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### Assistant Editors' Interview with Dr. Berkeley Franz and Dr. Dan Skinner

Cathryn Molloy  
*James Madison University*, molloycs@jmu.edu

Erin Trauth  
*High Point University*, erin.trauth@gmail.com

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## RHM Journal Interview with Dr. Berkeley Franz and Dr. Dan Skinner

September 2018

*RHM Assistant Editor Dr. Cathryn Molloy interviews Dr. Berkeley Franz (Ohio University) and Dr. Dan Skinner (Ohio University) on their article, "From Patients to Populations: Rhetorical Considerations for a Post-Patient Compliance Medicine"*

**CM: Dr. Cathryn Molloy, RHM Assistant Editor**

**BF: Dr. Berkeley Franz, Ohio University**

**DS: Dr. Dan Skinner, Ohio University**

CM: Hello, everyone. Today in my capacity as one of the three assistant editors for the RHM journal, I'm interviewing Berkeley Franz and Dan Skinner on their essay, "From Patients to Populations: Rhetorical Considerations for a Post-Patients Compliance Medicine." And just to introduce them: Berkeley is a medical sociologist whose research and teaching focus on community based philosophy, social theory, and health policy. She has worked both domestically and internationally on community-based research projects aimed to improve health outcomes and develop health care services guided by local perspectives. Dan is a health policy professor and is the author of numerous articles on politics in healthcare published in journals such as the *Journal of Health Politics, Policy and Law*, the *Journal of Medical Humanities*, the *Review of Politics*, and *Public Administration Review*. Among their many health and medicine related publications, Franz and Skinner are currently editing a volume Titled *Not Far from Me: Stories of Opioids in Ohio*, which is under contract with the Ohio State University Press and are working on a book titled *Medical Urbanism: Hospital City Neighborhoods and Community Health* with the University of Chicago Press. Both authors teach at the Heritage College of Osteopathic Medicine at Ohio University. Welcome Berkeley and Dan, and thank you so much for agreeing to be interviewed. DS: Thanks for having us. CM: Great, so the first question I have for you about your wonderful essay that will be in the second issue of the RHM Journal is: Dan, you are a political scientist by training and Berkeley, you're a medical sociologist, so can you tell us a bit more about how you came to rhetoric in general and how you came to the rhetoric of health and medicine specifically?

DS: I guess I'll start; you know this, for me, this focus on rhetoric goes back to my doctoral dissertation which is another book that I'm working on and will hopefully be finished soon. Which is really on the rhetoric of medical necessity; that's actually the title of the book and the book is to some degree. It's a work of political theory and a work of rhetorical analysis. In that book I'm really looking at how the rhetoric of necessity --of medical necessity--is shaped through political debates. So I look at for example you know mental health and medical necessity in terms of what gets called necessary, what is not, looking at reproductive debates and looking at medical marijuana debates. So for me this goes back to the way I really got excited about political theory in the beginning which as RHM readers know you know our common point there would be somebody like Aristotle and just thinking about the role of persuasion in politics. So for me this has been a long project of being interested in this and then of course coming through the RHM world, Judy Segal's books in particular, be no surprise to our RHM readers. So that was an influence.

CM: Oh definitely, yeah, she is huge for all of us. So that makes total sense, great, and your next book sounds great too. I'm so looking forward to reading that.

DS: Thanks.

BF: So I'm a bit more new to the rhetoric of health medicine. There's a lot of overlap between this and sociology in terms of studying you know healthcare organizations and how language and practice settings have changed over time. But I would say that in sociology there's at you know a large focus on theory but not so much on rhetoric. So I was drawn to that in particular and thinking about not just studying you know how organizations and medical care change but actually talks about the language now that has kind of a politics behind it.

CM: Good, thank you, okay, so you both are teaching at the Heritage College of Osteopathic Medicine at Ohio University. Can you tell us a bit more about your work with medical and education?

