is not the case. The notion that notes might simply be automated and generalized strikes this CPDT member as insufficient. Instead, their content, including their tone, should be directed at the specific participant, thereby building a relationship with them that is founded on their needs, their goals, and their vision of *eudaimonia*.

In spite of these difficulties, the respondents mention one of the great benefits of the online environment: its capacity to increase accessibility to a range of individuals, some of whom might not participate in lifestyle management in any other way. As one coach suggests,

> *But what's changed is that when I came on board, I didn't think it could work. Actually, it's much more effective. One of my major frustrations as a lifestyle counselor and coach is that there's only one of me. Reaching more people more effectively was always a problem and exhausting . . . The other thing I like very much about it is that you can coach from anywhere and you can reach anybody. They can be in the farmlands, they can be inner city, they can be anywhere, and you can be anywhere. That's very cool stuff. It's a good protocol, very, very good stuff.*

The idea that the online environment can collapse space, and even time, so that individuals can be reached anywhere is nothing new; however, what this coach points to here is a transformation in the conception of online counseling. At first, and given previous work in a face-to-face environment, this coach felt that the transition to the OLSS might not work; however, after utilizing the protocol and engaging with participants online in a sustained way, this coach feels that it is "*very, very good*." This coach's experience with the collapse of physical space and expansion of virtual space has been deeply positive and opens the door to reaching far more participants than ever before. Additionally, as another coach points out, some participants would not participate in the program if not for the online component:

> *I think this is a very good idea for a lot of the participants, and I also feel there's a lot of participants that don't want the face-to-face that know they need to lose weight that know they need it that know there's somebody there watching them,*

> *but yet they don't have to come to an office or take time out of their busy day. They can do it online, and they're still going to get the responses . . . there are so many people so busy nowadays, they want to do things, but they don't want to take the time to go and get it done. But, if they can do it online, they feel better about it. I think its working . . . I definitely feel more comfortable. I feel I can say what I need to, and I know that I'm getting through and I know my tone and my pitch are right and that they are understanding what I'm saying.*

In short, this comment suggests that the acceleration and complexity of modern life has made face-to-face counseling difficult for many participants. In order for them to reach their goals, being able to engage with coaches online is perhaps their only option. Again, we hear echoes of rhetoric as "a productive architectonic art."[137] Given that counseling is moving online, there is certainly a risk that it may become less personalized, less direct, less in tune with the needs of particular individuals. However, this comment intimates that a key element of "verbal rhetoric," the cultivation of tone in the formation of persuasive discourse for a particular audience, may address the perceived impersonality of the technological medium.[138] This is, of course, not a justification for abandoning all face-to-face encounters. Nor is it a valorization of turning to the online setting to solve all of the problems with acceleration and complexity in modern life. One solution supported by this author is to slow things down and reclaim our physical humanity. However, virtuality need not be viewed as a complete evil. One can detect the hesitancy of the respondents, at least at first, to embrace the online portal, but, having worked with it, they are now willing to embrace its role, among a variety of other tools, in the promotion of health.

Finally, as with all technological tools, breakdowns and errors occur. As one CPDT member notes, "*[The OLSS] has been riddled probably with a few more problems, technological problems, than we would wish to have.*" This is a reality of modern healthcare and something that will continue to be a problem, not only for online interventions but also for the variety of

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[137] McKeon, "The Uses of Rhetoric," 48.
[138] McKeon, "The Uses of Rhetoric," 63.

highly technological clinical interventions that are increasingly available. However, remaining tied to the situation, the particular, and the experiential carries with it all sorts of risks as well. Even face-to-face communication will never be perfected. What we can learn from the perspectives of the interviewees recorded in this section is that new situations demand inventional resources, in this case, the resources of rhetoric.

4.4 *PHRONESIS*, CONSTITUTIVE RHETORIC, AND LIFESTYLE MANAGEMENT

Several themes have emerged across the many interview comments described in the previous sections that bear repeating. First, the notion that lifestyle management is a dialectical process, a mode of *paideia* that calls for ongoing interactivity and cooperative problem-solving takes us back to the "Chronic Care Model."[139] Recall that chronic diseases cannot be resolved easily in the clinical setting, especially when physicians are overwhelmed by high numbers of patients and too little time to manage their specific problems. The role of the lifestyle coach is to fill this gap, to guide patients through interaction and intervention; to keep them on track. Second, the notion that sound chronic care practices may only emerge through iterative and collaborative development draws directly on McKeon's notion of rhetoric as "architectonic" (chapter 2).[140] In other words, interdisciplinary activity, fed by ongoing interactions between practitioners with very different epistemic and practice-based orientations, is at the heart of the OLSS coaching strategy. Thus, the interview comments of lifestyle coaches and CPDT members recounted above

[139] Edward H. Wagner, "Chronic Disease Management: What Will It Take To Improve Care for Chronic Illness?" *Effective Clinical Practice* 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action," *Health Affairs* 20, no. 6 (2001): 64-78.

[140] McKeon, "The Uses of Rhetoric."

yield important substance regarding how the structuring features of rhetoric play a role in the cultivation of their practices allowing them to improve through engagement with one another and the ongoing effort to fit general principles to specific cases (the dual dialectics discussed earlier in this chapter). Directly related to this theme is the need to personalize, to prioritize the often idiosyncratic (or at least specific) problems of participants. This is in keeping with my key term *phronesis* as developed in chapters 1 and 3. Finally, the shift to the online medium has provided key inflections for the discussion of rhetoric's role in a highly "technological age."[141] In short, rhetoric plays, according to one respondent, a "*sorting*" function related to the art of arrangement in rhetorical theory and practice. That is, through the direct interaction made possible by the translation of "verbal rhetoric" into the online medium of the OLSS platform through careful attention to composition and tone, the lifestyle coaches address the risks associated with shifting the medium of communication, a concern Plato addressed long ago as the spoken turned into the written word.[142]

Beyond these themes, my analysis in this chapter yields insights for both rhetorical theory and the practices of healthcare practitioners. First, in terms of rhetorical theory, I believe I have made a strong case for a different (and quite possibly complementary) model of constitutive rhetoric than the one that Charland has offered. Instead of subjects being interpellated by discursive regimes far beyond their control, what I see in the words and documents produced by the OLSS CPDT members and lifestyle coaches is rigorous, reflective, and action-based moves to constitute their practices in ways that manage the divide between professional paternalism and patient autonomy.[143] In particular, the interviews have shown how complicated the constitutive

[141] McKeon, "The Uses of Rhetoric."
[142] McKeon, "The Uses of Rhetoric," 63.
[143] Charland, "Constitutive Rhetoric," 138.

process is and how the terms of the humanist tradition, bound up in the Greco-Roman conception of *paideia*, provide a map for reflectively constituting and re-constituting identity as a dialectical, pedagogical, and profoundly rhetorical affair. Thus, what we are left with, from a rhetorical standpoint, is the notion that the rhetoric of health and medicine must attend to the constitutive features of professional identification in order to unlock alternative possibilities for practice and that, in doing so, what we may find is not a monolithic medical paradigm being unreflectively reproduced but an approach to patient care that is rooted in *phronesis* and the cultivation of *eudaimonia* for everyone, regardless of their specific definitions.

This is where the worlds of Charland and McKeon intermingle. Where Charland imagines the constitutive function of rhetoric as a means to construct audiences through interpellation and ideological creep, McKeon raises the notion that the constitutive features of rhetoric are really about the cultivation of practices that cut across different domains and require the integration of different epistemic and practical approaches to solving shared problems. He argues that rhetoric as "architectonic" should "be positive in the creation, not passive in the reception of data, facts, consequences, and objective organization. It should be an art in which what any one says to be the case, judges to be good or evil, connects in relations, and establishes with some show of system and principles, is relevant as subject-matter, content, and product."[144] That is, for McKeon, rhetoric acts a s sort of generative machine, a site at which ideas, actors, and modes of life come into contact and form innovative concepts and tools for approaching the vicissitudes of technological life. He thus provides a more hopeful, and in the case of my respondents, relevant conception of the constitutive possibilities of rhetoric.

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[144] McKeon, "The Uses of Rhetoric," 63.

Second, in terms of health practitioners, this chapter has revealed a variety of areas for future research in the cultivation of best practices for lifestyle management. These include the various processes of constitution, from training to experiential learning. What the respondents suggest is that only a mixture of upfront training combined with attention to the particularities that only experience can provide is sufficient in the preparation of coaches to engage in the task of guiding patients to lose weight and manage co-morbid conditions. Furthermore, and in line with this insight, the respondents have variously pointed to the balance that must be struck between the generalization of knowledge (so central to medical research today) and the specificity of practice-based knowledge that may not ever reach the level of complete and general applicability. Moreover, the respondents suggest that the background assumptions of lifestyle management are rooted in the ancient tradition of dialectic, what they call "*guiding*" and that such guiding is not consistent with paternalism. Dealing with this tension will continue to be an important element of research into lifestyle management. Aside from the issues of training and pedagogy, the interviewees provide a host of insights for would be practitioners and researchers, in particular, those focused on the shift from face-to-face counseling to the online environment. Importantly, they suggest that tone, invention, wording, and access are overlapping areas in need of additional research.

Finally, this chapter has provided an additional case study into the attributes of professional practice, joining a multitude of such studies in the domain of medicine (and other domains).[145] The innovation on these studies in this chapter is the suggestion that *phronesis* might capture the wide-ranging issues of experiential learning and not simply the virtue-based concerns of bioethics (see chapter 3). Instead of deploying the term *phronesis* in its hackneyed

[145] Outside of medicine, see e.g., Donald A. Schön, *The Reflective Practitioner: How Professionals Think in Action* (Basic Books, 1983).

context, as a marker of the virtuous subject, this chapter has deployed it time and again as a means to think through a form of learning that is rooted in experience, oriented toward praxis, and fundamentally concerned with language. The next chapter continues this work, this time in the context of patient experiences with lifestyle change.

5.0 RHETORICAL DYNAMICS OF PATIENTHOOD IN AN ONLINE LIFESTYLE INTERVENTION

> If the patient's knowledge and skills (literacy) are not commensurate with those of the doctor, then the skill attainment vision of health literacy leads to the patient as a pale shadow of the physician. Such literacy might empower the patient and make him more independent in the health system, but results in a dangerous independence. Empowerment might lead the patient to overestimate his real competencies and to favour deleterious health choices inspired by insufficient expertise. If, on the contrary, the patient's knowledge and skills are "close" to those of the doctor, then health literacy is tantamount to making the patient into a health professional, a goal that is unrealistic and unreachable.[1]

> Ill people still surrender their bodies to medicine, but increasingly they try to hold onto their own stories. Refusing narrative surrender becomes one specific activity of reflexive monitoring, and thus an exercise of responsibility.[2]

5.1 PATIENTS AS *PHRONIMOI*

My work in chapter 5 provides new and important substance to the claim that medical practitioners are engaged in an art as opposed to a science (that is, *phronesis*), a claim that has been made many times in the medical literature. This chapter turns to the less travelled domain of the patient as *phronimos* initiated in chapter 3. In other words, this chapter makes good on the promise to describe the role patients play in the reimaging of the healthcare encounter through *phronesis* and, in particular, the process of lifestyle management. Following from my work in chapter 5, *phronesis* may be viewed as one form of *paideia* (education). As a mode of training and praxis, *phronesis* dialectically transforms the "antecedent *paideia*" of the patient (a form of

[1] Sara Rubinelli, Peter J. Schulz, and Kent Nakamoto, "Health Literacy Beyond Knowledge and Behaviour: Letting the Patient Be a Patient," *International Journal of Public Health*, 54 (2009): 308.

[2] Arthur W. Frank, *The Wounded Storyteller: Body, Illness, Ethics* (Chicago: The University of Chicago Press, 1995), 16.

life that has created health problems) and offers a pathway to health and, more broadly, the good and fulfilling life (*eudaimonia*).[3] In this chapter, I deal specifically with the experiences of the participants in the Online Lifestyle Support System (OLSS) pilot study as reported by them in exit interviews in order to provide evidence that *phronesis* plays a definitive role in the practices that constitute their self-care.[4] I do this in order to contribute to the development of a conception of *phronesis* rooted in the world of the patient, or, in philosophical vernacular, "the care of the self."[5] Importantly, this turn provides content to the other half of the dialectical relationship between providers and patients that I map in chapter 5 by shifting the focus to patients and the various skills, habits, modes of reasoning, and types of learning (especially grounded and experiential) specific to their role in the cultivation of their health. In this regard, the work of this chapter is: (1) descriptive in the sense that it provides a description of how patients engage in their own care, and (2) normative in the sense that it provides robust arguments for a particular, and deeply humanist, conception of lifestyle change that may inform future iterations of the OLSS study and beyond.

In working through the constitution of the patient as caregiver of and for the self in the context of lifestyle management, I build on Sara Rubinelli, Peter J. Schulz, and Kent Nakamoto's

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[3] Martha C. Nussbaum, *The Therapy of Desire: Theory and Practice in Hellenistic Ethics* (Princeton: Princeton University Press, 1994), 97. On the concept of *eudaimonia* utilized here see e.g., Martha C. Nussbaum, *The Fragility of Goodness: Luck and Ethics in Greek Tragedy and Philosophy*, up. ed. (Cambridge: Cambridge University Press, 2001), 6 (fn). As Nussbaum points out here, John M. Cooper has developed a conception of *eudaimonia* rooted in the Aristotelian system that takes it as "human flourishing." On this, see John M. Cooper, *Reason and Human Good in Aristotle* (Cambridge, MA: Harvard University Press, 1975).

[4] Keep Samr (chapter 1) and Mary (chapter 3) in mind throughout as they provide a conceptual backdrop for the themes I find in the OLSS interviews.

[5] On the Platonic conception of "care of the self" see his *Alcibiades*. For a contemporary discussion of the philosophy of self-knowledge and self-care in Plato (and the Hellenistic tradition generally), see Nussbaum, *The Therapy of Desire*; Michel Foucault, *The Hermeneutics of the Subject: Lectures at the Collège de France 1981-1982*, ed. by Frédéric Gros, trans. Graham Burchell (New York: Picador, 2005); Michel Foucault, *The Care of the Self*, trans. Robert Hurley (New York: Vintage Books, 1988). Throughout this dissertation, I follow Nussbaum's conception of philosophical therapy and the care of the self.

patient-centered notion of health literacy as "phronesis" an a process of "letting the patient be a patient":

> Understanding health literacy as phronesis ultimately corresponds to our idea of what ''health empowerment'' really means. It entails neither the pale shadow of the professional's expertise nor the relativist denial of its possibility. It is not merely challenging the ''authority'' of the professional. The value of engaging in self-reflection ''informed'' by explicit goals as well as a base of declarative and procedural knowledge is to allow the patient to be a patient; interacting with health professionals effectively (asking the right questions) so as to enhance their health and, in a real sense, taking ownership of it. For the health provider, health-literate patients, far from being a threat, are an asset; patients who can make clear their health concerns, not only in terms of disease or disability but also in terms of health as an integral element of life.[6]

This perspective on *phronesis*, one of the only I have found that addresses the question of patients and the forms of knowledge they bring to the table, is one with which I largely agree. I have written elsewhere that the act of "asking the right questions," described here by Rubinelli, Schulz, and Nakamoto, is one of the central pillars of *phronesis*.[7] Their turn to a view of patient *phronesis* that "reflects the individual's capacity to contextualise health knowledge for his or her own good health [and] to decide on a certain action after a full appraisal of what that specific action means for them" is very close to the conception of *phronesis* I plan to defend in this chapter.[8] In particular, their attention to the capacity for "self-examination" is well taken as Aristotle views this as a core feature of "deliberative excellence" which is a constituent element of *phronesis.*[9] Moreover, their conceptual starting point that patients must engage in self-care *as*

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[6] Rubinelli, Schulz, and Nakamoto, "Health literacy," 310-311.

[7] John J. Rief, "Widening Applications of Phronesis in the Clinic and Beyond: Patients as Decision Makers," in the proceedings of the *7th Conference on Argumentation of the International Society for the Study of Argumentation (ISSA)*, 2011, CD-ROM.

[8] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309.

[9] On the role of deliberation (as a rhetorical skill) in *phronesis*, see Lois S. Self, "Rhetoric and *Phronesis*: The Aristotelian Ideal," *Philosophy and Rhetoric*, 12, no. 2 (1979): 130-145. See also Aristotle *Nicomachean Ethics* VI.v.1-2. In this passage, Aristotle argues that "We may arrive at a definition of Prudence [*phronesis*] by considering who are the persons whom we call prudent. Now it is held to be the mark of a prudent man to be able to deliberate well about what is good and advantageous for himself, not in some one department, for instance what is

patients is essential to the adequate translation of the concept of *phronesis* into the domain of patients. Without it, *phronesis* would lose its particularity and its situatedness within the individual experiences and decisions of patients seeking to care for themselves. In other words, failing to acknowledge the particularity of patient *phronesis* would undermine the effort to contribute to the development of more effective chronic care delivery primarily because chronic patients must take actions to care for themselves; they must care for themselves beyond the domain of the clinic and within their everyday lifeworlds.[10]

Building on these insights from Rubinelli, Schulz, and Nakamoto, this chapter features a case study that explores the quality of dialectical exchanges (what I have called dialectical *paideia*) between practitioners and patients, focusing on how such exchanges shed light on the element of *phronesis* as a mode of "self-examination" and a process of experiential learning.[11] Consideration of participant interview data paves the way for deeper discussion of the fundamental ground on which *phronesis* is developed, *paideia*, ultimately suggesting that *phronesis* is not gained simply through health literacy or through interaction with trusted healthcare professionals but also through the daily accumulation of experience within a socio-

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good for his health or strength, but what is advantageous as a means to the good life in general." Of course, Aristotle denies the term *phronesis* to specific modes of deliberation (e.g., about health); however, if Rubinelli, Schulz, and Nakamoto's argument that health is "an integral element of life" is correct, it is possible to collapse the distinctions that Aristotle is drawing here, that is, *eudaimonia* or "the good life in general" may include health as one central feature. Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309-311. Thus, health may be viewed as important content in the broader forms of deliberation which Aristotle points to here. Further, as I follow Nussbaum's version of Aristotle's arguments, the particular becomes more and more central to *phronesis*. In this way, the more general issues can only be unlocked once the "priority of the particular" is taken seriously. On this, see Martha C. Nussbaum, "The Discernment of Perception: an Aristotelian Conception of Private and Public Rationality," in *Love's Knowledge: Essays on Philosophy and Literature* (Oxford University Press, 1990), 66. Finally, regarding all of the arguments about the *phronesis* vs. *techne* question in this section, see my analysis of the medical analogy in Aristotle's ethics in chapter 3 of this dissertation.

[10] Edward H. Wagner, "Chronic Disease Management: What Will It Take To Improve Care for Chronic Illness?" *Effective Clinical Practice* 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action," *Health Affairs* 20, no. 6 (2001): 64-78; Arthur Frank, *The Wounded Storyteller*; Arthur Kleinman, *The Illness Narratives: Suffering, Healing, & The Human Condition* (Basic Books, 1988).

[11] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309.

cultural context. Moreover, I show how the virtual context of online lifestyle training provides one model for how *phronesis* might be promoted in patients seeking to lose weight and manage co-morbid conditions. The shift to the virtual setting recognizes the major transition to health information technology in the delivery of chronic care and, in particular, how new forms of technology and modes of interaction may benefit from a rhetorical perspective rooted in *phronesis*.[12]

By moving beyond (and expanding upon) the provider role into the realm of the patient in the ways I describe above, I provide a site for the cultivation of a particular model of *phronesis* as related to patienthood, one that emphasizes the role of the engaged, "activated," and prepared patient.[13] It is my contention in the pages ahead that the OLSS pilot study provides the unique opportunity to uncover the rhetorical work of medicine in the cultivation of such patients. As such, this chapter directly engages the question of how and to what extent *phronesis* can both (1) describe the process of lifestyle management in a way that is distinct from yet complementary with other critical terms circulating in health pedagogy (e.g., "self-efficacy" and the "transtheoretical approach") and (2) provide a warrant for the increasing transition to humanistic models and concepts in the domain of healthcare pedagogy and patient education.[14] Still more important, I argue that *phronesis* may contribute more than new descriptive and critical approaches to patient self-care. It may also provide a missing link in the clinical approach to

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[12] On the importance of accounting for technological change and its implications on the modes of communication humans use to build systems of knowledge and communities, see Richard McKeon, "The Uses of Rhetoric in a Technological Age: Architectonic Productive Arts," in *The Prospect of Rhetoric: Report of the National Developmental Project*, edited by Lloyd F. Bitzer and Edwin Black (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1971), 44-63.

[13] On the concept of "activation," see e.g., Debra L. Roter, Ruth Stashefsky-Margalit, and Rima Rudd, "Current Perspectives on Patient Education in the U.S.," *Patient Education and Counseling* 44 (2001): 79-86.

[14] On "self-efficacy," see Albert Bandura, *Self-Efficacy: The Exercise of Control* (New York: W.H. Freeman Company, 1997). On the "transtheoretical approach," see James O. Prochaska and Carlo C. DiClemente, "The Transtheoretical Approach," in *Handbook of Psychotherapy Integration*, eds. John C. Norcross and Marvin R. Goldfried, 2nd ed. (New York: Oxford University Press, 2005), 147-171.

behavior change, one that gets at how individuals change who and what they are in the service of their health and how they balance their health with their larger lifeworld.[15]

In short, the pages ahead provide a context for the iterative emergence of the patient as *phronimos* in three stages. First, I move into the domain of lifestyle change specifically, investigating a humanistic approach rooted in several key terms and ideas drawn from the Greco-Roman tradition of philosophical therapy.[16] Second, I put these terms (and a model that joins them together) to the test by analyzing patient feedback to their experiences in the OLSS pilot study, in particular, those elements of the feedback focused on participant experiences with online coaching. Third, in the conclusion of this chapter, I summarize my findings and argue that the approach to lifestyle change I defend in section 5.2 (and throughout this dissertation) may help to elucidate gaps in contemporary medical understandings of behavior change.

5.2 A HUMANISTIC MODEL OF LIFESTYLE CHANGE

The rhetorical and deeply humanist account of lifestyle change I develop throughout this dissertation consistently draws upon the rich Greco-Roman tradition of philosophy as therapy.[17] However, as I point out in chapters 1 and 3, philosophy is not the only therapeutic practice that the Greeks developed. In addition, and perhaps more importantly, rhetoric is a therapeutic art, one animated by the power of *logos* to act upon the mind like a drug (*pharmakon*).[18] But rhetoric need not act like a drug, removing agency and autonomy from the process of lifestyle

[15] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309-310.
[16] Nussbaum, *The Therapy of Desire.*
[17] Nussbaum, *The Therapy of Desire.*
[18] Gorgias, "*Gorgias' Encomium of Helen*," in *The Older Sophists, The Older Sophists: A Complete Translation by Several Hands of the Fragments in Die Fragmente Der Vorsokratiker Edited by Diels-Kranz with a New Edition of Antiphon and of Euthydemus,* ed. Rosamond Kent Sprague (Indianapolis: Hackett Publishing Company, Inc., 2001), 50-54.

management. Instead, following my rhetorically inflected conception of *phronesis*, I deliver a *logos*-based approach to reasoned self-reflection and the revision of one's practices. Following this line shifts rhetoric away from the Gorgian model and allows it to play a constitutive role in the cultivation of practitioners and patients as well as the delivery and practices of care shared between them (something more akin to the Hippocratic tradition as described in chapter 2).[19]

Taking this perspective allows me to develop a rhetorical account of the relationship between the three ultimate terms introduced in the first several pages of this dissertation where I discuss Samr "Rocky" Tayeh's efforts to lose weight: *paideia*, *phronesis*, and *eudaimonia*. *Paideia* refers to the transmission of culture through *logos*.[20] That is, language, at least in the Greco-Roman tradition, is the primary medium through which culture is transmitted and stabilized from one generation to another.[21] Martha Nussbaum argues that there are different senses of the term *paideia*, particularly when one takes into account the development of the different schools of ethics in the Roman era (e.g., Epicureanism, Stoicism, and Skepticism).[22] As she points out, these schools, following the works of Plato and Aristotle from the Greek tradition, take it as a mission to root out the "antecedent *paideia*" of their pupils and replace it with an aspirational *paideia.*[23] The distinction between these two senses of *paideia* is critically important in the context of lifestyle management. As Nussbaum notes, "antecedent *paideia*" refers to the

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[19] Joan Leach, "The Art of Medicine: Valuing Communication," *The Lancet* 373 (June 20, 2009): 2104-2105.

[20] Werner Jaeger, *Archaic Greece: The Mind of Athens*, vol. 1 of *Paideia: the Ideals of Greek Culture*, 2nd ed., trans. Gilbert Highet (New York: Oxford University Press, 1945); Nussbaum, *The Therapy of Desire*. See chapter 4 for more detail.

[21] For one view of the critical role of rhetoric as the medium of *paideia* in ancient Greece, see Isocrates' *Hymn to Logos* in his *Nicocles*, 5-10. Takis Poulakos argues that "Having linked rhetorical education with political life, Isocrates gave to those aspiring to educate themselves a means for deliberating the destiny of their city. More than that, the link between rhetorical education and political life he sought to secure opened a space from within which it would be possible for Athenians to regard educational activities as so many occasions to make themselves proficient in political deliberation, public controversy, and societal debate." Takis Poulakos, *Speaking for the Polis: Isocrates' Rhetorical Education* (Columbia, SC: University of South Carolina Press, 1997), 104.

[22] Nussbaum, *The Therapy of Desire.*

[23] Nussbaum, *The Therapy of Desire*, 97.

socio-cultural inputs (what health practitioners would call the social determinants of health) that have cultivated practices and modes of being that lead to illness and suffering.[24] Put another way, "antecedent *paideia*" refers to the background noise of culture (both material and symbolic) as well as the systematic attempts made by a culture to educate its members in the proper ways of life.[25] Over and against this version of *paideia* is a form of the concept that is aspirational and embraces the potential for self-transformation. That is, the Hellenistic philosophers (in a myriad different ways) seek to replace the cultural traditions of the present with a new mode of becoming, a way of transforming oneself in the pursuit of self-fulfillment and *eudaimonia* or "human flourishing."[26]

For example, the Epicureans accomplish this task by removing their pupils from the comfortable confines of their daily lives and providing them with a new locale, a garden, from which to engage in self-cultivation.[27] This garden provides, "an enclosed therapeutic community, at some distance from the city. It is rather self-sufficient economically; its members have few reasons to be in contact with their former associates in the city."[28] While I do not argue here that individuals should be completely removed from their cultural location or the relationships that give their lives meaning as they pursue weight loss, I do think the drive of the Epicureans to challenge the spatial, temporal, and spiritual location of pupils by placing them in

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[24] Nussbaum, *The Therapy of Desire*, 97.

[25] Nussbaum, *The Therapy of Desire*, 97. A respected reviewer at the National Communication Association's 97th annual meeting (2011) mentioned that I might consider the term *doxa* instead of *paideia* here. After some discussion, we agreed that *doxa* really applies to the formation of opinion in a general sort of way. In other words, it refers to a public form of knowledge-production that the likes of Plato would claim is insufficient to be named wisdom but that Aristotelians would recognize as useful, socially constructed knowledge. But it does not really capture the meaning of *paideia* as I use it here. *Paideia*, following Jaeger and Nussbaum, is not just opinion or knowledge but rather an entire cultural context that educates the individual in proper actions, norms, deliberative strategies, and ways of life.

[26] Cooper, *Reason and Human Good in Aristotle*, 1986.

[27] Nussbaum, *The Therapy of Desire*, 119-120 (and throughout).

[28] Nussbaum, *The Therapy of Desire*, 119.

a garden space devoid of cultural noise can provide some important insights in my unpacking of the concept of *paideia*. Recall that the OLSS provides a virtual space through which individually guided learning and dialectically rich interaction with coaches is made possible. This new site interrupts "antecedent *paideia*" and provides a new context in which learning and development may take place.[29] In the second half of this chapter, I investigate the extent to which the OLSS provides a rhetorical situation for the cultivation of new practices as a virtual *paideia* that allows for self-transformation.

Taking the notion of aspirational *paideia* as the undergirding framework or site of lifestyle management suggests that there is a way to challenge the preconceptions of one's culture, to develop a faculty or capability that might assist in the deconstruction of current norms (both internal and external) in favor of new norms and modes of interpretation and action. This language should sound familiar to the reader given the work already done in chapters 1, 3, and 4. It refers to a particular mode of *paideia* in practice: *phronesis*. As Aristotle notes, *phronesis* is developed through immersion in everyday experience (both experience of the natural world and of one's cultural milieu). The final outcome of such experiential learning is a dispositional state or "supreme directing faculty" that assists the individual in negotiating the gaps between their generalized modes of thinking and acting and the specific problems they face.[30] In other words, the model I propose for understanding lifestyle management draws on the general notion of *paideia* and then specifies it as the level of *phronesis*. What this suggests is that any aspirational effort to transform *paideia* (or the educational parameters and sites of meaning making through which one cultivates the practices of self that are best captured by the term *phronesis*) will need

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[29] Nussbaum, *The Therapy of Desire*, 97.

[30] Aristotle, *Nicomachean Ethics*, VI.vii.7. See also Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309-310.

to involve the cultivation of the capacity to engage in self-deliberation, interpretation, and the translation of the general into the specific needs at a particular point in time (*kairos*).

Moreover, when speaking of the Greco-Roman tradition, it is important to analyze the outcome (the goal, the thing to which one aspires) that frames the practices chosen by individuals in their efforts to achieve it. As noted in the previous section, according to Aristotle, the goal of *phronesis* is not a particular outcome (e.g., I want to be healthy, I choose a practice to achieve health, I become healthy). Instead, *phronesis* is animated by a concern with *eudaimonia*. A conservative and virtue-based account of *eudaimonia* might be very particular, oriented toward specific religious and moral doctrines. A health-oriented account of *eudaimonia* would feature only those elements that contribute to the health of one's body and longevity of one's life.[31] Moving beyond these narrow interpretations, I propose that *eudaimonia* involves a plurality of conceptions of fulfillment, flourishing, and goodness that are left to individuals and communities to define, revise, and realize over and over again. This is, in a nutshell, Nussbaum's conception of Aristotle's ethics, one that challenges utilitarian conceptions of satisfaction and deontological conceptions of moral duty, instead favoring pluralist conceptions of the good life and the activities that compose it:

> Aristotle saw people not as striving to maximize a state of satisfaction, and also not as striving to perform a list of duties. He saw them, instead, as striving to achieve a life that included all of the activities to which, on reflection, they decided to attach intrinsic value. He thought of the problem of life-planning as one that fundamentally involved deliberation about a rich plurality of rather general ends, in which the deliberator asked what concrete form of "moderation" or "courage" made most sense for his own life. Put in these terms, Aristotle's ethical enterprise is not unreachably "other" or impossibly foreign. Indeed, it might well be argued that it fits what real people do when they think about their

[31] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309.

> lives – even in present-day America – better than do the abstractions of utilitarian moral theory.[32]

This mutability of *eudaimonia* implies that it may or may not include a direct concern for health, or more to the point, the form of health aspired to may change from person to person. Some individuals may actively resist medical understandings of health in their everyday lives, instead deciding to favor other frameworks and values for achieving their sense of fulfillment. Furthermore, some individuals may seek to balance health with other sorts of goals so that the model of health utilized by physicians and other providers may not ever be completely realized. For this reason, *eudaimonia* is difficult to specify or speak about in terms of goals or outcomes because it involves the entire life process and overall aspirations of the individual. While my primary context is lifestyle management in the pursuit of weight loss, *eudaimonia* as defined here suggests that lifestyle management should involve a complicated process of balancing weight loss goals with other goals in the cultivation of a lifestyle that does not fully comport with a particular provider's sense of health but rather with the individual patient's sense of life as a holistic process.[33] Importantly, this sense of balancing broader life concerns with weight loss goals is in keeping with the concepts of patient autonomy and informed consent currently circulating in medical practice and scholarship.[34] My focus on *eudaimonia* here is an effort both to celebrate this move in 20th and 21st century medical practice and to foreground its importance in weight loss interventions because I believe this is central to their remaining ethical and humane. Finally, other models of lifestyle change currently in use recognize the importance of

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[32] Martha C. Nussbaum, *Cultivating Humanity: A Classical Defense of Reform in Liberal Education* (Cambridge: Harvard University Press, 1997), 119-120. On this, see also Martha C. Nussbaum, *Upheavals of Thought: The Intelligence of Emotions* (Cambridge: Cambridge University Press, 1991), 31-33.

[33] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309-310.

[34] Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 6th ed. (New York: Oxford University Press, 2009), 99-148.

eudaimonia but do not always deal with its complicated implications on achieving health and well being. As I show in the next section, the particular needs and values of patients at times get in the way of achieving weight loss and require either a renegotiation of the patient's goals or a re-interpretation of the meaning of progress toward these goals.[35]

In short, the humanistic model of lifestyle change I propose here implies that the patient as *phronimos* aspires to *eudaimonia* and achieves it through the complex and always ongoing process of "self-examination" and deliberation about health and about those elements with which health is balanced as well as the experiential process of learning needed to achieve this state.[36] Instead of seeking direct and final outcomes (e.g., weight loss), *phronesis* as a mode of *paideia* in pursuit of *eudaimonia* is best understood as a revisable process through which humans improve their dispositions, habits, and the like without ever fully perfecting these and with multiple goals in mind. In this way, the model I am proposing embraces Kenneth Burke's insight that humans are "rotten with perfection."[37] Combating this rottenness means accepting imperfection while simultaneously remaining committed (perhaps even obsessively) with the revision of one's practices and ways of life so as to (even if imperceptibly) come close to one's understanding of *eudaimonia*.

In the next section, I show how the model of lifestyle change adumbrated here accomplishes the task of elucidating how patients become capable of self-care. Most importantly, I show how the dialectical *paideia* of the OLSS cultivates a concern for the particular, enhances patient education and skill development, and provides a context for the rhetorical realization of the strong relationships needed to achieve health improvements (in particular) and *eudaimonia*

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[35] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309-310.
[36] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309.
[37] Kenneth Burke, "Definition of Man," in his *Language as Symbolic Action: Essays on Life, Literature, and Method* (Berkeley: University of California Press, 1966), 16.

(in general). In addition, I show how the virtual environment of the OLSS provides a unique educational space (one inflection of *paideia*) for the cultivation of *phronesis* and the search for *eudaimonia*. In the conclusion, I suggest how this humanistic and deeply rhetorical account fills in some gaps left in two other models of behavior change currently circulating in the medical literature.

5.3 THE CULTIVATION OF PATIENT SELF-CARE IN THE OLSS

5.3.1 Data Collection and Methods

The work for this chapter began in 2009 when I initiated my collaboration with the research group that developed and piloted the OLSS. At the time, the pilot study data, particularly participant exit interviews, were being analyzed to determine the overall effectiveness of the OLSS in promoting weight loss and the level of participant satisfaction with the online platform. Initial indications suggested that the study was quite successful. The 45 participants of the original 50 who completed the entire one-year program lost an average of 4.8 kilograms.[38] In addition, the exit interviews completed with participants bore out a high level of satisfaction with the online intervention tools as well as evidence of improved capabilities to manage weight through diet and physical activity.[39] Beyond these findings, the research group was interested in unlocking the communication outcomes produced by the intervention including: (1) the

[38] Kathleen M. McTigue, Molly B. Conroy, Rachel Hess, Cindy L. Bryce, Anthony B. Fiorillo, Gary S. Fischer, N. Carole Milas, and Laurey Simkin-Silverman, "Using the Internet to Translate an Evidence-based Lifestyle Intervention into Practice," *Telemedicine & eHealth*, 15, no. 9 (2009): 851-858.

[39] Kathleen M. McTigue, Tina Bhargava, Cindy L. Bryce, Molly Conroy, Gary S. Fischer, Rachel Hess, Laurey Simkin-Silverman, and Susan Zickmund, "Patient Perspectives on the Integration of an Intensive Online Behavioral Weight Loss Intervention into Primary Care," *Patient Education and Counseling* 83, no. 2 (2011): 261-264.

implications of coach and participant interaction on health outcomes, (2) whether the pilot program improved the communication between participants and their primary care providers, and (3) the extent to which participants' communication skills were enhanced. These questions catalyzed my initial interest in collaborating with this research group and eventually yielded this dissertation project.

Unlike my work in chapters 4 and 6, for this chapter, I did not personally design and conduct the interviews.[40] Instead, the University of Pittsburgh's Institutional Review Board gave me permission to engage in a secondary data analysis of the interviews after they were completed.[41] These exit interviews were completed with 35 of the original 50 eligible participants. All participants were invited to participate via e-mail (with telephone follow-ups). The interviews were conducted on the phone and lasted around 30 minutes. A semi-structured interview script with 13 overarching questions was designed to facilitate the interview process. A trained interviewer who was not associated with the OLSS completed all interviews. The interviewer was given additional follow-up prompts so as to encourage discussion and allow for rich details to emerge during the interviews. The interviews were audio-taped and transcribed.[42] I was given a full copy of the transcripts in the spring of 2009.

My first analysis of the interviews was a collaborative project focused on the expression of *phronesis* by participants. For this project, we analyzed only those interview questions "focused on the participants' experience with the lifestyle intervention and their routine primary

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[40] My only involvement in the crafting questions for the interviewees was the invention of several questions regarding whether and to what extent participants experienced enhanced communication skills, in particular skills that might assist them in interacting with their primary care physicians during routine care.

[41] I received approval from the University of Pittsburgh's Institutional Review Board for secondary data analysis on December 8, 2009. IRB # PRO09110527.

[42] John J. Rief, Gordon R. Mitchell, Susan L. Zickmund, Tina D. Bhargava, Cindy L. Bryce, Gary S. Fischer, Rachel Hess, N. Randall Kolb, Laurey R. Simin-Silverman, and Kathleen M. McTigue. "Promoting Patient *Phronesis*: Communication Patterns in an Online Lifestyle Program Coordinated with Primary Care." *Health Education & Behavior*, forthcoming.

care."[43] Our goal was to show how and whether the OLSS intervention promoted patient *phronesis* in the way I have described it in 5.2.[44] This study utilized a collaborative qualitative coding strategy to control for subjectivity and to define specific parameters of analysis. This allowed us to craft an argument for an audience of medical researchers and active clinical practitioners. Ultimately we developed two codes. The first was designed to capture the expression of *phronesis* by participants in their interview responses and was comprised of two parts: "(1) (a) the participant demonstrated insight into the interaction between behavior (lifestyle choices) and health; and (b) that experience was facilitated by participation in the lifestyle management program."[45] This code provides a definition of *phronesis* that is highly efficient for locating direct evidence of experiential learning and enhanced capacity to draw connections between behavior and health outcomes (part a). It also provides a clear way to connect such expressions with the OLSS rather than with the wider net of experiential learning that all humans undergo on a regular basis (part b). The second code was designed to capture the already prevalent conception of patient "activation" in the medical literature.[46] As we describe in the forthcoming version of this essay (cited below), activation is connected to *phronesis* and a term that is of major import to CCM practitioners.[47] The findings of this research indicate that expressions of *phronesis* (as narrowly defined above) and "patient activation" are prevalent in

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[43] Rief, Mitchell, Zickmund, Bhargava, Bryce, Fischer, Hess, Kolb, Simkin-Silverman, and McTigue, "Promoting Patient *Phronesis*."

[44] Rief, Mitchell, Zickmund, Bhargava, Bryce, Fischer, Hess, Kolb, Simkin-Silverman, and McTigue, "Promoting Patient *Phronesis*."

[45] Rief, Mitchell, Zickmund, Bhargava, Bryce, Fischer, Hess, Kolb, Simkin-Silverman, and McTigue, "Promoting Patient *Phronesis*."

[46] Rief, Mitchell, Zickmund, Bhargava, Bryce, Fischer, Hess, Kolb, Simkin-Silverman, and McTigue, "Promoting Patient *Phronesis*"; Debra L. Roter, Ruth Stashefsky-Margalit, and Rima Rudd, "Current Perspectives on Patient Education in the U.S.," *Patient Education and Counseling* 44 (2001): 82, 85.

[47] Rief, Mitchell, Zickmund, Bhargava, Bryce, Fischer, Hess, Kolb, Simkin-Silverman, and McTigue, "Promoting Patient *Phronesis*"; Wagner, "Chronic Disease Management"; Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action."

the interviews. 31% of the participants express some level of *phronesis* in at least one of their interview responses. Of these, 73% express some level of "patient activation." Overall, this project provides ample evidence that *phronesis* in some form is playing a role in the practices of lifestyle change that the participants are learning and putting to use in the OLSS.[48]

For the purposes of this chapter, I build upon the study summarized above by investigating a different set of questions to analyze the specific elements of lifestyle coaching that promote an overall framework for lifestyle management in the OLSS. Thus, my interest in this chapter is not to chart the frequency of *phronesis* in participant responses but rather to articulate a variety of inflections of the concept that emerge from my close reading of the participant interviews.[49] In order to accomplish this task, I have selected a different sub-set of questions from the exit interviews. These questions focus on the quality and impact of the coaching offered by the OLSS (Table 3). I have two reasons for focusing on these questions. First, these questions offer an excellent point of comparison between the coaches' experiences and the participants' experiences with the program. In other words, by looking at these questions, I can analyze the other side of the dialectic between providers and patients introduced in chapter 4. Second, these questions are meant to elicit the implications of dialectical *paideia* on participant satisfaction and success.[50] Thus, they offer an excellent site for investigating the interconnections between *phronesis*, *paideia*, and *eudaimonia* (5.2).

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[48] Rief, Mitchell, Zickmund, Bhargava, Bryce, Fischer, Hess, Kolb, Simkin-Silverman, and McTigue, "Promoting Patient *Phronesis*."

[49] Kenneth Burke, "The Philosophy of Literary Form," in *The Philosophy of Literary Form: Studies in Symbolic Action*, 3rd ed. (Berkeley: University of California Press, 1973), 1-137; Martin J. Medhurst, "Eisenhower's 'Atoms for Peace' speech: A case study in the strategic use of language," *Communication Monographs* 54 (1987): 204-220; Bent Flyvbjerg, *Making Social Science Matter: Why Social Inquiry Fails and How It Can Succeed Again* (Cambridge: Cambridge University Press, 2001).

[50] Recall from chapter 4 that my understanding of dialectical *paideia* substantially overlaps with the concept of "guiding" from the motivational interviewing literature. On "guiding," see Stephen Rollnick, William R.

Table 3. Interview Questions (Participants)

Questions about Experience and Satisfaction with Lifestyle Coaching
1) What was your experience with the [OLSS] lifestyle coaching?
2) What was most useful about the coaching?
3) What was least useful about the coaching?
4) There were 2 kinds of coaching notes. Periodically, the coaches sent out coaching messages. They also responded to specific questions. Which of these approaches was most helpful to you?
5) How satisfied were you with the level of support provided by the lifestyle coaching?
6) Would you have achieved the same level of lifestyle changes without the coaching?
7) Did the coaching help you work through barriers and develop problem-solving skills for future lifestyle challenges?
8) How did the coaching help you work through the barriers and develop problem-solving skills?

As the next several sub-sections unfold, I report on the variety of themes that emerge from my reading of the participant responses to the questions in Table 3.[51] As with the coaches, I highlight four primary themes with a variety of sub-themes (Table 4). These themes match those I report from the coaching interviews very closely: (1) dialectical *paideia* (*elenchus*), (2) collaborative problem-solving (which is close to the "collaborative knowledge production" I describe in chapter 5), (3) "the priority of the particular," and (4) human contact in the online environment (which is close to the "online environment: invention and tone" theme in chapter

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Miller, and Christopher C. Butler, *Motivational Interviewing in Health Care: Helping Patients Change Behavior* (New York: The Guilford Press, 2008), 7, 11 and throughout.

[51] As noted in chapter 1, my approach to criticism throughout chapters 4-6 is rooted in Bent Flyvbjerg's concept of social science understood through the lens of *phronesis* and Kenneth Burke's conception of tracking language through a text. See Bent Flyvbjerg, *Making Social Science Matter: Why Social Inquiry Fails and How It Can Succeed Again* (Cambridge: Cambridge University Press, 2001); Kenneth Burke, "The Philosophy of Literary Form," in *The Philosophy of Literary Form: Studies in Symbolic Action* (Berkeley: University of California Press, 1973), 1-137.

5).[52] These themes dialectically engage the themes from the coaching interviews, yielding opportunities to develop a more textured account of *phronesis* as well as the related terms *paideia* and *eudaimonia.* In pursuing adumbration of experience through the eyes of the individual participants, this approach complements the research group's earlier study, because it fills in the gaps and fissures in the *phronesis* coding mechanism we used there, in particular by showing how, why, and to what extent *phronesis* is developed through the OLSS as well as how this development is blocked or derailed. Success and failure are thus rendered equal in this reading strategy as they both provide a way to engage the question of how best to design lifestyle management strategies for imperfect human beings. Finally, this approach constitutes rhetorical analysis in that it seeks to unveil the grounded practices of individuals without necessarily generating generalizable knowledge claims about how people should communicate. As the sub-sections unfold, this insight becomes particularly salient. Finally, I should note that, unlike in chapter 5, I unpack quotations from far too many participants to provide each with a pseudonym. While it at times leads to clunky syntax, it makes it easier for me to report on their comments without consistently referring to a list of 35 names.

Table 4. Interview Sub-Theme Map (Participants)

Theme	Sub-Themes
Dialectical *Paideia* (*Elenchus*)	Intervening / Interrupting Providing Alternative Encouragement Internal Motivation/ "Self-Efficacy" Partnership and Social Support

[52] Nussbaum, "The Discernment of Perception," 66.

Table 4 (continued).

Collaborative Problem-solving	Overcoming Failure Dealing with Barriers Trouble-Shooting Technical Breakdowns Crafting Tools for Self-Management Collective Knowledge Production Knowledge Insufficient on its Own
"The Priority of the Particular" (Personalization)	Personalization as a General Feature Specific Examples of Personalization Difficulty of Personalization
Human Contact (Online)	Benefits of Online Environment Human Contact versus Automated Feedback *Kairos* (asynchronicity)

5.3.2 Dialectical Paideia (Elenchus)

> *OLSS Participant: I think just knowing someone was sort of keeping an eye out for you and actually – I don't want to say they cared about you, but in a way they were sort of checking up on you I guess is a better way of explaining it and that was . . . nice because you didn't feel like . . . oh, I'm doing this thing and I feel like I'm not getting any support. Like I totally felt like if I had a question or if I didn't understand anything . . .*
>
> *Interviewer: You had someone to turn to or some support.*

Much like the lifestyle coaches and members of the Coaching Protocol Development Team (CPDT), the participants in the OLSS speak at length about the importance of what I call dialectical *paideia* (chapter 4), or what Epictetus (following Plato) calls *elenchus*.[53] Recall that dialectical *paideia* has many features including the importance of engaging with interlocutors when making decisions, the importance of interrupting or intervening into one another's practices so as to question them and create space for thought, and the need to provide guidance

[53] A. A. Long, *Epictetus: A Stoic and Socratic Guide to Life* (Oxford: Clarendon Press, 2002), 74.

about how to change one's practices for the better.[54] These are all, as I argue in chapter 5, not merely elements of dialectic but rhetorical acts that assist in the co-construction of lifestyle change and the constitution of individuals capable of self-care. Thus, the participant interviews provide additional support for my claim that dialectical *paideia* takes the patient/provider relationship beyond motivation and into a realm of collectively produced knowledge and action, in short, the realm of rhetoric.

