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A Rhetoric and Philosophy of Interprofessional Healthcare Education: Communication Ethics in Action

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A RHETORIC AND PHILOSOPHY OF INTERPROFESSIONAL HEALTHCARE EDUCATION:

COMMUNICATION ETHICS IN ACTION

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ABSTRACT

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Dissertation supervised by Janie Fritz, Ph.D.

Healthcare professionals belong to a moral community. Caring for patients is a community act carried out by healthcare professionals working in teams within complex political and organizational systems. This teamwork is crucial to quality patient outcomes; however, incivility threatens to derail necessary and effective collaboration towards the common organizational good. Necessarily, interprofessional healthcare education is becoming a required element for pre-health professionals. Currently, schools are using competency-based approaches to interprofessional education to teach ethics/values, roles/responsibilities. communication, and teamwork. For reasons explicated throughout this dissertation, the categorizing of these particular elements as competencies is problematic and cultivated within a positivistic and empirical worldview. By exploring concepts of professionality/interprofessionality, biomedical discourse, and

ethics, this dissertation shows how a focus on competency frames conversation, shapes certain outcomes, and limits the educational opportunity for impactful exploration of difference and meaning. A rhetoric and philosophy approach to team building is recommended as a necessary complement to the current educational model.

DEDICATION

This work is dedicated to those that choose to be kind to one another at work.

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I would like to express my gratitude to Dr. Janie Fritz, my dissertation advisor, for her enthusiasm, encouragement and guidance throughout the dissertation writing process. I appreciate her energy, patience, and insights, especially in the areas of ethics and interpersonal communication. This dissertation was inspired by her book on professional civility.

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I would also like to thank Dr. Richard Thames for his participation on my dissertation committee and helpful insights into the history and theory of rhetoric, especially into the rhetorical theory of Kenneth Burke and Jeffrey Walker.

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CHAPTER 1: INTRODUCTION AND RATIONALE

American healthcare is deeply rooted in our industrial past.[1] A 1907 article titled "Making Steel and Killing Men" estimated that ten percent of steel workers were killed or incapacitated while working.[2] Survivors rarely received compensation, yet often lost the ability to work and provide for their families. After decades of suffering physically and economically, labor unions demanded protection. The result was the creation of health insurance as well as the hiring of company doctors.[3] At the beginning of the twentieth century, potential income losses from being injured at work were, on average, four times more[4] than medical expenses.[5]

An increased demand for healthcare in the 1920s led to a substantial rise in cost. Rising incomes[6], increased quality standards[7], technological advancements[8], urbanization[9], and medicine being taken more seriously as a science[10] helped to transition medical treatment from the company clinic to the hospital. By the end of the decade, patients expected medical care to be "precise, scientific, and effective."[11] With the publication of the American Medical Association's (AMA[12]) American Medical

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[1] Bill Toland, "How Did America End Up With This Health Care System?," *Pittsburgh Post-Gazette* (Pittsburgh, PA), April 27, 2014.
[2] William B. Hard, "Making Steel and Killing Men," *Everybody's Magazine 17,* no. 5. (1907).
[3] Toland, "How Did America End Up."
[4] William Beye and The State of Illinois, *Report of the Health Insurance Commission* (Springfield, IL State Journal Co., 1919)
[5] Melissa A. Thomasson, *Health Insurance in the United States*, ed. Robert Whaples (Tucson, AZ: Economic History Association, 2003).
[6] Ibid.
[7] Ibid.
[8] Ibid.
[9] Edwin J. Faulkner, *Health Insurance* (New York: McGraw-Hill, 1960).
[10] Thomasson, "Health Insurance."
[11] Charles E. Rosenberg, *The Care of Strangers* (New York, NY: Basic Books, Inc., 1987).
[12] The American Medical Foundation was founded in 1847 to advocate the advancement of medical science and uphold standards for medical education. Subsequently, the Judicial Council was formed in 1873 to address issues of medical ethics.

Directory[13] in 1906[14], the formation of the Council on Medical Education[15] in 1904[16], and the subsequent medical education criticisms of the 1910 Flexner Report[17], medicine in the United States improved alongside developments in medical education. Tougher standards for medical school entrance, and more rigorous training created better doctors, but there were fewer of them. The increased requirements caused forty medical schools to close between 1910 and 1922.[18] As the supply of physicians decreased, the price of care began to rise.[19]

Increasing costs prompted the formation of Blue Cross in 1929. During the Great Depression pre-paid healthcare helped families obtain needed care and helped hospitals maintain business during periods of low revenue.[20] Over the following forty years employers began to offer health insurance to employees as an additional form of compensation, and the federal government established Medicare and Medicaid in 1965 to

[13] The American Medical Directory was a list of more than 128,000 licensed physicians. Today, this list is referred to as the AMA Physician Masterfile.
[14] "AMA History," American Medical Association, accessed November 13, 2017, https://www.ama-assn.org/ama-history#Key%20Historical%20Dates
[15] The Council on Medical Education (CME) collects information and provides recommendations in regards to educational policy at all levels of medical education.
[16] "About the Council on Medical Education," American Medical Association, accessed November 13, 2017, https://www.ama-assn.org/about-council-medical-education
[17] The Flexner Report, a review of medical education written by educator and reformer Abraham Flexner, championed scientific knowledge as the definition of the modern physician. This report helped to shift education away from less scientific proprietary schools and towards a standardized medical training centered on the biomedical model.
[18] "Medical Education in the United States: Annual Presentation of Educational Data for 1922 By the Council on Medical Education and Hospitals." *Journal of the American Medical Association 79,* August 12, 1922, 633.
[19] Thomasson, "Health Insurance."
[20] Ibid.

provide healthcare for those unable to afford care.[21, 22] As enrollment increased, so did demand for healthcare.[23]

The cost of health care has created a challenging health climate for both providers and patients.[24] In the late 1960s, the Department for Health, Education, and Welfare called for a decrease in divided labor within health care fields.[25] In the 1970s, both the World Health Organization (WHO) and the Institute of Medicine (IOM) highlighted interdisciplinary education as important to eliminating these divisions.[26] These reports mark the beginning of a perpetual shift toward efficiency through interprofessional collaboration. The relatively new focus on healthcare teams needs to be matched with corresponding education reform. Numerous publications from The Institute of Medicine (IOM) show weaknesses in academic preparation for new graduates entering health professions.[27, 28, 29] These reports show inadequacies in understanding patient populations as well as a lack of team-based skills. In 2003, the Institute of Medicine recommended educational reform as a crucial step for improving health care quality.[30] This report has

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[21] Ibid.
[22] According to the Centers for Medicare & Medicaid Services, 37 percent of national health expenditures, totaling nearly 1.2 trillion dollars, were for Medicare and Medicaid in 2015. "National Health Expenditures Fact Sheet," Centers for Medicare and Medicaid Services, accessed October 27, 2017, https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html
[23] Thomasson, "Health Insurance."
[24] Elaine R. Rubin and Stacey L. Schappert, eds., *Meeting Health Needs in the 21st Century* (Washington, DC: Association of Academic Health Centers, 2003).
[25] Mary A. Lavin et al., "Interdisciplinary Health Professional Education: A Historical Review," *Advances in Health Sciences Education 6*, (2001): 25-47.
[26] Dewitt C. Baldwin, "Some Historical Notes on Interdisciplinary and Interprofessional Education and Practice in the USA," *Journal of Interprofessional Care 10*, (1996): 173-87.
[27] *Health Professions Education: A Bridge to Quality,* ed. Ann C. Greiner and Elisa Knebel (Washington, DC: National Academies Press, 2003).
[28] Linda T. Kohn, Janet M. Corrigan, and Molla S. Donaldson, eds., *To Err is Human: Building a Safer Health System* (Washington, DC: National Academies Press, 2000).
[29] *Crossing the Quality Chasm: A New Health System for the 21st Century,* Institute of Medicine, (Washington, DC: National Academies Press, 2001).
[30] *A Bridge to Quality*, Greiner and Knebel, eds.

been the impetus for the inclusion of specific interprofessional healthcare competencies by accrediting agencies.[31]

Healthcare in the United States no longer involves isolated, interpersonal exchanges between physicians and patients. Today, caring for a patient is a community act, carried out by teams of healthcare professionals, in increasingly complex organizational systems. The professionals themselves are cultivated within distinctive professions with unique histories, roles, and ethical codes.[32, 33, 34] These diverse, professional identities often clash, creating instances of incivility in the workplace.[35, 36] Workplace conflict is a ubiquitous component of organizational life. Janie Fritz[37], in her book *Professional Civility: Communicative Virtue at Work,* refers to this phenomenon as a "crisis of incivility."[38] This crisis costs both the individual and the institution. Individuals experience a diminished quality of life at work and increased stress,[39] while institutions see greater turnover, decreases in productivity, and, more importantly, distraction from the organizational "good."[40] Incivility at work can be detrimental in

[31] Interprofessional Education Collaborative Expert Panel. *Core Competencies for Interprofessional Collaborative Practice: Report of an Expert Panel* (Washington, D.C.: Interprofessional Education Collaborative, 2011).
[32] Eliot Freidson, *Profession of Medicine* (New York: Dodd & Mead, 1970).
[33] Magali Sarfatti Larson, *The Rise of Professionalism: A Sociological Analysis* (Berkeley, CA: University of California Press, 1977).
[34] Harold L. Wilensky, "The Professionalization of Everyone?," *American Journal of Sociology 70*, (1964): 137-58.
[35] Janie Fritz and Becky Omdahl, eds., *Problematic Relationships in the Workplace* (New York: Peter Lang Publishing, 2006).
[36] Janie Fritz, *Professional Civility: Communicative Virtue at Work* (New York, NY: Peter Lang Publishing, 2013).
[37] Janie Fritz is Professor of communication and rhetorical studies at Duquesne University. She is the author and/or co-author of four books that focus on interpersonal relationships within organizations. Fritz's *Professional Civility: Communicative Virtue at Work* blends interpersonal communication, organizational communication, and communication ethics in a way that highlights the protection and promotion of institutional good.
[38] Fritz, *Professional Civility,* 1.
[39] Fritz and Omdahl, *Problematic Relationships.*
[40] Ronald C. Arnett, Janie Fritz, and Leeanne Bell, *Communication Ethics Literacy: Dialogue and Difference,* (Thousand Oaks, CA: Sage, 2009).

certain organizations. For instance, healthcare organizations hold effective patient outcomes as the common organizational good. Distraction from this good due to incivility can have detrimental effects, not only on patients, but also on the organizations and individuals providing care.[41, 42, 43, 44] One study even estimates that incivility leads to approximately one thousand deaths at work per year.[45]

The increased prevalence of team-based care is directly related to demands for increased productivity in healthcare settings.[46, 47] The resulting integration of professionals into collaborative environments creates clear challenges that include redefining professional identities and boundaries,[48] engaging in constructive dialogue while navigating the language of medicine,[49] and understanding where a specific, professional ethical code fits within the many codes embodied within a diverse healthcare team.[50] Inattentiveness to these challenges can easily manifest as incivility. Ronald C.

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[41] Susan Luparell, "Incivility in Nursing: The Connection Between Academia and Clinical Settings," *Critical Care Nurse 31*, no. 2 (2011): 92-95.
[42] Elizabeth Holloway and Mitchell Kusy, "Systems Approach to Address Incivility and Disruptive Behaviors in Health Care Organizations," in *Organization Development in Healthcare: Conversations on Research and Strategies (Advances in Health Care Management, Volume 10,* ed. Jason A. Wolf et al. (Bingley, UK: Emerald Group Publishing Limited, 2011): 239-65.
[43] Debra Gilin Oore et al., "When Respect Deteriorates: Incivility as a Moderator of the Stressor–Strain Relationship Among Hospital Workers," *Journal of Nursing Management 18*, (2010): 878–88.
[44] Dianne M. Felblinger, "Bullying, Incivility, and Disruptive Behaviors in the Healthcare Setting: Identification, Impact, and Intervention," *Frontiers of Health Services Management 25,* no. 4 (2009): 13-23.
[45] Scott Hutton, "Workplace Incivility: State of the Science," *Journal of Nursing Administration 36,* no. 1 (2006): 22-27.
[46] Thomasson, "Health Insurance."
[47] Rubin and Schappert, eds., *Meeting Health Needs.*
[48] Charlotte Royeen, Sarah Walsh, and Elizabeth Terhaar, "Interprofessional Education: History, Review, and Recommendations for Professional Accreditation Agencies," in *Leadership in Interprofessional Health Education and Practice,* ed. Charlotte Royeen, Gail Jensen, and Robin Harvan (Sudbury, MA: Jones and Bartlett Publishers, 2009).
[49] Scott Montgomery, "Illness and Image: On the Contents of Biomedical Discourse," in *The Scientific Voice* (New York, NY: The Guilford Press, 1996).
[50] Dolly Swisher, "Professionalization and the Ethic of Care: From Silos to Interprofessional Moral Community," in *Leadership in Interprofessional Health Education and Practice,* ed. Charlotte Royeen, Gail Jensen, and Robin Harvan (Sudbury, MA: Jones and Bartlett Publishers, 2009).

Arnett[51] warns that our tendencies toward individualism have endorsed the creation of a world that is no longer structured by shared virtues.[52] The professions themselves bend towards individualism, each having spent hundreds of years differentiating themselves from rival professions, and building thick silo walls to protect their leverage in the marketplace.[53, 54, 55] Interprofessional collaborative practice, recommended by many,[56, 57, 58] asks nothing less than the tearing down of these silos. The professional clings to the silo with one hand grasping for common ground with the other. Janie Fritz offers a foothold by suggesting civility in the way we communicate with each other as "a minimal common ground of the good."[59] Drawing from the virtue ethics tradition, she refers to this professional ideal as "communicative virtue".[60] As an ethical position, then, Fritz's dialogic starting place protects and promotes respect for the other and their narrative ground – their story.

Drawing from the work of Alasdair MacIntyre, Robert Bellah, Stanley Hauerwas, Charles Taylor, and Walter Fisher, Ronald Arnett and Pat Arneson use 'narrative' to mean, "a story held in the public domain by a group of people."[61] Professionals, for

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[51] Ronald C. Arnett is Professor and chair of the department of communication and rhetorical studies at Duquesne University where he holds the Patricia Doherty Yoder and Ronald Wolfe endowed chair in communication ethics. The majority of his work focuses on communication ethics, philosophy of communication, and dialogue. He has written twelve books and countless articles and book chapters.
[52] Arnett, Fritz, and Bell, *Communication Ethics Literacy.*
[53] Larson, *The Rise of Professionalism.*
[54] Alexander Morris Carr-Saunders and Paul Alexander Wilson, *The Professions,* (Oxford: Clarendon Press, 1933).
[55] Wilensky, "The Professionalization of Everyone?"
[56] *Framework for Action on Interprofessional Education & Collaborative Practice* (Geneva, Switzerland: World Health Organization, 2010).
[57] *A Bridge to Quality*, Greiner and Knebel, eds.
[58] *Recreating Health Professional Practice for a New Century: The Fourth Report of the Pew Health Professions Commission* (San Francisco, CA: University of California, The Center for the Health Professions, 1998).
[59] Fritz, *Professional Civility,* 3.
[60] Janie M. Harden Fritz, "Civility in the Workplace," *Spectra 47*, no. 3 (2011): 11-15.
[61] Ronald C. Arnett and Pat Arneson, *Dialogic Civility in a Cynical Age* (Albany, NY: SUNY Press, 1999), xiii.

example, are embedded within one such narrative. These professional narratives carry with them unique histories and heroes that embody certain values. Arnett and Arneson connect dialogue to civility in a way that counters habitual cynicism and emphasizes a balance between idealism and negativity. Their view of effective communication is grounded in respecting difference and being open to the possibility that one's purview may change. A position of thoughtless recalcitrance to difference guarantees incivility.

Arnett claims that "difference is not just a motto or slogan; it is the life-blood of the human condition in an era in which we must learn increasingly more about the Other."[62] Arnett paraphrases Martin Buber when he says, "dialogue begins with the ground on which one stands with an openness to learn from the Other, but never a willingness to forego the ethical ground that propels and shapes the identity of a communicator […]"[63] Arnett then adds, "The two lineages of communication ethics and dialogue point to narrative ground and difference, with metaphors giving us insight into both."[64] Arnett leads us to an important, yet often overlooked issue regarding dialogue and difference. Reducing incivility can be accomplished by prioritizing professional civility through civil dialogue. Arnett and Arneson help us to see that civil dialogue focuses on being open to difference and learning about and from the other.

Dialogue, then, as an act of meeting the other on their ground and listening to their story must use an efficient and appropriate system of signification to do so. Beginning a conversation in a particular nomenclature carries with it limitations,

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[62] Ronald C. Arnett, "Situating a Dialogic Ethics: A Dialogic Confession," in *The Handbook of Communication Ethics,* ed. George Cheney, Steve May, and Debashish Munshi (New York: Routledge, 2010), 54.
[63] Arnett. "Situating a Dialogic Ethics," 56.
[64] Ibid.

elevating certain metaphors and dismissing others. Ludwig Wittgenstein famously claimed that the language one speaks indicates the limitations and boundaries of one's world.[65] The 'common language of science,'[66] of which biomedical discourse[67] is made up, is riddled with rhetorical devices that propagate metaphors of machines and war.[68, 69, 70] These metaphors, although helpful in framing disease, are not appropriate for interprofessional encounters of a narrative nature.[71]

The healthcare professions have already started breaking silo walls. Interprofessional healthcare education has become a required part of accreditation for most healthcare programs.[72] There are even interprofessional competencies that students are required to master.[73] This necessary and important movement has started the conversation. However, the conversation is still mostly carried out by empiricists in the discourse of science, limiting its effectiveness with problems such as incivility in the workplace. The core-competency approach and the move towards interprofessional

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[65] Ludwig Wittgenstein, *Tractitus Logico Philosophicus,* (New York: Routledge, 2001).
[66] Albert Einstein, "The Common Language of Science," in *Ideas and Opinions* (New York: Broadway Books, 1995).
[67] The biomedical paradigm, also known as the biomedical model, can be traced back to a 1546 proposal by Italian physician, Girolamo Fracastoro, who postulated that disease is caused by tiny 'spores' that infect the body from direct and indirect contact (*De Contagione et Contagiosis Morbis*). His early theory set the stage for germ theory, which states that microorganisms cause many diseases. Louis Pasteur sparked this movement with his insights into the causes of disease and prevention through vaccination. This new way of viewing disease replaced miasma theory, which claimed that disease was caused by bad air (John M. Last, *A Dictionary of Public Health,* (Westminster College, PA: Oxford University Press, 2007). Germ theory caused the study of medicine to become much more empirical and atomistic, a movement that has dominated Western medicine ever since. The biomedical model is reductionist in its explanation of illness, and often excludes studying that which cannot be explained in terms of biology.
[68] Judy Segal, *Health and the Rhetoric of Medicine,* (Carbondale, IL: Southern Illinois University Press, 2005).
[69] Montgomery, *The Scientific Voice.*
[70] George Lakoff and Mark Johnson, *Metaphors We Live By* (Chicago, IL: University of Chicago Press, 1980).
[71] Montgomery, *The Scientific Voice.*
[72] "Center for Interprofessional Education and Collaborative Care," Virginia Commonwealth University, accessed November 12, 2017, https://ipe.vcu.edu/utility-bar/resources/accrediting-agencies-for-vcu-health-sciences-programs/
[73] IECEP, *Core Competencies.*

competencies, outlined below, are attempts to improve the quality of healthcare;[74, 75, 76, 77] however, the accrediting bodies and professional organizations at the forefront of the conversation have been cultivated within a positivistic purview. The Interprofessional Education Collaborative (IPEC), for example, was founded in 2009 and includes members from the professions of dentistry, medicine, nursing, pharmacy, and public health.[78]

Linguistic relativity implies that the world we see is shaped by the language we use.[79] Language and thinking are inextricably linked. It is my belief that a new perspective would be helpful in dealing with the less obvious challenges presented by collaborative healthcare practice. A rhetoric and philosophy of communication perspective may be very helpful in addressing that which biomedical discourse neglects.

The Purpose and Scope of this Dissertation

The purpose of this dissertation is to answer one primary research question: *What can rhetoric and philosophy of communication contribute to educating future health care professionals about ethical collaborative practice?* Because current trends are gravitating towards interprofessional healthcare competencies[80], my response to this question will attempt to work within the existing 'competency' paradigm, more specifically, on

[74] "IOM 1972 Report: Educating for the Health Team," Institute of Medicine, accessed January 15, 2018, https://nexusipe.org/informing/resource-center/iom-1972-report-educating-health-team
[75] *A Bridge to Quality*, Greiner and Knebel, eds.
[76] Institute of Medicine, *To Err is Human.*
[77] Institute of Medicine, *Crossing the Quality Chasm.*
[78] IEPEC, *Core Competencies.*
[79] Linguistic relativity, often referred to as the Sapir-Whorf hypothesis, is a theory that the structure of an individual's language affects that individual's worldview. Some proponents of this theory believe that thought is determined by language, placing strict limits on available cognitive categories. Jane H. Hill and Bruce Mannheim, "Language and World View," *Annual Review of Anthropology 21* (1992): 381-406.
[80] IEPEC. *Core Competencies.*

"communicative virtue"[81] as a competency for interprofessional healthcare education. The plan of this work is to *add* rhetorical and philosophy of communication perspectives *to* the existing literature on healthcare competency approaches to education, but to do so with a more thorough understanding of scientific nomenclature and professionalism. With *praxis* as a priority, my goal upon completion of this treatise will be recommendations for practical application of rhetoric and philosophy of communication theory as they apply to ethical collaborative practice.

The remainder of this introduction will provide some background information on health communication, including history, scope, and approaches that have been taken when researching interprofessional healthcare communication. Healthcare education will also be briefed, including the recent shift towards competency-based approaches and interprofessional healthcare education. Finally, a roadmap for the current project will be outlined chapter by chapter.

Health Communication

The following treatise on interprofessional healthcare education will be grounded in the field of communication studies, specifically an area referred to as health communication. A brief history of health communication as a sub-discipline of communication studies will be offered and linked to the content and scope of the present dissertation.

[81] Fritz, *Professional Civility*.

History and Scope

This dissertation topic is grounded in a field of study referred to as *health communication*. Simply put, health communication is the "social process" of "creating, gathering, and sharing" of health information.[82] Health communication inquiry focuses on either "health care delivery" or "health promotion."[83] Because interprofessional healthcare education focuses on the coordination of health care professionals for the purposes of providing more effective patient care, this dissertation will be grounded in communication as it relates to the delivery of health care.

Psychologists, medical practitioners, sociologists, and rhetoricians in the 1960s began to realize the importance of communication to processes of health and healing,[84] and began writing and researching related phenomena. Since the emergence of this lens, health communication has become a popular and regular research area in the fields of communication, business, public health, and is quickly infiltrating all of the health professions.[85] Evidence for this shift is seen in publications by healthcare accreditation boards such as the American Association of Colleges of Nursing,[86] The Association of American Medical Colleges,[87] and the Accreditation Council for Pharmacy Education[88], all of which list communication as essential to healthcare education.

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[82] Gary Kreps, Ellen Bonaguro, and Jim Query, "The History and Development of the Field of Health Communication," in *Health Communication Research: Guide to Developments and Directions* ed. Lorraine D. Jackson and Bernard K. Duffy (Westport, CT: Greenwood Press, 1998), 1.
[83] Ibid., 3.
[84] Ibid., 5.
[85] "Health Communication Division," *National Communication Association,* accessed November 12, 2017, http://www.ncahealthcom.org
[86] *Essentials of Baccalaureate Education for Professional Nursing Practice, Essential VI* (Aliso Viejo, CA: American Association of Colleges of Nursing, 2008).
[87] *Functions and Structure of a Medical School: Standards for Accreditation of Medical Education Programs Leading to the MD Degree* (Chicago, IL: American Medical Association: Liaison Committee on Medical Education, 2016).
[88] *Accreditation Standards and Key Elements for the Professional Program in Pharmacy Leading to the Doctor of Pharmacy Degree* (Chicago, IL: Accreditation Council for Pharmacy Education, 2015).

The concept of health communication as a field emerged in the late 1960s with the publication of Korsch et al.'s study of patient satisfaction in physician-patient encounters.[89] More formal establishment occurred in 1972 when the International Communication Association established the Therapeutic Communication Interest Group, thus giving health communication an academic home and legitimizing research.[90] The name was changed to 'Health Communication' in 1975.[91] This was followed in 1979 when the American Academy on Communication in Healthcare was established to promote research and education.[92] The primary research focus at this time (1960s-1970s) was on patient satisfaction[93, 94, 95] and recall, understanding, and adherence.[96, 97] In 1985, the National Communication Association formed what would become the health communication division[98], in 1989 the journal *Health Communication* was introduced by Teresa Thompson[99], and in the mid-1990s health communication courses started being offered as part of both graduate and undergraduate majors.[100] Around the same time, Tufts University School of Medicine and Emerson College offered the first M.S. in health

[89] Barbara M. Korsch, Ethel K. Gozzi, and Vida Francis, "Gaps in Doctor-Patient Communication: Doctor-Patient Interaction and Patient Satisfaction," *Pediatrics 42,* no. 5 (1968): 855-71.
[90] "History of NCA's Health Communication Division," National Communication Association*,* accessed November 12, 2017, http://www.ncahealthcom.org/History.html
[91] Ibid.
[92] "Mission and Vision," Academy of Communication in Healthcare*,* accessed November 12, 2017, http://www.achonline.org/About-ACH/Mission-Vision
[93] Korsch, Gozzi, and Francis, "Gaps in Doctor-Patient Communication."
[94] Klea D. Bertakis, "The Communication of Information from Physician to Patient: A Method for Increasing Patient Retention and Satisfaction," *Journal of Family Practice 5,* no. 2 (1977): 217–22.
[95] William B. Stiles et al., "Interaction Exchange Structure and Patient Satisfaction with Medical Interviews," *Medical Care 17,* no. 6 (1979): 667–81.
[96] Vida Francis, Barbara M. Korsch, and Marie J. Morris, "Gaps in Doctor-Patient Communication: Patients' Response to Medical Advice," *New England Journal of Medicine 280*, no. 10 (1969): 535–40.
[97] Philip Ley et al., "Increasing Patients' Satisfaction With Communications," *British Journal of Social Clinical Psychology 15,* no. 4 (1976): 403–13.
[98] "History of NCA's Health Communication Division." NCA.
[99] Kreps, Bonaguro, and Query, "The History and Development of Health Communication," 1-15.
[100] Ibid.

communication.[101] These collegiate programs were followed by governmental agencies forming research divisions dedicated to health communication.[102] A shift occurred in the mid-1990s with a focus on public health (partially due to the AIDS epidemic) and national attention being aimed at the American Public Health Association, dedicated to promoting public health. This was evident in the 1995 establishment of National Public Health Week and in 1999 when the APHA headquarters was relocated to Washington DC.[103] Also in 1999, The National Institutes of Health (NIH) created the Health Communication and Informatics Research Branch (HCIRB) dedicated to communicating information about cancer to targeted populations.[104] In 2004, the Centers for Disease Control and Prevention (CDC) created the National Center for Health Marketing (NCHM) for compiling marketing data.[105] The social marketing approach to health communication is often used as an effective way of broadcasting health information to targeted consumer groups.[106]

Health communication has also made its way into the clinical environment. Two examples are SBAR and the COMFORT model. SBAR[107] stands for Situation, Background, Assessment, and Recommendation. SBAR is a structured communication

[101] Ibid.
[102] Ibid.
[103] "Notable Dates," American Public Health Association, accessed November 12, 2017, https://www.apha.org/news-and-media/newsroom/online-press-kit/apha-history-and-timeline/notable-dates
[104] "Health Communication and Informatics Research Branch," National Institute of Health: Division of Cancer Control & Population Sciences, Behavioral Research Program, accessed November 12, 2017, https://cancercontrol.cancer.gov/brp/hcirb/
[105] "National Center for Health Marketing (CPB)," Centers for Disease Control and Prevention, accessed November 12, 2017, https://www.cdc.gov/maso/pdf/nchmfs.pdf
[106] *Making Health Communication Programs Work* (Washington, DC: National Cancer Institute, 2004).
[107] Kathleen M. Haig, Staci Sutton, and John Whittington, "SBAR: A Shared Mental Model for Improving Communication Between Clinicians," *Joint Commission Journal on Quality and Patient Safety 32,* (2006): 167-75.

protocol that facilitates clear and concrete information-sharing. The COMFORT[108] model is used mostly in end-of-life care. Each letter stands for a principle that is useful in these health care environments. They are Communication, Orienting, Mindfulness, Family, Openings, Relating, and Teamwork. The COMFORT model is much more ambiguous than the SBAR protocol; however, leaves room for interpretation and meaning making. Although helpful, it is worth noting that both of the communication models listed above come from outside the field of communication. They are born, not philosophically, but from necessity. Inherently, then, communication models that are born from science become tools for efficiency.

To understand health is to enter a complex and ongoing process that spans countless disciplines and sub-disciplines, studying both the physical world as well as the world of experience and phenomena.[109, 110, 111] To understand communication is equally complex and multidisciplinary. Communication scholars must also study worlds both material and phenomenological. Understanding the interplay of health and communication creates a two-by-two, with concrete, material observations and explications on one axis and vague, experiential encounters on the other. We also see various research areas emerge as these discipline-specific focus areas encounter physical and metaphysical worlds. One such area is Interprofessional Health Communication, or the communication and collaboration of and between health care teams.

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[108] Elaine M. Wittenberg-Lyles et al., "The COMFORT Initiative: Palliative Nursing and the Centrality of Communication." *Journal of Hospice and Palliative Nursing 12,* (2010): 282-94.
[109] Segal, *Health and the Rhetoric of Medicine.*
[110] Hans-Georg Gadamer, *The Enigma of Health: The Art of Healing in a Scientific Age,* trans. Jason Gaiger and Nicholas Walker (Palo Alto, CA: Stanford University Press, 1993).
[111] Fredrik Svenaeus, "The Phenomenology of Health and Illness," in *Handbook of Phenomenology and Medicine,* ed. S. Kay Toombs (Dordrecht, The Netherlands: Kluwer Academic Publishers, 2001).

Interprofessional Health Communication

Health Communication researchers have studied healthcare education and have also been vocal in the area of interprofessional education; however, the communication literature is lacking when it comes to rhetorical and philosophical approaches to interprofessional *healthcare* education (IPE). Most of the current approaches to IPE focus on the interprofessional communication of health care teams; and, for the most part, views communication *scientifically*, as mere information exchange.

Marshall Scott Poole[112] and Kevin Real examined health care team communication from the perspective of group dynamics. They sought to understand teams by studying five variables: interaction, interdependence, boundedness (level of supervision), commonality, and motivation to work together. Poole and Real created a health care team typology based on the different level/degree to which each variable is prevalent. The typology breaks health care groups into six categories: *ad hoc* (short period of time with short-term goals), *nominal care* (primary care physician makes the decisions and directs other professionals through consultation), *uni-disciplinary* (team is organized around a single discipline such as orthopedic surgery), *multi-disciplinary* (professionals from different disciplines worth beside each other, but remain independent, as often occurs in cancer treatment), *inter-disciplinary* (professionals from two or more disciplines work interdependently, make decisions together, and integrate), and *trans-*

[112] Marshall Scott Poole is Professor of communication at the University of Illinois. Author of several book chapters and peer-reviewed articles, his research interests include group communication, organizational communication, and information systems. Poole is also the Director of The Institute for Computing in the Humanities, Arts, and Social Sciences where he currently studies communication in virtual worlds.

disciplinary (professionals of a health care team are proficient in their discipline, but are cross-trained in another resulting in an overlap of health care competencies).[113]

Building upon their previous research on health care team typologies, Kevin Real and Marshall Scott Poole applied McGrath's input-process-output model[114] (IPO) to health care team communication. Their model is helpful in showing how the communication structures (inputs) such as meetings, briefings[115], checklists[116, 117], and communication channels can cause certain communication processes that, in turn, effect outcomes (output).[118] Poole and Real's work is helpful. By categorizing health care teams, it becomes more difficult to examine all health care teams in the same way. Context matters. By examining the effects of underlying structures on communication, they also help to show how certain structures can facilitate or limit constructive health care communication. Their treatment of interprofessional communication, however, remains solely transactional.

In contrast to the information exchange models, some scholars have studied health care teams using an interpretive approach. One popular perspective within this approach is social constructionism. A well-known example is Sutcliffe, Lewton, and Rosenthal's

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[113] Marshall Scott Poole and Kevin Real, "Groups and Teams in Health Care: Communication and Effectiveness," in *Handbook of Health Communication*, ed. Teresa L. Thompson et al. (Mahwah, NJ: Lawrence Erlbaum Publishers, 2003), 369-402.
[114] Joseph Edward McGrath, *Groups: Interaction and Performance* (Englewood Cliffs, NJ: Prentice Hall, 1984).
[115] Lorelei Lingard et al., "Towards Safer Interprofessional Communication: Constructing a Model of "Utility" from Preoperative Team Briefings," *Journal of Interprofessional Care 20,* (2006): 471-83.
[116] Alex B. Haynes et al., "A Surgical Safety Checklist to Reduce Morbidity and Mortality in a Global Population," *New England Journal of Medicine 360*, no. 5 (2009): 491-99.
[117] Lorelei Lingard et al., "Getting Teams to Talk: Development and Pilot Implementation of a Checklist to Promote Safer Operating Room Communication," *Quality and Safety in Health Care 14,* no. 5 (2005): 340-46.
[118] Kevin Real and Marshall Scott Poole, "Health Care Teams: Communication and Effeciveness," in *The Routledge Handbook of Health Communication,* 2nd ed, ed. Teresa L. Thompson, Roxanne Parrot, and Jon F. Nussbaum (New York: Routledge, 2011), 100-16.

examination of a teaching hospital. This example works well here because it focuses on interprofessional health care education. The researchers interviewed residents at a teaching hospital and asked them about their daily routines and medical mishaps they had experienced. Of the 70 reported medical mishaps, poor communication was the most common contributing factor. The residents admitted to being "embedded in a complex network of relationships," that affected their ability to manage patients. The researchers described 'poor communication' as "not simply the result of poor transmission or exchange of information." Instead they argue that it is much more complicated; poor communication involves factors such as "hierarchical differences, concerns with upward influence, conflicting roles and role ambiguity, and interpersonal power and conflict."[119] Sutcliffe et al. purposefully move away from the transactional model and imply that we need to focus more on meaning.

The following year, Eisenberg et al. were exploring miscommunication in emergency rooms. They identified miscommunication in patient evaluations, in the hand-off process, and the admission process. The issues, they argue, are not with information exchange, but with interpretation. As an example they explain how the stories told by the patient, "narrative rationality," are often incommensurate with the "technical rationality" of the professional health care providers.[120] Meaning becomes compromised in translation. Scientific approaches to human communication are helpful, especially for diagnosis and treatment, but to fully understand the dynamics of communication in action, issues of interpretation must always be included.

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[119] Kathleen M. Sutcliffe, Elizabeth Lewton, and Marilynn M. Rosenthal, "Communication Failures: An Insidious Contributor to Medical Mishaps," *Academic Medicine 79,* (2004): 186-94.
[120] Eric M. Eisenberg, "Communication in Emergency Medicine: Implications for Patient Safety," *Communication Monographs* 72, (2005): 390-413.

These examples are far from comprehensive, but provide a glimpse into the minds of those concerned with communication as it relates to professional collaboration in health care settings. These studies are representative of the dominant approaches and perspectives to this area of research. This dissertation is an attempt to enter the conversation. If a scientific paradigm has dominated interprofessional health communication reform to this point, specifically within educational environments, then a rhetoric and philosophy of communication approach may provide an appropriate counter-statement to help offset the atomistic, mechanical language that can lead to interpretive difficulties and patient mishaps.

Communication is one of the 'four' interprofessional competencies listed by IEPEC.[121] The mere inclusion of communication as a competency implies a sender-receiver, or transactional model of communication. This assumption carries with it the baggage of a positivistic worldview, distanced from seeing communication as lived experience. If, instead we viewed communication as a tool for creating our identity, shaping our social world, and building interpersonal and interprofessional bridges by navigating alterity, we begin to see communication as much, much more than a competency. A rhetoric and philosophy of communication perspective has rarely been applied to interprofessional health care communication. However, if communication is taught as a process, as it is in the transactional model, it becomes difficult to escape the scientific mindset and truly encounter the other. In order to more fully comprehend the challenges embedded within health care education in the current historical moment, it is

[121] IEPEC. *Core Competencies.*

necessary to review recent changes within the health care education environment, specifically the shift towards competencies and interprofessional practice.

Healthcare Education

At some level, all of us participate in health communication in our personal lives. Many, however, choose to enter healthcare professions where health communication becomes central to their careers. For these professionals, more specific communication training is helpful in learning to communicate health information to diverse populations.

Healthcare education itself has a long and storied tradition dating back to the times of Hippocrates and the Hippocratic School of Medicine. [122] Because of the breadth and depth of healthcare education in general, I will begin this review of literature by looking at the shift towards competencies in healthcare education as well as the shift from traditional healthcare education to interprofessional healthcare education. This shift prioritizes health teams over individual physicians and recognizes the increasing demands on healthcare professionals within the current organizational environment.

A Shift Towards Competency

Healthcare has always been a challenging professional environment. Constant technological innovation, policy changes, and a competitive business environment make healthcare environments difficult to predict. This makes preparing future healthcare professionals equally difficult. Exacerbating this complexity is an ever-changing patient population. Today's patients are more diverse[123] and are more likely to be living with a

[122] Hippocrates is widely known as the father of Western medicine. He was a proponent of using scientific methodologies in the art of medicine. Hippocrates believed that illnesses had natural causes. He promoted cleanliness of water, hands, and instrumentation more than 2,000 years before Semmelweis's germ theory of disease. He is well known for the Hippocratic Oath, which is an ethical standard sworn by physicians to this day with a core sentiment of non-maleficence.

[123] US Census Bureau data estimates that by 2043 minority populations will become a majority. By 2060, one-third of Americans will be Hispanic (more than double what they are today), black Americans will

chronic illness such as diabetes.[124] These issues become more complicated when we consider the fact that health care workers are and will be increasingly less diverse when compared with the overall population. The U.S. population consists of approximately 30 percent minorities, while only nine percent of physicians and six percent of registered nurses are minorities.[125, 126] Because of this disparity, intercultural communication competence has become a useful skill in healthcare settings.

Additionally, the cost of health care has created a challenging health climate for both providers and patients.[127] These added challenges require health care providers to be ever more efficient individually and as a member of a healthcare team. Because of the somewhat new emphasis on teamwork, students entering the health professions should be trained for this environment. This has been the impetus for education reform to include interprofessional healthcare education. "Interprofessional education and interprofessional collaboration have not often found a place in the education and practice of health." Furthermore, "silo-like division of professional responsibilities […] impacts delivery of services [*and is not*] integrated in a manner which meets the needs of both clients and the

comprise nearly 15 percent of the US population, and Asian Americans will constitute more than 8 percent. Additionally, within the same time span, the number of Americans over the age of 65 will double to approximately 92 million. This data has been taken from a census.gov report: Sandra Colby and Jennifer Ortman, "Projections of the Size and Composition of the U.S. Population: 2014 to 2060," last modified March, 2015, https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf

[124] According to the CDC, more than 115 million Americans are living with diabetes or prediabetes. This disease is responsible for more than 20% of health care spending. Information retrieved from the CDC website: "Diabetes: Working to Reduce the US Epidemic at a Glance 2016," Centers for Disease Control and Prevention, accessed March 16, 2017, https://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2016/diabetes-aag.pdf

[125] Ellyn Boukus, Alwyn Cassil, and Ann S. O'Malley, "A Snapshot of U.S. Physicians: Key Findings from the 2008 Health Tracking Physician Survey," *Center for Studying Health System Change 35*, (2009): 1-11.

[126] "Nursing Statistics, 2009," Minority Nurse, accessed January 15. 2017, http://minoritynurse.com/minority-nursing-statistics

[127] Rubin and Schappert, eds., *Meeting Health Needs in the 21st Century.*

professionals."[128] This lack of professional collaboration that is seen in the professional world can be seen also in the academic world. It makes sense, then, to begin this shift towards effective, professional collaboration at the university level.

Numerous publications from The Institute of Medicine (IOM) show weaknesses in academic preparation for new graduates entering health professions.[129, 130, 131] These reports show inadequacies in understanding patient populations as well as a lack of team-based skills. The IOM, thus, recommends educational reforms to address these areas, saying it is a crucial step for improving health care quality.[132] Along with a report calling for new safety standards[133], the IOM also reported the need to focus more broadly on quality-related issues. To address the latter, the IOM called for education reform stating that although certain changes have been made throughout the last century in healthcare education, "the fundamental approach to clinical education has not changed since the Flexner report of 1910."[134] The IOM research previously listed prompted the creation of a committee called the Committee on the Health Professions Education Summit (CHPES). Professionals from the various health fields gathered to discuss ways to better prepare the workforce to deal with the *Quality Chasm*. This particular IOM report included the need for skills such as "transparent communication, collaboration among health professionals, and the use of evidence in clinical decision-making for all health professionals."[135] The

[128] Danielle D'Amour and Ivy Oandasan, "Interprofessionality as the Field of Interprofessional Practice and Interprofessional Education: An Emerging Concept," *Journal of Interprofessional Care 1S*, (2005): 9.
[129] *A Bridge to Quality*, Greiner and Knebel, eds.
[130] Institute of Medicine, *To Err is Human.*
[131] Institute of Medicine, *Crossing the Quality Chasm.*
[132] *A Bridge to Quality*, Greiner and Knebel, eds.
[133] Institute of Medicine, *To Err is Human.*
[134] Institute of Medicine, *Crossing the Quality Chasm.*
[135] Gail Jensen, Robin Harvan, and Charlotte Royeen, "Interprofessional Education: Context, Complexity, and Challenge," in *Leadership in Interprofessional Health Education and Practice,* ed. Charlotte Royeen, Gail Jensen, and Robin Harvan (Sadbury, MA: Jones and Bartlett Publishers, 2009).

