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Medical Practice as Rhetorical Art Functional Medicine's Therapeutic Partnership

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MEDICAL PRACTICE AS RHETORICAL ART

FUNCTIONAL MEDICINE'S THERAPEUTIC PARTNERSHIP

by

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ABSTRACT

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The current rates of provider burnout are at an all-time high, and our healthcare system is currently seeing numerous providers leave the system. The U.S. Surgeon General has deemed burnout rates at crisis levels, creating an exigency for research and work to help ameliorate this issue. One main issue at the heart of provider burnout is the idea of meaning and purpose in one's professional life, and Functional Medicine methodology argues that it provides the means by which it can mitigate burnout while improving professional fulfillment and joy through deeper connections with patients. Their methodology is rooted in a concept called the "Therapeutic Partnership," which works to address both provider and patient health. This dissertation provides a look at how Functional Medicine's concept of the Therapeutic Partnership works to change current medical rhetorical paradigms by foregrounding a different understanding of the medical art and healing processes. At the heart of this study is the concept of *techne*, an ancient Greek rhetorical theory containing a nuanced concept of the nature of art. This project presents the Therapeutic Partnership as a case study illustrating how approaching medical practice as a rhetorical art can help improve provider burnout and patient care. Using a constructivist grounded theory methodology, 16 Functional Medicine providers were interviewed using semi-structured interviews. An important takeaway from this study is that conceiving of and practicing medicine as a *techne* can help mitigate and prevent burnout by aligning providers' practices with their professional values. Additionally, medicine as a *techne,* as evidenced in the

Therapeutic Partnership, uses rhetorical awareness and strategies to promote provider health, affording the opportunity for providers to embrace their own healing while improving their relationship with their profession and with their patients.

This dissertation is dedicated to all chronically ill persons
and the providers who care for them.

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CHAPTER I

INTRODUCTION

"If you're going to help a human being heal, it requires a much different story, a much different intent"—*Functional Medicine Provider*

Problem Statement

The provider burnout rate is currently at an all-time high; in 2022, the American Medical Association reported that 63% of providers reported being burned out (AMA, 2022). While the pandemic is partly to blame for the high level of providers experiencing burnout, the reality is that many providers were already feeling burnout even before COVID-19 appeared on the scene. In 2019, the National Academy of Medicine found that burnout rates among nurses ranged from 35-45% and the rate among physicians was 40-54% (National Academy of Medicine, 2019, p. 66). Burnout can be defined as "a combination of exhaustion, cynicism, and perceived inefficacy resulting from long-term job stress" (Reith, 2018, p.1). The COVID-19 pandemic worsened the strain on providers by calling on them to put their lives at-risk and work with little to no days off, which led to increased stress, anxiety, and depression (Sinsky et al., 2021); these experiences are described by Kessler, Aylward, and Trappey (2023) as the "harsh, traumatizing realities that physicians, nurses, and other HCPs have faced throughout the pandemic" (p. 102-103). Provider burnout rates amount to what the Surgeon General's Advisory called "crisis levels," with potentially negative and destabilizing consequences such as decreased quality in patient care and safety, decreased time spent between provider and patient, increased medical errors, hospital-acquired infections among patients, and staffing shortages (Surgeon General Advisory, 2022). In 2021 alone, 117,000 physicians left the workforce (Popowitz, 2023). For providers, the personal consequences of burnout can result in occupational injury, problematic substance-abuse, and

even suicide. Burnout may also threaten providers' professionalism, including affecting their fundamental ethical norms that are essential to the delivery of high-quality care (National Academy of Medicine, 2019). And, underscoring the gravity of the situation, Surgeon General Dr. Vivek H. Murthy stated that, "the stakes are high. If we fail to act we will place our nation's health at increasing risk" (Surgeon General Advisory, 2022, p. 4). Because of the pervasive consequences of burnout major medical organizations, including the American Medical Association (AMA), the Surgeon General's Office, as well as the National Academy of Medicine (NAM), have called for a systematic approaches to address not just structural and organizational, but also the culture of care. Addressing the culture of care means acknowledging the fundamental ethics of medical and health care, such as the oaths and values that motivate providers to enter the medical profession. However, when these ethical values are confronted and challenged in their environments, it can create a dissonance of values for the providers (National Academy of Medicine, 2019).