In developing this sense of dialectical *paideia*, I draw on Arendt's prescription for solving the harms of technological society – thinking while doing.[55] When one *does* something as if by rote, without thought or interaction with others, it forms a kind of labor, following Arendt, that can yield unintended consequences not only for the individual but for their entire relational network of friends, family members, co-workers, and others.[56] Burke has called this ontological state "motion" and it is not fitting for human beings that have the capacity not only to think but also to think about thinking.[57] There is not always an emphasis on the ability of patients to *act* as opposed to simply *move as told*, or alternatively, provide information to physicians as "data points" for the improvement of care.[58] While there is room in any account of the patient's role in lifestyle change for the notion that patients provide information to their physicians that

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[54] Rollnick, Miller, and Butler, *Motivational Interviewing in Health Care*, 7, 11, and throughout.

[55] Hannah Arendt, *The Human Condition* (Chicago: The University of Chicago Press, 1958), 5.

[56] Arendt, *The Human Condition*, 79-135.

[57] Here, I am drawing directly on Kenneth Burke's notion that human beings are capable of engaging in the "criticism of criticism." He writes, "Though all organisms are critics in the sense that they interpret the signs about them, the experimental, speculative technique made available by speech would seem to single out the human species as the only one possessing an equipment for going beyond the criticism of experience to a criticism of criticism. We not only interpret the character of events (manifesting in our responses all the gradations of fear, apprehension, misgiving, expectation, assurance for which there are rough behavioristic counterparts in animals) – we may also interpret our interpretations." Kenneth Burke, *Permanence and Change: An Anatomy of Purpose*, 3rd ed. (Berkeley: University of California Press, 1984), 6. On Kenneth Burke's theory of human motivation (as opposed to behavioristic action) see his *A Grammar of Motives* (New York: Prentice-Hall, Inc., 1952), esp. 64-69; Kenneth Burke, "(Nonsymbolic) Motion/(Symbolic) Action," *Critical Inquiry* 4, no. 4 (1978): 809-838.

[58] Kathryn Montgomery uses this language to describe the role of patients in the cultivation of physician *phronesis*. Kathryn Montgomery, "Thinking about Thinking: Implications for Patient Safety," *Healthcare Quarterly* 12, special issue (2009): e194.

can assist in making good diagnoses, this cannot be the only sense in which patients are made participants in their care.[59] Instead, the "activated, informed patient" must take control, must yield some form of power over their practices and the treatment modalities deemed relevant for their care.[60] My discussion of Arendt's work here links up with Rubinelli, Schulz, and Nakamoto's work on health literacy. They argue that "although there is a link between health literacy and behaviour, that link is neither necessary nor sufficient. What is needed to forge this link is the primacy of an existential goal of health enhancement."[61] This link, for them, is in part captured by the term *phronesis*.[62] That is, knowledge and action, what one says one knows and what one actually does, are not necessarily linked; they need a catalyst, a way to coordinate.

As I point out in the introduction to this chapter, Rubinelli, Schulz, and Nakamoto argue that there are major risks inhering in the coordination of thinking, speaking, and doing when it comes to health literacy. Most importantly, they contend that all too often, accounts of patient health literacy either view "the patient as a pale shadow of the physician" or health literacy as "tantamount to making the patient into a health professional, a goal that is unrealistic and unreachable."[63] One of the critical insights of this section is that participants in the OLSS, because they go through a process of dialectical *paideia*, are able to wield power over their condition, to challenge their ontological status by seeing that it might be otherwise.[64] According to Arendt, power may emerge from the coordination of language and action: "Power is

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[59] For example, Jerome Groopman offers the story of Anne Dodge who failed to receive an adequate diagnosis until someone finally listened to her entire illness story to illustrate how critical honest and robust interaction between providers and patients truly is to the effectiveness of health care encounters. Jerome Groopman, *How Doctors Think* (Boston: Houghton Mifflin Company, 2007), 1-48 (and throughout).

[60] Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action."

[61] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 308.

[62] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309-310.

[63] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 308.

[64] Remember that this is the ontological position of rhetoric as a field of study. See Trevor Melia, "Review," *Isis* 83, no. 1 (1992), 100.

actualized only where word and deed have not parted company, where words are not empty and deeds not brutal, where words are not used to veil intentions but to disclose realities, and deeds are not used to violate and destroy but to establish relations and create new realities."[65] Power is thus, following Arendt, a nexus of language and action coordinated through relational networks that act in consort for the transformation of states of affairs that are harmful to the community. Such power contains within it the possibility to change not only the individual but also the socio-political structures within which they exist, within which they make meaning and therefore use interpretation to craft their world. When one acts in consort with the words they utter, they have aligned *logos* with action in a way that is both truthful and contagious. Lifestyle change is a deeply therapeutic and constitutive process, one that might be "brutal" and thoughtless if it is not couched in the relationship between provider and patient and in the humanistic embrace of the thinking agent capable of acting on their own behalf.[66]

In short, Epictetus, Arendt, and Burke all offer a picture of human agency that is rooted in autonomy and in the (deeply humanistic) belief that individuals can take action to transform their own lives and, in so going, achieve *eudaimonia*. In fact, transformation is itself part of autonomous life. Without change, being remains locked in the unthinking cycle of labor.[67] This is not to say that individuals who are dealing with obesity and diabetes who refuse to change are somehow locked in the world of motion, incapable of thought. Instead, what I am suggesting here is that, should individuals decide to change their lives in order to lose weight and manage co-morbid conditions, this choice can be honored with an approach that respects their choice-making capacity.

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[65] Arendt, *The Human Condition*, 200.
[66] Arendt, *The Human Condition*, 200.
[67] Arendt, *The Human Condition*, 79-135.

Chapter 4 details the thinking while doing that inheres in the practices of lifestyle coaches. This sub-section details the other side of the thinking while doing dynamic: the participant (or patient). When paired with my work in chapter 4, this section provides the needed dyadic partner to show how the rhetorical and highly synthetic process of lifestyle coaching works. As the reader can see in Table 4, this section deals with a number of themes that indicate the ways in which dialectical *paideia* has been experienced by the participants in the OLSS pilot study. In particular, I deal with the following sub-themes all of which provide specific content regarding the meaning of dialectial *paideia* as related by the participants in their interviews: (1) intervening, (2) providing alternatives, (3) the importance of encouragement, and (4) the need for other factors such as internal motivation and the role of relationships with others beyond the context of the OLSS.[68] All of these themes indicate the different inflections given to dialectical *paideia* by the participants in the study.

One of the primary themes that emerges from my reading of the participant interviews has to do with lifestyle coaches dialectically intervening into the thought processes and practices of participants. One participant suggests, "*[the coaches] Were very helpful . . . a couple of times that I had not . . . logged in or done anything online because of my health issues . . . I'd get an email or even occasionally a phone call to check in and make sure that . . . I . . . still wanted to be in the program . . . that I was okay and able to . . . take part and stuff like that.*" This same participant goes on to say, "*it was most helpful for me for the coaches to reach out to me*." This participant then uses the metaphor of a "*hook*" to describe this process of reaching out, of being called back into the program. This is a central feature of the mode of constitutive rhetoric detailed in chapter 4 that my analysis stands at the heart of lifestyle coaching pedagogy. While

[68] This conception of "internal motivation" is very close to the concept of "self-efficacy." On this, see Bandura, *Self-Efficacy* and my discussion of it in the conclusion of this chapter.

some might read it as a mode of interpellative constitution, this participant shows that it is something more – an invitation to reinitiate their efforts at lifestyle change, to rejoin the relational network of the OLSS and continue with the program.[69] The notion of a "*hook*" reaching out and, rather than grasping, inviting a person back into conversation stands at the heart of many of the participant responses I detail in this section.

In this same vein, another participant reports that "*with the coaches, with them helping to push me on, it made it a little bit easier because I was held accountable to someone other than myself.*" This link between dialectical intervention and accountability is one of the critical points that comes up consistently throughout the interviews. It indicates that the ability to engage in lifestyle change is not fully internal; it cannot be explained through a model of communication or praxis that is limited to the individual. Instead, as Arendt points out, the power of action and the ability to transform one's world comes from the coordination of words and deeds and thinking while doing throughout a wider network.[70] For example, another participant suggests, "*I thought they [the coaches] were very helpful and doing everything they could to be supportive. They were always offering assistance if we needed it. There were a couple of times when I was getting off track and that was something I could count on them for*." This participant echoes the theoretical framing I have given to this entire section, primarily that it is easy to fall into doing without thinking, especially when contact with others is cut off or remains dormant. Being interrupted in this process through a dialectical intervention by an interlocutor can put someone back on track. As another participant notes, this same process can also yield corrections to bad practices: "*you may have thought something was good for you and it wasn't – it was bad. So it*

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[69] Maurice Charland, "Constitutive Rhetoric: The Case of the *Peuple Quebecois*," *Quarterly Journal of Speeh* 73 (1987): 133-150.

[70] Arendt, *The Human Condition*, 5, 200.

[the coaching] kinda tells you where you're at and what's right and wrong." Finally, and in line with this notion of correction through interruption, another participant notes, "*I think the people [coaches] were very helpful. It was great to get the emails . . . that gave you feedback about how well you were doing because I think sometimes you have unrealistic goals . . . you want to drop like 30 lbs and its not something that you can do.*" The internal drive to *do* without *thought* described here is one of the main things that the coaches and CPDT attempt to change. Setting goals rooted in a desire to fully overcome one's health problems through a quick fix violates the basic tenets of the OLSS and may not contribute to lasting health improvements.[71]

The previous paragraph brings to the fore another major theme in the participant interviews, primarily the role played by the lifestyle coaches in providing alternatives that may not have occurred to participants but that will assist them in staying on track and losing weight in a healthy way. Put another way, the process of lifestyle coaching requires, according to the participants, not merely the intervention of another to remind them about their goals and progress but also substantive content that allows alternative modes of action to emerge. As one participant notes: "*I think the number of times I sent one of the coaches an email about the program is, you know, maybe once or twice throughout the entire . . . process. But they would send me messages and, you know, because of that, they'd give something to respond to and something to kind of grab onto so to speak.*" This participant goes on to report at length about how coaches not only interrupted them in their daily activities through dialectical intervention but also provided

[71] The literature regarding quick fix dieting is vast and diverse. For a study showing modest weight loss and other health gains at one year of participation in several popular diet plans, see Michael L. Dansiger, Joi Augustin Gleason, John L. Griffith, Harry P. Selker, and Ernst J. Schaefer, "Comparison of the Atkins, Ornish, Weight Watchers, and Zone Diets for Weight Loss and Heart Disease Risk Reduction: A Randomized Controlled Trial," *Journal of the American Medical Association*, 293, no. 1 (2005): 43-53. For a systematic review of research regarding the effectiveness of diet-only weight loss programs, see Traci Mann, A. Janet Tomiyama, Erika Westling, Ann-Marie Lew, Barbara Samuels, and Jason Chatman, "Medicare's Search for Effective Obesity Treatments: Diets Are Not The Answer," *American Psychologist* 62, no. 3 (April, 2007): 220-233.

specific content about how to change and, in addition, how to interpret progress (or lack of progress):

> *I think it was mainly through that different perspective . . . That a third party can kind of bring to some things. You know . . . I'm very close with my own health issues and it's sometimes harder for me to have an objective perspective on my progress . . .Whereas . . . it's a lot simpler for . . . a third party, to come in and say oh well, you have lost ten pounds so far over the last couple of months. And . . . you know, that's a great thing . . . Where I might think, you know, I haven't done much or I haven't done very well and, you know, something from the coach that says . . . you have made good progress and you've been . . . working the program and doing this and that and it's . . . nice to have that other perspective from somebody else that's not so close to my own . . . thinking and my own issues.*

Here, several elements come to the fore; primarily that having another perspective can change the way that someone thinks about his or her progress in terms of lifestyle change. It can provide an alternative grounding for interpretation that assists in overcoming barriers such as failure.[72] But the critical element is the existence of someone on the other end. As this participant admits upfront, he or she did not often contact the coaches; instead, this participant would fall into a kind of rut and then suddenly be pulled back from the brink by the coaches or given new tools to handle unforeseen or difficult situations (both in terms of thinking and doing, interpretation and action).[73]

Another participant describes this sense of falling into a "*rut*" in this way:

> *Each time I ran into any kind of wall, I just would say . . . I'm in a rut . . . I really am getting tired of this. They'd [the coaches] say . . . we understand it. It's okay. It's common. Because that was my biggest problem. I kept getting off the program. And every time I did, I would write and say, you know, help. And they would come back and say okay, it's all right. Don't feel bad about it. Just keep on trying. You know, get out the paper. Start writing things down. And it worked. It worked every time.*

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[72] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 310.
[73] Arendt, *The Human Condition*, 5.

This participant adds important substance to the idea that the coaches provide alternative pathways for thinking while doing.[74] Here, the metaphors of the "*rut*" and running into a "*wall*" describe the moments when individuals fall into patterns of action that lack the critical thought necessary to break out of them, to select an alternative pattern. This process for patients is very similar to the problem with "pattern recognition" that some physicians face.[75] While recognizing patterns is central to the diagnostic process, it can also lead to problems when the disease process underway looks like one thing but is in fact something else. In a similar way, patients can fall into patterns of doing that are unhealthy, that must be interrupted to find a transformative pathway around them. In addition, this participant does not simply wait for the coaches to engage them. In this case, the participant asks for help and receives it.[76] Moreover, this participant describes a specific practice suggested by the coach to produce alternative approaches to solving their problems: going through a process of "*writing things down*" in an effort to critically engage unthinking practices.[77] Thus, dialectic (both with interlocutors and with oneself through the practice of writing) can allow both of these elements to emerge and take root in the mind and within the practices of the individual thus providing an alternative pathway to success. Recall here that for Aristotle and Isocrates, self-deliberation is an important element of *phronesis.*[78] Therefore, the words of this participant call forth direct evidence that *phronesis* is at work in the activities of the participants.

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[74] Arendt, *The Human Condition*, 5.

[75] On the problems associated with "pattern recognition" and its resolution through dialectical exchanges between providers and patients, see Groopman, *How Doctors Think*, 55-56 (and throughout).

[76] A process central to the adequate use of *phronesis* as a form of "self-examination." Rubinelli, Schulz, and Nakamoto, "Health Literacy," 310.

[77] Michel Foucault notes that writing is one of the primary means through which the Hellenistic philosophers believed one might correct her own practices through reflection. Foucault, *The Hermeneutics of the Subject*, 331-370.

[78] Aristotle *Nicomachean Ethics* VI.v.1-2. Isocrates *Nicocles* 5-10. It is also central to the framing of *phronesis* in Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309.

In addition, the participants often note that this mode of dialectical intervention and providing alternatives is done in a way that avoids blame. This brings me to another theme that runs throughout the participant responses: encouragement through dialectic. One participant reports that the style of encouragement offered by the lifestyle coaches plays a central role in cultivating useful interactions, primarily because it is offered as an alternative to blaming:

> *The Encouragement. The referencing to different alternatives. It was never a situation of being accusatory or I'd say blaming someone for not living up to their part of the deal, if you will. It was always just . . . positive and encouraging, you know, whatever happened in the past is the past, but let's move on from this point, what did we learn kind of stuff . . . the young lady who I had was excellent.*

This is no small point. A common thread in public discussions about lifestyle change and obesity is the way that focusing on weight as a health concern can cause stigmatization, guilt, and shame for those dealing with it. Negative judgment, whether it occurs in the public sphere or in the clinical environment, causes major psychological and emotional trauma for some individuals.[79] This participant reports that the OLSS lifestyle coaching approach confronts these problems by avoiding "*accusatory*" language and "*blaming*" instead focusing on "*encouragement*" and "*referencing different alternatives*." Thus, this quote shows how the previous theme of providing alternatives is linked to the process of encouragement. Giving alternatives to individuals instead of merely blaming them for failure is itself a method of encouragement, a way of providing meaningful support.

Another participant describes this idea through the lens of human weakness, failures, and inevitable imperfections:

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[79] I should also note here that blame and stigmatization are critical elements of the obesity problem that practitioners must deal with in the delivery of care. For example, see Abigail C. Saguy and Kevin W. Riley, "Weighing Both Sides: Morality, Mortality, and Framing Contests Over Obesity," *Journal of Health Politics, Policy and Law*, 30, no. 5 (2005), 870, 912-915; Emma Rich and John Evans, "'Fat Ethics' – The Obesity Discourse and Body Politics," *Social Theory and Health* 3 (2005): 341-358.

> *Well, one of the coaching things that's always useful that [my coach] provided and I'm sure [my coach] probably said this a hundred thousand times if once, is go into a holiday with a plan and then don't worry if you screw up, just start over the next day. That's a really good plan and I know all of the messages in the whole program including the coaching did that. But, its always useful when someone affirms your effort even though you messed up . . . the coaches were always there to say "take it easy on yourself, you're only human. Just get back on track."*

According to this participant, instead of engaging in blaming or negative reinforcement, the coaches, at least according to this participant, openly accept what Burke would refer to as the "foibles" that make humans what they are.[80] This is indicates a philosophy of pedagogy rooted in positive reinforcement and the acknowledgement that failure is part of the learning process. Another participant refers to this approach as "*non-judgmental*" which indicates that the dialectical interventions used by the coaches to help participants get back on track are not about drawing conclusions but are rather focused on situated problem-solving. I will turn to this issue more directly in 4.3.3 below.

Two other elements of the encouragement sub-theme build upon those already discussed with a slightly different emphasis. First, many participants use the language of staying positive. As one participant notes, the lifestyle coaches provide tips on, "*how to stay positive. How to just [sic recte, keep] planning every day. That part of it was just great because I think a lot of [the program] really is mental . . . if you can keep yourself focused on what you want . . . and go for it, it makes it so much easier to wake up in the morning and have a plan.*" Another participant

[80] On this, see Burke, *Grammar of Motives*, 319: "[Burke's critical attitude or posture] would find human foibles a theme for constant contemplation. But it would not make the mistake of thinking that the lore of human foibles stops with the depicting of different personal types in fictions. There is also the *categorized* lore of human foibles, as we find it expressed in proverbs or moral philosophy. Generalizations about human ways are as essentially humanistic as is the depicting of some particular person acting in some particular way; and they are needed to complete the act of humanistic contemplation. And all this comes to a head in the contemplation of men's linguistic foibles, which can so drastically transform their ways of life."

suggests the same insight, in this case providing a specific example of how a coach provided assistance in staying positive:

> *It was stress. I was under a lot of stress and when I stress, I eat sweets . . . And that's always been a downfall with me, but it was just darn stressful at that point, that I was just trying to get my mind off of it and I couldn't walk to wear off any of the stress cause I have scoliosis and sciatica at the time . . . but the encouragement was helpful*.

According to this participant, the dialectical intervention (e.g., interruption through the use of coaching notes fitted to the specific problems faced by participants) of the coaches provides support during a dark moment, when health problems have undermined the possibility of adequately engaging in the program. Second, many of the participants report that the coaches are enthusiastic and, thus, better able to help them maintain a positive approach to weight loss. One participant notes, "*[the coach's] general enthusiasm for what [the coach] was doing*" is "*contagious*."

A few participants offer insights that point in a very different direction from the sub-themes already discussed in this sub-section. First, at least one participant suggests that internal motivation is more important (at least for them) than contact with the coaches[81]:

> *Well, they [the coaches] were persistent . . . I'm sure if I were at another point in my life, much younger and perhaps heavier, I think they would absolutely be invaluable . . . I've been working on the exercise thing myself . . . for a number of years realizing that . . . I got to keep limber . . . Whether I would have done it without them [the coaches] . . . I was maintaining a pretty good active lifestyle for someone my age.*

This participant's suggestion that others might find the coaching useful meshes with "the priority of the particular" theme discussed in 5.3.4.[82] I mention it here because it pushes back against the value of dialectical intervention, indicating that some individuals might not benefit (or

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[81] Bandura, *Self-Efficacy.*
[82] Nussbaum, "The Discernment of Perception," 66.

experience a benefit) from it. I have not suggested in this dissertation so far that internal motivation plays no role or that it should not be emphasized in discussions of lifestyle change. Instead, I have focused on the relational elements, the dialectical exchanges between individuals, as central to the "power" needed to succeed in self-transformation.[83] This power inhering in dialectical exchange and rooted in the relational connections between different actors brings us back to Richard McKeon's notion of rhetoric as "architectonic."[84] One of the key elements of this "architectonic" function is arrangement, the artful organization of words, ideas, concepts, and actors into a synergistic whole.[85] That the online environment of the OLSS provides a context for cultivating such synergy, for arranging the interactions between different actors with different perspectives, shows the extent to which it draws on this "architectonic" function of language.[86] In addition, the fact that this process is occurring within a technological medium provides evidence for McKeon's defense of the importance of rhetoric and human interactivity in a technological age.[87] Furthermore, this participant shows that different individuals may benefit from different intensities of internal and external motivation. Dialectic as a sort of rhetorical therapy may have more value for some than others just as some pharmaceutical drugs have more or less therapeutic power depending on the patient in question, thus providing further evidence for the importance of prioritizing the needs of specific individuals when delivering lifestyle change interventions.

Another comment that moves beyond the themes already discussed has to do with the cultivation of other kinds of relationships outside the provider/patient nexus. For example, one

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[83] Arendt, *The Human Condition*, 200.

[84] Richard McKeon, "The Uses of Rhetoric in a Technological Age: Architectonic Productive Arts," in *The Prospect of Rhetoric: Report of the National Developmental Project*, ed. Lloyd F. Bitzer and Edwin Black (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1971), 44-63.

[85] McKeon, "The Uses of Rhetoric," 57, 63.

[86] McKeon, "The Uses of Rhetoric."

[87] McKeon, "The Uses of Rhetoric," 63.

participant notes, "*a lot of the success I experienced had to do with doing it with a partner. I would say that the coaching helped me through some time that I just didn't really want to do it anymore . . . But, it wasn't the most important aspect of the program for me.*" This participant reports two alternatives to the dialectical partnership between providers and patients: other relationships and other parts of the program. Again, it is not at all surprising that some participants might benefit more from the close relationships they have in their lives already. They may also benefit from other elements of the program including the online lessons or keeping track. Such elements capture the lifeworld of the patient in a way that makes transformation more possible and more consistent with the *eudaimonistic* context of each individual patient. Thus, this participant suggests that the mixture of elements needed for successful weight loss, their arrangement and importance, will differ based on the individual in question. Following this same line of thinking in the context of his "architectonic" view of rhetoric, McKeon argues that "In a technological age all men should have an art of creativity, of judgment, of disposition, and of organization. This should be adapted to their individual development."[88] In other words, the rhetorical skills that McKeon details are made relevant and useful through their "adapt[ation]," through their artful arrangement and variable applicability to different individuals with different needs, desires, goals, and resources. Achieving this sort of arrangement and specification when there are so many different elements to consider (e.g., differing lifeworlds, learning styles, means of communication, and relational networks) shows just how complex the adaptation of the OLSS to the needs of particular patients is. It also

[88] McKeon, "The Uses of Rhetoric," 63.

indicates just how pressing the development of "architectonic" skills may be in the effective delivery of lifestyle management.[89]

Expanding upon this concern with the particularization at the heart of successful lifestyle management, but moving in a more critical direction, one participant compares the lifestyle coaches to cheerleaders: "*they were extremely receptive, but sometimes it just seemed like they were too . . . cheerleaderish*." Of course, this is only one participant. Others seem to have benefited from the positive reinforcement they received. However, the fact that one participant reports this sense of cheerleading indicates the degree to which personalization and tailoring of care is so important. It also shows yet again how important the rhetorical worldview is to unlocking the implications of lifestyle change pedagogy. That is, audiences differ from one another and the construction of messages must be particularized in order to gain persuasive effect and inspire action.[90]

The participant responses in this sub-section suggest that dialectical *paideia* as a form of interruption, intervention, positive reinforcement, enthusiasm or the like, plays a central role in the relationship between the OLSS lifestyle coaches and its participants. In addition, these responses point out just how powerful thought and action, words and deeds, and dialectic can be in the cultivation of personal fulfillment and the transformation of self. As I show in the following sections, these ideals continue to spring anew as the participants describe their efforts to solve problems, address the everydayness of their experiences, and deal with the online environment.

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[89] McKeon, "The Uses of Rhetoric."

[90] Lloyd F. Bitzer, "The Rhetorical Situation," "The Rhetorical Situation." *Philosophy and Rhetoric* 1 (1968): 1-14.

5.3.3 Collaborative Problem-solving

> *Well, the fact that you could ask questions that were not in the lessons or maybe were not clear from the lessons . . . we weren't exactly inventing rockets here. So a lot of the questions are just simple, so what you do . . . if you go to a restaurant and you don't have any idea what the heck you're eating. You know, should you eat a half, a quarter and take the rest home, throw it away, share . . . what people already do know that you're still trying to figure out.*

> Even if other pathways to diagnosis prevail, the intuitive diagnostic process will always be with us . . . intuition and uncertainty are inescapable conditions of any instances of clinical decision making. From the point of view of theories of good reasoning and good argument, intuitive diagnoses are perfectly fine as long as the diagnostician has good reason to believe that intuition will produce the correct diagnosis in the case at hand. Evidence-based, logical medical practice does not necessarily mean reasoning and arguing logically from evidence in every particular case.[91]

The notion of solving problems in a relational and dialectical context extends upon my work on dialectical *paideia* above and hearkens back to the second theme discussed in chapter 4: collaborative knowledge production. The quote from Jenicek and Hitchcock's study of argumentation methods in clinical decision making that sits at the outset of this sub-section describes one way to understand problem-solving in clinical medicine: it is in the hands of physicians.[92] Physicians deal with uncertainty in diagnosis and treatment on a daily basis and, thus, most accounts of problem-solving in medicine focus on their practices. However, as I suggest in chapters 2 and 3, there is an increasing need to go beyond an examination of uncertainty, induction, and everyday decision making by *physicians* into the realm of shared decision making and the kinds of training needed to assist *patients* in making health-related

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[91] Milos Jenicek and David L. Hitchcock, *Evidence-Based Practice: Logic and Critical Thinking in Medicine* (American Medical Association Press, 2005), 189.

[92] This is also known as "clinical judgment." See, e.g., Alvan R. Feinstein, *Clinical Judgment* (Baltimore: Williams and Wilkins, 1967).

decisions for themselves.[93] The term "collaborative problem-solving" highlights the distinction between this theme and "collaborative knowledge production" from chapter 4. While there is substantial overlap in meaning and consequence between these two themes, the notion of "problem-solving" stands at the heart of other critical concepts like "self-management support," "activation," and the "informed, activated patient," and thus, is a sort of term of art to which I appeal in this section.[94] In addition, as I have discussed at length in the introduction to this chapter, "letting the patient be a patient," means treating the skills and epistemological status of patients differently and equitably.[95] I am not speaking here of creating a highly structured and generalizable model for pedagogy. Instead, my primary concern is the grounded, everyday practices of patients for whom healthcare is one element in a larger lifeworld.[96] Thus, "collaborative problem-solving" focuses our attention less on the cultivation of an entire body of knowledge (i.e., the knowledge needed to adequately assist patients in making good decisions) and more on the situated moments of decision making that emerge for patients and their healthcare partners in the day-to-day management of a lifestyle change regimen.

Therefore, in this section I unpack responses by participants that specifically relate to problem-solving as a matter of engagement between coaches and participants or as an outcome of the participants' overall participation in the OLSS (e.g., the completion of lessons in the online curriculum, keeping track, and the like which may not be associated directly with coaching). In some cases, the problem-solving methodology at play comes fairly close to the one

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[93] Rief, Mitchell, Zickmund, Bhargava, Bryce, Fischer, Hess, Kolb, Simkin-Silverman, and McTigue, "Promoting Patient *Phronesis*"; Rubinelli, Schulz, and Nakamoto, "Health Literacy."

[94] Wagner, "Chronic Disease Management"; Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action"; Thomas Bodenheimer, Kate Lorig, Halsted Holman, and Kevin Grumbach, "Patient Self-management of Chronic Disease in Primary Care," *Journal of the American Medical Association* 288 (2002): 2469-2475.

[95] Rubinelli, Schulz, and Nakamoto, "Health Literacy."

[96] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309-310.

described by Jenicek and Hitckcock.[97] There are certainly moments in the interviews, especially when considering the process of overcoming barriers, that participants bring issues to the coaches and receive advice about how to adequately manage these problems. This is nearly isomorphic with the traditional model of the provider/patient dyad in which the patient comes to the physician seeking diagnosis, prognosis, and treatment options. However, there are indications in at least some of the interview responses of another type of problem-solving, one born out of the coaching context but rooted in the experiential learning and decision making capacity of the participant rather than the advice or provision of alternatives by the coaches. That is, there are times when coaching does not seem to have played a major role in the development of lifestyle change skills for the participants. Sometimes an internal drive that is hard to decipher or account for seems to be at play. At other moments, the lessons from the online lifestyle curriculum seem that play a more central role. For this reason, this section challenges the thematic work of the previous section, indicating that while dialectic is an essential element in the OLSS, it is not always a determinative factor in the successes or failures of patients (at least not according to their own experiences). I see no problem with this as the approach I have been taking indicates that the particularity of individual experiences means different elements will play a more determinative role for different individuals. At the same time, I want to emphasize here that the vast majority of participants (when their comments are viewed holistically) tend to give the lifestyle coaches a great deal of credit for their success. In addition, the coaching seems to contribute to an increased capability within the participants themselves to engage in good decision making, thus adding evidence to support my claim that the participant responses indicate the development of *phronesis* as a mode of self-care.

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[97] Jenicek and Hitchcock, *Evidence Based Practice*, 189.

Multiple sub-themes emerge from my reading of participant responses that are directly tied to the issue of problem-solving, including: (1) overcoming failure, (2) dealing with barriers,[98] (3) troubleshooting technical breakdowns, (4) crafting tools for self-management (of which problem-solving is a primary feature), (5) the power of collective knowledge production (see chapter 5 for more context), and (6) the fact that knowledge (in itself) is often insufficient when attempting to solve problems. Again, many of these themes indicate the degree to which the dialectical elements of the lifestyle coach/participant relationship play a role in finding solutions to problems. As I suggest above, some of these themes indicate the degree to which the constitutive function of lifestyle coaching adumbrated in chapter 4 is not as central to the experience of some patients as one might think; however, this is only an indication of the experiential and practical differences between humans *as humans*. As such, this section complicates the story told in the previous section and provides evidence that the "rough ground" of experience is neither predictable nor fully measurable but rather textured, complex, and, at times, contradictory.[99]

The first cluster of sub-themes I detail here focuses on solving particular sorts of problems, that is, the participants face specific barriers to progress and often, although not always, seek the advice of the coaches. The first of these is overcoming failure. One participant puts the problem this way: *"The coaching along with some of the lessons specifically I think were great in kind of defeating my own issues with failure. You know, not doing things well enough and, you know, small amounts of progress are still progress."* According to many of the

[98] This is a concern that Rubinelli, Schulz, and Nakamot discuss in their work. Barrier can stand in the way of making necessary lifestyle changes. Yet, according to them, seeking guidance from someone with expertise may assist in overcoming such barriers. Thus, this sub-theme charts the extent to which seeking advice provides the needed assistance to overcome barriers. Rubinelli, Schulz, and Nakamoto, "Health Literacy," 310.

[99] Ludwig Wittgenstein, *Philosophical Investigations*, rev. 4th ed., ed. by P. M. S. Hacker and Joachim Schulte, trans. G. E. M. Anscombe and P. M. S. Hacker (Malden, MA, Wiley-Blackwell, 2009), S107; Joseph Dunne, *Back to the Rough Ground.*

participants, it is easy to fall into the belief that one failure means constant and never-ending failure. In addition, there is the problem of not being able to see progress when it is occurring. As this participant points out, coaching (and to some extent the lessons offered in the lifestyle curriculum) assists in dealing with these problems. Through collaboration (and dialectical *paideia* as described in the previous section), these problems can be addressed and overcome. Furthermore, this particular quote (and several detailed below) indicates the extent to which the approach of the OLSS, grounded in *phronesis*, provides an interpretive lens through which participants may make sense of their world.[100]

In addition, many participants report other barriers they face beyond the problems of failure and slow progress. One of these has to do with exercise. One participant notes, "*Like with exercise. I didn't have to do it all at one time. I could space it out. It would be just as valuable . . . I was really going gung-ho . . . but then they would say . . . you could split it up . . . And that was becoming a barrier because it wasn't pleasant.*" The problem of overdoing it and, thus, hurting oneself or avoiding exercise is a common one and this participant needs the engagement with a lifestyle coach to renegotiate the quality and intensity of an exercise regimen. Another participant reports, "*I remember specifically with exercise . . . when I said I didn't have time, or this was a problem or that was a problem, they gave different suggestions on how to get it in*." Still another participant states, "*some of the feedback, well if you tried to add this many more minutes every week, you can up your activity by this much or you know try to do this type of activity versus another. There were those types of responses back. And I looked over my week's progress, I do better*." As these participants suggest, two problems individuals commonly face

[100] Recall that my conception of *phronesis* is grounded in experiential learning; however, one cannot simply learn from experience without an interpretive and deliberative framework. Deliberation is central to the concept of *phronesis* as developed by Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309-310.

when dealing with exercise is how to fit it into a schedule and do the right sort to achieve weight loss. Here, these problems are handled through a form of dialectical and grounded discussion. These three examples build on the insight of this dissertation, primarily that individuals have very different problems and that solving them requires both the capacity of the individual to report the issue they are experiencing and the situational responses of an expert or mentor who can help the individual to overcome it through self-care. The key to these examples is that only in tandem, with proper feedback between both parties, could these issues truly be resolved.

Another kind of barrier for which the participants turn to coaches for collaborative problem-solving has to do with lifestyle barriers that revolve around work and other scheduled activities. For example, one participant offers this story:

> *I was leaving after a time of 34 years of employment at the school district, full-time employment into full-time ministry, but the time barriers or maybe eight to ten hour days was going to be reduced considerably so I would spend a lot more time at home. Well, the reality was what opened up was community ministry opportunities . . . So what I ended up doing was even having less time that I thought I was going to have as a result of it. And since I was traveling sometimes 150, 300 miles a day back and forth, it got to be quite exhausting and . . . by the time I got home, I was just too tired . . . Well, the one thing that it did [coaching] is it didn't focus on the problem as much as it focused on alternatives and moving forward from this point. To say, you know, don't get bogged down in what you weren't able to accomplish. Let's see what you did accomplish and let's kind of build on that.*

This participant echoes the problem of failure and progress mentioned above but adds the issue of time constraints, something that many people face in a highly accelerated and labor intensive world. This quote, above all, indicates the importance yet again of Arendt's concern with collaboratively engaging in action.[101] One individual cannot surmount the considerable time constraints presented by the need to make a living and pursue goals that are, in one way or another, at odds with one another. Yet in a relationship with others, for instance with a coach,

[101] Arendt, *The Human Condition*, 190.

transformation and progress becomes possible. Another issue directly related to time and schedules that comes up throughout the responses has to do with holidays: "*holidays were always stumbling blocks for me . . . It was a barrier . . . and we would sort of work through these things and then afterwards, it was really nice because they said [the coaches] like how did you get through Thanksgiving? Or how did you make it through Christmas.*" Again, the coaches dialectically manage these issues with participants, providing not only alternative ways to maintain diet and exercise but also different ways to frame and interpret progress, or alternatively, lack of progress.

Another barrier that many of the participants mention has to do with developing new skills to overcome old habits and ways of thinking, or, to use Nussbaum's language, combat "antecendent *paideia*."[102] It is in this context that some of the participants report a sort of self-initiated problem-solving that they have developed over time by working through the lessons in the OLSS lifestyle curriculum. The coaches play a very small role in these responses indicating that for at least some participants, the dialectical elements of lifestyle coaching I describe in the previous section are not always in play. For example, one participant notes,

> *I think the overall thing I gained from the program was a better understanding of nutrition. I was pretty good at that before, the problem is when you live your whole life with the excess weight it just doesn't disappear overnight. So, I made a lot of changes over the course of the last few years from when I was diagnosed with diabetes, but I'm having a problem strictly with the weight loss, and it doesn't get any easier as you get older. I think in that area, now that I still find myself . . . looking at things and saying 'No, that's not worth all these fat grams' and you know I'll still go to Starbucks and get my coffee, but I get it without the whip that's 12 grams of fat. I'll drive people crazy because I'll cite things like that . . . So yes, I definitely [think] there were some positive points because it [the OLSS] makes you more aware. I think at one point . . . somebody was gonna take that Calorie King book and shove [it] up my you-know-what . . . but you know I was really following it to a "T" and I was doing it to the extent that it became a burden for me and that's one of the reasons I ended up dropping out of the*

[102] Nussbaum, *The Therapy of Desire*, 97.

> *program when I did because I could not focus on that, it was becoming too much of a hassle.*

While this participant admits to having dropped the program, the content of the first half of the response could not be clearer: this participant is able to utilize the lessons learned in the lifestyle curriculum and apply them to everyday decisions and problems. Here, coaching does not seem to have played a very substantial role, despite the fact that this response comes in the context of questions about coaching. Moreover, this participant reports that, while he or she can engage in the right sorts of decision making, a constant focus on health (as opposed to other elements of *eudaimonia*) can take its toll. One lesson to be drawn from this is that lifestyle change may work in fits and starts, progress may be slow (as can be seen in the quotes previously discussed), and it may be something that, at least for some people, cannot be a fully sustained process. Another possible interpretation is that this participant might benefit from more direct coaching, something he or she seems to have missed in the program. Either of these interpretations produces key insights about how lifestyle pedagogy might be applied to the specific needs of an individual (e.g., allowing people to back away or coaching them to take time away from lifestyle change may be a healthy action to take).

Another participant reports a very similar, somewhat internal drive to make the right decisions, a drive derived less from coaching and more from knowledge provided by the OLSS lifestyle curriculum[103]:

> *Well without that program and being involved, I mean, as far as I went, no I wouldn't have achieved anything because you know, even though I have always been aware of what I eat . . . and reading labels and everything, I mean it just kind of reinforced what I already knew and so . . . I didn't have a problem with that, but it was helpful. I am always reading about stuff like that so whatever information I got from them was beneficial to me.*

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[103] Bandura, *Self-Efficacy.*

This participant reports an already internalized knowledge of health-related behaviors but limited capacity to manage their health without participation in the program. The knowledge of how to be healthy is assumed here; the program offers "*information*" which, as we have seen, is not necessarily action- oriented; however, for this participant, the program offers a context in which to engage latent knowledge and skills. In a slightly different way, another participant notes this same internalized capacity but also indicates that knowledge of how to act is not isomorphic with the capability or motivation to act[104]:

> *Because even now, even though I'm not doing it the way I should and its total laziness, I still know that if I eat my normal breakfast of oatmeal, a cup of soy milk and a tablespoon of raisins, I have the good breakfast . . . If I eat a salad and something for lunch – even if I don't log on, even if I don't journal, I know that's good . . . I weight my food, but pretty much now I can pretty much guess it out . . . I've learned all that – yeah. I've learned recognition you could say. I've learned all that.*

Viewing these two responses in tandem provides an opportunity to revisit my claim that *phronesis* goes beyond simple *techne* (learned skills and behaviors) and beyond knowledge of what to do. To reiterate, the coordination of thinking while doing is one hallmark of what can be called *phronesis*.[105] Both of these participants suggest that they *know* what to do, that they have adequate information. The first indicates a general knowledge of health already extant before the study and the second indicates that the learned behaviors emerge directly from the intervention. The question remains, what element takes someone from knowledge to action (and their coordination)? In the first instance, it would seem that the OLSS program somehow activates extant knowledge. In the second, knowledge is gained through the OLSS program but does not always lead to action ("*I'm not doing it the way I should and its total laziness*"). Explaining this

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[104] A point made throughout the literature on *phronesis*. In the context of patients, see Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309.

[105] Arendt, *The Human Condition*, 5.

gap, I have argued, is highly complex, but *phronesis*, the process that coordinates experience, thought, and action, seems to be the right conceptual tool for the job.

Other participants describe problem-solving as a matter of collaborative knowledge production featuring *phronesis*. For example, one participant observes, "*By sharing information that, you know, what other people have encountered or some other tips they, the coaches have learned from other people about how they approach certain issues. I think that was very helpful*." This participant lends credence to the claims made by the coaches and members of the CPDT that the coordination of knowledge gleaned through experience can play a highly positive role in the cultivation of solutions. Blending experience with the information contained in the lessons on diet (in this instance) allows this participant to make the right choices when eating at a restaurant. While this description seems closer to *techne* (e.g., to a list of good foods and calorie counts), it also suggests that accessing such knowledge is only possible once experience is shared, coordinated, and delivered. Of course, not all participants benefit from this sort of interactive knowledge production. Some provide answers to questions about coaching by saying things like, "*I did not work it long enough to get that aspect*," or "*I don't know*." Even when knowledge is coordinated and the lessons are accurate and well-produced, lifestyle interventions may not help everyone in losing weight or gaining the knowledge and capability to lose weight.

The various sub-themes circulating around the concept of problem-solving (e.g., exercise, time, scheduling, failure, the role of knowledge, etc.) suggest the scope of problems that one may face in attempting to lose weight and manage other chronic problems. Importantly, the insights the participants offer indicate the degree to which *techne* (e.g., specific habits, skills, and the like) is often critical in problem-solving. *Phronesis* comes into play as well, especially when knowledge and skills (again, *techne*) are ready to hand, but action is lacking. While I have

argued against a fully *techne*-based account of lifestyle change (see chapters 2 and 3), it is undeniable that *techne* plays a key role in describing skills that can be learned and put to use by a participant who has achieved some level of *phronesis* as well. Beyond the interface between *techne* and *phronesis*, the participants also indicate the variety of ways in which the dialectical collaboration between them and lifestyle coaches works. In some cases, the traditional clinical model (as understood by Jenicek and Hitchcock) in which physicians provide therapeutic solutions to patients seems to be at work.[106] There is some indication by the participants that at times, this is the most effective way to get a needed answer, often one having to do with *techne* or the particular skill or decision needed to achieve a specific outcome. However, other participants suggest that this model is not always enough, that knowledge is sometimes present without action. For them, the process of working with a coach to reframe experiential knowledge and their sense of progress (or lack thereof) assists them in overcoming barriers to activating their knowledge and *doing* something differently.[107] Still others report that the coaching may have not played a very important role at all, instead referencing the informative nature of the lessons and how they took action to use this information on their own (or, in some cases, failed to do so). This complicated picture suggests the degree to which some individuals already have certain traits such as "self-efficacy" while others may need additional support, support that is best described as *phronesis* (or the activation of knowledge that is not possible in isolation but only comes through coordination).[108] In the same way, "motivational interviewing" which covers many of the elements of my conception of dialectical *padeia*, is one method through which

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[106] Jenicek and Hitchcock, *Evidence Based Practice*, 189.
[107] Arendt, *The Human Condition*, 5.
[108] Bandura, *Self-Efficacy*.

participants seem to have overcome barriers, but it is not determinative of success.[109] In short, this complex set of descriptions and methods of solving problems indicates that there are remainders or "recalcitrances" at the edges of the concepts currently circulating in the medical literature that only *phronesis* may elucidate.[110] The next section shows how for many participants, *phronesis* is at the heart of successful interactions with the lifestyle coaches and how it assists in specifying generalized knowledge to address particular barriers, especially barriers that block the coordination of knowledge with efficacious action.

5.3.4 "The Priority of the Particular"[111]

> *[The coaches] try to adapt the program to you personally*. -- Participant

> The authors of the book called *Opinions from Cnidus* have given a correct account of the symptoms in patients suffering from various diseases and, in some cases, of the ultimate effects of the disease. Thus far indeed anyone might go, if he inquired diligently of each patient what his symptoms were, without being a physician. But these authors have omitted a great deal of what the physician should learn from his patient without his telling him; details which vary from case to case but the interpretation of which may sometimes be of vital importance.[112]

> Phronesis plays on this ''all things considered'' dimension: as an act of self examination it becomes the capacity of making health information relevant for action by recognizing those personal needs or limitations that can prevent its full appraisal and application in good health decisions.[113]

As with the coaches and the CPDT, one of the primary themes that emerges in the participant responses has to do with specificity of feedback, in particular its fit to the personal needs of the

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[109] Rollnick, Miller, and Butler, *Motivational Interviewing in Health Care*.

[110] I am borrowing the notion of "recalcitrance" from Kenneth Burke. See Kenneth Burke, *Permanence and Change*, 255-261. See also J.E. McGuire and Trevor Melia, "How to Tell the Dancer from the Dance," in *Science, Reason, and Rhetoric*, eds. Henry Krips, J.E. McGuire, and Trevor Melia, (Pittsburgh: The University of Pittsburgh Press, 1995, 73-93): 75.

[111] Nussbaum, "The Discernment of Perception," 66.

[112] Hippocratic writer, "Regimen in Acute Diseases," in *The Medical Works of Hippocrates*, ed. John Chadwick and W. N. Mann (Oxford: Blackwell Scientific Publications, 1950), 128.

[113] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309.

individual participant. In the passage above, the Hippocratic writer discusses the interpretive capacities of the physician, his ability to read patients without even hearing their words, outside the interpretive jungle of *logos*, on the body itself. This view, one that has been refined by modern science through the increasing use of visual technologies to render the body fully transparent, stands at the heart of the biomedical model of acute care.[114] As I argue in chapter 3, chronic care has challenged this view, articulating the power and importance of the words of patients, of their knowledge of their illness. Part of this challenge has involved the recognition that patients cannot escape their role in the cultivation of their own health. Patients are now in need of a model of knowledge and action that fully accounts for their role in the process of chronic care *as patients* (5.2). This section details the importance of particularity as an animating feature of the OLSS intervention, this time from the perspective of the participants. I have already described *phronesis* and "the priority of the particular" at length in chapter 4; what follows next is a description of the various sub-themes related to particularity and personalization in the participant responses.[115] Throughout their responses, the participants detail three primary sub-themes: (1) personalization as a general feature of the OLSS intervention, (2) specific examples of personalization, and (3) the difficulties inherent in personalization. All of these sub-themes paint a picture of the role of the particular in the OLSS intervention that

[114] On the role of technology and its implications for medical diagnosis and the body as a site for visual analysis, see Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A. M. Sheridan Smith (New York: Vintage Books, 1994); Stanley Joel Reiser, *Medicine and the Reign of Technology* (Cambridge: Cambridge University Press, 1978); Keith Wailoo, *Drawing Blood; Technology and Disease Identity in Twentieth-Century America* (Baltimore: Johns Hopkins University Press, 1997).

[115] Nussbaum, "The Discernment of Perception," 66.

supports my conception of *phronesis* and its role in working beyond gaps and remainders left over by currently circulating concepts in behavior change literature.[116]

The participants consistently report the general importance of personalization in the OLSS intervention. The value of "*personalized inputs*" comes up time and again. In fact, most of the participants report that the main value of coaching is directly tied to the goal of personalization. Recall that the coaches provide specific feedback and answers to questions posed by the participants. In addition, participants receive scheduled or automated notes from the coaches. At almost every turn, participants seem to favor specificity over automation (a topic that comes up again in 5.3.5 below). However, some participants report a synergy between the two, the automated notes assisting in keeping them on track and the tailored notes assisting with particular problems. For example, in response to the question, "What was most useful about the coaching?" one participant responds, "*The fact that they gave you feedback and suggestions on what you might be doing different[ly] to lose more or be more successful in the overall program*." In terms of specific feedback, the participants report two different kinds. The first is the delivery of notes directed at specific problems and questions. The second has to do with feedback to the participants' progress in working through the online lifestyle curriculum.