CHPES meetings yielded a list of core competencies that could be applied to all of the many health professions. The list included providing patient-centered care, working in interdisciplinary teams, employing evidence-based practice, applying quality improvement, and utilizing informatics.[136] While other competencies are important, the Committee believed that standard competencies across curriculums would be the best way of achieving more consistent patient-centered care. This is the origin of competency-based education for health professionals.

Competency Approaches to Health Care Applied to Professional Development

Upon entering the 21st century, there became a growing interest in competency-based educational models with the overarching goal of improving individual and corporate performance in the health care industry. An Institute of Medicine report exemplified this vision, arguing for a "core set of competencies across the professions."[137] The report argues that improving healthcare quality can only be accomplished through educational reform and professional development. This shift in healthcare pedagogy was partially in response to earlier IOM reports that highlighted major shortcomings in the American healthcare system.[138, 139] The Joint Commission, an independent health care accreditation and certification organization, published a paper claiming support for competency-based education from "many educational accreditation and professional certification bodies across the health professions."[140] The growing

[136] Ibid., 7.
[137] *A Bridge to Quality*, Greiner and Knebel, eds.
[138] Institute of Medicine, *To Err is Human*.
[139] Institute of Medicine, *Crossing the Quality Chasm.*
[140] *Health Care at the Crossroads: Strategies for Improving Health Care Profession Education* (Oakbrook Terrace, IL: The Joint Commission, 2005).

consensus for competency-based education is not inherently a negative phenomenon; it does, however, raise new questions.

While the various professions are determining their own competency priorities, another movement was occurring within health care education. Health care is administered in most settings, not from a bedside physician, but by a health care team. Interprofessional collaboration became its own area of focus, with its own core competencies to consider. A consortium of colleges gathered in 2011 to deliberate this new area of focus.

It is important to differentiate here the core competencies for health professionals from the core competencies for interprofessional healthcare education. The interprofessional competencies are a subset of "working in interdisciplinary teams" addressed by the CHPES and the IOM. This dissertation will focus solely on interprofessional healthcare education because anything related more specifically to the health professions may fall outside the scope of communication studies, rhetoric, and philosophy of communication.

Interprofessional Healthcare Education

According to the World Health Organization, *interprofessional education* is defined as "students from two or more professions learn[ing] about, from and with each other to enable effective collaboration and improve health outcomes."[141] The same WHO report defines *interprofessional collaborative practice* as "multiple health workers from different professional backgrounds work[ing] together with patients, families, carers [sic], and communities to deliver the highest quality of care."[142] The Interprofessional

[141] *Framework for Action,* World Health Organization.
[142] Ibid.

Education Collaborative uses these definitions from the WHO, and they are provided here to offer operational definitions of the terms. We see from these definitions that the common term, *interprofessional*, carries with it an element of action, albeit interaction. It is the learning and the working that matters. Thus, when we see *interprofessional*, we may assume a working and learning together of professionals and aspiring professionals. The goal of interprofessional health care education is to teach students to become functional members of a health care team. According to the Institute of Medicine (IOM) "An interprofessional team is composed of members from different health professions who have specialized knowledge, skills, and abilities."[143] The team has a shared goal of providing patient-centered care, which is accomplished dialectically, by "synthesizing their observations and profession-specific expertise" to make collaborative decisions for "optimal patient care."[144] Although the Center for Advancement of Interprofessional Education (CAIPE) admits that there are many different definitions of interprofessional education, some elements are common to the CAIPE, the WHO, and the IOM.

Table 1
Common elements of interprofessional education

IPE Includes	Learners from two or more health professions The joint creation of a collaborative learning environment Developing knowledge, skills, and attitudes that promote teamwork Focus on interprofessional interaction and reflection Focus on shared decision-making and responsibility
IPE Does Not Include	Members of only one health profession discussing IPE IPE curriculum created by member(s) of only one health profession Lack of reflective interaction among different health professionals Faculty members failing to relate topics to interprofessional interactions Single perspective clinical experiences with no shared decision-making

Table 1 highlights the collaborative, reflective, and interaction-centered nature of IPE.

[143] *A Bridge to Quality*, Greiner and Knebel, eds.
[144] Ibid.

The interprofessional education movement in health care was partially in response to a publication from the Pew Health Professions Commission identifying areas of needed reform and calling for professional health care programs to include interdisciplinary collaboration[145] and require standards for competency.[146] The Pew report was not the first to highlight the benefits of interprofessional practice, but it was more a catalyst for change at the curriculum level.

In the late 1960s, the Department of Health, Education, and Welfare called for a decrease in divided labor within health care fields.[147] Early attempts to create interdisciplinary programs we not very effective. Students did not like the training, often did not show up, and did not recommend the training to others[148]; however, early attempts at interdisciplinary training offered valuable insights for future curricular design. For instance, while participating in these interprofessional programs, "student satisfaction increased when they were allowed to maintain their professional identity."[149] These findings illustrate the importance of having a professional 'home' when working in interdisciplinary groups. Abdicating one's professional identity in a collaborative environment leaves behind the gift of that professional's unique perspective and creates professional refugees.

Insights such as this helped guide health care education in the 1970s, leading to expansion of interdisciplinary programs.[150] During this decade, both the WHO and IOM

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[145] Daniel A. Shugars, Edward H. O'Neill, and James D. Bader. *Healthy America: Practitioners for 2005. An Agenda for Action for US Health Professional Schools* (Durham, NC: The Pew Health Professions Commission, 1991).
[146] *Recreating Health Professional Practice for a New Century.* Pew.
[147] Lavin, "Interdisciplinary Health Professional Education."
[148] Ibid.
[149] Royeen, Walsh, and Terhaar, "Interprofessional Education," 30.
[150] Patricia Hinton Walker et al., "Building Community: Developing Skills for Interprofessional Health Professions Education and Relationship-Centered Care." *Journal of Allied Health 27*, (1998): 173-78.

supported interdisciplinary education[151] and the US federal government offered funding opportunities for professional higher education programs to incorporate proven concepts into their curriculum.[152] By the end of the 1970s, to address duplicity in courses, "basic science colleges" were created as institutions of collaboration to act as an efficient pipeline to more specialized professional training.[153] We cannot call this education 'interprofessional,' due to the fact that undergraduate students do not yet have a professional identity.

Changes in leadership during the 1980s saw the US separate from the rest of the world in its interprofessional education trajectory. The rest of the world expanded the reach of IPE in many areas of practice. For instance, *The Journal for Interprofessional Care* arrived in the UK in 1986 and The Center for the Advancement of Interprofessional Professional Education was established a year later. While developed nations were expanding the breadth and depth of IPE, the US government cut funding in nearly all areas of collaborative education. One exception was in the field of gerontology, which had multiple sources of funding.[154] Research in the late 80s often had a critical edge, often highlighting the benefits of IPE and arguing that student growth and patient outcomes should trump politics and fiscal shortsightedness.[155] Around the same time the WHO called for health care education programs to focus programs towards the needs of

[151] Baldwin, "Some Historical Notes."
[152] Claire Hale, "Interprofessional Education: The Way to a Successful Workforce," *British Journal of Therapy and Rehabilitation 10*, (2003): 122-27.
[153] Lavin. "Interdisciplinary Health Professional Education."
[154] Royeen, Walsh, and Terhaar, "Interprofessional Education."
[155] David G. Satin, "The Difficulties in Interdisciplinary Education: Lessons from Three Failures and a Success," *Educational Gerontology* 13, (1987): 53-69.

the populations. The report highlights "multiprofessional education" as "one such program."[156]

The transition to the 1990s saw rising health care costs resulting in an increase in people without health insurance. At the same time, evidence was growing that the US health system was failing its citizens.[157] The obvious need for greater efficiency directly resulted in attention being redirected to interprofessional education; however, endeavors were still grossly underfunded.[158] Nonetheless, subsequent research on interprofessional healthcare education highlights ten main barriers. Funding, as mentioned, is the first, followed by faculty that were not trained interprofessionally,[159] resistance from faculty and students,[160] strong traditional pressure,[161] perceived status and power disparities among different professions,[162] lack of time, physical resources,[163] language (refer to the 'language of science' discussion above), administrative naïveté about the value of IPE,[164] and finally accreditation (perhaps a necessary barrier, but a barrier nonetheless). These barriers differ in type and complexity. Some are resource-prohibitive (funding, time, space); some are bureaucratic in nature (administration, accreditation), while others

[156] *Learning Together to Work Together for Health: Report of a WHO Study Group on Multiprofessional Education of Health Personnel: The Team Approach* (Geneva, Switzerland: World Health Organization, 1988).
[157] Baldwin, "Some Historical Notes."
[158] Valentina L. Brashers et al., "Interprofessional Health Care Education: Recommendations of the National Academies of Practice Expert Panel on Health Care in the 21st Century," *Issues in Interdisciplinary Care, National Academies of Practice Forum 3*, (2001): 21-31.
[159] Royeen, Walsh, and Terhaar, "Interprofessional Education."
[160] Swisher, "Professionalization and the Ethic of Care."
[161] Royeen, Walsh, and Terhaar, "Interprofessional Education."
[162] Swisher, "Professionalization and the Ethic of Care."
[163] Stephanie F. Gardner et al., "Interdisciplinary Didactic Instruction at Academic Health Centers in the United States: Attitudes and Barriers," *Advances in Health Science Education: Theory and Practice 7*, no. 3 (2002): 179-90.
[164] Royeen, Walsh, and Terhaar, "Interprofessional Education."

require a shift in perspective – the very thing IPE is designed to provide. These barriers are outlined in Table 2.

Table 2
Interprofessional health care education barrier types

Resource Prohibitive	Funding Time Space
Bureaucratically Prohibitive	Lack of Perceived Value by Administration Accreditation
Perspective Prohibitive	Faculty and Student Resistance Tradition (IPE requires change to *status quo*) Faculty Not Trained in IPE Perception of Disparities in Power and Status Language

Like all barriers, there has to be a motivation to move forward. The ever-growing body of research, beginning in the 1960s, has started to provide the *logos* for persuasion. Today, evidence showing the benefits for interprofessional healthcare education is vast,[165, 166, 167, 168, 169, 170, 171] and can directly be associated with improvements in both health care delivery and patient outcomes.[172]

[165] Noelle C. Andrus and Nancy M. Bennett, "Developing an Interdisciplinary, Community-Based Education Program for Health Professions Students: The Rochester Experience," *Academic Medicine 81,* no. 4 (2006): 326–31.
[166] Scott A. Banks and Kristin K. Janke, "Developing and Implementing Interprofessional Learning in a Faculty of Health Professions," *Journal of Allied Health 27,* no. 3 (1998): 132-36.
[167] Gillian Barrett, Rosemary Greenwood, and Kath Ross. "Integrating Interprofessional Education Into 10 Health and Social Care Programmes," *Journal of Interprofessional Care 17,* no. 3 (2003): 293–301.
[168] Melissa Blair Gilkey and Jo Anne L.Earp. "Effective Interdisciplinary Training: Lessons from the University of North Carolina's Student Health Action Coalition," *Academic Medicine* 81 no. 8 (2006): 749–58.
[169] Charles B. Hamilton, C. Alex Smith, and Janice M. Butters, "Interdisciplinary Student Health Teams: Combining Medical Education and Service in a Rural Community-Based Experience," *Journal of Rural Health 4*, no. 13 (1997): 320-28.
[170] Joanie M. Hope et al., "Bringing Interdisciplinary and Multicultural Team Building to Health Care Education: The Downstate Team-Building Initiative," *Academic Medicine 80,* no. 1 (2005): 74–83.
[171] Alan W. Johnson et al., "CLARION: A Novel Interprofessional Approach to Health Care Education." *Academic Medicine 81* no. 3 (2006): 252-56.
[172] Scott Reeves et al., "Interprofessional Education: Effects on Professional Practice and Health Care

More recently however, with the intent to create a more homogenous understanding of interprofessional education, the IOM has worked to develop core competencies for health professions education (not to be confused with Interprofessional Health Care Education Competencies). These are competencies that all health professionals should have upon graduation. These include the ability to "work in interdisciplinary teams: cooperate, collaborate, communicate, and integrate care in teams to ensure that care is continuous and reliable."[173] Furthermore, competencies that should be achieved through interprofessional education are "team organization and function, assessing and enhancing team performance, intrateam communication, leadership, resolving conflict and consensus building, and setting common patient care goals."[174] As the concepts of IPE become more concrete, it is clear to see the emergence and evolution of a competency approach to interprofessional health care education. These competencies inevitably focus on optimizing professional strengths through teamwork, effective communication, understanding roles and professional responsibilities, and working towards a common, patient-centered goal.

A Competency Approach to Interprofessional Healthcare Education: The IECEP Model

The Interprofessional Education Collaborative is made up of the American Association of Colleges of Nursing, the American Association of Colleges of Osteopathic Medicine, the American Association of Colleges of Pharmacy, the American Dental Education Association, the Association of American Medical Colleges, and the

Outcomes (update)," *Cochrane Database of Systematic Reviews 23,* no. 1 (2013): CD002213.
[173] *A Bridge to Quality*, Greiner and Knebel, eds.
[174] Shauna M. Buring et al., "Interprofessional Education: Definitions, Student Competencies, and Guidelines for Implementation," *American Journal of Pharmaceutical Education 73,* no.4 (2009): 59.

Association of Schools of Public Health. The collaborative embodies the CAIPE, WHO, and IOM concepts of interprofessional education. This expert panel published a report[175] that outlined a vision of interprofessional collaboration in healthcare achieved by a *core-competency* approach to interprofessional health care education. The goal of this education is to train students so that they enter the workforce able to work within a health care team, so as to deliver team-based care.

The interprofessional collaborative competencies build upon the specific disciplinary competencies, which, of course, are different for each profession (and for different roles and specialties within a profession). The expert panel also mentions the need for students to begin interacting across disciplines while they are still students. By "deliberately working together,"[176] students should be better prepared to create and maintain patient-centered health care systems. The IECEP report lists four main competencies for interprofessional health care education. They are Ethics/Values, Roles/Responsibilities, Communication, and Teamwork.

Organization: Structure of the Dissertation

The first chapter introduced us to health communication including the history and scope. The argument was introduced that interprofessional healthcare education is something health communication has neglected. Insights into the current state of healthcare education were given including competency-based approaches to both healthcare education and interprofessional healthcare education. The organization of the rest of the project will be discussed below.

[175] IECEP, *Core Competencies.*
[176] IECEP, *Core Competencies,* 3.

The second chapter examines the history and evolution of the various healthcare professions in an attempt to better understand the concept of *interprofessional*. Researching the origins and evolution of the professional may offer insights that could help explain many of the challenges inherent with interprofessional practice. The concept of the 'professional' carries with it associated concepts of prestige, education, expertise, and a certain level of autonomy. It may be assumed that professionals are individuals that have endured a rigorous and specialized training. It may also be assumed that 'professional behavior' brings with it an increased expectation to be ethical. Healthcare professionals are part of a moral community, and with this membership come accountability, certification, standardization, and trust. Though these associations easily come to mind today when we think of professionals, it was not always the case. Tracing the origins of the professions back through history, we find an intimate relationship between professions, governments, ideologies, social status, and autonomy. Because this dissertation examines the relationships *between* professions, better understanding what we mean by professional is relevant to this dissertation and is worth exploring.

The chapter begins by examining the history of professions, and then examines the professionalization of healthcare characterized by differentiation. Characteristics of pre-industrial and modern professionalism are then compared. This section is followed by an introduction to interprofessionality, which, in this context, is situated within the healthcare professions. Insights and definitions from Janie Fritz as well as the Interprofessional Education Collaborative Expert Panel lead this section. The chapter ends with a discussion of the professional 'oath' as an *act* of professing values. The oaths of various health professions are compared.

The third chapter addresses the language of science. The language we use shapes our world; therefore, this chapter examines the nature of biomedical discourse and its potential effects on interprofessional healthcare education. From the time of Francis Bacon, scientific discourse has necessarily objectified, distanced, and de-humanized that which it examines, while ignoring the phenomenological experience of everyday life. Scientific discourse as a tool for rational thinking is helpful; yet the language has become synonymous with truth itself. Rules have been convoluted with function. This chapter explores the history and evolution of scientific discourse including its hidden agenda of: exclusion, personification of processes and results, elevation of content over authorship, and the separation of morality. Issues of accessibility and power inherent in scientific language create interprofessional barriers that can hinder cooperative practice. This chapter relies heavily on Scott Montgomery's *Scientific Voice,* which draws insight from Michel Foucault, Jean-Paul Sartre, Ludwig Wittgenstein, J. L. Austin, John Searle, Roland Barthes, and Jacques Derrida. Additionally, postmodern insights from Mikhail Bakhtin and Jean Francois Lyotard are included. The chapter ends with a discussion on Dialectic Shifting as a possible skill to counteract the hidden effects of scientific discourse.

In the fourth chapter, rhetoric and philosophy of communication is offered as a complementary approach to biomedical discourse. The chapter is divided into two parts: philosophy of communication and rhetoric. A brief overview and approaches to each will be discussed. The first half of the chapter introduces philosophy of communication as a counter-statement to scientific discourse. When communication is taught scientifically, as a process, it becomes difficult to escape the scientific mindset and truly encounter the

other. A philosophy of communication perspective allows us to recognize preconceptions in our own use of language. It allows us to recognize alterity as part of the human condition and offers a framework for approaching the other on their narrative ground. A philosophy of communication perspective brings to the foreground the ethics and values, which are veiled in scientific discourse. Philosophy of communication shifts the focus from processes to content, namely content-focused dialogue, which inherently breathes life back into the author. Communication is lived experience. It creates and modifies the social world; and, because this dissertation is concerned with learning how to collaborate interprofessionally, learning what matters to the other must be given primacy. This section is informed primarily by Ronald C. Arnett, Pat Arneson, Ramsey E. Ramsey, and Martin Heidegger. This section ends by looking at Hans-Georg Gadamer's *The Enigma of Health*, which describes health as a phenomenon.

The contemplative nature of philosophy discovers content that is materialized via the tools of rhetoric. Therefore, the second half of chapter two provides an overview of rhetoric, which ends with applications to interpersonal interactions in healthcare settings. Namely, rhetoric can be used to build trust, provide hope, instill values, educate patients and cohorts, shift perceptions about illness and the body, and improve compliance. Closer to the scope of this dissertation, rhetoric can also be used to negotiate professional identities within healthcare settings. Professor of rhetoric Judy Z. Segal's *Health and the Rhetoric of Medicine* will be used to bring rhetoric into the domain of healthcare. She draws from the works of Aristotle, Michel Foucault, Perelman and Olbrechts-Tyteca, Kenneth Burke, and Lakoff and Johnson to illustrate the role of rhetoric in professional

healthcare settings. Rhetoric is useful here because, although it is a discipline unto itself, it is interdisciplinary by nature.

Chapter five uses insights from the previous four chapters to discuss ethics and values for interprofessional healthcare practice and education. The need for interprofessional discussion of values and ethics is in direct response to the ever-increasing prominence of team-based care. Before this movement, physicians were the primary health care provider. While each specialty has made progress away from the paternalism of the 20th century, these changes have happened within the boundaries of each profession. Traditional, silo-like professionalism is embedded with concepts, values, and ethics that are specific to one specialty and often conflict with other professions. Defining values and ethics within an interprofessional competency pries these concepts from their individual professions and attempts to create a collaborative value structure from which to build cohesive healthcare teams.

This chapter will approach interprofessional ethics from a rhetoric and philosophy of communication perspective by first grounding healthcare in a moral community with patient care as a universal common good. In order to enter the current conversation, it is important to know what has been done so far. Three current approaches to ethics and values of interprofessional healthcare education will be discussed. I will enter this conversation with a philosophical lens, with a brief discussion of ethical theory followed by a thorough discussion of the Virtue Tradition. Drawing heavily on Alasdair MacIntyre and Edmund Pellegrino, I will bring the virtues into the healthcare professions with an in-depth look at the virtues of trust, compassion, phronesis, justice, fortitude, temperance, integrity, and self-effacement. MacIntyre's *After Virtue* will then be discussed and

applied to interprofessional healthcare incivility. According to Janie Fritz, civil communication is itself a virtue; and, her insights will guide the application to civility in the healthcare workplace. Fritz's work will connect professionalism to ethics through communication and language, bringing the three previous chapters together.

The chapter will offer two alternative ethical approaches from a philosophy of communication perspective. The first is Carol Gilligan's 'Ethics of Care,' which centers around responsibility and is grounded in the phenomenology of Maurice Merleau-Ponty and Martin Heidegger. The second approach, inspired by Emmanuel Levinas elevates the face of the Other to the forefront. Healthcare professionals will be framed as answering the call to responsibility to and for the other, and interprofessional healthcare education is seen as a chance to listen to the Other and discover that they are not alone in their burden. The chapter will end by examining the different approaches to ethics in interprofessional healthcare education and framing them not as competing ethical theories, but as complimentary.

In the conclusion I reconcile the discussions of language, alterity, rhetoric, professionalism, and ethics, and draw insights pertaining to interprofessional healthcare education and team building. The discussion will begin by explicating many of the challenges uncovered in the chapters on language and (inter-)professionalism. The conversation will then shift to alternative approaches to addressing these challenges, namely a philosophy of communication and rhetoric approach. The discussion will continue by framing communicative virtue as something that can and should be learned in pre-professional health programs. This position will include the importance of

engaging other healthcare professionals on a relational level and doing so outside of scientific discourse.

CHAPTER 2: HEALTHCARE AS A PROFESSION

This dissertation centers on approaches for professionals to work better interprofessionally. Because the idea of the professional is central here, and because we may be carrying assumptions of what it means to be a professional, I believe the concept of professionality itself needs to be re-examined. Researching the origins and evolution of the professional may help us to better understand the professional in this current, transitional, historical moment.

Professionality

The concept of the 'professional' carries with it associated concepts of prestige, education, expertise, and a certain level of autonomy. It may be assumed that professionals are individuals that have endured a rigorous and specialized training. It may also be assumed that 'professional behavior' brings with it an increased expectation to be ethical. Professionals are part of a community within their chosen profession, and with this membership come accountability, certification, standardization, and trust. Though these associations easily come to mind today when we think of professionals, it was not always the case.

The archetypical profession has a certain idealism in society today. Professions are seen as a way to climb the social ladder through hard work, and offer stable employment and relative workplace autonomy. If we trace the origins of the professions back through history, we find an intimate relationship between professions, governments, ideologies, social status, and autonomy. Because this dissertation examines the relationships *between* professions, better understanding what we mean by professional is relevant to this dissertation and is worth exploring.

Freidson[1] explains the idea of autonomy within the professions as being "distinct from other occupations in that it has been given the right to control its own work."[2] This autonomy, however, really depends on the government to protect and promote the given profession. Thus, professions are incubated when governments, or the elite, share the ideological ethics of the profession. At first, then, professions would be dependent on these outside forces for their support. Autonomy would be achieved gradually through the acquisition of specialized knowledge, and once the professions are granted the power of self-examination, they become much less reliant on outside forces,[3] and virtually control their own professional world. Not only does the profession gain autonomy through the acquisition of knowledge, but also begins to shape their own reality, a worldview that defines standards of superiority. "Professionals live within ideologies of their own creation."[4] Freidson's statement begins to highlight the separation of professionals from both non-professionals, and others professions.

If we explore the earliest known professions (pre-industrial professions), medicine and law, we can see overlap in their reliance on science and rational thought. In the latter part of the eighteenth century, a major cultural shift gave birth to the enlightenment and the industrial revolution. Science and rational thought reduced uncertainty about the physical world and reduced fears of instability. A new focus on progress and change usurped aristocratic entitlements, estate ownership, and religious motivations, and offered

[1] Eliot L. Freidson was a professor of sociology at New York University who spent his professional career studying and writing about the professions, specifically in the field of medicine.
[2] Eliot Freidson, *Profession of Medicine* (New York, NY: Dodd & Mead, 1970), 78.
[3] Magali Sarfatti Larson, *The Rise of Professionalism: A Sociological Analysis* (Berkeley, CA: University of California Press, 1977), xii
[4] Larson, *Rise of Professionalism,* xiii

the confidence to create a new economic model. Adam Smith's[5] powerful ideas about specialized labor forces[6], and David Ricardo's[7] economic insights such as the law of diminishing marginal returns[8] and concept of comparative advantage[9] gave direction to this new capitalistic system. The industrial revolution that followed completely altered the economic, political, social landscape. William J. Goode[10] trivializes the rise of professionals as "typical byproducts of modern industrial society."[11] Large industry with many specialties created an environment for an explosion of professionalism.

The emergence of modern professions may have been a byproduct of the industrial revolution, but it is important to note that the economy and society were being completely reorganized around the marketplace.[12] With a large, poor, working class, and a new group of industrialists and entrepreneurs, professions allowed individuals to create "special categories of the social division of labor,"[13] thereby separating themselves from the poor. This separation was protected through professionalization, which Larson sees as a "process by which producers of special services sought to constitute and control a

[5] Adam Smith is a well-known eighteenth-century Scottish economist and philosopher. He is most famous for his *Wealth of Nations*, which is considered the first modern economic treatise. Smith's economic theory was the foundation of the free market economy.
[6] Reference to Adam Smith's *The Wealth of Nations* published in 1776.
[7] David Ricardo was an eighteenth and nineteenth-century political economist. Inspired by Adam Smith, he is most well-known for his contributions to economic theory, namely, the law of diminishing returns and his idea of comparative advantage.
[8] Ricardo's law of diminishing marginal returns is a fundamental concept in production theory and related to efficiency of inputs and outputs. The theory posits that when increasing a factor of production (more employees, more machines), at some point inputs will become less efficient, yielding increased production costs without a corresponding increase in output.
[9] Ricardo's idea of comparative advantage was really an argument for free trade. The basis of the idea is that a nation will be financially better off if they import lower-cost products instead of making them domestically.
[10] William Josiah Goode is a twentieth-century professor of sociology at Stanford University. Author of 20 books on sociology, he also served as President of the American Sociological Association.
[11] William J. Goode, "Encroachment, Charlatanism, and the Emerging Profession: Psychology, Sociology, and Medicine." *American Sociological Review 25* (1960): 902-914.
[12] Karl Polanyi, *The Great Transformation,* (Boston, MA: Beacon Press, 1957).
[13] Talcott Parsons, "A Sociologist Looks at the Legal Profession," in *Essays in Sociological Theory*, ed. Talcott Parsons (New York, NY: The Free Press, 1949).

market for their expertise." He argues that "marketable expertise is a crucial element in the structure of modern inequality,"[14] thereby making professionalization a collective effort to move upwards in society at the expense of the non-experts.

To clarify, the new markets for professionals created in the 1800s created a new form of inequality.[15] These inequalities were based on "socially recognized expertise […which was gained through] education and credentialing."[16] The professionalization in the nineteenth century was simple from an economic perspective, selling expertise for money. In order to make this work, however, the markets needed to be controlled. To control a professional market, and the subsequent ability to move upwards in society, the education and credentialing processes needed to be highly regulated. The idea, like any commodity, was to create scarcity and leverage it in the marketplace.

Although the professions are market-driven and ideologically limited, the professional must still be seen as trusted (credible) and mostly unbiased (rational). The professions, with their focus on science and rational thought, appear to have a certain disinterestedness for "capitalist profit motives,"[17] and a detachment from society,[18] perhaps making them trustworthy in the eyes of both the state and the consumers. This trust, however, is assumed to belong to the dominant, and often more traditional ideologies. In reality, however, professionals, grounded in science and reason, often lean towards progress and change. Pure intellectuals, thus, must often balance the acquisition of knowledge and implementation of change with their desire to remain in a certain social

[14] Larson, *Rise of Professionalism,* xvi
[15] Ibid., xvii
[16] Ibid.
[17] Ibid., xiii
[18] Karl Mannheim, *Ideology and Utopia* (New York, NY: Harcourt, 1936), 155-156.

class and maintain the trust of the masses. Perhaps here we begin to see the essence of the professional emerge. The professional is not just a subject-matter expert, they are part of both an "occupation and […] social strata."[19] The professional is both empowered and constrained by the professional communities of which they are a part.

Though there was a new market for professionals, including an increased demand, the concept of the professional was still born from the pre-industrial model. The transition from pre-industrial professional to modern professional was a shift from the entitled, professional elite cultivated through "gentlemanly education,"[20] to a professionals molded in a formal education system centered on pre-professional programs and clinical training. Before this practical instruction, and dating back to the middle ages, professionals distinguished themselves from "traders and artisans"[21] through both a university and the Church education. The gentlemanly education was a liberal education. During and after the Enlightenment and subsequent industrial revolution, both credibility and authority began to shift from inherent "power and prestige" through educational entitlement, to formal training and processes of certification and credentialing,[22] or a system based on merit.

In the early 1800s, there were really only three widely recognized professions that included divinity (which was closely tied to university professorship), law, and medicine.[23] However, between 1840 and 1897, thirteen new professional organizations were formally established in the United States. Chronologically, they included the

[19] Larson, *Rise of Professionalism,* xvi
[20] Ibid., 4.
[21] Ibid.
[22] William Johnson, "Educational and Professional Lifestyles: Law and Medicine in the Nineteenth Century," *History of Education Quarterly, Summer* (1974): 185-207.
[23] Alexander Morris Carr-Saunders and Paul A. Wilson, *The Professions* (Oxford: Clarendon Press, 1933), 289-294.

professions of dentistry, medicine, civil engineering, pharmacy, teaching, architecture, veterinarians, social work, librarians, lawyers, accountants, nurses, and optometry.[24] These professions seem to closely follow the same formally established professions in England, and at the end of the 19th century, we see capitalism evolve into its current form, dominated by large corporations. Professionals, then begin to exist primarily within these large, highly structured corporate systems, reflective of our present historical moment.

Professionalization of Healthcare

Of the thirteen new professions listed above, nearly half of them can be placed in the field of medicine. This is not surprising considering how long these disciplines had been acquiring knowledge. Medical practice and practitioners (healers) can be found in texts possibly dating back to 3,000-5,000 BC (China and Egypt). The earliest verifiable Chinese text, the *Huangdi Neijing* (written between the 5th c. and 3rd c. BC), represents the foundational Chinese medical text including both theory and diagnosis.[25] In Egypt, the *Edwin Smith Papyrus* dates back as far as 3000 BC.[26] This treatise is often said to be written by Imhotep[27] and contains information regarding basic anatomy, specific ailments, prognosis, as well as cures. Skeletal remains from this time period have even shown evidence of basic dentistry.[28] Different from the Chinese *Huangdi Neijing,* the Egyptian text focuses on surgery and detailed human anatomy, rather than herbal

[24] Harold L. Wilensky, "The Professionalization of Everyone?" *American Journal of Sociology 70* (1964): 137-158, 141.
[25] Paul U. Unschuld, *Huang Di Nei Jing Su Wen: Nature, Knowledge, Imagery in an Ancient Chinese Medical Text* (Oakland, CA: University of California Press, 2003).
[26] James Henry Breasted, *The Edwin Smith Surgical Papyrus*, (Chicago, IL: University of Chicago Press, 1930).
[27] Imhotep was a 27th century B.C. astrologer, architect, physician, and minister to Egyptian king, Djoser. He was later worshipped in Egypt and Greece as the god of medicine and often identified with Asclepius, the Greek god of medicine.
[28] Robert Silverberg, *The Dawn of Medicine* (New York, NY: Putnam, 1967).

medicine and holistic therapies. The more holistic medical approach can also be seen in the ancient Indian text, the *Atharvaveda*, dating as far back as 1200 BC.[29] Around the same time as the Indian text was written, so too was the first Babylonian text, the *Diagnostic Handbook*, written by the chief scholar, ummânū. In addition to diagnosis, prognosis, and cures, this text includes basic symptomology using logical evidence that included detailed physical exams;[30] thus, making the *Diagnostic Handbook* more closely related to the *Edwin Smith Papyrus*. The first Greco-Roman medical writings can be found in Homer's *Iliad* (c. 1250-800 BC). Here we find the two sons of Asklepios[31] acting as physicians. Asklepios, of course, became the god of healing. Medical centers in the ancient world were called *Asclepieia*, where patients could receive medical advice and have surgery performed, usually under opium-induced anesthesia.[32]

The famous Hippocrates appeared in Greece during the 4th and 5th century BC. He and his pupils were among the first to describe in detail many illnesses and treatments. He is best known for the *Hippocratic Corpus*[33] and the Hippocratic Oath,[34] which physicians still use today (although extensively modified). Also from this period, we see the physician, as a professional, appear in Plato's *Gorgias*. Galen appears in the second

[29] Michael Witzel, "Vedas and Upanisads*,"* in *The Blackwell Companion to Hinduism* ed. Gavin Flood (Hoboken, NJ: Wiley-Blackwell, 2003), 68.
[30] Manfred Horstmanshoff and Marten Stol, *Magic and Rationality in Ancient Near Eastern and Graeco-Roman Medicine,* (Leiden: Brill, 2004).
[31] Asklepios was a physician in Homer's *Iliad* and was subsequently worshipped as the Greco-Roman god of medicine.
[32] Guenter B. Risse, *Mending Bodies, Saving Souls: A History of Hospitals* (New York, NY: Oxford University Press, 1990).
[33] Many early medical teachings can be found in these 60-70 medical texts, usually attributed to Hippocrates and his followers. The texts range in content including specific medical cases and conditions, epistemology, gynecology, medical ethics, and many others.
[34] The Hippocratic Oath is an oath of ethics taken by graduating physicians. The oath has been modified numerous times since the fifth century B.C. Two of the principles that exist from the original oath are non-maleficence (do no harm) and confidentiality.

and third centuries AD. Known as the greatest of the ancient physicians, Galen's medical teachings and anatomical models were used in universities through the Middle Ages.[35]

Although holistic treatments for illness can be found in the earliest medical writing, more scientific pharmacological texts show up for the first time around 1550 BC with the *Ebers Papyrus*, containing over eight hundred pharmaceuticals. A more comprehensive pharmacological compilation appears for the first time in Rome between 50-70 AD. The *De Materia Medica* was encyclopedic in scope, and included hundreds of herbal cures for disease. Written by Dioscorides[36], this reference book replaced the *Hippocratic Corpus* and was used well into the 19th century.

A few hundred years after Dioscorides, around 300 AD, the Roman Empire ordered hospitals to be built in every city. With these hospitals came the need for "nurses." Both male and female nurses were charged with caring for the sick. During the Middle Ages, the need for nurses grew alongside the Catholic church, which called for hospitals to be built next to all existing churches and monasteries. Nurses, mostly nuns and monks, were charged with caring for the sick regardless of nationality or religion. The duties of nurses continued to expand and many even made house calls. The expansion of nursing followed the expansion of the Catholic church, and, during the church's decline following the protestant reformation, so too did nursing fall. The elimination of hospitals caused the field of nursing to remain idle throughout the 1600s and 1700s. Modern nursing, like the other professions, rose during the Enlightenment and the Industrial Revolution. In 1860, Florence Nightingale, gaining valuable experience

[35] Faith Wallis, *Medieval Medicine: A Reader* (Toronto, Ontario: University of Toronto Press, 2010), 14.
[36] Dioscorides was a medic in the Roman army who was trained in medicine with an emphasis on pharmacology. His botanical studies of plants and their pharmacological potential greatly enhanced the existing knowledge of the time.

fighting infection during the Crimean War, opened the first nursing school in London.[37] The demand for nurses continued to grow throughout America's history. World War I and World War II sparked a huge demand for nurses and offered invaluable training. By the 1960s, there were approximately 170 Bachelors of Science in Nursing (BSN) programs nationwide.[38] Today, there are over 670 nursing schools in the U.S. working to supply the growing demand for nurses nationwide. According to the U.S. Bureau of Labor Statistics, Registered Nurses (RNs) have been the largest growing profession since 2008.[39] With 3.1 million registered nurses, nursing is currently the largest of the health care professions.[40]

To this point, we have seen the origins of the physician, the surgeon, the dentist, the pharmacist, and the nurse. While they were not referred to as professionals, most of the practitioners discussed studied in a system of organized apprenticeship and worked to further knowledge in their specialty, illustrating common characteristics of the modern professional. During the Middle Ages, medical men existed in the upper and lower echelons of society. Those with lower social status tended to practice in more rural areas. Beginning in the 1500s, there was an increasing prevalence of medical men throughout England. The business of medicine became much more profitable in the 1600s for both

[37] Sandra B. Lewenson, "Integrating Nursing History into the Curriculum," *Journal of Professional Nursing 20* no. 6 (2004): 374-380.
[38] Martha Scheckel, "Nursing Education: Past, Present, Future," in *Issues and Trends in Nursing: Essential Knowledge for Today and Tomorrow,* ed. Gayle Roux and Judith Halstead (Burlington, MA: Jones and Bartlett Publishers, 2009).
[39] "Occupational Employment and Wages for 2009," U.S. Bureau of Labor Statistics, accessed April 14, 2018, https://www.bls.gov/news.release/archives/ocwage_05142010.pdf
[40] *The Registered Nurse Population: Findings from the 2008 National Sample Survey of Registered Nurses* (Washington, DC: U.S. Department of Health and Human Services Health Resources and Services Administration, 2010).

elite physicians and the lowly apothecaries, who achieved relative legitimacy in the 1700s, gaining socioeconomic distance from the mere druggist.[41]

It was also around the 18th century that the surgeons were gaining prestige. As an organized group, surgeons formed their own guild when they broke away from the Barbers' Company in 1368, calling themselves the Fellowship of Surgeons; however, reunited with barbers by decree in 1540 and becoming the Company of Barbers and Surgeons. They remained united until the aforementioned rise in professionalism, where they once again broke away from the barbers and became the Company of Surgeons (1745). In 1800 they were renamed the Royal College of Surgeons.[42] From this brief history of organized surgeons, we see pre-industrial professionals in a sense, both collaborating and differentiating themselves from another profession. This gradual process of differentiation came to a head at the end of the 18th century. Urbanization and more efficient means of communication made the world smaller resulting in increased pressure for more professional organizations, and, of course, more need for regulation.

The aforementioned changes created ideal conditions for the creation of professional health markets in the United States. The restrictions of the British Royal College of Physicians did not apply in America, which opened the door for many to enter the field by taking a few classes at proprietary schools. In fact, competition for these students led the schools to lower their standards quite dramatically. This phenomenon resulted in a rapid growth of the professional physician and the standardization of

[41] Larson, *Rise of Professionalism,* 11.
[42] Fu Louis Kuo Tai, "The Origins of Surgery: From Barbers to Surgeons," *The Annals of the College of Surgeons Hong Kong 4* no. 1 (2000): 35-49.

training.[43] The universal need for health-related services did not benefit health 'professionals' until the markets were monopolized. Until that time, the high demand merely created equally intense competition.[44] Low standards at American medical schools prohibited lawmakers from requiring practitioners from being licensed, because the licenses carried little weight in the minds of the public.

The different medical associations of the mid nineteenth century continued the slow process of differentiation between "graduate physicians" and "unlicensed empirics."[45] Although increasing standards in medical schools, standardizing education, and "enforcing codes of professional etiquette"[46] helped to create better physicians, there was still a need to qualify the graduate in the minds of the public. This sentiment was echoed in the late 1800s by Richard Shryock[47] when he commented "most laymen had nothing but contempt for medical science, while holding their own family doctor in great respect."[48] This observation is telling in that is elevates public trust over science. The post-industrial process of professionalization, then can be seen as not only creating specialized markets for health professionals, but shifting public perception about medical science as a whole. Without a new public perception towards science, the demeanor and "priestlike"[49] wisdom of the family physician mattered more than his "medical

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[43] William G. Rothstein, *American Physicians in the Nineteenth Century: From Sects to Science* (Baltimore, MD: The Johns Hopkins University Press, 1972), 100.
[44] Larson, *Rise of Professionalism,* 21.
[45] Ibid.
[46] Ibid.
[47] Richard Harrison Shryock was an influential medical historian and professor of American history at the University of Pennsylvania. Shryock served as director of the Institute of the History of Medicine at Johns Hopkins University.
[48] Richard H. Shryock, *The Development of Modern Medicine* (Philadelphia, PA: University of Pennsylvania Press, 1936), 267-269.
[49] Larson notes that in secular society, private, interpersonal relationships that would have existed between priests and parishioners, now existed between physicians and patients. The private, and somewhat confessionary role of the priest was being assumed by the family physician perhaps illuminating an innate desire for an impartial, parental source of wisdom.

effectiveness."[50] The private nature of the family doctor – patient relationship, however, may have been a weakness during the process of professionalization. Those practicing outside of an established professional organization lacked the benefit of peer review to share opinions, support one another, a trademark of professional etiquette that enhances one's "social credit."[51] This professional etiquette was being taught and reinforced within the university setting. Thus, similar to the church and the hospital during the Middle Ages, professionalization and the traditional university had a symbiotic relationship, each depending on, strengthening, and adding credibility to the another. The differences between the graduate physician and the uneducated practitioner continued to grow and eventually laws were put into place outlawing uncertified medical practice.

An interesting observation of the evolution of the medical professions is the focus on differentiation, an intentional distancing form other 'professionals.' The ideas inherent in specialization, made popular by Adam Smith (but existing throughout the history of medical practice), are geared towards separating the content and delivery of knowledge and creating unique identities of what it means to be part of a particular profession. Freidson illustrates that this differentiation was initially motivated by a desire to control one's own work, and gain relative autonomy. Another motivation for differentiation, as exemplified by Larson, was gaining control of professional markets. As we move into the 21st century and a focus on healthcare teams, it may be important to remind ourselves that for thousands of years the medical professions have been focused, not on collaboration, but on separation.