Addressing this point in the provider burnout conversation, the Institute for Functional Medicine (IFM) stated that it believes that a main reason for this burnout is because providers may feel that they "are managing diseases instead of really restoring health" (IFM, 2024). A way to mitigate this cyclic process, they argued, is by taking a system-biology approach, which means understanding the body as a series of interworking, interrelated systems. With this approach, there is a different understanding of the role of the patient-provider relationship; this understanding is manifested in what FM calls The Therapeutic Partnership. Dr. Robert Luby, IFM Executive Director of Medical Education, stated this partnership works "to ensure that *physicians and patients* (my italics) are satisfied with that relationship, and that becomes a therapeutic partnership, and actually a therapeutic intervention, in and of itself" (IFM, 2024).

Thus, this partnership becomes an active form of professional self-care while also transforming the clinical experience. FM methodology builds on existing modes of provider-patient partnering, such as patient-centered care, but also takes it a step further by emphasizing the importance of provider care as part of the Therapeutic Partnership. As such, providers are encouraged to consider themselves first, and IFM Educator Lisa M. (Perry) Portera said that providers should take "better care of ourselves first so we can be available to [patients]," (IFM, 2024). For FM providers, they are given the typical advice of ensuring adequate sleep, exercise, and nutritional habits, but what is unique is that self-care techniques are embedded in the clinical methodology. To date, FM's methodology and its rhetorical elements (i.e. why and how communication happens the way it does) as a potential intervention to provider burnout has not been studied, and a study is warranted to discover how certain aspects of this approach can be emulated in general clinical spaces.

Study Purpose

This study works to explore how FM philosophy and methodology may serve as an intervention to burnout and its subsequent patient care issues by encouraging providers to bring rhetorical awareness (i.e. awareness of why and how they communicate) to themselves and their clinical practice; this awareness can mitigate provider burnout through metacognitive rhetorical strategies—which can be understood as ways to conceive of and understanding how communication impacts their experiences as providers—that may transform how they see themselves, engage with their patients, and practice the medical art. These transformations are primarily done through the self-identification of the provider as a "healer," which brings a different aim and purpose to their medical practice. In their clinical practice, this identification is manifested in FM's foundational tool: the Therapeutic Partnership. As a tool, the Therapeutic

Partnership works to change current medical rhetorical paradigms by highlighting a different understanding of the medical art and healing processes; FM providers stated these understandings align more with their identification as healers, and results in the relationships they wish to have with their patients. As healers, FM providers are encouraged to see themselves as their first patient, which requires being physically and mentally in tune with themselves. Furthermore, this self-engagement requires being highly conscious of how they enter in and engage during clinical visits, bringing a rhetorical awareness to the medical art. Ultimately, FM providers' orientations to themselves as healers can be used to create a framework for other providers to resist oppressive practices in their own work where possible and to embrace the idea of themselves as healers, possibly transforming themselves and their practice.

Study Approach

This study takes a Rhetoric of Health and Medicine (RHM) approach. RHM is an interdisciplinary field that engages with rhetoric through the intersection of research, health and medical practices, and patient advocacy (Rhetoricians of Health and Medicine, n.d.). The aim of RHM scholarship is to "study and help manage the rhetorical negotiation involved in intersections of healthcare communication, patient education, and evidence-based medicine" (Angeli & Johnson-Sheehan, 2018, p.1). Research is rooted in practicality and usefulness and works towards the benefit of stakeholders in the medical community. The study of the rhetorical practices of complementary and alternative medicine (CAM) falls under the RHM umbrella and given that about 40% of US adults use CAM (Stubbe, 2018), and noting the rapidly expanding community of FM (The Institute for Functional Medicine, 2019; The Institute for Functional Medicine, 2021b; Today.com, 2022),[1] a study is warranted to understand how this medical community's rhetorical practices affect providers' professional experiences and approaches with

patients. Although it is understood that clinical care is an experience for patients as well as providers, this study intentionally focuses on FM providers' perspectives. By initially focusing on providers' perspectives, we can learn about how their experiences, beliefs, and values contribute to the proliferation of this medical community, as well as how they believe their rhetorical approaches (i.e. how the philosophy translates into certain way of communicating) to clinical care affect their professional identities and clinical practices. Furthermore, this study adds to discussions in rhetorical studies by taking a comprehensive view of medical rhetoric that begins with a historical look at the rhetorics of medicine and rhetorical framings of clinical communication. These contributions are made by developing theories on how providers understand and view their profession, and how these perceptions affect their own rhetorical negotiations as medical professionals. This work also adds to existing RHM literature regarding provider perspectives, work that has helped to enrich our understanding of the complex role and experience of what it means to be a medical professional in today's world.