In terms of messages directed at specific kinds of problems posed by the participants, one participant states, "*I just know that every week I would receive a message. And every time I got a message, it was personal. It was meaningful. And it was helpful*." It is unclear in this response which type of message the individual is talking about; however, the mere fact that it feels personal indicates the degree to which this participant values a feeling of personalized care that

[116] I have used the term "personalization" here because it is commonly used by the participants and coaches to express what I have called *phronesis*. Likewise for terms such as "tailoring" and "particularity." For the purposes of this section, I view all of these terms as gesturing to the same process of cultivating *phronesis*.

can contribute to the ongoing effort to improve the OLSS online interface between lifestyle coaches and participants. Other participants provide more context about the differences between the kinds of notes offered in the program and the role they play. One participant notes a preference for, "*The ones [coaching notes] that responded mostly to my questions. The other ones [automated or scheduled notes] again, it kept me on track, but there was maybe specific things that I wanted to ask or something that I needed to explain so it was better to just have the one-on-one*." Other participants report the same feeling, primarily that "*by giving specific advice on specific issues or specific questions as they came up*," the coaches provide the kind of feedback needed to help the participants achieve their goals. Still another participant suggests that "*every communication I received was pretty much on an individual basis to see how I was doing*." This seems to not only assist participants in dealing with the problems they face but also generates an overall sense of relational depth, "partnership," and the like.[117] For example, another participant states, "*Someone really knows who I am and what I'm trying and is responding to it. That's unique. I mean . . . it was like you were going to some . . . high class spa and they said . . . we're working with you and we're going to help you succeed.*" Overall, the general impression of the messages received by participants in the OLSS program, whether scheduled and automated or specifically tailored, is that these messages assist in crafting a high-quality collaborative environment that attends to not merely the general issues of weight loss but also the particular problems individuals face in achieving it.

In terms of feedback from the coaches about the progress of participants in completing their lessons, similar impressions emerge from the interviews. For example, one participant reports, "*[the coach] would just - - based on my . . . answers to my questions throughout the*

[117] Bodenheimer, Lorig, Holman, and Grumbach, "Patient Self-management of Chronic Disease in Primary Care," 2469.

lesson . . . would just give me tips or suggestions. Even just ask questions like . . . why did you decide to do this? Maybe next time try this. So that was helpful." Another participant articulates this same process in the following way: "*Whenever there was information – whenever they would go through and look at the remarks or the comments I had made, I could tell that they had gone through the lessons that I had gone through and been able to add support, as well as alternatives and some extensions on the lessons*." Still another participant uses the metaphor of the "*personal trainer*" to describe the level of support the coaches offer, especially in terms of the lessons. These participants suggest that the coaches not only respond to specific questions posed in the asynchronous message system created for the OLSS but also to their progress in completing the online lifestyle curriculum. Recall from chapter 5 that the coaches work through the lessons with their participants, addressing their problems with the lesson content and providing feedback (almost like a teacher to a student) to their answers and the ways they have worked through the problems posed. This indicates another and perhaps deeper level of personalization that the metaphor of the "*personal trainer*" is meant to capture. Viewing these two layers of personalization in tandem shows just how much work is done by the coaches to provide needed feedback to individual participants, to negotiate between the general goals of the OLSS curriculum and the specific problems faced by participants. In short, what these participants are reporting is that the coaches provide the needed translational point, the element of rhetorical negotiation needed to make general ideas fully applicable to the needs of the individual.[118] Following McKeon, it is the interaction between the coaches and participants here that allows for insights into how more general features of healthcare become relevant for the individual. This is not simply an internal, cognitive process but rather a rhetorical and interactive

[118] On this, see my discussion of the general vs. specific dyad in rhetorical theory in chapter 4.

one. In short, it draws on the persuasion and transformation that can only come from sustained interaction, one of the key elements of rhetoric's "architectonic" function.[119]

Moreover, the participants provide a series of specific examples regarding how this effort at personalization impacts their experience and their ability to meet their goals. One of the primary areas of concern for the participants has to do with maintaining good diet and exercise. For this, many participants found specific feedback critical. In terms of food and diet issues, one participant reports, "*they [the coaches] would take an actual look at what I was eating and suggests maybe you need more protein, are you really sure you're having enough variety. Those were again just to reinforce the rigor of the discipline needed. Just knowing that I would be asked about encouraged me to be more careful*." In this case, the specific issue of protein and the knowledge that the coaches would track and check in about specific elements of diet seems to push this participant to take more care and pay more attention to his or her food choices. This insight is important in that it links the focus on personalization with the effectiveness of dialectical intervention (section 5.3.3). Without specificity and attention to the particular problems of the individual, at least in this case, dialectic fails to inspire the sort of attention to personal practices needed to maintain a diet regimen. Other participants note the way in which specific feedback about their choices provides a way to re-interpret their sense of progress (something I discuss in section 5.3.3 in terms of problem-solving): "*I had gone to a buffet at [a local restaurant] . . . I felt badly being there, although . . . I really wanted to be with my family . . . I picked with care from the buffet . . . but[the coach] wrote back to me . . . [and] . . . said congratulations on how you selected from the buffet*." Crucially, this response indicates the extent to which feedback based on particular actions and experiences can have an impact on the

[119] McKeon, "The Uses of Rhetoric," 56-57.

way a participant thinks about his or her actions and transforms them in the future. It also provides evidence that this participant has gleaned skills in food selection necessary to maintain a healthy diet. This may indicate both an understanding of the *techne* of diet (the need to pick certain types of foods) and the *phronesis* ("deliberative excellence") to utilize this understanding even when one finds oneself in non-ideal circumstances, such as the buffet at a restaurant.[120]

Another participant relates a different problem with diet: "*when I felt I was losing too much weight – I wasn't getting enough calories . . . they would always find an answer for me. They put me in touch with a dietician. They'd find a contact for me*." I have included this response because it shows how much care is taken to resolve particular problems. This participant needs assistance with balancing his or her diet and does not yet have the capacity to work through this problem alone. Thus, a highly collaborative model of working with coaches and a dietician is put in place to work the problem dialectically. Participants report similar support when it comes to exercise. For example, one participant notes, "*I had got like in a rut and I was like 'oh I'm really struggling here' and that was when I first started not being able to walk – do my walking . . . And they [the coaches] kept helping me like – say 'come on you can do this.*'" Overall, a large number of the participants report that receiving specific assistance in terms of diet and exercise made a huge difference for them.

Beyond the issues of diet and exercise, the participants also report other issues of an even more specific nature that the OLSS lifestyle coaches assist them with over time. One participant discusses a problem with his or her foot: "*When I had questions about my foot, they called me back immediately. There was no waiting. You know, I had a couple of other questions. Every time I called in, somebody would always call be back immediately*." This participant points out

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[120] Aristotle, *Nicomachean Ethics*, VI.v.1-2.

that one method of contact open to participants is calling for support. Whether via phone or email message, personalization is still the central theme. In addition, this participant values the immediacy of feedback, something that is not always possible in the traditional clinical model. Another participant describes a need for additional tracking resources and how his or her coach assists them in addressing this need: "*I had asked [the coach] about . . . purchasing something to continue tracking and I had asked about [the] website and that and [the coach] researched that and got back to me. And actually I've tried some of the things that [the coach] found for me and have been very happy with that.*" This response indicates the degree to which at least some OLSS coaches work to provide the knowledge, skills, and tools (*techne*) needed to assist participants in taking care of themselves (*phronesis*). Furthermore, some participants report that specific assistance with intervening life issues is critical:

> *You know,[the coach would] give a little summary and then . . . knew what was going on in my life and . . . [would] . . . say . . . how difficult it is to try to even log into the [OLSS] when . . . I was dealing with funerals and sick parents. And it was nice to think that . . . the person actually does know and read what I said is going on in my life . . . even when I was saying we talked about my mother-in-law passed away and my father-in-law was in critical [condition] and I was doing so much running . . . I really didn't even have time for meal planning and [the coach] would talk about little helpful hints and reminders that you have to put yourself first in these situations.*

In short, this participant's words show the extent to which intervening life factors can impede progress toward health and *eudaimonia*. Instead of judging this person or ignoring his or her problems, the coach instead works to deal with them, with the grounded and deeply experiential and emotional difficulties of loss. By addressing this problem directly and bringing general ideas down to the specific level of this participant, the coach that is described here provides for the particular needs of this participant. This passage also indicates the degree to which *techne* can lend itself to *phronesis*. By providing tips that presumably could be generalized while

simultaneously grounding them in the experiences of this participant, this coach provides a model of rhetorical translation. In other words, *techne* lends itself to repetition and generalization, but life is a process (*phronesis*). By managing the gap between the two, this dialectical exchange between participant and coach indicates the degree to which personalization has real substance and can implicate the participant's outcomes and sense of progress. It also indicates the degree to which the OLSS program can actually work within the textured life experiences of participants dealing with such complicated life issues. Furthermore, all of this suggests the degree to which the translation of general chronic care tools into the domain of the patients requires understanding the specific needs, idiosyncrasies, and barriers that patients experience in caring for themselves. This has major implications for translational research in which the goal is to make research and evidence-based interventions relevant to patient care. Following the interview comment above and those throughout this section indicates that such translation cannot always assume that a strategy developed in one study will work for every patient out there. Instead, the translational process continues in the provider-patient relationship and the specification of evidence and interventions into the lifeworlds of patients.[121]

Furthermore, personalizing content, as any teacher knows, is a difficult process. One participant acknowledges this: "*I understood that it must have been exceedingly difficult to personalize for each participant, but within the parameters available to the coaches, they did a really good job of that*." However, whether such personalization works in every instance and whether it is possible to consistently personalize the content of a lifestyle curriculum, the effort to do so seems to have a major impact on the ability of the participants to work around the problems they face and get the answers they need. The responses detailed in this section point to

[121] A critical component of the model of *phronesis* defended by Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309-310.

several important findings. First, as I have indicated throughout, there seems to be a connection between *techne* and *phronesis* in the experiences of the participants. Many acknowledge that specific answers and skills (*techne*) help them to address particular problems. How *phronesis* connects with *techne* in this section is complex. It involves both the acknowledgment that there is a problem by the participants and the communication of this problem to the coaches (the rhetorical use of *phronesis*).[122] It also involves the translation of a particular element of lifestyle *techne* into the specific experiences and needs of the participant, a communicative process that is deeply grounded in *phronesis* given its attention to particular details and the negotiation of skills to fit these details.[123]

In addition, there is a rhetorical valence to this process. As some of the participants note, the ways in which the *techne* (skills and knowledge) of weight loss are imparted, the tone used, whether they are grounded in the specific experiences of the individual, implicates whether they are successfully integrated into the actions of the participant. Moreover, this section shows how the coaches' emphasis on personalization and tailoring is reflected in the participant interview responses (detailed in chapter 4). That is, the quotes I foreground in this section demonstrate that, at least for some participants, the coaches have been successful in their efforts to address the specific needs of the participants. Finally, this section indicates the extent to which the specificity of coaching, its personalization, is tied to its perceived quality from the participants' point of view. This is a topic that receives substantial development in the next section as investigate the issue of human contact in the online environment of the OLSS.

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[122] Self, "Rhetoric and *Phronesis*."
[123] Rubinelli, Schulz, and Nakamoto, 309-310.

5.3.5 Human Contact in the Online Environment

> *Interviewer: What was most useful about the coaching?*
>
> *Participant: The human contact. Because left to my own devices, if something doesn't come up in front of me everyday, then I will tend to forget about it.*

> All that was necessary to complete the degeneration of reason into calculation was to equate concepts with collections of objective features, e.g. house = object, shelter, for man; man = thing, living, thinking. By the time Hobbes wrote, around 1600, it was possible to claim not only that reasoning meant reckoning, but that reckoning was nothing more than "the addition of parcels." Four centuries later we so consider reckoning our essence that, trying to create machines in our own images, we see only the problem of creating machines that can make millions of inferences per second.[124]

> Cyberspace offers itself as an awesome transformation of space and time, an immense and easily accessible dwelling place for people to meet, possibly feel at home with others, and thereby know-together what is going on in their lives. People can provide information and, perhaps more importantly, a caring caress to others.[125]

For the lifestyle coaches and the CPDT, the primary themes that emerge regarding the online environment have to do with the uncertainty generated by shifting the medium (from face-to-face to online) through which they deliver counseling (see chapter 5). Most importantly, the coaches focus on the complexity of invention in the online setting (i.e., writing messages and delivering them asynchronously to participants) and the problem of tone (i.e., how diction can implicate the ways in which electronic messages are read and interpreted by participants). Other elements of

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[124] Hubert L. Dreyfus and Stuart E. Dreyfus, *Mind Over Machine: The Power of Human Intuition and Expertise in the Era of the Computer* (New York: The Free Press, 1986), 203. Crucially, this distinction between reckoning and reasoning in Dreyfus and Dreyfus' account is rooted in their historical observation regarding the degeneration of the meaning of the term logos. They point out that Aristotle viewed humans as fundamentally engaged in "*logos* [which] could still mean speaking, or the grasping of whole situations, as well as logical thought. But when *logos* was translated into Latin as *ratio*, meaning 'reckoning,' its field of meaning was decisively narrowed." Dreyfus and Dreyfus, *Mind Over Machine*, 203. Thus, my work in this chapter suggests a need to recover Aristotle's conception of *logos* in order to overcome calculative modes of thought that are, according to Dreyfus and Dreyfus, on the rise in the computer age. See also Hubert L. Dreyfus, *What Computers Still Can't Do: A Critique of Artificial Reason* (London: The MIT Press, 1992).

[125] Michael J. Hyde, *The Life Giving Gift of Acknowledgment: A Philosophical and Rhetorical Inquiry* (West Lafayette, IN: Purdue University Press, 2006), 225.

the interviews I completed with the coaches suggest that the online environment holds hope of reaching a larger number of individuals especially those that do not want to enter (or cannot make it to) the clinical environment for whatever reason. For the participants, a slightly different set of themes emerge from their experience of the online setting, most of which are concerned with the need for genuine human contact in achieving their weight loss goals.

In the quotation above, Hubert L. Dreyfus and Stuart E. Dreyfus describe the reduction of human reasoning to "reckoning" (i.e., the simple recollection of information) at the heart of the computer age.[126] The belief that computers can, with specific inputs, provide valuable information outputs, and that this is somehow directly analogous to the actions of the human mind, is their central concern. Here, I argue that their work raises important issues for healthcare organizations, especially those built around the core concepts of the CCM. Chapter 2 suggests that one of the crucial elements of the CCM is the delivery of care.[127] In 21st century medical practice, one delivery mechanism that has become increasingly relevant (in terms of cost cutting and reaching the largest possible number of patients) is information technology.[128] In short, the healthcare system is being reorganized around health information technology as a strategy to supply high quality, timely, and cost effective care to millions of individuals dealing with chronic care; however this reorganization raises the specter of a loss of human contact and the "intuition" needed to handle specific problems grounded in the experiences of idiosyncratic patients.[129] This problem raises a number of questions, most importantly: To what extent can

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[126] Dreyfus and Dreyfus, *Mind Over Machine*, 203.

[127] Wagner, "Chronic Disease Management."

[128] Eric Topol, *The Creative Destruction of Medicine: How The Digital Revolution Will Create Better Health Care* (New York: Basic Books, 2012).

[129] Dreyfus and Dreyfus defend "a nonmechanistic model of human skill" and a "rethinking [that] will lead to a new definition of what we are, one that values our capacity for involved intuition more than our ability to be rational animals." This is, in a nutshell, the meaning of *phronesis*. Dreyfus and Dreyfus, *Mind Over Machine*, xviii and 206 respectively.

automated systems take over for human beings in the delivery of care and how does this impact its quality?

The results of the OLSS pilot study point to limitations of automated systems, and the form of calculative "reckoning" that Dreyfus and Dreyfus describe, to account for human "intuition" or to the specific needs of individuals as they attend to their lifestyle change regimen.[130] In other words, while automation is one of the major breakthroughs of the electronic medium, it is not, in itself, sufficient to provide *care* as opposed to *information about care*. This point is supported by the conceptual distinction between *phronesis* and *techne* that has been punctuated by analysis of participant interview responses. It also presents a daunting challenge to health care providers seeking to implement the "Chronic Care Model" (CCM) in an electronic age.[131] The OLSS illustrates how health information technology can synergize electronic training resources with asynchronous human contact in the form of coaching notes (chapter 4). As such, this dissertation provides a context for investigating one solution to the problem that Dreyfus and Dreyfus have described in terms of the computer age and others have detailed in the arena of healthcare delivery.[132] While there have been attempts to understand some elements of the health information technology revolution, few scholars have attended specifically to the experiences of participants using an online weight loss curriculum in tandem with online coaching.[133]

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[130] Dreyfus and Dreyfus, *Mind Over Machine*, 206 (and throughout).

[131] Edward H. Wagner, "Chronic Disease Management: What Will It Take To Improve Care for Chronic Illness?" *Effective Clinical Practice* 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action." *Health Affairs (Millwood)* 20, no. 6 (2001): 64-78.

[132] In fact, Hubert Dreyfus added "practical wisdom" to his model of expertise to address these issues in a similar way to the approach I am taking in this chapter. See Hubert L. Dreyfus, *On the Internet: Thinking in Action* (New York: Routledge, 2001), 46-48, 120, 126. Thus, it should come as no surprise that Flyvbjerg connects Dreyfus' arguments regarding expertise to *phronesis* in his, *Making Social Science Matter* (see especially, chapter 2). On the health care connection, see Topol, *The Creative Destruction of Medicine.*

[133] McTigue, Conroy, Hess, Bryce, Fiorillo, Fischer, Milas, and Simkin-Silverman, "Using the Internet to Translate an Evidence-based Lifestyle Intervention into Practice," 851-858; McTigue, Bhargava, Bryce, Conroy, Fischer, Hess, Simkin-Silverman, and Zickmund, "Patient perspectives on the integration of an intensive online

This section unpacks participant feedback to the electronic coaching they received during their participation in the OLSS study.[134] How the participants experience the virtual world crafted by the OLSS, especially their interactions with coaches, provides at least an initial sense of how health information technology may either succeed or fail in crafting the kinds of "partnership[s]" needed to augment weight loss and the management of co-morbid conditions.[135] For the purposes of this subsection, I am mainly interested in thematically mapping the issues that the participants raise in terms of the theoretical resources I have developed. My reading of the participant responses reveals three related sub-themes that elucidate the problems of human contact in the online environment: (1) the benefits of the online environment, (2) the need for human contact as opposed to automated feedback, and (3) the *kairotic* (time-based, see chapter 5) issues involved in receiving feedback in the asynchronous environment of the OLSS.[136] Finally, I ask the reader to keep in mind that while I am not directly addressing the themes raised by the coaches (chapter 4), they do link up with many of the comments made by the participants.

Many of the participants indicate the extent to which the online environment and the modes of contact it facilitates are beneficial. Even though the OLSS provides few opportunities for direct contact with other human beings, one participant declares, "*It was social – here's somebody [the coaches] out helping you*." The fact that an online program can produce such a positive assessment of sociality indicates the extent to which, at least for some of the participants, the OLSS managed the right mixture of automation and human contact. The

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behavioral weight loss intervention into primary care," 261-264; Rief, Mitchell, Zickmund, Bhargava, Bryce, Fischer, Hess, Kolb, Simkin-Silverman, and McTigue, "Promoting Patient *Phronesis*."

[134] While some of the participants mention the online curriculum, I do not have space to detail their responses about this element of the program here. I do intend to map these responses as well in future studies.

[135] Bodenheimer, Lorig, Holman, and Grumbach, "Patient Self-management of Chronic Disease in Primary Care," 2469.

[136] There is one more theme that emerges from the responses regarding technical breakdowns; however, this issues has already been covered in section 5.2.3 and is the subject of a new research project I have proposed to complete after the dissertation.

participants provide many arguments in favor of the online model used by the OLSS. One of these, flexibility, is something that the coaches mention as well (chapter 5). For example, one participant suggests,

> *The thing that was great about the coaching was that it wasn't – it didn't have the feel of strictly online – it was strictly an online resource without any . . . human contact . . . it had like kind of the best of both worlds. It had actual people that [you] could converse with, but the flexibility of stuff online so I could do my tracking and whatever whenever I had the whim or the time.*

Two critical elements emerge from this response. First, this participant reports that the program, though almost entirely delivered in an online setting, still provides "*actual people*" on the other end of the line. This has the implication of crafting a "*best of both worlds*" scenario in which the permutation of human contact and electronic, asynchronous messaging and tracking provide a balanced approach. The cold, mechanical method of "reckoning" does not fully dominate the experience of this participant, in fact, it is not part of the experience at all.[137] Second, this response suggests that the online curriculum, in tandem with human coaching, provides flexibility so that progress can be made based on the schedule and interests of the participant. This second element links up directly with my concern about *phronesis* and the need to personalize the content and style of lifestyle management. Another participant echoes this sentiment, providing additional substance to the claim that going online need not undermine the qualities of human contact most important to some people, that is, having someone there for you when you need them: "*The whole idea is that we don't have to have face-to-face contact and that it would be – that they were there for me whenever I needed them.*" In fact, for some of the participants, the ability to control the timing and content of their interactions with coaches is comforting. Another participant reports how much they value, "*that I could not physically have*

[137] Dreyfus and Dreyfus, *Mind Over Machine*, 203.

to talk to someone, but that there was always somebody there for me." This is one of the elements of the program that the coaches mention as well. As I show in chapter 5, the coaches indicate the extent to which some individuals prefer a style of contact that does not require spatial or temporal synchronicity.

The flexibility and asychronicity valued here is buttressed by a more general sense that the human contact the coaches provide assists participants in meeting their goals. However, for some of the participants, the value of "*human contact*" has less to do with "*flexibility*" and more with the need to have a dialectical partner, the need for the intervention of another human being (on this see 5.3.2). In a sense, for some of the participants, ongoing contact with the coaches is a primary driver for their success. One participant notes that the most important element of the program is, "*The human contact. Because left to my own devices, if something doesn't come up in front of me everyday, then I will tend to forget about it.*" It is unclear whether this participant is speaking about scheduled or tailored messages here; however, the general sense that having someone on the other end providing a context for dialectical engagement is clearly a very important element in this participant's overall strategy of lifestyle change. Without interaction of some kind through "*human contact*" this participant feels he or she would not be able to adequately complete the program. Furthermore, another participant points out a sad but true feature of contemporary chronic care, the need for but simultaneous lack of a support structure at home:

> *In my situation, it was just simply knowing that they were there. I don't have a support system at home so it was nice to know that if I wasn't feeling the need to reach out they were contacting me saying 'how are you doing? Is there anything we can do to help you?' and I thought that was a great thing because the whole problem that most folks like me have is they don't have the support.*

But for the coaches providing care, support, guidance, and general interactivity, this participant would lack these elements as well as the support structure needed to be successful. This feeling is confirmed by other participants who report a similar level of satisfaction with the quality of the online coaching in the OLSS: "*I was very satisfied. It was great. It was really a lot of support and if you had any issues, there was someone there to help you.*"[138] When viewed together, these participant responses make an important point. When individuals lack a support network (e.g., family, friends, etc.), they may not do as well. As such, one of the roles of healthcare providers engaging in chronic care is to craft a support structure, a relational "partnership" with their patients.[139] Of course, doing this in an online setting is complicated by the lack of direct contact; however, this participant shows that it is at least possible to provide a patient with the feeling that they have support, that they are receiving attention, guidance, and help when they need it. Whether the participants report that the online coaching is valuable due to its "*flexibility*" or because it provides the opportunity for dialectical interventions to get them back on track, the responses described thus far indicate that for some of the participants, the right mixture of automation and human contact has been achieved by the OLSS. Moreover, the fact that different participants latch onto different elements of the coaching that they found effective indicates the degree to which the OLSS can be tailored to meet the particular needs of specific participants. Thus, while there is not agreement among the participants as to the sort of support structure they need, there is agreement among a large number of them that the OLSS provides the modalities of human interaction they feel are necessary for their success.

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[138] My thematic mapping in this chapter provides added support for the findings of the research group investigating the OLSS pilot results. See McTigue, Bhargava, Bryce, Conroy, Fischer, Hess, Simkin-Silverman, and Zickmund, "Patient perspectives on the integration of an intensive online behavioral weight loss intervention into primary care," 261-264

[139] Bodenheimer, Lorig, Holman, and Grumbach, "Patient Self-management of Chronic Disease in Primary Care," 2469.

However, not all of the participants feel this way and criticisms can be found throughout the interviews. The rest of this section details a few of these criticisms (sub-themes 2 and 3). First, some of the participants indicate that more human contact (or a different quality of human contact) may be needed. For example, one participant notes, "*The support was built in, like I guess the research was on the computer stuff, I kind of needed more personal contact than I did get. Because [the coach] said I could call . . . But that's just my nature. I need . . . I like a voice. I'm not a computer person. And I know this was a computer research thing really.*" While this participant does not provide a specific account of the sort of "*personal contact*" missing from the OLSS coaching, this response (among others) indicates that for some participants, the dialectical engagement and support valued by some of the participants quoted earlier is not sufficient for them. Other participants are more specific when leveling this criticism, noting the need for a human "*face*" to interact with: "*Sometimes it[s] good to meet face-to-face. Over a year, maybe a couple of times and go over things.*" Another participant suggests, "*Maybe I'm just the type of person that needs to put a face – sometimes you didn't know who the person was you were exchanging information with, what their background was*." Beyond the issue of having direct contact with the coaches, of having a "*face*" to interact with, another participant notes a desire to have consistent and robust interactions with one coach (as opposed to several different coaches at different times during the intervention):

> *I think the problem was – my person changes 3 times . . . if there was a negative, it would have been that . . . I think they were very positive. I got the sense that . . . [one coach] I think was with the longest and [the coach] . . . started to get to know me. So, there was a personalized aspect to that . . . And if I came upon a particular stumbling block like if I was getting ready for a vacation or the holidays were very difficult for me. And you know, [the coach] had tips to offer.*

This response, although it is the only one to mention the problem of dealing with multiple coaches, indicates that one problem with the online coaching may be the lack of a strong

relationship with one provider. There is some research that suggests individuals do better when they feel they have built a strong relationship with their providers.[140] Trust is a central concern but so too is the cultivation of "*personalized*" care. In other words, the ability to provide care that is tailored to the needs of the individual person may come from knowing them well. When multiple providers are working with one person and have less contact time with them, it may, following this participant, erode the possibility for personalization. This response provides and insight that should play a role in future iterations of the OLSS, primarily the possibility of personalizing care for participants through sustained contact with one care provider. In a broader sense, as team-based care and specialization continue to mount as major concerns in 21st century healthcare, more work must be done to understand how the multiplication of caregiver roles implicates the experience of the individual patient who may or may not receive the attention or gain the sort of relationship they want from with their providers (see chapter 3).

In addition, these responses bring to the fore a major issue in communication research, that is, the ways in which the "*face*" of another (or its lack) implicates our experience of interacting with her. Michael J. Hyde, following the works of major continental philosophers such as Emanuel Levinas, argues that one foundation of the ethics of communicative encounters resides in the face, the physical existence, of another human being.[141] For this reason, electronic coaching messages might be said to fail in the cultivation of relationality and "partnership" precisely because they work around the problem of actually having to see and feel the other's presence.[142] Research about the actual consequences of online interactivity is mixed in its view

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[140] See e.g., Susan Dorr Goold and Mack Lipkin, "The Doctor-Patient Relationship: Challenges, Opportunities, and Strategies," *Journal of General Internal Medicine*, 14, suppl. 1 (1999): S26-S33.

[141] Hyde, *The Life Giving Gift of Acknowledgment*, 85 (and throughout).

[142] Bodenheimer, Lorig, Holman, and Grumbach, "Patient Self-management of Chronic Disease in Primary Care," 2469.

of the possibility of cultivating meaningful relationships that provide support, community, and care for people who otherwise lack it.[143] My purpose in mentioning Hyde's work is to show how the themes that emerge from the participant responses link up with problems that are currently under investigation in communication scholarship. What these participant responses indicate is that, at least for some individuals, the online setting may not provide sufficient human contact. Alternatively, they may indicate the need to change the ways in which online contact is achieved with certain people or the need to supplement online contact with face-to-face contact.

The second major criticism put forward by the participants has to do with automation. These criticisms take us back to the basic design of the OLSS coaching protocol (see chapter 4), in particular, the use of scheduled, automatic notes with static content. Some participants found the scheduled, automated notes less helpful, even annoying at times. For example, one participant opines, "*I would just have to say, like I said again with the emails, some of it was more just like oh, you've – according to our thing, you've logged in like three times in a week. And it's like okay. I didn't really find that helpful.*" This participant suggests that scheduled and automatic notes that report on progress are not helpful, that these do not contribute substantially to the experience of engaging in the OLSS intervention. Other participants go even farther, suggesting that these notes are "*robotic*":

> *I didn't care for the sort of robotic responses you got. You know, three quarters of the responses were robotic. You know . . . congratulations, you've logged into [the OLSS] so many times this week and, you know, you've spent so many minutes doing this and so many days out of seven, blah, blah, blah . . . I don't think you need that. I think you know very well how much you've logged on or not logged on. And again, I can appreciate if you're a coach and you've got 10 or 15 or 20 people you're trying to do this for. You don't really want to write a little personal note to everybody every week. That's kind of a . . . burden.*

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[143] For a nice account of the "emancipation" and "melancholy" created by a turn to the virtual environment, see Michael Keren, *Blogosphere: The New Political Arena* (Lanham, MD: Lexington Books, 2006).

The use of the term robotic here should take the reader back to the argument made by Dreyfus and Dreyfus regarding the modes of calculative thinking emblematic of the computer age.[144] The use of the term "*robotic*" here suggests not only that the content of the notes being described is impersonal but also that this lack of personality implicates the tone of the message being delivered. This tone is described by the use of "*blah, blah, blah.*" The repeated use of the term "*blah*" yields a variety of interpretations. This participant may be saying that, because some messages seem robotic and repetitive, they indicate a lack of attention to their specific needs. He or she may also be suggesting that such notes are not useful, that they are extraneous to the process of lifestyle change and to the progression of the OLSS program. Whatever the final intention, "*blah, blah, blah*" indicates that there is a problem with the automated notes (at least for some participants) and that some revision in either its content or its mode of delivery may be needed. However, this participant also notes that such messages may be necessary given the complexity of providing feedback to a large population of participants. This is a major problem facing any healthcare organization that attempts to implement the use of health information technology to take the place of certain elements of clinical care. In doing so, providers can reach a larger portion of individuals, but they may lose that personal touch that patients are looking for and that is part and parcel of developing robust relationships. Another participant uses the same language, confirming that this interpretation goes beyond the idiosyncrasies of one participant: "*But there was also the standard little message that you have logged on so many times out of so many times, blah, blah, blah . . . You know, it just doesn't – just really didn't impact me one way or the other*." Again, the automated or "*standard*" messages do not seem helpful for this

[144] Dreyfus and Dreyfus, *Mind Over Machine*.

participant and may actually create problems especially in terms of the lifestyle coach/participant relationship.

Other participants use a different term to describe the same problem. They argue that the scheduled, automated messages seem "*canned*." For example, one participant notes, "*I guess the canned messages that said 'you achieved this,' 'you've done this.' Those were not personalized except for the statistics, and I really didn't find them to be helpful*." Another participant uses the same language: "*I did find the coaching messages were kind of canned . . . that kind of turned me off*." The term "*canned*" has special salience for rhetorical scholars and intercollegiate debate coaches alike. When I attended my first high school debate tournament, I arrived with speeches for and against the topic at hand. As I debated, my judges responded with disgust: "You're speech was canned. It was unpersuasive." They were responding to the fact that I was reading speeches written well before I had ever met my opponents. As such, these speeches, while they may be responsive to the arguments my opponents were making, did not show that I was fully engaged in the debate, that I was paying attention and crafting my arguments in such a way as to deal with the specific issues being raised by the other side. Reading these canned speeches also took away from the sense that I was engaged in conversation, that I cared about what those in my immediate audience were thinking. This is a basic insight of rhetorical theory, primarily that a speech that does not seem fitted to a specific moment and a specific audience is less persuasive, less likely to engender the audience's trust or inspire action.[145] The participants in the OLSS pilot study quoted here suggest something very similar and this insight links up with other themes and theoretical concepts I have been detailing throughout this dissertation. If positive feedback given to the participants comes in the form of a "*canned*" or "*robotic*" message, it is

[145] Bitzer, "The Rhetorical Situation."

less likely to inspire feelings of progress and hope for the future. As such, the more that lifestyle coaches (and healthcare providers in general) can provide tailored feedback, the more likely it is to persuade patients that things are going well (or poorly) and that progress is being made (or could be made faster), etc. Put simply, given the risks of depersonalization inherent in going online, the use of scheduled, automated messages in the electronic delivery of healthcare requires sustained reflection. While I do not think that messages such as these are inherently problematic, there may be room to consider how they are produced and for whom. For example, the participant feedback here suggests that some individuals may not benefit from having these notes sent to them. While none of the participants report that they stopped engaging in the lifestyle intervention because of the notes, this is something to think about and ask about in future iterations of the study. In addition, such notes might come across better if coupled with tailored feedback or specific details about the individual participant. These are just a few possible solutions; more work is certainly needed to unravel this problem.

Moreover, there are participants for whom the email interface for receiving coaching notes is itself problematic. One participant suggests,

> *I'm not big on e-mail or anything like that. I just don't – even though I have an e-mail address, I just don't give it out. I just don't use a computer that much. I don't like to be tied down like that. I think it's a good source of information. I'm on the web – you know, looking up stuff, if I need a carpenter or whatever to do work. I mean I do that or if a hobby – I look up stuff or you now – but other than that, I'm not big in that respect . . . I appreciate the people – you know, but I'm just not big on that.*

In this response, this participant catalogues a number of elements that online communication researchers have already noted, primarily that there are many different types of internet users and

that different modes of communication may be needed to deal with these various types.[146] That is, there are individuals for whom email is simply not a preferred mode of interaction. This indicates that developing new methods for delivering messages and sharing knowledge may assist in crafting a version of the OLSS that holds true to *phronesis* as a critical element. Simply put, in order to personalize or tailor coaching, there may be a need for tailoring not only the content but also the chosen media.

The third major criticism that can be found in the participant responses has to do with a term I use throughout chapter 5: *kairos*. In chapter 4, I discuss the asynchronous model of communication used in the OLSS pilot study. In short, the messaging between participants and coaches is time-lagged. Participants complete lessons and send questions or concerns to the coaches and the coaches respond when they have time to do so. It is a model that should be familiar to anyone who has ever taught a college course. Students send emails (sometimes at the last minute!) and teachers respond when they can (often not fast enough!). This same problem seems to have plagued some users of the OLSS program. For example, one participant reports, "*Sometimes they [the coaches] were a little hard to get a hold of just because people had other jobs and worked, a lot if it was just scheduling conflicts with my schedule too*." Another participant suggests the same problem, this time using an amusing analogy: "*I think they [the coaches] were more than adequate but again, the pace was just driving me insane. You know it was like watch[ing] a glacier melt pre global warming. I'm not that patient. I'm sorry.*" There are many ways to interpret these comments. On the one hand, it is easy to say that these participants expect too much, that there is no way to provide instantaneous feedback to everyone

[146] The literature on this subject is vast and diverse. For a summary of the variety of ways of communicating online including style, tone, and method, see Andrew F. Wood and Matthew J. Smith, *Online Communication: Linking Technology, Identity, & Culture*, 2nd ed. (Mahwash, NJ: Lawrence Erlbaum Associates, Inc., 2010).

involved in an online intervention. Staffing and scheduling issues make this impossible both practically and financially. Or, put in a different way, these participants could be interpreted as the "problem students" in a college course. There is just no pleasing them because their demands go well beyond the capacities of any human system. On the other hand, these participants raise an important rhetorical point. Any message, whether it is a speech made by a leader in a time of crisis or a note regarding a problem that a patient is having, is made meaningful, at least in part, through its timely deployment.[147] That is, the power of *logos* has a time limit. This is a central feature of what rhetorical scholars have called the "rhetorical situation" and it is something to which anyone who wants to craft a persuasive message must attend.[148] Taking this perspective, it is possible to agree with both interpretations proffered above: there will be individuals that are hard to please, but there is also good reason to increase the speed or timeliness of messages and thus increase their persuasive impact (as much as is *humanly* possible).

This section shows just how complicated the issue of maintaining human (or humane) contact in an online environment truly is. The diversity of interview responses indicates that this issue is not one that can be handled in a systematic or standardized way. In fact, following Dreyfus and Dreyfus, "intuition" or what I have called *phronesis* is the better approach.[149] Given the wide variety of issues here (automation, striking the right balance, *kairos*, the "*face*", etc.), it seems like the best way to move forward with the integration of health information technology into chronic care is to revise and rework approaches *in situ* (something that the OLSS has done and continues to do). One way to achieve this end is to ask participants to provide feedback about the medium itself over the course of the intervention, making small changes that are

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[147] See chapter 4 on the role of *kairos* in the OLSS.
[148] Bitzer, "The Rhetorical Situation."
[149] Dreyfus and Dreyfus, *Mind Over Machine*, 206 (and throughout).

possible along the way and planning major refits when it seems necessary. I have made a few other suggestions along the way including giving patients a variety of options for how the interact with coaches and combining automation with tailoring (in the same note) as much as possible. However, one thing that does seem clear throughout all of the responses is that having a person on the other end of the line is a crucial element. Whether it is just the feeling that there is someone monitoring and able to help if necessary or the actual content of their feedback, the coaches are the essential element of the online interface for almost all of the participants. This finding has major implications for chronic care in a general sense. As healthcare organizations continue to face rising rates of chronic illness and the obviously linked problem of out of control costs, the quick fix may be to put more and more healthcare delivery into the hands of fewer and fewer individuals. Eventually, delivery may be in the hands of automated systems that provide information and feedback based on prompts as opposed to directly responding to an individual based on a shared, relational understanding. What the OLSS participants point out is that information technology is not a problem, so long as the human element is not fully lost. "Reckoning" systems cannot replace "intuitive" systems, at least not yet.[150] *Paideia* and *phronesis* remain irreducibly complex and human systems of rhetorical interactivity in the service of, among other things, lifestyle change.

5.4 CONCLUSION

The participant comments about the quality of lifestyle coaching and its role in their weight loss regimens indicate that, for them, lifestyle change is a highly complex affair riddled with failures,

[150] Dreyfus and Dreyfus, *Mind Over Machine*, 203, 206. Dreyfus, *What Computers Still Can't Do*.

small successes, and constant efforts at re-framing. What my findings suggest is that lifestyle change is a dynamic process and this is not surprising. If experience itself is "rough," textured, and riddled with misinterpretations wrought by at times failed human perceptions, then the management of life should certainly suffer from similar problems.[151] This point is well known to rhetoricians for whom the humanistic study of *logos* indicates that there is no formula for the perfect act of persuasion. Failure is a constant possibility, success an ideal that is only sometimes achieved.

In addition, the insights of the participants recorded and analyzed in the previous section provide added value to the ongoing improvement and design of the OLSS. Many of the participants report high levels of satisfaction with the mode of dialectical *paideia* used by the coaches. They view the dialectical intervention of the coaches as central to their experience with the OLSS and critical to their ongoing efforts to lose weight. Thus, this dialectical coaching style is a critical element of the OLSS (for both the coaches and participants) and one that deserves added development with attention to the specific details that these participants report (e.g., the need for interruptions and ongoing, interactive exchanges, and the like). Further, many of the participants, though discussing very different sorts of problems (e.g., failure, holidays, deaths in the family, workplace changes, and the like), highlight the critical theme of problem-solving in their responses. They further inflect the notion of problem-solving through the lens of the particular, suggesting that addressing problems in the OLSS (or any lifestyle intervention) requires attending to the needs of individual participants. Finally, the participants provide a variety of insights regarding the virtual space of the OLSS and the need for ongoing human contact. Unlike the hermetically sealed Epicurean garden discussed in section 5.2, the virtual

[151] Wittgenstein, *Philosophical Investigations*, S107; Dunne, *Back to the Rough Ground.*

environment of the OLSS seems to have fostered (at least for some participants) ongoing, robust, and effective relationships with the OLSS lifestyle coaches.[152] For others, however, elements like the scheduled coaching note seem to have given them a sense that the virtual setting is "robotic" or less human than they would have liked. I take this issue up again in chapter 7.

All of these insights show the degree to which the background *paideia* (in terms of place and experiential inputs) of the OLSS allows the emergence of *phronesis* that enhance the aspirational journey in search of *eudaimonia* for the participants in the OLSS. Further, the mode of rhetorical therapy constituted by *paideia*, *phronesis*, and *eudaimonia* avoids the "interpellative" understanding of constitutve rhetoric articulated by Charland.[153] As I discuss in chapter 4, there are approaches to analyzing the problem of lifestyle management that would view the therapeutic model I describe here as thoroughly manipulative and coercive. The notion that power is unidirectional (and paternalistic) in the OLSS simply cannot be supported. Participants choose to take part in the intervention and consistently challenge the coaches to provide specific support and negotiate the complicated terrains of their life experiences. Far from promoting a single picture of *eudaimonia* or surreptitiously trapping individuals within a set of practices that force them to be other than who and what they are, the coaches (based on the reports of the participants) function as mentors. Because they are mentors, they do have certain forms of expertise that exceed the capacities of the participants, but there is no indication that such expertise is used to silence or coerce participants into actions they are not willing to take. In fact, the opposite seems to be the case. Thus, my defense of rhetorical therapy as a constitutive process in chapter 4 is supported by the words of the participants detailed in this chapter. In a related way, this chapter yet again shows the extent to which *phronesis* can and should be

[152] Nussbaum, *The Therapy of Desire*, 119.
[153] Charland, "Constitutive Rhetoric," 133-150.

rescued from the political and used as a concept in the domain of medical practice, a finding that rhetoricians should heed.

This chapter also contributes to ongoing scholarly efforts to understand the intricacies of lifestyle management already underway in clinical and academic medicine. Here, I discuss two of these models and gesture toward various gaps within them that my model potentially resolves. First, one of the most prevalent approaches to lifestyle change (or behavior modification) currently in use is Albert Bandura's theory of "self-efficacy."[154] This theory has been developed over the course of decades and is the topic of substantial scholarly discussion. Therefore, I cannot cover all of the intricacies of the theory here. Instead, I offer a basic schematic map of "self-efficacy" and draw out the primary differences between it and the model I propose above. Bandura's approach begins from an understanding of human cognition and activity very close to my own. He argues that "People are proactive, aspiring organisms who have a hand in shaping their own lives and the social systems that organize, guide, and regulate the affairs of their society."[155] Thus, Bandura accepts the notion that individuals are not just cogs within a cultural milieu (*paideia*) but actively engage in its construction as well as in the revision of their own modes of living and thinking. He also grounds his approach within a larger conception of "social cognitive theory" that adopts a view of self-reflection very close to that of Aristotle's *phronesis*:

> Social cognitive theory rejects the dualistic view of the self. Reflecting on one's own functioning entails shifting the perspective of the same agent rather than converting the self from agent to object or reifying different internal agents or selves that regulate one another . . . In social cognitive theory, the self is not split

[154] On the early development of the concept, see Albert Bandura, "Self-efficacy: Toward a Unifying Theory of Behavioral Change," *Psychological Review*, 84, no. 2 (1977): 191-215; Albert Bandura, "Self-Efficacy Mechanism in Human Agency," *American Psychologist*, 37, no. 2 (1982): 122-147. For his most robust (and lengthy) discussion of the concept including its grounding in social cognitive theory, see Bandura, *Self-Efficacy*.

[155] Bandura, *Self-Efficacy*, vii.

> into object and agent; rather, in self-relation and self-influence, individuals are simultaneously agent and object.[156]

Thus, individuals are able to think about their own practices and act on their own ways of thinking and doing. In this sense, Bandura's understanding of "social cognitive theory" overlaps with my concept of *paideia* and its particular instantiation as *phronesis*. What it implies is that cultural inputs both help to construct the individual and are open to reflection and revision. That is, "The self is socially constituted, but, by exercising self-influence, individuals are partial contributors to what they become and do."[157]

"Self-Efficacy" is one of the elements that can be developed through such reflection on the cultural inputs within which the individual is constituted: "Perceived self-efficacy refers to beliefs in one's capabilities to organize and execute the courses of action required to produce given attainments."[158] Crucially, this perception of efficacy or the sense that one can carry out a set of actions to achieve certain results, is grounded not only in the individual but also within the larger context of one's society. Bandura argues that different societies provide better and worse contexts within which to achieve the perception and reality of "self-efficacy." He opines, "Beliefs of personal efficacy constitute the key factor of human agency. If people believe they have no power to produce results, they will not attempt to make things happen."[159] Thus, assisting individuals to achieve their lifestyle goals (whether this is weight loss, getting over addiction, or attaining democratic rights and civil liberties not yet guaranteed) requires not only the cultivation of a sense of "self-efficacy" within the individual but also a larger social context in which individuals can rightfully see themselves as capable of producing change.

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[156] Bandura, *Self-Efficacy*, 5.
[157] Bandura, *Self-Efficacy*, 6.
[158] Bandura, *Self-Efficacy*, 3.
[159] Bandura, *Self-Efficacy*, 3.

All of the above is largely in keeping with the model I propose. One of the main differences between Bandura's understanding of lifestyle change and my own has to do with the primary mechanism of change he describes. While I admit whole-heartedly that individuals need to have a sense of personal efficacy in order to aspire to and achieve transformative action, this is only one element among many that may be needed. In other words, *phronesis* (which roughly corresponds to self-efficacy in Bandura's model) is not simply concerned with developing perceptions of "self-efficacy" but also with the modes of "self-examination" and interactivity with others needed to improve skills and decisional capacities.[160] While Bandura acknowledges this, his term "self-efficacy" is limited to a particular element (a perceived sense of one's own capacity for change) and no matter how much revision he engages in, it will remain tied to the internal belief in one's capacities rather than the process through which such capacities are realized. In other words, according to Bandura, "perceived self-efficacy is concerned not with the number of skills you have, but with what you believe you can do with what you have under a variety of circumstances."[161] *Phronesis* and the rhetorical elements that frame its cultivation fill in this gap in Bandura's approach by providing a more robust articulation of how the particular experiences and modes of communication used by individuals influence their general capacity to make changes in their lifestyles and achieve not just a particular goal (e.g., weight loss) but the broader sense of *eudaimonia*.[162] Thus, *phronesis* is directly tied to action whereas "self-efficacy" is related to action as a belief that makes action more likely and more effective.