BF: Yeah, so it's an interesting role to be in a medical school you know it's always interesting to teach students that don't have the same degree that you have. You don't have the same background but it's also an incredible opportunity to influence a real you know profession, in terms of having a practical outcome. So it's interesting taking some of the theory of the work that we do and try to put it into practice; in some ways it's a challenge to do that as well, as we're finding ways through lectures, through small group facilitation, to help doctors understand how the medical profession has changed, how it continues to change, as well as some of the real you know critiques of doctor/patient interactions, for example, or the healthcare system. But it's not a traditional role; we don't teach traditional classes; there are no instructors of records; so we interact with students in a much more informal way. I would say we would be used to teaching for example in the College of Arts and Sciences or something like that and so we're kind of relearning how to integrate you know our own expertise into this very different kind of discipline without owning a lot of time with students because we don't have traditional classes in that sense. DS: I would say that as social scientists, Berkeley and I, and we're members of an interdisciplinary department—Department of Social Medicine--so you know we have a bunch of colleagues who really run the gamut in terms of their disciplinary backgrounds which is something that RHM is a real home for-- you know a bunch of people who just fit together because they fit together and for no other reason--- they have common interests. I will just say that I mean as RHM readers know, you know the typical medical student doesn't have a deep humanities background, isn't going to be well-versed in a lot of what animates RHM, so I think that's one of our missions is really to not just get students to think about the rhetorical practices in terms of like patient communication, how to deliver bad news, I mean that's all part of it that kind of thing, but generally just to really appreciate the depth of you know the power relationships you know the way in which language and conceptual thinking is at the root of what they do.

CM: Okay, excellent, I like what you said Berkeley, too, about it being such an opportunity because many of us that work in RHM, we teach rhetoric students and so we don't always have the opportunity to sort of reach people who are going to be working directly with patients, so that is a wonderful opportunity. Okay so back to your essay, which again, I really enjoyed reading, it uses rhetorical principles to show how linguistic shifts meant to mitigate the quote "deep ethical problems of non-compliance discourses on quality of care" ultimately fail through a sight of hand only they only reify the power dynamics they seem to challenge. You call this "rhetorical repackaging" and for listeners who have not yet read the essay you show, for example, how the shift from compliance to more seemingly respectful to patients terms, like concordance and adherence, are not able to truly perform the conceptual shifts they are designed to deliver. You call this a rhetorical shell game—great coinage --from your other very formidable body of work do you have other examples of this failure of terminological changes to impact actual material epistemological change?

DS: Well there's two things I want to say. The first is that reworking the rhetoric doesn't always guarantee reworking the material relationships and we live in a society with that often has a thin, my interpretation, a kind of thin liberal shell, so people learn to not use racist language or they learn to you know maybe not be able-ist in their their discourse or learn you know because of you know sexual harassment training or gender training that they learn how to you know how to speak in a certain way, but it doesn't always affect the actual more subtle dynamics when you're in these spaces, and I think it's that disjunction between language and materiality that you know you see this happening a lot; I think race is a big one—really learning how to alter how we handle you know racists patient scenarios or institutions that you know where sexism is just been rampant for so long, but any number of trainings is not necessarily going to really transform the places. It's a long process so those are the kinds of things I think about that we do have this kind of push and pull between reworking language which is a good thing, It's an important thing, and I'm glad that people stopped using certain terms and are maybe more aware of it, but it doesn't always guarantee institutional transformation in a deeper sense.

BF: And I have a healthcare example; in fact we have a paper that we just published on this topic but and we talked about this in this paper – about this important shift to population health that we're seeing in medicine right now focusing less on patients as individuals and more about communities and larger groups of people in terms of being able to prevent things or also just seeing upstream factors that affect

whole groups of people, for example in poor housing or racial discrimination or things like that that we know are really important in terms of driving health outcomes so medicine talks you know a lot about population health the way that things are changing in terms of focusing lots less on positions and more on this prevention work, and we see new requirements for hospitals what we're working on. So what you see in practice is that people have adopted this new language but they haven't really adopted the philosophy of starting to think about community engagement, for example, and so we just published this paper about how people use of language of population health but they use it really differently so you know a very small amount of hospitals and physicians really think about it in terms of community-based engagement and prevention; a lot of them think about it as just reworking their existing patient populations; they don't really move beyond that; I think about just managing their kind of existing population of patients and not really getting outside of the kind of clinical sphere in terms of prevention or starting to engage some of the social aspects of disease and so I think there's a real coming challenge in terms of shifting towards that perspective. Even though the language has already moved in that direction, there's still a lot of kind of left behind in terms of older clinical models.

DS: I think there is a concern, I know we have this, as a political scientist, I have this concern that people not see changes in rhetorical structures as political victories, so, for example, you know the idea that you know that people are talking in a certain way that they're using inherent so they're using concordance or whatever that might actually be worse than just using the language of compliance and wrestling with it because it reminds them that they're not out of the woods and I think we do worry about this idea, that, yeah, okay, we've trained people and there is speaking in a certain way and that they maybe think that as a result they've freed themselves of certain power relations that might actually be more intent because they're not being observed anymore because everybody thinks again that they're out of the woods.