[50] Larson, *Rise of Professionalism,* 22.
[51] Ibid., 23.

Based on the above research, we can identify similarities between pre-industrial and modern professions, which include relying on science and rational thought, having a certain level of inherent trust, and striving for a certain amount of relative autonomy. What is perhaps more apparent, however, are the differences in the characteristics of each. The differences are outlined below.

Table 3
Comparing Characteristics of Pre-Industrial and Modern Professionalism

Characteristics of Pre-Industrial Professionalism
**Credibility and Authority gained through entitlements and apprenticeship (including a liberal arts education gained through both the university and the church)* **Reliant on governmental support, thus, supportive of government ideologies* **Autonomy achieved through the acquisition of specialized knowledge* **Blurry boundaries between professions* **Individual differentiation*
Characteristics of Modern Professionalism
**Credibility and authority gained through merit and peer review (defined by a formal, specialized, and standardized education at the traditional university).* **Professions create their own ideologies (which empower and constrain)* **Autonomy achieved via a professional community's ability to self-examine* **Clear boundaries between professions (clear roles and responsibilities)* **Differentiation by the professional community to separate from non-professionals (professional training differentiated individuals from the poor, working population).* **Driven by markets for expertise - Professionalization was a process where producers of specialized services attempted to control markets for it. Professional specializations fill market-driven demand (mostly from large corporations).*

Now that we have explored the concept of the *professional* as it has evolved throughout human history, specifically in healthcare fields during the industrial revolution, we can have a more enlightened conversation about concepts of *interprofessionalism*. The examination of professionalism has also highlighted an intentional movement within each profession to differentiate it from other professionals and from non-professionals. This motivation to differentiate can be seen as a critical and deeply-seated obstacle to interprofessional communication. It may be beneficial to attack this obstacle head-on by adopting a communication strategy that begins with the ear. As we will later see, many interprofessional healthcare education curricula include *roles and responsibilities* as a necessary competency for collaboration. Chapters four and five will address this competency in depth and offer rhetorical and philosophy of communication-based insights that focus on active and attentive listening to the *other*. We will begin, however, to construct our concept of interprofessionality with current constructs of the term.

Interprofessionality

The Interprofessional Education Collaborative Expert Panel[52] grounds their definition of interprofessionality in the work of D'Amour and Oandasan.[53] Their definition sees interprofessionality as a "process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the client/family/population."[54] They further elaborate that this process requires

[52] Interprofessional Education Collaborative Expert Panel, *Core Competencies for Interprofessional Collaborative Practice: Report of an Expert Panel* (Washington, D.C.: Interprofessional Education Collaborative, 2011).
[53] Danielle D'Amour and Ivy Oandasan, "Interprofessionality as the Field of Interprofessional Practice and Interprofessional Education: An Emerging Concept." *Journal of Interprofessional Care* 19, supplement 1 (2005): 8-20.
[54] D'Amour, and Oandasan, "Interprofessionality," 9.

ongoing learning through the interaction of professionals. According to D'amour and Oandasan, interprofessionality is a sort of mindset where professionals explore issues of patient care and education "while seeking to optimize the patient's participation."[55] They argue that thinking interprofessionally requires thinking outside one's own profession because interprofessionality has "values, codes of conduct, and ways of working" that are unique and exist outside of each individual profession.

In light of the previous discussion on professionalization, D'Amour and Oandasan's definition, which focuses on integration and "thinking outside" one's profession, gains complexity. Now that we understand the deep-rooted nature of each profession's values, roles, and communication styles, we can become more realistic about approaches to professional collaboration. We can also see the importance of early interprofessional interaction.

Civility

Interprofessionality is only possible when a working environment is characterized by civility. Unfortunately, research shows that almost all employees have experienced rude behavior at work.[56] Healthcare workplaces becoming faster, more complex, and diverse places stress on professionals that often takes the form of incivility. This, sometimes thoughtless and unintentional behavior yields a loss of interpersonal common sense, [57] often leaving employees or cohorts feeling disrespected. Consequences of

[55] Ibid.
[56] Christine Porath, "Make Civility the Norm on Your Team," *Harvard Business Review* (January, 2018), https://hbr.org/2018/01/make-civility-the-norm-on-your-team
[57] Fritz, *Professional Civility*.

incivility include decreases in performance,[58] employee turnover,[59] and negative customer (patient) interactions.[60,61] Additionally, employees that feel disrespected are less engaged, avoid teamwork, don't share knowledge with others, and are less creative. In short, incivility kills collaboration.

Because healthcare is administered by teams that rely on collaboration, civility becomes vital for healthy patient outcomes. Civility derives from the Latin *civilitas*, meaning 'relating to citizens.' And so, the concept of 'relating' is inherently associated with politeness, courtesy, and respect. However, because these associated concepts are culturally contingent, the meaning of civility should be negotiated within the confines of each healthcare team. The *act* of defining civility creates an accountability to that socially-constructed meaning.

Janie Fritz: Professional Civility

Janie Fritz discusses in depth what it means to be a professional.[62] She argues that professions are enveloped in tradition, and warns that professionals are in the midst of a crisis, marked by incivility. By grounding professional communication in a virtue of civility, she transitions nicely to a perspective of interprofessionality. She grounds her understanding of professional civility in the work of Alasdair MacIntyre's virtue ethics, William Sullivan's civic professionalism, and Bruce Kimball's history of the true

[58] Christine Porath and Christine Pearson, "The Cost of Bad Behavior," *Organizational Dynamics 39* no. 1 (2010): 64-71.
[59] John Boudreau and Wayne Cascio, *Investing in People: Financial Impact of Human Resources Initiatives* (Indianapolis, IN: FT Press, 2008).
[60] Christine Porath, Debbie Macinnis, and Valerie Folkes, "Witnessing Incivility Among Employees: Effects on Consumer Anger and Negative Inferences About Companies," *Journal of Consumer Research 37* (2010), 292-303.
[61] Christine Pearson and Christine Porath, *The Cost of Bad Behavior: How Incivility is Damaging Your Business and What to Do about It* (New York, NY: Portfolio, 2009).
[62] Fritz, *Professional Civility.*

professional ideal."[63] Fritz's work will be referenced in the chapter on virtues/ethics and featured in a future chapter on communication as it pertains to healthcare education.

Oath: The Act of 'Profession'

Additionally, health care professionals possess a certain body of knowledge useful to their particular craft. Whether a surgeon, a nurse, or a pharmacist, this knowledge has been acquired for thousands of years and is held "in trust for the good of the sick."[64] If we view medical education, not as the personal possession of medical knowledge, but as a societal privilege, an invitation into a calling for social good, then we can see the responsible use of that knowledge as a social pact. Some health care professionals solidify this pact in the form of an oath. For instance, the Student Academy of the American Academy of Physician Assistants (SAAAPA) has adopted the following oath:

The PA Professional Oath

I pledge to perform the following duties with honesty and dedication:
I will hold as my primary responsibility the health, safety, welfare and dignity of all human beings.
I will uphold the tenets of patient autonomy, beneficence, nonmaleficence and justice.
I will recognize and promote the value of diversity.
I will treat equally all persons who seek my care.
I will hold in confidence the information shared in the course of practicing medicine.
I will assess my personal capabilities and limitations, striving always to improve my medical practice.
I will actively seek to expand my knowledge and skills, keeping abreast of advances in medicine.
I will work with other members of the health care team to provide compassionate and effective care of patients.
I will use my knowledge and experience to contribute to an improved community.

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[63] Annette M. Holba, "Reviewed Work: Professional Civility: Communicative Virtue at Work by J. M. H. Fritz," *Journal of Business Ethics 115* no. 3 (2013), 645-49, 645.
[64] Edmund Pellegrino and David Thomasma, *The Virtues in Medical Practice* (New York, NY: Oxford University Press, 1993), 36.

I will respect my professional relationship with the physician.
I will share and expand knowledge within the profession.
These duties are pledged with sincerity and upon my honor.[65]

The first line of the PA Professional oath, 'I pledge to perform the following duties with honesty and dedication' corroborates Pellegrino and Thomasma's focus on honesty and duty. We also see within the oath a commitment to interprofessional practice, both with physicians and 'other members of the health care team.'

If we look now to nursing, a revised version of Florence Nightingale's Pledge is commonly recited by graduating nursing students at pinning ceremonies.

The Nursing Pledge

I solemnly pledge myself before God and in the presence of this assembly, to pass my life in purity and to practice my profession faithfully. I will abstain from whatever is deleterious and mischievous, and will not take or knowingly administer any harmful drug. I will do all in my power to maintain and elevate the standard of my profession, and will hold in confidence all personal matters committed to my keeping and all family affairs coming to my knowledge in the practice of my calling. With loyalty will I endeavor to aid the physician in his work, and devote myself to the welfare of those committed to my care.[66]

In 1893, this pledge, modeled after the Hippocratic Oath, was created to pay homage to Florence Nightingale and the Christian history of the nursing. The pledge includes elements of trust, responsibility, and devotion; however, it has a much different feel than that of the PA Oath. The nursing pledge is much more submissive, focusing on reliably following instructions (original versions of the pledge especially) and limiting liability. The pledge above (given to nurses at a 2017 conference) has been modified to promote nursing as a practice of faith and devotion.

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[65] American Academy of Physician Assistants. (2000. Reaffirmed 2013). *Guidelines for Ethical Conduct for the Physician Assistant Profession,* accessed August 7, 2017, https://www.aapa.org/wp-content/uploads/2017/02/16-EthicalConduct.pdf

[66] "Florence Nightingale Pledge," American Nurses Association, accessed August 7, 2017, http://www.nursingworld.org/FlorenceNightingalePledge-2017

Whatever oath or pledge is recited represents a 'profession' or promise to the public. The 'profession' bonds professionals through a "collective responsibility" that transcends "self-interests, exigency, and even social, political, and economic forces."[67] Health care professionals are part of an inherently moral community that enters into healing relationships with patients based first and foremost on trust.

The oath of each individual profession is indicative of the values and professional standards they promote and protect. When working in a health care team, which oath should be used? Although elements of cooperation can be found in nearly all the professional pledges, should there be an oath specifically for interprofessional practice? The WHO believes that such an oath "could serve as a means of promoting collaboration which has the potential to improve patient outcomes and safety."[68] This question has also inspired the work of Brown, Garber, Lash, and Schnurman-Crook who propose just such an oath. Using the Interprofessional Education Collaborative Expert Panel's (IECEP) 2011 report as a guide (this is the same study that lays out the IPE competencies used in this dissertation), they attempt to develop an interprofessional oath that identifies shared professional values. During an interprofessional leadership course, medical students, PA students, and nursing students, working in multidisciplinary teams, were asked to create their own interprofessional health-care professional oath. The researchers emphasized that these oaths should focus on shared values. The 18 oaths were reviewed and combined to form the following oath:

[67] Pellegrino and Thomasma, *The Virtues in Medical Practice*, 36.
[68] *Framework for Action on Interprofessional Education & Collaborative Practice* (Geneva, Switzerland: World Health Organization, 2010).

Proposed Interprofessional Oath

> We make this oath in due faith and we recognize the unique role of being a healthcare professional and the associated responsibilities which include honesty, faithfulness, compassion and collaboration.
> We pledge to promote health in individuals and the community rather than just treating the sick. We will protect privacy and confidentiality.
> The patient is the ultimate priority and focus of our care. Our role is to empower, teach and promote health in the patient, treating all persons equally and appropriately. The patient is more than a body and we will benefit the patient rather than harm.
> Our care will be of the highest quality, safe, and based on evidence. We will seek to provide care within our scope of practice with ever-growing knowledge and skills.
> We will work with others to provide care, recognizing the unique skills of each and we will seek to collaborate effectively on the healthcare team.[69]

The ethical concepts that the researchers found within these proposed oaths included "honesty, promoting health, research, respect for team members, faithfulness, compassion, equality, patient autonomy, privacy, confidentiality, beneficence, safety, and justice."[70] If an oath binds a moral community, then an interprofessional oath would be a symbolic 'profession' among professionals that, while part of a profession they are part of a larger, professional moral community. It could also be noted that the end result of Brown et al.'s project is less important than the cooperative process of construction.

[69] Sara Brown, Jeannie Garber, Judy Lash, and Abrina Schnurman-Crook, "A Proposed Interprofessional Oath," *Journal of Interprofessional Care 28* no. 5 (2014): 471-472.
[70] Ibid., 472.

CHAPTER 3: THE COMMON LANGUAGE OF SCIENCE

Rationale: Trapped Within a Biomedical Discourse

Because our health care system, including medical education, has been cultivated within a biomedical paradigm,[1] it is important to ask the following question: How does the biomedical paradigm (and the type of discourse it manifests) affect our approaches to interprofessional healthcare education? While commencing research into the present topic, a fundamental observation became apparent: nearly all discussions about healthcare are, *a priori*, lodged within the biomedical model of healthcare created with an equally stubborn biomedical discourse. The core-competency approach to healthcare education is an attempt to improve healthcare *quality*, yet the accrediting bodies and professional organizations have been cultivated within a positivistic and empirical worldview. It may be helpful, then, to become somewhat familiar with the contents of this discourse. Scott Montgomery's chapter entitled "Illness and Image: On the Contents of Biomedical Discourse" [2] explores this idea and will be used heavily in the following section.

The Common Language of Science

On October 2, 1941, Albert Einstein, a name synonymous with science, gave a radio address that he titled, "The Common Language of Science."[3] His speech focused on epistemology and scientific discourse as a tool for rational thought. Einstein states "The mental development of the individual and his way of forming concepts depend to a high

[1] The biomedical paradigm refers to an approach to diagnosis and treatment that focuses primarily on physical disease processes. This paradigm focuses solely on biological processes and does not consider environmental, social, and environmental factors as contributing to patient health.
[2] Scott Montgomery, "Illness and Image: On the Contents of Biomedical Discourse," in *The Scientific Voice* (New York, NY: The Guilford Press, 1996).
[3] Albert Einstein, "The Common Language of Science," in *Ideas and Opinions,* ed. Alan Lightman (New York: Broadway Books, 1995), 335.

degree upon language. This makes us realize to what extent the same language means the same mentality."[4] What Einstein is saying is that language and thinking are intricately linked. This powerful idea will be a cornerstone of this discussion, but did not originate with Einstein. In fact, in the same year as Einstein's public address, American linguist, Benjamin Whorf passed away. Just as Einstein is famous for his theory of general relativity, Whorf's most famous contribution to language is called 'linguistic relativity,' which implies that "the language one speaks shapes the world one sees,"[5] or put simply, language determines thought. Going back even further, philosopher and semiotician, Charles Sanders Peirce,[6] makes a similar claim that "all thought is in signs."[7] Peirce takes a more epistemological approach to language, which he lays out in his tripartite semiotic theory, which eventually informs his famous *pragmatism*.[8] Peirce's claim offers a vision of language that is fundamentally and necessarily distant from the 'objects' of the world. This may be an important concept to remember as we start talking about scientific discourse and illusions of truth within it. Furthermore, thinking about language in terms of signs was not new to Peirce. St. Augustine states that we can learn nothing from signs themselves, only from what the signs represent.[9] Augustine claims that conventional signs (as opposed to natural signs, like smoke from a fire) are subjective. The lesson from Augustine is that we need other sources of knowledge than just signs (words) alone.

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[4] Einstein, "The Common Language of Science," 335
[5] Philip. E. Ross, "New Whoof in Whorf: An Old Language Theory Regains its Authority," *Scientific American* 266 no. 2 (1992): 24-25.
[6] Charles Sanders Peirce is a logician, mathematician, scientific philosopher, and semiotician most well-known for his semiotic theory and for founding American pragmatism.
[7] Charles Sanders Peirce, *The Writings of Charles S. Peirce: A Chronological Edition, Volumes 1-6. And 8,* ed. Peirce Edition Project (Bloomington, IN: Indiana University Press, 1982), 213.
[8] Pragmatism is a movement in the field of philosophy that determines truth and meaning based on "practical consequences." Pragmatism, thus, accepts practical ideas and rejects unpractical ones.
[9] Augustine, *De Doctrina Christiana: A Classic of Western Culture,* ed. Duane W. Arnold and Pam Bright (Notre Dame, IN: University of Notre Dame Press, 1995).

These ancestral concepts warrant reflection because those that *speak* primarily in the tongue of scientific discourse, characterized by Scott Montgomery[10] with terms such as "dispassion, neutrality, detachment, intellectual purity, [and] objectivity,"[11] may begin to *think* primarily in terms of scientific discourse, and all of the social and historical distillations that are embedded within it. Taken further, if scientific discourse de-humanizes and objectifies human beings and cultures, then the scientists, who are more likely to think in these terms, are more likely to de-humanize and objectify the world outside of their sterile, professional environments. What is omitted, then, is the phenomenological experience of human life; a concept alluded to in Michel Foucault's[12] *Archaeology of Knowledge*, which according to Scott Montgomery, was in response to the "professionalization of knowledge and the uptake of scientific discourse as a model form of truthful communication."[13] By invoking the 'method' of archaeology, Foucault attempted to 'objectively' uncover grammatical and logical structures that existed beneath a subjects' consciousness as they acquired knowledge. One objective of Foucault's work was an attempt to determine how conceptual systems of different historical periods limited the possibilities of both language and thought. Foucault also warns against a retrospective, structuralist view of the history of ideas, and the

[10] Scott Montgomery is an author and professor at the University of Washington. A geoscientist by trade, his publications merge the sciences with the humanities. He has written 12 books and over 200 scholarly articles. His book *The Scientific Voice: Essays on Language in Science* is an historical account of scientific discourse and culture, which examines how language and metaphors have evolved to reinforce the biomedical paradigm.
[11] Scott Montgomery, *The Scientific Voice* (New York, NY: The Guilford Press, 1996), 31.
[12] Michel Foucault was a twentieth century French philosopher who wrote critically and extensively on the histories of ideas as the pertain to the social sciences. His works often focus on the relationship between knowledge and power. Additionally, Foucault examined the histories of the medical sciences from a philosophical and psychosocial lens. His works here include *History of Madness, The Birth of the Clinic,* and *Madness and Civilization.*
[13] Montgomery, *Scientific Voice,* 32

assumption of one, long, continuous narrative. Foucault says that in doing so we impose our subjective worldview on the past. Moments of transition between ideas are rarely logical and continuous, but often violent and disruptive. Foucault was interested in the 'rules' of language. He believed that meaning sprung from these rules. Foucault's approach to language was thus different from the meaning-laden semiotic approach of Peirce.

Inspired by Foucault's unique approach to discursive history, it may be helpful and fitting for this dissertation to briefly explore the origins of scientific discourse. Intentionally 'de-animated' discourse can be traced back to the Royal Society of London[14], which was one of the first 'modern' scientific organizations inspired, in part, by Francis Bacon and other early scientific writers from the 16th and 17th centuries. Bacon was concerned with abstract and subjective processes and procedures of science. He stated in 1620 that "the manner in which the experiment was conducted should be added" to scientific publications so that "men may be free to judge for themselves whether the information obtained from that experiment be trustworthy or fallacious," and so that more exact methods can be discovered.[15] Bacon was skeptical of subjective interpretation and wanted to know *how* the scientist came to their conclusions. The *how* for the scientist concerns method. In addition to sterilizing language, Bacon's objective, then, was to unveil, improve, and standardize scientific methodology so that both scientific inquiry

[14] The Royal Society of London originated in 1660 from a group of natural philosophers and physicians that demanded a shift from authority-based science to truth gained from rigorous experimentation and clear communication regarding scientific methods. The Royal Society is still in existence today as an independent scientific academy in the UK.

[15] Francis Bacon, "Preparative Toward Natural and Experimental History: Description of a Natural and Experimental History Such as May Serve for the Foundation of a True Philosophy," in *The Works (Vol. VIII),* trans. James Spedding, Robert Leslie Ellis, and Douglas Denon Heath (Boston, MA: Taggard and Thompson, 1863).

and discourse would "more closely approximate the 'primitive purity' of things."[16] This is the type of thinking that Jean-Paul Sartre[17] was responding to when he wrote: "The word, which tears the writer of prose away from himself and throws him into the midst of the world."[18] Sartre illustrates how a simple word, and the associations that come with it, can tear a scientist or a professional away from their singular focus and allow them to explore all the different ideas that are embedded within that word. Scientists' objectives are, in part, to distance themselves from what they are studying including experiential or subjective thinking. Experimental design is a process for achieving this end. Moreover, because words, with their endlessly colorful and diverse associations, can 'tear' the scientist away from the search for truth, the Baconian plan was to de-animate these words, to take the life out of these words so as to allow scientific discourse the transfer of 'pure,' untainted information.

Social constructionist[19] thinking, however, adds complexity to the Royal Society of London's plan. From this perspective words and language gain meaning and complexity through their shared use. Wittgenstein adds that the meaning of words exists within a "language game,"[20] which are "embedded in broader patterns of actions and objects,"[21] which Wittgenstein calls "forms of life." Wittgenstein's pupil, J. L. Austin

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[16] Montgomery, *Scientific Voice,* 34.
[17] Jean-Paul Sartre was a twentieth-century French philosopher and writer known for his contributions to existentialism and phenomenology. His most well-known work, *Being and Nothingness,* explores the conflicts between authenticity and conformity (bad faith).
[18] Jean-Paul Sartre, *What is Literature?* trans. Bernard Frechtman (New York, NY: Philosophical Library, 1949), 15.
[19] Social Constructionism is a popular communication theory originating from Berger and Luckman's *The Social Construction of Reality.* Meaning is created socially instead of individually. Through a coordinated process, we learn about the world through the sharing of perspectives, or constructs, of reality, and the social validation of our own perspectives. Social constructs can include anything from science to identity.
[20] Ludwig Wittgenstein, *Philosophical Investigations* (New York: Macmillan, 1953), 7.
[21] Kenneth Gergen, *An Invitation to Social Construction* (Thousand Oaks, CA: SAGE Publications, Ltd, 2000), 35.

adds that we "do things with words."[22] "Performative utterances"[23] are, thus, are a form of action, moving a chess piece in the larger form of life (the game of chess). Austin adds that "we must attend to the *performative,* character of our language, how it functions within a relationship."[24] Austin's ideas were later adopted by John Searle[25] with his Speech-Act Theory, which details various rules, propositions and conditions, illustrating ways in which speech goes beyond merely describing reality and takes on a more functional and predictive quality.

What, then, does this mean for scientific discourse? The plan of the Royal Society of London was to create a language where one meaning or referent is dedicated to each word, or sign, in order to create and maintain a thoroughly objective language. However, we can see that this can only be done when only a few speak the language and understand the rules of language 'game' called *science*. "When we engage in actions such as *describing, explaining*, or *theorizing*, we are also performing a kind of cultural ritual."[26] To realize that science is a ritualistic game, with rules, propositions, conditions, and an objective of pursuing truth, then we can clearly see that any attempt to sterilize science from culture is a failure to see science *as* culture. Furthermore, it can be problematic to convolute functions and rules. Trying to tell the truth is a *rule* of science; however when truth-telling is assumed to be a *function* of scientific discourse, science fails to be the cultural game that it is, the "game of truth,"[27] and becomes the "form of life" itself.

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[22] John Langshaw Austin, *How to Do Things with Words* (Cambridge, MA: Harvard University Press, 1962), 5.
[23] Ibid.
[24] Gergen, *An Invitation to Social Construction,* 35.
[25] John Searle is a philosopher and writer specializing in the philosophy of mind and language. Concepts from his *Speech Acts* were influenced by both Austin and Wittgensteing. He is currently Professor Emeritus at UC Berkeley.
[26] Gergen, *An Invitation to Social Construction,* 36.
[27] Ibid.

Wittgenstein clarifies this argument with a fictional dialogue in his *Philosophical Investigations*, "So you are saying that human agreement decides what is false and what is true? – It is what human beings *say* that is false and true; and they agree in the *language* they use. That is not agreement in opinions but in forms of life." [28] "Forms of life" that use scientific discourse, then, often give meaning to the world blinded by their own ontology. This discussion leaves us with an overarching question helpful when discoursing in the language of science – What are we taking for granted?

Thus, scientific discourse, born alongside the scientific method, has since spread and evolved. Scott Montgomery calls it "the grand master narrative of modernism, ideally suited to its content."[29] Since the 19th century, scientists and those who read the scientific journals have not reflected much on the linguistic qualities of scientific discourse, almost treating it as *a priori*. A danger may exist then in assuming that this language is devoid of alternative meanings. The language is trusted because it is seen as objective, devoid of politics, culture, and perhaps even of history. One inherent assumption with scientific language is that it carries absolute truth and objectivity at the exclusion of plurality. A certain type of faith is required to use this language, according to Montgomery, a faith in the presumed accuracy that goes along with it. Montgomery says "language can be made a form of technology, a device able to contain and transfer knowledge without touching it."[30] Montgomery suggests that the language of science, characterized by codes and conventions, is purified from rhetorical devices, and thus, rhetorical influence. Scientists that work in this "mill of hypothesis and data,"[31] accept their subservient role to this

[28] Wittgenstein. *Philosophical Investigations*, 88e-241.
[29] Montgomery, *Scientific Voice,* 2.
[30] Ibid.
[31] Montgomery, *Scientific Voice,* 3.

language. By acting as a servant to the language and not the creator or author of the language, the scientist, then, becomes inferior to the language itself.

At this point is not reasonable to think that we can change the language of science, nor would we want to. To argue for its utility one need only look at the technological innovations over the last 200 years for verification. Our technological advances, including advances in medicine, go hand-in-hand with scientific progress, which have only been possible because of a dense and concise language of endless connotation. The system of concepts that makes up scientific language, says Einstein, "has served as a guide in the bewildering chaos of perceptions so that we learned to grasp general truths from particular observations"[32] The processes and procedures of inductive reasoning, and the scientific language that allows for its explication, have a clear and visible power in the material world. Montgomery reminds us of common words used in science, words like *evidence*, *documentation*, and *proof*.[33] These words imbue the language itself with an objective quality, where truth is assumed, often without question. Montgomery alludes to the Industrial Revolution and the subsequent spread of positivistic thinking, which ran right alongside the rise of the university giving, in a sense, science and technology the voice and responsibility to bear truth.

Scientific language is not only used by professionals in the hard sciences, but by professionals in general. Montgomery adds, Nearly all "modern professional writing follows the lead of science."[34] We can see proof of this in the rise of the academic journal over the book, in the way that we cite sources in our writing, and Montgomery illustrates

[32] Einstein, "The Common Language of Science," 337.
[33] Montgomery, *Scientific Voice,* 3.
[34] Ibid.

in the structured, standardized, and explanatory way that science is written, usually starting with an introduction, having some kind of a main text, often containing hypotheses, and usually ending in some kind of the concluding section, which may include implications, discussion, limitations, and areas for future research. Furthermore, the standardization of professional education over the last 150 to 200 years has created a rather rigid vocabulary. It is more the way that these papers are written, more so even than their content, that leads people down a path of linear, rational thought, and dictates how information will be processed, rather than how the ideas themselves matter in the minds of those reading.

Let us now ask how a better understanding of scientific discourse can lead to improvements in cooperation among healthcare professionals. To answer this inquiry we need to more clearly uncover the hidden agenda the discourse. Scott Montgomery attempts to deconstruct scientific discourse from both a modern and postmodern perspective. He writes:

> Technological discourse might be said to contain a mixture of modernist standards and post-modern realities. While the former allow for scientific substance, and dictate a great deal of the experience of authorship, the latter cannot be ignored, for they prove in the end that the writing and reading of this language is a densely cultural (one might say human) activity in which many fascinating and crucial influences, conflicts, and ambitions have been deposited.[35]

[35] Ibid., 6.

What does Scientific Discourse Do?

Creation of insiders and outsiders

Montgomery isolates three main attributes of scientific discourse from a modern perspective. The first being the *creation of insiders and outsiders*. Montgomery says "Technical language sets up a barrier between those who can speak and understand and those who cannot."[36] He quotes Roland Barthes[37] when he says "exalts, reassures all the subjects *inside*, and *rejects* and *offends* those *outside*."[38] Montgomery then goes on to talk about how this division between insiders and outsiders splits the speaking world in half, with half speaking the language, and half not, which has more to do with passivity than the illiteracy.[39] Montgomery states that this inaccessibility of language for much of the speaking world holds the power of intimidation.[40] The power acquired through inaccessibility, those who speak and those who do not, often manifests in terms of social status. This attribute highlights the inverse relationship between information and accessibility.

Montgomery then characterizes scientific discourse as mystifying the ordinary[41], which we have probably all experienced when somebody uses the Latin name for a plant, insect, or animal instead of the common name. Scientific discourse reifies, and with this reification comes possession, and with this possession comes a power to control. Push

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[36] Ibid., 7.
[37] Roland Barthes was a twentieth-century French linguist, semiotician, and social and literary critic. His work influenced the Structuralism and Post-Structuralism movements. A recurring theme in his work is that convention can limit creativity; thus, creativity must involve continuous change in style and form. To do this one must be resilient and critical of underlying assumptions, or mythologies.
[38] Roland Barthes, "The Division of Languages," trans. R. Howard, in *The Rustle of Language* (New York, NY: Farrar, Straus, Giroux, 1973), 122.
[39] Montgomery, *Scientific Voice,* 7.
[40] Ibid.
[41] Ibid.

back, then, against this control becomes difficult. As Roland Barthes states, "I was fascinated by scientific language, euphoric for me precisely to the degree that I had no resistance to offer it."[42] Barthes implies the inherent difficulty in repulsing that which one cannot understand. This can be coupled with an assumption that those on the inside, those that speak scientific discourse, would not want to push back against something that privileges them.

An aspect of scientific discourse that is partially responsible for creating inaccessibility is the tremendous compression of the language. "It is a form of speech made super heavy by modes of shorthand condensation, by substitution, redefinition, fusional reduction of terms, and by the continual adding on of new and more precision-oriented nomenclature." [43] As a tool for information transmission, this language is highly effective. Scientific discourse, in a sense, sacrifices expressiveness "for a chance to approach the performative,"[44] Montgomery invokes the words-as-actions perspective of J. L. Austin in his statement that scientific language does "not merely try to document or articulate knowledge, but to transact it as well."[45] To dilute this language diminishes its function. For those on the inside, the use of scientific discourse can pack a lot of information into a small amount of space, so substituting this language for a more common one ends up decreasing the amount of information that is transmitted, or what Montgomery calls "sacrificing information for accessibility."[46]

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[42] Roland Barthes, "Day by Day with Roland Barthes," in *On Signs,* ed. M. Blonsky (Baltimore, MD: Johns Hopkins University Press, 1985), 102.
[43] Montgomery, *Scientific Voice,* 9.
[44] Ibid., 10.
[45] Ibid.
[46] Ibid.

One important side effect of the language of science is that it creates an "insider voice" used by professionals to "gain legitimacy" and maintain their status through the "exclusion" of others.[47] This insider-outsider exclusion becomes a real challenge to interprofessional collaboration where some elements of language may overlap but other elements create distance. The information/accessibility dichotomy has a power dynamic as well where those with more access to the language hold power over those with less access. While the differences in scientific language access are obvious between healthcare professionals and non-professionals, there are levels of accessibility among healthcare professionals as well. In professional healthcare environments this can be seen in hierarchies and pay scales that correlate with levels of scientific language literacies. As previously mentioned, the in-group/out-group attribute of scientific discourse highlights the inverse relationship between information and accessibility. This may represent an obstacle when collaborating interprofessionally.

The Personification of Processes and Results

Montgomery's second characteristic of scientific discourse from a modernist perspective deals with the *authorship, or the "who" of technical speech*. Montgomery calls attention to "grammatical and syntactic strategies that attempt to depersonalize, to objectify all premises, such that they seem to achieve the plane of ahistorical essence."[48] When readers encounter statements such as "Recent advances have shown" or "Analyses were performed,"[49] we often do not reflect on the fact that the *processes*, *procedures,* or the *evidence* end up becoming the subjects that perform actions and, thus, take on the

[47] Ibid., 4.
[48] Ibid., 13.
[49] Ibid.

responsibility or accountability for what happens afterwards.[50] The language then, itself, tends to separate the author from any individual or social processes that occur during the research process. Montgomery elaborates that "minimal use of pronouns and habitual reliance on transitive verbs"[51] act to simplify the syntactic qualities of the writing. "What seems to appear is Truth, not a claim for it; the scientist, not a particular individual; data, not writing."[52] When writing takes this syntactically simple, and accountability-free attribute, the human behind the writing disappears.

Another procedural characteristic of scientific writing that convolutes authorship also reinforces the insider-outsider dichotomy. Scientific articles always close with a list of references that include insiders and rarely include non-scientific sources. Scientific discourse 'done well' very carefully and intentionally excludes voices, which Montgomery calls "sealed professionalism."[53] Voices and worldviews from outside the profession remain silent in the world of scientific discourse.

Content Trumps Authorship

Montgomery's third characteristic of scientific discourse from a modernist perspective deals with *the 'who' of authorship.* The third characteristic is similar to the second characteristic, the 'who' of technical discourse, which exemplified the personification of processes, procedures, and results.

Montgomery refers to scientific writing as a type of "death of the self, a literary annihilation."[54] He is speaking about the lack of love that comes from scientific writing,

[50] Ibid.
[51] Ibid.
[52] Ibid.
[53] Ibid., 16.
[54] Ibid., 21.

where it is uncommon to use personal pronouns like I, or we, and to completely submit to the codes and conventions of scientific writing. Roland Barthes calls this the act of "making content everything, expression nothing."[55] Writing in this sense eliminates any "components of personal speech itself: play, humor, exaggeration, diversion, excitement, anger."[56] In scientific discourse then language becomes secondary to content, always. Montgomery uses the example of Watson and Crick's seminal paper on DNA to illustrate this point. The discovery of the structure of DNA by Watson and Crick was a profound scientific discovery with implications that far superseded science itself and directly spark questions concerning ethics, culture, and the future of humanity; however the codes and conventions of scientific discourse trap them in a monochromatic world of content, bracketing out any implications that their discovery could unlock answers to physical existence. Watson and Crick's excitement is clearly missing in their statement, "This structure has novel features which are of considerable biological interest."[57] Their 'profound' statement shows no signs of human authorship, of love.

Scientific writing is the exemplar for what structuralists claim for writing in general: a focus, not on authorship, but on form and function as it relates to meaning creation. For structuralists, language, and the study of it, becomes a scientific endeavor, able to be studied and understood in its fixed state. With his "Structure, Sign and Play in the Discourse of the Human Sciences," and *Of Grammatology*, Jacques Derrida argues that meaning is not fixed, but unstable and contingent. Derrida's deconstruction lies within a larger poststructuralist movement. Barthes applies central tenets of Derrida's

[55] Ibid.
[56] Ibid.
[57] James Dewey Watson, *The Double Helix. Text, Commentary, Reviews, Original Papers* (New York, NY: Norton, 1980), 237.

deconstruction to authorship in his seminal essay, "Death of the Author" where he argues for collaborative authorship between the original author's writing and the reader's unique interpretation. Barthes claims, "to give a text an Author is to impose a limit on that text, to furnish it with a final signified…"[58] Taken together, "if anything is destroyed in a deconstructive reading, it is not the text, but the claim to unequivocal domination of one mode of signifying over another. A deconstructive reading […] analyses the specificity of a text's critical difference from itself."[59] Methods of deconstruction and poststructuralist thinking, then, may act as a counter-statement to science's self-referential claims to truth.

Education, then, becomes important to include in this conversation. Scientific writing is most often taught at the university level, with courses on science writing, technology writing, or simply "how to write clearly and effectively."[60] Young scientists are being methodically taught in college to eliminate their voice and focus on content in the most condensed terms possible. Other than problems of exclusion and shifting accountability, this also creates problems of motivation, since this type of writing is "neither particularly interested in language, nor the writer."[61] Scientific writing, thus, is seen as a chore, nothing to get excited about. As noted above, scientific writing has lost the *love*. A potential remedy to this love-loss may be as simple as "*reading* good writing. Students should be reading professional journals, but also Shakespeare.[62]

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[58] Roland Barthes, "The Death of the Author," in *Image-Music-Text,* trans. Stephen Heath (London: Fontana, 1977), 147.
[59] Barbara Johnson, "The Critical Difference: Balzac's 'Sarrasine and Barthes's 'S/Z,'" *Diacritics*, *8* no. 2 (1978): 2-9.
[60] Montgomery, *Scientific Voice,* 23.
[61] Ibid.
[62] Robert A. Day, *How to Write and Publish a Scientific Paper* (Philadelphia, PA: ISI Press, 1979), 160.

To summarize, Montgomery lists three essential characteristics of scientific discourse from a modernist perspective: "its ability to split the speaking world, it's erasure of origins and influences, and it's repression of the individual writer."[63]

If scientific discourse claims truth based on its separation from politics and culture, it should be scrutinized more than other forms of discourse, based on logical fallacies inherent in self-referential truth-telling. Those who understand science can be the only ones that write about why science is truth, so discussions of truth can only be had by those included in the group. It begs the question: Can truth be separate from culture and social interaction?

This discussion relates closely to the present dissertation on interprofessional healthcare education because, presently, nearly all of the writing that has been done on the subject comes from within scientific discourse itself. For instance, the Interprofessional Education Collaborative (IPEC), which has assembled the list of interprofessional competencies used in this thesis, is made up of experts from the fields of nursing, osteopathic medicine, pharmacy, dentistry, medicine, and public health. The professional collaborators were *all* trained, albeit at various levels, in the language of science. That is the main rationale for the present work, calling for pluralism or a multivocality in order to bring back what has been lost from scientific inquiry, and add culture and history back into the conversation when trying to understand how to better collaborate as a team in the healthcare environment.

[63] Montgomery, *Scientific Voice,* 24.

Separating Morality from Science

Montgomery reminds us that scientific discourse was not always characterized by linguistic separation. He references scientific speech before the end of the nineteenth century that included alternative discourses. Montgomery lists scientists such as Galileo, Leibnitz, Newton, Darwin, and Freud as far more universally expressive and willing to "borrow from other forms of discourse" [64] These scientists were known as natural philosophers. Montgomery reminds us "when Copernicus composed his famous *De revolutionibus*[65]*,"*[66] during the Renaissance, "differences between science, philosophy, and literature hardly existed at the level of basic discourse."[67] Montgomery also illustrates Darwin's scientific prose, which appealed to wide-ranging audiences, and was also technically legitimate.[68] This reminds us that legitimation, whether intentional or unintentional, is socially determined.

Only in recent years has all other non-technical speech been driven out of scientific discourse. This process of distillation emerged alongside the professionalization of science, the rise of the university, and as previously mentioned, coincided with the shift from writing scientific books to peer reviewed journal articles. The scientist "no longer writes of moral matters or offers analogies for philosophical reflection."[69] Relevant to the current dissertation, this eschewing of morality and ethics from scientific writing should raise a red flag as to a primary obstacle that needs, not to be overcome, but reflected upon, as we try to decide how scientific professionals can learn to cooperate

[64] Ibid., 26.
[65] *De Revolutionibus* is the famous work by Nicolaus Copernicus which suggested that the Earth rotated around the sun. This controversial work was a competing paradigm to Ptolemy's geo-centrism.
[66] Montgomery, *Scientific Voice,* 26.
[67] Ibid.
[68] Ibid., 27.
[69] Ibid., 29.

with one another in a professional healthcare environment, where ethics and values are at its center.

Postmodern Perspectives of Scientific Discourse

In addition to Montgomery's modernist perspective on scientific discourse, he also offers a more postmodern look at scientific discourse when he states:

> There is a very practical reason why scientific discourse fails in its bid to become fully universal in every way; it remains divided among the many separate languages of the contemporary world, each of which impresses a quality of difference upon it. In what way or manner is science in French different from that in German or English or Russian or Hindi? What kind of structural or semantic changes take place when it is transferred from one language to another?[70]

Derrida discusses metaphorical writing within the language of science as "orienting research and fixing results."[71] Mikhail Bakhtin's view that every text is always and already part of a larger discourse, is expounded upon by Roland Barthes who says "a text is not a line of words releasing a single theoretical meaning… but a multidimensional space in which variety of writings, none of them original, blend and clash."[72] Barthes paints a picture of an ongoing and complex battleground of discourse and meaning that cannot be controlled or contained. Montgomery adds that "other structures, other voices, other context of meaning are always there, waiting, as it were, for emancipation."[73]

Two postmodern scholars that have addressed scientific discourse in depth are Mikhail Bakhtin and Jean Francois Lyotard[74].

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[70] Montgomery, *Scientific Voice,* 44.
[71] Jacques Derrida, *Writing and Difference,* trans. Alan Bass (Chicago, IL: University of Chicago Press, 1978), 17.
[72] Barthes, "Death of the Author," 147.
[73] Montgomery, *Scientific Voice,* 46.
[74] Jean-Francois Lyotard was a twentieth-century French philosopher best known for his interpretation of postmodernism. Lyotard laments the demise of the meta-narrative and the rise of the little narratives when it comes to postmodern science. He claims this shift carries with it a de-legitimation, where faith in the scientists' search for truth is no longer assumed and replaced by data and technology.