The second theory that deserves some attention here is the "transtheoretical approach" to behavior change. This model, developed by James O. Prochaska and Carlo C. DiClemente,

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[160] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309-310.
[161] Bandura, *Self-Efficacy*, 37.
[162] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309.

elucidates the connections between multiple psychotherapeutic approaches to assisting patients in achieving change. They note that "the transtheoretical approach" combines "four crucial dimensions: the processes of change, the stages of change, the pros and cons of change, and the levels of change."[163] In other words, "the transtheoretical approach" attempts to identify how individuals change, the various stages through which individuals go as they attempt to achieve change, and the various evaluative judgments that might be made about the lifestyle change individuals are undergoing including its benefits and disadvantages and the degree to which change has really been achieved. For example, this approach identifies five different stages that describe where any given individual may be at in their process to achieve change: (1) "Precontemplation", (2) "Contemplation", (3) "Preparation", (4) "Action", and (5) "Maintenance."[164] Prochaska and DiClemente argue that understanding the stage a patient is at may improve a provider's ability to address the problems and needs of that patient. The focus on stages is certainly in keeping with my defense of "the priority of the particular" or the notion that individuals require personalized care that deals with their specific problems at any given moment in time.[165] However, the model I propose adds important content to the stages by describing how individuals might be made capable of moving from one stage to the next. While Prochaska and DiCelemente note a variety of "processes of change" such as "consciousness-raising" and "self-reevaluation," they do not engage in the direct analysis of how individuals learn to utilize these processes or how they eventually emerge as *phronimoi*, capable of caring for themselves.[166] Thus, while this approach engages some of the same issues as mine, in particular the need for personalized care, it does not provide a theoretical backdrop for explaining how individuals

[163] Prochaska and DiCelement, "The Transtheoretical Approach," 148.
[164] Prochaska and DiCelement, "The Transtheoretical Approach," 150.
[165] Nussbaum, "The Discernment of Perception," 66.
[166] Prochaska and DiCelement, "The Transtheoretical Approach," 150.

come to embody new dispositions or utilize new skills. This is a gap that *phronesis* as a process of experiential learning can certainly fill.

This chapter builds on the theoretical and conceptual developments of chapters 3 and 4 while also providing unique content that may assist in filling out other models of lifestyle change. My goal is not to replace such models but rather to provide a humanistic and rhetorical approach that helps to articulate the communicative connections and modes of health performance they do not always effectively capture. The words of the participants I discuss here suggest just how important *phronesis* is to them and to the ongoing attempts to make sense of the problem of lifestyle-related illness in the 21st century.

6.0 RHETORICAL "ASSAYS" FOR THE TRANSLATION AND DISSEMINATION OF CLINICAL RESEARCH

> Gorgias' scepticism about the ability to communicate knowledge was met by a Hippocratic optimism that at least some strategic communication could work to get medical knowledge out to broader audiences as well as to other practitioners and investigators who need to know. Against Gorgias, contemporary researchers seem prepared to shrug off the feeling that communicating about research is futile, even impossible. Perhaps they are ready to start talking rhetorical strategy. The time of a Hippocratic revolution in communication is nigh.[1]

> So, there sprang up in Greece a class of professional teachers who advertised themselves as experts in socially useful knowledge, that is, in the art of worldly wisdom and success. An itinerant band of teachers began to wander from city to city gathering young men around them and giving them lessons in anything that may be regarded as useful. These men who filled the current educational gap, to their private profit, in the absence of colleges and Universities, were collectively known as the sophists.[2]

6.1 ADDRESSING TRANSLATION AND DISSEMINATION AS RHETORICAL ENDEAVORS

Chapters 4 and 5 concern a particular sort of rhetorical activity, one rooted in the dialectical practices of constitution and therapy that exist between providers and patients in the Online Lifestyle Support System (OLSS), and as I argue, in the general practices of "partnership" that characterize modern clinical care.[3] In this chapter, I turn from these issues to consider a different inflection of the rhetorical practices relevant to clinical research, one that assists in animating the

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[1] Joan Leach, "The Art of Medicine: Valuing Communication," *The Lacet* 373 (2009): 2105.

[2] Dilip Parameshwar Gaonkar, "Aspects of Sophistic Pedagogy" (PhD diss., University of Pittsburgh, 1984), 59.

[3] On this, see e.g., Thomas Bodenheimer, Kate Lorig, Halsted Holman, and Kevin Grumbach, "Patient Self-management of Chronic Disease in Primary Care," *Journal of the American Medical Association* 288 (2002): 2469-2475; Sara Rubinelli, Peter J. Schulz, and Kent Nakamoto, "Health Literacy Beyond Knowledge and Behaviour: Letting the Patient be a Patient," *International Journal of Public Health*, 54 (2009): 307-311.

movement of the situated knowledge produced within the OLSS pilot study into the clinical environs where providers and patients do their everyday work. I frame this movement from research-to-care through the use of two terms: translation and dissemination. These terms significantly overlap; however, where translation refers to the promulgation of research findings into the clinical domain (chapter 2), dissemination refers to the more specific and often corporate process of advertizing and selling such interventions. In this regard, the OLSS acts as a case study that provides insights for larger discussions about the rhetorical processes that connect clinical research with those who are meant to benefit from it.[4]

I have described all of these elements before suggesting that they are part of the larger commonplace implied by the "Chronic Care Model" (CCM) architecture that seeks to connect research to care (chapter 2).[5] As I show throughout this chapter, these different terminological and conceptual arenas significantly overlap, but their discussion as discrete parts of the larger architecture of clinical care provides a sort of schematic map through which to make sense of rhetoric's role in shaping knowledge and action across the field of 21st century medicine (chapter 2). This introduction outlines several issues that will pervade my analysis throughout, most

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[4] My arguments in this regard overlap with other arenas of medical research and activity, especially evidence-based medicine or EBM. The notion that medical care improves when it is rooted in high-quality evidence is now old hat throughout the various health professions; however, the question of how evidence is deployed and what kinds of evidence might be useful when convincing practitioners to change their practices or adopt new interventions is an understudied phenomenon. Especially given my focus on the corporate world of dissemination practices and on the iterative process of translation that back them, my work contributes new insights that may implicate how EBM researchers and practitioners think about their work. Thus, I see the work of this chapter as contributing directly to translational research and dissemination, with implications that EBM scholars may find useful as well. For excellent work on EBM and its relationship to argumentation theory and clinical decision making, see e.g., Milos Jenicek and David L. Hitchcock, *Evidence-Based Practice: Logic and Critical Thinking in Medicine* (American Medical Association Press, 2005). For excellent rhetorical analyses, philosophical investigations, and critical assessments of the use of evidence in medicine, see Jason Grossman, ed., "Evidence in Evidence-Based Medicine," Special issue, *Social Epistemology: A Journal of Knowledge, Culture, and Policy* 22, no. 4 (2008): 325-460.

[5] Edward H. Wagner, "Chronic Disease Management: What Will It Take To Improve Care for Chronic Illness?" *Effective Clinical Practice* 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action." *Health Affairs (Millwood)* 20, no. 6 (2001): 64-78.

importantly a discussion of a different part of the rhetorical tradition from those detailed in earlier chapters that has relevance for my discussion of the rhetorical work involved in making clinical research relevant to the demands of the clinic: the Sophistic tradition.[6] In line with this shift, the orienting quotes above suggest the general tendency of this chapter. I have already discussed Joan Leach's notion of the "Hippocratic revolution in medicine" (the first quote at the top of this chapter) at some length in chapter 2.[7] Suffice it to say here that she gives the Sophists, primarily Gorgias, a less than central role to play in the activation of communication as a mode of translation and dissemination. Dillip Gaonkar's study of Sophistic pedagogy (the second quote at the top of this chapter) suggests a different way of thinking about how Sophistic activities might relate to translational research and dissemination. Rather than focusing on a single Sophist, he articulates the wider frame that makes up Sophistic pedagogy, not the least of which is the role the Sophists played in democratizing knowledge in the context of major transitions in Greek civic life.[8] As I suggest in this chapter, the related acts of translation and dissemination rely on views and practical activities similar to those used by the Sophists to develop their pedagogical approaches and achieve uptake of their views in Greek society.

In short, my task in this chapter is to unpack the various rhetorical practices used and expressed by members of the Coaching Protocol Development Team (CPDT) and the Corporate Dissemination Team (CDT) that has been tasked with distributing the OLSS to new clinical environments. My work proceeds in three stages. First, I identify a framework (rooted in Sophistic conceptions of rhetoric and human knowledge described above) for understanding how

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[6] In other words, my work in this chapter provides further elucidation of my "clinically relevant and demand-driven" understanding of the rhetoric of medicine. On this, see my work in chapter 1 and Gordon R. Mitchell, "Switch-Side Debating Meets Demand-Driven Rhetoric of Science," *Rhetoric and Public Affairs* 13, no. 1 (2010), 111.

[7] Leach, "The Art of Medicine," 2105.

[8] Gaonkar, "Aspects of Sophistic Pedagogy," 19-104.

rhetoric might contribute to the cultivation of connections between research and care: "rhetorical assays." Second, I unpack comments by members of the CPDT regarding the role of *phronesis* in the dissemination of the coaching practices they are developing for the OLSS. Third, I move directly into interviews I completed with the CDT members in order to investigate how rhetorical assays connect research to corporate dissemination and finally to clinical end-users. All of this is done to contribute specific and applied examples of the uses of rhetoric in the translation and dissemination of research.[9]

6.2 THE SOPHISTIC MOVEMENT

Dillip Gaonkar's study of the Sophistic movement that spread throughout ancient Greece in the 5th century B.C.E. provides for an interesting case study in the transmission of knowledge as a cultural practice (*paideia*).[10] He articulates in great detail both the context in which Sophistry developed and the methods through which it was promulgated.[11] First, and following the work of a variety of classical scholars, Gaonkar suggests that the 5th century Greek city-states (e.g., Athens and Sparta among many others) were undergoing a radical transformation from aristocracy to civic participation.[12] This transition, according to Gaonkar, called forth the need

[9] Excellent work has been done in rhetorical studies to understand the flow of research findings from the laboratory to the sites of technological application; however, much of this work has focused on the rhetorical tools used in the writing of scientific articles. While this is one option for understanding the dissemination of the OLSS, for the purposes of this chapter, I have chosen to focus on the more direct lines of communication between the clinical researchers at the university and the CDT tasked with selling the OLSS to new clinical environments. On the role of the scientific article as a rhetorical device for achieving professional and public uptake of new findings, see e.g., Judy Segal, "Reading Medical Prose as Rhetoric: A Study in the Rhetoric of Science" (PhD diss., University of British Columbia, 1988); Alan G. Gross, Joseph E. Harmon, and Michael S. Reidy, *Communicating Science: The Scientific Article from the 17th Century to the Present* (West Lafayette, IN: Parlor Press, 2002).

[10] Gaonkar, "Aspects of Sophistic Pedagogy."

[11] Gaonkar, "Aspects of Sophistic Pedagogy."

[12] Gaonkar, "Aspects of Sophistic Pedagogy," 19-104.

for a transformation of the educational practices of Greek communities. Put simply, if the multitude are called to engage in civic life, then this multitude is in need of the skills and ways of knowing and acting necessary for effective participation.[13] Thus, a new group of teachers, the Sophists, emerged offering their "socially useful knowledge" of various subjects and practical approaches to civic life.[14] In fact, as his study bears out, the Sophists were highly engaged thinkers, constantly testing their methods of teaching against the backdrop of cultural conventions and needs: "[the sophists] were a group of dynamic thinkers, at times fragmented, committed to the method of trial and error, but constantly driven to bold improvisation."[15] In a sense, they were engaged in "demand-driven" teaching.[16] This was their selected approach for knowledge transmission and it was directly tied to the study of *logos* and to making their knowledge "useful."[17]

Following Gaonkar, we can say that 5th Century Greece provides one of the first examples in western history of the emergence of a "complex modern society" in which "only an expert can supply in a systematic manner socially useful knowledge."[18] Gaonkar notes that the way to overcome this problem of expertise is to craft new educational opportunities for society at large. His study shows that the Sophists answered this call and, in addition, had a lasting impact on major debates about science, culture, and philosophy. Indeed, as Gaonkar notes, the Sophistic movement's effort to manage the newly "complex" world of Greek life in the 5th century included major critiques and transformations of Greek science and philosophy.[19] As Gaonkar so ably points out, many Greek scientists and philosophers preferred metaphysical explanations

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[13] Gaonkar, "Aspects of Sophistic Pedagogy," 57-59 (and throughout).
[14] Gaonkar, "Aspects of Sophistic Pedagogy," 59.
[15] Gaonkar, "Aspects of Sophistic Pedagogy," 65.
[16] Mitchell, "Switch-Side Debating Meets Demand-Driven Rhetoric of Science," 111.
[17] Gaonkar, "Aspects of Sophistic Pedagogy," 59, 79-80, 120.
[18] Gaonkar, "Aspects of Sophistic Pedagogy," 58-59.
[19] Gaonkar, "Aspects of Sophistic Pedagogy," 58-59, 72-76.

rooted in religious tradition rather than the empirical observations and laboratory work we are familiar with today.[20] Much of their work was detached from practical consequence and, according to Gaonkar, grounded in "otherwordliness."[21] Against this version of scientific work and philosophical reflection, the Sophists defended a mode of cultural education (*paideia*) and the "practical" application of knowledge.[22] That is, "they considered the study of culture more beneficial [than the study of nature] for their pupils in the preparation for civic life."[23] Finally, Gaonkar argues that because of this focus on culture, the Sophists could not create a stable or systematic approach to teaching. Instead, he suggests, "The sophists were flexible teachers."[24] That is, they focused on the needs of their students, indicating a key acceptance of one of the primary themes of this dissertation – the role of *phronesis* in addressing the specific needs and experiences of practitioners and patients alike.

This debate, between the Sophists and the philosopher-scientists of ancient Greece detailed in Gaonkar's work may not at first seem to have much in common with the contemporary activities of science. However, there is one element that is quite relevant to contemporary medical research and care. One of the problems with contemporary medical research is that it does not find its way into clinical care quickly and efficiently. This has created a great deal of consternation among patient advocates and activists as well as their providers. In 2003, then director of the National Institutes of Health (NIH), Elias Zerhouni, announced a new "Roadmap" meant to directly synergize the work of clinical researchers and practitioners

[20] Gaonkar, "Aspects of Sophistic Pedagogy," 72-76.
[21] Gaonkar, "Aspects of Sophistic Pedagogy," 72-76.
[22] Gaonkar, "Aspects of Sophistic Pedagogy," 72-76.
[23] Gaonkar, "Aspects of Sophistic Pedagogy," 74.
[24] Gaonkar, "Aspects of Sophistic Pedagogy," 76.

(chapter 2).[25] This "Roadmap" details a variety of new trajectories for research and care (discussed more directly in the next section). Most importantly, it was designed to deal with the increasingly complex world of medical care in which the expertise needed to treat patients cannot be concentrated in one person but rather in networks of researchers and providers working collaboratively. In this way, contemporary medicine is facing a problem that is much like that of the Sophists in 5th century Greece. The need to translate sophisticated knowledge into applied practice, to increase the dissemination of knowledge, and to coordinate the communicative pathways for these activities is, at least in part, rooted in the same "demand-driven" concerns of the Sophists detailed in Gaonkar's study.[26] Where the Sophists were interested in the promulgation of "*politike techne*" or the art of civic and political life, contemporary medical researchers and providers are concerned with the dissemination of new findings needed to enhance not civic life but the health of patients.[27] Furthermore, when it comes to behavioral and lifestyle issues such as obesity, this knowledge needs to make it past clinicians and other providers to the patients themselves who are in need of care (chapters 2, 3, and 5). Such dissemination of knowledge is not simply about making sure that information makes it from point A to point B. Instead, as the rest of this chapter suggests, the translation and dissemination of knowledge requires attention to the cultural and communicative environment in which the knowledge is produced and for which it is meant and ongoing deliberation about the best way to utilize new knowledge in the specific environs of clinical care.[28] Thus, translational

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[25] On the National Institutes of Health Roadmap, see Elias A. Zerhouni, "The NIH Roadmap," *Science* 302, no. 5642 (2003): 63-64, 72; Jocelyn Kaiser and Jennifer Couzin, "Speeding Up Delivery: NIH Aims to Push for Clinical Results," *Science* 302, no. 5642 (2003): 28-29; Elias A. Zerhouni, "Translational and Clinical Science – Time for a New Vision," *The New England Journal of Medicine* 353, no. 15 (2005): 1621-1623.

[26] Mitchell, "Demand-Driven Rhetoric of Science," 111.

[27] Gaonkar, "Aspects of Sophistic Pedagogy," 2.

[28] For an outstanding argument regarding the important role of communication, argumentation, and deliberation in the dissemination of clinical research findings, see Gordon R. Mitchell and Kathleen M. McTigue,

researchers and scientists are in need a form of training much akin to that offered by the Sophists. As Gaonkar notes, the Sophists, "promised to impart knowledge and also to provide instruction on how to use that knowledge wisely and successfully."[29] I argue throughout this chapter that this is the missing link in the translational story. The dissemination of information is one thing but its creative use requires a completely different pedagogical focus. Finally, in terms of obesity and other lifestyle related illness, a democratization of participation in care (to include even the notion of self-care) is needed.

All of these are Sophistic themes in the landscape of contemporary medicine and indicate the degree to which the rhetorical and pedagogical practices of the Sophists might provide important insights in the project of enhancing the movement of research from the laboratory ("otherworldliness") to the clinic.[30] As Gaonkar points out, rhetorical practices emerge for particular moments and with particular needs ("demands") in mind[31]: "The resources of language and the symbolic nature of man refer to the ultimate grounds of rhetoric and confirm that rhetoric is a permanent possibility open to man. However, that possibility embedded in man's nature and in his language is activated in specific historical circumstances."[32] For this reason, I view the Sophistic movement as a rich and inventional resource for illuminating contemporary problems without imaging any true isomorphism between ancient Greece and today.

"Translation Through Argumentation in Medical Research and Physician-Citizenship," *Journal of Medical Humanities* 33 (2012): 83-107.

[29] Gaonkar, "Aspects of Sophistic Pedagogy," 74-75.

[30] Gaonkar, "Aspects of Sophistic Pedagogy," 72-76.

[31] Mitchell, "Demand-Driven Rhetoric of Science," 111.

[32] Gaonkar, "Aspects of Sophistic Pedagogy," 168-169.

6.3 RHETORICAL "ASSAYS": CONNECTING RESEARCH TO CARE

Whilst scholars from across the allied health disciplines continue to argue for improved communication at every level of medical practice, all too often these calls are hortatory rather than substantive. That is, they acknowledge a need for but often do not engage in the invention or cultivation of grounded practices that might catalyze real transformation in the communication practices of clinical researchers or clinicians.[33] For example, Stephen Woolf rightly argues that efforts to produce useful evidence in clinical research and deliver it to downstream practitioners in part requires attention to, "the disciplines that inform the design of those interventions, such as clinical epidemiology and evidence synthesis, *communication theory*, behavioral sciences, public policy . . . [and the list goes on]."[34] Unfortunately, Woolf does not expound upon what the role of communication theory might be in enhancing translation. It makes the list but is not specified or put to use. Addressing this gap in the literature, Gordon R. Mitchell and Kathleen M. McTigue argue that "The task [of translation in the medical research setting] is different in kind from sheer information processing; it demands forms of communicative dexterity that enable translation of ideas across differences and facilitate cooperative work by interlocutors from heterogeneous backgrounds."[35] Mitchell and McTigue show throughout their study that clarion calls for attention to communication must be followed by definitions, theoretical understandings, and practical applications of communication as a mode of thinking and doing.[36]

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[33] Mitchell and McTigue, "Translation Through Argumentation," 90-98.

[34] Steven H. Woolf, "The Meaning of Translational Research and Why It Matters," *Journal of the American Medical Association* 299, no. 2 (2008): 211. Emphasis added. On this, also see Feldman, Arthur M. "Does Academic Culture Support Translational Research?" *Clinical and Translational Science* 1, issue 2 (2008): 88; Zerhouni, "Translational and Clinical Science," 1622-1623.

[35] Mitchell and McTigue, "Translation Through Argumentation," 92.

[36] Hannah Arendt, *The Human Condition* (Chicago: University of Chicago Press, 1958), 5; Mitchell and McTigue, "Translation Through Argumentation."

It is for this reason that I argue for a "clinically relevant, demand driven rhetoric of medicine" throughout this dissertation (chapter 1)[37] Assisting in the translation and dissemination of insights that are relevant to clinical practices and that match with ongoing demands in medical research gives rhetoric a chance to show its value.[38] As I have said, this understanding of the rhetoric of medicine is not the only that one might take and I do not mean to suggest that rhetorical scholars should become indentured servants to big science (or any other more powerful ally). Instead, I argue that rhetoricians may miss out on unique opportunities to shape real world practices in the clinical domain if their work ends up serving only the needs of an insular (i.e., rhetorical or communication) audience. This opportunistic stance, as I show below, is in keeping with the Sophistic tradition and shows how rhetoric may expand its influence without succumbing to a thin strategy of "globalization" or to strategies that ultimately denigrate the importance of building the discipline in a "sustainable" way.[39] In fact, as I argue in chapter 1, producing "clinically relevant, demand driven" insights provides for sustainability. It does so by building the sorts of connections that can and should exist between the rhetorical arts and the variety of professional practices that make up medicine (chapter 2). In addition, building

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[37] Gordon R. Mitchell, "Demand-Driven Rhetoric of Science," 111.

[38] Phillip Kitcher suggests that rhetoric may play an essential role in the process of scientific discovery and its articulation beyond the research setting. His insight is one with which I largely agree. See Phillip Kitcher, "The Cognitive Functions of Scientific Rhetoric," in *Science, Reason, and Rhetoric*, ed. Henry Krips, J. E. McGuire, and Trevor Melia (Pittsburgh, PA: The University of Pittsburgh Press, 1995), 47-66.

[39] In his germinal study of Sophistical rhetorical theory, John Poulakos argues that three terms capture the primary calling cards of Sophistic rhetoric: "opportunity, playfulness, [and] possibility." Opportunity refers to the task of the rhetor in finding "opportune rhetorical moments (kairoi)" for persuasion. I build on this notion of opportunity as directly linked with *kairos* throughout this chapter. See John Poulakos, *Sophistical Rhetoric in Classical Greece* (Columbia, SC: University of South Carolina Press, 1995), 56-57, 62-63. Furthermore, Poulakos works this notion of opportunity into his definition of rhetoric in an earlier essay: "Rhetoric is the art which seeks to capture in opportune moments that which is appropriate and attempts to suggest that which is possible." See John Poulakos, "Toward a Sophistic Definition of Rhetoric," *Philosophy and Rhetoric* 16, no. 1 (1983): 36. On the globalization of rhetoric (and the "thinness" that it potentially invites) see Dilip Parameshwar Gaonkar, "The Idea of Rhetoric in the Rhetoric of Science," in *Rhetorical Hermeneutics: Invention and Interpretation in the Age of Science*, ed. Alan G. Gross and William M. Keith (Albany: The State University of New York Press, 1997), 33 (and throughout). On the cultivation of "sustainability" in the rhetorical study of medicine, see E. Johanna Hartelius, "Sustainable Scholarship and the Rhetoric of Medicine," *Quarterly Journal of Speech* 95, no. 4 (2009): 467 and throughout. I address these issues in more depth in chapter 1 of this dissertation.

such relationships is in keeping with the historical foundations of the arts of medicine and rhetoric (chapter 3). Furthermore, my move to this model of research is not simply opportunistic or merely grounded in the project of widening rhetoric's net for the enhancement of the discipline as such (even though these are certainly goals with which I agree).[40] In the next few paragraphs, following Mitchell and McTigue (among others), I expand upon my argument here that rhetoric's role in translation and dissemination must be carefully defined and understood.[41]

So what role can rhetoric play in moving translational researchers from an "information processing model" to a model that values the revisability of knowledge and the persuasive issues involved in its transmission?[42] According to Zerhouni, enhancing the prospects for effective research to care pipelines requires the "methodologic research necessary to develop or improve research tools" that fuel "clinical and translational research" turning them into "powerful engines of creativity."[43] Following the Sophists for whom the translation of knowledge was a primary pedagogical and rhetorical issue (section 6.2), I argue here that rhetoric is a sort of "assay" (or, following Zerhouni, a "methodologic research" tool) through which scientific findings are made available, relevant, and persuasive to practitioners.[44] The term "assay" is used in biomedical research to describe the various solutions used in experimentation. Placing something in assay is

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[40] Robert Hariman, "Status, Marginality, and Rhetorical Theory," Quarterly Journal of Speech 72 (1986): 51.

[41] For more on rhetoric's role in translation (both in medicine and between scientists and publics) see Mitchell and McTigue, "Translation Through Argumentation"; John Lynch, *What Are Stem Cells? Definitions at the Intersection of Science and Politics* (Tuscaloosa, AL: University of Alabama Press, 2011); Lisa Keränen, *Scientific Characters: Rhetoric, Politic, and trust in Breast Cancer Research* (Tuscaloosa, AL: University of Alabama Press, 2010); Leach, "The Art of Medicine"; Judy Z. Segal, *Health and the Rhetoric of Medicine* (Carbondale, IL: Southern Illinois University Press, 2005); John Lyne, "Contours of Intervention: How Rhetoric Matters to Biomedicine," *Journal of Medical Humanities* 22, issue 2 (2001): 3-13.

[42] Mitchell and McTigue, "Translation Through Argumentation," 92.

[43] Zerhouni, "Translational and Clinical Science," 1622.

[44] Zerhouni, "Translational and Clinical Science," 1622. My understanding of rhetoric as an assay for translation and dissemination owes a great deal to Mitchell and McTigue; however, their work focuses on "argumentation as a translation medium" whereas my goal is to show how the Sophistic tradition of rhetoric in particular helps to form a rhetorical approach to translation and dissemination. See Mitchell and McTigue, "Translation Through Argumentation," 94.

meant to reveal new insights about it, to generate knowledge. However, "assay" has a much more complicated terminological history, one that reveals how this term might provide a conceptual apparatus for the study of rhetoric in the context of translation and dissemination. As I show, the term assay is broad enough to cover the various meanings of rhetoric, including its analytical, productive, and ontological inflections; however, my primary interest is in the cultivation of rhetoric as the primary medium through which clinical discovery becomes clinical practice.[45] Moreover, the connection between Richard McKeon's view of rhetoric as "architectonic," especially his commitment to interaction between different epistemological and disciplinary domains, and my view of rhetorical assays will slowly converge throughout the rest of this chapter.[46] In part, rhetorical assays are the medium of interactivity that McKeon views as central to the synergy needed to address complexity and the "'fragmentation' of knowledge."[47]

The Oxford English Dictionary provides several definitions of "assay" that elucidate its wide-ranging meaning. First, its general meaning is "the trying (of a person or thing); trial imposed or endured by any object, in order to test its virtue, fitness, etc."[48] The entry goes on to suggest that an assay is a "'Trial,' tribulation, [or] affliction" suffered in order to achieve some new insight or to understand some process, individual, or thing in a clearer way.[49] This meaning of the term connects it directly to the historical roots of rhetoric as a discipline. At least as far as the Greek tradition of rhetoric is concerned, the art emerged as a means to manage the aftermath

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[45] Trevor Melia, "Review," *Isis* 83, no. 1 (1992), 100.

[46] Richard McKeon, "The Uses of Rhetoric in a Technological Age: Architectonic Productive Arts," in *The Prospect of Rhetoric: Report of the National Developmental Project*, edited by Lloyd F. Bitzer and Edwin Black (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1971), 56-57.

[47] McKeon, "The Uses of Rhetoric," 51.

[48] "assay, n.". OED Online. March 2012. Oxford University Press. http://www.oed.com/view/Entry/11756?rskey=6znzZz&result=1&isAdvanced=false (accessed May 20, 2012).

[49] "assay, n.". OED Online.

of the reign of the Tyrants in Sicily in the 5th century B.C.E.[50] The Sophistic movement, as well as other approaches to the training of rhetoric, thus came about as a means to deal with the crimes committed by the Tyrants (including lost property and other damages). In this way, rhetoric developed in the courtroom as a way to test various arguments and make fair and equitable decisions. Of course, the definition above implies a wider sense of the term trial that might include non-legal venues for testing someone's mettle (think of Job in the biblical tradition); however, the term may be "casuistically stretched" from this vantage point to cover the use of *logos* to test various arguments, to determine which is the better argument and, therefore, allow it to prevail.[51] What is most important about these meanings of the term is their reference to a "process" and a "product."[52] In other words, an "assay" is a process that is used to generate knowledge or to transform a subject or object (product). Rhetoric is also a "process," one that uses *logos* as its primary medium and one that tests the use of language as a strategy for the dissemination of arguments (products).[53] In this way, viewing rhetoric as an assay foregrounds how it can work as a linguistic solution, or medium, through which arguments are tested for their persuasive impact. Here, I am deploying a sense of rhetoric as a remedy used to address some blockage in communication and practice. As I show when I transition into my

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[50] John Henry Freese, "Introduction," to Aristotle's *The "Art" of Rhetoric* (Cambridge: Harvard University Press, 1926/2000), xii-xiii. On this, also see Gaonkar, "Aspects of Sophistic Pedagogy," 53-69.

[51] On reasoned debate and its role in allowing the better argument to prevail, see Gaonkar, "Aspects of Sophistic Pedagogy," 80. On "casuistic stretching," see Kenneth Burke, *Attitudes Toward History*, 3rd ed. (Berkeley: University of California Press, 1937/1984), 229-232.

[52] Here, I am drawing on terms developed by Joseph Wenzel to differentiate between different kinds of argumentation: "*process*, *procedure*, and *product*." According to Wenzel, rhetoric is a process, logic provides for the analysis of products, and deliberation is a procedure for decision making. I argue here that rhetoric may be a process and a product. That is, one may go through a rhetorical process aimed at persuasion and also produce a rhetorical product that is disseminated in textual form (or verbally to an audience). Thus, I reanimate Wenzel's terminological taxonomy under the term rhetoric (as opposed to argumentation) in order to show how rhetoric may work in different ways and through different kinds of tools. Joseph W. Wenzel, "Three Perspectives on Argument: Rhetoric, Dialectic, Logic," in *Perspectives on Argumentation: Essays in Honor of Wayne Brockriede*, eds. Robert Trapp and Janice Schuetz (New York: International Debate Education Association, 2006): 15.

[53] Leach discusses this problem in terms of importance of "valuing both process and content" in the communicative conduits linking research to care. Leach, "The Art of Medicine," 2104.

interview analysis later in this chapter, this remedy involves inventive attempts to address contingent aspects of the rhetorical situation that erect barriers to successful communication and knowledge translation. Thus, rhetoric is the means through which practitioners test both the relevance and use-value of scientific findings and make them portable not merely as information but as knowledge framed through the lens of persuasion.

"Assay" also refers to "Experiment. put it in assay: make the experiment, try it."[54] This experimental sense of the term "assay" comes closest to its biomedical meaning. It literally refers to the experimental process that generates new scientific insights. Thus, one will hear medical researchers speak of the selection of different "assays" each with its benefits and disadvantages as a tool for answering the specific questions (hypotheses) asked. The Sophistic conceptualization of rhetoric is also quite experimental. For the Sophists, rhetoric challenges the notion that knowledge is stable. Its ontological and epistemological stance is skepticism, the embrace of uncertainty (section 6.2).[55] It is for this reason that Sophistic rhetoric and scientific experimentation have a great deal in common. Part of scientific practice is the acceptance of uncertainty and the need to continue questioning one's results across time. Following this connection to the end of the line, we might say that rhetoric is an experimental approach to the invention and delivery of *logos*. This means that the selection of rhetoric as an assay is rooted in ongoing efforts to map "the various means of persuasion" and apply them opportunistically.[56] Finally, this sense of rhetoric as an assay opens up the possibility of understanding the scientific process in a clearer way. On the one hand, once evidence is gathered and hypotheses confirmed,

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[54] "assay, n.". OED Online.

[55] Or, as Gaonkar notes, "The sophists, like their 4th-century disciple, Isocrates, preferred to impart useful though only probably information rather than what they considered usable through certain knowledge." Gaonkar, "Aspects of Sophistic Pedagogy," 75.

[56] Aristotle's *Rhetoric*, I.i.12-14; Poulakos, *Sophistical Rhetoric in Classical Greece*.

scientists move from the realm of uncertainty into the more stable ground of "normal science."[57] However, establishing a fact and producing knowledge does not guarantee its translation into action.[58] Rhetoric is the medium through which this is made possible and is, thus, an assay for further scientific discovery at a secondary level, the level of practitioners who use science to engage in their everyday professional lives.[59]

The sense of assay I describe above implies a process, a mode of testing, trying, or experimenting with something. Other definitions of the term imply a slightly different meaning. For instance, it may also refer to "Experience," or "the faculty of trying or judging things."[60] This meaning of the term should bring the reader right back to *phronesis* or the experiential learning needed to engage in daily decisions and practices (chapters 3, 4, and 5). That is, various modes of experience, interpretation, and means of reasoning may also be called assays. In chapters 3, 4, and 5, I argue that *phronesis* as a particular form of *paideia* is made manifest in the OLSS as both a site and set of practices for cultivation. In this sense, I have already been speaking of a particular rhetorical assay, the online platform for the OLSS. Connecting this sense of assay with those above, it should become clear that a rhetorical assay might have many different inflections. It might be the test or trial of words on the pathway to persuasion or it may be a context through which knowledge produces connect their knowledge to discrete practices in the world. It might also be the experiential estuary of *phronesis,* the context of learning within a particular milieu (*paideia*), or the like. The most critical element of my concept of rhetoric as

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[57] Thomas S. Kuhn, *The Structure of Scientific Revolutions*, 3rd ed. (Chicago: University of Chicago Press, 1962/1996), 23-42.

[58] Arendt, *The Human Condition*, 5.

[59] Leah Ceccarelli, *Shaping Science with Rhetoric: The Cases of Dobzhansky, Schrodinger, and Wilson* (Chicago: The University of Chicago Press, 2001).

[60] "assay, n.". OED Online.

assay (to be used throughout the rest of this chapter) is that it is rooted in *logos*. Words are the critical apparatus for discovery and transaction within a rhetorical assay.

All of these connections between the scientific and rhetorical within the definitions of the term assay suggest that the concept may play a role in unlocking not just new insights but also an evaluation of various processes at play in the translation and dissemination of medical knowledge. This insight is critical, especially when it comes to elucidating other kinds of assays that may not produce the communicative or *logos*-based insights needed to cultivate better connections between research and clinical care. That is, despite a variety of efforts to champion the incorporation of communication insights into not only the provider/patient relationship but also at the nexus between medical researchers and clinicians, the correct rhetorical assay has not necessarily been applied in all instances.[61] Simply put, communication is often applied as an empty moniker, a name for something that is missing in the process of medical discovery but that is not given a lot of substance.

In the following sections, I articulate the granular elements of rhetoric as an assay for the translation and dissemination of medical research into clinical care that fills in the gaps left in current conversations regarding the communicative connections between research and care. Thus, this chapter sheds light not only on how the OLSS is moving beyond the clinical research setting but also on the role rhetoric plays in this movement (and may play in a more general sense). I accomplish this task by analyzing interviews I completed with the Coaching Protocol Development Team (CPDT) and the Corporate Dissemination Team (CDT) of the OLSS. Both of these groups establish the role of rhetoric as an assay for translation and dissemination. In

[61] Leach, "The Art of Communication."

addition, reading their interviews in tandem in this chapter shows how the issues of translation and dissemination are understood at the upstream and downstream levels.

6.4 THE COACHING PROTOCOL DEVELOPMENT TEAM (CPDT): THINKING ABOUT TRANSLATION UPSTREAM

Before I move into the discussion of my interviews with members of the CDT, I first return briefly to the respondents detailed in chapter 4. Part of my analysis in chapter 4 features the iterative development of the coaching protocol (i.e., *Lifestyle Coach Training* and the *Lifestyle Coaching Guide*) for use by lifestyle coaches in the OLSS. The lifestyle coaches and members of the Coaching Protocol Development Team (CPDT) suggest that this process is deeply grounded, experiential, and specific. Given these elements, the two members of the CPDT make important comments about the possibilities for translating and disseminating this iterative process the insights it has gleaned to other clinical environments. Thus, while I am returning to interviews already discussed in a previous chapter, I am now geared to look at the same data with an eye toward analyzing how the protocol relates to another part of the architecture of chronic care: translation and dissemination (chapter 2). This is in keeping with the "architectonic" strategy of this dissertation.[62] Connecting insights from one commonplace of care to another is central, I argue, to the overall synergy and transformation of the elements of the CCM and chronic care generally.[63]

The two members of the Coaching Protocol Development Team (CPDT) already introduced in chapter 4 provide context for understanding how the issues of translation and

[62] McKeon, "The Uses of Rhetoric."
[63] McKeon, "The Uses of Rhetoric."

dissemination are understood from the perspective of academic clinical research. That is, the CPDT members suggest in their interviews that one of the issues they consistently address as they develop the coaching protocol and engage in the iterative cultivation of best practices with the coaches is how both of these might best be translated into the commercial domain and disseminated to other clinical environments. Importantly, their words support my understanding of rhetorical assays (6.3) by describing not only the creation of the protocol document but also a set of processes through which this document might be translated into the particular needs of any clinical setting. In this section, I detail the elements of their interviews in which these topics are addressed utilizing the thematic map below (Table 5).

Table 5. Interview Theme Map (CPDT: Translation and Dissemination)

Themes (*indicates theme shared by both respondents)
Lifestyle Coach Training and the *Lifestyle Coaching Guide* as Rhetorical Products*
The Need for a Rhetorical Process*
Grounded/Experiential Knowledge (*phronesis*)
Cost-Effectiveness

As the reader can see, both members of the CPDT mention two overlapping themes: *Lifestyle Coach Training* and the *Lifestyle Coaching Guide*, which they refer to as the "*coaching protocol*" or just "*protocol*," are described as a rhetorical "product."[64] In addition, both of them mention the need for a rhetorical "process" in the development of best practices.[65] Beyond these shared themes, One of the CPDT members plays up the importance of grounded and experiential

[64] Wenzel, "Three Perspectives on Argument," 15.
[65] Wenzel, "Three Perspectives on Argument," 15.

knowledge (*phronesis*) in the cultivation of best practices, indicating the need for not only a rhetorical "product" and associated "process" that may be shared but also a commitment to continued discovery in new clinical environments if the OLSS is to be successful.[66] The other CPDT member plays up the importance of cost-effectiveness, another critical issue facing not only the uptake of new clinical interventions but, in particular, the use of diet and exercise training programs in the clinical setting (see section 6.5.4). All of these issues are discussed by the members of the Corporate Dissemination Team in their interviews indicating the connection between upstream and downstream efforts at translation and dissemination. The next several paragraphs provide context and detail regarding the comments made by the CPDT members regarding translation and dissemination.

First, both CPDT members describe the need for a rhetorical "product" that can be easily shared, that is, for a coaching protocol.[67] At one point one of them opines, *"That would be really exciting, that we could affect positive change not just in the . . . people who participate in our studies but maybe that some other groups could adapt [the OLSS] for their setting, and that's why we needed a coaching protocol, because [of] the whole idea of translating this into other populations*." This comment suggests two important insights. One is that translation is part of the OLSS mission. That is, the designers of the coaching practices for the OLSS have been considering the complexities of translation from the outset of the study. Thus, the role of the coaching protocol is not just training new OLSS coaches for future iterations of the study. It is also meant to provide a pathway to translation and dissemination in other clinical environments. More importantly, one CPDT member points to a major issue in the dissemination of new findings: simplicity. Enacting new processes for weight loss in a clinical setting is no easy task

[66] Wenzel, "Three Perspectives on Argument," 15.
[67] Wenzel, "Three Perspectives on Argument," 15.

(see section 6.5.4). Thus, the translational process of making the findings of the OLSS available to other clinical practitioners requires some level of simplification. For this reason, the dialectic of the general and the specific (chapter 4) is played out in the area of translation as well. During the process of iteratively developing the coaching protocol, the CPDT and coaches can spend the time necessary to develop specific approaches to each problem that confronts them. They have a fixed number of participants, a shared space in which to develop best practices, and a single web portal for the coordination of rhetorical activities. This situation drives the grounded, experiential, and particular methods chosen to make the OLSS more effective. Of course, as the net widens to include other clinical environments, all of this experiential data may not be transferable, except in the form of principles and practices that can be summarized in the form of a document (and perhaps additional training materials). For this reason, as one CPDT member points out, one element of the translation of the OLSS is the reduction of complex insights rooted in experience and gained through *phronesis* into insights that are general and transferable.

Furthermore, one CPDT member provides additional support for this strategy of simplification and its implications for the knowledge that the CPDT and coaches build together on a daily basis. In response to a question regarding the need for a coaching protocol in the first place, this respondent opines, "*I think the fact that from the start it was a new approach . . . this sort of online coaching. It had never really been done before to this extent . . . I think we felt it was something that would be very helpful not only to do this type of program and do it well but also to generalize it to other programs and researchers.*" Here, this CPDT member provides another argument regarding the need for a protocol that dovetails with the issues raised above. Most importantly, this respondent argues that because of the newness of the design of the OLSS, that it "*had never really been done before to this extent,*" the move to translate it to other clinical

environments and prepare it for dissemination requires a protocol that may help future practitioners begin the process of implementation. This CPDT member uses the term "*generalize*" which should bring to mind yet again the dialectic of the general and specific. The rhetoric of translation will, at a certain point, embrace the general in lieu of the specific, following the comments already recounted, because this helps to facilitate uptake in new settings. Providing an account of all of the experiential knowledge gathered is not feasible and may not assist in promoting the uptake of the OLSS.

The next theme indicates a potential problem in the translation of the OLSS. Both CPDT members discuss the fact that the OLSS team has developed a rhetorical "process" for collaborative knowledge production (chapter 4).[68] This process is something that is unique to the OLSS that may not exist in other places. This is another reason mentioned by one of the CPDT members for the creation of the protocol: "*I think the biggest reason we need a protocol is so that others can do what we have done and won't have to start from scratch especially because they're not going to have the team of researchers or this combination of the coaching staff as well as the researchers here*." In other words, the generalized protocol is an attempt to capture as many of the insights of this process as possible so as to avoid the problem of "*start[ing] from scratch*." However, despite the intentions of the protocol, both CPDT members suggest that one roadblock to the implementation of the OLSS elsewhere is that nothing can really make up for the lack of a team like the one that has been assembled for this study. One CPDT member articulates the problem this way: "*We just have this amazing team of people, and we realized not every environment where [the OLSS] could be enacted is going to be a resource as rich as ours . . . For us, its been formalizing and crystallizing . . . what we've learned along the way*." In other

[68] Wenzel, "Three Perspectives on Argument," 15.

words, the process, and perhaps even more importantly, the modes of expertise involved, in the cultivation of the OLSS are not directly transferable. The protocol is one way to deal with this problem, to widen the circumference of potential practitioners and clinical sites by generalizing as much as possible. Another CPDT member confirms the importance of the process used to improve the OLSS, echoing the collaborative knowledge production theme I discuss in chapter 4: "*there's always going to be minor changes to the curriculum and the programming as we go through iterations . . . We're sort of adapting to different patient populations, different levels of coaching experience*." Capturing these minor changes, generalizing them, is one of the goals of the CPDT and the coaches; however, no protocol document could possibly contain all of the insights gleaned through the experience of developing and testing the protocol.

In this regard, one of the CPDT members also mentions the problem of training coaches, a process that may or may not be as feasible in other environments: "*Now, we're at a good point where we have very experienced coaches again, and we're still consistently working on tips to handle certain situations so that everybody can handle it the same way.*" This comment pushes back against some of the work I have done to suggest that there is really no way to fully account for the particular experiences of each individual; however, it also indicates the need for experienced coaches, again supporting my claim that the OLSS has a set of practices for coach training (one of which is the ongoing, iterative process I map in chapter 4) that cannot be transmitted via a single document (this is a problem mentioned by the CDT in the next sectin). In short, the persuasive and constitutive elements of the experiential process through which the coaching practices for the OLSS have developed is not something easily transferred to others, therefore complicating the translational story.

Beyond the issue of creating a generalized protocol document and the problem of capturing the grounded and experiential modes of training used to prepare coaches in the OLSS, both CPDT members mention additional translational issues that need to be addressed. One way to assist other clinical practitioners in actualizing the creative energies of the OLSS in their own environments is knowledge sharing, especially between the OLSS coaches and those working to become lifestyle coaches elsewhere. For example, one CPDT member argues that "*as a translational model . . . I think the coaches themselves would be really instrumental in teaching other people about how this is done, hearing firsthand what are the ups and downs and pitfalls of doing online coaching."* While the protocol documents (*Lifestyle Coach Training* and *The Lifestyle Coaching Guide*) may assist other practitioners in implementing the OLSS for themselves, it is the people and the rhetorical (pedagogical) skills they have learned through the constitutive process of becoming lifestyle coaches that may be most important in the arena of translation. This should take the reader back to the arguments about human contact and personalization in chapters 4 and 5. Written instructions may or may not fully provide the sorts of insights needed during the training process. Their translation and dissemination require dialectical engagement and conversation with those who have been through the process. This CPDT member goes on to suggest why the coaches might be so important in this regard by reporting on one coach's activities in particular: "*[X is] one of those people [who] always knows the right thing to say and the right way to say it, but it's not magic, it's . . . training . . . [it's] the coaches themselves who have a lot of practical expertise.*" Crucially, this comment describes the rhetorical prowess of one of the coaches and, what's more, this prowess is "*not magic*" but rather a matter of "*training*."[69] What this CPDT member points to is the importance of experience and

[69] One critical link between these comments here the Sophistic tradition is the belief that training can

training in cultivating "*practical expertise*" in the use of rhetorical skills that make it easy to decipher "*the right thing to say and the right way to say it*." In short, in this comment, this CPDT member suggests both that an ability to "*say the right thing*" is central to lifestyle coaching, thereby enshrining rhetoric as a key tool in the OLSS coaching strategy, and that this skill may be learned. More importantly, learning this skill is directly tied to the dialectical, constitutive, and therapeutic process of becoming a lifestyle coach within the OLSS. It is not gleaned merely through reading the more general principles in the coaching protocol (although these are also important as a starting point and ongoing guide). This has serious implications for translational research. What these comments point to is the importance of having a rhetorical assay for transmission in the form of the coaches themselves. They may have an important role to play in sharing the skills necessary to accomplish the task of lifestyle coaching and their words (bearers of their experience) are the assay through which others may be tried and found fit for this kind of clinical activity. Finally, this method of translation brings the role of *phronesis* back to the fore; rhetorical action is viewed as the primary means through which grounded experiences may be shared.