CM: Mmm-hmm, and that's one of the most important things that you all are sort of contributing with this piece, I think, is helping people to think more about as you say that these linguistic changes don't always translate to actual progress. So really really good, okay, so the next question I have for you is your essay argues that shifting from the patient-physician dyad and compliance to a population and community health framework would make the kinds of changes that renaming compliance other seemingly less threatening terms cannot. That said you're careful to point out that discursive shifts and scholarship do not always reach in the trenches healthcare worker, so as educators in a medical school, how do you promote post compliance framework for your students and I know you did mention earlier sort of like that the tricky space you're navigating not being an instructor of record, not teaching traditional courses, and that kind of thing, but do you have any sort of day-to-day practice pedagogical practices through which you're pushing this post compliance framework?

DS: We had read all as much of the compliance literature, and it's a fairly vast literature at this point, where we are really immersed in this and been kind of struck by how many people had been working on this, and for a long time to him it seemed like a consensus to develop that you know compliance was not an effective discourse or an appropriate or ethical discourse. That said, so I was talking to a clinical colleague, and I told them what we were working on, and this person said well I must not have gotten the memo that compliance is not allowed. It really does strike me that a you know scholarly literature doesn't necessarily mean that it's going to affect clinical spaces, especially because clinicians do read literatures, but they might not, they're not, reading this literature. But the other one was that in some cases it's just you know it persists much more we, Berkeley and I, you know, we'll be in presentations and things, we'll text each other just we hear compliance spoken again and again and again in these very uncritical ways and it's actually kind of striking to us how it's still lodged in so many discourses despite being so discarded or so critiqued in our RHM kind of literature. BF: It's almost seen as being you know a lot of questions pushback on being politically correct and seen as like you know a lot of clinicians will say compliance, oh I guess I should have said it here, and I should have said concordance, almost as a joke you know it's really thinking that the language is shifted but nothing really else has changed like they don't necessarily really believe that it should have ever changed because there still is this physician centrality at the heart of medicine in the doctor-patient interaction, and so I think it's hard to shift the culture in terms of our actual efforts to you know work with medical students to get them understand why it may be problematic. I think for me personally as a sociologist I'm really influenced by data that suggests that you know doctor patient interactions really don't matter in terms of improving patient outcomes. Really teaching students

about you care a lot about health outcomes and you really need to think about more than your, you know, small interaction with a patient. You have to look outside of that, you have to look at social determinants of health, and doing that isn't necessarily going to really alter the kind of model of compliance because it's really going to kind of complicate that idea but even also challenge, you know, focus historically this very small aspect of medicine instead of focusing on a whole host of other factors.

So for me that really kind of pushes them in a direction of really kind of questioning compliance but also questioning the clinical model in general.

CM: Wow, that's brilliant, because you're almost deflating their ego a little in the process to be like, look, your actual interactions with patients-- not so much--- but all of these other things -- yes. Helping them to see the bigger context seems like a really smart way, so.

DS: Yes and these are hard conversations to have and it's part of our job as social scientists to push back on some of the physician centric approaches. I mean it's it's kind of amazing -- we have these discourses that are you know threaded through medical education outpatient or patient centricity, whatever it might be, but at the end of the day you know lots of physicians, they became med students and then physicians because they wanted to make decisions, and they're wrestling with the fact that these decentralization models are in cooperation- collaboration. Sometimes it means that they're not the quarterbacks or the deciders or whatever metaphor you want to use here. You know I know Judy Segal, they are giving us a list of those you know, but dislodging of them of that a little bit is really hard work. I just have to say the other day the second point I just want to make is that you know compliance seems to persist in large part as a frustration point because there's so much focus on malpractice and legal vulnerability so a lot of our students and our clinical colleagues will say look you know I'm going to be sued if they don't do what you know they put them in a vulnerable legal position if patients don't do what they told them to do. So really it's not just about a doctor-patient relationship and compliance it's also lodged within larger rhetorical structures like legal rhetoric, legal matter, medical rhetoric.

BF: Absolutely, and I have to say you know I think as a medical educator I've learned something from my students and my clinical colleagues and that I have a little bit more empathy for their position in terms of understanding compliance because working with people can be really challenging and sometimes you know you've had all this education, you know what's good for patient and you feel like you really want to help them, and the patient doesn't you know want to listen to you. I feel like over time sometimes the physicians really get burned out by that. They have this something to offer and they can't offer it and so I do feel like I've learned a little bit just from working at a medical school in terms of what it's like on a day to-day basis. You've been trained to help somebody and you're not able to-- there is a little bit of frustration even if they're not quite understanding the inherent problems in that. I think it's a real opportunity just to kind of learn a bit more about the clinical environment and relationship and some real kind of tensions within that and just people are really you know-- hard sometimes --but it's important to recognize the kind of relational challenges that are part of the clinical encounter but I appreciate a bit more I guess being in this environment than I would have if I hadn't been.