Mikhail Bakhtin

According to Mikhail Bakhtin, the Russian theorist on language, meaning is created through our utterances in relation to others. The words gain meaning through context, which may include culture, community, time, place, and the other's expressions. Words for Bakhtin, then, are always embedded in a history, or chain of ongoing context-rich moments. Meaning does not originate from abstract sentences out of context. Scientific discourse, then, according to Bakhtin, will either fail in its attempt to eschew culture and history, *or* we must view scientific discourse as situated in a culture, community, history, and place of scientific discussion. Bakhtin also argues that a spoken word is always addressed to someone, "provoking and answer,"[75] with the anticipation of some kind of response. Bakhtin states that speech is "inherently responsive […] any utterance is a link in the chain of communication."[76] Bakhtin's perspective allows us to view all discourse as dialogic. This inseparable links words and context. Scientific discourse must also be inherently dialogic, always contributing to a larger conversation. Scientific discourse, then, cannot live in its sterile, dictionary form. Bakhtin continues, "Neutral dictionary meanings of the words of a language ensure their common features and guarantee that all speakers of a given language will understand one another, but the use of words in live speech communication is always individual and contextual in nature."[77] Applied to professional, scientific discourse, Bakhtin helps us understand the importance of context, and the impossibility of separation from it. We may begin to see

[75] Mikhail Bakhtin, *The Dialogic Imagination: Four Essays* (Austin, TX: University of Texas Press, 1992), 279-280.
[76] Mikhail Bakhtin, *Speech Genres and Other Late Essays,* trans. Vern W. McGee (Austin, TX: University of Texas Press, 1984), 68.
[77] Bakhtin, *Speech Genres,* 88.

that culture, history, community, and the voices of others have been perpetually underappreciated.

The speech experiences of individuals develop over time, through interaction and assimilation with others speech patterns. Bakhtin refers to this concept as *heteroglossia*.[78] For the health professional, we can understand this by stating that the speech of medical professional is a combination of styles borrowed from other medical professionals they have interacted with. Taken further, the more a health professional is isolated from other health professionals (or others in general), the less interaction and assimilation from those outside, and the more difficult it will become to start communicating with similar words and styles. Thus, the more healthcare professionals exist and communicate in silos, the less polyphonic their particular discourse becomes. The risk, then is a kind of 'closing off' of the discourse. From. Bakhtin's *The Dialogic Imagination*, "discourse lives, as it were, beyond itself…; if we detach ourselves completely from this connection, all we have left is the naked corpse of the world, from which we can learn nothing at all about the social situation or the fate of a given word in life."[79] A detached scientific discourse, then, teaches us nothing about the world.

Bakhtin actually "develops a scheme for delineating how natural science and the humanities differ in their approach to language."[80] Bakhtin claims, unsurprisingly, that the human sciences have much more of a dialogue with culture than do the hard sciences or natural sciences. This is mainly because, according to Montgomery, the human

[78] Heteroglossia is a term created by Mikhail Bakhtin which translates to the feature of containing multiple languages. The term is used by Bakhtin to describe national languages as being composed of a multiplicity of languages that often co-exist in a state of tension or competition with one another.
[79] Bakhtin, *Dialogic Imagination,* 292.
[80] Montgomery, *Scientific Voice,* 25.

sciences study other forms of discourse, including "documents, literature, art, music, [and] criticism."[81] The reason that the humanities are important in scientific discourse is because they do not just involve the content of science or the content of the material world, they involve direct communication and direct analysis of other types of speech, other voices.[82] Bakhtin reaffirms Montgomery's claim that scientific discourse personifies non-textual things, abstract truths, and gives them a voice. This voice is "the scientist."[83] The scientist is both the writer of scientific discourse and the reader of scientific journals, and scientific writing.[84] The scientist is faceless, nameless, without history, and without culture. The scientist speaks only in monologue.

Jean Francois Lyotard

Jean Francois Lyotard agrees with Montgomery's assessment of scientific discourse in that it distances itself from non-speakers of this discourse. Lyotard goes further in *The Postmodern Condition*, however, and makes clear distinctions between scientific knowledge and narrative knowledge (knowledge gained through narrative). He arrives at his conclusions from a language-as-action perspective introduced above by Bakhtin; through devices he calls 'language games.' Language games are structures and rules governing knowledge statements. Different games have different rules. Lyotard begins this investigation by differentiating scientific knowledge and narrative knowledge, which he claims are in "competition and conflict with each other."[85] Categories of language games that Lyotard analyzes are *denotative,* such as, 'The patient is sick.'; and

[81] Ibid.
[82] Ibid.
[83] Ibid.
[84] Ibid.
[85] Richard Niesche, *Deconstructing Educational Leadership: Derrida and Lyotard* (New York, NY: Routledge, 2013), 8.

performative declarations, which do more than just describe, they are not true-false statements and may change the state of something, such as 'I promise to take the full course of antibiotics.' Lyotard also includes *prescriptive* categories, such as 'Pick up your medication on the way home.' These games deal with what *ought* to be done.

Lyotard's analysis finds four common elements across games: the sender, receiver, referent (subject or object), and the meaning. Lyotard also identifies three invariant rules within these games: 1) the rules are not inherently legitimate, but are explicitly or inexplicitly agreed upon between participants, 2) without rules there is no game, and 3) "every utterance should be thought of as a 'move' in a game."[86] These rules are significant when considering social bonds created during the course of a game. "The observable social bond is composed of language moves."[87] Thus, language games are not really about the language itself, but the "type of social interaction encouraged and facilitated through language."[88] Studying scientific discourse and the rules that govern it, then, becomes extremely relevant to social interactions facilitated through its use.

Lyotard carries his analysis further by making a comparison between narrative knowledge acquisition (through narration) and scientific knowledge acquisition. He explains the importance of narrative knowledge including the triumph of the 'hero,' and the subsequent judgment and evaluation of the self against this benchmark. A narrator is deemed competent by having heard the story before. The "narratee gains access to this

[86] Jean-Francois Lyotard, *The Postmodern Condition: A Report on Knowledge,* trans. Geoff Bennington and Brian Massumi (Minneapolis, MN: University of Minnesota Press, 1984), 10.
[87] Lyotard. *The Postmodern Condition,* 11.
[88] Niesche. *Deconstructing Educational Leadership,* 9.

authority by listening."[89] Access, then, for narrative knowledge and the authority that comes with it, requires only an ability to process the language of the narrative.

Following Lyotard's discussion of narrative knowledge games, he frames his main argument by stating "postmodern society is characterized by the incommensurability between languages games."[90] Focusing specifically on scientific discourse as a language game, he shows this game is not comparable to the narrative language game. His argument has five main properties. According to Lyotard, 1) "Scientific knowledge requires that one language game, *denotation*, be retained and all others excluded."[91] Furthermore, 2) scientific knowledge is not necessarily part of social bonding, 3) the required competence lies solely with the sender, 4) the mere act of reporting science does not give it validity, and 5) science assumes a memory of past scientific discourses.[92] It becomes initially apparent in the Lyotardian analysis that much of the incommensurability has to deal with exclusion, social bonding, and legitimation… "both clash and fail to see the other as valid. It is not possible to validate narratives on the basis of scientific knowledge and vice versa."[93]

Lyotard focuses heavily on the ideas of validation, or what he refers to as legitimation. "It is through legitimation that science gains its credibility."[94] This relegates the 'grand narrative'[95] to an inferior position. Lyotard argues that scientific discourse, as

[89] Ibid., 10.
[90] Ibid., 9.
[91] Lyotard. *The Postmodern Condition,* 25-26.
[92] Ibid.
[93] Niesche. *Deconstructing Educational Leadership,* 10.
[94] Ibid.
[95] A grand narrative, also referred to as a metanarrative, is introduced by Jean-Francois Lyotard in *The Postmodern Condition* and refers to knowledge that can be gained through storytelling. The grand narrative connects events in a society and makes sense of history. Throughout history the grand narrative has been a way of explaining the world to others. In hearing a story, one is qualified to "legitimately" pass on the

a language game, legitimizes itself in the way it acquires 'proof.' Proof is acquired as a function of efficiency and performativity. Knowledge, no longer being good for its own sake, needs legitimation through efficiency. This commodification of knowledge can now be packaged and sold. The relevance to the current dissertation now becomes clear. Healthcare education packages and sells scientific knowledge within a criterion of performativity. In doing so, grand narratives are subjugated and marginalized because they cannot 'prove' their value to the system. With this same logic, scientific discourse and a focus on performativity and efficiency, constrains itself from new ideas.

The plan of the Royal Society of London during the 17th century, for the creation of a language devoid of extraneous meaning, was destined to fail on its promise to de-animate, it may have tranquilized the animal inside the word, but the anesthetic had its own side effects… exclusion, objectification, self-legitimation, sterility, and creative limitation.

The Return of the Natural Philosopher

Montgomery calls for a more postmodern approach to science writing, integrating "multiple discourses: history, politics, economics, cultural criticism, art, literature, philosophy, mythology, personal anecdotes, fantasy, biography, and much more. Only by means of such integration can science be given back its natural place within the general culture."[96] So, what Montgomery is calling for is not a change to scientific discourse itself but understanding that scientific discourse is only one language, one code, one language game among many, and that good writers speak in the language of science,

knowledge of the story. From Lyotard's postmodern perspective, *all* knowledge becomes narrative in nature.

[96] Montgomery, *Scientific Voice,* 53.

while at the same time acknowledging the existence of other perspectives. So, what postmodernists such as Derrida, Barthes, Bakhtin, and Lyotard may advocate, would be, in a sense, an appreciation for pre-nineteenth century scientific discourse, a return from the scientist to the natural philosopher. They would not abandon scientific discourse altogether, but would acknowledge the inherent biases within the language itself. Scientific language would resort to the place of 'tool,' to be used instrumentally – not deterministically. "Told through and beside these other voices, […] science regains its living, its *ordinary* location in the physiology of culture. It becomes something knowable, something with a reality of connectedness."[97] Part of what Montgomery may be calling for here is a return of the author itself, the return of accountability back to the human being and away from personified processes. Derrida and Barthes would agree with authorship and accountability, but would remind us that the author is a small part of the hermeneutic process. With the author back in their place, the interpretive process can resume. Legitimacy can, once again, be granted by the other.

To conclude the discussion and analysis of scientific writing, the question remains, what can we learn from the deconstruction of scientific discourse that we can apply to interprofessional healthcare pedagogy? Regarding inter-professional dialogue, while keeping in mind the history of professionalization and the silos of both professional skill and language that it creates, Rowland Barthes states "the language of the same suffices us […] We lock ourselves into […] our own social, professional cell, and this sequestration has a neurotic value: it permits us to adapt ourselves as best we can to the fragmentation of our society."[98] Barthes statement alludes to a feeling of security that

[97] Ibid.
[98] Barthes, *The Division of Languages,* 116.

comes with shared linguistic competence. This, no doubt, facilitates professional bonding; however, also creates distance. The uncertainty and discomfort of estrangement remains one of the barriers to interprofessional cooperation.

For the present work it may also be helpful to keep in mind that "specialization leads to overlap as well as divergence."[99] What we have seen in the last hundred and fifty years are combinations of seemingly different disciplines such as biology and chemistry into biochemistry, which was coined in 1850. It is moments like this in which we realize our interdependence and our need to increased collaboration. This involves, not only a sharing of concepts, theories, and ideas, but a sharing and hybridization of our language itself… the language of science, thus, morphs and changes with new ways of thinking and perceiving the world. Although created to stand outside of language, the language of science ultimately submits to the rules of any other nomenclature.

[99] Montgomery, *Scientific Voice,* 55.

CHAPTER 4: THE NEED FOR MULTIPLE PERSPECTIVES IN HEALTHCARE: A RHETORIC AND PHILOSOPHY OF COMMUNICATION APPROACH

Philosophy of Communication

Overview and Approaches to Philosophy of Communication

This dissertation is about improving interdependent, professional relationships with a common goal of quality patient care. In the United States today, health care teams deliver the majority of patient care. That being said, we desire better working relationships, in part, because we desire effective and efficient teams. Thus, to achieve the shared goal of quality patient care, we must establish and maintain quality interprofessional relationships. A first step in working towards this end is understanding and acknowledging *alterity*[1], or our state of being different from others. This otherness can be either a chronic source of conflict or an ocean of perspectives. The attitude from which we approach *alterity* will determine the quality of working relationships, thus, the quality of patient care.

Ronald C. Arnett and Patricia Arneson have worked with the concept of alterity, or *Otherness*, as it applies to communication ethics and philosophy of communication. In their treatment of the subject they begin with the assumption that we are born into Otherness, and dwell within it. This "diversity of positions"[2] represents different ideas inherent in "otherness"[3] – ethics, values, and virtues grounded in unique histories. They use an example "… one can understand capitalism and communism as contrasting philosophies of communication that find their origins in differing assumptions about the

[1] Alterity comes from the Latin word *alter,* which means 'to make different.'
[2] Ronald C. Arnett and Patricia Arneson, eds., *Philosophy of Communication Ethics: Alterity and the Other* (Madison, NJ: Fairleigh Dickinson University Press, 2014), xi.
[3] Ibid.

good life engaged in the marketplace."[4] This example is helpful here because it exemplifies fundamental differences in socioeconomic structure (capitalism versus communism), but also illuminates a common goal (the good life). We can easily make the connection that differences in professional values, may originate from different ideas about patient care. If we heed the insights of Arnett and Arneson, our focus shifts from processes (of relationship building) to content (what values matter to us). If we truly want to understand the Other, in this case, those from other professional silos, we must "learn what philosophies of communication and ethics matter to the Other, as well as to ourselves."[5] This learning should arise from genuine, content-focused conversation.

Hans-Georg Gadamer[6] says "We say that we 'conduct' a conversation, but the more genuine a conversation is, the less its conduct lies within the will of either partner."[7] Gadamer's comment points to the inherent desire to control the conversational environment, to control the process, a desire born of the scientific ethos and deeply embedded within the language of science. Much of the research on communication and professional relationship building is engaged from an empirical, post-positivistic approach, the social science equivalent of the scientific method. Scientific methodologies, from which the biomedical model of medicine is derived, are process oriented. These processes are inherent in the inductive approach to reasoning. Inductive reasoning begins with observation and generating theories from them. Research from this

[4] Ibid.
[5] Ibid., xii.
[6] Hans-Georg Gadamer is a twentieth-century German philosopher. Gadamer's dialogic approach to philosophy is greatly influenced by Platonic-Aristotelian thinking and shows a desire for the practical application of philosophy. Greatly influenced by Heidegger, Gadamer's philosophical hermeneutics is outlined in his major work *Truth and Method,* where he grounds the nature of human understanding in experience, communication, and tradition.
[7] Hans-Georg Gadamer, *Truth & Method* (New York: Bloomsbury Academic Press, 2004), 385.

approach looks for patterns, creates theories, and tests them with hypotheses. Good science leads to accurate prediction that is repeatable. This need for repetition requires standardizing and controlling the environment, which is done via strict processes and procedures. Understanding the limits of the biomedical paradigm can illuminate a new path towards understanding each other. Philosophy of communication breaks the urge to control communication and opens one up to the possibilities of otherness. Using a philosophy of communication perspective, grounded in content, offers a valuable compliment to the process-driven biomedical model.

Philosophy of communication examines communication as lived experience. The term blends philosophy with communication, which have always been intimately related. Philosophy can only become manifest through communication, making it reasonable to investigate communication philosophically.[8] This endeavor involves communicating about both communication and philosophy, and about their relationship to one another. Communication from a philosophical perspective acts to bring others near, while "keeping the self intact."[9] Communication is an invitation to converse.

Some problems emerge when trying to define philosophy of communication. Attempts to reify either philosophy or communication undermine the dynamic nature of each. Ramsey notes that communication "is fundamental for relating with the world, with others, and with ourselves. [Furthermore], there needs to be a rigorous account of how these relations are constituted, and philosophy [is] the means for providing such an analysis."[10] Human beings are born into a world and into a community that is already

[8] Briankle Chang and Garnet Butchart, *Philosophy of Communication* (Cambridge, MA: MIT Press, 2012).
[9] Ibid., 9
[10] Ramsey Eric Ramsey, *The Long Path to Nearness: A Contribution to a corporeal Philosophy of Communication and the Groundwork for an Ethics of Relief* (Amherst, NY: Humanity Books, 1998), 2.

using language; therefore, human beings are "always in language."[11] This inescapability from language means that language is a central part of being in the world. Communication is not merely a way of expressing our existence, but is part of our existence. Pat Arneson, in her book *Perspectives of Philosophy of Communication,* states, "Philosophy of communication examines questions related to the nature and function of human communication."[12] This human expression occurs in specific contexts, but is rooted in various cultural and historical backgrounds. Philosophy of communication is a journey of exploration into the background of "self, other, and society"[13] as a whole.

Within the present context, philosophy of communication assumes that society is created and modified through communication. This is a shift in perspective from traditional, sender-receiver models of communication. Communication from this perspective must be analyzed philosophically. This does not mean it is unimportant to study the objective speech acts themselves; however, it is a fundamental argument of this work that communication is much more than a 'competency' of interprofessional communication; communication is a tool for creating societies, shaping identity, making sense of our alterity, expressing ourselves to others and building bridges into other worldviews.

This approach to communication and philosophy highlight the inadequacies of current communication pedagogy. When communication is viewed scientifically, communication is looked at as merely reproductive and representational.[14]

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[11] Ibid., 95.
[12] Pat Arneson, *Perspectives on Philosophy of Communication* (West Lafayette, IN: Purdue University Press, 2007), 8.
[13] Ibid.
[14] Lenore Langsdorf, "Philosophy of Language and Philosophy of Communication: Poiesis and Praxis in Classical Pragmatism," in *Recovering Pragmatism's Voice: The Classical Tradition, Rorty, and the*

Mathematician, Claude Elwood Shannon, and scientist, Warren Weaver, created the most popular model of communication in the past seventy years. Published in *Bell System Technical Journal,* the Shannon Weaver model of communication[15] (originally known as the mathematical theory of communication) clearly illustrates the process-oriented nature of traditional communication education. Because we view and teach communication as a process, it becomes increasingly difficult to remove oneself from the scientific mind. This is specifically what a philosophy of communication approach can offer, a new way thinking and seeing. Communication becomes an art of interpretation from an orientation to the world that is "open to possibility."[16] There is a creative benefit to approaching communication philosophically, as seeking possibilities outside of oneself. Calvin Schrag believes that worldviews are expressed with every utterance or action.[17] This makes interpretation and meaning-making an ongoing event. Thus, a philosophy of communication approach to interprofessional healthcare education assumes that all members of the healthcare team have a narrative situated within a culture and history, with worldviews and identities created by and sustained through language.

Therefore, a philosophy of communication perspective offers a new way of thinking about health, health care, and healthcare education. For instance, Martin Heidegger's understanding of health as an unimpeded ability to understand, to tune-in to the world, and to participate in discourse is useful not just in understanding the concept of

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Philosophy of Communication, eds. Lenore Langsdorf and Andrew Smith (Albany, NY: SUNY Press, 1995).

[15] Claude Shannon, "A Mathematical Theory of Communication," *Bell System Technical Journal 27* (1948): 379-423. The work was republished as a book with Warren Weaver in 1963 as: Warren Weaver and Claude Elwood Shannon, *The Mathematical Theory of Communication* (Champaign, IL: University of Illinois Press, 1963).

[16] Arneson, *Perspectives on Philosophy of Communication,* 9.

[17] Calvin O. Schrag, *Communicative Praxis and the Space of Subjectivity* (West Lafayette, IN: Purdue University Press, 2003).

health, but also in offering a new way of approaching healthcare education. Health education today emphasizes thinking and talking (Shannon Weaver), but lacks focus when it comes to attunement, or feeling. This dissertation will attempt to compliment the biomedical model and the 'language of medicine', by approaching health and healthcare education through the spectacles of philosophy of communication.

Philosophy of Communication and Healthcare

Gadamer and The Phenomenon of Health?

Health communication in its most basic form is nothing more than communicating about health. It makes sense then to begin with the question: What is health? This is not a new question. The ancients understood the importance of health for multiple reasons. First, all men desired a general feeling of well-being. Second, the ancient Greeks fought constant wars and good physical condition was a matter of national defense. Third, gladiators and Olympic competitors required good health and physical fitness. In fact, even the famous physician, Galen[18], was appointed by the Roman government to advise the diets and exercise regimens of Roman athletes.[19] There is little difference in the way we view health today. We no longer fight to the death in arenas, and most of the wars we fight do not require hand-to-hand combat; however, for the last seventy years, the World Health Organization has defined health in a way that emphasizes that ancient notion of well-being. Health is "a state of complete physical,

[18] Galen of Pergamon was perhaps the most prominent Greek physician and surgeon working in ancient Rome during the 2nd c. His theories of medicine, including anatomy, physiology, neurology, and pathology were influential at medieval universities well into the middle ages. Surgeons used his dissections of monkeys and anatomical drawings as guides until human dissection was more accepted and illustrated, most notably in Vesalius's *De Humani Corporis Fabrica*, in 1543. Galen is well known for his insights into medicine and for his interest in the philosophy of medicine.

[19] Angela Cushing, "Illness and Health in the Ancient World," *Collegian 5* no. 3 (1998): 44.

mental, and social well-being and not merely the absence of disease or infirmity,"[20] This definition allows those living with chronic conditions, such as type-1 diabetes, or HIV to be considered healthy. At the same time, those that are in pristine physical health may be dealing with severe depression, or emotional abuse, and so may be considered unhealthy. Health implies a state of harmony with physical bodies, mental states, and interpersonal relationships. The WHO definition allows room for interpretation.

The present work will assume that health is an enigma, and will not attempt to reify it. I will, however, offer a non-traditional perspective from which to conceptualize health. Fredrik Svenaeus[21] looks at health as a phenomenon. Embedded within this lens is the understanding that the science of medicine can never answer all of the questions encountered in the clinic. Svenaeus sees limitations in the language of medicine, and instead suggests a language of lived experience, specifically the language of phenomenology. A language of lived experience offers a vehicle to express "the feelings, thoughts, and actions"[22] of someone actively experiencing the world. Svenaeus is by no means discounting the importance of physiology, or of the biomedical model. Our physical bodies set the parameters from which we are able to experience the world, including illness, and the biomedical paradigm, in which modern medicine is grounded, has allowed us to live life without constant worry of disease and death. What Svenaeus is offering is an additional way to look at health. When communicating with patients, the language of medicine can be somewhat atomistic, treating individuals as a collection of

[20] "WHO Definition of Health," *World Health Organization*, accessed March 15, 2017, http://www.who.int/about/definition/en/print.html on March 15, 2017.
[21] Fredrik Svenaeus is a researcher and professor at the Center for Studies in Practical Knowledge in Södertörn University in Stockholm, Sweden. His works take a phenomenological perspective and focus mainly on the philosophy of medicine, biomedical ethics, and the medical humanities.
[22] Fredrik Svenaeus, "The Phenomenology of Health and Illness," in *Handbook of Phenomenology and Medicine,* ed. S. Kay Toombs (Dordrecht, The Netherlands: Kluwer Academic Publishers, 2001), 87.

cells. Phenomenology offers a more holistic lens from which to view patient interactions. This lens allows us to try to determine how a patient is experiencing a particular physiological state, and what meanings can be drawn from that experience.

A phenomenological approach to health and illness does not begin with EMR/EHR (electronic medical/health records) codes, biomedical diagnoses, and pharmaceutical prescriptions. It begins, as Husserl intended, with 'the things themselves,' in this case the 'things' are the unwell patients. Furthermore, a phenomenology of illness seems much more tangible than a phenomenology of health. Illness brings with it feelings of pain, nausea, uncertainty, and sometimes meaninglessness. These are phenomena to which one can attune. If we think of disease as a biological state or process, then illness can be understood as the experience of that biological state. Health as an experience, it seems, can only be defined in relation to illness (as we understand darkness as an absence of light). Svenaeus phrases it nicely when he says that health "effaces itself in an enigmatic way."[23] Svenaeus is alluding to Gadamer's *The Enigma of Health*, where Hans-Georg Gadamer acknowledges health as elusive, but describes health as a state where we are open to new things, ready for adventure, and, in doing so, forget ourselves.[24] Gadamer attempts to define health without contrasting it to illness, and in doing so uses the language of Martin Heidegger. Gadamer writes:

> Health is not a condition that one introspectively feels in oneself. Rather it is a condition of being there (Da-Sein), of being in the world (In-der-Welt-Sein), of being together with other people (Mit-den-Menschen-Sein), of being taken in by an active and rewarding engagement with the things that matter in life – It is the rhythm of life, a permanent process in which equilibrium re-establishes itself. This is something known to us all.[25]

[23] Ibid., 88.
[24] Hans-Georg Gadamer, *The Enigma of Health,* trans. Jason Gaiger and Nicholas Walker (Stanford, CA: Stanford University Press, 1993), 143-144.
[25] Ibid., 144-145.

It is worth noting here that Gadamer defines health as 'openness,' just as a philosophy of communication demands openness to alterity. Health professionals can attend to their own health by sharing with one another and reflecting on "the things that matter in life."[26] Gadamer's phenomenology of health does not differ much from the definition put forth seventy years ago by the World Health Organization. They both include a state of physical, mental, and social well-being. Gadamer's use of Da-Sein is in itself meaningful. Martin Heidegger creates the word in his magnum opus, *Being and Time*. Da-Sein is the 'being-there' of existence, but also involves the 'asking' of what is means to *be* there. Da-Sein, then, includes conceptually a mental and physical state of being. According to Heidegger, the outside world is not external to Da-Sein, but constitutive; thus, meaning is made/given through our actions. Meaning is active. So, meaning is not dependent upon appearance, but on use. Svenaeus argues that illness presents resistance to everydayness. We become, in a sense, out of tune, not with the world (it is not external), but with ourselves. Svenaeus calls illness, a "form of homelessness."[27] It may be helpful for both patients and providers to discuss illness through the metaphor of homelessness as it offers a common and relatable frame of reference.

For Heidegger, the tools we use for action include understanding (thinking), attunement (feeling), and discourse (talking). Meaning is created through these interdependent actions as Da-Sein binds itself to the world and to others. Communicating, experiencing, and reflecting in this sense become a manifestation of health itself. The active process of creating meaning is what connects us to the world, and what makes us

[26] Ibid.
[27] Svenaeus, "The Phenomenology of Health and Illness," 90.

healthy. Health, then, must be considered "not a passive state but rather […] an active process – a balancing."[28]

Philosophy of Communication and Interprofessional Practice

As we learned in the Introduction, interprofessional collaboration occurs when professionals from various disciplines work together to deliver high quality of care." This dissertation, however, is more concerned with the education of future collaborators, with interprofessional education. We have determined from the CAIPE, the WHO, and the IOM that interprofessional education should be centered on interaction, collaborative learning, and reflection. How, then, can philosophy of communication contribute to these essential educational elements?

To begin to answer the above question, it is important to highlight one fundamental difference between the scientific perspective and the philosophy of communication perspective. In the former, communication is a transactional process to which one can become competent. For scientists and positivists, communication recreates representations of the world. In the latter, communication is much more than a competency. Communication shapes identity, creates and continually modifies meaning, acts as a bridge between ourselves and others, constructs and destroys society, and is the way we all live in the world. Communication is an interpretive activity that creates meaning and does not merely represent.

A primary component of philosophy of communication is difference. Research on alterity highlights the importance of acknowledging our differences from one another. The attitude with which we approach difference will determine how well we collaborate

[28] Ibid., 95.

with others. Welcoming 'otherness' opens the pre-professional up to diverse perspectives. The open student listens to the 'other' with the intent to understand, not to reply or control the communicative environment. A student that can reconcile differing value structures receives the benefit of multiple perspectives, better understands their own values, and is better equipped to locate common ground.

Philosophy of communication views communication as lived experience. Where scientific thinking frames communication as transactional, as processes to be controlled and manipulated, a philosophy of communication perspective view communication phenomenologically. The world is experienced through language. Words offer invitations to converse, to be with and understand others. Interprofessional education activities that promote genuine and meaningful conversation allow participants the opportunity to experience different worldviews within a specific context of healthcare.

The speech experiences of individuals develop over time, through interaction and assimilation with others speech patterns. Bakhtin refers to this concept as *heteroglossia*. For the health professional, we can understand this by stating that the speech of medical professional is a combination of styles borrowed from other medical professionals they have interacted with. Taken further, the more a health professional is isolated from other health professionals (or others in general), the less interaction and assimilation from those outside, and the more likely that health professionals will start communicating with similar words and styles. Thus, the more healthcare professionals exist and communicate in silos, the less polyphonic their particular discourse becomes. The risk, then is a kind of 'closing off' of the discourse. To combat this, healthy dialogue between different health professionals must become an important component of healthcare education. Dialogue

becomes a principal vehicle of action and for fostering heteroglossia. There are, however, different ways of thinking about dialogue.

Dialogue as Philosophy: Multiple Perspectives on Dialogue

Dialogue is no less than an act of philosophy. When we consider philosophy we are often reminded of Socrates and his method of questioning. He would often ask questions such as 'What is love?' Socrates asked questions, answered questions, and most importantly *listened* to arrive at answers.

Plato's *Laches*: 420 BC

In the West, Plato was probably the first to systematically use dialogue as a literary form. The first instance of this was seen in his *Laches,* a dialogue on courage. The dialogue involves moral questions about raising sons and whether they ought to learn how to fight in armor, and Socrates, in his usual fashion, turns the dialogue into a philosophical inquiry, an "investigation into the nature of courage." The conversation ends in *aporia* and does not really uncover an answer to the question. This is because Plato's focus is more on the process of the Socratic method, which tries to bring "correct notions to birth." In Lamb's introduction to the Loeb edition he argues that:

> …we should observe the care bestowed on evolving the general notion of a quality, as distinct from its various concrete instances, and the insistence on the universality of knowledge, which must somehow embrace all the virtues, and can suffer no limitation in point of time. The way is thus prepared for the doctrine of the permanence and invariability of the true objects of knowledge. [29]

[29] W.R.M. Lamb, "Introduction to Plato's *Laches,*" in *Plato: Laches, Protagoras, Meno, Euthydemus,* trans. W.R.M. Lamb (Cambridge, MA: Harvard University Press (Loeb Classical Library), 1977), .3.

Plato believes that knowledge is universal and that true knowledge knows itself to be knowledge and is based on reason. True knowledge is invariant and does not depend on external objects to determine it. It also transcends sense-perception and moves toward the idea or universal, which is intuitively, and *a priori* known to the soul (True knowledge is not inductive). Plato's ideas of knowledge are closer to those of Locke, where ideas, or more specifically the nature of things, can be known intuitively.

Plato's early concept of dialogue can be seen immediately in his introduction to *Laches.* He says early on that:

> …we think we should speak our minds freely to friends like you. Some people, of course, pour ridicule on such appeals, and when consulted for their advice will not say what they think, but something different, making the inquirer's wishes their aim, and speaking against their own judgment.[30]

Here, Plato shows a sophisticated conception of dialogue being genuine and not predetermined. For Plato as well as many contemporary scholars, dialogue emerges as a by-product as *we* genuinely relate to each other.

After Plato, dialogues became more popular as a major literary genre and continued in various states of popularity from antiquity to modern times. The Platonic dialogues, as a genre, experienced a sort of resurgence in the 20th century with Santayana's *Dialogues in Limbo* and Murdoch's *Two Platonic Dialogues*. The dialogues are great examples of 'dialogue in action,' and are often used by philosopher to exemplify the process of truth-seeking.

[30] Plato, *Laches,* trans. W.R.M. Lamb (Cambridge, MA: Harvard University Press (Loeb Classical Library), 1977), 7.

Most of the research on dialogue today, however, is not dialogic in structure, but emphasizes the importance of perspective when engaging the other. Cissna and Anderson in the essay "Communication and the Ground of Dialogue," offer four unique, contemporary perspectives on dialogue.

Martin Buber

The first perspective on dialogue listed by Cissna and Anderson is that of Martin Buber. In contrast to the linear process of information transmission, which was a popular communication model during the first half of the 20th century, Buber offers a definition of dialogue that focuses on the relationship with the other, or Thou. He writes: "There is genuine dialogue… where each of the participants really has in mind the other or others in their present and particular beings and turns to them with the intention of establishing a living mutual relation between himself and them."[31] This concept of dialogue places the human being as the central focus of the dialogic exchange, not the message, per se.

Matson and Montagu draw extensively from Buber in *The Human Dialogue*, and view dialogue as a "transactional process concerned with the development of self, the knowing of other, and the formation of human relationships."[32] They emphasize dialogue as a "task to be achieved,"[33] and not simply a transaction of information sharing. Buber's philosophy of dialogue is existential, for him existence is an encounter. We are engaged 'at all times' in ether an I-It or an I-Thou interaction. His concepts are clarified in his most popular work, *I & Thou*, where he differentiates between the I-Thou relationship

[31] Martin Buber, *Between Man and Man*, trans. Ronald Gregor Smith (Boston, MA: Beacon Press, 1955), 19.
[32] Kenneth N. Cissna and Rob Anderson, "Communication and the Ground of Dialogue," in *The Reach of Dialogue: Confirmation, Voice, and Community,* eds. Rob Anderson, Kenneth N. Cissna, and Ronald C. Arnett (NY: Hampton Press, Inc., 1994), 11.
[33] Floyd Matson and Ashley Montagu, eds, *The Human Dialogue: Perspectives on Communication* (NY: Free Press, 1967), 8.

and the I-It relationship. The I-Thou relationship is an authentic and intimate exchange between two beings. This relationship has neither structure nor content and cannot be measured. The I-It relationship is the most common and confronts encounters as I-Object encounters, even with other beings. All objects are mental representations and controlled. The I-It relationship is monologic. True dialogue occurs within the world of I-Thou, and suggests that any subsequent practical learning must occur in a reflection upon the I-Thou encounter.

Conversation Analysis

The second perspective on dialogue included here involves "dialogue to denote human conversation."[34] This perspective was developed in the late 60s and early 70s by sociologist Harvey Sacks, though inspired by Erving Goffman's "The Interaction Order." The approach began to gain popularity in the 1980s and 90s with the works of Beach (1989), Craig and Tracy (1983), Hopper (1992), McLaughlin (1984), Nofsinger (1991)[35], Markova and Foppa (1990), and Tannen (1989). This research focused on the details of conversation such as etiquette, turn-taking[36], and greeting management,[37] and was usually quantitative in nature. The methods usually involve videotaping conversations, analyzing every detail of the interaction, and reaching inductive conclusions based on patterns of interaction.

Markova and Fopper, for example, define dialogue as "face-to-face interaction between two or more persons using a system of signs."[38] This perspective tries to answer

[34] Cissna and Anderson. "Communication and the Ground of Dialogue," 11.
[35] Ibid.
[36] Harvey Sacks, Emanuel A. Schegloff, and Gail Jefferson, "A Simplest Systematics for the Organization of Turn-Taking for Conversation," *Language 50* (1974): 696-735.
[37] Ibid.
[38] Ivana Markova and Klaus Foppa, *The Dynamics of Dialogue* (NY: Pearson higher Education, 1990), 1.

questions such as ‘what is dialogue’ and ‘how does it operate?’ This is different than the Buberian approach which views dialogue as an existential event that transcends and kind of analysis.

Mikhail Bakhtin

The third approach to dialogue can be represented by the work of Mikhail Bakhtin. His concept of dialogue is that ideas by nature are dialogical; “they are held in response to others and in anticipation of what others may say. An utterance is always a reply.”[39] Bakhtin saw dialogue not as a communicative achievement, but as a function inherent in language itself. His concept of dialogue was not rigid, but could exist in varying contexts and lengths of time. For Bakhtin, “the simplest and most classic form of speech communication”[40] is when two people converse with one another in an alternating fashion for a given amount of time.

Dialogue for Bakhtin, as previously stated, can materialize in many different forms; for instance, “a series of scholarly papers dealing with a particular topic published over a number of years by various authors constitutes a dialogue.”[41] Dialogue, then, is not only the alternating of roles, but how one incorporates the other into his/her utterance. This is an important concept for Bakhtin as “even the slightest allusion to another’s utterance gives the speech a dialogic turn,”[42] and since every addressed utterance is just a link in a chain of previous and future utterances, all utterances that acknowledge a past utterance or future utterance can be thought of as dialogic in nature. Bakhtin argues that “an utterance is never just a reflection or an expression of something already existing

[39] Bakhtin, *Speech Genres,* 91.
[40] Ibid.*,* 75.
[41] Cissna and Anderson, “Communication and the Ground of Dialogue,” 12.
[42] Bakhtin, *Speech Genres,* 94.

outside it that is given and final. It always creates something that never existed before, something absolutely new and unrepeatable."[43] The idea of unrepeatability takes dialogue, and the utterance altogether out of the realm of the empirical analysis. This perspective may even apply to thought.

For Bakhtin, even individual consciousness is a social process, not autonomous. In fact, the self can only materialize by fusing with others. Bakhtin writes: "I achieve self-consciousness, I become myself only by revealing myself to another, through another and with another's help… Cutting oneself off, isolating oneself, closing oneself off, those are the basic reasons for loss of self."[44] By fusion, Bakhtin does not mean a joining or assimilation, but a complementation by differentiation. For Bakhtin, dialogue does not lead to action – dialogue *is* action. "In dialogue a person not only shows himself outwardly, but he becomes for the first time that which he is… not only for others but for himself as well. To be means to communicate dialogically. When dialogue ends, everything ends."[45] He shares the Burkeian belief that identification happens by simultaneously experiencing similarity and difference, 'what I am' and 'what I am not.'

Hans-Georg Gadamer

One final perspective on dialogue can be seen in Hans-Georg Gadamer. Gadamer believed that people are embedded in a unique history and culture, which create certain prejudices that affect subsequent interpretations. While we cannot escape our biases, we do need to understand what they are in order to foster a more thorough understanding of the situations we encounter. His most popular work *Truth and Method* argues that the two

[43] Ibid., 119-120.
[44] Tzvetan Todorov, *Mikhail Bakhtin. The Dialogical Principle* (Manchester: University Press, 1984), 96.
[45] Bakhtin, *Speech Genres*, 252.

terms (truth and method) are incompatible. He criticizes the two most common modes of human inquiry: scientific approaches modeled after scientific methodologies and a desire to achieve original authorial intent. Gadamer argues that the meaning of a text can no be reduced to an author's intentions; instead, meaning lies in the context in which one is interpreting.

Truth and Method was Gadamer's way of "resuscitating a dialogic conception of knowledge."[46] Gadamer's concepts of knowledge can be applied to dialogue because Gadamer looks at the relationship between interpreter and text and subsequently acknowledges and represents ways of thinking and of questioning. Like Bakhtin, dialogue for Gadamer can exist between a person and a text, which does not require the I-Thou experience required in Buber's concept of dialogue. Knowledge then, for Gadamer, "becomes a developmental process of questioning positions, a process that presumes both an historical positioning and an immersion in a particular tradition."[47] On Gadamer's concept of 'dialogic conversation, Warnke writes: "… just as in conversation, the result is a unity or argument that goes beyond the original position of the various participants; indeed, the consensus that emerges in understanding represents a new view and hence a new stage of the tradition."[48] Gadamer adds his thoughts on conducting such conversations:

> To conduct a conversation means to allow oneself to be conducted by the subject matter to which the partners in the dialogue are oriented. It requires that one does not try to argue the other person down but that one really considers the weight of the other's opinion. Hence, it is an art of testing. But the art of testing is the art of questioning… To question means to lay open, to place in the open. As against the fixity of opinions, questioning makes the object and all its possibilities fluid…

[46] Gadamer, Hans-Georg. *Truth and Method,* p. 4
[47] Cissna and Anderson, "Communication and the Ground of Dialogue," 12.
[48] Georgia Warnke, *Gadamer: Hermeneutics, Tradition, and Reason* (Stanford, CA: Stanford University Press, 1987), 104.

> Thus a genuine conversation is never the one that we wanted to conduct… The partners conversing are far less the leaders of it than the led. No one knows in advance what will 'come out' of a conversation. Understanding or its failure is like an event that happens to us… All this shows that a conversation has a spirit of its own, and that the language in which it is conducted bears its own truth within it – i.e., that it allows something to 'emerge' which henceforth exists.[49]

In Gadamer, as well as all four conceptions of dialogue, space is created for something new to emerge, a new object subject to interpretation. The resulting knowledge is something that could not have been achieved in isolation. Furthermore, "the theory of communication underlying a dialogic conception of relationship represents a way of understanding the world. In particular the world of other selves as well as one's self."[50] From this perspective the world can only be understood in the meeting of the self and the other, and the combination of hermeneutics and 'being' with another.

Rhetoric: Overview and Approaches

A Brief History

The philosophical concepts discussed above represent reflective and dialectic methods of perceiving the world (including concepts of health) and discovering truth. Yet, truth without action does nothing to improve our social world. Furthermore, many individuals are not moved to act from logic alone. Thus, the tools of rhetoric are essential

[49] Gadamer, *Truth & Method,* 367.
[50] Cissna and Anderson, "Communication and the Ground of Dialogue," 13.

in getting people to act toward a common good. Rhetoric, in this sense, is much more than mere persuasion; rhetoric must be grounded in the good.

Rhetoric, however, was not always seen as a constructive tool for disseminating truth; rhetoric could potentially cause great harm. The battle between rhetoric and philosophy goes back more than 2,400 years and is central to Plato's early dialogues. To better understand the anti-rhetoric perspective, it is important to understand how rhetoric was being used in ancient Greece. Citizens studied the art of public speaking in order to participate in Athenian society. Athens was a direct democracy, meaning they did not elect representatives to vote on their behalf, every Athenian citizen (that was not a slave) cast an individual ballot. Improving one's speaking ability, improved their chances of persuading others to vote with them in political and legal matters. In order to improve their rhetorical prowess, citizens would hire teachers of rhetoric called *Sophists*, the most famous of which were Protagoras, Isocrates, and Gorgias. It was common practice for a Greek defendant or politician to hire a Sophist to write a speech for them, which they would memorize and deliver in a public venue as if it was their own. Unsurprisingly, this Sophistic rhetoric drew strong criticism from philosophers of the day.