Another CPDT member raises one last issue I want to cover in this section: cost-effectiveness: *"I think we are trying to do it in a way that's cost efficient and within a clinical practice. One of the [issues] we . . . debate . . . is, for instance, the length of a coaching note, how much time you're putting into a coaching note. To be cost-effective, it has to be within a certain parameter."* Cost-effectiveness may at first seem far afield from the rhetorical mode of *phronesis* I defend throughout this dissertation as well as the notion of rhetorical assays under investigation here; however, it is directly relevant to the issue of translation. If an intervention is

improve one's capacities, that these are not in born or magical traits but traits that can be learned through the textured process of doing and experiencing. See Gaonkar, "Aspects of Sophistic Pedagogy," 15.

too expensive, it is highly unlikely that clinicians and insurers will implement it in their clinics. In addition, this CPDT member argues that there is a direct tie between the symbolic and the material at the site of the coaching note. Simply put, the length of a note and the amount of time that it takes to produce implicates the overall cost-effectiveness of the OLSS as a clinical service. As much as it might be ideal to spend as much time as one wants writing a note (and including however much content one wants), doing so may undermine the overall effort of the intervention to remain cost-effective enough to implement. Of course, there are always arguments to be made about the overwhelming costs of health care and the need to make necessary care accessible and affordable. But, in a very simple sense, expense is tied up in the persuasive possibilities pertaining to translation. It is, following my work in chapter 4, a special topic or "*eide*" of the clinical setting that requires attention.[70]

These comments by CPDT members on the issues of translation and dissemination indicate the extent to which the OLSS designers have considered the problem of making their product attractive to other clinicians. They also indicate the degree to which this process is rhetorical. First, the coaching protocol itself is a rhetorical "product," a document that contains the generalizable elements of a deeply constitutive and dialectical developmental process.[71] Second, the process of coach training is a rhetorical "process," one that cannot be fully captured in the coaching protocol.[72] Echoes of Plato's arguments in the *Phaedrus* should be coming to the fore for the reader when unpacking this insight. Simply put, a static text cannot speak for itself, defend itself, or situate itself so that it fits the specific problems its readers may face.[73] In short,

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[70] On this, see Sharon Crowley and Debra Hawhee, *Ancient Rhetorics for Contemporary Students*, 4th ed. (New York: Pearson/Longman, 2009), 120.

[71] Wenzel, "Three Perspectives on Argument," 15.

[72] Wenzel, "Three Perspectives on Argument," 15.

[73] Plato's *Phaedrus* 275d-277a.

the written word (although very useful for many purposes) does not necessarily promote the transmission of ideas that are rooted in experience, at least not by itself. While there is no doubt that documents produced through a dialectical process will be better suited to the particular, they will fall short if not combined by human contact in the form of the spoken word. Third, and directly related to the point just made, one of the CPDT members argues that, as part of the translation and dissemination of the OLSS, human contact may be critical. The lifestyle coaches themselves are the bearers of rhetorical (and other) skills of relevance to the implementation of effective versions of the OLSS at other sites. One of the implications of this insight is the need for ongoing participation of the OLSS lifestyle coaches from research setting to the implementation of the OLSS at new clinical sites. That is, they both suggest that the OLSS program cannot work without human coaches and without sharing the experiential knowledge (*phronesis*) they glean through their participation in the OLSS. Finally, the comments analyzed in this section suggest that my development of a rhetorical assay for translation and dissemination is relevant to their experiences, grounded in clinical relevance, and rooted in the demand for enhanced capacities for the research-to-care journey. Many of the issues I discuss in this section come up again (with slightly different inflections) in 6.5. The members of the CDT add substance (and completely new insights) to the need for rhetorical work, especially between academic, clinical research and the corporate and clinical environments to which its work can and should be transformed into action. Any interconnections between the themes in this section and those developed in 6.5 may point to the "architectonic" features of translation and dissemination including the complexities involved in transforming an iterative "process" into a "product."[74] Rhetoric, we may find, is the way to re-energize the coaching protocol (and the

[74] Wenzel, "Three Perspectives on Argument," 15; McKeon, "The Uses of Rhetoric."

OLSS), to make it relevant to the needs of individual practitioners and patients, and to inspire the development of the iterative and developmental processes key to its success.

6.5 THE CORPORATE DISSEMINATION TEAM (CDT): RHETORICAL ASSAYS CONNECTING RESEARCH TO CARE

6.5.1 Data Collection and Methods

During the summer of 2010, I designed an interview project to capture the rhetorical practices used by the Corporate Dissemination Team (CDT) to sell the OLSS to clinical practitioners and health systems in national and international contexts.[75] My primary reason for tackling this topic is to understand the pathways through which the lifestyle coaching strategies and online curriculum of the web-based platform of the OLSS (chapters 4 and 5) make their way past the clinical research setting and into the wider arena of chronic care for obese and diabetic patients. For this project, I designed a set of questions for the CDT aimed at eliciting their sense of the role they play in the translation and dissemination of clinical research as well as their understanding of the interconnections between the academic research setting and the wider environment of everyday clinical care (Table 6). My interviewees were identified through consultation with the CDT. They were then informed about the purpose of the study, and asked if they would agree to participate (Appendix B). These interviews were completed on site at the CDT headquarters in October, 2010. They were recorded and transcribed and lasted between 21

[75] The OLSS program has been licensed to the Corporate Dissemination Team (or CDT throughout) and the copyright has been assigned to the University of Pittsburgh. The researchers do not receive proceeds from its sale.

and 65 minutes.[76] This project was reviewed and approved by the University of Pittsburgh's Institutional Review Board.[77] Below, I report on the content of three of these interviews.

Table 6. Interview Questions (Corporate Dissemination Team)

Interview Questions
• What is [OLSS]?
• What originally attracted [the CDT] to getting involved with the [OLSS] project?
• What are the differences, if any, between the [OLSS] pilot program at [the university] and the [OLSS] program product now for sale through [the CDT]?
• What is [the CDT's] role in the production and distribution of [the OLSS]?
• What are the major challenges that you see in disseminating online evidence-based interventions for promoting health?
• How does your dissemination strategy address those challenges?
• What kinds of advertising, promotion and distribution of [the OLSS] is [the CDT] currently developing/implementing?
• Who is your audience?
• What promotional angles have you found to be most appealing to your audience?
• What has been least appealing to your audience?
• What have you learned over time in adapting your message?
• In your opinion, who are the most important potential customers that [the CDT] is targeting with its promotional campaign?
• What is the relationship between the scientific evidence generated by the [the university] researchers and the promotional campaign [the CDT] is working on?
• What reactions have you experienced from audiences at conferences and potential buyers to your [OLSS pitch]?
• What is the role of [the CDT] in rolling over customers from [the OLSS] pilot studies to actually purchasing and implementing [the OLSS program]?

[76] The interviews were recorded by me and transcribed by a research assistant, Jeffrey Kurr, who was reimbursed through funds generously provided by the ICRE/CTSI fellowship mentioned in the acknowledgements of this dissertation. Full transcripts of the interviews are retained by the author.

[77] It was submitted for exempt review and received approval from the IRB. University of Pittsburgh IRB # PRO10060085.

Table 6 (continued).

• How are participants recruited for [the OLSS] pilots initiated by potential buyers? What role does [the CDT] play in this recruitment process? • Is there anything else you would like to add?

In this section, I again make use of the close reading strategy I describe in chapters 4 and 5.[78] Here, I use this reading strategy as a method to unpack the rhetorical assay used by the CDT to translate and disseminate the OLSS intervention. This assay involves two primary conduits for the movement of clinical research into clinical care. The first connects the OLSS research team with the CDT. The second is the rhetorical work (both in terms of marketing and implementation) utilized by the CDT to convince clinicians and other healthcare workers to implement the OLSS in their clinics with their patients.

Throughout my discussion of these interviews, I refer to my interviewees as "CDT members" or "respondents." Each of them has played an important role in the translation and dissemination of the OLSS. A close reading of their interviews yields several important themes that connect with my discussion of the need for a rhetorical assay in the cultivation of strategies for translation and dissemination. As summarized in Table 3, three primary themes emerge from a close reading of the responses of the CDT members: (1) synergizing clinical research with corporate dissemination, (2) marketing to specific clinical domains ("the priority of the particular"), and (3) implementation as a service and mode of persuasion.[79] As in chapters 4 and

[78] Kenneth Burke, "The Philosophy of Literary Form," in *The Philosophy of Literary Form: Studies in Symbolic Action*, 3rd ed. (Berkeley: University of California Press, 1973), 1-137; Martin J. Medhurst, "Eisenhower's 'Atoms for Peace' speech: A case study in the strategic use of language," *Communication Monographs* 54 (1987): 204-220; Bent Flyvbjerg, *Making Social Science Matter: Why Social Inquiry Fails and How It Can Succeed Again* (Cambridge: Cambridge University Press, 2001).

[79] Martha C. Nussbaum, "The Discernment of Perception: an Aristotelian Conception of Private and Public Rationality," in *Love's Knowledge: Essays on Philosophy and Literature* (Oxford University Press, 1990), 66.

5, these themes significantly overlap. That is, many of the issues that the respondents discuss have elements that cut across all of the themes under consideration. However, for the sake of clarity and for providing a set of insights that highlight the major movements of the interviews, I divide them into three larger layers and a variety of sub-themes (Table 7). Following my work in 6.3, I argue that all of these are elements of translating and disseminating clinical research through a rhetorical assay. I also investigate what has been termed "reverse translation" or the process through which discoveries made during marketing and implementation are reported back to researchers and help frame ongoing improvements in the cultivation of new interventions.[80]

Table 7. Interview Sub-Theme Map (Corporate Dissemination Team)

Themes	Sub-Themes
Synergizing Clinical Research with Corporate Dissemination	The distinction between and fusion of technology with clinical services; The digital code of the OLSS as an architecture developed for the coordination and delivery of evidence-based lifestyle change; The academic/corporate nexus as the driver for effectively combining clinical research with health information technology and persuading others to use it (*ethos*); The limitations of translating academic, clinical research into the clinical environment (*kairos* and *phronesis*)

[80] On "reverse translation," see Alexandr A. Kon, "The Clinical and Translational Science Award (CTSA) Consortium and the Translational Research Model," *The American Journal of Bioethics* 8, no. 3 (2008): (author manuscript, available online).

Table 7 (continued).

Marketing to Specific Clinical Domains	Knowing your specific audience ("the priority of the particular")[81]; "The medium is the message"[82]; The critical role of verbal speech; Marketing as a mode of rhetorical pedagogy
Implementation as Service and Mode of Persuasion	The specificity of implementation ("the priority of the particular")[83]; Implementation Support (as service and mode of persuasion); Roadblocks to implementation

6.5.2 Synergizing Clinical Research with Corporate Dissemination

> *It was almost luck, in some sense, it was very fortuitous that the University . . . and the researchers [there] . . . were actually engaged in a program to translate that particular study [the Diabetes Prevention Program or DPP] as it was one of the ones we looked at as sort of evidence that behavior change could work and one that proved that you couldn't scale those kinds of tools with intense human interaction, you needed to look at technology.* -- CDT Member[84]

> Science becomes a "cultural space": it is made locatable (and interpretable) by spatial segregations that highlight contrasts to other kinds of knowledge, fact-making methods, and expertise; boundaries define insiders and outsiders, while labeled landmarks give distinctive illustrations of each side; scale is enlarged to show internal differentiations within science or reduced to make science a single spot . . . coordinates tell us where we end up when we move away from science in various directions – toward faith to the East perhaps, politics to the West, techno-wonders to the South, error and ignorance to the North. We arrive at meaningful

[81] Nussbaum, "The Discernment of Perception," 66.

[82] Marshall McLuhan, *Understanding Media: The Extensions of Man* (Cambridge: The MIT Press, 1994), 7-21.

[83] Nussbaum, "The Discernment of Perception," 66.

[84] On the DPP, see William C. Knowler, Elizabeth Barrett-Connor, Sarah E. Fowler, Richard F. Hamman, John M. Lachin, Elizabeth A. Walker, and David M. Nathan, "Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin," *The New England Journal of Medicine* 356, no. 6 (2002): 393-403.

> understandings of science (its products, people, practices, and potentials) by seeing or hearing about its place on a map, and we form images of its contents and capabilities by remembering where it has been located in spatial relation to places it is not.[85]

Thomas F. Gieryn's influential study of the "cultural boundaries of science" indicates that scientific discovery and uptake is rooted in the variable credibility of scientific research and practice (through time and across different socio-cultural and political spaces) as well as the "demarcations" crafted to make sense of the place of science amidst a variety of other epistemic and practical domains.[86] Scientific research is thus one place on a larger "cultural map" and its movement from site to site is made possible through a rhetorical assay, that is, through the use of *logos* to transmit upstream scientific discoveries to downstream practitioners and publics.[87] Gieryn's approach to analyzing the cultural situatedness and dissemination of science focuses on the cultivation of *ethos* ("credibility") by scientists and scientific advocates.[88] Lisa Keränen calls these normative dispositional traits the "scientific ethos" and suggests in her work that scientific controversies circulate around competing conceptions of the scientific endeavor and the character traits necessary to engage in scientific research.[89] According to her groundbreaking work, the rhetorical "process of characterization" of scientists and scientific research that

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[85] Thomas F. Gieryn, *Cultural Boundaries of Science: Credibility on the Line* (Chicago: The University of Chicago Press, 1999), 10-11. For similar arguments regarding the movement of science through various socio-cultural locales, see John Ziman, *Real Science: What It Is, and What It Means* (Cambridge: Cambridge University Press, 2000); Helga Nowotny, Peter Scott, and Michael Gibbons, *Re-Thinking Science: Knowledge and the Public in an Age of Uncertainty* (Cambridge: Polity Press, 2001).

[86] Gieryn, *Cultural Boundaries of Science*; (on "demarcation") Charles Alan Taylor, *Defining Science: A Rhetoric of Demarcation* (Madison: The University of Wisconsin Press, 1996).

[87] Gieryn, *Cultural Boundaries of Science*, 1-35.

[88] Gieryn, *Cultural Boundaries of Science*, 1.

[89] Keränen, *Scientific Characters*, 24-27. On the role of credibility in the rhetoric of science, also see Carolyn R. Miller, "The Presumptions of Expertise: The Role of *Ethos* in Risk Analysis," *Configurations* 11 (2003): 163-202; On the role of evidence in crafting professional *ethos* in medicine, see Colleen Derkatch, "Method as Argument: Boundary Work in Evidence-Based Medicine," *Social Epistemology: A Journal of Knowledge, Culture and Policy* 22, no. 4 (2008): 372, 384 (and throughout).

stakeholders use to judge whether science has gone wrong or particular scientists have gone astray tends to play a critical role in major scientific controversies as they unfold.[90]

In the context of the OLSS and its translation and dissemination beyond the domain of clinical research, the question of *ethos* as credibility and as a term that captures the larger dispositional and constitutive traits of the scientific endeavor is not a matter of public controversy.[91] There is no major public controversy regarding the OLSS and the expansion of its use. However, the interface between upstream clinical research (medical science) and downstream clinical care (medical practice) is certainly at issue when it comes to the uptake of the OLSS by new clinical sites. In addition, while there may not be an ongoing "credibility contest" regarding the OLSS, the move to establish *ethos* is certainly part of the CDT's mission of translation and dissemination.[92] Furthermore, following Gieryn, the different socio-cultural locations, political layers, and economic speed bumps through which science must pass in order to impact human practices and lives play a key role in the interview accounts of the CDT as they consider their daily activities as translators and disseminators of a health intervention developed in the clinical research setting. Moreover, the connection between science and the technologies and practices its findings support represents one of the central *topoi* of the responses by CDT members detailed in this section.

Furthermore, and perhaps most importantly, the members of the CDT argue throughout their interviews that while the value of evidence-based clinical approaches to lifestyle change is clear, the persuasive force of clinical studies is at times muted by the lag time involved in

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[90] Keränen, *Scientific Characters*, 6.

[91] Keränen suggests that *ethos* may have a larger role to play than in the cultivation of credibility. For her, *ethos* captures, "the widely shared cultural values or implied norms that characterize a group of people." Keränen, *Scientific Characters*, 26.

[92] Gieryn, *Cultural Boundaries of Science*, 1; Keränen, *Scientific Characters*, 71.

producing high quality clinical research (as opposed to developing strategies in various clinical domains and piloting them without publishing findings). That is, the assay that connects behavioral discoveries to the practical locations in which clinical care is achieved and the technological advancements through which care may be delivered is not smooth and direct but riddled with potential problems and attendant possibilities. Thus, the rhetorical assay that supports the translation of lifestyle change strategies developed in the research setting into the corporate environment and the subsequent dissemination of such strategies cannot be captured through a simple sender-receiver model of communication. Rhetoric with its associated states of uncertainty, mutability, revisability, disagreement, and rejoinder plays a critical role in translational research and clinical product dissemination. These problems suggest various "demarcations" in the forms of practice, modes of decision making, and strategies of discovery and articulation that differentiate clinical science from those who translate and disseminate it and, finally, its end-users.[93] In this way, the movement from clinical research to clinical practice traverses the map that Gieryn describes and at least one of the critical issues at play has to do with the cultivation of *ethos* both in terms of evidence-based practices (which represent credibility and legitimacy in contemporary behavioral and biomedical approaches to care) and the distinctions between the concerns, expectations, dispositional traits, and norms utilized to judge the efficacy of research findings in the real world of the clinic.[94] In this way, the CDT members are replicating a process very similar to that undertaken by the Sophists who worked to traverse the cultural landscape and bring their knowledge to bear on the applied contexts in which their students lived.[95]

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[93] Taylor, *Defining Science.*
[94] Gieryn, *The Cultural Boundaries of Science*, 10-11.
[95] Gaonkar, "Aspects of Sophistic Pedagogy," 57-59, 74-76.

These are only two of the issues I will discuss in this section (and those that follow); however, they point to the fact that cultivating *ethos* for evidence-based lifestyle interventions and negotiating the interface between science, technology, and clinical practice (the various cultural and epistemic domains of human activity involved in the OLSS) are at issue in the CDT's efforts to disseminate the OLSS and augment the number of clinical locations actively implementing it as a response to obesity and its co-morbidities. In short, this process also involves the cultivation and translation of *ethos* (in terms of credibility and as a set of accepted norms and practices) across different academic and practical communities. The rest of this section details the process of synergizing clinical research with corporate dissemination (the first theme in Table 7), a process that involves the movement of clinical research out of the academic environment and into the vast and diverse arenas of clinical care in the 21st century. The complexities of this theme are captured by four primary sub-themes that emerge from my reading of the CDT interviews: (1) the distinction between and fusion of technology with clinical services; (2) the digital code of the OLSS as an architecture developed for the coordination and delivery of evidence-based lifestyle change; (3) the academic/corporate nexus as the driver for effectively combining clinical research with health information technology and persuading others to use it (*ethos*), and (4) the limitations of translating academic, clinical research into the clinical environment (with a focus on the particularities of translation and the *kairos*-based issues involved in the production of clinical research in an academic environment). In each of these four ways, the members of the CDT express the movement of clinical findings and clinical practices across the different arenas of cultural and epistemic activity (e.g., the culture of the research setting vs. the culture of the non-research clinical environment). In addition, these themes suggest some *ethos*-based or credibility focused issues that are involved in the translation

and dissemination of clinical research; however, instead of focusing on the ways in which scientists and publics negotiate the meaning of science, I am invested here in describing the ways in which corporate disseminators of innovations in clinical care and health information technology view and communicate with the clinical researchers with whom they collaborate. To my knowledge, this is an understudied rhetorical process and vantage point from which to initiate the consideration of these issues, one that yields important insights for the development of translational research, and the practices of dissemination.[96]

Understanding the synergy between the clinical research environment and the corporate world of dissemination in the OLSS requires some attention to the distinction between the virtual environment created by the CDT and the evidence-based curriculum and coaching strategies developed by the CPDT in coordination with the university research team. That is, part of this synergy is rooted in the different roles played by the researchers and practitioners at the university and the members of the CDT. One way to distinguish these roles is to clearly delineate between the application (or code) of the OLSS and the evidence-based clinical services developed during the OLSS pilot study (the first sub-theme above). As one CDT member points out,

> *[The OLSS] is an online version of the NIH's Diabetes Prevention Program [DPP] where the application automated 90% of the face-to-face intervention of the original DPP and the only linguistic confusion is there's the [OLSS] application and there's the [OLSS] service, which is more than the application. The application is the code that presents an internet-based experience. The service is the entire experience that the patient, the clinician, and the clinician's host organization have to implement, deploy, and provide the support for someone to mimic what happened in the DPP.*

[96] The only study that currently engages all of these issues is Mitchell and McTigue, "Translation Through Argumentation."

Another CDT member uses similar language to express the dual nature of the OLSS: "*[The OLSS] both refers to the application itself but more importantly the complete service which couples the application with the coaching and the complete sort of way it rolls out from a clinical setting. The best thing about it is what the patient would call what they're receiving from the clinic.*" In other words, the portions of the OLSS that I focus on in chapters 4 and 5 represent one half of the picture. The other half is the technological application, the web-based platform that is the medium for communicating the curriculum originally developed for the DPP and revised for the OLSS (chapter 1).[97] This platform is the CDT's primary responsibility (that and selling the overall application and service as a package to new clinical environs).

More can be said about these comments. In particular, the first comment above opens with a discussion of the National Institutes of Health and its development of the DPP. The DPP is an evidence-based curriculum that has already been through a clinical trial and compared with a pharmaceutical intervention (chapter 4).[98] *Lifestyle Coach Training* also mentions the DPP on its very first page (chapter 4). This is no accident. Recall that one of the primary ways to establish the credibility of a clinical intervention is to show that it has evidence behind it, primarily the sort of evidence yielded through a clinical trial.[99] The rhetorical move to mention it at the very beginning of the interview, as this CDT member does, shows that the concern with credibility and the clinical trial model is also present for the CDT, a point that is borne out throughout the rest of this interview and those of the other respondents. Another way of putting this point is that the service portion of the OLSS is drawn out of clinical research both at the

[97] I intend to eventually write about the actual design of this platform from a visual rhetoric perspective; however, as this dissertation project unfolded, the opportunity did not present itself.

[98] Knowler, Barrett-Connor, Fowler, Hamman, Lachin, Walker, and Nathan, "Reduction in the Incidence of Type 2 Diabetes with Lifestyle Intervention or Metformin," 393-403.

[99] Keränen, *Scientific Characters*, 33-36. For a criticism of the at times unreflective *ethos* established through evidence-based methods, see Jason Grossman, "A Couple of the Nasties Lurking in Evidence-Based Medicine," *Social Epistemology: A Journal of Knowledge, Culture and Policy* 22, no. 4 (2008): 333-352.

level of the DPP and the OLSS research team. As one CDT member points out, "*The production is really driven by [the university research team] . . . in terms of what is the product itself . . . what we [the CDT] do is we develop the pieces that they ask for. And then I'd say the only other things we develop independent[ly] for them are the operational things, how do you manage applications better, how do you do that.*" Simply put, the OLSS has two domains, the internet-based domain of the application, the domain of the CDT, and the evidence-based methods for achieving lifestyle change developed for the DPP and refined for the OLSS, the domain of the university research team.

Much more can be said about the relationship between the application and code on the one hand and the service on the other, primarily that it represents the most robust point of connection between that OLSS pilot study and the corporate world of the CDT. This connection touches on one of the main rhetorical tools of this dissertation: the negotiation between the general and the specific. In other words, the code and application provide a sort of general "*architecture*" (the second sub-theme above) through which the OLSS is disseminated to new clinical environs and made available to new coaches and participants. As one CDT member points out,

> *The platform is the underlying code on which the [OLSS] application or others that we build run, and the platform is our core asset. That platform is to me like . . . a pre-fab house . . . that . . . has ten rooms. That room could be the recruitment room, the enrollment room, the education room, the goal setting room, the monitoring room, the tracking room, the mitigation room, the link to family and coach, the link to family and friends, the data analysis room. I think that was ten or something in that range. The code is like the architectural plans for those rooms.*

Here, an architectural metaphor is used to explain how the application and service interrelate. The application or code used to design the virtual world of the OLSS creates a general context or "scene" into which the specific elements of the OLSS service are placed and then made available

to participants.[100] As I suggest in chapter 5, this "scene" houses a sort of virtual *paideia*, an electronic site at which education and lifestyle change occur.[101] Put another way, much like the "Chronic Care Model" (CCM) provides an architectural map for the sorts of rhetorical activities critical to the implementation and delivery of care (chapter 2) so too does the OLSS application provides a mechanism for the delivery of the OLSS curriculum and lifestyle coaching to participants at a multitude of clinical sites.[102] One CDT member provides a specific example of this when describing the message creation process for coaches: "*The coach actually writes a message within the context of the application, but the message is not generated by the application. You call that the application-enabled message . . . The application is the technology, it's the code that presents what's within the [OLSS] application.*" In other words, the code and the application are the medium through which the human-created messages of the coaches are passed to participants in the OLSS.

One CDT member expands on the architectural metaphor explaining in great detail how the relationship between the CDT and the researchers at the university acts as a driver for interdisciplinary work (the third sub-theme above) and for the effective synthesis of the web-based features of the OLSS and the clinical research driven services it facilitates:

> *The partnership with the University . . . and a curriculum called the DPP was to say, "What rooms do you want to use?" "How big do you want them?" "What are the connections between the rooms?" "What wallpaper, flooring, etc. do you want to have in that architectural development?" . . . When the University . . . got funded . . . to transform the face-to-face [curriculum of the DPP] to an online version, we felt like we were the perfect company to build that with them because we had the technology, we had the know-how for the platform for the rooms, and*

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[100] On "scene" see Kenneth Burke, *A Grammar of Motives* (New York: Prentice-Hall, Inc., 1952), 127-170.
[101] Burke, *Grammar of Motives*, 127-170.
[102] Edward H. Wagner, "Chronic Disease Management: What Will It Take To Improve Care for Chronic Illness?" *Effective Clinical Practice* 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action." *Health Affairs (Millwood)* 20, no. 6 (2001): 64-78.

> *they had a fabulous history of creating intensive lifestyle components of the DPP, highly skilled technology people at the University . . . the faculty committed to going through the hard work and saying what it was the platform, the application, should deliver, and it allowed us to really take our company to a different level . . . Not only did it stress and push and enhance our platform, not only was it a great partnership with people who had historical and actual clinical methodological and technological and research capacity, but it was right in our field of expertise . . . but it was the roots, the start, the transformation of the company from internally looking which took two years to build that application, that platform to then be able to test it and try it.*

This description of the relationship between the university research team and the CDT indicates just how important the "*know-how*" or *techne* of web-based care delivery is when attempting to translate "*face-to-face*" modes of counseling into an online environment. That is, this response elucidates a sort of map for cooperation between technological and clinical expertise (*episteme*) as well as the basic *techne* needed to develop and implement technological solutions for the delivery of care. These insights are critically important in the increasingly technologized world of healthcare delivery. What this comment suggests is that the architectural features of the online medium are not sufficient to provide adequate care to obese and diabetic patients. Furthermore, this comment indicates that the connection between the corporate context in which such health information and communication technologies might be developed and enhanced and the clinical research environment in which evidence-based interventions are cultivated is an essential driver for the successful implementation of projects like the OLSS. Finally, this comment again indicates the degree to which such a cooperative nexus is developed through a rhetorical assay. That is, the technology of the OLSS is a communicative medium that then allows for the dissemination of a *logos*-based or rhetorical therapy in the form of the online curriculum and lifestyle coaching (chapters 4 and 5). Working together, using the architectural features of the OLSS platform, provides the needed energy for translation and dissemination. The cooperation

between the university research team and the CDT is then a rhetorical catalyst, a spark that allows for experimentation, critical judgment, and innovation.

Another CDT member provides further context for understanding the rhetorical assay that connects the CDT back to the university research team. As this comment suggests, this relationship allows for collaborative production and negotiation of knowledge (chapters 4 and 5):

> *I think one of the things that is interesting is how we do respond to customer questions as it's ongoing. And part of that is we need to interact with [the university] who designed it to get answers, part of it are things you couldn't have anticipated. We'll often get questions about [the OLSS], and we'll have to go back to . . . [the university research] team [and ask things like] "Why aren't carbs more predominantly featured?" We're not the clinical experts who developed it, we know it and over time we picked up a lot of it.*

While this comment focuses on the collaborative production of knowledge claims, it expands on this issue to consider the ongoing cultivation of a positive feedback loop, facilitated by a rhetorical assay between the research and corporate worlds. What this CDT member describes is a form of "reverse translation" through which knowledge downstream is reversed back through the rhetorical assay into the research setting.[103] As problems arise they are handled through the collaborative and rhetorical processes of explanation, negotiation, and correction. This CDT member continues to discuss this element of translation, further specifying elements of the process described in the comment above:

> *The biggest [issue] has been some of the diet choices around not including carbs if their patients have diabetes or some of the micro-nutrients things. It's a little bit less now, but a couple years ago, the [popular diet fad] thing was a big deal, so those kinds of issues occasionally will get somebody who thinks the focus on fat grams is wrong and that's outdated and the new science shows something else. That's been sort of an interesting thing to manage which is the strength of [the OLSS] . . . it has this research proven protocol and it's been demonstrated. The challenge is then fixed and it has to be that way and telling clinicians we get you want to change it, but this has been shown to work and it has to stay that way. Sometimes they're valid questions that have good answers we just don't know*

[103] Kon, "The Clinical and Translational Science Award."

> *them. So one of the things we've done is try to build a list of frequently asked questions that we give to clinicians beforehand and then we can keep that up-to-date. I think that has been one of the challenges with an evidence-based program. When a pill is evidence-based, it does one thing . . . [the OLSS] is so many different multiple interactions across time that it's a little bit hard to know everything.*

This response suggests that the sort of collaborative knowledge production I detail in chapter 4 and that the members of the CPDT highlight in section 6.4 transcends the context of clinical research and acts as one element of the rhetorical interface between the research and corporate domains. The members of the CDT, if they are to continue the development and sale of an evidence-based lifestyle change platform and simultaneously troubleshoot the problems faced by end-users, must continue their engagement with the clinical researchers at the university. This indicates that the process of translation from clinical research site to corporate dissemination site, at least as far as the OLSS is concerned, is a two-way street. End-user problems and the issues that the CDT face make up a positive feedback loop of information, troubleshooting, and problem-solving, all of which are cultivated through ongoing consultation between researchers and corporate disseminators. This is one of the reasons I have adopted the term assay to describe the rhetorical processes involved in translation and subsequent dissemination. The communicative pathways here are not just tasked with transferring information but also with the collaborative production of solutions, trials, and experimentation. For this reason, much of the rhetorical work being done here is experimental and about the creation of revisable solutions to problems that emerge in specific situations. Furthermore, the ongoing collaboration with university researchers allows for the invention of responses to other forms of knowledge and evidence, those applied by end-users who are pulling on their own knowledge regarding the practices of lifestyle management. Responding to these forms of knowledge and evidence is important as they threaten to undermine the specific elements of the OLSS that make it evidence-

based, effective, and consistent with the research outcomes of the OLSS pilot study (and its future iterations). It also provides a warrant for continuing to use the OLSS as opposed to other kinds of tools that might be available on the market. This collaborative and multi-directional process is directly related to McKeon's conception of rhetoric as "a productive architectonic art."[104] Again, such interactivity and its artful arrangement (making sure that the rhetorical assay at one level informs and transforms those at other levels) suggests how important the "architectonic" mode of rhetoric is to the chronic care commonplace of translation and dissemination.[105]

In addition, the comment above brings back one of the main issues described by the members of the CPDT in 6.4: the creation of a protocol that can be adopted in new clinical environments. Part of this involves the transcendence of the iterative process used to initially develop the coaching practices of the OLSS (chapter 4). The specific is generalized at the site of the coaching protocol in which the primary principles and common *topoi* of coaching are summarized. Of course, in such a process, some elements are left out, but the coaching protocol remains the primary textual conduit (one that is consistently revised and made fit for new circumstances) for translating and disseminating the knowledge produced by clinical researchers to clinical practitioners. Moreover, the process described in the comment above regarding the formation of answers to frequently asked questions accomplishes a different but related rhetorical task – *prolepsis*. *Prolepsis* involves building in responses to potential counter-arguments and questions that may be raised against a text or speech.[106] Thus, the process of crafting a list of frequently asked questions builds a rhetorical resource to respond to potential

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[104] McKeon, "The Uses of Rhetoric," 48.
[105] McKeon, 'The Uses of Rhetoric," 56-57.
[106] For more on the term "prolepsis," see Michael Leff and Jean Goodwin, "Dialogic Figures and Dialectical Argument in Lincoln's Rhetoric," *Rhetoric & Public Affairs* 3, no. 1 (2000): 59-69.

interlocutors and cut off misunderstandings that lead to decreases in sales or roadblocks in implementation. Put another way, generalizing the main questions and problems that individuals may have with the OLSS system involves collaboratively compiling a list of issues that people have experienced (*phronesis*), solving these problems or misunderstandings, and crafting responses. In a way this rhetorical move allows the CDT to pass on its knowledge about the problems end-users may face and how these can be addressed.

The CDT descriptions of what I am calling their rhetorical assay, one that acts as a nexus between the research and corporate environments of the OLSS, provides yet another benefit for the CDT: *ethos*. As I discuss briefly above, the CDT builds its arguments in favor of the OLSS around its evidence-based development. When discussing why the OLSS is a successful intervention and how it might be disseminated even more broadly than it currently is, one CDT member suggests, "*I feel like the bottom line is that having it evidence-based, having the capacity to get wisdom from the creators of the program when things are confusing to me or others whether on clinical [issues] or other [problems] is really critical. It really does make the whole product better.*" Of course, the production of more evidence may be used to improve the OLSS as a product but the research process plays an even more important role, one that goes beyond the collaborative revision and improvement of the application and service. One CDT member argues that evidence is important in the dissemination of evidence-based lifestyle change interventions because such interventions are different from other kinds of web-based applications, especially in terms of content and audience:

> *We are not typically direct-to-consumer . . . [The OLSS] could be modified, but if you think about what's out there, you have direct-to-consumer where you can go on [popular medical information and weight loss sites] and get an intervention . . . But it's not [an] intervention over time, its not research-based, but most importantly, they're not linked to a clinician.*

According to this CDT member, one of the main benefits of the CDT's connection with the clinical research world is the ability to act as a conduit for evidence-based interventions developed in that world. While there are some translational difficulties (which I discuss below and in the next two sub-sections), the ongoing cooperation between the university research team and the CDT constitutes a rhetorical assay for the movement of upstream findings into the broader clinical domains of the CDT's customers. Furthermore, this assay provides not only evidence but also *ethos* and the means for persuasion. Recall that for Aristotle, determining "the means of persuasion" in any given case is essential.[107] The comment above indicates the degree to which the CDT has considered its audience, clinicians, as well as the sort of evidence clinicians may need to make use of an intervention of this type. This concern for audience needs and experiences cultivates a high degree of *ethos* for the CDT and suggests that one of the primary norms of corporate dissemination, at least as practiced by the CDT, is the use of clinical research findings.

This CDT member articulates one last benefit of the partnership between the university research team and the CDT: the ability of the CDT to not only disseminate evidence-based interventions but implement them and persuade clinicians to use them in the specific environments in which they work:

> *For example, if you're a worksite, you need less evidence than if you're a health plan then if you were a clinician who was actually seeing the patient. Understanding that different level of evidence and understanding the difference of how those deployments and implementations are different is the whole market of what we can do as a company because we understand that continuum given the team we assembled . . . That's a niche that very few companies have.*

Just as the Sophists democratized and spread knowledge and rhetorical practice (see section 6.2), the CDT provides specific inflections of the *episteme* of clinical research to practitioners who

[107] Aristotle's *Rhetoric* I.i.12-14.

want to implement the OLSS program. That is, they are engaged in the translation of the evidence-based OLSS intervention into the web-based application and finally the specific clinical environments where it will be used. This level of translation and dissemination is made possible through the cooperation between the research and corporate worlds and indicates the degree to which the rhetorical issues of *ethos* and knowing your specific audience are critical in the dissemination of new interventions. I take these issues up again later, but these comments specifically address the cooperative energy of the research and corporate partnership that drives the CDT's work and show how the OLSS application and service are synergistically constructed and persuasively disseminated due to this partnership, again indicating the "architectonic" role that rhetoric plays here.[108]

The other respondents confirm the understanding of the partnership between the research and corporate environments detailed in the paragraphs above and provide further evidence of the *ethos* and other persuasive effects it yields. For example, one CDT member directly connects this partnership to the successful marketing work of the CDT:

> *It's absolutely critical. It turns out from a sales standpoint that it's a second order part of the conversation . . . the way the conversation goes is, "Do you care about weight as a clinic?" "Is it impacting your outcomes?" "Is it impacting your cost structure?" "Are your patients leaving?" "Do you care about engaging them?" Then it's, "Would a solution like this solve that?" Then you get to the question of does it work, does it not, how do we know. That's mainly the role of the evidence. That conversation is not so linear, you sort of jump around. Really, the early stage of the evidence is enough to know that it was done out of a research setting, that it came from the DPP, that it is being studied, that there are some results. So it's a little less about the actual evidence at that stage, it's more about the fact that it's an evidence-based program, that it comes out and is tied to clinical research. That's very important to the customers because they want to know there's efficacy behind it and that it's being done in a rigorous fashion. The evidence itself isn't really looked at . . . until they say they're interested and they like it. Then we typically get them access, or point them to the recently published articles.*

[108] McKeon, 'The Uses of Rhetoric."

This comment points to two different ways in which the evidence produced in the clinical trials (for the DPP) and the pilot study (for the OLSS) can be used in the context of making a sale. In one sense, the existence of evidence, the fact that this lifestyle intervention has been tested based on the rigorous demands of clinical research, is sufficient to get clinicians on board. That is, the *ethos* of science is posited without direct evidence. Another CDT member provides further context for this claim, stating that "*The effect is selling a program that is evidence-based [which] means that you don't have to necessarily prove who is in the club . . . when you have an evidence-based implementation that takes away a roadblock for people. People believe, "This has been studied very well". . . they trust the science.*" Thus, the existence of studies backing up the OLSS intervention plays an enthymematic role in the cultivation of credibility for CDT members as they work to sell the OLSS product.[109] Later on, the scientific articles (the official conduit for the transmission of new findings) may be used to answer specific questions and provide support for specific decisions made in the design of the curriculum and its delivery. This bifurcation in the modes of presenting evidence suggests the degree to which clinical research (and the clinical trial model) always already has a high degree of *ethos* with some clinical practitioners.[110] However, it also suggests that the mere existence of such evidence does not always translate into practice changes. Only through direct persuasion and marketing by the CDT are the findings of the OLSS pilot study and the DPP put into play, at least for the clinicians with whom the CDT members interact (see 6.5.3 for more on this).

Despite all of this creative energy and collaborative invention of new knowledge and persuasive tools, there are definitely drawbacks (the fourth sub-theme above) to the nexus of

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[109] Aristotle's *Rhetoric* I.ii.13.

[110] Keränen, *Scientific Characters*, 33-36; Grossman, "A Couple of the Nasties"; Derkatch, "Method as Argument."

university research and corporate dissemination under investigation in this sub-section. Thus, there are times when the rhetorical assay fails, either because of unforeseen barriers or critical distinctions between the academic and corporate environments. These drawbacks have to do with two related issues: (1) *kairos* – the "*time cycle[s]*" of clinical research and the corporate need for information and technological innovation in a timely manner and, (2) *phronesis* which, in this case, has to do with the specification of generalized evidence-based lifestyle management strategies in the context of specific clinical domains (an issue I raise again in section 6.5.4 when I discuss implementation). As I have already discussed in the opening sections of this chapter (6.2 and 6.3), one of the critical insights of the Sophistic movement is the uncertainty of particular situations and the need for timely (*kairotic*) approaches to handling this uncertainty. One of the problems with the uncertainty engendered by specific moments in time and particular places is that they present irreducibly complex and idiosyncratic barriers that cannot always be addressed adequately though the simple application of already acquired knowledge. In addition, when it comes to the amount of time it takes for the development of evidence that is rigorous enough to impact clinical practice, the issue of having knowledge at the right moment is even more complex. The history of medicine is replete with examples of diseases and outbreaks for which medical science was unable to produce timely answers. In addition, the NIH Roadmap was initially created to address the overly long process of developing new drugs and interventions to address critical health problems in the short-term.[111] Thus, the question of how to address the timeliness of medical research and its application to human health is driving contemporary efforts to develop new skills and approaches to translational research and

[111] Zerhouni, "The NIH Roadmap," 64. One of the keys of the Roadmap is "Reengineering the Clinical Research Enterprise" which may assist in overcoming "inefficiency." See also, Kaiser and Couzin, "Speeding Up Delivery."

dissemination. The CDT members provide some interesting insights about this problem facing clinical researchers as they work to provide tools to clinicians working with patients and some clues as to how it may be addressed.

The first way in which the members of the CDT approach the problem of *kairos* in their responses is through a comparison of the different time cycles that pertain at different locations on Gieryn's "cultural map."[112] In other words, the respondents describe a variety of disconnects between the clinical research setting and their corporate and clinical settings that circulate around the issue of time. One CDT member describes in detail the different time cycles involved in the cultivation of knowledge and technological innovation necessary to improve the OLSS:

> *[The OLSS] is still sitting on our old technology. Imagine a website that we've tried to keep up to date, we've done what we can, but it's sitting on four year old technology . . . So, matching the technology evolution cycle to the product life cycle and the research life cycle is kind [of] hard . . . [the OLSS] took six months to build, a year to study, and another six to nine months to write up. Imagine two years, you're through four versions of a cell phone, that's a little bit of a trick in the particular area of longitudinal interventions on technology platforms so we've had to have a conversation with [the university research team], you may not see a lot of value right away from this, but we have to migrate it to the new technology platform or the database isn't going to be made . . . it's not being driven by their research agenda, it's being driven by a technology evolution.*

The analogy to cell phone technology in this response provides a nice lens through which to consider the productive limitations of the cooperation between the clinical research environment and the corporate environment. One of the unique problems facing the university researcher team involved in developing the OLSS is its reliance on technology. As this CDT member points out, clinical research moves at a much slower rate than technological innovation such that researchers may end up producing practice innovations and other new findings that are not adapted to the changing conditions of the OLSS application (at the CDT) or the technologies available (or

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[112] Gieryn, *Cultural Boundaries of Science*, 10-11.

expected due to technological innovation) in different clinical environments. In short, clinical research cannot always move at the speed of market or technological innovation. This means that the technological medium of the OLSS may at times lag behind current methods of online communication and interaction. In short, the OLSS may at times fail to match the *kairotic* elements of contemporary electronic communication given the length of time clinical studies require to reach completion.

The problem described in the comment above involves much more than the mismatch between clinical research and corporate technological innovation. It also implicates marketing of the OLSS and the persuasive appeals of the evidence being produced by the university research team. The same CDT member quoted above continues:

> *We licensed [the OLSS] in . . . April or May of 2008. The article wasn't published until November of last year. So, we had a year and a half, and we were commercializing but not really robustly . . . We were sort of barred from talking about specific evidence until it was published. There was . . . a time where evidence was as much as it's from the DPP, it's being developed, being studied, and they've run a study as it was here are the outcomes. The outcomes have only been part of the conversation for the last year.*

In other words, given the disconnect between the speed of corporate marketing and client needs and the production of rigorous evidence in the clinical environment, the CDT has not always been able to rely on the evidence being produced by the university research team. Another CDT member expands on this problem:

> *But here's the fundamental challenge with using research, [the OLSS] . . . study will . . . take a year and a half to two years to complete. It's got a 3 to 6 month enrollment, they're on it for a year, then it takes time to study it. Let's say they're really fast in writing it and they get it accepted on the first trial. Probably three years from the date of enrollment (forget all that planning beforehand) until that data comes out. More than likely, we'll be on version 5 when that data comes out. So, the research that they do, high quality, randomized control trials, answer great questions, but will be on a version of the application at least three years old . . . and which we made modifications . . . [with the university researchers] help*

> *and direction making it so that the generalizab[ility] of the outcome is good science but not exactly what we need for the marketing side.*

In both of these comments, these members of the CDT argue that research is long-term and marketing is short-term. This distinction in time cycles means that while the CDT often relies on the evidence being produced in the clinical research setting, this evidence is not always available and may not be timely once it appears in published form. The scientific article, as important as it is for the cultivation of best practices and correction of problematic or obsolete practices in medicine, does not always emerge quickly enough to impact corporate and clinical environments beyond the research setting.

In some ways, this insight is not a new one. It has become a major concern for those interested in enhancing the movement of new interventions into clinical care. For example, one goal of the NIH Roadmap is to address this problem by decreasing the barriers to initiating clinical research.[113] Such movement is assisted through the synergy of the research and corporate environments, but this synergy itself has limitations that might only be addressed by accelerating the speed of research or developing marketing and implementation strategies that are not completely reliant on the clinical research environment (sections 6.5.3 and 6.5.4 below). Furthermore, the iterative and grounded (*phronesis*) strategies utilized during the development of the OLSS can at times undermine its application to new environments. As one CDT member points out,

> *To get people to agree to it they have to say, "Oh I understand that the DPP worked, but we're not doing the DPP, we're doing [the OLSS]. How do we know that the [OLSS] will work?" So the first study they did is very important, but it was a fairly small study, its 50 patients. It was not randomized. It was two years ago when it was completed. The version that we're using now is two versions past*

[113] Zerhouni, "The NIH Roadmap," 64. The Roadmap contains specific strategies for implementing "New Pathways to Discovery" and "Research Teams of the Future" both of which are meant to synergize interdisciplinary work and reduce roadblocks to initiating research in the first place.

> *what they tested. So, the first is people who understand data say, "Well, but what have you done for me lately? You got me a study from a while ago." So, we basically in a non-research setting describe our experience with these other settings. People value that a lot because they say, "Oh, so you've tried that with people like me. Tell me about X, because they're very similar to me. How did they do? What was their drop out rate? What was their outcome in a year?" Even though they know its not research and its a quality improvement approach, people like that . . . In other words, being able to say, "The [university research team] is still involved and continuing to enhance it. They've got two randomized control trials . . ." adds credibility but no results because it's not done.*

This adds another problem to the mix, primarily the limitation of clinical research to very specific conditions. In other words, when research is rigorous, it is designed within a specific set of constraints that may undermine its applicability, especially when it is focused on interventions that are processes with multiple technological and practice-based elements (like the OLSS). Therefore, given the idiosyncrasies of different practitioners and patients, the application of findings from the specific domain of the OLSS pilot studies (and future iterations) is limited by the changing parameters of implementation. Recall for instance the comments of the CPDT in section 6.4. One of the benefits of the research setting is the highly interdisciplinary nature of the team constructed to run the OLSS pilot study. Such levels of expertise and collaboration are not easy to accomplish in the first place and may not be easy to find in new environments. This yet again shows why the CDT members' work in the comments detailed over the last several pages to differentiate between the OLSS application and service is so important. One thing that the CDT cannot sell is the whole package of services provided in the university research setting because the individual practitioners and their cooperative milieu do not travel. This is the conundrum of approaching the world through an experiential lens, especially when considering the importance of generalizability of clinical research findings. At least one thing that my work in previous chapters and the comments by CDT members above suggest is that an approach to lifestyle change grounded in *phronesis* requires ongoing translation and negotiation along the

entire research-to-care assay (an "architectonic" finding discussed again in chapter 7).[114] Thus, the comments above indicate that clinical evidence and the rigorous research used to produce it are critical but not always useful or applicable in every circumstance.