CM: Absolutely I think that's another compelling part of your position now as researchers and writers is that a lot of times if you have someone coming from a purely humanistic perspective and they've never interacted more than just say going to a physician themselves or with a family member that they don't have that sort of like empathy for the position of the physician that they're not like just like that unilaterally like bad people or out to get patients or out to be like the heavy or something like that so.

DS: I certainly wouldn't want anybody to interpret this whole critique as just being you know just simply against physicians--really it's about diagnosing the whole pretty broad power dynamic within medicine anything. CM: And I think that definitely comes through and I hope that other readers agree but I definitely saw that and just thought that the specificity of the argument is another thing that just makes it a really strong piece. CM: Okay so the next question I have for you is: you argue that linguistic and material changes must work in tandem to intervene effectively in the problems inherent in non compliance discourses and their effects; you offer lay community health workers and health advisory boards as examples of community level health organizing as examples of the area of population health and its potential potential power to disrupt parallel relations. Do you have other examples you would be willing to share, even specific ones from your other field based research, to kind of open up the medical

BF: I have one that I would share, and I think it is an attempt to sort of open up the record a little bit less doctor focused and so this can work on an individual clinical level but they also can work on a community-based level in terms of kind of shifting the communication streams between physicians or hospitals or in kind of medical professionals and communities that the idea would be that you know any kind of medical encounter or health services encounter should be first of all a lot longer than it typically is right now-- you know most clinicians have on average seven to ten minutes or so with the patient; there's not a lot of opportunity to understand a patient's background, for example their history, their environment, their religious life, or community support and where they live, things like that, so opening up an opportunity for patients to share a lot more about where they're coming from which it really kind of contextualized -- why or why not a patient may not take a medication or may not exercise or may not make to their appointments ---right I mean there are a lot of clinical practices that really adhere on a three-strike rule - you missed three appointments, you're off you can never be patient there anymore-- don't offer opportunities to understand a little bit about what's going on and so these open records not only allow for better communication between doctors and patients but they also allow for better practice design and for health services that really meet the needs of communities that live in an area so I think it's a real opportunity to open up more communicative kind of spaces whether it be for a doctor and a patient or for yeah, a community.

DS: I would just put in a quick plug for our book on hospitals and communities which we're writing with our colleague John Wynn at University of Massachusetts. We really, the premise of that book is, the kind of way we're approaching it methodologically is trying to look at ways which hospitals can rethink kind of who they are and how they interact with communities and they may, for example, think that they're really open to the community but then if you talk to communities we find out that they're not at all, we're not perceived that way anyway or even one of my, you know, the most amazing things I kind of had to wrestle with was hospitals literally, you know, the neighborhood would be across the street and the neighborhood would say things like we feel so distant from the hospital, so even you know geography and geo- spatial terms you know just the lived experience of walking streets can oftentimes be quite different than how hospitals think when they're looking across the street at these places and saying 'we're right here -- we keep inviting you to things and you never come,' but because the community doesn't necessarily feel that closeness.

CM: Right, well I mean you've convinced me, I definitely I'm definitely gonna read your book because like I said it just loved your article, so I know that you're both really strong thinkers and writers, so okay, so thanks for bearing with me. I've got one more question for you which is what's next for your work with post patient compliance medicine. and yeah. I guess you partially answer it by talking about your book a bit. Are there other concepts that you're working out that complement this work that you want to talk about?

DS: I wanted to just say it: Berkeley and I have a pact to not start any new projects for a while because just about how great it would be able to be - how great it would be to be able to in do interviews just to listen to the clinicians talk about compliance and do discourse analysis of some sort but to really get some empirical you know fragments to work with because we walk around the halls of our institutions and we know you know and other institutions you hear this language all the time and it's in this vicissitudinal way; it's sort of just like people just say it it's and they're not saying it critically they're not saying it to be disruptive or to be resisting an entire literature, they're not you know counter revolutionaries or anything, but the language persists, and I think that being able to listen to how it's used would tell us more than we are able to accomplish in a theoretical piece and I think we'd flagged that at one point as something we'd like to do but that that would be the dream for next step for this so it's not a different concepts a different way into thinking about compliance.

CM: I would love to see that work, although I admire your pact because you do have voluminous scholarship happening and it's very very impressive, so I don't doubt actually that you are a writing team that will get to that next project, so that'll be exciting to see. So it has been so great. When Lisa and Blake passed on your essay to us and I read the title I was excited and then when I read it I just kept-- every page I'm like-- wow, these two are amazing writers, this is so well researched, this has so much great literature

covered in it, and I just find you both really impressive and I appreciate you taking the time to talk with me.

DS: Thanks for saying all those nice things!