Plato's most famous attack on rhetoric can be found in *Gorgias* where he introduces his main contention that rhetoric is concerned only with persuasion via manipulation and lacks true knowledge of justice. James Herrick[51] paraphrases Plato stating, "[…] an adequate view of justice must be grounded in true knowledge (episteme), and aim at the well-being of the individual and the city-state (polis)."[52] In

[51] James Herrick is a scholar and professor of communication at Hope College in Holland, Michigan. He has written extensively on the history of rhetoric, argumentation, and the interplay of science and religion.
[52] James Herrick, *The History and Theory of Rhetoric: An Introduction, Second Edition* (Boston, MA: Allyn & Bacon, 2000), 54.

dialogic form, Plato invokes Socrates to debate three increasingly sophisticated interlocutors at a dinner party. The first dialogue between Socrates and Gorgias is aimed at determining the nature of rhetoric, specifically whether it is a true art, or *techne*.[53] Plato corners Gorgias into agreeing that rhetoric deals with the use of persuasive words in court, which Gorgias calls justice. It is here that Plato illustrates the distinction between true knowledge about justice and mere opinion about it. For Plato, "to understand justice is to love it, and at the same time to recognize just how repulsive injustice is."[54] Plato accuses the Sophists of presupposing a just outcome and teaching tricks to achieve that predetermined and often false view.

During the next debate with Gorgias's student, Polus, Socrates makes the argument that rhetoric is nothing but a 'knack' for 'flattery' that involves no real knowledge and "aim[s] at pleasure without consideration of what is best."[55] Socrates concludes that rhetoric is a counterfeit art. It is also here that Plato expounds his philosophy of health. "Real health, for Plato, is a state of well-being in which one is in full possession of mental and physical powers; and is directing those powers toward good ends such as justice. Health also involves self-control and peace of mind."[56] For Plato health does not ensue, but is "pursued through various arts that demand effort, discipline, and even pain."[57] He even goes as far as to identify the "four true arts of health, two for the body and two for the soul, an art of maintenance and an art of restoration for each."[58]

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[53] According to Plato, any true *techne* must involve specialized knowledge of something, and result in some beneficial outcome. Health care providers, for instance, have specialized knowledge of the human body and strive to help individuals and communities live healthier lives.
[54] Herrick, *History and Theory of Rhetoric.* 56.
[55] Plato, *Gorgias,* trans. W.R.M. Lamb (Cambridge, MA: Harvard University Press (Loeb Classical Library), 1925), 465.
[56] Herrick, *History and Theory of Rhetoric,* 57.
[57] Ibid.
[58] Ibid., 58.

Table 4
Plato's Arts of Health

	Body	**Soul**
Maintain	Gymnastics	Legislation
Restore	Medicine	Justice

What we can learn from Plato's concept of health is the importance he places on justice. Legislation is meant to keep us from going astray morally and the judicial system is meant to restore the health of the soul. "It is of utmost importance, then, that a judge understand the true nature of justice."[59] Plato's argument against Gorgias now becomes clear. The Sophist teaches tricks to imitate health (of the soul) and convince (flatter) people that they are healthy (justice has been served) when they are not. Plato then lays out a corresponding "sham art" for each of the four arts of health. The sham arts claim the outcomes of the true arts but lack any true knowledge of the subjects.

Table 5
Plato's Sham Arts of Health

	Body	**Soul**
Maintain	Makeup (lets people appear healthier than they are through artificial coloring and ornamentation)	Sophistic (self-interested political speeches to influence legislation)
Restore	Cookery (home remedies that make people feel good in the short term)	Rhetoric (create beliefs about justice that manipulate true judgment)

[59] Ibid.

In Plato, rhetoric and health are intimately connected through the soul, and it is rhetoric's potential damage to the soul that drives his unfavorable treatment of the 'sham arts.' They create injustice, which for Plato is the worst evil, even worse than the suffering of injustice.[60] As a remedy, Plato demands that a steadfast and virtuous ethical grounding must drive the use of rhetoric. This marriage of goodwill and rhetoric can be found in rhetorical treatises throughout antiquity and the middle ages, and is a recurring theme in contemporary rhetoric.

The final debate in *Gorgias* involves Socrates and Callicles. In this dialectic Socrates agrees that rhetoric can be beneficial but only if it is used to bring about justice; and, because Plato had already accused the Sophists of lacking true knowledge of justice, the argument turns toward the relationship between rhetoric and true knowledge. This, in turn becomes a discussion of the difference between opinion (*doxa*) and true knowledge (*episteme*). Socrates's attack shifts from rhetoric toward the Sophists use of rhetoric. Socrates admits that rhetoric can be extremely valuable when applied to the pursuit of truth or in revealing injustice. In fact he claims that "this is the best way to spend one's days: to live and die in the pursuit of justice and other virtues."[61] By illustrating that rhetoric can achieve a beneficial outcome (true justice), Plato hints that there may, in fact, be a true art (techne) of rhetoric. This techne is elaborated in Plato's *Phaedrus*.

In *Phaedrus*, Plato defines rhetoric as "an art of influencing the soul through words."[62] His definition of rhetoric does not conceptualize rhetoric as inherently good. For Plato, the true rhetorician must also be a philosopher. For "'when an orator who

[60] Ibid., 59.
[61] Plato, *Gorgias,* 527e.
[62] Plato, *Phaedrus,* trans. Harold North Fowler (Cambridge, MA: Harvard University Press (Loeb Classical Library), 1914), 553.

knows nothing about good or evil undertakes to persuade a city in the same state of ignorance' the results are disastrous;"[63] therefore, before anyone embark on a study of rhetoric, they should first seek truth, which comes from philosophical inquiry. Plato dedicates much of *Phaedrus* to philosophical inquiry into the nature of the soul, which he separates into three parts: love of wisdom, love of nobility, and a love of appetite. For rhetoric to achieve its goal, which for Plato is "to establish order in the individual and in the city-state," then "the wisdom-loving part of the soul [must persuade] the other two parts to submit to its control."[64] Plato's *techne* of rhetoric, then, involves an "ordering of the two lower parts so that they can obey reason, in the same way as good government depends on the lower orders obeying the wise rulers."[65] It can be implied then that the ultimate goal of rhetoric is persuading an audience that is led astray by ego and pleasure to return to reason. The lover of wisdom (philosophy) must always drive the chariot if the destination is truth and justice. When one or both of the horses begin to stray, rhetoric may act as the reins.

While Plato sees rhetoric as subservient to philosophy, Aristotle views them as equal. He begins his famous *Rhetoric* with "Rhetoric is the counterpart of Dialectic."[66] The opening claim is a deliberate response to his mentor, Plato. In short, Aristotle is saying that public speaking and logical discussion cannot be separated. "Moreover, his logical works show an equal regard for the interconnection of rhetoric and logic, particularly in the area of *inventio,*"[67] which will be explained below. "At every point he

[63] Ibid., 515.
[64] Herrick, *History and Theory of Rhetoric,* 66.
[65] Ibid.
[66] Aristotle, *Rhetoric,* trans. John Henry Freese (Cambridge, MA: Harvard University Press (Loeb Classical Library), 2000), 3.
[67] James J. Murphy, *Rhetoric in the Middle Ages* (Berkeley, CA: University of California Press, 1974), 7.

is concerned with definition, with implication, and with the relation of one art to another."[68] This deep connection of logic to rhetoric is central to understanding Aristotle's concept of rhetoric.

Logic must be demonstrated, and in this we find rhetoric's utility. According to Aristotle, the function of rhetoric is not mere persuasion, "but rather to discover the means of coming as near such success as the circumstances of each particular case allow."[69] Comparing rhetoric to medicine, Aristotle adds that "it is not the function of medicine simply to make a man quite healthy, but to put him as far as may be on the road to health; it is possible to give excellent treatment even to those who can never enjoy sound health."[70] In his analogy, Aristotle limits the outcomes of rhetoric to what is possible for a particular audience and situation. The art of rhetoric is primarily concerned with discovering these possibilities, which drives his famous definition: "Rhetoric may be defined as the faculty of observing in any given case the available means of persuasion."[71] This definition is still used by contemporary rhetoricians to define their field.

Aristotle not only defines the function of rhetoric, but also offers four ways in which rhetoric is useful in everyday life. His first reason is that when everything else is equal "true and just ideas would usually prevail on their own."[72] If judges do not make decision based on truth, it must be "due to the speakers themselves."[73] In short, the truth needs capable speakers to deliver its message.

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[68] Ibid.
[69] Aristotle, *The Rhetoric and the Poetics of Aristotle* (NY: McGraw-Hill Higher Education (Modern Library College Editions), 1984), 23.
[70] Ibid.
[71] Ibid., 24.
[72] Herrick, *History and Theory f Rhetoric,* 76.
[73] Aristotle, *Rhetoric,* 11

Aristotle's second reason that rhetoric is useful relates to the audience. With some people "[…] even if we possessed the most accurate scientific knowledge, we should not find it easy to persuade them by the employment of such knowledge. For scientific discourse is concerned with instruction, but in the case of such persons instruction is impossible."[74] Simply stated, Aristotle plainly states that there are people whom one cannot instruct. Because literacy was so important to civic life, most Athenian citizens after the sixth century B.C. were literate and capable of high-level thinking.[75] Therefore, we may interpret Aristotle's statements not as lacking the mental ability to learn via reasoning, but more of a stubbornness to engage new ideas. Facts alone cannot persuade everyone. Rhetoric can help address this challenge by making "connections between the point we are arguing and beliefs already held by the members of our audience [… more specifically, their] experiences, values, and beliefs."[76] Rhetoric, for Aristotle, can help a speaker identify with an audience.

Rhetoric is also useful because it allows one to examine and explicate both sides of an issue to better see the facts. This is the spoken form of the dialectic process commonly seen in argumentation and debate. Understanding both sides of an argument greatly helps in the construction of one's argument and in the refutation of a counterargument. Herrick adds that "this skill in argument advances the three benefits inherent to the practice of rhetoric: testing ideas, advocating points of view, and discovering relevant facts and truths."[77]

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[74] Ibid.
[75] Alfred Burns, "Athenian Literacy in the Fifth Century B.C.," *Journal of the History of Ideas 42* no. 3 (1981): 371-387.
[76] Herrick. *History and Theory f Rhetoric.* 76.
[77] Ibid.

The fourth and final reason that rhetoric is useful has to do with defending oneself against attacks. Aristotle writes, "it is absurd to hold that a man ought to be ashamed of being unable to defend himself with his limbs, but not of being unable to defend himself with speech and reason, when the use of rational speech is more distinctive of a human being than the use of his limbs."[78] Aristotle's fourth reason is driven by his insights into the nature of man. In his *Politics*, Aristotle claims "[…] man is by nature a political animal." Aristotle goes on to clarify what he means by political animal.

> The mere voice, it is true, can indicate pain and pleasure, and therefore is possessed by the other animals as well [⋯], but speech is designed to indicate the advantageous and the harmful, and therefore also the right and the wrong; for it is the special property of man in distinction from the other animals that he alone has perception of good and bad and right and wrong and the other moral qualities, and it is partnership in these things that makes a household and a city-state.[79]

In sum, Aristotle is saying that we have purpose, and we use our capacity for speech to communicate observations and values to one another to foster collaboration. And, where some animals fight for what they want with their limbs, it is more natural for human beings to defend themselves with speech and reason.

Table 6
Aristotle's Four Reasons Rhetoric is Useful

According to Aristotle, rhetoric is useful because…	
1	Truth needs capable speakers to deliver its message
2	Rhetoric can help a speaker identify with an audience
3	It allows one to examine and explicate both sides of an issue to better see the facts

[78] Aristotle, *The Rhetoric and the Poetics of Aristotle*, 23.
[79] Aristotle, *Politics,* trans. H. Rackham (Cambridge, MA: Harvard University Press (Loeb Classical Library), 1932), 1.1253.a.1

4	It gives man the ability to defend himself in the way that an animal uses its limbs

Aristotle sees rhetoric as very practical and attempts to systematize an art of persuasion. Within his system there are three elements of speechmaking, three rhetorical situations (settings), and three modes (ways) of persuasion.

The three elements of speechmaking are the speaker, the subject, and the audience. It is the type of audience (public, judges, lawyers, politicians), according to Aristotle, that determines the type of speech. The speech types are labeled according to the rhetorical settings and are as follows: judicial (forensic), epideictic (ceremonial), and deliberative (political). These settings deal with the past, present, and future respectively. Judicial rhetoric is used in the courtroom and "either attacks or defends somebody."[80] These speeches "reconstruct the past"[81] and address questions related to justice. Epideictic rhetoric is usually seen in public ceremonies such as speeches of commemoration or dedication where a person receives praise (or sometimes blame). Deliberative rhetoric looks to the future and asks questions focused on "the best or most advantageous (*sympheron*) course of action to be taken by the state."[82] These speeches argue for the adoption or abortion of a certain political policy and should be guided by the concept of *eudaimonia*[83], which translates to "human well-being, happiness, or fulfillment."[84]

Eudaimonia is closely related to Aristotle's overall concept of ethics and is echoed in the first sentence of *Nicomachean Ethics*: "Every craft and every inquiry, and

[80] Aristotle, *The Rhetoric and the Poetics of Aristotle*, 32.
[81] Herrick. *History and Theory f Rhetoric.* 81.
[82] Ibid., 79.
[83] Ibid.
[84] Anthony Kenny, *Aristotle on the Perfect Life* (Oxford: Clarendon Press, 1996), 4-5.

similarly every action and project, seems to aim at some good; hence the good has been well defined as that which everything aims."[85] He argues that this final end, first, must be chosen for its own sake and never as a means to some greater end, and second, the *concept* cannot be used except for a final end. Aristotle concludes that *eudaimonia* is this end, the highest human good, and the answer to his famous question, "What is the good life?" Political rhetoric, then, must be grounded in the ethical desire for *eudaimonia*, general human flourishing. Once again, an ancient philosopher connects rhetoric to health, not as flattery, but as a tool to pursue it.

For Aristotle, the three rhetorical situations listed above represent most speaking situations. Aristotle, however, is most generally known for his three modes of persuasion, *ethos*, *pathos*, and *logos*. These modes or 'proofs' answer Plato's questions, as found in *Gorgias,* regarding the content of rhetorical education. Rhetoric teaches the three ways of effecting persuasion. "The first kind depends on the personal character of the speaker; the second on putting the audience into a certain frame of mind; the third on the proof […] provided by the words of the speech itself."[86]

Ethos is used by Aristotle in *Nicomachean Ethics* to mean "moral, showing moral character."[87] Because Aristotle's definition of ethics is so closely related to human flourishing, moral character would mean being generally concerned with *eudaimonia*. This goodwill is one of the three characteristics of ethos, the other two being virtue and *phronesis* (*phronesis* is described in depth in the chapter on ethics). Aristotle later

[85] Aristotle, *Nicomachean Ethics,* ed. Lesley Brown, trans. David Ross (NY: Oxford University Press, 2009), 1.
[86] Aristotle, *The Rhetoric and the Poetics of Aristotle*, 24-25.
[87] Aristotle, *Nicomachean Ethics*, Book 2, 1103.a.17

describes these characteristics as "good sense, good moral character, and goodwill."[88] Ethos opens the door to persuasion as we are inclined to agree with credible people who want the best for us. Without ethos, the other two modes of persuasion are irrelevant.

Pathos, or the stirring of emotion, is not an emotional manipulation, but an appeal to intelligent and rational human beings that experience the world. A speaker should develop knowledge of certain beliefs and feelings that may affect one's judgment. They can then move the audience into the "right frame of mind"[89] to be able to judge correctly. Aristotle writes "Our judgments when we are pleased and friendly are not the same as when we are pained and hostile."[90] Speakers that use *pathos* to persuade tap into audience motivations. Aristotle uses anger as an example stating that it is important to know three things about anger before we can evoke the emotion: the state of mind of an angry person, the types of people that normally invoke this emotion in others, and typical reasons people become angry.[91]

Logos is the third mode of persuasion for Aristotle. *Logos* refers to an audience appeal grounded in reason. These appeals usually take the form of a syllogism, which is a simple three-part deductive logic consisting of a major premise (a general truth), minor premise (specific example of that general truth), and a conclusion. Aristotle describes the syllogism in more detail in his *Topica.* The most famous example of a syllogism is: All men are mortal (general), Socrates is a man (specific); therefore, Socrates is mortal (conclusion). In the context of a speech, these syllogisms often take the form of an *enthymeme*, which is a shortened syllogism. The above example may sound like this:

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[88] Aristotle, *The Rhetoric and the Poetics of Aristotle*, 91.
[89] Aristotle. *Rhetoric*, 1358.a.
[90] Aristotle, *The Rhetoric and the Poetics of Aristotle*, 25.
[91] Ibid., 92.

Socrates is mortal because he is a man. In a healthcare setting a persuasive *syllogism* may look like this: The normal blood sugar level for an adult is 70-140 mg/dl (milligrams per deciliter); the patient's blood sugar is 40 mg/dl; therefore, the patient needs a glucose tablet. The corresponding *enthymeme* may sound like this: Give the patient a glucose tab because his blood sugar is 40.

Aristotle is consistent in his "philosophic approach to the problems of communication."[92] For Aristotle, *logos* is always grounded in the truth of the speech itself, by the *enthymemes* representing a solid deductive process. Only when pure deduction fails should we rely on examples and other supporting evidence to convince our audiences. Aristotle clearly wants to argue from general principles to specific conclusions. Arguing from examples will shift the argument from deductive to inductive; thus, will shift the argument to balance on the uncertainty of the inductive leap.[93] The conclusions of induction can be influential, but cannot be stated with absolute certainty (If the major premise is true and the minor premise is true, then the conclusion must also be true).

In the remainder of his treatise, Aristotle approaches rhetoric somewhat scientifically, dividing and examining relevant speech elements and creating rules for specific situations in order to achieve maximum persuasive effect. He includes a section on style, arguing primarily for clarity. "Clearness is secured by using words (nouns and verbs alike) that are current and ordinary."[94] Aristotle discusses the persuasiveness of

[92] Murphy, *Rhetoric in the Middle Ages*, 7.
[93] An inductive leap is a term used to describe the necessary generalization of specific examples to a general population. There will always be an inductive leap when it is impossible to measure every instance of occurrence. For example, throughout history every human being that was born has eventually died; therefore, all human beings are mortal.
[94] Aristotle, *Rhetoric,* 1404b.

being natural and avoiding the somewhat artificial feeling of an overly artistic speech. Although not central to his *Rhetoric,* Aristotle includes advice for the organization or arrangement of a speech, and offers tips for effective delivery. Furthermore, he introduces concepts used in contemporary argumentation including common logical fallacies[95] and common topics (*topoi*) and refutations.[96] Throughout his *Rhetoric*, Aristotle consistently maintains rhetoric as the delivery vehicle for true knowledge in the pursuit of justice.

Although rhetoric was born in Greece, it was adopted by Rome and became central to their liberal arts education. Two early Roman rhetoricians, Cicero and Quintillian, stand out as solidifying rhetoric as "*the* system of education in the Roman Empire."[97] Cicero's rhetorical writings would, in fact, be cemented in liberal education for the next 1,800 years.

Marcus Tullius Cicero was Rome's greatest speaker during the first century B.C. His intuitive understanding of the people of Rome, supercharged his mastery of public argumentation theory.[98] He is credited with adapting Greek rhetoric to make it more accessible to Roman orators and more focused on judicial rhetoric than on Greek deliberation. Often overlooked was his gift of translation. He created Latin terminology that was "capable of expressing the meaning of the Greek ones."[99] His first attempt to do this, *De Inventione*, was admittedly a bit "rough;"[100] however, was written when he was

[95] Aristotle deals heavily on the detection of logical fallacies in his *De Sophisticis Elenchis.*
[96] Aristotle expands on the concept of *topoi* in his *Topica.*
[97] Calvin Troup, *Temporality, Eternity, and Wisdom: The Rhetoric of Augustine's Confessions* (Columbia, SC: University of South Carolina Press, 1999), 13.
[98] Christopher P. Craig, *Form as Argument in Cicero's Speeches: A Study of Dilemma, American Classical Studies #31* (Atlanta, GA: Scholars Press, 1993).
[99] Christian Habicht, *Cicero the Politician* (Baltimore, MD: Johns Hopkins University Press, 1990), 2.
[100] Martin Lowther Clarke, *Rhetoric at Rome* (New York, NY: Barnes & Noble, 1953), 53.

nineteen years old. One of his major themes from this work was the importance of both wisdom and eloquence in rhetorical education, echoing both Aristotle and Plato. He begins his treatise with the following:

> I have often seriously debated with myself whether men and communities have received more good or evil from oratory and a consuming devotion to eloquence. For when I ponder the troubles in our commonwealth, and run over in my mind the ancient misfortunes of mighty cities, I see that no little part of the disasters was brought about by men of eloquence. When, on the other hand, I begin to search in the records of literature for events which occurred before the period which our generation can remember, I find that many cities have been founded, that the flames of a multitude of wars have been extinguished, and that the strongest alliances and most sacred friendships have been formed not only by the use of reason but also more easily by the help of eloquence. For my own part, after long thought, I have been led by reason itself to hold this opinion first and foremost, that wisdom without eloquence does too little for the good of states, but that eloquence without wisdom is generally highly disadvantageous and is never helpful.[101]

Cicero, like Aristotle and Plato (more in *Phaedrus* than *Gorgias*), understood the world-altering potential of rhetoric, and the importance of grounding eloquence in wisdom. Cicero, however, is more Aristotelian in his understanding of wisdom. For Romans in general, wisdom is acquired "through practical experience, expert knowledge, and a sense of responsibility in both private and public life."[102] Cicero's understanding of wisdom shaped rhetorical education in a way that gave special attention to "philosophy, ethics, and other disciplines important to careful thinking and good government."[103] In addition to these focal areas, Cicero divided the study of rhetoric into five parts commonly referred to as the five canons of rhetoric. These are: Invention, Arrangement, Expression (Style), Memory, and Delivery. These canons are not original to Cicero and can be found

[101] Cicero, *De Inventione*, trans. H. M. Hubbell (Cambridge, MA: Harvard University Press (Loeb Classical Library), 1968), I.i.1, 3.
[102] James M. May, *Trials of Character: The Eloquence of Ciceronian Ethos* (Chapel Hill, NC: University of North Carolina Press, 1988), 6.
[103] Herrick. *History and Theory of Rhetoric*, 96.

in Aristotle's *Rhetoric*. These five canons can be used to serve each of the three functions of oratory: to teach, to delight, and to persuade.

Invention, which Cicero calls the most important, is the discovery of valid arguments. This systematic investigation for arguments draws heavily on philosophical inquiry and the discovery of proofs. *Inventio* is also a creative endeavor because each speech is tailored for a specific audience in a particular historical moment. Thus, invention involves finding balance between convention and invention.

Arrangement, the second canon*,* is the organization of the discovered arguments into their proper order. The goal is to arrange arguments for maximum persuasive appeal. Classical rhetoricians often used the following organizational order: Introduction (state your thesis, captivate your audience, and build credibility), Statement of facts (educating the audience so they can gain context for your argument), Division (this is a transition between the statement of facts and your first argument that provides a preview of the rest of your speech), Proof (main body of speech, construction of logical arguments), Refutation (highlighting weaknesses in the counter-argument), and Conclusion (emotional summary).

Cicero refers to *style* as "the fitting of the proper language to the invented matter."[104] Style does not focus on content, but on how that content is delivered. There are, in fact, five virtues of style developed in Greece by students of Aristotle and adopted by both Cicero and Quintilian for use in Roman education. These virtues are: correctness, clarity, evidence, propriety, and ornateness.

[104] Cicero. *De Inventione*, I.vii.9-viii.

Correctness refers to the matching of vocabulary, grammar, and usage of words or groups of words to the conventions of a given language and culture.[105,106,107] Similar to correctness, *Clarity* refers to the intelligibility of the language. Clear language is not ambiguous and uses common terminology. Clarity can be aided by other rhetorical strategies such as repetition.[108] *Evidence* as an element of style does not refer to logical proofs; it refers to the vividness of the descriptions of events and how effectively the speech creates emotional affect.[109] Propriety, also referred to as *decorum*, is an element of style that fits appropriate words to the specific subject matter, audience, and speaker. Propriety takes circumstances into account. The fifth virtue of style, *ornateness*, focuses on the rhythms of words and their aural appeal.[110] Developing a mastery of style is an audience-centric activity that allows an orator to deliver content in an appealing package.

The fourth canon, memory, "is the firm mental grasp of matter and words."[111] The importance of public oratory in Greek and Roman culture necessitated the exercising and reliance on memory. Speeches were not given from notes; in fact, the ancient Greeks often looked down on the act of note taking itself. Plato's *Phaedrus*, for instance, included a warning against relying on the written word:

> If men learn this, it will implant forgetfulness in their souls; they will cease to exercise memory because they rely on that which is written, calling things to remembrance no longer from within themselves, but by means of external marks. What you have discovered is a recipe not for memory, but for reminder. And it is no true wisdom that you offer your disciples, but only its semblance, for by telling them of many things without teaching them you will make them seem to know

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[105] Aristotle. *Rhetoric.* 3.5
[106] Cicero, *Rhetorica Ad Herennium,* trans. Harry Caplan (Cambridge, MA: Harvard University Press (Loeb Classical Library), 1954), 3.
[107] Quintilian, *Institutio Oratoria,* trans. H. E. Butler (Cambridge, MA: Harvard University Press (Loeb Classical Library), 1980), 8.1.2.
[108] Ibid. 8.2
[109] Ibid. 8.3.61-71.
[110] Ibid. 8.3.
[111] Cicero, *De Inventione*, I.vii.9-viii.

> much, while for the most part they know nothing, and as men filled, not with wisdom but with the conceit of wisdom, they will be a burden to their fellows.[112]

Memory, in a sense, is related to Aristotle's notion of ethos, which encompasses perceptions of intellect, competence, and dynamism.

There were certain techniques that students of rhetoric would perform to exercise their memory. These included memorizing long speeches through memory techniques such as *loci*, Latin for *places*. This technique involves the visualization of familiar physical places within one's spatial memory, such as the layout of your home. By 'placing' elements of your speech in different rooms of your house, one simply walks through their house to easily recall information. This technique was inspired by the story of a Greek poet named Simonides[113], whom Cicero credits with inventing "the science of mnemonics."[114] Quintilian also praises Simonides for his ability "to excite pity" in his writing.[115] In addition to remembering existing speeches, speeches are also created to *be* memorable using techniques of elaborative encoding with the goal of making meaningless content meaningful.

The fifth canon, *delivery*, is "the control of voice and body in a manner suitable to the dignity of the subject matter and the style."[116] Where rhetorical invention is the discovery of content for a speech, delivery is the performance of that content. Modern instruction of delivery usually involves rate, volume, tone, and use of pauses; however, ancient orators also spent a lot of time studying "movement, gesture, posture, [and] facial

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[112] Plato, *Phaedrus*, 274c-275b.
[113] Simonides of Ceos was a Greek lyric poet of the fifth century B.C. He is well-known for his wisdom, his colorful use of language, his contributions to mnemonics for memory, and for adding four letters to the Greek alphabet.
[114] Cicero, *De Oratore,* trans. E.W. Sutton and H. Rackham (Cambridge, MA: Harvard University Press (Loeb Classical Library), 1948), 465-67.
[115] Quintilian, *Institutio de Oratoria,* 10.1.64.
[116] Cicero, *De Inventione*, I.vii.9-viii.

expression[…]."[117] Thus, Greco-Roman political speeches had a much different feel than contemporary political rhetoric.

In addition to translating Aristotle for the Roman audience and introducing the five canons of rhetoric, Cicero also argues for the use of humor and that an orator should be broadly educated.[118] For Cicero, great orators are rare. The audience is always of central concern and so an orator must be in tune with *all* of humanity, concerning themselves with the "common practice, custom, and speech of mankind."[119] This involves the study of philosophy, art, literature, law, history, ethics, and foreign languages because "it is from knowledge that oratory must derive its beauty and fullness."[120] In speaking the language of mankind, the orator's central focus is on the audience. He does not pander to the ignorant, as Plato suggested in *Gorgias*.

If Cicero was Rome's greatest speaker, then Quintilian was its greatest teacher. Where Aristotle laid the foundation for rhetorical theory and Cicero applied Aristotle's theories to the Roman orator in his many important pragmatic rhetorical works, Marcus Fabius Quintilianus focused on the complete education of the orator. Quintilian, as he is known, "was placed in charge of the first public school of Rome"[121] by the Emperor Domitian. His most important work, *Institutiones Oratoriae Libri XII* (12 books covering the Institutes of Oratory), was nothing short of a complete and systematic review of the rhetoric to date. *Institutio Oratoria* is often described as four works in one including "a treatise on education, a manual of rhetoric, a reader's guide to the best authors, and a

[117] Herrick, *History and Theory of Rhetoric,* 97.
[118] Cicero, *De Oratore,* I.ii-v.6-18.
[119] Ibid*.,* I.iii.12.
[120] Ibid*.,* I.v.20.
[121] James J. Murphy, *Quintilian: On the Teaching of Speaking and Writing, Translations from Books One, Two, and Ten of the Institutio Oratoria* (Carbondale, IL: Southern Illinois University Press, 1987), xvi.

handbook of the moral duties of the orator."[122] This "cradle to grave"[123] education was liberal in nature, designed to be "a complete educational [program] for young Romans who were to become the leaders of the state."[124] These so called citizen-orators would lead through careful analysis, reflection, eloquent speaking, and decisive action in situations including "trials, in councils, at the assemblies of the people, in the senate, and in every province of the good citizen."[125]

First and foremost, Quintilian's orator "had to be a good man, able to speak well."[126] He uses Cato the Elder's famous *vir bonus, dicendi peritus*, or "the good man skilled at speaking"[127] to emphasize the moral component in his definition of rhetoric. To begin an education with this moral imperative, Quintilian urges parents to be careful with the people that interact with a child, such as friends and nurses. Parents should also be as highly educated as possible.[128] As Quintilian states in his preface, "Nothing is unnecessary to the art of oratory."[129] This statement echoes Cicero's description of rhetoric. However, Quintilian differs from Cicero and Aristotle in that he focuses primarily on morality in the education of the orator. Quintilian's definition highlights what Cicero implied by uniting wisdom and eloquence. For Cicero, (as well as Socrates, Plato, and Aristotle) wisdom has an inherent moral quality grounded in truth. This wisdom, unlike the pure philosophy of Socrates and Plato, burdens the orator with social

[122] Charles E. Little, *Quintilian the Schoolmaster* (Nashville, TN: George Peabody College for Teachers, 1951), vol. II, 41.
[123] Herrick, *History and Theory f Rhetoric,* 106.
[124] Olga Tellegen-Couperus, ed., "Introduction," in *Quintilian and the Law: The Art of Persuasion in Law and Politics* (Leuven, Belgium: Leuven University Press, 2003), 11.
[125] Murphy, *Quintilian: On the Teaching of Speaking and Writing*, XII.11.1.
[126] Ibid.
[127] Quintilian, *Institutio Oratoria*, XII.1.1.
[128] Ibid., I.1
[129] Ibid., preface, 5.

responsibility. The "ideal orator is no philosopher because the philosopher does not take as duty participation in civic life."[130] Taken together, the works of Quintilian and Cicero grounded rhetorical education for centuries to come.

Rhetoric, however, nearly lost its foothold during the rise of Christianity and the fall of Rome. There was a strong disdain for rhetoric by early Christian scholars because it represented all they disliked about Rome.[131] The pagan art of rhetoric had no place in the delivery of scripture. One proponent of this view was Tertullian who famously wrote "What indeed has Athens to do with Jerusalem? What concord is there between the Academy and the Church? What between heretics and Christians?"[132] It was St. Augustine of Hippo that famously challenged this anti-rhetoric prejudice with the publication of *De Doctrina Christiana*, specifically Book IV. The first three books are philosophic in nature, focusing on interpreting the Scripture. The fourth book of *De Doctrina Christiana* was written nearly 30 years later. It was not completed until 427, after the fall of Rome in 410.

James Murphy refers to book IV as "the first manual of Christian rhetoric."[133] Yet, perhaps more significant than the how-to nature of the book, is the argument to which it rebuts. As Murphy states, "it is the fourth book which contains an outspoken plea for the use of *eloquentia* in Christian oratory."[134] Augustine acknowledges the

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[130] Arthur E. Walzer, "Quintilian's 'Vir Bonus' and the Stoic Wise Man," *Rhetoric Society 33* no. 4 (2003): 25-41, 26.
[131] Joseph M. Miller, Michael H. Prosser, and Thomas W. Benson, eds., *Readings in Medieval Rhetoric* (Bloomington, IN: Indiana University Press, 1974), xiii.
[132] Gerard L. Ellspermann, "The Attitude of the Early Christian Latin Writers Toward Pagan Literature and Learning," *Catholic University of America Patristic Studies 82* (1949): 23-42.
[133] Murphy, *Rhetoric in the Middle Ages*, 57.
[134] James J. Murphy, "St. Augustine and the Debate about a Christian Rhetoric," in *The Rhetoric of St. Augustine of Hippo,* ed. Richard Leo Enos and Roger Thompson et al. (Waco, TX: Baylor University Press, 2008), 205-218, 215.

dangers inherent in empty eloquence,[135] even referencing Cicero's similar warning in *De Inventione* of wisdomless eloquence. However, Augustine argues that eloquence is valuable in promoting evil *or* justice. He also makes the argument to those that maintain the idea that eloquence is a tool used by only the wicked by showing that those preaching lies have the tools of eloquence and the preachers of truth remain "sluggish, cold, and somnolent."[136] Why should the wicked have the advantage? Here Augustine declares, "the art of eloquence should be put into active service, and not rejected out of hand because it is tainted with paganism."[137] Augustine reiterates his point, explaining that "eloquence is that to be used in teaching, not that the listener may be pleased by what has horrified him, nor that he may do what he has hesitated to do, but that he may be aware of that which lay hidden."[138] Simply stated, "the purpose of Christian eloquence is to clarify obscure points of doctrine, not to make audiences like what they previously disliked."[139]

Because of his formal training in classical rhetoric, Augustine understood that "the audience would not accept the teaching without a speech that was pleasing to the ear."[140] Augustine also knew that incorporating rhetorical elements, such as the Ciceronian styles,[141] would be an effective tool for converting the people of Hippo to Christianity. Throughout *De Doctrina Christiana*, Augustine promotes another

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[135] Augustine, *On Christian Doctrine,* trans. D. W. Robertson, Jr. (Upper Saddle River, NJ: Prentice-Hall, 1958), IV.V.8
[136] Ibid., IV.II.3.
[137] James J. Murphy, "Saint Augustine and the Debate about a Christian Rhetoric," *Quarterly Journal of Speech 46* (1960): 400-10.
[138] Augustine, *On Christian Doctrine,* IV.XI.26.
[139] William Wiethoff, "The Merits of 'De Doctrina Christiana' 4.11.26," *Rhetoric Society Quarterly 15* no. 3/4 (1985): 116-18, 116.
[140] Ernest Fortin, "Augustine and the Problem of Christian Rhetoric." In *The Rhetoric of St. Augustine of Hippo,* ed. Richard Leo Enos and Roger Thompson et al. (Waco, TX: Baylor University Press, 2008), 219-233, 219.
[141] Cicero's three styles are plain, middle, and grand. The plain style is intended to be strictly informative, the middle style is pleasant to listen to, and the grand style informs, pleases, and persuades. Each style carries with it certain levels of eloquence and rhetorical devices appropriate for its intent.

Ciceronian ideal, that of learning broadly in so far as it helps one interpret Scripture or be able to relate to members of the congregation. This was a breath of fresh air for a congregation used to the rather boring, homiletic style. The fourth century "marks a high point of popularity for the simple 'homily' style of preaching."[142] Although Christians of the early fifth century were expected to leave the pagan rhetoric at the door of the church, Augustine spent his life trying to convert the people of Hippo to Christianity using all of the pagan tools at his disposal.

Although there are many similarities between the rhetoric of Cicero and Augustine, there are many divergences as well. Ciceronian rhetoric focused on individual achievement, which often led to pride. Augustine's Christian *elocutio* subordinated the rhetorician to the Scriptures. "The Christian orator is above all a teacher who embodies the Biblical text, whether by using the 'rule of charity' to paraphrase the truths found in Scripture, by simply repeating the actual words of the Bible, or by leading a life of charity that constitutes a kind of speech without words."[143] Similar to Comargo, Fortin argues that Cicero valued "persuasion and pleasing the audience over teaching", where Augustine values *doctrina*, or "teaching, as the most valuable duty of Christian rhetoric."[144]

Although Augustine did much to preserve the study of rhetoric, over time the fundamentals of Greco-Roman rhetoric became disassembled and divided.[145] For instance, rhetoric, which was originally used to develop "persuasive cases through the

[142] Fortin, "Augustine and the Problem of Christian Rhetoric," 213.
[143] Martin Camargo, "Non Solum Sibi Sed Aliis Etiam: Neoplatanism and Rhetoric in St. Augustine's De Doctrina Christiana," *Rhetorica: A Journal of the History of Rhetoric 16* no. 4 (1998): 393-408, 393.
[144] Fortin, "Augustine and the Problem of Christian Rhetoric," 219.
[145] Brian Vickers, *In Defense of Rhetoric* (New York, NY: Oxford University Press, Clarendon Press, 2002).

discovery and arrangement of arguments,"[146] was associated more with written style as preparation for preaching. Invention and arrangement were replaced in the educational curriculum by "dialectic and logic."[147] Rhetoric was no longer the counterpart of dialectic. For the church, as well as education, rhetoric *became* dialectic. Elements of the rhetorical arts could be found in various rhetorical arts, namely, preaching, letter writing, and poetry.[148] Jeffrey Walker[149] argues that these changes to rhetoric do not indicate a decline, but a modification, which he calls a "literaturizing,"[150] or changes in *style*. For Walker, these modifications do not represent new thinking, but a return to the original Greek rhetoric, before Rome adapted it for more pragmatic and utilitarian purposes. Walker argues that *poetry,* rich with style, was the original form of rhetoric, especially epideictic, and that Platonic and Aristotolic thinking demoted poetry to study in grammar (the art of letters).[151] The metered nature of poetry served a mnemonic function blending the canons of style and memory and giving permanence to oratorical creations. Even written speeches of the day were meant to be read aloud. Written text eventually took over this role from poetry, and the "mnemonic function of metered discourse was rendered obsolete."[152] Poetry, with its powerful ability to blend *logos* and *pathos*, became synonymous with only metered verse.[153] With this evolution, epideictic rhetoric changes from poetic in style and form to audience-centric and logos-driven. With poetry no longer

[146] Herrick, *History and Theory f Rhetoric,* 123.
[147] Ibid.
[148] For a thorough treatment of these three rhetorical arts in the Middle Ages, refer to James J. Murphy's *Rhetoric in the Middle Ages.*
[149] Jeffrey Walker is an author and professor of rhetoric at the University of Texas. His works focus on rhetorical theory and analysis, the history of rhetoric, and the connection between rhetoric and poetics.
[150] Jeffrey Walker, *Rhetoric and Poetics in Antiquity* (New York, NY: Oxford University Press, 2000), 55.
[151] Ibid, 290.
[152] Ibid, 21.
[153] Ibid, 25.

being taught as part of rhetoric, interest in poetry began to decline, and thus the rhetorical power of poetry was absent in Roman rhetorical education.

Aside from some slight adaptations "to the needs of their day,"[154] classical rhetorical education remained mostly unchanged throughout the middle ages. The reason for this may have been that "the political climate which had encouraged such writing in ancient Greece and Rome simply did not exist in medieval Europe."[155] Murphy reminds us that "most of the ancient documents dealing with the perceptive tradition continued to be studied and used throughout the Middle Ages."[156] What is important is not so much the evolution of rhetoric in the Middle Ages, but that these works were kept alive. In the schools, Aristotle, Cicero, Quintilian, and the Bible were the undisputed, and mostly unquestioned, expert sources of this period in education, which is referred to as scholasticism.

Classical rhetoric saw a considerable increase in attention from 1350-1600, where "assumptions and institutions that had held sway for centuries were radically challenged, including the Christian worldview and the Catholic Church."[157] In this era, Lorenzo Valla[158] was perhaps the most influential humanist scholar.[159] In addition to his contributions to the Latin language, he helped rhetoric break free from the stagnation of

[154] John O. Ward, "From Antiquity to the Renaissance: Glosses and Commentaries on Cicero's *Rhetorica*," in James J. Murphy, ed., *Medieval Eloquence: Studies in the Theory and Practice of Medieval Rhetoric* (Berkeley, CA: University of California Press, 1978), 44.
[155] James J. Murphy, *Three Medieval Rhetorical Arts* (Berkeley, CA: University of California Press, 1971), xxiii.
[156] Murphy, *Rhetoric in the Middle Ages,* 89.
[157] Herrick, *History and Theory of Rhetoric*, 145.
[158] Lorenzo Valla was a well-known Italian humanist as well as a Catholic priest. He translated many books into Latin and is probably best known for exposing the "Donation of Constantine" as a fraud. This document was supposedly given to the Catholic Church by Constantine himself, formally transferring power from Rome to the Pope. The church used this document to legitimize its power.
[159] Donald R. Kelley, *Renaissance Humanism* (Boston, MA: Twayne Publishers, 1991), 35.

scholasticism. He attacks the Aristotelian tradition, namely the overuse of dialectic and philosophy, and argues that a more Quintilian rhetoric should be the foundation for education. Valla shows similarity to the ancient sophists in that he explicitly places eloquence over philosophy. "Philosophy is like a soldier or a tribune under the command of oratory."[160] Morality, for Valla, came not from philosophy, but from community standards and rhetoric would guide ethical deliberation.