For all of these reasons, the synergy that exists between the university research team and the CDT is riddled with paradoxes. On the one hand, the evidence produced by the clinical research team is what makes the OLSS unique. It is not just another online weight loss program. It is actually backed by the rigorous methods of clinical science. The CDT relies on the *ethos* of clinical science to market the OLSS to clients thus showing just how important the synergy between researchers and disseminators is to the translational process. At the same time, movement from one location to another on Gieryn's map is no easy task.[115] At times, the evidence produced by the university research team does not come quickly enough (*kairos*) to implicate either the rhetorical strategies used by the CDT or the actual practices implemented at new clinical locations outside the original research setting (*phronesis*). In addition, this evidence does not always come pre-packaged for dissemination. That is, the iterative and experiential (*phronesis*) practices used to develop the OLSS (see chapters 4 and 5) are not always easily translated to new environments or persuasive when it comes to marketing the OLSS. Thus, part of the dissemination process used by the CDT is the rhetorical negotiation of these issues with the specific needs of end-users in mind. Furthermore, the comments made by the CDT detailed in this section provide a great deal of evidence for the cultivation of rhetorical strategies that accelerate the process of "reverse translation."[116] That is, the more that corporate dissemination

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[114] McKeon, "The Uses of Rhetoric."
[115] Gieryn, *Cultural Boundaries of Science*, 10-11.
[116] Kon, "The Clinical and Translational Science Award.

teams and end-users can be folded back into the research process and the more the research process itself can be accelerated, the more effective behavioral interventions may become.

6.5.3 Marketing to Specific Clinical Domains

> *But our main goal is in distribution. Commercializing it, heavy marketing and sales, and lead generation activity, convincing clinics to pilot it and try it, and then supporting them to roll it out.* -- CDT Member

> *So, it's to build up a marketing and sales strategy with a pipeline, it takes 1000 people you talk too to get 100 who are interested to get 10 who are really into it to get 1 sale. It's the pipeline sale approach . . . Once you've closed a sale . . . the person has agreed to provide the [program]. By the way, our customer is never the patient; our customer is the entity that is going to host it [the OLSS].* -- CDT Member

> Often, communication challenges are viewed through the lenses of advertizing and marketing. But a business view lends only limited insight into how humans use language to facilitate collective learning, build common understanding and overcome communication barriers. Contemporary research in argumentation theory provides conceptual tools forged from ancient traditions and honed in contemporary applications . . . research methods that integrate a broad range of such communication tools can facilitate translation of basic science into improved health outcomes.[117]

In this section, I utilize the ancient art of rhetoric as developed by the Sophists (and others) to unpack the practices utilized by the CDT to facilitate dissemination. In particular, I deploy Martha Nussbaum's notion of "the priority of the particular" which she attributes largely to Aristotle, Poulakos' notion of *kairos* as rhetorical opportunity or "the opportune moment," Gaonkar's arguments regarding the pedagogical focus of the Sophists, and Lloyd Bitzer's conception of "the rhetorical situation" that involves the cultivation of speeches for particular

[117] Mitchell and McTigue, "Translation Through Argumentation," 97-98.

audiences.[118] All of these rhetorical tools, along with several others iteratively developed below, help to make sense of the four primary sub-themes at play in the interviews under the larger heading of "marketing": (1) knowing your specific audience, (2) "the medium is the message," (3) the critical role of verbal speech and face-to-face contact, and (4) marketing as a mode of rhetorical pedagogy (for rhetors and audiences).[119] Each of these themes provides additional substance to my claim that rhetoric is a sort of assay (i.e., experimental medium, trial, and the like) for the resolution of barriers to translation and dissemination.

Throughout their responses, the respondents describe the importance of knowing one's audience and fashioning messages based on this knowledge (the first sub-theme above). While this may seem like a relatively straightforward process, it involves a set of complicated rhetorical tools that are not always available to the clinical scientists who engage in the work of creating new behavioral interventions. That is, clinical scientists are not always known for their rhetorical virtuosity when dealing with different audiences (in this case, different kinds of clinical end-users).[120] This is one reason why the CDT is so important for the OLSS research team and its efforts to find new clinical environments for the implementation of its findings. Producing a way to interface with specific audiences is critical if the OLSS is to be anything more than an effective clinical research tool. At this juncture, *phronesis* comes to the foreground yet again. The process of crafting messages grounded in the opportunities presented by different situations and the needs of individual end-users requires attention to the particular. In short, it requires a

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[118] Nussbaum, "The Discernment of Perception," 66; Poulakos, *Sophistical Rhetoric in Classical Greece*, 56-57, 62-62; Poulakos, "Toward a Sophistic Definition of Rhetoric," 36; Gaonkar, "Aspects of Sophistic Pedagogy"; Lloyd F. Bitzer, "The Rhetorical Situation," *Philosophy and Rhetoric* 1 (1968): 1-14.

[119] I draw the phrase "the medium is the message" from McLuhan's famous work *Understanding Media*, 7-21.

[120] Leach, "The Art of Medicine."

prioritization of the individual needs of particular clinics, clinicians, and patient populations.[121] For this reason, at least one part of the CDT's missions is the study of how audiences receive their messages and how to craft more effective messages for future sales.

Unpacking the quotations of the CDT that fall under the theme of knowing one's audience requires some specific attention to the rhetorical theory involved in crafting persuasive appeals. As Bitzer suggests, at least one element of crafting an effective message is addressing oneself to what he calls a "rhetorical audience."[122] Such audiences are able to take action based on the persuasive appeals of the rhetor.[123] Reframed in the context of translation/dissemination, finding clients requires finding those who may actually benefit from purchasing one's product. Thus, the need to know one's audience is a central *topos* in the interviews (the first sub-theme above). All three respondents detail the diversity of audiences to which they orient their rhetorical activities. Of course, the rhetorical strategy used to appeal to each group of clinicians is slightly different as the issues and patients they deal with on a regular basis are not the same. As one CDT member points out, "*some of them [clinicinans/clients]we go after proactively and some of them opportunistically*." This is due in part to the sense the CDT has (developed through experience) about whether or not a particular kind of clinical practice or health care organization is likely to have an interest in the OLSS. First among these audiences is "*diabetes centers.*" The same CDT member continues: "*While the [OLSS] service isn't about diabetes specifically, it's very important for people with type-2 diabetes to have [a] weight management service. There's great evidence that it works as an adjunct to medicine. We've identified academic and non-academic centers as a specific target where we have a deep understanding of what their benefits*

[121] Nussbaum, "The Discernment of Perception," 66.
[122] Bitzer, "The Rhetorical Situation," 8.
[123] Bitzer, "The Rhetorical Situation," 8.

are." According to this CDT member, one of the best and most important target audiences for the CDT is comprised of centers that treat diabetes, specifically due to their need for weight management tools. Another CDT member makes the same point when suggesting that one of the main audiences for the OLSS is, "*Diabetes programs, diabetes centers. I guess mid-size physician medical groups. Those are the most important clients to us. People that are already thinking of going to scale.*" Yet another CDT member confirms this focus: "*The main audiences for [the OLSS] now are large multi-specialty practices, sort of diabetes clinics and tertiary diabetes centers*." Thus, what Bitzer would call an "exigency," the existence of a need or "imperfection marked by urgency" is most present in those organizations looking to manage diabetes, one of the main co-morbidities of obesity.[124] Or, as another CDT member suggests, "*Providing more service to their participants [is] an objective of theirs. So more often that's the type of client that we're going to be interested in*." In other words, diabetes centers have become a focus for the CDT because such centers are oriented toward behavior change in the first place. They are already looking for ways to make changes to their services and delivery of care that can amplify the health oriented decision making and self-management of their clients. While this is a fairly straightforward insight, it cannot be forgotten in the project to enhance translational research and the rhetorical assay that connects research to care. Seeking out those individuals most in need of one's knowledge and tools is an *a priori* consideration in effectively enhancing the uptake of evidence-based clinical interventions.

The CDT works with other clinical settings as well such as "*chronic care management organizations*" and "*primary care settings in medical groups*." These audiences are often engaged in "*care management support often involved with weight management*" and have such

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[124] Bitzer, "The Rhetorical Situation," 6.

large patient populations that some automation (like that offered by the OLSS) may be attractive to them. One of the primary issues that differentiates these groups from smaller diabetes clinics is size. As one CDT member notes, "*We find that if you're really big, you don't want to talk to us. The million, two million covered lives, yeah maybe. But 40,000 to 100,000 covered lives of which 60-70% are adults of whom 50% are overweight and sedentary of whom 5% may want the program and 1% who sign up. It gets you a pretty good number*." In other words, too many covered individuals may be a disincentive to engage in the OLSS because, the reader should recall, it involves not merely automation but also coaching (chapters 4 and 5). The larger the organization, the more complicated the implementation because you need to train and place larger numbers of coaches. Or, as one CDT member puts it, "*It's [the OLSS] designed closer to a therapeutic relationship, but we've had success with them ["large disease management company"* or *"large health plan"] mainly because of people who are colleagues . . . who I would then talk to.*" The "*therapeutic relationship*" that stands at the heart of the OLSS is not an easy thing to implement on a large scale. The comment above indicates that the OLSS is more fitted to the needs of smaller practices that manage tighter groups of practitioners and smaller patient populations. The moments when larger health plans and companies decide to look at the OLSS are fostered not so much by a different message but rather by the personal connections that the CDT has with industry insiders who are willing to take a chance on their word. These insights provide additional support for the claim that complicated lifestyle interventions involving both automation and new healthcare practitioner roles may not be easily translated into large settings, thus making the process of dissemination more complicated and calling for additional rhetorical work.

The insights discussed above have important consequences for translational research and the NIH Roadmap. It is not enough to generate new evidence and make this evidence available and persuasive to clinicians. Some interventions, particularly lifestyle interventions, face an even larger hurdle than others because they require simultaneous organizational, practitioner, and technological transformations. That is, they face problems that call for "architectonic" interventions aimed at synergizing multiple layers of human interactivity and action.[125] In addition, one problem associated with translating and disseminating clinical research into clinical care is that some new interventions may or may not find uptake based on what Bitzer would call the material and situational "constraints" of clients (as opposed to their failure to understand the importance and efficacy of new interventions).[126]

Moreover, knowing your audience not only means paying careful attention to their material and situational "constraints" but also to the ways in which they organize their decision making process.[127] That is, organizations approach decision making with different strategies, some of which are deeply hierarchical and thus rooted in power dynamics that make persuasion a game of identifying the right person or the correct version of the message most likely to travel along the decision-making tree. As one CDT member points out:

> *Part of it [making a sale] has to do with the dynamics of decision making in health care settings. One of the big things we learned is that this is not a simple sale . . . if you look at an organization there are individuals who actually use the application, the coach, the nurse, the doctor, and they have to accept it, they have to like it and think its good. It's an easy sale . . . The next buyer is the economic buyer, who's got the money, going to make the decision, how do you get them to see value. Then there's the group who it just has to meet a certain standard, or I can't even let you talk about it, where's the evidence, where's the proof its going to work in my setting. The challenge is the people who are most enthusiastic about it often have the least power in the hierarchy of decision making.*

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[125] McKeon, 'The Uses of Rhetoric," 56-57.
[126] Bitzer, "The Rhetorical Situation," 8.
[127] Bitzer, "The Rhetorical Situation," 8.

This comment identifies several different segments of an organizational structure that might be found in any health care organization or clinical environment, each of which requires a slightly different version of the rhetorical strategy employed by the CDT. First, there are those who use applications and services like the OLSS such as "*the coach, the nurse, [and] the doctor*." As this CDT member points out, these individuals are the most likely to see its value and back its large-scale adoption. With this group, "*it's an easy sale*." But these individuals do not commonly hold the power of the purse in their various organizations. The next type of client mentioned by this CDT member is "*the economic buyer*." For this group, of course a more powerful group than clinical practitioners, the key is "*value*" or showing that the OLSS can help to address health needs at an acceptable cost (or even potentially save money in the process). This is not always an easy task as I show in the next section (6.5.4). Then there are those who seek evidence as the primary means of persuasion. That is, they want to have "*proof its going to work in my setting*." This group (which remains largely unspecified in the comment above) could stand in for any practitioners or buyers who are committed to using proven interventions and who want to know that the intervention will work. This is important to them because of the major costs associated with implementing new interventions and because they are concerned with actually improving health outcomes in their setting.

In other words, this group wants evidence fitted to their context.[128] This is a major rhetorical issue because it requires not simply showing that clinical evidence backs the DPP style

[128] This insight is connected to Jenicek and Hitchcock's claim that evidence is not neutral information and that clinical decisions are not made based simply on the evidence at hand. Context and other issues are critical in the interpretation of evidence and in making decisions about the best quality care for specific individuals. See Jenicek and Hitchcock, *Evidence-Based Practice*, 189 (and throughout). Jason Grossman suggests that one way to address differences in opinion over quality of evidence, the method of its creation, and its application is to adopt a sort of "methodological pluralism," something akin to what the CDT members do as they translate the OLSS from one site to the next. Grossman, "A Couple of the Nasties," 347-349. Grossman also claims that evidence-based medicine

curriculum and online implementation of the OLSS but also that this evidence is applicable to the clinical setting at hand. The insights described on the last several pages yet again show how message particularization is rooted in the specific needs and interests of audience members. The major implication for translational work is that evidence has different meanings and applications. Practitioners are likely to see results and focus on them but economic buyers and individuals higher up on the decision making tree will want to have cost projections and clear articulations of how highly complicated lifestyle interventions designed in the clinical research environment may work in their specific practice.

Hierarchical clinical settings also produce problems in terms of message circulation and whether or not certain individuals who may like the notion of implementing the OLSS are likely to speak with superiors (and others) about it. As one CDT member points out, "*In some cases, they [potential clients] were uncomfortable pushing it because they have a very hierarchal setting . . . So, it's dangerous to go out on a limb. The dynamic of all those things has made us recognize that we have to think about all those different people in a sale, make sure we address their needs.*" In other words, it is not just a matter of finding a contact at an organization and beginning the sale. Projecting the various objections that may be made at different levels and

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often moves in the direction of valuing certain kinds of evidence with no consideration of context: "These rules [of EBM] are to be applied rigidly . . . without any consideration in particular contexts" regarding whether these rules support practitioners in the effort "to use current best evidence." Grossman, A Couple of the Nasties," 334. Again, the CDT seems to be invested in the idea that evidence is a changing element of their persuasive appeals and, thus, cannot be applied "rigidly" (Grossman's term) but, following Grossman's argument, must be applied to specific "contexts" (Grossman's word). Grossman goes on to show that many things can implicate the quality of evidence in any particular case. His most apposite example illustrates the ways in which clinical sites, the places where people receive care, may actually implicate the creation and applicability of evidence generated at those sites. Grossman, "A Couple of the Nasties," 337-340, especially 338. In addition, Derkatch's study focuses on "complementary and alternative medicine" and the ways in which its practices do not match the demands of evidence-based medicine (something like the way in which certain clinical sites have different needs, practices, and issues that the CDT must address). Thus, this chapter bears out Derkatch's claims in a new setting, the translation of lifestyle interventions to new clinical sites. Derkatch, "Method as Argument," 373 (and throughout). In short, this note bears out the claim that the CDT's comments throughout this chapter confirm arguments being made regarding the need to challenge hardening conceptions of evidence within the EBM model that is currently dominant in healthcare.

cultivating the right sorts of evidence to back up answers to these objections is also part of the process. Recall from the previous section that this is the rhetorical strategy of *prolepsis,* this time expressed as a strategy in the direct communicative interface of marketing. The use of this strategy, one that involves brainstorming various objections or concerns of different audience members, can assist in overcoming the problem of power (rooted in hierarchical environments) and can make it easier to assist individuals at lower positions within the hierarchy to push the adoption of the OLSS.

Aside from *prolepsis*, determining who might be an ally within a healthcare organization and working to find the most effective messages for them is also a major concern. One CDT member articulates this process in the following way: "*We learned that we had to have messages for each one of those different segments and that different people in an organization have different capacity to sell that message . . . the person who does the training of the coaches who is herself a coach may resonate with the coaches better*." Utilizing the right individuals, the most effective rhetors, in the delivery of messages plays an important role in the process, one that facilitates and compliments the *proleptic* process already described. This CDT member uses the example of the individual tasked with training coaches. They might assist in crafting a highly effective argument for those individuals whose professional practices are close to those of the OLSS coaches, that is, for healthcare practitioners who are not necessarily physicians or high up in the hierarchy of their organization. Recall that while getting "*the economic buyer*" on board is an important element, the CDT member quoted above also stresses that those who actually use the application and engage in the service must come to like it or it will not go to scale (i.e., reach maximum saturation within a particular health care organization or clinic).

Another CDT member provides some additional insight into the specific sorts of message creation needed when marketing the OLSS, this time from the perspective of clinicians who are not necessarily prepared to adopt the program or engage in more direct and intensive lifestyle counseling:

> *We remind them that their patients are doing this anyway. Their patients are going to [popular online weight loss sites], but they're not successful, they're doing it without you. You should be part of that, help your patients help themselves. So that's part of the appeal. The problem is when you turn around and say how much time it is, its not like they're already doing it that much. They aren't automating a process they're already doing. They don't really do deeply engaging counseling and coaching around weight . . . The rare places where they are doing it, they see it as a benefit, but then you have the challenges that its slightly different from what they're already doing or it doesn't quite fit their current approach, and you have to worry about that . . . you can't start the conversation assuming that clinicians care about their patient's weight and recognize there's value in helping them lose weight. You have to go back to a conversation that says, "What are you doing about it? How is it impacting you? Are you seeing that they are coming in more often?" You have to walk them through the problem, the clinical problems that they aren't able to attend currently, so they can see there's a need for it . . . The biggest thing we've learn[ed], when we've been able to get a clinic to say, "Yes, the weight, obesity of our patients, either in primary care or with other conditions, impacts things we care about." We have a much easier time helping them see they should invest to solve it.*

This CDT member articulates several important insights regarding the cultivation of rhetorical strategies for clinicians who have not considered weight loss to be a treatment priority. In this case, the rhetorical concept of "*presence*" best describes the process of articulating a need that might not appear pressing to clinicians.[129] That is, this CDT member argues that clinicians are sometimes not aware of the gaps in their care delivery and are not always thinking about the fact that patients often turn to non-clinical tools to lose weight. In order to make this problem present

[129] Chaïm Perelman and Lucie Olbrechts-Tyteca, *The New Rhetoric: A Treatise on Argumentation* (Notre Dame: University of Notre Dame Press, 1971/2003), 117. As Perelman and Olbrechts-Tyteca declare, "one of the preoccupations of a speaker is to make present, by verbal magic alone, what is actually absent but what he considers important to his argument or, by making them more present, to enhance the value of some of the elements of which one has actually been made conscious."

to them directly and thus show them that they should consider making a change, this CDT member articulates a strategy of informing them about the kinds of things that overweight and obese individuals deal with and the sorts of options they have. In addition, another part of this process of making the problems of obese and overweight patients present to clinicians is showing how a new behavior change strategy might aid in ameliorating the problems that they are already experiencing with these patients. As one CDT member points out, sometimes clinicians have not thought about the fact that their overweight and obese patients are coming in more often and, yet, are not doing as well as other patients. By providing a way to understand this problem and address it, the CDT is able to make a problem and solution present to their audience.

Aside from the particular kinds of practitioners and buyers the CDT works with, another CDT member provides an additional layer that contributes to this sub-theme. Knowing one's audience is not just about knowing what they want, what they may need, or what might make them more likely to buy a particular product. In addition, as I have already suggested following Bitzer, rhetorical situations are rooted in material "constraints" that implicate the effectiveness of certain rhetorical activities.[130] In the case of the OLSS as it was spinning out into new clinical environments beginning in 2007, one of the primary "constraints" that emerged and has continued to impact sales is the recession that rocked the United States in 2008 and has had global consequences ever since.[131] As one CDT member points out,

> *When the recession began, we had lined up in our pipeline a whole bunch of groups that said, "Oh yeah, I can try this. I'll do fifty patients. It won't cost that much. I'd love to see it. I know it's the cutting edge, it's the future. I need to do it." The recession came, and many of them went away and they basically said, "I'm sorry. I just laid off my staff. I have no patients coming in. I don't have the bandwidth to try something new even when you tell me its not that much work, it's work." Those are the two biggest barriers.*

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[130] Bitzer, "The Rhetorical Situation," 8.
[131] Bitzer, "The Rhetorical Situation," 8.

Dealing with specific audiences requires understanding the material "constraints" that implicate their current actions and decision making strategies for the future.[132] Unfortunately for the OLSS, the recession has made it difficult for many clinics to consider new service and technological tools that might help their patients. This insight is important not only in terms of the ongoing success (or potential failure) of the CDT's efforts to augment the uptake of the OLSS. It also implicates efforts to improve translational research. At least one element that needs to be worked out is how new health interventions will be paid for and who will provide the support.

Beyond the issue of connecting with specific audiences and individuals, the members of the CDT speak about the ways in which the clinical evidence (service) and online application of the OLSS provide a persuasive medium through which to sell the program (the second sub-theme above). Following Marshall McLuhan, I have called this theme "the medium is the message" in order to indicate the degree to which the evidentiary and technological features of the OLSS variously support and enervate the persuasive activities of the CDT.[133] I have already discussed the issue of evidence and its role in cultivating *ethos* and persuasive effect in the last section (6.5.2) and above in my discussion of the sub-theme regarding knowing your audience; however, one CDT member provides some additional content regarding clinical evidence that bears discussion under this sub-theme:

> *The general reaction [to the OLSS] is people recognize that a lot of thought and wisdom went into the building of it. They get it very quickly. They'll say, "This is a core behavior change initiative even if I've never heard of the DPP. I can see what [the university research team] did" . . . It becomes very obvious to anyone who has any experience in these if you compare them to other interventions like*

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[132] Bitzer, "The Rhetorical Situation," 8.
[133] McLuhan's, *Understanding Media*, 7-21.

> *this, that it's high quality, well thought through, that there's a logic behind it, that there's behavior change theory, it just leaps off the page.*

This comment should take the reader back to section 6.4 and the notion that translation begins upstream in the clinical research environment. Recall that the members of the Coaching Protocol Development Team argue that one of the main benefits of the iterative, collaborative, and interdisciplinary work of the university research team is that it allows for the cultivation of a highly effective and well thought out intervention. This CDT member suggests that this hard work, especially in terms of integrating evidence-based behavior change strategies and working through the translation issues of putting these strategies into an online curriculum, makes the OLSS attractive to potential buyers. In addition, this comment also suggests that the quality of the OLSS provides a way around the problem of specifying how it might work in particular clinical domains. Often, buyers and associated practitioners can tell that the work effort has been significant and that the OLSS draws on theoretical and practice-based guidelines that are consistent with what they know about effective weight management interventions. While this CDT member does not provide specific examples in this regard, this insight is critically important for translational research, in particular because it suggests how important thinking about translation upstream is to the process of accomplishing downstream sales. In this sense, the evidence and rigorous testing that have formed the OLSS and made it what it is are themselves a medium for translation, persuasion, and marketing.

In addition to evidence as a persuasive medium, the respondents argue that the technological platform or application on which the OLSS is provided acts as a medium for dissemination; however, it is not always effective. As one CDT member points out,

> *They also recognize that it's built on technology that's four years old. For example, it has no social networking within it . . . Everybody can come up with a technological advancement or modification to it and its not there. That's fine, but*

> *the reaction I get is "I get it. I understand it. I can imagine my patients using it. But, how come when I look at other things people are offering, it's . . . more modern looking. It's got these other functions like social networking." I go, "The research shows that this works," and it does make it more challenging. But there's reasons it's not there.*

Crucially, this comment indicates the degree to which the evidentiary backing of the OLSS and its technological features do not always work synergistically during the sales process. As I argue in section 6.5.2, the lifecycles of academic, clinical research and technological innovation do not always coincide. New behavioral findings are not always delivered in a *kairotic* (timely) way, at least not in a way that allows for the integration of new technological features (e.g. social networking) that might enhance the communicative medium of lifestyle management. As this CDT member points out, the relationship between the university research team and the CDT does not always allow for the best permutations of new modes of electronic communication (e.g., social networking) with new behavioral strategies.

At the same time, this CDT member argues that some clients understand this disconnect, primarily because it is rooted in the ongoing commitment of the university research team to producing sound and reliable evidence. Social networking has not been rigorously tested, that is, its implications for lifestyle change remain unclear. In order to incorporate these changes, more research must be done. Of course, this argument from evidence is sometimes effective and sometimes not, but it shows the degree to which a lack of synergy between the research environment and the demands of the market can implicate the uptake of new interventions, another finding with serious implications for dissemination.

Despite these problems with slow technological innovation in the development of the OLSS, there are other elements of the CDT dissemination strategy that are highly effective. One CDT member argues that the benefits of the CDT's approach to implementing the OLSS

application is that they provide security and hosting tools so that specific clinics need not invest the time and money into building their own version of the OLSS. In other words, utilizing the software is as simple as having the computers and bandwidth to open it. Here again, the medium of the OLSS accomplishes a persuasive effect that suggests just how important design is to the uptake of interventions, especially those that require the use of information technology:

> *The reason I'm brought [in] at particular phases during the sales process is to put the client's mind at ease about acceptance of another online . . . program. It's been positive because a lot of people when they are first are being sold another piece of software think its something they're going to have to support. Our approach is software as a service model, that tends to be very palatable to an IT organization . . . we have a very secure implementation of [the OLSS] and we use a . . . well known hosting company and very well known security parameters that make IT [information technology] organizations feel comfortable and we get over those hurdles.*

This comment provides substance to my claim that "the medium is the message" (at least in part) when it comes to selling the OLSS to new clinical environments. Translational researchers would do well to consider the problem of hosting and technology support in the uptake and use of clinical interventions that have an online component. By providing these elements and articulating the ways in which this provision makes implementation easier, the CDT is able to sell some new clients who might have hesitated.

One issue that I have not yet discussed in this section is where the rhetorical strategies of the CDT are enacted. In other words, where do they go to find an audience? In a sense this is a problem at least as old as the Sophistic movement in ancient Greece. As both Poulakos and Gaonkar point out, the Sophists traveled in the ancient world finding new and interesting ways to impress their audiences and find new students.[134] Even when not directly teaching about rhetoric, they were using rhetoric as a tool of dissemination. Their work was enhanced by the need in the

[134] Poulakos, *Sophistical Rhetoric in Classical Greece*, 25-32; Gaonkar, "Aspects of Sophistic Pedagogy," 59.

late 5th century and early 4th century for rhetorical skill in the law courts and other civic spaces. As Gaonkar points out, the various and sundry citizens of the Greek city states were engaged in a process of becoming democratic and were thus enticed by the *logos*-based pedagogies of Gorgias, Protagoras and others.[135] Most importantly, their craft was disseminated by rhetorical performance, by face-to-face interactions. While some wrote treatises and other works, their day-to-day existence was focused on finding audiences who might listen to their rhetorical creations and lessons. This is clear in Plato's dialogues in which many Sophists are prominently featured at gatherings organized by their students for pedagogical displays and debates.[136]

In a similar way, the members of the CDT engage in the use of rhetoric and movement from place to place (the third sub-theme above) as a means to sell the OLSS to new clients. Their commitment to this sort of interaction, especially given the highly mediated and technological communication environment of the 21st century, shows just how crucial *logos* in the form of the spoken word is in the practices of dissemination. One CDT member articulates a variety of sites for the direct, face-to-face dissemination of the OLSS:

> *The most in terms of if you measure resources of time and money that we do to promote [the OLSS] is . . . attend trade shows. We had a booth at the [major professional conferences and meetings] . . . we as individuals will go to a lot of these conferences and try to meet people. So the primary way is to try to . . . in conferences attended by clinicians present this as the kind of tool they should look at . . . Most of it is . . . networking.*

This CDT member suggests that the lion's share of time and resources spent on promoting the OLSS goes to attending trade shows. This indicates the one-on-one nature of the rhetorical strategy used by the CDT. Another CDT member provides additional support for this take on the

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[135] Gaonkar, "Aspects of Sophistic Pedagogy," 57-59, 91, 120.
[136] See e.g., Plato's *Gorgias* and *Protagoras*.

rhetorical strategies of the CDT and articulates a nuanced defense of face-to-face contact:

> *Nothing beats face-to-face or discussion. I hate to admit it but people buy from people they like. And, particularly when early adopters have lots of things they could do and don't have the time, the money, or the staff to actually do it, why would they pick this over something else? . . . You have to get people who feel comfortable and think you're doing things in the right way and that you're going to be there for them. The early adopters in particular need to have personal relationships or feel that way . . . But even once you get somebody, think of it, you have a prospect list, once you get a live one who is still far from signing . . . we still need to have our force of credibility and the fact is that we can talk about things that they care about beyond what the application does. The application doesn't solve their problem, the service helps solve a problem if we can help them define it. It's still a pretty nuanced sale.*

Rhetorical performance, direct interaction, and building a network are all central strategies that would seem very familiar to the Sophists of 5th and 4th century Greece. What's more, this CDT member suggests that even when direct interaction has cultivated trust, the "*credibility*" of the program is still in need of rhetorical support. That is, direct interaction is step one. As part of this interaction, all of the arguments I describe above including the importance of weight loss interventions, the evidence-based nature of the program, and the quality of the service as opposed to others that might be available must be established. All of this adds up to what this CDT member calls a "*nuanced sale*" in which direct interaction and persuasion are critical tools needed for success.

This same CDT member goes on to describe an additional way in which rhetorical performance and travel play a role in the activities of the CDT: "*[A member of the CDT is] available to speak anytime, anyplace, anywhere . . . talking about the field and where it's going. They've [audiences have] been as small as 20 to as large as a 100 . . . "*. In other words, aside from direct, face-to-face interactions, one of the CDT members engages in public performances meant to enhance the public uptake of not only the OLSS but also transitions in the field of behavior change that support the increasing use of interventions like the OLSS. These insights

yield major implications for translation and dissemination. Developing a great intervention and crafting messages to sell it does not necessarily guarantee success. Instead, cultivating face-to-face encounters in which to deliver and retool one's messages is also important. This indicates the extent to which the experimental elements of rhetoric as an assay are critical to the process of translation. It also confirms McKeon's argument that "verbal rhetoric" still has a role to play in our highly networked and technological age.[137] Working and reworking one's rhetorical approach in the grounded arena of conversation is an experimental and collaborative process that goes well beyond simple marketing and business models. It goes right to what Mitchell and McTigue call the "mutual learning across epistemological chasms" needed to fully capture what translation and dissemination are all about.[138]

In addition to cultivating messages for specific clients, utilizing the evidentiary and technological medium of the OLSS as tools in persuading buyers, and engaging in rhetorical activities and travel in search of audiences akin to the Sophists, the CDT members also discuss their cultivation of what can be called a rhetorical pedagogy for clients (the forth sub-theme above). One CDT member describes a process of dialectical engagement and listening that is not far from the collaborative knowledge production strategies used by the lifestyle coaches and the Coaching Protocol Development team (chapter 4):

> *So, really understanding it's not just the message, the medium is the message, the message is the medium. How you give it, how you say it, who says it, how you listen more than what you say, and asking good questions I think has been the key*

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[137] McKeon, "The Uses of Rhetoric," 63.

[138] Mitchell and McTigue, "Translation Through Argumentation," 94. In addition, I should note that this CDT member mentions the use of a website for disseminating the OLSS and finding new clients. This is clearly not in the vein of public speech. However, this CDT member acknowledges that, "*We got a couple leads every so often from people who were searching for online weight management programs and they come to us through the website. We're in the process of enhancing that and making it better. We did not optimize that. We did not spend a lot of time so the website would generate a huge amount of business.*" This confirms my reading that the vast majority of dissemination activities undertaken by the CDT are accomplished through rhetorical performance, either face-to-face and/or one-on-one interactions of public performances with live audiences.

> *thing that we learned. Rather, than my tendencies to tell people things, a better approach is have them self-discover by asking questions of them, so they then can say that to themselves.*

As this comment suggests, part of the strategy of the CDT is to provide an interactional medium for the cultivation of trust, listening, and collaborative engagement. In such a medium, the members of the CDT are able to guide their clients toward "*self-discovery*" by listening closely to them and reframing their rhetorical work to more effectively persuade their clients, or more to the point, so their clients might actually engage in acts of self-persuasion made possible through interaction. This CDT member goes on to describe one of the main benefits of this strategy:

> *The second part of that is in any one of these relationships, we may not be talking to everybody who makes a decision, and the person we're talking to has to have language to talk to someone else. It's really the derivative language that's even more important. You and I talking, I can answer your questions, I can do ok. Getting you to feel comfortable to get to explain that to somebody else is really a big challenge.*

Here, the act of listening to clients and helping them to discover the reasons they might want to utilize the OLSS is a mode of rhetorical pedagogy in which clients are given the rhetorical resources to persuade other stakeholders in their organization. Recall the earlier sub-theme about knowing your audience. One of the issues raised in this sub-theme has to do with the problem of convincing practitioners and "*economic buyers*" to support the same kind of intervention. Thus, issues of cost, health outcomes, and evidence are crucial in different ways for different individuals in the organization. What this CDT member suggests is that one method for effectively translating new interventions is to give the resources of rhetoric developed by the CDT to clients so that they can engage in an informed deliberation on their own terms. This indicates that rhetoric is not simply a persuasive tool in the dissemination of new interventions but also a collaborative and pedagogical one. Finally, this process links up directly with the Sophistic move to deliver not just information and material to their students but also the skills

needed to act and live in the democratic worlds of their various city-states. The CDT is not simply delivering information, they are providing a means to act and live in the arena of clinical care and lifestyle management. They are also providing rhetorical strategies to defend the OLSS and its approach to lifestyle management to their clients. In other words, as opposed to simply making their arguments and hoping to gain adherents, they draw their clients into the practices of persuasion needed to transform their clinical locales and fully adopt the OLSS.

All of the sub-themes in this section provide insights that implicate the ongoing development of translation and dissemination. First, evidence does not travel smoothly. That is, different audiences may view evidence differently. This complicates the role of evidence and suggests that the findings developed in the clinical research setting require the additional assay of rhetoric to find homes in the cognitive and practical domains of healthcare practitioners.[139] Second, and especially when it comes to health information technology, "the medium is the message."[140] In other words, the market will often expect technological innovations even when such innovations outstrip the capacities of clinical researchers to provide evidence about their effectiveness. This is no clearer than in the comments about social networking and its conspicuous absence (at least for some clients) in the pilot version of the OLSS. This indicates the degree to which the NIH Roadmap and support for translation faces a major barriers that cannot be overcome by more research and technological innovation but only through efforts to synergize these two parts of the larger puzzle of high-tech care. In addition, technological

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[139] In other words, evidence does not work on its own to clarify treatment and intervention decisions. That is, there is often disagreement about the role of evidence and its quality/applicability in any particular clinical situation and between different clinical situations. On this insight and its import in EBM scholarship, see Jenicek and Hitcock, *Evidence-Based Practice*; Jason Grossman, "A Couple of the Nasties," 333-352. Moreover, as I have already detailed earlier, some research has suggested that evidence claims differ from one medical community to the next, much like the CDT members suggest evidence must change depending on the client at hand. See Derkatch, "Method as Argument."

[140] McLuhan, *Understanding Media*, 7-21.

innovation in itself is not valuable to clinical researchers but it may be to potential clients. Combining the technological and evidentiary media of a particular intervention is a subtle and complicated affair but one that the CDT suggests is necessary to effective translation. Third, the use of public performances is a critical part of the rhetorical strategies used by the CDT. This indicates the extent to which information technology is not necessarily the best or only way to translate and disseminate new findings. Instead, direct, face-to-face encounters have been more effective than others for the CDT. This shows how important trade shows, conferences, and other gatherings are to the ongoing translation and dissemination of new clinical interventions. Ongoing support for such venues is a must if the NIH Roadmap is to be a success. Finally, rhetorical pedagogy is a central part of marketing for the CDT. Thus, the arguments made by Mitchell and McTigue regarding the understudied phenomena of "collective learning" as more critical than simple "advertizing" and "marketing" studies has been largely confirmed by my analysis in this section.[141]

6.5.4 Implementation as Service and Mode of Persuasion

> *Don't forget the sale doesn't end when they start the evaluation; the sale goes on forever particularly if the goal is to go to scale, which is the real issue. Going to scale, the person clearly has the purse strings. How do you have them say, " . . . I commit, [I'll] pay for the evaluation internally . . . if you show the following outcomes, I'll go to scale." Nobody is going to do that upfront, but that's the challenge.* -- CDT Member
>
> Initial implementation begins when practitioners begin using evidence-based practices in their contacts with their first consumers. This stage involves creating new realities for and transactional connections among practitioners, organizations, and supporting systems. Trainers and coaches from the purveyor group are helping practitioners learn the rudiments of new clinical or intervention skill sets in the process of creating mastery of the evidence-based practices. Considerable effort is put into helping the first practitioners be successful with the first

[141] Mitchell and McTigue, "Translation Through Argumentation," 97-98.

> consumers of the new program in order to demonstrate the value of the program in the new location. Purveyors also are working with directors and managers to define roles, learn new skill sets, and further the process of creating new organizational cultures to support performance-based operations. Staff selection, training, coaching, and evaluation require well informed and skilled trainers, coaches, evaluators, and administrators. These functions appear to be essential to the initial and continuing success of an implementation site and careful thought needs to be given to how the implementation site can become self-sufficient with respect to the skillful use of the implementation drivers (or develop long-term relationships with outside contractors to gain access to those resources). Fidelity measures, staff performance measures, and program evaluation measures are carefully monitored and the information is acted upon promptly.[142]

The comment at the top of this section offers an excellent transition from the realm of marketing into the complicated domain of implementation. As this CDT member points out, the sale is always ongoing. That is, once clients have adopted the OLSS (either for a short-term trial or a long-term implementation), the CDT continues to foster their interest and commitment to it. This is achieved through a process of implementation support. The CDT offers assistance in realizing the use and uptake of the OLSS by clients in the form of implementation resources and strategies. In this way, the act of implementation is not only a translational one but also a rhetorical one. Implementation becomes a means of realizing clinical integration of the OLSS and persuading clients to continue to use the OLSS and potentially take it to full scale with their patient populations.

The problem of implementation is at the heart of translational research and corporate dissemination. As I have repeatedly pointed out in this chapter, simply having clinical findings, evidence, and newly minted and effective interventions does not guarantee their use (or their effective use). Translation is so important to addressing this gap that an entire area of study

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[142] Dean L. Flixsen, Sandra F. Naoom, Karen A. Blase, Robert M. Friedman, and Frances Wallace, *Implementaiton Research: A Synthesis of the Literature* (Tampa, FL: National Implementation Research Network, Louis de la Parte Florida Mental Health Institute, University of Florida, 2005), 98 (http://ctndisseminationlibrary.org/PDF/nirnmonograph.pdf).

known as "implementation science" has emerged.[143] As the second quote above indicates, implementation science is a deeply rhetorical affair in which "transactional connections" are used to cultivate relationships between various stakeholders. These connections assist in the process of "helping practitioners learn" the use of new products and interventions, eventually yielding "mastery of evidence-based practices" and clinicians and clinical sites that are largely "self-sufficient." The final element of implementation science that is central to what the CDT does is "program evaluation" or the act of determining how well particular interventions and protocols are working and improving them. All of these are translational acts that require a rhetorical assay, an experimental and suasive space for transaction, interaction, and debate among various stakeholders looking to improve the health of their patients.

The rest of this section unpacks the implementation support offered by the CDT. Throughout, I argue, following the words and insights of the CDT, that implementation can be seen as a mode of persuasion. A close reading of the interviews reveals several sub-themes related to this argument: (1) the specificity of implementation ("priority of the particular"), (2) implementation support, and (3) roadblocks to implementation.[144] While discussing these sub-themes, I use a similar set of rhetorical concepts as those already deployed in sections 6.5.2 and 6.5.3, adding a few where necessary to describe specific processes or tasks. Thus, the Sophistic charge, in particular the notion that opportunity and *kairos* are critical to the uptake of one's message and ways of knowing, informs analysis of this section, providing another opportunity to

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[143] Flixsen, Naoom, Blase, Friedman, and Wallace, *Implementaiton Research*; Russell E. Glasgow and David Chambers, "Developing Robust, Sustainable, Implementation Systems Using Rigorous, Rapid and Relevant Science," *Clinical and Translational Science* 5, issue 1 (2012): 48-55; Suzanne Ross, John Lavis, Charo Rodriguez, Jennifer Woodside, and Jean-Louis Denis, "Partnership Experiences: Involving Decision-Makers in the Research Process," *Journal of Health Services Research & Policy* 8, suppl. 2 (2003): S2: 26-34.

[144] Nussbaum, "The Discernment of Perception," 66.

observe how Sophistical pedagogy provides a framework for understanding the practices of translation and dissemination.

Throughout the interviews, all of the respondents provide substantial context for understanding how implementation works to specify general principles, practices, and approaches to particular clinical environments (the first sub-theme above). This follows the basic logic of Martha Nussbaum's understanding of "the priority of the particular" in Aristotle's approach to experiential learning and *phronesis*.[145] On this general point, one CDT member opines,

> *I think it's critical to distinguish the two [the application and service of the OLSS] because if you've [seen] one deployment of the OLSS service, you've seen one deployment. Every one of them is different because of the reality of the real world where they're all provided in the context of a clinical and therapeutic relationship hosted by a sponsor of some sort.*

This comment articulates a distinction between the application (code) and service of the OLSS. As this CDT member suggests, these elements change based on the individual clinic and particular clinicians that make use of the OLSS. While the basic format of the application remains the same, the kinds of service (coaching, direct human interaction, and contextual elements specific to the clinical site) that are delivered to patients shift due to the grounded and experiential elements of "*the real world*." The complex contours of the real world necessitate changes, not only in terms of the therapeutic relationships between providers and their patients (chapters 4 and 5) but also in the translation of evidence-based clinical interventions from the research environment into the domain of everyday clinical care. As such, all of the work I have done to describe the elements of the therapeutic and dialectical relationship between providers and patients is given a slightly different (but clearly related) inflection here, one in which

[145] Nussbaum, "The Discernment of Perception," 66.

research findings must be translated in order to account for the granularity of everyday experience.

The members of the CDT provide even more context for understanding these differences when they describe the transition from the university research site into their world of marketing and implementation. For example, one CDT member suggests that, "*The program itself is different from [the university research team's] implementation of a program because there's definitely specific implementation[s] that they've got.*" Another CDT member provides a bit more detail, suggesting that the clinical setting changes as it moves from the university site to the various clinical sites that the CDT works with:

> *The basic premise is that you've got an application that stays the same as a fundamental structure wherever you go, but by definition because we are deploying them in the context of a clinical setting and the context of a clinical relationship that the individual in some way or other has with the patient, things are different . . . the [OLSS] pilot that they [sic recte did] was specifically in one type of clinical setting, it was primary care. Individual clinicians recruited the patients, coaches worked side-by-side or more as a consultant to those groups. They didn't necessarily come from that primary care practice, but they were provided to the patient but it wasn't as if the primary care doctor became the coach. It was a separate entity, a separate group of people who became the coaches who were trained . . . specifically their role was to provide coaching in the [OLSS] pilot, which would also be true in the randomized control trials going on now [at the university and other sites]*.

Here, this CDT member articulates the primary differences between the research sites utilized by the university research team and the corporate and clinical domains of the CDT. The primary difference is in terms of the type of environment in which the OLSS is rolled out. For the OLSS pilot study, patients were recruited through their primary care physicians and were provided a service in tandem with their primary care. That is, coaches working for the university research team provided service through the OLSS application. Their physicians and other providers at the primary care site did not take part in providing the curriculum and coaching support. Of course,

this may not be true when it comes to new clinical environments where the application and service are deployed within the clinic, utilizing the providers and grounded expertise of that environment to realize the implementation and delivery of the OLSS service. The comments above provide context for understanding one of the major contributions of this chapter to the study of translational research and the improvement of the rhetorical assays that connect research to care. The specificity of the research setting (including all of the requirements that must be fulfilled in order to begin a research study) may limit translational potential. In other words, the generalizability of research findings can be implicated (or even limited) by the vicissitudes of the research setting. This insight seems even more relevant in the context of complicated interventions that are processes (as opposed to a single intervention like a pill or surgical procedure). Lifestyle interventions are long-term processes with so many features (which of course rely on particular material and situational constraints of various clinical environments) that the research done to understand how they might work in multiple contexts, how they might be universalized to some extent, is highly complicated. For this reason, the CDT members point out time and again that a different (yet complimentary) research process is undertaken with new clients to see how the OLSS will work for them. They refer to this as piloting or evaluation and I will return to it shortly.

Furthermore, the respondents articulate a highly complex set of differences between the OLSS pilot study and the context in which they are trying to sell the OLSS to new clients. That is, aside from noting that the pilot study is rooted in the primary care setting, they provide several specific distinctions between the pilot and the environments of their clientele that spin out the importance of implementation support and the specificity of implementation needs in any

given clinical setting. First, they note that recruitment, enrollment, and orientation differ from site to site in terms of strategy and effectiveness. One CDT member notes that,

> *The biggest difference in the [OLSS] as it was rolled out in the pilot study (and as the university is rolling it [out] in their other studies) and the way it's rolled out in [the] commercial setting is the way patients are recruited, identified, and the first enrollment, and there are a number of different ways that's been done. That's probably a question coming up. It's more about recruitment/enrollment of the patient and not so much the service.*

This comment suggests that the main difference between the OLSS pilot study and the "*commercial*" environment has to do with the recruitment and enrollment phase of the implementation process. This CDT member goes on to suggest that this is an increasingly important question for the CDT and the university research team. Another CDT member provides even more detail regarding the distinctions noted above:

> *Every deployment that we do has . . . questions that they have to figure out. The first is how are we going to recruit . . . Our deployments vary so greatly that recruitment and enrollment . . . is quite different. In some cases, it's exactly the same as [at the university]. It might not be a primary care setting or it might be a diabetes specialty clinic . . . In a diabetes specialty clinic, the recruitment is the same . . . In others, they send out a newsletter, and people respond to the newsletter, triple the amount they thought. Instead of enrolling a hundred, they end up enrolling three hundred fifty patients. And they had no face-to-face relationship, no telephone relationship, and it was far more like a call management or care management relationship. And, there's everything in between. So, recruitment and enrollment is dependent on the site.*

This CDT member points out that the way in which individuals are recruited has implications on the number of patients who actually join and utilize the program. This is no small issue when one of the goals of the CDT is to achieve full-scale implementations. If the recruitment strategy is off, then clients may not reach the numbers they need to justify the continued use of the OLSS. Furthermore, this CDT member yet again shows how the OLSS pilot can and will never be exactly like the clinical environments of the CDT's clients. Each client must figure out a way to recruit patients and provide a service to them (whereas with the pilot, primary care physicians

were asked to recruit but not provide the service). This certainly adds a layer of complexity to the process and creates roadblocks for implementation. This CDT member adds that recruitment strategies can also have an implication on the health outcomes of patients: "*How they recruit determines the drop out rate in the first month after enrollment . . . These are people who have a significant weight challenge impacting their health and have had significant challenges . . . it's likely that you're not going to succeed with many of the patients.*" In other words, many of the sites that the CDT serves are working with patients that have severe weight problems (and related co-morbidities). The sorts of patients that the clinic serves, their history with weight loss, the complexity of their health conditions, and a multitude of other issues may implicate whether or not the OLSS works well for a particular clinical site and group of patients.