Theoretical Approach

The main theoretical approach in this study is *techne*, a rhetorical theory that refines the meaning of what an art is. This study builds on RHM studies that foreground *techne* in health and medical spaces (Edwell, Jack, and Singer, 2018; Arduser, 2022) by operationalizing *episteme* (scientific knowledge), *sophia* (wisdom), and *phronesis* (practical wisdom) as parts of *technai*; I use this idea to illustrate how FM providers' identification as being a part of the "healing arts" brings a rhetorical consciousness to their own self-awareness and their clinical work. This healer identification then results in a unique conception of medical *techne*, one that aligns with the values they associate with the healing arts.

Within the three elements of a *techne*, in FM, *episteme builds on scientific knowledge*, means understanding disease as multidimensional (i.e. more than just physical complications), allowing providers to build on their medical training and consider the complex etiology of disease. This approach allows for more clinical curiosity, less algorithmic approaches to diagnoses, ultimately making the clinical process a more creative and enjoyable process, providers stated. In FM, *sophia* can be seen as its guiding wisdom, which at its core is focusing on the "root cause" of illness; by addressing the root cause of illness, providers stated that they align more with their professional values, mitigating burnout and helping patients get better as opposed to, as one provider stated, seeing them "get worse more slowly." Finally, *phronesis can* be seen in FM in various ways, such as enacting patient-led treatment plans and implementing patient epistemology in the clinical methodology. By centering the patient-provider partnership, providers stated, there is less pressure on them to have all the answers, allowing the provider the space to truly partner with patients and create a deeper, more meaningful relationship with them. These relationships are key to maintaining joy, they said, as it humanizes the clinical experience for both provider and patient. This theoretical understanding helps to understand how rhetorical awareness can mitigate the problem of provider burnout; by envisioning medical practice as rhetorical art, providers stated that through FM methodology, especially through the concept of the Therapeutic Partnership, they are now aligned with the healing arts and living out their ideal professional identity. This transformation, they stated, brings a renewed sense of self and purpose, allowing them to experience what they call "clinical joy," and mitigating the effects of provider burnout.

Study Findings

The findings of this study indicated that bringing a rhetorical focus that foregrounds the patient and provider as partners can transform a provider's own professional self-awareness and subsequently affect how they practice medicine. For the providers in this study, they specifically identified themselves as being a part of the healing arts and being a "healer," a culturally loaded and sometimes controversial term. However, in using the rhetorical identification of the provider as "healer," the providers in this study said they align themselves with the idea of helping patients achieve holistic healing in three domains: mind, body, and spirit. The healer identification, they stated, subsequently influences how they practice medicine, which is primarily rooted in the concept of the Therapeutic Partnership, a clinical tool that is founded on a deep rhetorical awareness from both patient and provider. This Therapeutic Partnership renders the idea of medicine as a *techne*; this *techne* allows for a plurality of epistemologies, embracing the complexities of illness and disease so as to partner with nature and the patient instead of attempting to dominate them. As such, the results of this study showed that FM methodology foregrounds rhetorical awareness, acknowledging that rhetoric is an element of medicine that will never change because medicine is ultimately intimate work between two humans aiming to discover disease processes to relieve suffering. Furthermore, the providers stated that FM methodology understands that disease does not exist out of context, and with this perspective, FM patients and providers work collaboratively through rhetorical work that foregrounds and values all of the knowledge and experience brought to the clinical encounter; this method allows providers and patients to feel engaged and validated, and allows providers to further their understandings of illness as a lived reality that requires a multi-epistemic approach. Simply put, FM emphasizes that *rhetoric is the medical art,* which means that practicing medicine is

practicing and developing a positive communicative relationship between patient and provider, one that foregrounds the persons involved in that relationship. To practice medicine is to engage in a deeply human connection that is just as valuable as the science that informs the practice. And this awareness acknowledges that although the science may change, a value system that emphasizes this communication and partnership is the bedrock upon which medicine is practiced.