Towards the end of the Renaissance there was another push towards logic and dialectic over rhetoric. Instrumental in this shift was Agricola,[161] who was interested in the logical appeals of speech and wrote extensively on argumentation.[162] Agricola's influence sought to place rhetoric, once again, as synonymous with ornamentation. Picking up where Agricola left of was Peter Ramus[163], who strongly opposed Aristotelian scholastic education. He proposed "an alternative approach to learning that did not make reference to authorities such as Aristotle or Cicero at all."[164] He explicitly blames Aristotle for lacking systemization and for the ongoing confusion between rhetoric and dialectic, calls Cicero "verbose,"[165] and challenged Quintilian for his ignorance of the fact that eloquent speakers could be evil.[166] Because of Ramus's influence, rhetoric as a field of study was relegated to the margins of education, namely the study of style.

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[160] Jerrold E. Seigel, *Rhetoric and Philosophy in Renaissance Humanism* (Princeton, NJ: Princeton University Press, 1968), 142.
[161] Rodolphus Agricola was a fifteenth century Dutch humanist who was a master of Latin and skilled in argumentation. Influenced by Cicero and Quintilian, he is most well-known for reintroducing dialectic to rhetorical education.
[162] Agricola's *On Dialectical Invention* written in 1479 was one of the most important treatises on logic of the late Middle Ages.
[163] Peter Ramus was a sixteenth-century rhetorician interested in pedagogy. He is famous for his criticisms of both scholasticism and Aristotle's elevated place in medieval education. He worked to reform the medieval curriculum to make it more practice-oriented and useful.
[164] Herrick, *History and Theory of Rhetoric*, 163.
[165] Peter Ramus, *The Questions of Brutus*, trans. Carole Newlands (Davis, CA: Hermagoras Press, 1992), 8.
[166] Peter Ramus, *Rhetoricae Distinctiones in Quintilianum* (Arguments in Rhetoric Against Quintilian), trans. Carole Newlands (DeKalb, IL: Northern Illinois University Press, 1986), 84.

Walter J. Ong[167] exposes Peter Ramus's *Remarks on Aristotle* as incompetent, filled with falsehoods and misrepresentations, and also unmasks Ramus for attacking Aristotle's dialectic "without giving evidence of understanding it."[168]

The separation of dialectic and rhetoric had radical consequences when it came to education. Peter Ramus "may have exerted an even more dramatic influence over Western education by driving a wedge between reason and language in his effort to demote rhetoric."[169] With this shift, language becomes a "neutral tool for expressing the discoveries of other disciplines,"[170] and not worthy of study itself. Ong points out that the entire education system becomes overly simplified and reductive. For example, Ramus recommends the use of summaries, clear headings, and familiar examples to simplify the writing and reading processes.[171] "Ramus' streamlined reorganization of the age-old Western tradition of logic and rhetoric seemed to signal a reorganization of the whole of knowledge and indeed of the whole human lifeworld."[172] Ong's claim implies that Ramus not only changed the definition of rhetoric to include only elocution and pronunciation, but also affected the whole of human consciousness.

Fast-forward almost two centuries and we begin to see the social and education effects of Ramist thinking. Italian rhetorician, Giambattista Vico[173] writes, "the greatest

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[167] Walter Ong was a twentieth-century scholar, English professor, and Jesuit priest. Considered by many as a media ecologist, much of Ong's scholarly work focuses on the impact of technology on both culture and consciousness. Throughout his academic life, he speculated on the nature of language as he traced its evolution throughout history, specifically in transitional periods from orality to literacy.
[168] Walter J. Ong, *Ramus: Method and the Decay of Dialogue* (Chicago, IL: University of Chicago Press, 1983), 24.
[169] Herrick, *The History and Theory of Rhetoric*, 163.
[170] Ibid.
[171] Ramus, *Arguments in Rhetoric Against Quintilian: Translation and Text of Peter Ramus's Rhetoricae Distinctiones in Quintilianum*, ed. James J. Murphy, trans. Carole Newlands (Carbondale, IL: Southern Illinois University Press, 2010).
[172] Ong, *Ramus: Method and the Decay of Dialogue*, xv.
[173] Giambattista Vico was a professor of rhetoric at the University of Naples in the seventeenth and eighteenth century. His major work, *The New Science*, outlines much of his innovative and anti-Cartesian

drawback of our educational methods is that we pay an excessive amount of attention to the natural sciences and not enough to ethics." He specifically points to that part of ethical education "which treats of human character, of its dispositions, its passions, and of the manner of adjusting these factors to public life and eloquence."[174] Vico laments that the study of politics and human nature has been all but abandoned for the study of physical phenomena. This results in young men that are "unable to engage in the life of the community, to conduct themselves with sufficient wisdom and prudence; nor can they infuse into their speech a familiarity with human psychology or permeate their utterances with passion."[175] Vico's assessment of 18th century youths as apolitical, socially ignorant, and passionless is of no surprise considering Ramus' reductive agenda.

Vico challenged the *status quo* of early eighteenth century education by questioning the very nature of human thought itself. In his *New Science*, Vico claims that education systems focus on the natural sciences because "whenever men can form no idea of distant and unknown things, they judge them by what is familiar and at hand."[176] Because man, out of conceit "makes himself the measure of all things,"[177] truth becomes limited to the perception of human observation. He offers a compelling argument that "historical method could be just as exact as mathematics."[178] These inquiries led him to write extensively on poetry and mythology, which give us clues into the origins of human

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thinking on philosophy, language, history, poetry, and rhetoric. He resists the reductive tendencies of science by emphasizing human consciousness and individual truths alongside more universal, scientific truths.

[174] Giambattista Vico, *On the Study Methods of Our Time* (1709), trans. Elio Gianturco (New York, NY: The Bobbs-Merrill Company, Inc., 1965), 33.

[175] Vico, *On the Study Methods,* 33-34.

[176] Giambattista Vico, *Scienza Nuova* (1725), ed. and trans. Leon Pompa (Cambridge, England: Cambridge University Press, 2002), *60*

[177] Ibid.

[178] Herrick, *History and Theory of Rhetoric*, 172.

language and thinking. Vico's thought was that "primitive men were necessarily poets because they possessed strong imaginations which compensated for the weakness of their reason."[179] The history of these common human arts could give us insight into human thinking and potentially help us "sort out common sense in a given moment."[180] This focus on shared human learning, creative thinking, and dialogue was a new, common-ground approach to pre-enlightenment education based on learning about human history, cooperation, and a "willingness to unite fragility of insight with temporal clarity."[181] Vico's approach was much different than the natural science focus of the late Renaissance. With emphasis on developing practical judgment, student thinking would be fundamentally changed. Students would be better equipped to deal with contingency and lead their communities both practically and morally.

Vico believed that "rhetoric was essential to all the arts and all human ways of making sense of the world. By means of language, humans have imposed order on a fundamentally disordered nature."[182] He elevates poetry to a level of importance not seen since the pre-Socratics. Vico believed that the metaphors and analogies of early man displayed an innate human ability to discover relationships between seemingly unrelated things; something that logical deduction alone is unable to do. Human thinking is poetic in nature; thus, as Jeffrey Walker would later corroborate, rhetoric itself must be grounded in poetry. A rhetorical education would be centered on "practical decision

[179] Peter Burke, *Vico* (Oxford, England: Oxford University Press, 1985), 2.
[180] Ronald C. Arnett, Janie Harden Fritz, and Annette M. Holba, "The Rhetorical Turn to Otherness: Otherwise than Humanism," *Cosmos and History: The Journal of Natural and Social Philosophy 3* no. 1 (2007): 115.
[181] Ronald C. Arnett, Pat Arneson, and Leeanne M. Bell, "Communication Ethics: The Dialogic Turn," *The Review of Communication 6* no. 1-2 (2006): 62-92, 83.
[182] Herrick, *History and Theory of Rhetoric*, 173.

making about matters that did not yield to scientific analysis, issues like law, art, ethics, and politics."[183] A rhetorical education needed to be education for daily life.

While Vico may have paved the way for rhetoric to reclaim lost territory and reshape education, social changes in eighteenth century Britain allowed Vico's vision to gain traction. To help combat increasing religious skepticism, the churches studied and applied rhetoric in both their preaching and writing. At the same time a more general cultural shift from oral to written discourse brought attention back to English prose as a subject useful for study.[184] Perhaps an even greater change occurred in the language of scholarship. English was replacing traditional Latin, which greatly increased access to knowledge.[185] Those that were excluded from knowledge were suddenly invited into it. Women were one of the largest benefactors of the shift away from Latin as they were being admitted to British universities in record numbers.[186] Furthermore, eighteenth century urbanization brought together different English dialects, some more polished than others. Rhetorical education, thus, included "education in proper diction" and was vital for personal advancement and upward mobility in British society.

The elocutionary movement, made famous by Jane Austen's *Pride and Prejudice*, focused on "public manners, poise, and expressiveness,"[187] rhetoric's performative function. Social performance, specifically speech, was often an indicator of social class; thus, improving one's public speaking often translated into improving one's social status.

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[183] Ibid.
[184] Winifred Bryan Horner, "Writing Instruction in Great Britain: Eighteenth and Nineteenth Centuries," in *A Short History of Writing Instruction,* ed. James J. Murphy (Davis, CA: Hermagoras Press, 1990), 124-25.
[185] Herrick, *History and Theory of Rhetoric*, 175.
[186] Horner, "Writing Instruction in Great Britain," 136-37.
[187] Herrick, *History and Theory of Rhetoric*, 176.

Eventually, the social movement found its way into British education. Thomas Sheridan[188] was an educator of the time who fought for education reform to correct the "neglect of elocution or rhetorical delivery,"[189] especially in the education of preachers. He laments how often one shamelessly speaks to hundreds of people "in such disagreeable tones and unharmonious cadences, as to disgust every ear; and with such improper and false use of emphasis, as to conceal or pervert the sense."[190] Sheridan was fighting to shift rhetoric, once again, to favor delivery over invention and arrangement. The rhetorical training he designed entails "facial expressions, gesture, posture, and movement," which some saw as an education more in acting than speaking.[191] It makes sense, then that some argued these practices "led to declamation without sincere conviction and earnest feeling."[192] These arguments echo Plato's concern that eloquence without wisdom lead to men being filled "not with wisdom, but with the conceit of wisdom,"[193] or Cicero's warning that "eloquence without wisdom may frequently hurt [the state], and can never be of service to them."[194]

Rhetoric's shift may have increased the chasm between dialectic and invention, but it opened the door for more depth of study in "literature, literary criticism, and

[188] Thomas Sheridan was an eighteenth-century scholar and education reformer who championed practice in elocution for public speaking curricula. In his definition of elocution, Sheridan includes articulation, pronunciation, and accent. His methods led him to argue for a standard English to aid in clarity.
[189] Herrick, *History and Theory of Rhetoric*, 177.
[190] Thomas Sheridan, *A Discourse Introductory to a Course of Lectures, 1759* (Farmington Hills, MI: Gale Ecco, 2010), 25.
[191] Herrick, *History and Theory of Rhetoric*, 178.
[192] Wilbur Samuel Howell, *Eighteenth-Century British Logic and Rhetoric* (Princeton, NJ: Princeton University Press, 1971), 145.
[193] Plato. *Phaedrus*, 275a-b
[194] Cicero. *De Inventione,* preface.

writing generally."[195] The belletristic movement[196] in rhetoric was concerned with "examining the specific qualities of discourse and their effects."[197]

Although the belletristic movement had expanded the scope of rhetoric within British education by further separating it from dialectic, there were some philosophically minded rhetoricians devoted to reuniting philosophy and eloquence under the umbrella of rhetoric. Inspired by David Hume's[198] scientific approach to philosophy, George Campbell approached both rhetoric and philosophy through a scientific lens. For Campbell, science was any "organized and rational account of a subject."[199] Therefore, "all art is founded on science," as are "theology and ethics," which he refers to as "the most sublime of all sciences."[200] Campbell applied new scientific discoveries of the human mind to the study of rhetoric. In doing so, Campbell developed a scientific theory of eloquence grounded in his belief that people are moved "only by those ideas it accepts as truthful and good."[201] He divided up the human mind into different faculties, which spoke their own languages (i.e. language of logic, language of emotion) and performed their own functions (i.e. seeking understanding, seeking beauty), and played an independent role in the persuasion process. Campbell's scientific theory of elocution

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[195] Herrick, *The History and Theory of Rhetoric*, 178.
[196] The belletristic movement in eighteenth century Britain was an educational shift in rhetoric focusing on the beauty of letters and language, *belles lettres*, and their emotional impact on an audience. Influential writers of this movement included Scottish-born Hugh Blair, William Barron, Alexander Jameison, and Lord Kames.
[197] Barbara Warnick, *The Sixth Canon: Belletristic Rhetorical Theory and Its French Antecedents* (Columbia, SC: University of South Carolina Press, 1993), 4.
[198] David Hume was an eighteenth-century philosopher whose writings were often critical of established philosophical systems. He was adamantly critical of *a priori* metaphysics for lacking observable evidence, which have led some to label him atheistic. In his *Enquiry,* Hume focuses his empirical approach to human understanding on the human mind in order to locate fundamental laws that govern perception. Hume's thought influenced great minds like Adam Smith, Immanuel Kant, Jeremy Bentham, and Charles Darwin.
[199] Herrick, *History and Theory of Rhetoric*, 183.
[200] George Campbell, *The Philosophy of Rhetoric*, ed. Lloyd F. Bitzer (Carbondale, IL: University of Southern Illinois Press, 1963), xlv.
[201] Howell, *Eighteenth-Century British Logic and Rhetoric*, 580.

represents attempts to marry the eloquence of Vico and Sheridan with the Enlightenment zeitgeist.

Throughout the Enlightenment and subsequent Industrial Revolution, logical positivism replaced rhetoric as the preferred method to deal with contingency in all matters. The scientific method that created the industrial world was also making rhetoric impractical and relatively useless. Observation replaced dialectic as the go-to method for seeking truth.

At the beginning of the twentieth century, rhetoric was all but obsolete. However, intellectuals began to witness their beloved logical positivism shape unconscionable social structures such as fascism in Europe and Russia, and gross social inequalities born from industrial capitalism. The intellectual community was slowly losing confidence that the thinking of Hume and Campbell should be applied to issues of human society and morality. The tools used to study causation in the natural world are not sufficient, nor appropriate for questions regarding values and human decision-making, human motivation, and the intricacies of power and politics. As academics searched for a new logic, attention shifted, once again, towards rhetoric, specifically "argumentation and the audience."[202] Even scientists understood the role that human motivation plays in interpreting data, creating institutions, allocating funding, and in formulating theories;[203] thus, they too were intrigued by the potential of rhetoric to improve their positions in scientific debates.

Philosopher Chaim Perelman and Madame L. Olbrechts-Tyteca sought to find a way to rationally prove moral claims "in a culture in which there are few agreements

[202] Herrick, *History and Theory of Rhetoric*, 196.
[203] Ibid.

about values."[204] In *The New Rhetoric,* they elevate the benefits of public argumentation over reliance on absolute truths, such as God. They also emphasize the importance of audience. They write that "knowledge of those one wishes to win over is a condition preliminary to all effectual argumentation."[205] For, the audience and argumentation are inseparable. Their audience-centric rhetorical perspective focus on three audience types: the universal audience, encompassing "the whole of mankind;"[206] the "single interlocutor,"[207] experienced through interpersonal interaction; and deliberation with the self. Within each of these audience situations, the goal of the speaker is to "make certain facts present"[208] to a particular audience, or what Perelman and Olbrechts-Tyteca call "presence."[209] The speaker establishes presence by choosing "to emphasize certain ideas and facts over others, thus encouraging an audience to attend to them."[210] The idea of presence is similar, in part, to rhetorical magnification.

Through the strategic use of language, a speaker can magnify certain ideas, bringing them to the foreground of an audience's thought. This directing, or attuning, an audience to one idea while necessarily minimizing other ideas, is often called magnification. Kenneth Burke understood the power of language to direct our thinking. For Burke, our culture, identity, and our experiences are contained within our language. Because of its symbolic nature, "language thinks for us;" thus, the words we *present* or magnify to an audience shape their thinking as well.

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[204] Ibid., 197.
[205] Chaim Perelman and Lucie Olbrechts-Tyteca, *The New Rhetoric: A Treatise on Argumentation,* trans. John Wilkinson and Purcell Weaver, (Notre Dame, IN: University of Notre Dame Press, 1971), 20.
[206] Ibid., 30.
[207] Ibid.
[208] Ibid. 116-117.
[209] Ibid.
[210] Ibid., 117.

While Perelman and Olbrechts-Tyteca focus on the mere presenting of ideas to audiences, Kenneth Burke sees this *presenting* (magnification) as a way to identify with other human beings on a deep level. Burke's rhetorical perspective is important to contemporary rhetorical education and will be briefly introduced.

Burke's Identification and Rhetoric

Burke's definition of rhetoric places the human animal in motion. Human actors use words as meaning-laden symbols to induce identification, thus cooperation. If, then, one wishes to construct social cohesion or cooperation, rhetoric becomes the primary tool of the social carpenter. It is through the means of rhetorical discourse that human animals "overcome social estrangement, or, at least, attempt to do so."[211] Therefore, by granting primacy to issues of identification, one confronts the "implications of *division*"[212] head on.

Burke's *A Rhetoric of Motives* considers the "possibilities of classification in its *partisan* aspects," considering all the ways individuals oppose one another, or "become identified with groups more or less at odds with one another."[213] Indeed, if men were not at odds with one another, "there would be no need for the rhetorician to proclaim their unity."[214] Burke claims "Wherever there is persuasion, there is rhetoric. And wherever there is meaning, there is persuasion."[215] Symbolism, rhetoric, and identification are intimately linked in the motive of 'belonging.' Burke states in *A Rhetoric of Motives*: "We are in pure symbolic when we concentrate upon one particular integrated structure

[211] Barbara Biesecker, *Addressing Postmodernity: Kenneth Burke, Rhetoric, and a Theory of Social Change* (Tuscaloosa, AL: University of Alabama Press, 2000), 41.
[212] Kenneth Burke, *Rhetoric of Motives* (Oakland, CA: University of California Press, 1969), 22.
[213] Ibid.
[214] Ibid.
[215] Ibid., 172.

of motives. But we are clearly in the region of rhetoric when considering the identifications whereby a specialized activity makes one a participant in some social or economic class. 'Belonging' in this sense is rhetorical."[216] If human beings have a primary motive to belong, then "people belong to one another through identification,"[217] which is accomplished through audience-centered language.

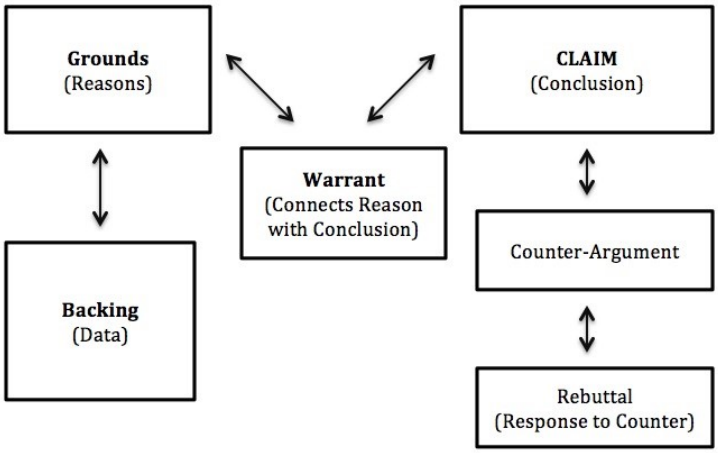
Perelman and Olbrechts-Tyteca and Kenneth Burke ground argumentation in the audience and the symbolic, respectively. "The force of persuasive appeal propels conviction and response."[218] When negotiating for values, personal and professional identities, or roles and responsibilities, "context and audience unite"[219] as differing sides move towards mutually beneficial outcomes. Argument in this sense is an ethical responsibility, one that shapes the culture and environment of a healthcare organization. The ethical action of healthy argument avoids thoughtlessness by fostering participation in the process of value construction and decision-making.

Another argumentation theorist, Stephen Toulmin focuses more on argument structure, specifically on the development and analysis of argument components. Understanding that different argumentation situations (argument fields) may necessitate different elements of form, Toulmin isolates six key standards for assessing arguments that are always present, regardless of the argument context (field-invariant). The six key

[216] Kenneth Burke and Joseph R. Gusfield, *On Symbols and Society* (Chicago, IL: University of Chicago Press, 1989), 186.
[217] Thomas O. Sloane, *Encyclopedia of Rhetoric, Volume 1* (New York, NY: Oxford University Press, 2001), 376.
[218] Ronald C. Arnett, Sarah M. DeIuliis, and Matthew Corr, *Corporate Communication Crisis Leadership: Advocacy and Ethics* (New York, NY: Business Expert Press, 2017), 76.
[219] Ibid.

factors of an argument are: claim, grounds, warrant, backing, counter-argument/rebuttals, and qualifier.[220] A simplified version of the model can be seen below:

Figure 1
Simplified Toulmin Diagram



Toulmin's model acts as a dissection table for an argument in that it allows the isolation of argument components for close examination and discussion. Scholars can separate claims from reasons and get a picture of how or *if* they connect. Additionally, Aristotelian argumentation works in a rational world with rational decision-makers; however, is difficult to use in everyday argumentation. Toulmin offers a new way of evaluating the rationality of everyday arguments without adhering to the strict limitations of the syllogism.

This brief history of rhetoric is by no means exhaustive; however, it is clear that throughout its 2,400-year history, it has been controversial. Rhetoric's five canons have been shuffled between philosophy, literature, writing, speaking, and even psychology,

[220] The Toulmin diagram originates with Stephen E. Toulmin's 1958 *The Uses of Argument*. The diagram used here is an original representation of his concepts.

continually asking the questions: What is the place of truth in rhetoric? And, what is the place of rhetoric in education?

There is power in truth, but only when acted upon; thus, Aristotle believes truth needs a messenger. There is power in language; and so, Quintilian demands that a good speaker first be ethical. Burke sees rhetoric as a tool to counter estrangement and connect to one another. Walker reminds us that we are creative by nature by highlighting innate human creativity as evidenced by the poetic origins of rhetoric. Because there are few agreements about values, Perelman and Olbrechts-Tyteca start deliberation not with moral claims, but with the audience – prioritizing the conversation over winning an argument.

In the end, rhetoric is a powerful tool for enacting truth. Rhetoric can both help people gain insight into their thinking and get people to act toward a common good. Through its reflective and explicative functions, rhetoric provides tools for living in civil society. Logical positivism and the predominantly natural science focus in healthcare education is important for understanding the material world but ignores the more human components of experiencing the world. Vico argues for education that enhances practical judgment by focusing on shared learning, creative thinking, and dialogue.

The next section will explore current research and writing regarding rhetoric and healthcare.

Rhetoric and Healthcare

For Cicero, great orators are rare. In speaking the language of mankind, the orator's central focus is on the audience, and so, an orator must be in tune with *all* of humanity including culture, foreign languages, history, philosophy, art, literature, law,

and ethics. Although theoretically rational, Cicero's advice for the aspiring orator does not seem plausible for the aspiring healthcare professional.

What, then, can we learn from rhetoric that can be useful when applied to healthcare? Perhaps rhetoric's utility is in its interdisciplinary nature. Rhetoric as a tool lives amidst contingency and complexity, two adjectives that are also easily attributable to most healthcare experiences. Rhetorical study has untapped explanatory power and offers the opportunity "to reflect on health and medicine's complexity."[221] A rhetorical approach to healthcare allows us to analyze the persuasion inherent in most health-related messaging and most medical encounters. The rhetorical analysis forces us to ask questions like "'Who is persuading whom of what?' and 'What are the means of persuasion?'"[222] in order to increase our understanding of health situations.

Judy Segal[223] claims that a rhetorical perspective is helpful in understanding healthcare as discourse-in-use, as public discourse, as commercial discourse, as professional discourse, and as discourse of service.[224] As previously covered in the chapter on scientific discourse, the goal of the Royal Society of London was to de-animate scientific language. A rhetorical perspective allows us to identify a persuading actor, which in this case is the Royal Society of London. Rhetoric also allows us to consider the motivations for this change and perhaps more importantly the unintended consequences of this shift in terms of ethics, power, and authorship. For instance, we learned in chapter two that a more compressed and inaccessible language creates insiders

[221] Judy Segal, *Health and the Rhetoric of Medicine,* (Carbondale, IL: Southern Illinois University Press, 2005), 156-57.
[222] Ibid., 2
[223] Judy Segal is an author and professor at McGill University in the Science and Technology Studies Graduate Program. Her scholarship appears in numerous journals and focuses on the intersection of culture, rhetoric, science, and health. She is on the editorial board for the journal, *Rhetoric of Health and Medicine.*
[224] Segal, *Health and the Rhetoric of Medicine,* 154-55.

and outsiders and therefore legitimate and illegitimate voices within various healthcare exchanges. Furthermore, a sterile language personifies processes and results (i.e., these findings suggest…; the results indicate…), which gives precedent to content, namely form and function, over authorship. With this reprioritization we also see accountability shift from the person to the inanimate, which also helps explain the elimination of morality from the discourse.

Segal's inclusion of 'discourse-in-use' reminds us that the language itself acts surreptitiously, carrying meaning that often predetermines outcomes. "We converse in this discourse and are persuaded by it into some things and out of others."[225] Segal illustrates how this persuasive power is present in language when we talk about health. There are hidden values within our metaphors.

Values and Metaphors

Scholars from sociology, anthropology, history, ethics, nursing, and other medical fields have addressed values in healthcare by studying specific metaphors.[226] For example, the machine metaphor originating in the seventeenth-century led to healthcare becoming synonymous with "disease cure."[227] A common counter to the machine metaphor is the "human being as an organism"[228] metaphor. Segal recognizes the *diagnosis is health* metaphor common in American hospital and clinical settings. Much of healthcare today is simply the "administration of diagnostic tests."[229] Additionally, metaphors of war, sports, and technology and commonly associated with medicine,

[225] Ibid., 154.
[226] Ibid., 117.
[227] Joan Boyle and James Morriss, "The Crisis in Medicine: Models, Myths, and Metaphors," *A Review of General Semantics 36* (1979): 261-74, 273.
[228] Marlaine C. Smith, "Metaphor in Nursing Theory," *Nursing Quarterly 5* no. 2 (1992): 48-49, 48.
[229] Ibid.

especially in American culture.[230] When discussing biomedical discourse, Laurence J. Kirmayer[231] argues that "when values are explicit, they may be openly debated." However, metaphor has the power to "smuggle" values into a discourse that proclaims itself free of values.[232] Kirmayer's warning is that metaphor works beneath the surface, thus, often avoids rhetorical scrutiny. Therefore, any debate about healthcare takes place within the language of biomedicine.

Kenneth Burke suggests that "the nature of our terms affect the nature of our observations," and that "much that we take as observations about 'reality' may be but the spinning out of possibilities implicit in our particular choice of terms."[233] Burke then would support Segal's position that the unquestioned use of biomedical discourse to discuss healthcare policy predetermines outcomes before the debate begins. Thus, rhetorical analysis should be used as a way to uncover and analyze these hidden meanings in the context of healthcare. "Examining metaphor is one way of shifting the ground of debate – from the values we think *about* to the values we think *with*."[234]

Segal highlights certain metaphors prevalent in healthcare today, specifically, *the body is a machine*, *the person is genes, health is diagnosis, medicine is war*, and *medicine is business*. These are worth exploring in more detail because each metaphor shapes thinking about health and medicine in different ways.

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[230] Howard F. Stein, *American Medicine as Culture* (Boulder, CO: Westview, 1990).
[231] Laurence J. Kirmayer is professor and philosopher of psychiatry at McGill University. He also acts as director of the Division of Social and Transcultural Psychiatry and Co-director of the Culture, Mind, and Brain Program. He actively researches the culturally sensitive mental health services available to immigrants, refugees, and Indigenous people. His most recent works focus on cultural concepts as they pertain to psychological stress.
[232] Laurence J. Kirmayer, "Mind and Body as Metaphors: Hidden Values in Biomedicine," in *Biomedicine Exmined,* ed. Margaret Lock and Deborah R. Gordon (Dordrecht: Kluwer, 1988), 57.
[233] Kenneth Burke, *Language as Symbolic Action* (Berkeley, CA: University of California Press, 1966), 46.
[234] Segal, *Health and the Rhetoric of Medicine,* 119.

The body is a machine metaphor suggests the human body is a collection of parts that can be fixed or replaced when they are not working properly. Biomechanical thinking frames our concept of illness as a cause and effect of dysfunctional systems. The resulting discourse is exemplified by phrases such as 'run down,' 'beat up,' 'neglected,' 'finely-tuned athlete,' 'fit as a fiddle,' and talking about food as 'fuel.' Segal also includes the computer metaphor as a more recent addition to mechanistic thinking. We often refer to our physical brain as a 'hard drive' and the content of our brains as 'data.' Brain scientists often teach neuroanatomy by analogizing the brain in terms of neural processing, levels of programming, information transfer. Neuroscientist, Jill Bolte Taylor, differentiates the processing of information in the right and left-brain hemispheres as serial processing (left brain) and parallel processing (right brain).[235]

Kenneth Burke takes issue with the computer as a model for human thought in that a computer, being an artifact, not an animal, does not "act."[236] The difference then between machine thinking and human thinking lies in motives and expression. A computer moves, but the human being acts symbolically. To convolute the two causes problems in either mistaking the computer for a human or by treating the human like a machine. Furthermore, "a mechanical notion of the body produces a mechanical notion of health care. A society working with a mechanical model of medicine will prefer the sorts of interventions that are observable and measurable."[237] These observable and measurable outcomes manifest in another metaphor that has invaded human health, *health is diagnosis*. Systemic issues arise when diagnostically-minded health

[235] Jill Bolte Taylor, *My Stroke of Insight: A Brain Scientists Personal Journey* (New York, NY: Penguin Books, 2006).
[236] Burke, *Language as Symbolic Action*, 63.
[237] Segal, *Health and the Rhetoric of Medicine,* 122-23.

professionals and policy makers tend to focus on "health-care policy rather than health policy."[238] Paul Farmer addresses this issue while treating tuberculosis in poverty-stricken Haiti. He realized that taking the course of antibiotics was not enough, patient also needed to eat. Farmer ran an experiment where he treated half of his patients with only antibiotics and the other half with antibiotics and food. After the treatment course was completed, all of the patients receiving the drugs and food made a full recovery compared to only 48 percent of the drug-only control group.[239] The *body is a machine* metaphor reduces the complexity of a system to its parts. Treating affected parts and not the whole being creates policy that focuses on the efficiency of the observable. When diagnosis becomes synonymous with health, the metaphor has fundamentally shaped our collective philosophy of medicine.

The machine metaphor (as well as health is diagnosis) has become ever more reductive in a new metaphor, *the person is the sum of his/her genes.* Genes are often referred to as our 'blueprints.' When the person becomes their genes, health is framed by a determinism that often shifts focus from the environmental and social factors of health. Segal differentiates thinking in terms of germs versus thinking in terms of genes where the former is an attack from outside the body, and the latter an attack from within. Gene thinking may cause us to feel betrayed by our own bodies.[240] The betrayal fuels an already prevalent mind-body dichotomy which may lead to existential disassociation. We no longer feel at home in our own bodies, a certain existential homelessness.

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[238] Ibid., 123.
[239] Tracy Kidder, *Mountains Beyond Mountains: The Quest of Dr. Paul Farmer, A Man Who Would Cure the World* (New York, NY: Random House, 2009).
[240] Segal, *Health and the Rhetoric of Medicine.*

Another manifestation of the machine metaphor surfaces in the way we often speak of disease as 'infiltrating' or 'invading' the body. The *medicine is war* metaphor can be seen in the way we talk about 'fighting' cancer. Cancer is 'invasive' and needs to be 'detected' before it 'colonizes.' Bodies' 'defenses' need to be 'fortified' and 'strengthened' to 'defeat' the 'onslaught' of disease. Susan Sontag adds that "Treatment also has a military flavor. Radiotherapy uses the metaphors of aerial warfare; patients are "bombarded" with toxic rays. And chemotherapy is chemical warfare, using poisons."[241] In addition to the context of cancer, the war metaphor is also commonly associated with terminal illness and euthanasia. Doctors play the role of the hero, fighting against evil. Death is often seen as defeat.

Once the mechanistic view of healthcare establishes roots, it naturally becomes sponsored by another pervasive metaphor, *medicine is business*. While the business of *health* can include nutrition, exercise, stress reduction, tobacco cessation, education, social groups, and brain exercises. The business of health-*care* includes diagnostics, pharmaceuticals, and administration (insurance companies, health system administrators, and intermediaries). Within this metaphor, patients are transformed into consumers of diagnostics and drugs. An efficient provider is the king or queen of the twenty-minute visit. Patient education is replaced by the prescription pad.

"The truth is that good health care is *un*economical for the same reason that it is good business: People who are saved from early deaths live to spend more money on health care or have more money spent for them."[242] An important goal of any business is to make money and save money, yet this goal is incompatible with the goals of

[241] Susan Sontag, *Illness as Metaphor and AIDS and Its Metaphors* (New York, NY: Picador, 2001), 65.
[242] Segal, *Health and the Rhetoric of Medicine,* 126.

healthcare. For instance, illness prevention causes people to live longer, which means they will cost the health system more money over time. Economically speaking, "the cheapest medical consumer is not the healthy person but the dead one. A health-care system cannot then be *motivated* by the desire to save money any more than it can be motivated by the desire to make it."[243]

The power of the business metaphor is often overwhelming. Attempting to discuss policies that focus on health in terms of equality and access are countered by metrics of cost and ideologies of socialism. The outcomes of any conversation of health are predetermined by the language of business. Willard Gaylin[244] argues that Americans need to have a conversation about healthcare that includes "the goals of medicine, the meaning of 'health,' who shall live and who shall die (and who shall decide)."[245] Only by having conversations about the covert values that are ever-present in healthcare discourse can we wake up these "sleeping metaphors"[246] and rediscover our concept of health and care.

Despite the efforts of the Royal Society of London to de-animate scientific speech, there remains power in the words we use in clinical and educational settings. Understanding the power of the metaphor is important in exposing hidden values and can be useful in finding new ways to discuss healthcare. For instance, introducing a metaphor of 'ecology' may yield discussions that focus on 'integrity,' 'balance,' 'diversity,' and

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[243] Ibid.
[244] Willard Gaylin is an author and Professor of Psychiatry at Columbia. He co-founded The Hastings Center, an independent bioethics research organization, which helped to establish bioethics as a field. Gaylin has written twenty books and over 140 peer reviewed articles on the subjects of psychoanalysis, technology, ethics, and the nature of being.
[245] Willard Gaylin, "Faulty Diagnosis: Why Clinton's Health-Care Plan Won't Cure What Ails Us," *Harper's Magazine 207* (1993): 57-64, 57.
[246] Segal, *Health and the Rhetoric of Medicine,* 127.

'conservation.'"[247] In addition to understanding the power metaphors have in shaping and framing health conversations, narratives can be just as influential.

Health Narratives

David Morris[248] famously wrote "The delicate balance between biology and culture, as it alters in a continuous flow, is what constitutes the elusive truth of illness."[249] Narrative reminds us that each health experience is unique and helps to reanimate individual voices from the purgatory of statistics and applied data analytics. In the social sciences, narratives are used as a research method to better understand how lived experiences shape concepts of social reality. Becoming popular in the 1980s, narratives of illness have often been used in medical sociology and medical anthropology to highlight the limited scope of biomedical discourse, as well as point out "the role of culture and society in understanding health, illness, and suffering in everyday lives."[250]

An important distinction between disease and illness was made early on in the applied study of health narratives. Here, disease refers to any "biological dysfunction of the physical body;"[251] and, illness is defined as a "syndrome of experiences, a set of words, experiences, and feelings which typically run together for members of a

[247] George J. Annas, "Reframing the Debate on Health Care Reform by Replacing Our Metaphors," *New England Journal of Medicine 333* (1995): 744-47.
[248] David Morris is an author and professor of literature at the University of Virginia. He started the Taos Writing Retreat for Health Professionals. Morris's scholarship focuses on the intersections of pain, illness, and culture.
[249] David B. Morris, *Illness and Culture in the Postmodern Age* (Berkeley, CA: University of California Press, 1998), 9.
[250] Arima Mishra and Suhita Chopra Chatterjee, "Introduction," in *Multiple Voices and Stories: Narratives of Health and Illness,* ed. Arima Mishra and Suhita Chopra Chatterjee (New Delhi, India: Orient Blackswan Private Limited, 2013), 1.
[251] Ibid.

society."[252] This distinction allows a more interpretive approach to understanding illness and medicine through a context of culture. This approach assumes that "medicine and clinical reality itself are culturally constituted."[253] Unfortunately, narrative is rarely used in diagnosis. Medical decision-making "remains largely rooted to the grand narrative of medicine and its focus on the body and a single isolable disease."[254]

Philosopher Mikhail Bakhtin reminds us that words gain meaning through context, which may include culture, community, time, place, and the other's expressions. The spoken word is always embedded in a history, or chain of ongoing context-rich moments. Meaning does not originate from abstract sentences out of context. Even scientific discourse must be viewed as situated in a culture, community, history, and place of scientific discussion. "Narrative is a fundamental way of giving meaning to experience. In both telling and interpreting experiences, narrative mediates between an inner world of thought-feeling and an outer world of observable actions and states of affairs."[255] Storytelling, then, can be a way to better understand illness in contemporary social contexts and locate the individual patient within this larger context.

The importance of narrative in the health context lies in existing power imbalances of clinical encounters. The focus of contemporary medicine is on pathophysiological deviations from the statistical average. As biological systems become fragmented, so too does the social, spiritual, and emotional person. What is being

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[252] Byron Good, *Medicine, Rationality, and Experience: An Anthropological Perspective* (Cambridge: Cambridge University Press, 1994.), 5.
[253] Mishra and Chatterjee, "Introduction," in *Multiple Voices and Stories,* 2.
[254] Suhita Chopra Chatterjee, "Are Narratives a Legitimate Tool of Diagnosis?," in *Multiple Voices and Stories: Narratives of Health and Illness,* ed. Arima Mishra and Suhita Chopra Chatterjee (New Delhi, India: Orient Blackswan Private Limited, 2013), 291.
[255] Cheryl Mattingly and Linda Garro, *Narrative and the Cultural Construction of Healing* (London: University of California Press, 2000), 1.

overlooked is "the impact of socially constructed barriers to functionality and well-being, whether they are physical, attitudinal, or institutional obstacles."[256] Health practitioners and researchers have recently recognized "the importance of sociocultural factors in disease and disability and has developed new standards for knowledge and approaches to care that draw on the work of social scientists and researchers in the humanities."[257] Shifts towards more humanistic healthcare are often seen as more participatory and often begin "with listening to patients' accounts, their stories of what brought them to health care."[258] A health narratives approach to health research, provider and patient education, and medical practice may involve "including qualitative analyses of patients' stories, the study of published narratives of illness and disability, and clinicians' narratives."[259] Heeding the words of rhetorician Kenneth Burke, narratives can "immunize us by stylistically infecting us with the disease," while at the same time giving us an "allopathic strategy of cure."[260] For Burke, narrative, being creatively produced by and through culture, has the power to protect, promote, and restore our sense of well-being.

Two rhetorical tools that have proven useful in healthcare are metaphors and narratives. A major value of studying metaphors is uncovering hidden value structures in the words we use. Revealing hidden values in biomedical discourse allows for open debate about these values. After examining metaphors such as '*the body is a machine*,' '*the person is genes,' 'health is diagnosis,' 'medicine is war*,' and '*medicine is business,'*

[256] Rebecca Garden, "The Humanities, Narrative, and the Social Context of the Patient-Professional Relationship," in *Health Humanities Reader*, ed. Therese Jones, Delese Wear, and Lester D. Friedman (New Brunswick, NJ: Rutgers University Press, 2014), 128.
[257] Ibid.
[258] Judith Lorber, *Gender and the Social Construction of Illness* (Lanham, MD: Rowman & Littlefield, 2000), 99-100.
[259] Rebecca Garden, "The Humanities," in *Health Humanities Reader*, 129.
[260] Kenneth Burke, *The Philosophy of Literary Form: Studies in Symbolic Action* (Berkeley, CA: University of California Press, 1973), 65.

it becomes clear how our terminology can often predetermine the outcomes. Health narratives add meaning through context and shift agency back to the patient and their families. Narratives gave individual faces to general statistics and reemphasize the importance of social and environmental factors in health and illness. The next section will examine applying rhetorical tools to interprofessional healthcare education.

Rhetoric and Interprofessional Healthcare Education

Now that the concepts of rhetoric have been introduced, what can they contribute to educating future health care professionals about ethical collaborative practice? Although abundant literature exists at the intersection of health and rhetoric, the literature focusing a rhetorical lens on interprofessional healthcare education has yet to be established.

A philosophy of communication approach to interprofessional healthcare education offers different ways of discovering truths about ourselves, about health, and about each other. Truth without action, however, does little to improve our community. Discussing rhetoric in the context of interprofessional healthcare education allows students to see the benefits of a rhetorical understanding on multiple levels. For instance, rhetoric can strengthen interprofessional relationships through storytelling and the use of identification to build common ground and trust; rhetoric can be a tool for strengthening arguments to test ideas; or, rhetoric can be viewed as having clinical application, such as in motivational interviewing techniques.

The previous chapters have oriented the reader to thinking about language and communication as meaningful and constructive. The rhetoricians introduced above have discussed elements of rhetoric such as context, content, audience, and purpose which are

still important to identifying with one another and building a shared sense of community. The importance of rhetoric in interprofessional healthcare education lies in the early shaping and articulation of values, attitudes, and personal and professional identity.