In addition to recruitment and enrollment, another CDT member argues that the methods of orientation change from site to site with different implications in terms of health outcomes and program success: "*The biggest difference for me is the way they [the university research team] orient people. They have in-person orientations and most if not all of the clients that we have do not do in-person orientations. We wonder if that actually has any value. I guess . . . [in terms of] retention we haven't really seen it.*" This adds to the overall picture I am drawing (based on the comments of the CDT members) regarding the divergence between the implementation of the OLSS in the research setting and its implementation in the wider world of the CDT. Most importantly, all of the comments thus far suggest that the methods used by the university research team do not always translate easily to other sites, thus necessitating new strategies to account for these differences. Alternatively, the members of the CDT may at times be unwilling to translate certain concepts from the original version of the program due to their focus on selling the product and fitting their message to specific end-users. Thus, these comments are not, in

themselves, evidence that the OLSS is untranslatable. However, the value-added from these comments has less to do with whether they prove there are problems with translation and more to do with how corporate disseminators approach perceived barriers to dissemination. The comment above about orientation and whether it is achieved face-to-face or in some other way (and the fact that this difference does not implicate retention) is just one example of how the real world implementation of the OLSS yields different results and insights from the research setting. While these findings do not match the rigor of the clinical research environment at the university, they could be used to form new hypotheses and manage on-the-ground differences in a way that makes the OLSS more easily translatable to new clinical locations (or more palatable to the CDT).

Finally, one CDT member argues that in addition to context, patient engagement and preparation (two elements over which many clinical domains have very little control, at least initially) play a major role in the style of implementation selected by the CDT and the long-term success of specific implementations for particular clients:

> *The second fundamental difference [between the OLSS pilot and the commercial environment] is . . . the context in which the application is deployed . . . Imagine the one where there is no relationship and there is no telephone other than if the patient has a challenge or problem compared to the place where the patient comes back every month or two or three for routine diabetes or primary care, getting all the other stuff they need in the context of the application providing education, goal setting, monitoring, tracking, and weekly coaching from the person who works in the clinic who knows you and sees you for other reasons.*

Again, the style of care provided by the clinical environments in which the OLSS is implemented can have a direct impact on its success as a program. In primary care settings or settings where there is deep investment in ongoing interaction between providers and patients (e.g., diabetes clinics), it is more likely that the program will be a success. These attributes of the clinical setting play a role both in terms of the style of implementation selected and the effectiveness of

the OLSS for that particular clinical site. In addition, the agents within that clinical setting, the clinicians and patients, also play a role in making the OLSS a success. As one CDT member suggests, patients are differentially engaged and prepared, thus making it difficult to determine how well the OLSS will work for them:

> *The drop out rate is really in many ways in the first month determined by how engaged the patient is, how understanding they are of what the intervention is, how they are oriented towards what the experience will be like. So if you do a really good job with that, your drop out rate will be much less in that first month . . . So the context of recruitment and enrollment is key. The context of the follow on support can be quite different. The frequency of face-to-face visits for the booster effect, the halo effect of the clinician, can be quite different.*

This comment highlights how it is not possible for the research environment to fully encapsulate all of the differences one might expect to see with patients, especially when it comes to lifestyle interventions. This is not to say that clinical research has no value in attempting to decipher the most effective approach to addressing obesity. Instead, what this CDT member seems to be saying (along with the other respondents) is that different clinical environments will do better and worse based on their recruitment, enrollment, orientation, and context. Further, depending on the types of patients they see and how well they prepare them for the program, they will experience differential levels of success.

Given all of these differences, especially the ways in which the clinical context and its various stakeholders interact in the formation of specific implementations of the OLSS, the CDT has fashioned tools to make implementation easier and more effective as a tool for marketing (remember, the sale is always ongoing). Thus, I turn here to the comments by the CDT regarding the implementation support they provide as a mode of service and, crucially, persuasion (the second sub-theme above). Throughout the interviews, the members of the CDT describe three different elements of implementation support: (1) initial set-up and recruitment, (2) training

within context (*phronesis*), and (3) evaluation and piloting (implementation as persuasion). Each of these is discussed in turn below focusing on how the rhetorical assay that connects research and care is solidified through implementation support. As one CDT member points out, part of the goal with the initial set-up phase is turning the OLSS into something that clients "*own*" both as a product and as a process that they are deeply invested in seeing to completion and long-term integration into their clinical services: "*We . . . begin the [OLSS] implementation with site-build, configuration parameters. We also work with getting the scheduling for training set up . . . We identify when recruiting strategies need to be brought up . . . we want to learn as much about them as possible then give them the support they need.*" In other words, once a sale has been made and a client has chosen to utilize the OLSS (at least for a trial) the CDT immediately begins the process of determining which kinds of training, recruitment materials, and other service "*configuration parameters*" may be needed to achieve the first implementation. Again, these elements vary from site to site just as the native capacities of different clinical sites differ. Instead of attempting to transform these sites (thus, creating a major access barrier for clinical uptake in new environments) the CDT instead works to craft a version of the OLSS that can be implemented quickly, efficiently, and effectively at any particular site.

One of the ways in which the CDT assists in with initial set-up in new clinical locations is the development of discrete recruitment strategies. Recall from above that recruitment is a primary element that differs from site to site. For this reason, it is a major focus of the CDT. One CDT member suggests that they do this is through a "*recruitment landing site*" and the provision of rhetorical resources such as "*letters*" and "*brochures*": "*We have a recruitment landing site that is unique for that particular site. We have materials that are generic that the organization can use to recruit. It might be a recruitment letter, it might be a poster, [or] it might be a*

brochure." this same CDT member provides additional examples of the recruitment resources the CDT offers new clients: "*We then have generic materials that we've created ranging from hard copies of letters, posters, brochures, to a landing site that is recruitment specific. So a patient is seen . . . Then on that recruitment site, they get a little demo of the product . . . they get a sense of what they need to do.*" So, from the very beginning, the specific issues that implicate strategies of implementation are addressed in the form of implementation services. As this CDT member points out, one of these services is the provision of a variety of recruitment resources including a web-site that addresses the problem of patient preparation (described above) and products that help to increase the interest of patients in a particular clinical population including letters, brochures, posters, and the like. In particular, the "*recruitment landing site*" is an excellent example of experiential learning in action (*phronesis*). That is, patients are given the opportunity to experience how the intervention might work before committing to it in the long-term. This prepares them to engage in the program and addresses the specific issue of retention. In terms of the "transtheoretical model," this phase of recruitment might be seen as addressing the gap between "contemplation" and "preparation" stages on the one hand and "action" on the other.[146] The comments above provide a situated example of how *phronesis* as a mode of experiential learning addresses the distinctions between these stages and improves the chances for patient recruitment and retention in a proven lifestyle change intervention. What's more, this "*recruitment landing site*" is not part of the program as developed at the university. As one CDT member suggests, "*We have a recruitment website that we've provided to clients that isn't a part of the [OLSS] product. It's part of our [OLSS] offering.*" In other words, providing substantial

[146] James O. Prochaska and Carlo C. DiClemente, "The Transtheoretical Approach" in *Handbook of Psychotherapy Integration*, eds. John C. Norcross and Marvin R. Goldfried, 2nd ed. (New York: Oxford University Press, 2005), 150.

recruitment tools, and a website for patient preparation, is part of the CDT mission. While one can imagine clinical studies that investigate the effectiveness of different recruitment strategies, the comments here indicate the degree to which recruitment can be handled only in the grounded setting of sales and implementation beyond the sphere of clinical research. These strategies are delivered in a *kairotic* fashion to clinics so that they can quickly implement the OLSS at their site. Finally, as time goes on, the CDT generalizes these strategies, learning how to deal with particular kinds of clinical settings. As another CDT member points out, "*Our role has been to recognize that clinics will do similar things and we can help them do that better by giving them . . . template material*." Thus, the CDT manages the dialectic between the general and the specific, much like the Coaching Protocol Development Team and lifestyle coaches of the pilot study. As experience accumulates, certain kinds of strategies are generalized to specific kinds of clients and clinical settings. This does not undermine the claim I am making regarding the specificity of implementation. Instead, it suggests that the work of implementation eventually moves from grounded and mutable decision making (*phronesis*) to more stable and generalizable approaches (like *Lifestyle Coach Training* and *The Lifestyle Coaching Guide*).

Moreover, the CDT not only provides recruitment materials, it actively evaluates native recruitment strategies. As one CDT member points out, many clients already have some sense of how they want to recruit, but they may not have tested this strategy and are not necessarily geared to deal with the recruitment problems they end up facing:

> *One of our clients actually decided they wanted to put employees that were very healthy on the program or pregnant women on the program that were very healthy. Early on, we identified that as being difficult . . . This is a behavior change, people that are very active aren't going to be patient with a program that they've learned provides tools for tracking and that sort of stuff. I wouldn't say that physically active people or people that have a good comprehension of nutrition is the population that should be using this program. We have a catalogue of recruitment material that we provide them plus an evaluation*

> *mechanism, but then we identify early on their recruitment strategies and provide support that they need for those.*

This CDT member combines the insight that recruitment requires evaluation and revision with a specific example of how recruitment may go awry. In this case, one client decided to go after a patient population that might not benefit from or deeply invest in the behavior management strategies offered by the OLSS. Interestingly, in addressing this problem, this CDT member draws not only on the CDT's experiences with recruitment in general but also the original clinical evidence that supports the use of the OLSS in the first place. In other words, clients that want to recruit populations that do not fit the basic parameters of obesity and diabetes will face problems not only with recruitment but also with long-term success. This CDT member indicates that the recruitment evaluation done by the CDT addresses these issue by synergizing knowledge about successful recruitment with the clinical intent of the OLSS.

Beyond initial set-up and recruitment phase, the CDT engages in even more robust implementation work including training providers in how to use the application and deliver the associated services of the OLSS. Recall that the OLSS is both an application and a service. Thus, individual providers need training in using the web-based platform and enacting the coaching services that have been developed by the university research team and perfected by the lifestyle coaches and Coaching Protocol Development Team (chapter 4). Again, this process is not as simple as handing off *Lifestyle Coach Training* and the *Lifestyle Coaching Guide* documents to new practitioners. As the Coaching Protocol Development Team members point out (section 6.4), the coaching strategies they develop are revised based on the particular needs of specific patients. They also discuss the need to translate these practices in a way that allows for their effective implementation at other sites. This is the role of the CDT. As one CDT member points out, "*we do coach training and support, and we produce some of those materials.*" Another CDT

member provides an extensive account of the methods the CDT uses to provide coach training and coaching support to clients as they implement the OLSS:

> *The second phase is we have to help train them. Because our model, and this is what [the university research team] put into the program that makes sense to us, is to have the coaching most often done by a member of the host organization . . . We have to train them. We don't train them on the content, almost all of them come with content expertise . . . We train them on how to use the application and how to think of the service.*

This CDT member suggests that the primary goal of the CDT when it comes to coach training is the use of the application and the general orientation of the services that it is meant to deliver. Thus, the primary strategy of the CDT is to have members of host organizations engage in coaching. The CDT does not provide human coaches to clients. Instead, it assists already expert providers to engage in the process of coaching as developed in the OLSS pilot and specified to their clinical context.

Of course, training coaches is not as simple as the comment above might indicate. Another CDT member provides additional context and a more nuanced account of the various roles in the implementation of the OLSS from supervisor to coach to patient:

> *We've actually created something called the "[OLSS] Implementation Program." I'm trying to get it termed "[OLSS] Onboarding," . . . We've approached it from the fact that the more we empower coaches to understand how to use an online behavior change intervention and also be a good coach, the better success we will have. We've really taken it from when we first started to provide some rudimentary training to provide a very . . . comprehensive training program where there's [a] curriculum, there's training sessions, and there's constant feedback that our clinical service representative gives the coaches. There are three roles in [the OLSS]: supervisor, coach, patient. Generally when a new customer comes on board, they don't have the capability to supervise. They're learning the program themselves, so we take on that role until they're trained to a particular point to where they can supervise the coaches. That varies from one customer to the next.*

According to this comment, the CDT provides implementation support by taking on a supervisory role in "*onboarding*" the members of the host organization into the OLSS

application and service. It also suggests that while some of the earliest implementations did not take on the problem of coach training very substantially, over time this has grown into one of the major efforts of the CDT. This confirms the work of the Coaching Protocol Development Team (as well as their comments in section 6.4) insofar as it indicates just how important practitioner preparation is to the process of successfully implementing the OLSS. In other words, just as the university research team found that coach training is an essential element in lifestyle change interventions, the CDT has found that translating such interventions requires substantial investments in coach training (both in terms of time and money). In short, the complexity of transferring the coaching practices developed during the pilot study into new clinical domains has taken up a large share of the CDT's time as it rolls out new implementations of the OLSS.

The same CDT member goes on to specify several of the issues involved with coach training that could implicate future iterations of the OLSS research study and new implementations of the program. First, this CDT member articulates the anxiety and difficulties associated with taking practitioners who are used to face-to-face counseling and placing them in an online environment: "*On the coach's side though, there's a lot more that needs to be understood, first being a coach, then being an online coach, then being an online coach that uses [the OLSS]. I think that's probably one of the major challenges in my opinion.*" This comment largely confirms my observations in chapter 4 regarding the textured, dialectical, therapeutic, and constitutive elements that allow for the cultivation of practitioners as lifestyle coaches who inhabit a virtual *paideia*. Tellingly, this comment is being made by someone on the other end of the research-to-care pipeline. Thus, the importance of this problem and the fact that it should be a focus of continuing efforts to improve lifestyle change pedagogy for those who plan to engage in coaching is clear. Furthermore, this CDT member suggests that one of the specific difficulties

that coaches face is writing good notes (again, remember the major issues with the note writing process brought up both the coaches, Coaching Protocol Development Team members, and patients in chapters 4 and 5): "*Being able to efficiently but effectively write your coaching notes is a skill that is leaned. I mean it's about knowing where all the information is on the dash, patient detail page, to . . . not writing an entire book, that's not the point of the program*." This comment briefly summarizes one of the major issues with note writing in the online setting – *kairos*. If notes are to be effective in changing the ways patients approach their lifestyle change regimen and the completion of the OLSS curriculum, they must be short and delivered efficiently. Also, it emphasizes that this is a "*learned*" skill, not something that practitioners come ready to do by virtue of their previous training. Again, preparing coaches to deal with writing notes in this fashion is something that the CDT works on, but as we shall see, it is also becoming a roadblock to implementation given the amount of time and energy it takes. Moreover, this CDT member provides even more evidence of the constitutive features of lifestyle coach training articulating the lessons that have been learned about preparing coaches across a variety of different settings: "*Making this someone's job is far more effective and your retention is much higher. That's something we're trying to prove, from the objective insight, that's something we recommend.*" So, when it comes to coach training, one of the key insights the CDT has gleaned has to do with the nature of the coaching role. It is not something that, according to this CDT member, should be one of the many things that a practitioner handles on any given day. It should be their primary role. This allows them to focus on the skills development needed to interact with the patients utilizing the OLSS. This is no small point as it implicates implementation from a timing and cost perspective. Making some individuals at a particular site primarily responsible for engaging in coaching and maintaining the OLSS program

means that personnel will have to be taken from other areas or new personnel may need to be hired. I will discuss this more below. Fundamentally, the key to the insights about coaching on the last several pages is that this process is complicated, that it may need to be a more fundamental part of the implementation service, and that it is critical to deal with the specific issues facing coaches as they learn how to use the OLSS application and service (*phronesis*).

The final element of implementation support that the CDT members discuss at some length is the use of situated pilots and extensive program evaluations at each site. This element of the interviews provides the most evidence regarding the role of implementation support in persuading clients to go to scale. One CDT member calls these situated pilots and evaluations "*trial evaluations*" thus differentiating these from clinical research: "*It's not a clinical pilot . . . it's not a research pilot . . . Every customer to date [has] . . . started with a trial of anywhere from 20 to 25 patients to 50 to 75 . . . and one or two started with a couple hundred.*" This CDT member suggests that these "*trial evaluations*" are the primary way that the OLSS is marketed: "*The main promotion is [to] deeply discount*" rates for clients who decide to engage in a "*trial evaluation*." But what about these evaluations makes them so valuable and worth offering a discount? As another CDT member points out, "*We actually lose money on what we call a pilot, or the first phase of it . . . It costs us money to do [it]*." However, as a promotional angle, another CDT member argues that such evaluations are really the only way to get new clients on board: "*The only one we found that works is really this idea of trial evaluation. Instead of having to commit to hundreds of patients and years of the program, commit to 50 to 100 patients for a year. That's all your committing to . . . That's really been the only thing that sort of works.*" In other words, there are major roadblocks to immediately going to full scale and enrolling all of the patients at a particular clinical site who meet the basic parameters for the intervention. Cost

and time are major access barriers and the CDT attempts to remove these barriers through trials. In addition, such trials address one of the major implementation problems that discussed throughout this chapter: the translation of clinical research evidence into the rough and tumble world of different clinical care environments. As one CDT member points out, "*you get a lot of people who say, 'That's great, we believe it'll work, but it was also shown in one audience in one particular controlled [trial]. We want to make sure it works in our setting' . . . You're asking them to change what they do and they want to see that [it] works*." During such evaluations, "*we work very hard with them to roll out the pilot, and then every two to three months, we'll meet with them, talk about how it's going, show them . . . population report data*." In other words, the issue of translating clinical evidence into care is a major part of the implementation process. Just having evidence is not enough; the evidence has to be fitted to the particular environment in which an intervention is planned (*phronesis*, "priority of the particular").[147] Moreover, another CDT member elucidates a rhetorical strategy bound up in the name "*trial evaluation*": "*We like the term 'evaluation' because it implies there's a decision after it*." One could read this as a manipulative trick and level all of Plato's criticisms of Sophistry against the CDT here; however, I take a slightly different view. By setting up "*trial evaluations*" in this way, the CDT counteracts the inertia of clinical change. It provides a "rhetorical situation" in which an informed decision is called forth from available evidence and demonstration.[148] Finally, such "*trial evaluations*" are not just helpful for improving implementation at particular sites or providing the kind of evidence needed to persuade uptake of the OLSS, they also assist the CDT in improving its marketing and implementation mission. One CDT member points out that, "*I got them [clients] to commit to it even it's not a lot of money to be able to make sure they put*

[147] Nussbaum, "The Discernment of Perception," 66.
[148] Bitzer, "The Rhetorical Situation."

together the resources to do the coaching, to do the quality improvement evaluation, so they can learn and I can lean so the next appointment for them or somebody like them is better." So, these evaluations play an important persuasive and experiential learning function for the CDT and clients alike.

Finally, aside from the specificity of implementation and implementation support, the members of the CDT also discuss a variety of roadblocks to implementation (the third sub-theme above) including: (1) cost and incentives, (2) complexity (of the program as a service), (3) the need for good on-site personnel, and (4) coach training. Many of these have already been discussed in a variety of contexts throughout this section but briefly working through them in a systematic way indicates just how much stands in the way of making lifestyle interventions workable in new clinical environments. Thus, the comments below provide new action points for the NIH Roadmap agenda, especially in the area of lifestyle change interventions. The first major roadblock to implementation that the CDT members mention time and again is cost. As I have already alluded to the basic issue of paying for the service as a potential disincentive for clients (especially given the recession), I will focus here on the problem of health insurance re-imbursement. Currently (as of the interviews in 2010), behavior change interventions like the OLSS are not covered by health insurance. For this reason, clients (clinical sites) have to come up with funding or ask their patients to pay out of pocket for the service. As one CDT member points out, for the CDT, this is a double-edged sword: "*At this time, it's not reimbursed by health insurance or by anyone. As an aside, as a company, that's actually to my benefit . . . if this were reimbursed at a fair rate, everyone would be building . . . interventions like the [OLSS] . . . but that can only go for so long . . . getting them to part with money that's their own money is*

critical, and it's very difficult."[149] So, when it comes to the issue of what insurance companies are willing to pay for, interventions like the OLSS are not covered as yet.[150] However, from a business perspective, this allows the CDT to operate largely without competition. As soon as such strategies are reimbursed (if ever), competition may increase with unpredictable results regarding marketing and the quality of the programs that end up being selected by clinics. Despite this seeming advantage, as this CDT member points out, cost is a major issue for marketing and implementation. It remains a roadblock even when all of the other elements are turning in the CDT's favor (e.g., the value of the program for the health of patients, its overall quality, its legitimacy rooted in clinical trials, etc.). Furthermore, there is no clear pathway for interventions like the OLSS to gain reimbursement status from insurers. As another CDT member points out, "*Tools like [the OLSS and as opposed to "pharmaceuticals"] . . . don't have a natural process of how [to] get insurance reimbursement for it*." The reason seems to be that drugs have clear and often quite generalizable health outcomes and a clear cost structure. The OLSS, because its implementation is specific, may cost different amounts and require differential levels of investment by different clinics and health plans. Moreover, size is a major issue when it comes to cost. As another CDT member points out, having enough patients enrolled to make it cost effective for the clinic in question and profit generating for the CDT is critically important: "*The commercial model is to charge per patient that goes on, so you need a certain number of patients to make it worthwhile*." This CDT member also argues that the CDT has come up with some solutions to the cost problem, primarily at the marketing level. This CDT member suggests

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[149] I should not here that many of the cost related comments are specific to the United States. The CDT does some work in Canada and the method for coming up with funds under the national health system there is quite distinct (and in many cases easier) than in the U.S.

[150] See my discussion in my concluding chapter regarding changes on the horizon in terms of reimbursement and incentives for changes in practice with a focus on outcomes.

that, "*the standard sales/marketing way [to address cost] is to link the tool to solving a problem, the solution of which creates value to the customer*." According to this comment, this strategy often works, but cost remains a primary roadblock to successful marketing and implementation.

In addition to the issue of who is going to pay for the OLSS, there is another layer to the cost problem that has to do with the ways incentives are aligned for clinicians. One CDT member articulates the problem this way:

> *It all goes back to follow the money. The money is either the cash that it costs or the time it takes the staff to do it. The most important customers are the ones who aren't at the table. They're the ones who establish the policies, who give incentives for outcomes, who change the ways organizations think about funding, so that's the federal government, that's the insurance companies, etc. As an example with health care reform, as we get closer and closer to paying for outcomes rather than processes, if you can get the outcome payment to be there and to get the buyer in this case the clinician group to recognize that for example 50% of all outcomes for chronic illness is based on their behaviors. The other 50% are divided between their genes, health care, and environment. If 50% is behavior and you care about outcome because you're getting paid, you . . . better go to behavior. Getting the incentives aligned, so that outcomes matter financially even if its not minute to minute financially but fundamentally structured that way, that's the most important customer to get that to exist.*

In other words, another major barrier to lifestyle interventions in particular is that physicians and other clinical practitioners are not always paid based on outcomes or their performance. Instead, they are paid by procedure. This is a major controversy in the medical literature that I can only briefly touch on here. The argument goes that primary and preventive services are less likely to be done if healthcare practitioners are not paid as much to do them. That is, incentivizing complex procedures that are easily billed as opposed to long-term lifestyle management strategies that are not easily billed ends up favoring an acute model of care in which the OLSS is

less likely to gain users.[151] This CDT member later points out that overcoming this barrier is a key issue that can only be addressed through policy reforms at the governmental and corporate levels.

In addition to these cost-related roadblocks, the members of the CDT mention complexity as a major access barrier for uptake in new clinical environments. One CDT member points out that, "*while [the OLSS] is relatively easy to implement, it still requires . . . a quality improvement effort . . .you have to think about how you improve the quality of care you provide . . . that requires the capacity to do a quality improvement that requires you don't have ten other projects going on*." In other words, while the implementation support offered by the CDT does assist in overcoming many of the access barriers to realizing the implementation of the OLSS in a new clinical environment, it can be hard to accomplish when clients have far too much on the table already. The OLSS is competing for an audience in a world saturated by quality improvement efforts, new interventions, and new methods of handling preventive and primary care through the use of health information technology. Competing for time and attention in this environment is difficult and can lead to implementation failures.

The other main roadblock related to complexity has to do with on-site personnel. As one CDT member points out,

> *The thing we have to modulate in the conversation is how do we describe how much work there is for them. So they get that its rolling out for them . . . But, then they stop and say, " . . . I need coaches. Where am I going to get those people? I don't have them. I need to train them, I need to support them" . . . That conversation on how much time it takes for the clinic to do it is both a high value and a negative, and how you handle that is sort of a subtle conversation. It takes some time to walk through.*

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[151] On this controversy, see Meredith B. Rosenthal and Adams Dudley, "Pay-for-Performance: Will the Latest Payment Trend Improve Care?" *Journal of the American Medical Association* 297, no. 7 (2007): 740-744. I also take this issue up in my conclusion.

These observations foreground how lack of onsite personnel makes it difficult to find coaches, much less train them. As another CDT member points out, one of the main goals of the CDT is to reduce the burdens of coach training on new clinical sites: "*We'd like to reduce the impact of coach training . . . because it's not cost effective for us from a business perspective. Maybe there'll be an online training mechanism for coaches in the future once we get past a certain point*." In other words, coach training is not merely a barrier to implementation for new clients; it is also a burden for the CDT. Suggesting that the online medium might reduce this burden and increase the capacity of the CDT to provide implementation support is not very far afield from the original goals of the OLSS study: to increase the number of patients who might access lifestyle management pedagogy by turning to an online setting. However, it also indicates the degree to which economic forces might overwhelm good clinical practice. Chapters 4 and 5 argue that lifestyle coaches play a central role in the OLSS and that their training is achieved experientially and in direct collaboration. Thus, the transition to an online training program would need to be carefully conceived and likely include human contact.

The practices of implementation support and the need to specify implementations for new clinical environments are fundamentally tied to uncertainty and experimentation. That is, the CDT's work to provide implementation support is grounded in their acknowledgement that the sale is always ongoing and that their clients have specific needs. Just as the Sophists worked to make their teaching and their knowledge relevant to the specific demands of the communities in which they operated, so to does the CDT work to incorporate the differences between their various clients into opportunities for pedagogical work and mentorship. Finally, "*trial evaluations*" provide a context not only for the production of knowledge and evidence to a specific clinical site but also for the cultivation of new rhetorical strategies to address the issues

and concerns relevant to different clients. This is a fundamentally rhetorical act. It also shows how evidence is not merely information that travels from place to place without translation. Instead, evidence must be grounded in the needs and context of the audience (*ethos*) and redeployed based on new exigencies. This is one of the fundamental insights of this chapter for the study of translation and dissemination and it indicates the degree to which implementation plays a major role in the rhetorical assay connecting clinical research and care.

6.6 CONCLUSION

My work in this chapter to develop a "methodologic research" tool for the articulation (and potential improvement) of translation and dissemination in the form of a rhetorical assay significantly overlaps with Mitchell and McTigue's conception of "argument as a translational medium."[152] They have rightly pointed out that language plays a key role in the movement of clinical research through the dissemination pipeline to clinical care. They also point out the ways in which "argument drives constructive interchange" by allowing individuals at different locations in the research-to-care pipeline to share ideas and form collaborative solutions.[153] Their work in this regard focuses on "translational communication between distinct fields of scholarly inquiry" and "across the expert-public boundary."[154] My focus on the discrete practices of corporate disseminators yields several unique findings that support their argumentation-based approach to studying translational research as well as my conception of rhetoric as an assay (e.g.,

[152] Zerhouni, "Translational and Clinical Science," 1622; Mitchell and McTigue, "Translation Through Argumentation," 94.
[153] Mitchell and McTigue, "Translation Through Argumentation," 94.
[154] Mitchell and McTigue, "Translation Through Argumentation," 95.

experimental solution, mode of testing, and site of experiential learning).[155] As the interviews bear out, the practices of translation and dissemination are grounded in opportunity but fraught with roadblocks. Focusing on rhetorical resources rooted in the Sophistic tradition, the concept of the rhetorical assay used in my analysis in this chapter illuminates the three major thematic trajectories of the interviews: (1) synergizing clinical research with corporate dissemination, (2) marketing as rhetorical and grounded in the "priority of the particular," and (3) implementation as a service and mode of persuasion.[156]

First, much like the Sophists in 5th century Greece faced the increasing need among their audiences and students for pedagogical processes that might instill skills in civic life, corporate disseminators face an increasingly complex and differentiated set of clinical environments in need of new approaches to lifestyle management.[157] Thus, part of their role is to synergize the knowledge of the clinical research setting and laboratory (often far removed from clinical care) with the everyday needs of clinicians and patients. Doing this is no simple task primarily due to the *kairotic* problems that face such synergistic efforts. As the interviewees suggest, the time cycles of clinical research and corporate marketing are quite different. Clinical research takes a long time whereas making a sale and quickly implementing a product (especially if one intends to make a profit) is a short-term phenomenon. For this reason, cultivating *ethos* rooted in clinical evidence is complicated as the evidence is sometimes slow in arriving. In addition, this evidence is not always fitted to the particular needs of the clinical sites that the CDT works with on a daily basis (*phronesis*).

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[155] I should also point out that argumentation and rhetoric are terms that largely overlap, at least in my experience and my reading of Mitchell and McTigue's article.

[156] Nussbaum, "The Discernment of Perception," 66.

[157] Gaonkar, "Aspects of Sophistic Pedagogy."

What's more, my focus on the Sophistic movement and the resources of rhetoric as an assay for translation and dissemination in this chapter has shown that rhetorical performance and the importance of seeking out audiences for face-to-face contact that undergirded the ancient approach to rhetorical study and practice is still alive and well today.[158] That is, despite our increasing reliance on information technology as an alternative to direct, face-to-face communication, the members of the CDT argue that their most effective marketing tools are one-on-one interactions or public performances at medical conferences and other meetings. In this way, the ancient art of rhetoric is still playing an essential role, in this case by forming the constitutive moments of interaction that cultivate practice changes in the clinical environment. This implicates the NIH Roadmap and ongoing efforts to facilitate the movement of new interventions into clinical care. The more opportunities there are for close interaction between researchers and disseminators as well as disseminators and their clients, the more new interventions will find their way to clients who need them. Thus rhetoric, in the form of performance, directly implicates the degree to which patients receive life-changing and life-saving interventions.

Moreover, despite the *kairotic* roadblocks in the research-to-care pipeline described above, evidence and methods developed in the clinical research environment often function as a sort of medium for persuasion for the CDT as many of their clients immediately see the high quality lifestyle change strategies already incorporated into the OLSS. However, as the interviewees point out, this evidentiary and practice-based medium can easily be undermined by the technological medium of the OLSS (i.e., the application or code used to design the online interface). This medium is at times behind the broader trajectory of technological evolution (e.g.,

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[158] Poulakos, *Sophistical Rhetoric in Classical Greece*, 25-27; Gaonkar, "Aspects of Sophistic Pedagogy," 59.

the interface currently does not have a social networking feature). Thus, Marshall McLuhan's claim that "the medium is the message" certainly bears on the synergy (and its lack) between researchers and corporate disseminators in the area of online lifestyle interventions.[159] This lack of synergy at times undermines marketing and at others provides an opportunity for the invention of better arguments to convince probable buyers to proceed with implementation (or, the deployment of the "architectonic" resources of rhetoric).[160] However, the constant endeavor to appease clients brings risks as well, especially if such appeasement is rooted in financial or organizational motivations as opposed to a focus on patient care.

Finally, the rhetorical assay of translation and dissemination investigated in this chapter suggests that implementation is a necessary service and clear resource for persuasion. That is, the CDT relies on its ability to assist clients in implementation in order to convince them to proceed with going to scale. They do this through "*trial evaluations*" that provide direct evidence of the effectiveness of the OLSS for their patients. These evaluations point to an important but understudied phenomenon in translation and dissemination. There are multiple kinds of evidence used in promulgating a particular intervention. As the members of the CDT point out, the DPP-backed, evidence-based methods of the OLSS pilot are always part of the final product no matter the style of implementation. But clients often use the very nature of clinical research to devalue the findings of the university research team. In other words, they claim that the OLSS pilot study (and additional iterations) shows how the OLSS might work in an academic, clinical research setting with expert research and lifestyle coaching teams. This is not often the case in new clinical locations. As the members of the CPDT suggest in their responses detailed in 6.4, this is a problem that the university research team has considered but for which there is no direct

[159] McLuhan's, *Understanding Media*, 7-21.
[160] McKeon, 'The Uses of Rhetoric."

solution, at least not at the level of clinical research. However, dissemination teams have the unique opportunity to offer evaluations of the OLSS as implemented in new domains. This process allows them to specify the OLSS in ways that meet the needs of their clients, thus using their own environments to produce evidence and arguments in favor of adopting the intervention. Thus, evidence takes on many forms in dissemination and the research article is not the primary means of persuasion, at least not during the implementation phase.

Finally, by articulating how rhetoric acts as an assay (experimental or methodological medium) for understanding and achieving translation and dissemination, this chapter shows that rhetoric plays a constitutive and central role in contemporary healthcare. While the members of the CDT discuss many different approaches to reframing their synergizing, marketing, and implementation strategies, much more could be done to facilitate faster integration of new interventions. While the CDT does mention a variety of roadblocks that rhetoric may not fully address (some architectural and policy-based, others situational and rooted in the specific problems of particular clinical locations), the primary problem is convincing clinicians to pick up new interventions quickly and efficiently.

7.0 RHETORICALLY RE-IMAGINING THE PERMANENT AND CHANGING FEATURES OF CHRONIC CARE

7.1 THE ROLE OF *"PERMANENCE AND CHANGE"* IN THIS STUDY

In *Permanence and Change*, Kenneth Burke argues that accounts of the "good life" tend to feature the "*generic* equipment of man as a social and biologic organism."[1] This is, of course, in keeping with the Greek tradition and, in particular, Aristotle for whom *eudaimonia* (the good, fulfilling, or flourishing life) is related to those things that are generally essential for ethical comportment and overall quality of human life.[2] However, as Burke points out, there is danger lurking when the various goods and virtues, the widely shared conceptions of life and its qualities, remain fixed within the cultural milieu (*paideia*). Against this state of affairs, Burke advances the claim that these "*generic*" qualities must be connected with a view of "being" that avoids stagnation and overcomes the assumption that the individual must "surrender . . . to temporal conditions as he finds them."[3] Furthermore, Burke's conception of "being" is rooted in his commitment to the discovery of the permanent *and* changing conditions of human life. Thus, his work is animated by an effort to understand what makes human beings function in a general sense and what allows them to *change their stars*, to challenge the social and historical conditions that undermine their specific conceptions of *eudaimonia*.

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[1] Kenneth Burke, *Permanence and Change: An Anatomy of Purpose*, 3rd ed. (Berkeley: University of California Press, 1984), 271.

[2] Aristotle *Nicomachean Ethics* I.ii.1-3 (and throughout). See also, Martha C. Nussbaum, *The Fragility of Goodness: Luck and Ethics in Greek Tragedy and Philosophy*, Up. ed. (Cambridge: Cambridge University Press, 2001), 6 (fn); Martha C. Nussbaum, *Upheavals of Thought: The Intelligence of Emotions* (Cambridge: Cambridge University Press, 2001), 31-32; Martha C. Nussbaum, *Cultivating Humanity: A Classical Defense of Reform in Liberal Education* (Cambridge: Harvard University Press, 1997), 119-120.

[3] Burke, *Permanence and Change*, 271.

Burke calls this view "metabiology," a term that indicates the extent to which the human body contains certain potentialities that call for sustenance and development.[4] For Burke, one of these potentialities is communication and its closely associated term, cooperation.[5] The rhetorical theorist, Bryan Crable, expands on this view, arguing that Burke's theory of metabioloby, "is an attempt to integrate the rhetorical resources of our human symbolicity and embodiment with the recalcitrance of the nonverbal situation" thus crafting a "critical theory of society."[6] Crable goes on to argue, "a metabiological rhetorical criticism makes evaluative claims regarding our efforts to meet a changing (recalcitrant) nonverbal situation with the resources of our symbolicity. Such a criticism asks us as critics to assess rhetorical efforts and pronounce them fit or unfit, suitable or unsuitable."[7] Thus, Crable elucidates a critical and normative bent to Burke's concern with the relationship between human biology and society. He suggests that rhetoric is, at heart, a critical art, able to interrogate social and institutional forces standing in the way of human fulfillment.

In short, for Burke, humans are symbolic creatures. Their ability to listen, speak, and hear conditions them for interactivity from the very moment of their birth. Taking a cue from Burke's point about how this is a permanent condition of being human and leading a fulfilling life, this final chapter draws upon findings from the previous chapters to propose that the art of rhetoric plays a central role in cultivating this "*generic*" feature of what it means to lead a good life.[8] Burke cautions that our biologic makeup does not imply that we will necessarily use our capacities in the proper way, and that larger institutional, socio-economic, and cultural forces can

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[4] Burke, *Permanence and Change*, 168.
[5] Burke, *Permanence and Change*, throughout.
[6] Bryan Crable, "Ideology as 'Metabiology,': Rereading Burke's *Permanence and Change*," *Quarterly Journal of Speech* 84 (1998): 317.
[7] Crable, "Ideology as 'Metabiology,'" 317.
[8] Burke, *Permanence and Change*, 271.

push us in multiple directions. In these cases, we may need to use our interpretive powers, reinvest ourselves in our symbolic capacities, and reorient ourselves to the world in order to reclaim our humanness. This is the *change* of which his title speaks.

The dialectic of *Permanence and Change* and the call for rhetorical intervention have been with us from the beginning of this dissertation. For example, the National Public Radio broadcast recounted at the beginning of chapter 1 is an excellent case in point.[9] Samr's battle with his obesity, his concern with his biologic health as well as the perceptions of others, is not just rooted in his specific experiences but also in the larger human concern with living a healthy life. While different conceptions of health (and its appearance) have obviously found their way into the popular imaginary across time, the pursuit of physical health, well being, and even excellence seems to be a more permanent element. We can see this in Aristotle's discussion of health in the *Nicomachean Ethics*. Time and again, he returns to examples that deal with how health might be achieved, his conception of health (often revolving around issues of diet), and the analogic relationship between physical and ethical excellence.[10] In this sense, Samr's *eudaimonistic* wish to lose weight and gain better health have been part of the human endeavor at least since the ancient Greeks. However, Samr's story also shows how specific socio-cultural and historic elements implicate his decision making. That is, Samr faces stigmatization due to his size, something rooted in his contemporary socio-cultural milieu.[11] He is also a member of a society in which high fat, high calorie foods are ubiquitous and easily accessible. In addition, he lives at a time and in a place where obesity is viewed in alternating, and sometimes contradictory

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[9] Samr Tayeh, "Battling Obesity: The Story of Rocky's Reduction," *All Things Considered*, National Public Radio Broadcast, April 10, 2007, p. http://www.npr.org/templates/story/story.php?storyId=9499004. Parts of this broadcast were originally recorded for "Samr 'Rocky' Tayeh's Struggle with Obesity," *All Things Considered*, National Public Radio Broadcast, December 29, 2003.

[10] See, e.g., Aristotle *Nicomachean Ethics* VI.vii.7.

[11] Amy E. Farrell, *Fat Shame: Stigma and the Fat Body in American Culture* (New York: New York University Press, 2011), 3 (and throughout).

registers as a health concern, a medicalized bodily state, a matter of personal responsibility, and a hindrance to sociality.[12] Finally, Samr's story unfolds at a time in human history where the confluence of medical technology (e.g., bariatric surgery) and new methods of lifestyle management (e.g., diet, exercise, and other elements covered by the term "lifestyle management") structure his options for weight loss. Following Burke, the complex interplay between the permanent features of *eudaimonia* (health, well being, and sociality) and the specific values and technologies that inform and transform these features (mass-mediated messages regarding health, technological fixes for health problems, new understandings of diet and exercise, stigmatization, and the like) open up space for, as Crable might suggest, reflection and critique.[13] Thus, Samr's story invites reflection about how to achieve *eudaimonia*, how the background influences of one's culture and of healthcare (*paideia*), brought to life by the constitutive powers of rhetoric, energize or enervate the developmental process (*phronesis*) necessary for the cultivation of health. These too are permanent questions related to the human condition.

Mary's story, a fictional narrative introduced in chapter 3, as a way to highlight gaps between providers and patients in the context of lifestyle management, provides another narrative lens with which to understand how the dialectic of permanence and change plays out in the human drama of the search for health. As we saw throughout her interaction with Dr. Taylor, Mary faces many problems that we can identify as permanent features of what it means to be human. She is bound in time and must make decisions about how to balance her family and work

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[12] Dana L. Cloud, *Control and Consolation in American Culture and Politics*: *Rhetorics of Therapy* (Thousand Oaks: Sage Publications, 1998); Abigail C. Saguy and Kevin W. Riley, "Weighing both Sides: Morality, Mortality, and Framing Contests Over Obesity," *Journal of Health Politics, Policy, and Law* 30, no. 5 (2005): 869-921.

[13] Crable, "Ideology as 'Metabiology,'" 317.

life with her desires to be healthy. Her interaction with Dr. Taylor dramatizes the epistemic and communicative divides between patients and their providers that have been perennial topics of conversation at least since the time of Gorgias and Hippocrates. Recall from chapter 2 that Gorgias defends a manipulative model of persuasion as a means to gain the adherence of patients whereas the Hippocratic writer favors a form of mutual cooperation in the effort to achieve health.[14] And yet, Mary's situation is specific and contingent, as much connected to these recurrent conversations about the limited nature of human capacity (being bound in time) and the need for some form of effective communication between providers and patients as to her daily activities and barriers to successful weight loss. For these reasons, achieving *eudaimonia*, in Mary's case, requires understanding the dialectical interplay between these permanent and changing features of human existence and communication.

These two narratives underscore the value of rhetorical ways of understanding human interactivity as a key feature of, and problem for, modern chronic care. Indeed, rhetoric's centrality in contemporary efforts to counter chronic disease anchors this dissertation's "demand-driven" method of analysis.[15] That is, as Samr and Mary's stories indicate, there is a demand for understanding how rhetoric plays a constitutive role in cultivating health and how it sits at the heart of major problems facing practitioners and patients who seek better health outcomes. Their stories indicate the degree to which the role of rhetoric in producing better health is both a specific and general concern. Rhetoric, when practiced well, is attuned to specific moments and

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[14] On the Gorgian and Hippocratic understandings of rhetoric and medicine, see chapter 2. On the distinctions between the Hippocratic and Gorgian approaches to communication in contemporary healthcare, see Joan Leach, "The Art of Medicine: Valuing Communication," *The Lancet* 373 (June 20, 2009): 2104-2105. On the issue of shared decision making and the mutuality of the provider-patient relationship, see David H. Smith and Loyd S. Pettegrew, "Mutual Persuasion as a Model for Doctor-Patient Communication," *Theoretical Medicine and Bioethics* 7, no. 2 (1986): 127-146.

[15] Gordon R. Mitchell, "Switch-Side Debating Meets Demand-Driven Rhetoric of Science," *Rhetoric and Public Affairs* 13, no. 1 (2010), 111.

actors, to their problems and concerns. However, and in keeping with Burke's insistence that critics not simply follow the dominant movements of history without criticizing them, I have oriented myself to problems in medicine while remaining true to some of the permanent normative features of human interaction established in the ancient Greek tradition. Of course, these too are up for critique and analysis. The Greeks do not offer the final vision of rhetoric or its related arts and concepts. And, of course, uncritically grafting the ancients' perspectives to our very different contemporary context would be a fool's errand. Yet, by investigating the changing features of chronic care through key inflections of the Greek tradition, it becomes possible to gain illuminating perspective on the permanent and changing elements of the human condition, and also to reveal vectors for criticism and innovation that might otherwise remain obscured from the vantage point of a more limited theoretical horizon.

Using these inflections of permanence and change, and the background normative conception of my role as a critic that they inspire, the next several sections summarize key findings across the last six chapters and speculate about their possible consequences for rhetorical theory and medical practice. Here, particular emphasis is placed on the grounded findings emerging from chapters 4, 5, and 6, which brought forth primary content in the form of documents and interviews generated during the Online Lifestyle Support System (OLSS) pilot study.

In the first section, I discuss the OLSS as a kind of virtual *paideia*, building on work done in chapter 5 to understand how shifting chronic care online raises important questions about human interactivity and rapport. I also discuss the relationship between this vision of *paideia* and the other Greek terms I introduced in chapter 1: *phronesis* and *eudaimonia*. I then move on to the

value added by taking an "architectonic" view of rhetoric throughout the dissertation.[16] I have already gestured to key architectonic inflections within my analysis chapters but here, I return to them, showing how McKeon's work, and my study design, have generated insights that other approaches might miss.[17] I then return to a question that stands in the background of much of my analysis: To what extent is lifestyle management a practice of freedom or domination? This question is related to a major conflict in rhetorical theory between postmodern and humanist conceptions of agency that have consequences for my own conception of lifestyle management and broader conversations about its role in medicine and society. I end by considering some potential future trajectories for research.

7.2 THE OLSS AS VIRTUAL *PAIDEIA*

The concept of *paideia* orients us to the problem of how education, and cultural constitution, might be achieved. Werner Jaeger contends that, for the Greeks, cultural performance, especially of the oratorical kind, is centrally important for the cultivation of individuals.[18] In a similar way, Martha Nussbaum contends that, for the Greco-Roman schools of philosophy (the Stoics, Epicureans, and Skeptics), *paideia* involves the use of "therapeutic arguments" that might transform the practices and beliefs of students.[19] Moreover, Jaeger suggests that the general Greek view of *paideia* links it directly with the tools of human communication. He writes, "[The

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[16] Richard McKeon, "The Uses of Rhetoric in a Technological Age: Architectonic Productive Arts," in *The Prospect of Rhetoric: Report of the National Developmental Project*, ed. Lloyd F. Bitzer and Edwin Black (Englewood Cliffs, NJ: Prentice-Hall, Inc., 1971), 44-63.

[17] McKeon, "The Uses of Rhetoric."

[18] Werner Jaeger, *Archaic Greece: The Mind of Athens,* vol. 1 of *Paideia: the Ideals of Greek Culture*, 2nd ed., trans. Gilbert Highet (New York: Oxford University Press, 1945).

[19] Martha C. Nussbaum, *The Therapy of Desire: Theory and Practice in Hellenistic Ethics* (Princeton: Princeton University Press, 1994), xi.

Greeks] considered that the only genuine forces which would form the soul were words and sounds, and – so far as they work through words or sounds or both – rhythm and harmony; for the decisive factor in all paideia is active energy, which is even more important in the culture of the mind than in the *agon* which exercises physical strength and agility."[20] That is, *paideia* achieves its most active and energetic state in words, in sounds, in performance, and in the direct contact between human beings. This is not to efface the important role of literature or the written word in the Greek conception of *paideia*. It too was considered the expression of such energy through language.[21] Moreover, the critical debate in ancient Greece regarding the power of the spoken as opposed to the written word has special import to the work of this dissertation.[22]

Chapters 4 and 5 argued that *paideia* helps to frame the educational practices of lifestyle coaches and their consequences for the participants of the OLSS. Specifically, I suggested that the notion of *elenchus* (dialectical engagement), famously developed by Socrates and adopted by the Stoic philosopher, Epictetus, stands at the heart of lifestyle management as a mode of pedagogy.[23] This dialectical interplay between teacher and student is, at root, something that the lifestyle coaches of the OLSS endeavor to perform (chapter 4). Throughout their interview responses, they report that one of their most important daily tasks is to engage the participants, to intervene when they seem to be having problems with their lessons, to answer questions posed, and to correct what appear to be negative beliefs or barriers to ongoing participation in the study. The participants report that, by and large, the coaches performed these tasks well, many arguing that only through this direct and sustained dialogue were they able to continue to engage in the difficult process of lifestyle management.

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[20] Jaeger, *Archaic Greece*, xxvii.
[21] Jaeger, *Archaic Greece*, xxvii-xxviii.
[22] On this, see Plato's *Phaedrus*.
[23] A. A. Long in his *Epictetus: A Stoic and Socratic Guide to Life* (Oxford: Clarendon Press, 2002).