Because rhetoric is grounded in ethics, and every craft aims at some good, it is important to contemplate that common good which interprofessional healthcare education protects and promotes. For example, healthcare professionals are individually dedicated to quality patient care. Because interprofessional healthcare education focuses on understanding other professions' values, roles, communication, and teamwork, we can assume that interprofessional education protects and promotes respectful and civil collaboration.

From Cicero we learn the importance of gaining wisdom through a broad education and practical experience tied to a sense of responsibility. This responsibility begins with learning to collaborate. Because effective patient care relies on healthcare teams, and team-based care relies on collaboration between different professions, pre-professional students have a responsibility to learn to collaborate. This can be done in a number of ways. For instance, students may begin by studying the literature on interprofessional healthcare collaboration to gain an awareness of the need. Furthermore, students of different disciplines may study together on a singular topic to gain a better understanding of different roles within a healthcare team. To further one's identity development and orientation to professional roles, students may collaborate in a supervised clinical context where they learn from healthcare professionals. The direct observation of effective teamwork demonstrates how different professional skills can mix to improve patient care.

Quintilian focused his rhetorical education on observation and imitation as well as careful analysis, reflection, eloquent speaking, and decisive action, educational capacities that are vital to all healthcare professionals. Quintilian understood that the best education begins at an early age in an environment of broad learning in language and culture which allows one to relate to more people. Thus, early exposure to healthcare professionals collaborating in their natural professional environment is a powerful pedagogical strategy.

Rhetoricians live in a contingent world with no clear answers, thus, begin by contemplating possibilities. These possibilities begin with the context and the audience. The contingent nature of rhetoric changes our focus on processes that can be mastered to a focus on content that must be learned. Our eyes must shift from sterile communication diagrams to history, culture, language, and ultimately the other person. Rhetoricians attune to the hopes, dreams, desires, motivations, and possibilities of individuals and communities.

As mentioned above, Aristotle claims rhetoric is useful because truth needs capable speakers and teachers. Pre-professional health students are charged with discovering these truths through scientific processes and subsequent analyses of health-related data. The responsibility that comes from finding truth is applying it and sharing it to benefit one's community. In addition to practicing, healthcare professionals must always be both teachers and lifelong learners. The ability to teach others, to effectively share their discoveries with members of their moral community, demands an interest not just in science, but in people.

Aristotle also says rhetoric can help speakers identify with audiences. Rhetoric taps into the innate human motive to belong. Rhetoric can be a tool for identifying, or showing consubstantiality with others by expressing goodwill, showing competence, and using audience-centric language. In short, rhetoric can build ethos. There is persuasive power in our character. We believe people that we like and respect. Elements of ethos include charisma, intelligence, experience, goodwill, and other personal characteristics that facilitate trust. A student is more likely to learn about the values and roles of other professions if their interlocutors are competent and worthy of respect. Without ethos, the doors to persuasion are closed.

Aristotle also mentions that rhetoric allows one to examine and explicate both sides of an issue to better see the facts. "Being forced to defend an idea provides an opportunity to test it."[261] Interprofessional healthcare education allows opportunities to build habits of advocating points of view from one professional perspective while at the same time discovering valuable truths in other perspectives. Paulo Freire[262] says "To safeguard myself against the pitfalls of ideology, I cannot and must not close myself off from others or shut myself into a blind alley where only my own truth is valid."[263] Because dogmatism cripples new learning, this orientation to openness is perhaps rhetoric's greatest gift.

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[261] Deborah Tannen, "The Power of Talk: Who Gets Heard and Why," in *On Communication*, ed. Harvard Business Review (Boston, MA: Harvard Business Review Press, 2013), 57-58.

[262] Paulo Freire was a Brazilian educator and author who dedicated his life to education and literacy. His most well-known work, *Pedagogy of the Oppressed,* outlined his philosophy of education. Freire championed literacy as a way to participate in political life. In doing so, Freire believed the best way to fight oppression and poverty was through education and the subsequent questioning of content. For Freire, the ability to read brings with it a responsibility to act, to inspire change.

[263] Paulo Freire, *Pedagogy of Freedom: Ethics, Democracy, and Civic Courage* (Lanham, MD: Rowman & Littlefield Publishers, Inc., 1998), 119.

As a focus on competency begins to shape interprofessional healthcare education, it is important to understand the limits of this approach. Focusing on efficiency, utility, and competency detracts from the opportunity to discover adjacent histories, cultures, and narratives. Within this approach is a tendency to predetermine outcomes and domesticate students. A philosophy and rhetoric approach to interprofessional healthcare education preserves the curiosity and sense of adventure that comes with meeting the other. It fosters an openness to learning from the other and relinquishing control – necessary for effective team-based care.

CHAPTER 5 : VALUES AND ETHICS FOR INTERPROFESSIONAL HEALTHCARE PRACTICE

Competency Rationale

The need for interprofessional discussion of values and ethics is in direct response to the ever-increasing prominence of team-based care. Before this movement, physicians were the primary health care provider. From the 18th century in England to mid-20th century America, the physician was part of a professional "community of gentlemen"[1] bound by Thomas Percival's (England) ethical precepts[2], which inspired much of the early code of ethics for the American Medical Association, founded in 1847. Along with a paternalistic approach to caring for the poor and the sick, the ethical code of the early AMA focused heavily on intra-professional etiquette, including consultations.[3] Decision-making in this era was the sole responsibility of the physician with little or no input from outside their tight-knit community. Pellegrino and Thomasma describe this era as one of "privilege and condescension," and admit that this elitist and undemocratic ethical model persists "among older physicians today."[4] While each specialty has made progress away from the paternalism of the 20th century, these changes have happened within the boundaries of each profession. Presently, every healthcare specialty has its own set of core values, focusing on the common good through a commitment to safety, efficiency, and effectiveness.[5] These assumptions remain somewhat unchallenged. The literature seems to assume that the values and ethics lie within the idea of a professional identity.

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[1] Pellegrino and Thomasma, *The Virtues in Medical Practice*, 34.
[2] Thomas Percival of Manchester was an eighteenth-century English physician and ethicist. He is known for creating one of the first code of ethics for modern medicine. In Manchester, England, Percival championed for public and industrial health and coined the phrase "medical ethics.'
[3] Pellegrino and Thomasma, *The Virtues in Medical Practice.*
[4] Ibid., 34.
[5] IECEP, *Core Competencies*

Defining values and ethics within an interprofessional competency pries these concepts from their individual professions and attempts to create a collaborative value structure from which to build cohesive healthcare teams.

Traditional, silo-like professionalism is embedded with concepts, values, and ethics that are specific to one specialty and often conflict with other professions. More recent approaches to professionalism within the health professions focus more on creating "public trust."[6] This idea of trust may be a good foundation for interprofessional values and ethics, but needs further development. To date there have been three main approaches to interprofessional health care ethics: (1) virtues in common, (2) cooperation to provide health care as a right, and (3) relationships grounded in values. We will examine these three approaches as well as the concept of patient-centered care as a common goal. A rhetoric and philosophy of communication approach will then be examined followed by a brief analysis of the different approaches.

Health Care as a Moral Community

One important insight from Pellegrino and Thomasma that was partially inspired by the work of Alasdair MacIntyre is the conceptualization of medicine, or health care in general, as a moral community. This assertion is made because "its members are bound together by a common moral purpose."[7] Thus, in order to achieve this overarching purpose, there must be some "fundamental rules, principles, or character traits that will define a moral life consistent with the ends, goals, and purposes of medicine."[8] If we are to find common ground between a virtues approach to health care and a principles

[6] Ruth P. McNair, "The Case for Educating Health Care Students in Professionalism as the Core Content of Interpersonal Education," *Medical Education* 39 (2005): 456-464.
[7] Pellegrino and Thomasma. *The Virtues in Medical Practice,* 3.
[8] Ibid.

approach, it needs to be situated within a community, and the values of that community. MacIntyre asserts that the detachment of moral rules from a community causes those rules to "become nothing but a set of arbitrary prohibitions."[9] Therefore, as part of an inherently moral community, health care professionals have a certain obligation to care for the sick. Incidentally, as a member of a health care team, in order for individual professionals to achieve this end, they must also be able to effectively work together.

Pellegrino and Thomasma list three inescapable things that make medicine (and health care in general) inherently moral. They are: "(1) The nature of illness; (2) the nonproprietary nature of medical knowledge, and (3) the nature and circumstance of a professional oath."[10] When a person becomes ill, they find themselves in an uncomfortable state of uncertainty, dependence, and vulnerability. In a typical sick visit, the patient reveals intimate and very private physical and psychological information to a stranger, whom they are required to trust. This relationship has no equivalent outside of the health care context. Health care professionals are bound by the nature of illness itself and the trust that is vital to facilitate the encounter. Health care must be, first and foremost, a community of trust. Additionally, health care professionals have a specific skill that deals specifically with medical needs. Pellegrino and Thomasma echo Thomas Jefferson[11] when they state, "The existence of a genuine medical need constitutes a moral claim on those equipped to help."[12] Therefore, there is an unspoken call that those with

[9] Alasdair MacIntyre, *Three Rival Versions of Moral Enquiry: Encyclopedia, Genealogy, and Tradition* (Notre Dame, IN: University of Notre Dame Press, 1990), 139.
[10] Pellegrino and Thomasma, *The Virtues in Medical Practice,* 35.
[11] Referring here to Jefferson's famous statement: "If there's something wrong, those who have the ability to take action have the responsibility to take action."
[12] Edmund Pellegrino and David Thomasma, *A Philosophical Basis of Medical Practice* (New York, NY: Oxford University Press, 1981).

the ability to help have the responsibility to help. The health care community as a whole has the responsibility to help. This common charge binds the community.

Universal Common Good: Effective Patient-Centered Care

Values and ethics have been discussed as a necessary part of healthcare since antiquity, but have only recently been discussed in terms of professional competencies. Recent discussions of the subject have created a virtual consensus among healthcare professionals that healthcare should first and foremost be patient-centered. This idea of patient-centeredness was born out of a re-focusing on quality after the IOM's report showed quality shortcomings in multiple healthcare areas. Throughout the discussions of patient-centeredness, there seems to be lacking a conversation of what it means to be patient-centered. There exists an obvious moral element to the concept, one that recognizes patients as living beings that experience illness in unique ways and often require treatment of both body and mind. It is also easy to see how education itself reinforces a pathology-centered, or population-centered mindset. Students often learn about the human body by studying cadavers, which desensitizes them to the living patient[13]; likewise, they also study population data to understand health trends, enticing the practitioner to look beyond the individual.

Focusing primarily on the patient brings with it a need to fully understand what patient-centered care means. Overlooking this essential step has led to superficial models that lack authenticity. Policies that are touted as fostering patient-centeredness should "strengthen the patient-clinician relationship, promote communication about things that matter, help patients know more about their health, and facilitate involvement in their

[13] Alan Bonsteel, "Behind the White Coat," *The Humanist 57* (1997): 15-19.

own care."[14] These recommendations focus on meaningful, educational, and patient-autonomy-focused communication.

To truly focus on the patient also means changing the language in which conversations are carried out. For centuries physicians have dominated the dialogue about healthcare. Because patients today are an active part of the decision-making process, and ethics itself involves decision-making, patient-provider communication must take place with an *a priori* conversational ethic. This ethic is one of partnership and collaboration, one that requires a certain level of empathy and emotional intelligence. This ethic must also be supported by healthcare organizations that are often efficiency-driven, leaving little time for patient engagement. Patient-centered care must focus on the quality of both personal and professional relationships[15], and because healthcare teams are increasing in both size and complexity, quality patient-centered care must also be a focus at the organizational level.

[14] Ronald Epstein and Richard Street, "The Values and Value of Patient-Centered Care," *Annals of Family Medicine 9* no. 2 (2011): 100-103, 101.
[15] Ibid.

Current Approaches

Virtues in Common

The 'virtues in common' approach to values and ethics in interprofessional healthcare education comes from the work of McNair (2005)[16] and Stern (2006)[17]. In 2005, Ruth McNair recognized the trend towards health care teams and understood the importance of common ethical grounding in the health care teams. She also recognizes the difficulty of incorporating teamwork and professionalism into the undergraduate curricula. Some of the challenges are a lack of knowledge about the roles of other professions, a lack of teamwork skills in general, and differing levels of respect for the different professions.[18] McNair argues that differences in professional ethical codes can lead to exclusivity, create rivalries, and these divisions are reinforced through curricular role-modeling in college.[19] McNair's study recommends teaching professionalism and shared values. She presents interprofessionalism *as* a value, a value shared by all to better prepare students for working in health care teams. She also recommends a way to evaluate levels of professionalism.

David Stern's *Measuring Medical Professionalism* is an attempt to evaluate professionalism, and is also a response to growing mistrust of physicians in the U.S. He presents cases of unprofessional behavior including misconduct and selfishness and argues that the remedy is an expectation of professional behavior. What is needed, according to Stern, is a way for medical professionals to measure and analyze their own

[16] McNair, "The Case for Educating Health Care Students in Professionalism."
[17] David Thomas Stern, *Measuring Medical Professionalism* (New York, NY: Oxford University Press, 2006).
[18] McNair, "The Case for Educating Health Care Students in Professionalism."
[19] Ibid.

professional behavior. His book is an attempt to offer a framework to evaluate professionalism. McNair and Stern both argue for interprofessionalism with common values as part of college curricula.

This movement was carried forward by the creation of the Interprofessional Professionalism Collaborative[20] who attempt a definition of interprofessionalism: "Consistent demonstration of core values evidenced by professionals working together, aspiring to and wisely applying principles of altruism, excellence, caring, ethics, respect, communication, [and] accountability to achieve optimal health and wellness in individuals and communities."[21] The definition proposes starting with core values; however, offers a list of positive, professional traits that lacks in utility when attempting to design an interprofessional curriculum. For example, how can we build altruism into a college course?

Cooperation and Equal Distribution

A second approach to values and ethics in interprofessional healthcare education comes from the Tavistock Group.[22] Their report from 1999 proposed five ethical principles for health care providers to hold in common. These five were later expanded to seven following a large meeting and subsequent debate in 2000.[23] They include: healthcare as a right, balance between individual care and population-centered care,

[20] The Interprofessional Professionalism Collaborative was founded in 2006 to develop assessment instruments for interprofessional professionalism to be used by educators. They refer to professionals working together as interprofessional professionalism.
[21] "Definition of Interprofessional Professionalism," Interprofessional Professionalism Collaborative, accessed March 20, 2017, http://www.interprofessionalprofessionalism.org/behaviors.html
[22] The Tavistock Group was started by Don Berwick, Frank Davidoff, Howard Hiatt, and Donald Smith. In 1999, they coordinated a meeting of medical professionals from different fields on Tavistock Street at the headquarters for the British Medical Association. The seven Tavistock Principles were created at this meeting in an attempt to ground health care in a system of core values.
[23] Don Berwick, Frank Davidoff, Howard H. Hiatt, and Richard Smith, "Redefining and Implementing the Tavistock Principles for Everybody in Health Care," *BMJ 323* (2001): 616-620.

providing comprehensive care, cooperation between all involved, continuous improvement, safety focus, and openness.[24] This idea is similar to McNair's 'virtues in common,' and acknowledges that ethical codes are usually discipline-specific, but expands the idea of a health care team to include "everybody involved in health care."[25] This includes those involved in creating and shaping the health care system, those that work within it, and even those that use it. Some challenges to this approach are that it is difficult to measure and evaluate certain values. Group proponents suggest that healthcare organizations consider adopting the seven ethical principles on good faith and view them as more aspirational and less formal.[26]

In response to the Tavistock Group's publication, the Justice in Health Care Foundation published a list of five ethical principles in 2001. The list includes: health as a primary goal, access based on need, accountability for everyone involved, health care system choice, and a focus on education.[27] Where the Tavistock Group started from the viewpoint of the provider, the Justice in Health Care Foundation focuses more on educating and empowering the patient, arguing that positive change would come from the users of the system.

Both lists of ethical principles are similar in that they focus on improving healthcare and that society has an obligation to provide health care based on need. This inclusion in both lists has direct effects on healthcare policy. This approach to values and ethics in interprofessional healthcare takes a stand that health care is a human right, and

[24] Ibid.
[25] Frank Davidoff, "Changing the Subject: Ethical Principles for Everyone in Health Care," *Annals of Internal Medicine 133* (2000): 386-389.
[26] Berwick, et al., "Redefining and Implementing the Tavistock Principles."
[27] Ibid.

that it is everyone's responsibility to cooperate in order to deliver on this promise. This approach also includes education, but offers little in terms of pedagogical reform.

Relationship-Centered Values

A third approach to values and ethics in interprofessional healthcare education is multifaceted, focusing primarily on quality relationships. These relationships include *intra*professional, *inter*professional, and relationships with patients. This approach also goes beyond relationships to include ethical considerations that may arise when collaborating on policy and program creation. This third approach is the one favored by the IPEC because of its focus on quality relationships as they relate to collaborative care.

A focus on relationships brings respect and trust to the forefront, which in turn, yields collaboration and honors diversity. One proponent of this approach to interprofessional healthcare education is Jody Gittell.[28] Her book *High Performance Healthcare*[29] seeks to find ways that complex organizations can solve the quality-efficiency paradox, where focusing on one diminishes the other. After studying the airline industry, she saw something unique in the way the Southwest Airlines coordinated their communication and their actions. She introduces the concept of "relational coordination," which she has shown to be a "powerful driver of both quality and efficiency outcomes."[30] Gittell theorizes that when organizations have high levels of interdependence, their work is the most effective when coordinated by individuals that have common goals, learn

[28] Jody Hoffer Gittell is currently professor of management at Brandeis University and the Executive Director of the Relational Coordination Research Collaborative. Her work focuses mainly on organizational performance, organizational change, and relational coordination. Her latest book, published by Stanford University Press is titled *Transforming Relationships for High Performance: The Power of Relational Coordination.*

[29] Jody Gittell, *High Performance Healthcare: Using the Power of Relationships to Achieve Quality, Efficiency, and Resilience* (New York, NY: McGraw Hill, 2009).

[30] Gittell, *High Performance Healthcare,* xiv.

from one another and have relationships built on mutual respect. She adds that these relationships are nurtured by communication that is frequent, timely, accurate and focused mainly on problem solving, rather than blaming.[31] She notices that employees coordinate fairly well with their colleagues, but not very well with other professions.

Rhetoric and Philosophy of Communication Approaches

The focus of this chapter is the values and ethics of interprofessional health care education. Most of the research that analyzes the values of health care focuses on the philosophy of health and medicine, the physician-patient interaction, or the virtues of a physician. Even the current approaches described above do not adequately conceptualize values before using the terms. For instance, both McNair (above) and Stern (above) recommend teaching and evaluating professionalism and shared values; however, neither acknowledges different meanings of professionalism. From the earlier section (from the introduction) on professionalism we learn that each profession evolved with a focus on differentiating themselves from the other professions (and non-professions). Even the term 'values' is almost too vague to be useful, especially in a time of increasing plurality among health care workers in the U.S. Another group concerned with the values of interprofessional care, the Tavistock Group (above), proposes ethical principles to hold in common. How is this different than a focus on professionalism? What exactly are principles? And how do they become grounded and productive in acts of healing? Finally, Gittell's (above) focus on relationships makes sense, but are her values in contrast to those of McNair, Stern, and the Tavitock Group? These questions imply that a

[31] Ibid.

deeper understanding of ethics and values is needed *before* we can discuss the values of interprofessional health care education.

One can approach discussions of values and ethics from a number of established frameworks. We could approach ethics from a *deontological* perspective, which would establish ethical codes for interprofessional practice. Within this approach we find moral concepts such as the 'Golden Rule,' or perhaps Immanuel Kant's "categorical imperative."[32] Another approach could be *consequentialism*, a 'the end justifies the means' perspective that subjugates methods. The philosophy of Machiavelli and the utilitarianism of Jeremy Bentham and John Stuart Mill would fall somewhat under this approach to ethics. Pragmatists, such as John Dewey and Charles Sanders Peirce, argue for a *pragmatic ethics* that treats ethics in a similar way to science, that principles and morals can be refined and improved through scientific inquiry. Finally, ethics can be approached via the classical virtues, which focus on individual character. A study of *virtue ethics* usually begins with the contrasting views of Plato and Aristotle. Plato views virtues as ends in and of themselves, while Aristotle sees virtues as means to pursue the common good. Historically, these approaches to values and ethics have been posed as competing frameworks; however, there are areas of overlap that will be briefly discussed.

This rhetoric and philosophy of communication approach to ethics and values will begin with an analysis of virtue ethics *alongside* other ethical traditions and will attempt

[32] In 1785, Immanuel Kant introduced the philosophical concept of the categorical imperative to help evaluate one's motivations to act morally. It was in response to popular hypothetical imperatives of his day. Kant disagreed with the contingent nature of if/then moral reasoning and offered an alternative that suggests moral decisions be made through pure practical reasoning. Furthermore, these decisions are universal, not relative. As stated by Kant, the categorical imperative instructs us to "act only according to that maxim whereby you can, at the same time, will that it should become a universal law." As cited in Immanuel Kant, *Grounding for the Metaphysics of Morals,* trans. James W. Ellington (Indianapolis, IN: Hackett, 1993), 30.

to respond to some of the underlying themes mentioned above (current approaches section) so as to enter the established conversation. The conversation will then be directed towards a response to Gittell (above), and her focus on 'relational coordination' grounded in respect and having common goals. Her approach opens up a discussion of relationship building through respect for others. Finally, the above approaches include the concept of interprofessionality as a virtue in and of itself. Fritz's work on professional civility acts a nice supplement to this train of thought.

The Virtue Tradition

The virtues can be traced back to Ancient Greece. Socrates believed that there was only one virtue, the virtue of knowledge,[33] a concept defended by University of Pittsburgh philosophy professor, John McDowell. McDowell calls virtue a capacity for perceiving how one should act. This "perceptual capacity" is the only true virtue; all others are merely "specialized sensitivities,"[34] a sentiment consistent with the ancient Stoics. Plato shares the Socratic sentiment that virtue is an end in itself. Differing from the Socratic mono-virtue system, the *Republic* includes the Four Cardinal Virtues. These virtues (also used also in traditional Christian teaching via Cicero, St. Ambrose, and St. Thomas Aquinas[35]) included *Prudence*, an ability to judge time-appropriate actions, *Courage*, or the strength to confront and endure one's fears, *Temperance*, which includes self-control, moderation, and sexual restraint, and the most important of the Four Cardinal Virtues, *Justice*, or fairness and righteousness.

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[33] Plato, *Meno,* trans. W.R.M. Lamb (Cambridge, MA: Harvard University Press (Loeb Classical Library), 1977).
[34] John McDowell, "Virtue and Reason," *The Monist 62* no. 3 (1979): 331-350.
[35] Perhaps the most comprehensive treatment of the Christian virtues can be found in the *Summa Theologiae* and the *Commentaries on the Nicomachean Ethics* written by St. Thomas Aquinas between 1265 and 1274. These were often used as instruction manuals for theology students in the Middle Ages.

Professor of communication and ethicist Ronald C. Arnett asserts that communication ethics center around choice and choice begins by protecting and promoting a given good.[36] The question becomes 'How can we determine this good?' An Aristotelian concept of ethics is echoed in the first sentence of *Nicomachean Ethics*: "Every craft and every inquiry, and similarly every action and project, seems to aim at some good; hence the good has been well defined as that which everything aims."[37] Aristotle's definition of the "good," thus, is fundamentally teleological. Taken alone, his definition is circular and less than helpful. MacIntyre's comment: "In ethics we are guided by general considerations to general conclusions, which nonetheless admit of exceptions."[38] MacIntyre's exceptions only add to the confusion. MacIntyre includes concepts of courage and wealth generally being good, but in certain instances leading to destruction. Therefore, judgments about a given context become an important element of ethics. What becomes clear in both Aristotle and MacIntyre (not so much in Socrates and Plato) is that virtues require context; thus require *phronesis*.

Differing from both Socrates and Plato, Aristotle views the virtues not as ends, but as means to personal and public fulfillment. In his *Nicomachean Ethics*, Aristotle searches for the final end of which all action is directed. He argues that this final end, first, must be chosen for its own sake and never as a means to some greater end, and second, the *concept* can not be used except for a final end. Aristotle concludes that *eudaimonia*, poorly translated as 'happiness', but with an intended meaning closer to

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[36] Ronald C. Arnett, "A Conversation about Communication Ethics with Ronald C. Arnett," in *Exploring Communication Ethics: Interviews with Influential Scholars in the Field,* ed. Pat Arneson (New York, NY: Peter Lang, 2007), 53-68.
[37] Aristotle, *Nicomachean Ethics,* 1.
[38] Alasdair MacIntyre, *A Short History of Ethics: A History of Moral Philosophy from the Homeric Age to the Twentieth Century, 2nd ed.,* (Notre Dame, IN: University of Notre Dame Press, 2011), 59.

'human flourishing,' is this end, the highest human good, and an answer to his famous question, "What is a good life?" Aristotle sees this 'happiness' as activity of the rational personality, which he calls the soul, in harmony with virtue. He breaks this rationality into intellectual virtues (wisdom, intelligence, prudence) and moral virtues (liberality, temperance). Virtue is a result of education and practice, and centers on situational knowledge and understanding of the *mean* (the middle ground between two extremes). MacIntyre explains:

> What is courage in one situation would in another be rashness and in a third cowardice. Virtuous action cannot be specified without reference to the judgment of a prudent man – that is, of one who knows how to take account of circumstances. Consequently, knowledge of the mean cannot be knowledge of a formula, it must be knowledge of how to apply the rules to choices.[39]

Therefore, if virtue is an understanding of how to apply the mean to given situations, virtuous action would have to be the end product of profitable practical reasoning. He lists courage, temperance, ambition, friendliness, and modesty (among others) with the virtue of each being a "golden mean" between extremes. Aristotle also lists intellectual virtues, which deal with the mind. He lists intelligence (*nous*), science (*episteme*), theoretical wisdom (*sophia*), craftsmanship (*techne*), and most importantly practical wisdom (*phronesis*). Aristotle states, "As soon as he possesses the singe virtue of practical wisdom, he will also possess all the rest."[40] Aristotle's idea of *phronesis* is used by both Pellegrino and MacIntyre and so warrants further discussion.

Phronesis is rhetorical in nature because it is most useful when there are choices with no clear answers. In this way *phronesis* is different than both *nous* (understanding fundamental principles) and *sophia* (ability to reason from fundamental principles).

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[39] MacIntyre, *A Short History of Ethics,* 66-67.
[40] Aristotle. *Nicomachean Ethics*, 1145a1-2.

Phronesis is also action-oriented, and so it differs from *techne*, which deals with products. In this distinction we are reminded of Pellegrino's differentiation between science and ethics – one is dedicated to the material world (science and *techne*) while the other deals with reasoning amidst contingency. Science has an end other than itself, i.e. to cure a chronic illness. Both virtue ethics and phronesis deal with actions as ends in themselves.

In a way, Aristotle's elevation of *phronesis* to the top of his list of virtues shows more commonality with the pragmatism of Dewey, than it does with the deontology of Kant or the consequentialism of Bentham and Mill. *Phronesis* allows the moral virtues to be developed contextually and relative to an individual living in a distinct historical moment within a concrete situation. Alasdair MacIntyre agrees saying that virtues have to be born from the specific community in which those virtues will be practiced. He points out the similar root ethics has to *ethos*, which refer to character traits that represent ideals for a particular community. Simply put, virtues have to be grounded in a particular historical moment at a particular place. Author and former Cambridge lecturer, John Casey,[41] describes phronesis as "the ability to 'see' what is at stake where the application of rules may not be at all obvious, and to know how to respond." Casey elaborates, "It can go beyond knowing how to act. We can think of the man of practical wisdom as having moral imagination."[42] Casey's explanation reveals even more similarity to rhetoric in the importance of *inventio*, the first of the five canons, centered on discovery

[41] John Casey (1939-) is an author of five books and a former lecturer of English at Cambridge. He was also the former editor of *The Cambridge Review.* His most popular book, *Pagan Virtue* challenges the Kantian ideal of 'good will' by comparing ancient Roman and Greek virtues with those found in Christianity.
[42] John Casey, *Pagan Virtue: An Essay in Ethics* (Oxford, England, UK: Clarendon Press, 1991), 47.

and creativity. We can now begin to see ethics and morality as 'acts' that require both philosophy and rhetoric.

In addition to Socrates, Plato, and Aristotle, other thinkers have offered their own lists of virtues. MacIntyre recognizes Homer as offering virtues in his *Iliad* and *Odyssey*. Homer's virtues include hospitality, physical power, courage, cleverness, and most importantly *excellence*. Like Aristotle, these virtues, while intrinsically important in themselves, are means to achieve eternal glory, the greatest accomplishment one could attain. Eternal glory is Aristotle's *eudaimonia*. For Christians, the immortality of 'eternal glory' is realized by admittance to heaven, accomplished by avoiding sin (listed in the ten commandments and the seven Deadly Sins) and practicing the seven Principal Virtues, which are the Four Cardinal Virtues (listed above) and the Theological Virtues: faith, hope, and love.[43] The Principal Virtues are often listed as humility/modesty, generosity/charity, kindness/gratitude, patience/compassion, chastity/purity, temperance/moderation, and diligence/fervor. Five of the Principal Virtues overlap with Aristotle's moral virtues: modesty, liberality and magnificence, friendliness, temperance, and ambition. In Aristotle we do not find patience or purity, but we do find the intellectual virtues. As we continue the discussion of values and ethics in interprofessional healthcare education, we shall draw both from the ancient world as well as Judeo-Christian concepts of virtue. One main insight gained with the previous discussion is that the 'care tradition' in health care, or an 'ethics of care' (as opposed to an ethics based in virtue) *is* based in virtue; in fact, four of the seven Principal Virtues were elaborated by St. Ambrose by connecting the beatitudes to the Four Cardinal

[43] 1 Corinthians 13:4

Virtues found in the *Republic.* In fact, Ambrose is credited with retrospectively coining the term Cardinal Virtues, where the Latin *cardo* refers to a hinge (door hinge). The virtues, for St. Ambrose were, in a sense, the hinges of a moral life.

The *virtue* tradition is not new to health care. Both Greek and Judeo-Christian concepts of virtue have been used. For the Greeks, virtue lies within the individual actor, while, virtue for Judeo-Christians focuses heavily on relationships. Dedicating much of his career to interdisciplinary collaboration and the contemplation of virtue ethics in medicine, Edmund Pellegrino[44] may be the perfect *cardo* to start our discussion.

Edmund Pellegrino: The Virtues in Medical Practice

Professor of medicine and bioethicist, Pellegrino argues for a return to virtue ethics as a norm for medical practice.[45,46] Pellegrino necessarily differentiates science from ethics. "Science, that is, the use of the scientific method, tends to confine itself to the physical and perhaps psychological dimensions of human existence."[47] He places ethics in the "realm of what it is we *ought* to do and 'ought' carries with it the notion of responsibility, accountability, and how we reason about a moral question."[48] This line of thinking allows Pellegrino to definitively place ethics under the umbrella of philosophy "because it uses the methods of philosophy, i.e. moral contemplation on all aspects of

[44] Edmund Pellegrino, MD was professor of medicine and bioethics at Georgetown University. Pellegrino was one of the pioneers of modern medical ethics and led the movement to bring the humanities into medical school. He served as both chairman of the President's Council on Bioethics and president of The Catholic University of America. Many of Pellegrino's 600 publications focus on philosophy and ethics in the practice of medicine leading him to found the *Journal of Medicine and Philosophy.*
[45] Pellegrino and Thomasma, *A Philosophical Basis of Medical Practice.*
[46] Edmund Pellegrino, "Toward a Virtue-Based Normative Ethics for the Health Professions," *Kennedy Institute of Ethics Journal 5* (1995): 253-277.
[47] James Giordano, "*Foni phronimos* – An Interview with Edmund D. Pellegrino," *Philosophy, Ethics, and Humanities in Medicine 5* (2010): 16.
[48] Ibid.

human existence."[49] Although definitional, Pellegrino's distinction is key to understanding ethics as a completely different way of thinking, rather than the role of ethics within the sciences, such as in the 'ethical sciences' of George Campbell. This simple distinction opens the door for truly interdisciplinary work in the fields of philosophy and ethics.

Pellegrino's understanding of virtue ethics focuses on excellence of character that is teleologically oriented, rational thought over emotivism, and *phronesis* refined through practice.[50] Although Pellegrino's ethical prognosis is heavily Greek-influenced, he adds, "virtue cannot stand alone but must be related to other ethical theories in a more comprehensive moral philosophy than currently exists."[51] Although Pellegrino does not apply virtues specifically to environments of interprofessional collaboration, his intuitive respect for plurality makes him a logical segue into discussions of virtues in the health professions.

In Pellegrino and Thomasma's *The Virtues in Medical Practice,* they list eight virtues they believe to be important to medicine. They use the term 'virtue' throughout the text as a "habitual disposition to act in a certain way […] that facilitates and enriches the *telos* or purpose of whatever human acts we perform."[52] They list (1) fidelity to trust, (2) compassion, (3) phronesis, (4) justice, (5) fortitude, (6) temperance, (7) integrity, and (8) self-effacement. Each virtue will be briefly discussed as it relates to health care environments.

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[49] Ibid.
[50] Pellegrino, "Virtue-Based Normative Ethics," 256.
[51] Ibid., 253-277.
[52] Pellegrino and Thomasma, *The Virtues in Medical Practice,* 79.

Trust

"Trust is most problematic when we are in states of special dependence."[53] During these states of vulnerability and dependence, we often have no choice but to trust health care professionals. Trust allows us to avoid complexity. "No professional can function properly without discretionary latitude […] to limit that latitude is to limit the capacity for good as much as it may limit the capacity for harm."[54] Patient autonomy and the elevation of the contract are direct responses to a deterioration of trust. Medical decision-making exists in a word of contingency. Contracts, such as a living will, cannot predict these contingencies, and in many cases limit the "discretionary latitude"[55] of decision-makers. On the subject of replacing relationships with contracts, Pellegrino and Thomasma state, "A dialogical relationship is much better than a physician-paper one, since one's course of illness resembles a drama in which changes may take place daily."[56] This trust applies to both individuals and institutions. Institutions are systems that function within certain restraints. System trust becomes even more important with team-based care. The virtue of trust must belong to entire health care team. Taken further, there must be trust in the educational institutions and credentialing agencies as well. The 'system trust' becomes trust in the health care system in general. In sum, without the virtue of trust the health care professional (or any professional for that matter) cannot achieve its *telos*.

[53] Ibid., 65.
[54] Ibid., 69.
[55] Ibid., 70.
[56] Ibid.

Compassion

Compassion as a virtue can be characterized by the habitual disposition to act towards "healing, helping, and caring for someone who is ill."[57] Often compared to the Christian virtue of charity, compassion is different in that it has an intellectual as well as moral component. Compassionate individuals have an ability to tailor caring and healing to specific patients, and, to a certain extent, to suffer with them. This aspect of compassion makes it truly phenomenological and completely "embedded in a personal dynamic relationship."[58] Because the ends of health care (healing, helping, and curing) are "defined in terms of the patient's good, which consists not only of the medical good, but also the good as the patient perceives it herself, or her good as a human person or spiritual being."[59] Compassion, then becomes an attunement to another's unique situation, an opening up of oneself to understand and assist with the emotional, social, spiritual, personal, and physical illness experience. In *Being and Time*, Martin Heidegger[60] gives a name to the phenomenon of being. He calls this *Dasein*. *Dasein* always has *stimmung*, German for *mood*, but not just mood in general, a particular mood. The word also means tune, or attunement, often used in music to describe a matching of vibration or frequency. Here, the language of phenomenology can allow us to understand compassion as attunement of one person to another. Heidegger claims that our moods and

[57] Ibid., 79.
[58] Ibid., 80.
[59] Ibid., 80-81.
[60] Martin Heidegger was a German philosopher of the continental tradition. Heidegger is well-known for his contributions to philosophical hermeneutics and phenomenology. His *Being and Time* has been established as one of the seminal works of the twentieth century and focuses on the phenomenon of being, which he calls Dasein, or "being there." Heidegger sees 'care' as the primary characteristic of our "being there," which is different from philosophers like Decartes who focuses on our ability to think. For Heidegger, thinking itself is not central because we think *about* things and people that we experience.

attunements create an existence that is "never the same from day to day,"[61] and although limiting, it is this moodiness that opens the world to us, makes it accessible. This is helpful in understanding compassion, a dynamic attunement to a particular being that cannot be measured, only experienced.

Phronesis

Phronesis, prudence, or practical wisdom is an intellectual ability to understand what action or means should be taken in a particular situation that would be most conducive of the good. Unlike pure wisdom (*sophia*), *phronesis* is action-oriented, yet always moving teleologically toward the good. The specific good for a health care professional is "a right and good healing action for a specific person."[62] Phronesis, as a compass, keeping the other virtues pointed toward this end. This action orientation makes phronesis vital to health care. Phronesis helps to balance the other virtues, such as *respect for persons* where too little may lead to paternalism and too much undermines the provider's expertise. Unlike the attunement of compassion, caring for another human being is an activity, a practical initiative that requires not only moral components, but *techne*, or technical knowledge (knowing how to do something) as well. The contingent nature of illness immerses the caring and healing processes in a perpetual state of judgment and decision-making. Thus, if we view rhetoric as an art of decision-making in complex, uncertain situations, then health care is inherently rhetorical. Phronesis grounds the tools of rhetoric in a philosophy of the good.

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[61] Martin Heidegger, *Being and Time,* trans. John Macquarrie and Edward Robinson (New York, NY: Harper & Row, 1962), 111.
[62] Pellegrino and Thomasma, *A Philosophical Basis of Medical Practice,* 119-152.

Justice

Concepts of justice often vary across different cultures, but are often discussed in the context of three domains: individual actions, legal actions, and public policies.[63] Aristotle breaks the three domains into two types of justice. The first he calls "universal" justice referring to "justice as a whole."[64] This broader concept of justice is applied to individual morality and impacts on other people. The second type deals with "particular" justice[65] and can be applied to both legal and political situations in more specific contexts. Justice as a virtue often falls into the category of 'justice as a whole.' Plato defines justice as a cardinal human virtue that harmonizes reason, spirit, and appetite.[66] Both Plato and Aristotle acknowledge the legal aspects of justice, but focus mainly on the philosophy of fairness and balance. Justice can be applied to the individual, or it can be applied to the *polis* as harmony between different parts of the state. This is evident in the writings Augustine who looks to the heavens for his definition of justice. In *City of God* Augustine refers to justice as loving God and ruling oneself and the state in accordance with the laws of God. Justice becomes the main difference between the ideal and non-ideal political states.[67] Mahatma Mohandas K. Gandhi, famous for his philosophy of non-violence, says that "action alone is just which does not harm either party to a dispute."[68] Gandhi's non-violent sentiment blends with Augustine's Christian interpretation of justice in the writings and teachings of Martin Luther King, Jr. King echoes St. Thomas

[63] David Miller, "Justice," *The Stanford Encyclopedia of Philosophy Fall 2017*, ed. Edward N. Zalta, accessed March 6, 2019, https://plato.stanford.edu/cgi-bin/encyclopedia/archinfo.cgi?entry=justice
[64] Aristotle. *Nicomachean Ethics*, V.1-2.
[65] Ibid.
[66] Plato. *Republic,* trans. Christopher Emlyn-Jones and William Preddy (Cambridge, MA: Harvard University Press (Loeb Classical Library), 2013), IV, 443 b.
[67] Augustine. *City of God.*
[68] Mohandas K. Gandhi, *The Collected Works of Mahatma Gandhi, vol. 19* (Delhi: Government of India, Ministry of Information and Broadcasting, Publications Division, 1958), 233.

Aquinas when he writes, "a just law is a man-made code that squares with the moral law or code of God. An unjust law is a code that is out of harmony with the moral law."[69] King calls people to "constructive nonviolent tension" using "the method of nonviolence [that] is based on the conviction that the universe is on the side of justice."[70] His call to action is based on a warning that "injustice anywhere is a threat to justice everywhere."[71]

Justice is definitionally simple, but as a traditional virtue, is pragmatically complex. The complexity lies in the fact that this virtue has no mean; there is no appropriate amount of justice. This characteristic of justice is the root of its complexity. Rendering to others what they deserve is an all or nothing affair. Most applications of justice to health care have focused on the costs of health care and access to health care. Applying the virtue of justice to interprofessional practice makes sense if only that health care professionals work within a community and justice is a requirement for peaceful community. For St. Augustine[72] justice is rooted in love and 'true justice' can only exist in the *City of God*. We can only compare communities relative to one another. According to Augustine, without justice (which cannot exist on earth) we are left only with "gangs of criminals on a large scale."[73] Augustine's unattainable earthly justice implies a natural

[69] Martin Luther King, Jr., *Letter from the Birmingham Jail* (San Francisco, CA: Harper San Francisco, 1994).
[70] Martin Luther King, Jr., "Nonviolence and Radical Justice," *Christian Century 74* (1957): 165-167, 166.
[71] King, *Letter from the Birmingham Jail.*
[72] St. Augustine of Hippo was a fourth and fifth-century theologian, philosopher, and teacher of rhetoric. He is most famous for adapting classical rhetorical teachings for Christian education. During his tenure as bishop of Hippo in northern Egypt (396-430AD), Augustine wrote his famous *Confessions* and *The City of God.* He also wrote *De Doctrina Christiana* which focused both on discovering truth in scripture through biblical hermeneutics and delivering that truth via classical Greco-Roman (pagan) rhetorical techniques. Augustine's contributions to concepts of original sin, free will, time, memory, and justice had tremendous influence not only on Christianity, but on western philosophy and the whole of education throughout the middle ages.
[73] Augustine, *City of God* (New York, NY: Penguin Books, 1972), 139.

inclination towards selfishness. Thomas Hobbes[74] captures the natural state of society-less humans beings in *De Cive* (and later in *Leviathan*) when he writes the famous phrase *bellum omnium contra omnes*, or "the war of all against all."[75] Within the health care community, Augustine and Hobbes offer warnings regarding justice. Whether we believe human beings to act altruistically or not, it is hard to argue against the importance of fairness in the workplace. If one professional or one profession within a specific health care community takes more than their/its fair share of credit, compensation, status, power, autonomy, etc. there will be feelings of injustice – and the peace must be restored.