Paideia as a mode of dialectical engagement not only describes the critical pedagogical tools of the OLSS coaches but also leads to a conversation about the appropriate medium for the cultivation of the self. In Plato's *Phaedrus*, Socrates advances one of his most famous claims, that dialectical engagement is the only way to truly achieve wisdom.[24] Socrates juxtaposes his model of dialectical engagement with another method of learning, one rooted in the written word.[25] He criticizes orators who fully write their speeches and thinkers for whom the written word is their primary means of disseminating knowledge. What's more, in this argument, Socrates shows how a concern for the style of *paideia*, for the way in which knowledge is transmitted and shared and through which human beings come to be who they are, is centrally important. By orienting his audience to the question of how shifting the media of communication (for him from the spoken to the written word) carries with it consequences for learning and human interactivity, he poses what is a permanent question about the anxieties and problems that emerge when shifts in communication technology occur.

The emergence of new communication technologies for the delivery of health care raises major questions about the extent to which these technologies can effectively expand the clinical site to include the virtual spaces of 21st century life. Such expansion, some might argue, increases access to care (by collapsing the spatial and temporal divides between providers and patients) and assists doctors in handling every larger numbers of chronically ill patients. In his recent book *The Creative Destruction of Medicine: How the Digital Revolution Will Create Better Health Care*, Eric Topol (a medical doctor) articulates this view. He argues that the shift to the online medium in healthcare appears to be accelerating: "In the years ahead I expect some 50 to 70 percent of office visits to become redundant, replaced by remote monitoring, digital

[24] Plato *Phaedrus* 274-279.
[25] Plato *Phaedrus* 274-279.

health records, and virtual house calls."[26] For Topol, this represents a powerful way to enhance the "monitoring" of patients and to engage in "virtual house calls" by which he implies the expansiveness of the virtual clinic and the degree to which it might replace actual physical spaces of care.[27] He goes on to argue that "'New information technologies' will be used routinely to make interactions between doctors and patients far more efficient and convenient."[28] He stakes this claim on the idea that the use of online tools and other new technologies will connect physicians and patients by collapsing the physical space between them, thus enhancing the capacity of physicians to respond more quickly and directly to patient concerns. While he is largely a supporter of the move to the digital environment, Topol does offer an insight directly connected to the concerns raised by the both the lifestyle coaches and the participants of the OLSS: "Remote monitoring and diminished face-to-face visits between a doctor and patient can contribute to a significant degradation of intimacy, the loss of the literal healing touch."[29] He also notes that the "digital divide" will continue to limit access to the virtual media needed for "remote monitoring" and interaction.[30] Crucially, given that the relationship between new communication technologies and the effort to improve healthcare delivery is a relatively recent occurrence (and that the problems mentioned by Topol remain relevant), the more data that can be assembled the better.[31]

Chapter 5 framed the OLSS as a "virtual *paideia*," an online site through which participants are given access to lessons, workbooks, and contact with lifestyle coaches. To draw

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[26] Eric Topol, *The Creative Destruction of Medicine: How the Digital Revolution Will Create Better Health Care* (New York: Basic Books, 2011), 234.

[27] Topol, *The Creative Destruction of Medicine*, 234.

[28] Topol, *The Creative Destruction of Medicine*, 234.

[29] Topol, *The Creative Destruction of Medicine*, 239.

[30] Topol, *The Creative Destruction of Medicine*, 242.

[31] Kathleen M. McTigue, Molly B. Conroy, Rachel Hess, Cindy L. Bryce, Anthony B. Fiorillo, Gary S. Fischer, N. Carole Milas, and Laurey R. Simkin-Silverman, "Using the Internet to Translate an Evidence-based Lifestyle Intervention into Practice," *Telemedicine & e-Health*, 15, no. 9 (2009): 851-858.

out this concept, I utilized Nussbaum's analysis of the Epicurean "Garden," a place where students of the Epicurean school of philosophy could remove themselves from their wider socio-cultural milieu and focus on self-cultivation.[32] I ended up agreeing with Nussbaum that total isolation from the world in such a garden would undermine our humanness and our connectedness to community, something that might also undermine lifestyle management. As several participants articulate in their interview responses, their families and friends play a key role in their ongoing efforts to lose weight. However, the idea that the OLSS functions as a creative and inventional site, a "commonplace" for the direct interaction between participants and health knowledge (lessons and workbook) and participants and healthcare practitioners (lifestyle coaches), suggests that it is a form of aspirational *paideia*, one that seeks to focus patients on overcoming what Nussbaum calls their "antecedent *paideia*," or all those social, cultural, economic, and other barriers to achieving *eudaimonia*.[33]

Linking the OLSS to my discussion of the anxieties and risks of shifting healthcare online through its description as a virtual *paideia* yields important insights, not the least of which is the enduring importance of rhetoric and human interactivity in the online environment. These anxieties and problems were made apparent in chapter 4, which analyzed how several lifestyle coaches and members of the protocol development team experience the shift from face-to-face counseling to online interaction with participants. Shifting to the new medium is a concern for them as it indicates the need for new skills, new approaches, and the emergence of a variety of new problems, some of which are not entirely foreseeable. Recall that one of the central elements of *Lifestyle Coach Training* and the *Lifestyle Coaching Guide* (the protocol developed to assist in

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[32] Nussbaum, *The Therapy of Desire*, 119-120 (and throughout).

[33] Richard McKeon, "Creativity and the Commonplace," *Philosophy & Rhetoric* 6, no. 4 (Fall, 1973): 199-210; Nussbaum, *The Therapy of Desire*, 97.

the training of lifestyle coaches) is the artful composition of online coach feedback to participants. In the OLSS pilot study, this feedback came in two forms. Some notes were scheduled and automated, containing general tips and inspirational content for participants. Other notes, written in response to participant progress and, at times, direct requests for assistance, were written with the specific needs of the participants in mind. Most importantly for the coaches, the shift from directly interacting with participants and exchanging notes with them through the online portal calls forth two related problems: the importance of "tone" and the lack of a "face."[34] "Tone," a concept generally connected with the spoken word, comes to the fore for the lifestyle coaches indicating their concern with crafting messages to the participants that will not be misinterpreted and that are fitted to their needs and concerns.[35] In addition, not having a "face" to look at means not being able to observe non-verbal cues in the participants' style of interaction.[36] These cues might be emotional or physical signs of distress, a health problem, or a lack of engagement with the program. This notion of the "face" as critical to both the ethical and meaningful interaction between interlocutors has been widely developed in rhetorical and philosophical theory.[37] While Topol argues that email might play a productive role in the cultivation of the provider-patient relationship, tone and the lack of a face remain a problem for the OLSS as it does not have a visual medium for face-to-face interaction.[38]

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[34] Michael J. Hyde, *The Life Giving Gift of Acknowledgment: A Philosophical and Rhetorical Inquiry* (West Lafayette, IN: Purdue University Press, 2006), 85 (and throughout).

[35] A general concern with online messaging in healthcare. See Topol, *The Creative Destruction of Medicine*, 189.

[36] Hyde, *The Life Giving Gift of Acknowledgment*, 85 (and throughout).

[37] Hyde, *The Life Giving Gift of Acknowledgment*, 85 (and throughout).

[38] Topol, *The Creative Destruction of Medicine*, 189.

For the participants, the virtual *paideia* of the OLSS, especially the interaction with lifestyle coaches, seems to have been a largely positive experience.[39] However, as chapter 5 showed, one of the key concerns of the participants links directly with the anxieties expressed by the coaches – the need for human contact. The participants report a variety of views regarding these notes. Some argue that the scheduled notes were too "*robotic*" for them, that they did not really address their needs and felt inhuman. Some participants, not surprisingly, complain that the length of time it took to receive notes was too great, undermining the quality of the interaction. Other participants indicate that the specific notes (and even the scheduled notes), written in response to their problems, were highly effective in keeping them on track. These different findings indicate that one issue facing the shift in medium to the online environment may be the variety of communication styles that people engage in and prefer. Accordingly, the ancient art of rhetoric, with its focus on the crafting of suasive messages for particular audiences, may have an important role to play in elucidating the challenges entailed in cultivation of effective online interactions between patients and their providers.

What's more, the notion that such rhetorical issues as tone, timing (*kairos*), and particularity play key roles in the online medium suggests the ongoing import of human contact as opposed to automated delivery of healthcare information.[40] Following Burke, just because we can do a thing or because historical forces are pushing us in the direction of some new "mechanization" does not mean that such trends are inescapable, or even preferable.[41] That is, just because asynchronous and automated feedback are possible does not mean that they will

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[39] Kathleen M. McTigue, Tina Bhargava, Cindy L. Bryce, Molly Conroy, Gary S. Fischer, Rachel Hess, Laurey Simkin-Silverman, and Susan Zickmund, "Patient Perspectives on the Integration of an Intensive Online Behavioral Weight Loss Intervention into Primary Care," *Patient Education and Counseling* 83, no. 2 (2011): 261-264.

[40] Hubert L. Dreyfus and Stuart E. Dreyfus, *Mind Over Machine: The Power of Human Intuition and Expertise in the Era of the Computer* (New York: The Free Press, 1986).

[41] Burke, *Permanence and Change*, 271.

always be effective or that their use absent the creative and artful powers of rhetorical composition (by human actors) should be contemplated. Importantly, the lifestyle coaches and many of the participants of the OLSS seem to have overcome the unreflective use of technology. Their words indicate the degree to which they thought about these issues and made powerful attempts to retain the human interactivity and dialectical engagement that most of them link with their ongoing development of *eudaimonia*. The OLSS participants show us how a virtual *paideia,* produced through online lifestyle management, can embrace reflection and critique, along with a healthy skepticism about the ultimate powers of the online medium for retaining something like direct human interactivity. This orientation resonates with McKeon's argument that rhetoric "relates form to matter, instrumentality to product, presentation to content, agent to audience, [and] intention to reason."[42] Thus, he suggests, "[rhetoric] should not make technology the operation of a machine, in which the message is the massage; it should not take its form from its medium."[43] In the next section, I articulate more fully how McKeon's work has informed this study and the findings that it produces when applied to the interactive commonplaces of chronic care (chapter 2).

[42] McKeon, "The Uses of Rhetoric," 63; Here, McKeon is referencing Marchall McLuhan's work. See Mcluhan's *Understanding Media: The Extensions of Man* (Cambridge: The MIT Press, 1994), 7-21.
[43] McKeon, "The Uses of Rhetoric," 63.

7.3 THE COMMONPLACES OF CHRONIC CARE CONCEIVED ARCHITECTONICALLY

Chapter 2 interrogated what I call, following McKeon's critical vocabulary, the commonplaces of chronic care as represented in the "Chronic Care Model" (CCM).[44] These commonplaces emerge from the interaction between providers capable of working in teams to provide excellent care, the cultivation of self-care among patients, and the adequate transfer of knowledge and new interventions from research sites to the clinical locales in which they may be activated in the improvement of health (also a topic of chapter 6). The second of these commonplaces, the cultivation of patients who can "pilot" their own care, seems a strange anomaly in a highly technological society.[45] What I mean by this is that 20th century medicine seemed to be on the constant march toward finding technological fixes for health care problems. Indeed, biomedicine has discovered a vast number of new techniques to treat acute illness.

Yet, in a parallel development, broad societal trends have yielded a new array of factors driving disease, especially chronic diseases with behavioral overlays. In response, medical leaders have developed new approaches, such as the CCM, to deal with this changing landscape. In this way, the CCM engages one of the permanent dialectics in medicine between the expertise, knowledge, and tools of the physician, and the need for patients to engage in their own care without the constant support of their providers. As Judy Segal artfully proves in her book, self-care has been a central feature of medicine across time (although it is inflected differently

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[44] McKeon, "Creativity and the Commonplace," 199-210; Edward H. Wagner, "Chronic Disease Management: What Will It Take To Improve Care for Chronic Illness?" *Effective Clinical Practice* 1 (1998): 2-4; Edward H. Wagner, Brian T. Austin, Connie Davis, Mike Hindmarsh, Judith Schaefer, and Amy Bonomi, "Improving Chronic Illness Care: Translating Evidence into Action." *Health Affairs (Millwood)* 20, no. 6 (2001): 64-78.

[45] Wagner, Austin, Davis, Hindmarsh, Schaefer, and Bonomi, "Improving Chronic Illness Care," 66.

depending on the specific moment).[46] Chapter 2 argued that the Hippocratic writer makes the patient a central actor in advancing their own health in exactly the way the CCM describes. Despite advances in technology and medical knowledge that might strip away the central role played by individuals in their own care, the role of the patient and patients' relationship with their providers remain central features of healthcare in need of development, critique, and transformation. The OLSS provides a specific case study into these elements of the CCM architecture, bringing to bear the words of actors at each level of the model to provide substance to the claims that I made in chapter 2 regarding the power of rhetoric to both analyze and enhance chronic care.

At the same time, the CCM deals with a changing aspect of medicine, its reliance on synergized teams of healthcare providers and on new information technologies to connect researchers, patients, and providers. This shift in communication style and the need for combining multiple disciplinary perspectives in the treatment of chronic disease calls out for a new "productive architectonic art" that can structure these elements, arrange them in a way that makes them accessible, useful, and easy to remember.[47] According to McKeon, rhetoric, with its own set of concerns, skills, and approaches, is just such an art. Drawing on ancient rhetorical tools including invention, judgment, interactivity, and the constitution of identity and community, McKeon argues that the sciences can find answers to the problems of complexity and fragmentation in modern life.[48] Following McKeon, I suggest that the ancient art of rhetoric can inform contemporary modern care, thus providing more evidence that an ongoing combination of the more permanent (the tools of human interactivity that make up rhetoric) and

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[46] Judy Z. Segal, *Health and the Rhetoric of Medicine* (Carbondale: Southern Illinois University Press, 2005), 21-36.

[47] McKeon, "The Uses of Rhetoric," 48, 54-57.

[48] McKeon, "The Uses of Rhetoric," 51.

changing (the specific problems facing a highly technologized healthcare system in which synergizing knowledge and practice is a key concern) features of human existence is a good way to promote innovation and solve problems facing contemporary researchers and practitioners.

In order to clarify how this "architectonic" method has worked over the course of my analysis chapters (4, 5, and 6), I highlight one theme that cuts across the interviews in a way that suggests the importance of synergy and arrangement in the delivery of chronic care: collaboration.[49] Recall that in chapter 4, the lifestyle coaches consistently speak about the iterative process they use to take the general principles of the coaching protocol (contained in *Lifestyle Coach Training* and the *Lifestyle Coaching Guide*) and apply them to the specific needs of their patients (*phronesis*).[50] This process involves not merely ongoing conversation but the artful organization of different specialty areas (e.g., counseling, nursing, physical training, nutrition, etc.) in an effort to craft messages to participants that help them overcome barriers. In addition, the feedback of the participants, their concerns and questions, frame an additional layer in need of incorporation into the collaborative milieu of the OLSS coaching process. That such collaboration between various fragmented pieces of information and knowledge domains is at the heart of the OLSS coaching strategy indicates its direct relationship with the CCM notion of cultivating "Prepared, Proactive Practice Teams."[51] It also suggests something even more fundamental: a link between the CCM architecture and the rhetorical process of human interaction and translation across different fields of study (part of rhetoric's "architectonic" function).[52] According to my work in chapter 4, artfully crafting a healthcare team requires the

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[49] McKeon, "The Uses of Rhetoric."

[50] Sara Rubinelli, Peter J. Schulz, and Kent Nakamoto, "Health Literacy Beyond Knowledge and Behaviour: Letting the Patient Be a Patient," *International Journal of Public Health* 54 (2009): 309-310.

[51] Wagner, "Chronic Disease Management."

[52] McKeon, "The Uses of Rhetoric," 56-57.

arrangement of knowledge in such a way that it can be distilled as useful and action-oriented advice for participants.

But this collaborative theme does not stop with the coaches. The participants articulate the need for ongoing engagement with their coaches to overcome barriers and address specific problems with achieving their goals.[53] Thus, the collaborative interactions used to generate specific applications of general principles within the OLSS coaching protocol and curriculum not only assist in cultivating a coaching team but also in the creation of an effective developmental process (*phronesis*) for the participants. One key example that emerges regarding this connection has to do with the differential needs, concerns, and communication styles of the participants. In chapter 5, one participant describes in detail how his or her life situation implicates the arrangement and hierarchy of tools he or she needs to glean from the OLSS. This participant argues that his or her strong family connections make the human contact of the OLSS less important, indicating that in this case, the messages prepared by the coaches (either automated and scheduled or specific and directed) are not as important as the support of and interaction with family. Other participants note elements of their lives that make the lessons or the coordination of the OLSS with their primary care more or less important based on their specific needs.

Thus, the "architectonic" view afforded by this dissertation's research approach yields two important findings at the provider-patient level. First, participants can and should engage in collaboration with their healthcare providers, but this collaboration requires an iterative and collaborative process folded into the training of lifestyle coaches.[54] In other words, the collaborative arrangement of different fields of study and different approaches to care (in tandem with attention to the needs of participants) is part of the experiential learning (*phronesis*) that the

[53] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309-310.
[54] McKeon, "The Uses of Rhetoric."

coaches undergo in preparing to engage in lifestyle management as a mode of *paideia.*[55] This experiential learning then frames the interactions between lifestyle coaches and patients, thus showing that rhetorical interactivity in the form of "collaborative knowledge production" and "problem-solving" (the thematic monikers given to these elements in chapters 4 and 5) developed in the OLSS are directly tied to and dependent upon one another.

Moving beyond the experiences of the coaches and the patients, we come to the role of collaboration in the experiences of the Corporate Dissemination Team (CDT). Chapter 6 investigated a critical link between the team charged with training and engaging in lifestyle coaching in the OLSS and the activities of the CDT that may be summed up in the National Institutes of Health term "translational research" and the more corporate moniker, dissemination.[56] In short, translation is the process whereby research findings are made applicable to clinical care. The mission of the CDT is to sell (disseminate) the evidence-based curriculum and online platform of the OLSS to new clinical sites, thus playing a complementary role in the promotion of translation. This requires direct interaction with the university researchers who designed the OLSS as well as with members of the Coaching Protocol Development Team (CPDT).

Chapter 6 began by investigating the words of members of the CPDT in order to get a sense for how the process of translation, from clinical researchers into the hands of disseminators, begins and implicates later efforts at translation between disseminators and new clinical sites. The members of the CPDT report that major barriers exist between the specialized

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[55] This confirms work in medical education theory that experience is at the heart of professional development for healthcare practitioners. See, e.g., Molly Cooke, David M. Irby, and Bridget C. O'Brien, *Educating Physicians: A Call for Reform of Medical School and Residency* (San Fransisco: Jossey-Bass, 2010).

[56] United States National Institutes of Health, "Glossary and Acronym List," http://grants.nih.gov/grants/glossary.htm#T [Accessed September 4, 2012].

research site of the university and the corporate setting of the CDT, especially with regard to how the respective sites view the complex, grounded, and experiential strategies used to refine the coaching process. That is, the collaborative efforts of the lifestyle coaching team cannot be summed up in short article or a list of key principles. Instead, the constitution of lifestyle coaches and their practices is a developmental process that can only be achieved through experience (*phronesis*). Thus, the CDT faces the prospect of making this process work in other settings. According to the members of the CDT, this requires ongoing interaction with researchers who can help to frame key concepts and strategies of the coaching process through their experiences, thus adding specific content to the protocol documents (*Lifestyle Coach Training* and the *Lifestyle Coaching Guide*) that cannot be easily transferred.

In addition, my interviews with the CDT bear out the fact that translating research to care is itself a collaborative process, one filled with multiple feedback loops connecting clinical end-users to disseminators and disseminators to researchers. Addressing specific questions and problems with implementation requires these collaborative measures, especially given the slow timeframe of academic research and the fast pace of clinical care. In addition, the members of the CDT suggest that the collaboration they engage in with clinical end-users is itself an experiential process (*phronesis*), one rooted in finding a way to match the OLSS structure with the specific conception of good healthcare at play in any given clinical setting (*eudaimonia*). Chapter 6 used the term "rhetorical assay" to elucidate the experimental and suasive medium needed to achieve the uptake of the OLSS. This concept provides additional content to the "architectonic" function of rhetoric.[57] It indicates that, following McKeon, rhetoric plays a role in cultivating sites for synergizing the work of researchers and practitioners, sites that are not just communicative but

[57] McKeon, "The Uses of Rhetoric."

also suasive.[58] Recall that the CDT often has to engage in collaborative dialogue and "*trial evaluations*" in order to persuade potential end-users to adopt the OLSS. Thus, the collaborative activities of the CDT (with the university and their potential buyers) play a central role in realizing the movement of the collaborative model of knowledge production and problem-solving developed during the OLSS pilot study into clinical sites where it may have an impact on promoting improved chronic care.

Tracing just one of the themes that emerges from the interview data – collaboration – through the three commonplaces of the CCM architecture indicates the powerful potential of using McKeon's concept of rhetoric as "a productive architectonic art" to enrich rhetorical criticism.[59] While McKeon imagines rhetoric as a productive art rather than one that engages in "semantic analysis" of texts, this project shows that attention to the words of actors at various levels of an overall system, chronic care, reveals the role that rhetoric plays in arranging and improving that system.[60] Thus, this dissertation indicates the usefulness of McKeon's approach as a productive *and* critical endeavor, an innovation of rhetorical theory that is as yet underdeveloped. McKeon's conception of rhetoric, inflected as a method for research, also has implications for healthcare researchers. In short, in order to understand how to improve the prospects for self-care, one of the central concerns of chronic care research and delivery, it is important to chart how each level of the research-to-care model implicates the overall architecture. For this reason, the interplay between the dual architectonics of the CCM and rhetoric supports a methodological revision that may have consequences for the ongoing prospects of translational research. Such research must find ways to integrate findings across

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[58] Gordon R. Mitchell and Kathleen M. McTigue. "Translation Through Argumentation in Medical Research and Physician-Citizenship." *Journal of Medical Humanities* 33, no. 2 (2012): 83-107.

[59] McKeon, "The Uses of Rhetoric," 48.

[60] McKeon, "The Uses of Rhetoric," 63.

various layers of the health system in order to understand how healthcare improvements, especially those oriented toward the highly experiential setting of lifestyle management, might be achieved. It remains to be seen how the grounded, iterative, and experiential elements that make up the theme of collaboration across the interview responses in chapters 4, 5, and 6 can be generalized as the OLSS scales up.

7.4 FREEDOM OR DOMINATION: THE ROLE OF LIFESTYLE MANAGEMENT IN CONTEMPORARY HEALTHCARE

At least since the time of Gorgias and his student, Hippocrates, the nature of the provider-patient relationship has been critically important.[61] The Gorgian approach, using rhetoric to manipulate and control others, and the Hippocratic approach which favors mutual partnership, are in this sense permanent features of medical practice.[62] This dialectic between paternalism and patient autonomy is still a central problematic in medicine, one that relates to the ongoing effort to understand how physicians and practitioners should relate to one another and the different forms of knowledge they bring to the table.[63] Fundamentally, one may ask, is medical therapy a practice of freedom or domination, a practice that is about realizing the specific goals of patients or about hailing patients into the healthcare system and constituting them as bodies in need of intervention and control?[64] Bioethics favors the former view and contemporary medical practice certainly moves in the direction of valuing the autonomy and decision making role of patients in

[61] Leach, "The Art of Medicine."

[62] This manipulative element in Gorgias is termed "sophistic" by Smith and Pettegrew who juxtapose it with a more mutual conception of rhetoric. Smith and Pettegrew, "Mutual Persuasion."

[63] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 308.

[64] Other authors have posed this question. See Rubinelli, Schulz, and Nakamoto, "Health Literacy"; Smith and Pettegrew, "Mutual Persuasion"; Joanna Zylinska, *Bioethics in the Age of New Media* (Cambridge/London: The MIT Press, 2009).

their own care. However, the move to make individuals responsible for their own care is itself a constitutive process, one that places a burden on patients that may have social and political consequences. As Dana Cloud suggests in her study of the "rhetorics of therapy" prevalent in contemporary U.S. culture, "the *therapeutic* refers to a set of political and cultural discourses that have adopted psychotherapy's lexicon – the conservative language of healing, coping, adaptation, and restoration of a previously existing order – but in contexts of socio-political conflict."[65] Cloud suggests that the therapeutic devices of medicine, those rooted in the activities of self-care, are too easily sutured to political beliefs about "individual or family responsibility" that remove the onus for changing the conditions of humanity from larger institutional forces and enervate "collective agency in the public project of social transformation."[66] While this may seem like an issue far afield from our concern with the internal processes of therapy within the clinical domain, Cloud's work pushes us to consider how rhetorics of self-care, once transported into the political domain (perhaps through public health efforts, among others), may actually forestall what Burke sees as needed revisions to institutions that "interfere with the establishment of decent social or communicative relationships."[67] Finally, as Segal points out, "What seems to be a challenge to paternalism may be a cagey new version of it. That is, in shared-responsibility medicine, patients have a voice because they are *granted* a voice."[68] Thus, as a rhetorical critic, I must attend to the question of whether the OLSS unwittingly replicates a model of therapy that could be used to ill effect in broader political settings or that simply masks the problem of physician paternalism.

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[65] Cloud, *Control and Consolation*, xvi.
[66] Cloud, *Control and Consolation*, xv, 19.
[67] Burke, *Permanence and Change*, 271.
[68] Segal, *Health and the Rhetoric of Medicine*, 35.

This brings us back to one of the key issues in chapter 4: the constitutive function of rhetoric.[69] That chapter explored the cultivation of lifestyle coaches as a constitutive process, turning from the larger socio-political and ideological concerns of Maurice Charland's work to consider constitution in the interpersonal dimension of communication. In doing so, I argued that Charland's view of constitutive rhetoric is too ideological to be applied to the healthcare setting. It is rooted in the notion that humans are constructed, sometimes openly and sometimes surreptitiously, by ideological forces over which we have little control.[70] This view, one that supports Cloud's arguments regarding the ideological creep of therapy into the political domain, is one that simply does not comport with the interview responses analyzed in chapters 4 and 5. Instead of viewing constitution as a larger socio-political process, my project inflects the concept through the specific experiences of individuals engaged in delivering and enacting a regimen of self-care. What the lifestyle coaches and participants suggest is that the constitutive process of enacting lifestyle change is more Hippocractic than Gorgian, more humanist and agency-centered than postmodern.[71]

In chapter 5, the OLSS participants consistently note that their interactions with lifestyle coaches featured "*encouragement*" and "*support*" rather than didacticism or paternalism. The relationships and rapport formed between the coaches and participants definitely aided in a process of interpersonal constitution that improved the coaches' skills to perform their role and the participants' capacities to engage in their own care. None of this smacks of hidden paternalism or of an effort to ideologically manipulate the participants of the OLSS. Much like Samr, most of the participants in the study want to lose weight. This is not imposed upon them.

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[69] John Lyne, "Rhetorics of Inquiry," *Quarterly Journal of Speech* 71 (1985): 65-73; Maurice Charland, "Constitutive Rhetoric: The Case of the 'Peuple Québécois,'" *Quarterly Journal of Speeh* 73 (1987): 133-150.

[70] Charland, "Constitutive Rhetoric."

[71] Leach, "The Art of Medicine," 2104.

Further, the matter of making patients more responsible for their care can be framed in a negative light, but most of the interview responses from participants cut in the opposite direction. They felt more prepared to do the things they needed to do to care for themselves, something necessary given the nature of chronic care (chapter 2) and something they ultimately desire. That is, when the process of constitution is entered into by choice and is framed as a matter of mutual support and collaboration, it is difficult to imagine that it somehow imposes ideology or undermines autonomy. Of course, it is impossible to know precisely where our preferences come from in the first place, but this does not mean that they are or must be structured by underlying ideologies over which we have no control.[72] In addition, the very fact that patients have a "voice" in the processes of collaboration that make up the OLSS intervention suggests that, while the intervention itself is fundamentally rooted in certain beliefs about health and wellness (drawn from medical understandings of the body), individual patients are invited to speak up about what they feel, what they need, the problems they face, and the like.[73] Lisa Keränen poses the agency question this way: "How much freedom does a speaker have in inventing a self through words?"[74] She poses this question to get at the heart of a fundamental divide in rhetorical studies between those who believe that speakers have agency, that they craft their public selves intentionally and with their own preferences and beliefs in mind (humanism) and the notion that larger forces tend to rob agency from the individual, undermining their creative and inventional capacities.[75] Keränen's response is to suggest that while larger forces do mold

[72] George Sher, "Our Preferences, Ourselves," *Philosophy and Public Affairs* 12, no. 1 (1983): 34-50.
[73] Keränen, *Scientific Characters*, 31-33.
[74] Keränen, *Scientific Characters*, 32.
[75] Keränen, *Scientific Characters*, 32-33.

and shape us, "rhetors still operate within a field of play in terms of their linguistic choices."[76] They use their "voice" to achieve what freedom may be achieved by the individual.[77]

In line with Keränen's argument, M.

Lane Bruner offers what I believe to be the most compelling argument regarding the role of agency in rhetorical activity. He suggests that the balance between the humanist agent and the postmodern subject can be struck at the site of *phronesis*. This postmodern *phronesis* need not be "a cynical but a practical wisdom based on the expectation that because identification happens as it does, the politically wise must interact with identification processes accordingly within the 'systems of governmentality' that prevail . . . the postmodern rhetorical *phronimos* is simultaneously a willful agent and a constrained subject."[78] While I have not been dealing explicitly with "systems of governmentality" in this dissertation, the discourses and ideological constraints that exist within contemporary medicine are a concern if patient autonomy and a pluralist *eudaimonia* are to be fundamental in the construction of lifestyle change. As I have suggested throughout, there is no way to finally eradicate the paternalism of medicine. At some point, we are all patients and we are all in need of expertise. However, the analyses in chapters 4 and 5 pointed to the fact that professionals may leave the door open for dialectical interactions with their patients, interactions that allow for the goals, needs, and situational expectations of patients to emerge and play their role in health-related decision making.[79] In this way, *phronesis* manages the divide between agency and ideology and between the Gorgian and Hippocratic

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[76] Keränen, *Scientific Characters*, 32.
[77] Keränen, *Scientific Characters*, 31-33.
[78] M. Lane Bruner, "The Rhetorical *Phronimos*: Political Wisdom in Postmodernity," *Controversia: an international journal of debate and democratic renewal* 2 (May, 2003): 91.
[79] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309-310.

traditions, by leaving individual experience a central role to play in the cultivation of the self.[80] Thus, we might say that the fears of lifestyle management being a new mode of domination are, to use Nikolas Rose's term "overblown."[81]

7.5 FUTURE DIRECTIONS FOR RESEARCH

The last several sections have summarized and expanded upon key findings from my analysis chapters. Overall, we have seen the degree to which rhetoric plays a powerful role in the constitution of practitioners and patients. We have also seen that rhetoric may be reframed as a conduit for the delivery of research to the clinic.[82] Moreover, these "architectonic" modalities of rhetoric provide a vocabulary for understanding the challenges associated with arranging pieces of the CCM, and finding ways to connect those pieces in ways that enable productive communication.[83] Studying connections between the various actors who coordinate in lifestyle management showcases how, as John Lyne notes, "the study of rhetoric . . . attends to matters often shaped at the intersection of science with practical reasoning."[84] That is, rhetoric is a critical conduit linking the knowledge and practices of clinicians, researchers, and corporate disseminators (all grounded, at least in part, in the development and use of scientific evidence in the delivery of care) with the lifeworlds of patients for whom practical concerns of health and well being (sometimes but not always determined by a scientific worldview) are central. In addition, and in line with the Burkean theme of this chapter, we have seen how the permanent

[80] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309-310.
[81] Nikolas Rose, *The Politics of Life Itself: Biomedicine, Power, and Subjectivity in the Twenty-First Century* (Princeton: Princeton University Press, 2007): 253.
[82] Joan Leach, "The Art of Medicine."
[83] McKeon, "The Uses of Rhetoric."
[84] John Lyne, "Contours of Intervention: How Rhetoric Matters to Biomedicine," *Journal of Medical Humanities* 22, no. 1 (2001): 13.

ideals of rhetoric, *paideia*, *phronesis*, and *eudaimonia* can aid in capturing and interpreting, arranging and even improving, discrete practices of lifestyle management (and more generally, chronic care). However, there are still important areas for further development and research.

First, there are a variety of questions that may be posed regarding the extent to which the OLSS and interventions like will attain a high level of uptake in clinical settings across the United States. The passage of the *Patient Protection and Affordable Care Act* by Congress in 2010 paved the way for increasing commitments to and financial support for preventive and primary care.[85] This has inspired new interest in "patient-centered" approaches to care and research methodologies that attempt to determine patient needs, concerns, and levels of satisfaction with the care they receive.[86] As I have already pointed out, lifestyle interventions like the OLSS have been designed to address the gaps in primary and preventive care for obese and diabetic patients, primarily the lack of time spent by many primary care providers on lifestyle changes that might improve outcomes for their patients.[87] However, despite these changes, it remains unclear whether clinicians and large healthcare organizations will move to incorporate lifestyle interventions like the one developed by the OLSS into their practices. As the members of the Corporate Dissemination Team (CDT) of the OLSS suggest, one of the main reasons for this has to do with the costs of implementing such programs. Given the economic recession of 2008, many healthcare organizations and providers have, according to my interviews with the CDT, become much more risk averse. This has created the need for better

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[85] U.S. Congress, *Patient Protection and Affordable Care Act*, H.R. 3590, Public Law 111-148, 111th Congress (March 23, 2010); Michael L. Millenson and Juliana Macri, "Will the Affordable Care Act Move Patient-Centeredness to Center Stage?" *Timely Analysis of Immediate Health Policy Issues* (Urban Institute): http://www.rwjf.org/qualityequality/product.jsp?id=74054&cid=XEM_A5765 [Accessed September 5, 2012].

[86] Millenson and Macri, "Will the Affordable Care Act," http://www.rwjf.org/qualityequality/product.jsp?id=74054&cid=XEM_A5765

[87] U.S. Preventive Services Task Force, "Screening for Obesity in Adults: Recommendations and Rationale," 2003, www.uspreventiveservicestaskforce.org/.../obesity/obesrr.pdf *[accessed August 22, 2012]*.

advertising and sales techniques that broach the subject of financing directly. Furthermore, the CDT members suggest that insurance reimbursement for programs like the OLSS is still a major problem. While healthcare reform may increase the number of items covered for reimbursement, it remains unclear after my interviews with the CDT whether insurers will warmly accept interventions like the OLSS.[88] What's more, the incorporation of lifestyle coaches into new clinical environments may itself be a barrier, according to my interviewees with members of the CDT, because coaches will need to be fully focused on the delivery of the intervention, rather than other clinical services, in order to be effective. All of these barriers indicate the degree to which the uptake of lifestyle interventions will not be based solely on their proven effectiveness. Finding ways to incentivize clinicians, to craft better messages for potential buyers and insurers, and to convince policy-makers that more funding and support for these efforts are needed warrant extensive study. Thus, rhetoric has a role to play in addressing these issues, as one of its primary concerns has always been the discovery of new modes of persuasion that respond to exigencies that might otherwise seem insurmountable.[89] Rhetoricians are positioned well to contribute unique insight into how the sale and promotion of lifestyle interventions might be improved.

In addition to these policy-based questions, issues surrounding the appropriate use of new communication technologies in the delivery of chronic care have come to the fore in this study, most notably in chapters 4 and 5. In these chapters, much was made of "coaching notes" and their role in the delivery of the OLSS intervention. As chapter 5 suggested, issues of "*tone*" and the lack of face-to-face interaction circulate around the use of these notes as they act as

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[88] A point that Topol makes regarding the production and delivery of emails, something that does not necessarily comport with the "typical fee-for-service model." Topol, *The Creative Destruction of Medicine*, 192.

[89] Lloyd F. Bitzer, "The Rhetorical Situation," "The Rhetorical Situation." *Philosophy and Rhetoric* 1 (1968): 1-14.

replacements for direct clinical counseling. As I do not currently have access to the content of the notes written by the lifestyle coaches, I am unable to more fully distill these problems or understand exactly how tone, a term that is rooted in verbal speech, might apply in a written format. For this reason, I plan to get access to this highly important content. Reading the notes as written and investigating the reactions of specific participants to the feedback they receive may provide more insight into how such notes are crafted and what improvements might be made through the application of rhetorical tools. In other words, connecting my findings from chapters 4 and 5 to specific analyses of the actual content of coaching notes may suggest more specific compositional advice for lifestyle coaches who engage in future iterations of the OLSS study. In addition, later iterations of the OLSS engage in different levels and intensity of communication with participants. That is, some participants receive more online contact with coaches than others. Comparing these different styles and intensities of interaction may suggest the degree to which the amount of interaction between lifestyle coaches and participants implicates the successful cultivation of rapport between them, something that may improve overall satisfaction and health outcomes.

The question regarding coaching notes and the style of feedback raised above suggests another avenue for future research. I have made much of the virtual *paideia* crafted by the OLSS. This virtual space includes online lessons, workbooks, and sustained interactions between lifestyle coaches and participants. Importantly, while the online lessons and workbooks are directly accessible to participants, the lifestyle coaches in the original OLSS pilot study were not. This asynchronous model of communication has benefits and disadvantages. While it makes the management of larger numbers of participants that much easier, it may in some cases have deleterious consequences on the quality of interactions. Thus, comparing this asynchronous

model to more interactive models such as online chats, social networking sites, and the like may yield important insights regarding the right mixture of asynchronous styles of feedback and more direct models in which the time between communications is shortened or eliminated. For example, Topol's work on the digital revolution in medicine suggests that video chats and other electronic means of communication may help to sustain something more like the face-to-face interactions of the clinic.[90] More work should be done to bear out this claim and to see how these various uses of technology might by combined to deal with patient needs while lessening the burden on healthcare practitioners.

Aside from these questions surrounding new communication technology and the delivery of chronic care, this study suggests important avenues of future research regarding the role of rhetoric in the development, cultivation, and uptake of lifestyle management by various publics. My work in this dissertation has focused almost exclusively on the clinical dimension of chronic care summed up in the relationship between providers and patients. While my interviews with members of the CDT expand this focus to consider the interface between dissemination teams and clinicians, my study stops short of investigating the extent to which larger publics may or may not adopt interventions like the OLSS. Groups like the *National Association for Fat Acceptance* and scholarly endeavors such as *Fat Studies* suggest that public perceptions of the medical industry in general and the public health agenda to address obesity in particular are not entirely positive.[91] Thus, controversies circulating around the meaning of the term obesity, the socio-cultural consequences of focusing on self-care, and the role of medicine and government in addressing the chronic health crisis could provide important inflections that clinically focused

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[90] Topol, *The Creative Destruction of Medicine*, 75.

[91] For the primary web home of the *National Association for the Advancement of Fat Acceptance* (NAAFA), see www.naafa.org. For a nice survey of the ground in Fat Studies, see Esther Rothblum and Sondra Solovay, eds., *The Fat Studies Reader* (New York/London: New York University Press, 2009).

studies such as mine cannot.[92] Combining clinical experiences with lifestyle management and broader public concerns regarding its social, cultural and public consequences would add important insights into the ongoing effort to address obesity. Such work might reveal added layers of the story, for instance the reasons that individuals have for taking part in lifestyle management regimens or, alternatively, refusing to do so and how clinicians and translational researchers might address these different groups by crafting better messages or transforming the ways they engage in care. Expanding the focus to include these public inflections is also in keeping with the current trends in rhetorical scholarship in which public controversies about science and medicine have taken center stage.[93]

Finally, I have argued that a capacious understanding of *phronesis* is appropriate to attend more effectively to the variety of practices that make up contemporary care. Following insights generated by scholars from rhetoric to philosophy, medicine, and public health, this dissertation has shown how the concept of *phronesis* can contribute important experiential insights ranging from the practices of physicians to patients and finally corporate disseminators. Moving in the direction of valuing experiential learning over other modes of knowledge production allows for the study of discrete and iterative processes of development that contribute not only to the important activity of "self-examination" but also the teaching role of experience itself.[94] The task of highlighting the role of experience in stitching together various epistemological domains and coordinating "eloquence and wisdom in action" is unending.[95] This study suggests that medicine may benefit from the concept of *phronesis* in a global way. From top to bottom, the individuals

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[92] For a nice example of such work, see Cloud, *Control and Consolation*.

[93] Keränen, *Scientific Characters*; John Lynch, *What Are Stem Cells? Definitions at the Intersection of Science and Politics* (Tuscaloosa: The University of Alabama Press, 2011).

[94] Rubinelli, Schulz, and Nakamoto, "Health Literacy," 309; Joseph Dunne, *Back to the Rough Ground: Practical Judgment and the Lure of Technique* (Notre Dame: University of Notre Dame Press, 1993).

[95] McKeon, "The Uses of Rhetoric," 48.

involved in the cultivation of health draw on experience to inform their decisions and reform their practices. Unfortunately, there is often a tendency in medicine to focus more on evidence and technology than practice.[96] Keeping *phronesis* front and center may assist in promoting the forms of research and practice needed to improve our collective capacities to "think what we are doing."[97] Thus, future research can and should attend to this process of combining words and deeds, thoughts and actions, in the variety of practices that make up our lives.

[96] See e.g., Cooke, Irby, and O'Brien, *Educating Physicians*; Kathryn Montgomery, *How Doctors Think: Clinical Judgment and the Practice of Medicine* (Oxford: Oxford University Press, 2006).

[97] Hannah Arendt, *The Human Condition* (Chicago: The University of Chicago Press, 1958), 5.

APPENDIX A

PROJECT DESCRIPTION AND INFORMATION SCRIPT: LIFESTYLE COACHES AND COACHING PROTOCOL DEVELOPMENT TEAM

Project Description:

The following questions deal with the development and implementation of the coaching documents and resources (protocol) produced during the [OLSS] program pilot study: (1) the original coaching protocol, "[OLSS] Lifestyle Coach Training," Copyright 2008, University of Pittsburgh, (2) a power point presentation, "[OLSS] Lifestyle Coach Training," (3) some supplemental coaching tips prepared for specific lessons on the virtual portal, "[OLSS] Lifestyle Coaching Guide," and, (4) "Summary of lifestyle coaching advice compiled from FY06 pilot through 9/1/09 (draft)." These documents will be made available to the interviewees and I will take careful note if interviewees reference specific documents in their answers. The goal of these interviews is to chart the development of the coaching protocol for [OLSS], understand how the protocol was integrated into the coaching process during the pilot study, and articulate the future plans of [OLSS] investigators as they continue to develop these coaching tools.

The questions are divided into two parts: (1) Questions for the Lifestyle Coaches, and (2) Questions for the [OLSS] Coaching Protocol Development Team. As these two groups will have slightly different perspectives on the history and circulation of the coaching protocol, I have designed questions for both groups accordingly.

These face-to-face interviews will be recorded, transcribed, and then analyzed by the investigator, John Rief, based on a mixed methods approach including but not limited to: textual

interpretation using rhetorical theory (especially drawn from classical Greek texts including Aristotle's *Rhetoric* and *Ethics*) and close reading for key themes, phrases, and other continuities across the interviews. No personal identifying information about the interviewee will be recorded or reported in any research documents produced following this interview. The only information that will be recorded is that these individuals are members of the coaching protocol development team or lifestyle coaches on the [OLSS] pilot study.

Information Script:

The purpose of this research study is to chart the development of the coaching protocol for [OLSS], understand how the protocol was integrated into the coaching process during the pilot study, and articulate the future plans of [OLSS] investigators as they continue to develop these coaching tools. For this reason, I will be interviewing members of the Coaching Protocol Development Team for [OLSS] and the [OLSS] lifestyle coaches who designed and implemented the pilot study as well as lifestyle coaches and investigators in the current iteration of the [OLSS] program. The interview questions deal with the development and implementation of the coaching documents and resources (protocol) produced during the [OLSS] program pilot study including: (1) the original coaching protocol, "[OLSS] Lifestyle Coach Training," Copyright 2008, University of Pittsburgh, (2) a power point presentation, "[OLSS] Lifestyle Coach Training," (3) some supplemental coaching tips prepared for specific lessons on the virtual portal, "[OLSS] Lifestyle Coaching Guide," and, (4) "Summary of lifestyle coaching advice compiled from FY06 pilot through 9/1/09 (draft)." These documents will be made available to the interviewees during the interview session and I will take careful note if interviewees reference specific documents in their answers. If you are willing to participate, you

will engage in a face-to-face interview that will be recorded, transcribed, and then analyzed as a textual resource for a dissertation project. There are no foreseeable risks associated with this project, nor are there any direct benefits to you. All responses are anonymous in terms of name and demographic data. No personal identifying information about the interviewee will be recorded or reported in any research documents produced following this interview. The only information that will be recorded is that you are a member of the coaching protocol development team or a lifestyle coach on the OLSS pilot study. Your participation is voluntary, and you may withdraw from this study at any time. This study is being conducted by John Rief, who can be reached at 303-548-0027, if you have any questions.

APPENDIX B

PROJECT DESCRIPTION AND INFORMATION SCRIPT: [Corporate Dissemination Team]

Project Description:

The following questions deal with the development and implementation of the dissemination campaign for the [Online Lifestyle Support System or OLSS] program by [the Corporate Dissemination Team or CDT]. In this regard, the investigator, John Rief, plans to ask about the uptake of the program, the reactions [the CDT] has experienced regarding its pitches to potential customers, and the use of pilot research programs to help potential buyers investigate the usefulness of [the OLSS] in their practice. The goal is to better understand how [the OLSS] is being disseminated to a variety of audiences and customers as well as the relationship between the pilot study data and the dissemination campaign.

These face-to-face interviews will be recorded, transcribed, and then analyzed by the investigator, John Rief, based on a mixed methods approach including but not limited to: textual interpretation using public address criticism (especially drawn from classical Greek texts including Aristotle's *Rhetoric* and *Ethics*) and close reading for key themes, phrases, and other continuities across the interviews. No personal identifying information about the interviewee will be recorded or reported in any research documents produced following this interview. The only information I will record is that these individuals are working on the [OLSS] dissemination campaign [XXXX].

Information Script:

The purpose of this research study is to establish how [the OLSS] is being disseminated to a variety of audiences and customers as well as the relationship between the [OLSS] pilot study data and the dissemination campaign. For this reason, I will be interviewing [members of the CDT], the company now licensed to sell [the OLSS]. The interview questions deal with the development and implementation of the dissemination campaign for the [OLSS] program by [the CDT], the uptake of the program by various audiences and potential customers, the reactions [the CDT] has experienced regarding its pitches to potential customers, and the use of pilot research programs to help potential buyers investigate the usefulness of [the OLSS] in their practice. If you are willing to participate, you will engage in a face-to-face interview that will be recorded, transcribed, and then analyzed as a textual resource for a dissertation project. There are no foreseeable risks associated with this project, nor are there any direct benefits to you. All responses are anonymous in terms of name and demographic data. No personal identifying information about the interviewee will be recorded or reported in any research documents produced following this interview. The only information that will be recorded is that you are an employee of [XXXX] currently working on the [OLSS] dissemination campaign. Your participation is voluntary, and you may withdraw from this study at any time. This study is being conducted by John Rief, who can be reached at 303-548-0027, if you have any questions.

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