Fortitude

Fortitude is often thought of as similar to courage, but contains moral as well as physical attributes. As Plato noted, evil people can be courageous.[76] One's willingness to suffer physically or emotionally for the sake of a greater good characterizes the virtue of fortitude. St. Augustine, St. Thomas Aquinas, and Aristotle capture elements of fortitude in their characterization of courage as a *steadfastness*. Aquinas notes that "pleasurable good and oppressive evil constrain a man to abandon reason," but for those with fortitude will be "accorded greater praise in proportion to the pressure he withstands, which would force him to fall or retreat."[77] Pellegrino and Thomasma apply fortitude to health care

[74] Thomas Hobbes was a seventeenth-century English political philosopher best known for his concept of the social contract, highlighting the relationship between natural rights and legal rights. Social contract theory, as outlined in his famous *Leviathan*, refers to the unwritten consent by individuals within a society to surrender some freedoms in exchange for the protection by the state of other rights. Choosing to live civilly requires a strong central authority to avoid a default 'state of nature' where we would be continually at war with one another.

[75] George Shelton, *Morality and Sovereignty in the Philosophy of Hobbes* (New York, NY: Springer, 2016), 22.

[76] Plato, *Laws I-VI,* trans. R. G. Bury (Cambridge, MA: Harvard University Press: Loeb Classical Library, 1926), I. 630b.

[77] Thomas Aquinas, *Summa Theologiae: Complete Set,* ed. The Aquinas Institute (Rochester, NY: The Aquinas Institute, 2012)*,* 2a2ae, q. 123, a. 11.

referring to it as inspiring confidence that health care professionals will be resistant to "temptation to diminish the patient's good through their own fears or through social and bureaucratic pressure, and that they will use their time and training resourcefully to accomplish good in society."[78] Additionally, a shift to 'the patient as a consumer' brings with it the temptation to shift responsibility away from the provider and their "moral obligation." It requires fortitude to "face adversity and yet bring about the good."[79] Applied to interprofessional practice, fortitude can be characterized as recalcitrance to agnosticism, or moral grit during interprofessional disagreement, especially amidst power inequalities or conflicts over roles and responsibilities.

Temperance

Discussed by Plato in *Charmides*, the Greek word *sophrosyne*, or temperance is often used synonymously with self-control, restraint, or modesty; yet, a closer definition from the Platonic dialogue may be self-knowledge, knowing what you know and what you do not know, and the subsequent virtue of not being something that you are not.[80] In *Gorgias*, Plato also refers to temperance as a general health of the soul.[81] The dialogues between Charmides, Critias, and Socrates also hint at elements of respect, openness, modesty, and humility within temperance. To clarify, temperance is knowing what you know, but also being open to learn from those that know what you do not know. We can see this clearly in the Greek *sophos,* meaning wisdom, as the root of *sophrosyne.* In this respect, temperance is vital to healthcare education (as well as IPE) as the conceit of wisdom, hubris, and arrogance, often lead to professional incivility and patient harms.

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[78] Pellegrino and Thomasma, *The Virtues in Medical Practice,* 114.
[79] Ibid.*,* 113.
[80] Plato, *Charmides*, trans. W. R. M. Lamb (Cambridge, MA: Harvard University Press, 1927), 173a-d.
[81] Plato, *Gorgias,* 504c, 507.

The current health care environment is making it harder for physicians and surgeons to develop what is commonly referred to as the 'God complex.' Easy access to medical information online has given patients the confidence to question their health care providers and demand more individual solutions to their unique conditions. In an exchange of power and hubris, the information revolution may be beneficial in countering the God complex; however, may have the reciprocal effect of allowing untrained patients to claim medical expertise.

Integrity

Integrity as it pertains to health care can be approached in two distinct ways. The first deals with the integrity of persons and the second focuses on the person possessing integrity. In the first sense, integrity is the equivalent of health. A person with integrity is balanced physically, mentally, and intelligently. Illness disrupts this balance and alienates one from their body. "The sick body or mind rebels against the whole. The self itself becomes fractured," threatening one's sense of identity.[82] Integrity of the person can also be seen as integrity of values. If we see a particular person as defined by the sum of their values, it is quite possible that those values may be in contrast to those attempting to heal. When a person is ill, then, they are at risk of having their core values challenged. This vulnerability of values was the impetus for the movement towards patient autonomy. The underlying assumption in this shift is that "to usurp the patient's human capacity for self-governance is to violate the integrity of her person."[83] This desire for autonomy by the patient is always countered by the healer's own integrity/autonomy. This healer/patient tension of competing integrities is a wonderful example of Baxter and Montgomery's

[82] Pellegrino and Thomasma, *The Virtues in Medical Practice,* 130.
[83] Ibid.

Relational Dialectics[84]. At the center of their theory are dialectical contradictions formed during the "dynamic interplay between unified oppositions."[85] Relational dialectics are present in all relationships; thus, for the patient/healer relationship, the patient has a desire for privacy while the healer has a desire for transparency (albeit one-sided) and a certain level of submissiveness (taking a full course of medication even though the patient may not understand the rationale). Interprofessional relationships also have dialectical contradictions. A new nurse practitioner may desire autonomy and freedom, while at the same time depending on the collaborating physician. This dependence/freedom contradiction can be seen as a necessary and healthy tension.

Integrity can also be approached from the 'person of integrity' perspective. Different than the 'integrity of persons,' which focuses on balance and autonomy, this approach focuses on the character of the healer, namely, their ability for thoughtful interpretation and application of principles, such as a patient's autonomy, during the extent of the healing relationship. The burden of responsibility shifts back to the healer, who must take the patients' values into consideration when making decisions. Thus, the issue of trust reappears as being central to the relationship. From this perspective, the virtue of integrity implies a certain predictable "intellectual honesty."[86] Although the virtue of integrity lies within the healers, decisions should be made primarily with the interest of the patient.

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[84] Leslie Baxter and Barbara Montgomery's 1996 theory highlights the messiness of interpersonal relationships by focusing on the ongoing tensions created by dialectical contradictions.
[85] Leslie Baxter and Barbara Montgomery, *Relating: Dialogues and Dialectics* (New York: Guilford Press, 1996), 8.
[86] Pellegrino and Thomasma, *The Virtues in Medical Practice,* 127.

Self-Effacement

Pellegrino and Thomasma include self-effacement as the final virtue important to the practice of medicine. Self-effacement refers here to a sort of modest selflessness. A health care professional that places the needs of a patient ahead of his or her own needs possesses this virtue. Self-effacement counters self-interest. Because self-effacement is inconspicuous, it may be difficult for patients to see. Perceptions of care as a commodity lead to a fear that health care prioritizes financial interests over their own. This fear of self-interest leads to increased desire for patient autonomy, to protect the voice of the patient. Self-effacement reclaims trust and grants the healer more latitude in health care decision-making.

Self-effacement is central to the concept of a profession. "A profession is […] a way of life in which expert knowledge is used not primarily for personal gain but for the benefit of those who need that knowledge."[87] The French philosopher, August Comte[88], weaves together the concept of self-effacement with the concept of altruism to create what he calls "altruistic beneficence." The idea of beneficence, from the Latin *beneficentia*, meaning kindness, generosity, and charity, has been central to medicine for some time. For Hippocrates, beneficence was the first principle of medicine. Beneficence refers to an obligation or duty to act in the best interest of others. The 'principle' of "altruism" was coined by Comte as a direct counter to self-interest. These terms, although similar, differ in that one (beneficence) stems from a sense of duty, while the other remains voluntary. That said, health care providers that are part of a professional

[87] Ibid., 147.
[88] Auguste Comte was a nineteenth-century French philosopher best known for his concept of positivism, which is a philosophy of science using logic and reason to process and interpret observable phenomena. Only empirical knowledge gained this way can be held as valid.

framework could not be altruistic in that they are already obligated by a professional code of care. Comte, by combining this moral obligation with a voluntary decision (or predisposition) to go beyond what is expected, comes close to a more comprehensive understanding of self-effacement.

The idea of beneficence as a virtue was, for the most part, unquestioned throughout antiquity and the medieval period. Virtue ethics was not really challenged as an ideology until the late 15th century. Niccolò Machiavelli[89] lived in a time of war and tyranny, where a virtuous life had little practical value. Self-effacement, for instance, could get you killed. Instead, he viewed virtue as an "expression of power, rather than a disposition to act well."[90] Machiavelli's concept of virtue inspired the physician Bernard Mandeville[91] who believed that society prospers through "greed, the desire for luxury, pleasure, and power."[92] In the 19th century, Friedrich Nietzsche sees the virtues as meaningless and impediments to achieving greatness. For the *Uebermensch*, virtues become vices.[93] A little less than a century after Machiavelli, Thomas Hobbes took a different approach to virtues when he distanced them from theology and grounded them in a pessimistic naturalism. For Hobbes, virtues were not the vices of Machiavelli and Nietzsche; virtues were tools of self-interest. Hobbes begins with an assumption that man

[89] Niccolò Machiavelli was a political philosopher, diplomat, and writer during the Italian Renaissance. He is best known for his contributions to modern political philosophy. His most famous work, *The Prince*, breaks politics from theology and even suggests that deceit and immoral behavior are sometimes required for a leader to stay in power. In this way Machiavelli takes a scientific and evidence-based approach to political theory.
[90] Pellegrino and Thomasma, *The Virtues in Medical Practice,* 149.
[91] Bernard Mandeville was a seventeenth and eighteenth-century physician and philosopher best known for his *The Fable of the Bees*, which introduced the concepts of division of labor and the 'invisible hand' seventy years before Adam Smith.
[92] Pellegrino and Thomasma, *The Virtues in Medical Practice,* 149.
[93] Friedrich Nietzsche, *On the Genealogy of Morals,* trans. Walter Kaufmann and R. J. Hollingdale (New York, NY: Vintage Books, 1967).

is not a social animal, a clear break from the Aristotelian mantra that man is, at his core, a social animal.[94] For Hobbes, society "is either for gain or glory: not so much for love of our fellows, as for love of ourselves."[95] Hobbes sees man as primarily selfish, motivated by survival and pleasure. Virtues, however, can be used to attain these primary motives. Self-effacement is an unnatural condition because it allows us to become vulnerable to others.

Applied to health care education and professional practice, we may assume that any healthcare organization operated 'tyrannically,' whether through dictatorship or bureaucratic hierarchy, will learn to see the virtues as vices. Self-effacement becomes a liability and self-promotion becomes necessary for survival. "The Machiavellian and Hobbesian strains are the heart of today's moral malaise and cynicism which seeks to give moral legitimacy to the professional's self-interest."[96] On the other hand, health care organizations operated as interdependent systems, modeled after democratic society, will foster a more Aristotelian view of the virtues.

Pellegrino points to two guiding figures in the field of virtue ethics that have inspired his thinking: Cambridge University Professor of philosophy, Elizabeth Anscombe, and Notre Dame Professor Alasdair MacIntyre. Because of his thorough historical and interpretive treatment of virtue ethics, the next section will focus heavily on the works of Alasdair MacIntyre; however, Anscombe's ideas regarding intention and consequentialism will texture this discussion.

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[94] Aristotle, *Politics.*
[95] Thomas Hobbes, *De Cive* (Whitefish, Montana: Kessinger Publishing, 2004), 14.
[96] Edmund Pellegrino, "Character, Virtue and Self-Interest in the Ethics of the Professions," *Journal of Contemporary Health Law & Policy* 5 no. 1 (1989): 60.

Alasdair MacIntyre: After Virtue

Because virtues guide decision-making, it becomes important to understand, not only *virtue* as a concept, but also how deductive logic informs present day disagreement. Alasdair MacIntyre follows a similar line of questioning at the beginning of *After Virtue.* Fundamental to MacIntyre's ethical theory is that ethics is a branch of philosophy (see Pellegrino's distinction between science and ethics above). After placing ethics firmly under the umbrella of philosophy, MacIntyre asserts that context (history, culture, situation) is fundamental to philosophy (and therefore to ethics); however, academic history carries with it the taint of the modern world. Therefore, because we cannot trust academic history as an unbiased starting place, MacIntyre attempts, primarily, to understand the very nature of moral disagreement in the present moment. He argues that disagreements today "go on and on and on" and never end. He calls these disagreements "interminable."[97] He isolates three main characteristics of common disagreements that lead to their interminable nature.

First, despite arguments being valid, that is, conclusions follow deductively from the premises, the premises themselves contain incommensurable concepts. The conclusions, then, are conceptually different as well. MacIntyre illustrates the process of arguing about conclusions to arguing about premises, which then become "pure assertion and counter-assertion."[98]

MacIntyre's second characteristic of disagreements in the present moment is that they have the appearance of "*impersonal* rational arguments and as such are usually

[97] Alasdair MacIntyre, *After Virtue, 3rd Edition* (Notre Dame, IN: University of Notre Dame Press, 2007), 6.
[98] Ibid., 8.

presented in a mode appropriate to that impersonality."[99] Arguments appear to be objective. To answer the question, 'Why should I act in this way?' is both rhetorical and philosophical in nature. It is rhetorical in that it involves the motivating tools of argumentation, and philosophical because it involves the metaphysical. 'Because one should act from duty, or fairness, or liberty, or efficiency, or because acting will bring pleasure to the masses' "presupposes the existence of impersonal criteria"[100] that 'appears' independent of personal preference. Combined with the first characteristic, we see a digression to arguing premises while presupposing objectivity. Thus, interminable disagreements.

MacIntyre's third characteristic of modern-day disagreement is that concepts are used out of context. "Moreover, the concepts we employ have in at least some cases changed their character in the past three hundred years; the evaluative expressions we use have changed their meaning."[101] MacIntyre offers 'virtue,' 'justice,' and 'piety' as examples of concepts that are not used the way they were during another historical moment. The observation that moral argument is treated simultaneously "as an exercise of our rational powers" and also as "mere expressive assertion" leads MacIntyre to argue that "the language of morality passed from a state of order to a state of disorder."[102] This presents a major obstacle for contemporary moral philosophy that is only exacerbated by the ahistorical teaching of moral philosophy as competition between concepts.

Different than questions of fact, which can be empirically verified, questions of value (moral judgments) express attitudes and feelings that are outside the realm of

[99] Ibid.
[100] Ibid., 9.
[101] Ibid., 10.
[102] Ibid., 11.

scientific method. “Questions of ends are questions of values, and on values reason is silent; conflict between rival values cannot be rationally settled. Instead one must simply choose.”[103] The expression of value exists in the realm of philosophy and is used rhetorically. One expresses attitudes often to influence others to adopt similar attitudes. The theory that surrounds this type of judgment is called *emotivism*. Traced back to C.L. Stevenson in the mid 1940s, emotivism was designed to be a theory of meaning. MacIntyre asserts that emotivism is not a theory of meaning, but a theory of use, or even a theory of management. He disassembles the assumptions inherent in emotivism and undermines its veiled authority and power. He invokes the work of Max Weber stating “no type of authority can appeal to rational criteria to vindicate itself except that of bureaucratic authority which appeals precisely to its own *effectiveness*.”[104] Furthermore, the only thing that can be rationally argued is the effective use of power. Thus, the emotivist has agnostic and opportunistic moral commitments. Values are derived from archetypal characters that perform certain social and professional roles. The human actor is contingent, has no *telos*, no end to which it is moving towards.

MacIntyre traces emotivism to the Enlightenment and the attempts to rationalize morality. Emotivism was a response to these failed attempts. MacIntyre argues that Kierkegaard’s ‘radical choice’[105] is still a choice, adopted for a certain reason, and “”how can that which we adopt for one reason have any authority over us?”[106] MacIntyre places

[103] Ibid., 26.
[104] Ibid.
[105] Radical choice is a tent of existentialism intimately tied to freedom. The concept was first laid out by Søren Kierkegaard in his *Either/*Or, and expanded upon by Friedrich Nietzsche (*Thus Spoke Zarathustra*) and Jean-Paul Sartre (*Being and Nothingness*). Kierkegaard suggests that there are two ways of choosing to live, ethically or aesthetically. The aesthetic adopts the existential belief that there are no pre-ordained values; thus, everyone has the freedom to choose for themselves what they value.
[106] MacIntyre, *After Virtue,* 42.

Kierkegaard's ideas as derivative of the ideas of Immanuel Kant. Kant's moral philosophy was deontological in nature, grounding morality in rationality. According to Kant, if humans are rational, then they are all subject to the rational rules of morality. Since all beings are bound by these rules, then the only thing that matters is one's "will to carry them out."[107] For both Kierkegaard and Kant, the virtues themselves, stemming from conservative, Lutheran teachings, were never in question, and could be discovered via a simple test: "can we or can we not consistently will that everyone should always act on it?"[108] MacIntyre illustrates how the logical breakdown in Kant's argument led Kierkegaard to move from the authority of rational morality to the authority of our own choices. What becomes apparent in MacIntyre's discussion is there seems to be a historical moment in which "the language of morality passed from a state of order to a state of disorder."[109] The rational thinkers of the Enlightenment attempted to replace the church as the foundation for moral thought. When philosophy failed to be functional in this regard, it was eschewed to the cultural margins, and has, in a sense, remained there.

Janie Fritz: Civility as a Communicative Virtue

Janie Fritz asserts that today's professionals and the organizations in which they work are experiencing a crisis of incivility[110] that can have detrimental effects for organizations. She includes high employee turnover, decreased productivity, and stress as negative outcomes that frequently impact organizations. Fritz references Pearson and

[107] Ibid., 44.
[108] Ibid., 45.
[109] Ibid., 11.
[110] Janie Harden Fritz, "Crisis Communication in the Workplace: Professional Civility as Ethical Response to Problematic Interactions," in *Communication Ethics and Crisis: Negotiating Differences in Public and Private Spheres*, ed. S. Alyssa Groom and Janie Harden Fritz (Madison, NJ: Fairleigh Dickinson University Press, 2012), 67-86.

Porath's book[111], *The Cost of Bad Behavior: How Incivility is Damaging Your Business and What to Do About It*, as a thorough review of negative outcomes associated with incivility in the workplace. Fritz lists detrimental communicative practices such as social undermining (negative emotions and evaluations to suppress the upward movement of others), harassment, rudeness, bullying, and backstabbing as examples of "organizational misbehavior"[112] that can contribute to these aforementioned negative effects. Fritz's main contention is that incivility undermines the quality of life at work, which compromises the "good" at which an organization, and the professionals which make it up, are directed.[113]

Possible Explanations for Increases in Incivility

Fritz offers explanations for the increase in organizational incivility. First, there has been an increase of informality alongside increased cultural and generational diversity. Fritz's rationale is that different groups may differ in their "implicit communication rules."[114] A second explanation for increased incivility may be an increase in the use of technology as a means of communication and the decrease in face-to-face communication, which may increase the likelihood of impulsive, thoughtless communication. Third, any business has to maintain economic health. This translates into a focus on profits and losses (P&L) and accountability for productivity. This increased demand for productivity is often at the center of interpersonal and organizational stress. Finally, Fritz offers a fourth explanation for increased incivility that involves changing

[111] Pearson and Porath, *The Cost of Bad Behavior.*
[112] Janie M. Harden Fritz, "Ethics Matters: Why Ethical Communication Makes a Difference in Today's Workplace," in *Workplace Communication for the 21st Century: Tools and Strategies that Impact the Bottom Line,* ed. J. S. Wrench (Westport, CT: Praeger, 2013), 39-60.
[113] Arnett, Fritz, and Bell, *Communication Ethics Literacy.*
[114] Fritz, *Professional Civility*, 2.

normative behaviors and assumptions of the greater society and the infiltration of these external norms to the internal, organizational environment. Fritz concludes that civility itself is no longer a social norm. Robert Putnam[115] paints a picture of the current historical moment, one defined by individualism, dishonest and thoughtless leadership, and economic insecurity.[116] Ronald Arnett[117] attributes this discord generally, as the lack of a common, societal, virtue structure.[118] Arnett et al.'s suggestion implies that there is no shared center from which to establish a collective integrity.

The present healthcare climate is one marked by specialization and efficiency, while at the same time emphasizing continuity of care. These characteristics seem fundamentally at odds, but do not need to be. These shifts in organizational structure, however, do bring with them an increased need for collaborative practice. As the healthcare landscape continues to take shape, it is important to continually monitor organizational communication against established interprofessional values – and offer correctives when needed.

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[115] Robert Putnam is an author and professor of public policy at Harvard University. He is most well-known for his book, *Bowling Alone*, which highlights the unprecedented breakdown in social capital since the 1960s. This collapse of community accompanies political unhappiness and depression. A main argument in his book is that the creation of peaceful community requires 'bridging capital' where individuals make friends with people that are unlike them. Without this type of social capital ethnic tensions increase and communities become less connected.

[116] Robert Putnam, *Bowling Alone: The Collapse and Revival of American Community* (New York, NY: Simon & Schuster, 2000).

[117] Ronald C. Arnett is Professor and Chair of the Department of Communication and Rhetorical Studies at Duquesne University. He has authored eleven books, has received eight book awards for his work in the fields of ethics, dialogue, and philosophy of communication, and was given the honor of Distinguished Scholar by the National Communication Association.

[118] Arnett, Fritz, and Bell, *Communication Ethics Literacy*.

Civility as a Resource

Fritz's research supports her contention that civility is a resource for professionals and the organizations in which they work. Viewing civility pragmatically allows the concept to become more than just civility for the sake of virtuous behavior towards others. It becomes an intangible asset, which lubricating the entire organizational system. P.M. Forni[119] expounds a rationale for civility as being thoughtful, reflective, and fostering a common sense of purpose between and among professionals. Not only does civility increase production, decrease turnover, and support personal and professional health, but civility fosters the behaviors that allow collaboration to occur. Thus, civility makes possible the delivery of effective patient care, the cornerstone of the moral community of healthcare. One scholar dedicated to ethical relationships within this ethical community is Carol Gilligan.

Ethics of Care

Carol Gilligan

Carol Gilligan is Professor at New York University. She is most well-known as a feminist, psychologist, ethicist, and the first tenured female at Harvard's Graduate School of Education. While at Harvard, Gilligan was influenced by the work of Lawrence Kohlberg, one of the most influential moral development scholars of the 1970s. Kohlberg believed that the moral development of individuals progressed in stages, beginning with the self, moving into social conformity, then "to external rules and forces, and, for the

[119] P.M. Forni is a professor at Johns Hopkins University and founder of The Civility Initiative. He is the author of three books. His first two books, *Choosing Civility,* and *The Civility Solution,* introduce the concept of civility and offer counters to incivility. The third book, *The Thinking Life,* takes ideas from the first two books and includes our increased dependence on technology as a contributing and exacerbating factor of thoughtlessness. He stresses habitual "good thinking" at the center of each of his books.

rare few, moving again to a stage where universal principles are internalized and applied."[120] According to his theory, people would advance ethically when their current ethical positions could not deal with encountered problems, forcing them into new ethical territory. For the most part, however, people's ethical positions would conform to society. Gilligan began to see holes in Kohlberg's stages theory.

With the legalization of abortion in 1973, Gilligan began interviewing women who were considering it. As she listened to their reasoning for the decision before them, she realized that some voices, particularly women, did not fit into Kohlberg's stages model. Gilligan recalls, "I was listening for how they constructed the decision they were making, who was involved, what were the parameters of their thinking about whether to continue or to end their pregnancy."[121] Gilligan was not able to place their moral reasoning into a particular category or stage. "I remember the sound of dissonance, a voice that did not fit into the categories of psychological theory or the terms of the public abortion debate."[122] Her revelations inspired her to create a new, adaptation of Kohlberg's theory which she called the *ethic of care*.

In the development of ethical reasoning, individuals usually begin by focusing on their own survival and acquiring that which they need and desire. A second level is achieved when the individuals begin to look out for others. They feel a responsibility to self-sacrifice, often putting others' needs in front of their own "in an effort to care for others, and to sustain relationships."[123] Additionally, some individuals entered a third

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[120] Lee Wilkins, "Carol Gilligan: Ethics of Care," in *Ethical Communication: Moral Stances in Human Dialogue,* ed. Clifford G. Christians and John C. Merrill (Columbia, MO: University of Missouri Press, 2009), 34-35.
[121] Carol Gilligan, "From a Different Voice to the Birth of Pleasures: An Intellectual Journey," *North Dakota Law Review* 81 (2005), 729.
[122] Ibid.
[123] Lee Wilkins, "Carol Gilligan: Ethics of Care," 36.

level of ethical reasoning that involves accepting the consequences of their actions and taking control of their own lives and their own decisions.[124]

Gilligan's ethics of care differentiated the moral reason of women and men into an ethics of care and an ethics of justice, respectively. She explains how these two modes of moral reasoning are fundamentally incompatible. An ethics of care bases moral judgments on careful calculation of responsibilities and relationships. Focusing more on narratives and context, one perceives moral dilemmas when these responsibilities or relationships conflict with one another. Conversely, an ethics of justice is centered around more formal and abstract moral rules.

Gilligan's impact can be seen in giving a voice to women at a time when most young girls acquiesced their identities and authentic voices to male authorities. Her ethics of care is still relevant to interprofessional healthcare education in its moral ontology centered around "relational responsibilities within professional health care."[125] Furthermore, "moral choices always have to account for the web of relationships, the relational networks and responsibilities that are an essential part of particular moral circumstances."[126] Care ethics places interpersonal relationships at its center. These relationships and the professional context inform ethics, identity formation, and collaboration. Taken further, care ethics explains the shared moral pull as an individual and collective response to human vulnerability.

Patricia Benner

[124] Carol Gilligan, *In a Different Voice* (Cambridge, MA: Harvard University Press, 1982).
[125] Per Nortvedt, Marit Helene Hem, and Helge Skirbekk, "The Ethics of Care: Role Obligations and Moderate Partiality in Health Care," *Nursing Ethics 18* no. 2 (2011): 192-200, 192.
[126] Ibid.

Partially in response to Edmund Pellegrino, Patricia Benner[127] offers 'care ethics' as a logical compliment to virtue ethics.[128] Benner implies that ethnocentrism, present in normative virtue ethics, can prevent "meeting the other in his or her own terms;"[129] thus, an ethics of care falls more in line with the Judeo-Christian, relationship-oriented, moral tradition by focusing on "meeting the other"[130] and doing so "with respect characterized by recognition, support for growth or self-acceptance, and/or allowing the other 'to be.'"[131]

Benner incorporates care ethics into her skill acquisition model[132], which is epistemological in nature arguing that nurses gain their nursing skills and patient knowledge over time, not just in the classroom. Benner adapted the five-stage, Dreyfus model of skill acquisition[133] and applied it to the clinical competency of nursing. Nurses use their experiences as new paradigms, which enhance critical thought. She describes a process of skill acquisition that, unlike academic training, does not begin with theory, but draws from experience. Inspired by Maurice Merleau-Ponty and Martin Heidegger, Benner further adapted this model of skill acquisition to include concepts of caring.

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[127] Patricia Benner (1942-) is a professor emerita and nursing theorist who joined the UCSF School of Nursing in 1982. While there she also held an endowed chair in ethics and spirituality. Her career was dedicated to nursing pedagogy, leading programs such as the Carnegie Foundation for the Advancement of Teaching's Preparation for the Profession.
[128] Patricia Benner, "A Dialogue between Virtue Ethics and Care Ethics," in *The Influence of Edmund D. Pellegrino's Philosophy of Medicine*, ed. David Thomasma (Dordrecht, Netherlands: Springer, 1997).
[129] Ibid., 48-49.
[130] Ibid., 47-61.
[131] Patricia Benner, "Caring as Knowing and Not Knowing," in *The Crisis of Care: Affirming and Restoring Caring Practices in Health Care Ethics*, ed. Susan S. Phillips and Patricia Benner (Washington, DC: Georgetown University Press, 1994), 42-62.
[132] Patricia Benner, *From Novice to Expert: Excellence and Power in Clinical Nursing Practice* (Upper Saddle River, NJ: Prentice Hall Health, 2000).
[133] The Dreyfus Model of Skill Acquisition argues that a student acquires a given skill by passing through five stages: novice, competence, proficiency, expertise, and mastery. The model was created by brothers Stuart and Hubert Dreyfus as they gathered research at UC Berkeley's USAF research center. The model was used primarily for assessment, defining standards, and pedagogy.

The moral theory of Carol Gilligan, the pragmatic model of Patricia Benner, and the relational coordination theory of Jody Gittell all place focus on interpersonal relationships and concern for others in order to achieve collective, moral objectives. Their perspectives of interpersonal responsibility act as a nice segue into a moral philosophy of the other. One scholar in particular, Emmanuel Levinas, grounds his entire moral philosophy in the Other.

The Face of the Other: Burden, Responsibility, and Meaning

Emmanuel Levinas: If not you, then who?

Emmanuel Levinas is a twentieth-century Jewish philosopher, author, and ethicist greatly influenced by the phenomenology of Martin Heidegger and Edmund Husserl. For Levinas, communication begins by listening, not speaking. Whether listening to a patient or to a professional colleague, listening connects one to an "ethical echo."[134] This echo links us to the very foundation of human existence and "turns us towards the face of the Other that moves us toward an accompanying attentive response."[135] This *a priori* "echo" to which Levinas refers is inspired by the Judeo-Christian proverb "I am my brother's keeper." Levinas believes we all have a fundamental responsibility to respond and attend to one another. His justification is that because we are social creates by nature, we need the other. Without the other, there is no I; thus, if we neglect the other "we cease to be human."[136]

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[134] Ronald C. Arnett. "Emmanuel Levinas: Priority of the Other," in *Ethical Communication: Moral Stances in Human Dialogue,* ed. Clifford Christians and John Merrill (Columbia, MO: University of Missouri Press, 2009), 200.
[135] Ibid.
[136] Ibid., 203.

Proxemics matter to Levinas. Our responsibilities begin with what is in front of us. The visual phenomenon of encountering the actual face of the Other reminds us of our ethical obligation and shifts us to "phenomenological listening;"[137] communication begins by listening. Accepting our human responsibility is not easy. Levinas even refers to it as being held hostage. Yet, "as one begins to attend to an ethical echo, one understands how burden and meaning comingle."[138] It is in this burden that we find our own meaning for our lives. Healthcare professionals may understand this better than most. They inhabit places of human vulnerability. They listen and hear 'Will you help me?' Whether called to respond by the professional oath, or by the call "I am my brother's keeper," the healthcare professional responds with 'Yes, I will.'

We are human. Healthcare workers may encounter a new, burdensome face every 20 minutes throughout their day. Levinas responds to this sort of response fatigue: "The face fades, and in its impersonal and inexpressive neutrality is prolonged, in ambiguity, into animality."[139] Interestingly, Levinas sees the ambiguity as good. "It is only this impersonal sense of disinterest that can lead, ironically, to a personal "God" and to genuine obligation for another initiated by a primordial and prefigured call for responsibility."[140] The call from the individual face is replaced by a broader call to responsibility in general.

Unlike Pellegrino, who places ethics under the umbrella of philosophy, Levinas places philosophy under ethics. Ethics is so fundamental to Levinas that the whole

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[137] Ibid.
[138] Ibid., 205.
[139] Emmanuel Levinas, *Totality and Infinity: An Essay on Exteriority,* trans. Alphonso Lingis (Pittsburgh, PA: Duquesne University Press, 1969), 263.
[140] Ronald C. Arnett, *Levinas's Rhetorical Demand: The Unending Obligation of Communication Ethics* (Carbondale, IL: Southern Illinois University Press, 2017), 131.

concept of 'I' is responsive by nature.[141] This shift in thinking frames helping others, not as acts of heroism, but as an obedience to the call to take on the burden of another. The call to help may be more salient for healthcare professionals in a clinical setting, yet the faces that call us care not about titles. In fact, our professional titles may disconnect us from one another and obfuscate the primarily responsive 'I' that defines us as human – because we are social.

For Levinas, "each encounter with another is an ethical awakening,"[142] or reminder of our ethical responsibility. The pre-reflective 'I' "has no name, no situation, no status. It has a presence afraid of presence, afraid of the insistence of the identical ego, stripped of all qualities."[143] In this moment of "pre-reflective proximity to another person,"[144] we find ourselves quite naked. In that initial moment of the encounter our egos are stripped of pride and its characteristic of "dominating imperialism."[145] In the clinic we come face to face with extreme and immediate alterity. In the clinical encounter the primary expectation of the patient is that someone will listen to their story. It is in their story that their concerns are explicated. It is no different with the interprofessional encounter. Although requiring less immediacy than ill patients, we encounter alterity nonetheless. When we encounter professionals from other disciplines we are faced with alterity, and our primary expectation is to tell our story and listen to the stories of others. The communication begins when we listen to the Other.

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[141] Ronald C. Arnett. "The Responsive 'I': Levinas's Derivative Argument," *Argumentation and Advocacy 40* no. 1 (2003): 39-50.
[142] Arnett, *Levinas's Rhetorical Demand*, 121.
[143] Emmanuel Levinas, "Ethics as First Philosophy," in *The Levinas Reader,* ed. S. Hand (Blackwell: Oxford, 1989), 31.
[144] Paul Komesaroff, "The Many Faces of the Clinic: A Levinasian View," in *Handbook of Phenomenology and Medicine,* ed. S. Kay Toombs (Dordrecht, The Netherlands: Kluwer Academic Publishers, 2001), 322.
[145] Emmanuel Levinas, "Substitution," in *The Levinas Reader,* ed. S. Hand (Blackwell: Oxford, 1989), 100.

Levinas reminds us that we find purpose in accepting the call to be burdened by others. When considering interprofessional healthcare education, there is opportunity not only to encounter the face of the other professional, but to establish a brotherhood and sisterhood of caring (keeping). Above all, Levinas's ethics as first philosophy[146] is a "counter to self-righteousness, which finds excessive confidence in ideas imposed on another person."[147] Although Levinas is clear that the responsibility to respond lies with each of us individually, through dialogue healthcare professionals from different specialties can collectively respond to the call 'I am here, will you help me?' with 'Yes, *we* will.'

[146] Emmanuel Levinas, *Otherwise Than Being or Beyond Essence,* trans. Alphonso Lingis (Pittsburgh, PA: Duquesne University Press, 1998), *56.*
[147] Arnett, *Levinas's Rhetorical Demand,* 2.

CONCLUSION

Summary

Healthcare professionals belong to a moral community. Caring for patients is a community act carried out by healthcare professionals working in teams within complex political and organizational systems. This teamwork is crucial to quality patient outcomes; however, incivility threatens to derail necessary and effective collaboration towards the common organizational good. Necessarily, interprofessional healthcare education is becoming a required element for pre-health professionals. However, the necessary integration of professionals presents clear challenges including competing professional identities, lack of shared values, lack of resources, and variation in biomedical language literacy. Negotiating these obstacles is necessary to realize the potential of this moral community.

Currently, schools are using competency-based approaches to interprofessional education. The IECEP lists four competencies for interprofessional practice: ethics/values, roles/responsibilities, communication, and teamwork. For reasons explicated throughout this dissertation, the categorizing of these particular elements as competencies is problematic. This particular competency approach attempts to ultimately improve healthcare *quality*, yet the accrediting bodies and professional organizations have been cultivated within a positivistic and empirical worldview focused primarily on *quantification*. Referring to values, roles, communication, and teamwork as competencies immediately affirms this empirical and quantitative worldview. This presumption alone frames conversation, shapes certain outcomes, and limits the educational opportunity for impactful exploration of difference and meaning.

This dissertation began with a question: *What can rhetoric and philosophy of communication contribute to educating future healthcare professionals about ethical collaborative practice?* To begin to answer this question we looked to the existing communication literature and found that most of the research on communication and professional relationship building is engaged from an empirical, post-positivist approach and is focused almost entirely on processes and procedures. We then embarked on a journey from pre to post-industrial professionalism and explored what it means to be a modern professional, and a subsequent exploration of interprofessionality. Until recently, the professions have intentionally moved to differentiate themselves from both non-professions and other professions; thus, a major challenge for interprofessional practice is to reconnect what has been intentionally disconnected.

We continued to answer our question by exploring the language of medicine, biomedical discourse. Nearly all scholarship about interprofessional healthcare education is explicated in the language of science. We began our inquiry by asking what it was biomedical discourse was doing – behind the scenes. We discovered that the language of science, born alongside the scientific method, carries with it an impartiality and objectivity that masquerades as absolute truth. Those that work in the "mill of hypothesis and data"[1] become subservient to the language, to the data. They lose authorship of language and become inferior to it. Additionally, the density and compression of scientific language creates insiders and outsiders, creating barriers between those that are fluent and those that are not.

[1] Montgomery, *Scientific Voice, 3.*

Another consequence of scientific language is that it personifies processes and results, separating the author from the processes, procedures, and evidence. Again, what appears is absolute Truth instead of just a claim for it. In any logical argument, data is used as backing or proof to support a particular rationale that is connected to a claim through a warrant – scientific language surreptitiously bypasses the reasoning process and goes straight to the truth claim.

We learn in studying the language of science that although it was created to be objective, sterile, and free of culture, yet it is impossible to separate language from culture and context. It is important to reiterate the importance of biomedical discourse, but also to remember that it is but one language of many. I *am not* arguing that scientific discourse be replaced, but to view it as a highly efficient tool for transferring information. I *am* arguing for integrating biomedical discourse with other discourses such as history, art, cultural criticism, philosophy, rhetoric, etc. For example, if the goals of interprofessional healthcare education are collaboration, and if collaboration involves trust, respect, knowledge sharing, engaging in constructive dialogue, then maybe scientific discourse is not the best tool to reach these objectives.

Rhetoric and Philosophy: Adding to the Conversation

Interprofessional healthcare education is tasked with improving collaboration between health professionals to ensure better patient outcomes. Thus, to achieve this shared goal we must establish and maintain quality interprofessional relationships. A first step in working towards this end is understanding and acknowledging *alterity*, or difference. A philosophy of communication approach to interprofessional practice can help professionals navigate alterity and turn potential conflict into opportunities for

personal and professional growth. The attitude from which we approach difference will determine the quality of working relationships.

From a philosophy of communication perspective, we come to understand that genuine conversations are not conducted *by* us; it is we that are conducted by the conversation. In designing interprofessional curricula, then, it is important to avoid the scientific desire to standardize and control. There should be space for genuine conversation to happen. A philosophy of communication perspective views communication not as the mere transmission of information, but as lived experience. We shape and are shaped by the language we use with others; thus, communication is action. Bakhtin introduces the idea of heteroglossia, which can be a useful byproduct of communicating with others. When professionals from different disciplines regularly interact, they start to combine language and styles. They borrow from one another.

Communication shapes identity, creates societies and powerful institutions, it bridges worldviews and helps us make sense of difference, it is our primary tool for expressing the world as we see it. Communication as a competency would be reproductive and mere representational, yet communication is fundamentally *pro*ductive and present. We live in a contingent world. Audiences change. Situations change. We express our worldviews with every utterance, which makes interpretation and meaning-making an ongoing event to which one can never achieve competency.

So where do we begin? If we are to achieve competence or mastery at something, let it be rhetoric. Rhetoric is grounded in ethics and focuses on the audience, prioritizing the conversation over winning. The tools of rhetoric can be learned and practiced. They include ethical perspective-taking, stirring emotion through storytelling and style, active

listening, creative writing and speaking using rhetorical devices and tropes, building credibility, information literacy, understanding how to use proofs (data, testimony) to support claims, arranging conversational elements for maximum affect, nonverbal communication, and memorization techniques – because a good first step to collaboration is remembering the names of those on your team.

Mastering the tools of rhetoric helps people gain insight into their own thinking and gives you tools for inviting people to act toward a common good. Rhetoric is both reflective and explicative, tools necessary for getting along on a team. Rhetoric can help people strengthen interpersonal relationships by listening, sharing narratives, and identifying with others by always looking for common ground. Rhetoric can help someone strengthen their positions in order to test ideas. Rhetorical tools can even be shared amongst healthcare professionals regarding techniques for patient compliance or motivational interviewing. For instance, there are simple rhetorical techniques that help people move from "sustain talk" to "change talk."

Interprofessional healthcare education should consider a curriculum focused on human experience and practical judgment, or *phronesis*. Phronesis is an intellectual ability to understand what action or means should be taken in a particular situation that would be most conductive of the good. Incidentally, the focus of such a *phronesis*-based rhetorical education would be shared learning, creative thinking, and dialogue.

As we consider dialogue as a focus for interprofessional healthcare education, it is important to ground dialogue in an ethics of civility. Civility in how we communicate with one another can act as a logical and ethical starting place for interprofessional collaboration. Civility as a virtue offers a common ground approach to collaboration.

Civility fosters meaningful dialogue that naturally leads to trust building, attentiveness and respect towards one another, and ultimately to an effective healthcare team. Civil dialogue is an *act* that primarily involves listening to the narratives of the other. In this dialogic *act*, meaning is continually created and personal and professional identities are formed.

I believe that a rhetoric and philosophy of communication approach to interprofessional education fills a void left wide open by our obsession with biomedical discourse. Healthcare workers are part of a moral community that responds to calls for help. Ever increasing demands on healthcare resources necessitates collaboration now more than ever. Collaboration requires respecting, understanding and learning from difference through civil dialogue.

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