Researcher Positionality

In *Illness as Metaphor*, Susan Sontag (1989) writes, "Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place" (p.3). For chronically ill persons, being citizens of "that other place" lasts a lifetime. My journey into the kingdom of the sick began quite early; as an infant and all throughout my childhood, I had digestive issues that perpetually kept me in discomfort. I began to just live with my digestive issues, accepting them for what they were since I was otherwise leading a normal, productive life. But then, at age 27, my body began to slowly break, and by 32, my body became something I did not recognize. It was no longer mine, it belonged to illness.

Countless searches eventually led me to find Functional Medicine (FM). FM is a medical approach that integrates a mind-body, systems-biology based understanding of medicine to discover *why* someone is sick in the first place, not just quell their symptoms.[2] This branch of medicine uses licensed medical practitioners who have training in this unique approach. Being a person of language and words, from my first visit I noticed that my FM provider used a communicative approach that was entirely different from what I had experienced before. She

acknowledged my experience and knowledge (I was an expert on my body at this point); she listened to me more than any provider had before, she acknowledged my frustrations, failures, and hopes. But most surprising to me was that she granted me a degree of agency in my care that I had never experienced before. Her words and statements not only questioned, but also subverted the typical patient-provider hierarchy. "You know your body better than anyone," she would say; and, when she proposed a treatment plan, she would ask what I thought about her ideas and if I had any of my own to share. It was a clinical experience unlike any other that I've had. While it took years to regain my health, I am now in a place of stability and healing. This was a major breakthrough in my health journey, and it came about through a partnership that cultivated and nurtured by a unique rhetorical approach that acknowledged my realities and epistemologies. This experience made me keen to research why and how rhetorical awareness is so essential to FM methodology.

Provider Focused RHM Literature

This study adds to a rich body of RHM literature regarding provider-perspectives in medical spaces. In these studies, scholars have used rhetorical methodologies to uncover how providers navigate what Angeli (2018) calls "complex, dynamic, situated rhetorical spaces" (p. 28). In the rhetorical situations that medical providers are a part of, they usually enter with an intended outcome or goal, and usually, that goal is to use the encounter to provide help or guidance to a patient in need. However, these interactions can be complicated by a number of factors including social stigmas (Cook et al., 2021), environmental factors, such as the ones explored by Angeli (2018) with EMS workers, and the issues noted in Smart's (2023) work with providers who saw their professional lives change drastically as efficiency rhetorics dominated during the course of the COVID-19 pandemic. For example, in Angeli's (2018) book she

described how EMS workers use rhetorical work to navigate these "high-stakes" situations (p. 13), stating that they rely on strategies such as multisensory invention, memory, and distributed cognition to "stabilize unpredictable environments" (p. 28). Her work ultimately argues that provider work is deeply rhetorical and necessary to facilitate workplace communication and patient-care. She likens this high stakes, unpredictable environment to other interactions, such as provider-patient talk, which has been studied by RHM scholars through various avenues.

Often, a common area of analysis with doctor-patient talk is the concept of agency, which is explored by Arduser (2018) when considering how agency manifests in the complex web of diabetes treatment and management. In her study, which included both provider and patient participants, agency was mediated and distributed through layers of technical and bodily knowledge. With respect to the providers in her study, she found that disease management can take the form of helping and encouraging patients to become an expert in order to help bridge knowledge gaps. The way they do this is by using persuasive speech to direct patients, and they try to position themselves as objective sources of information (Arduser, 2018). While agency is almost always a point of discussion when considering doctor-patient talk, importantly, RHM scholars Campbell and Angeli (2018) emphasize the idea that speech is just a part of the rhetorical work that providers engage in. In their 2019 study analyzing the communication of EMS workers and nursing students, they illustrated that "cues and intuition were transformed into responsive rhetorical action" (p. 358). Intuition, they argued, must be underscored as a significant part of the rhetorical work that providers engage in. Defining intuition, they wrote that, "intuition then, is more than an unconscious ability to inform action–it is a type of intelligence that develops from experience, and from the ability to be attuned to the surrounding environment and material conditions of a workplace" (p. 364). For the providers in this study,

intuition also plays a significant role in the rhetorical work they do, especially as they navigate patient narratives and concerns in an attempt to address the various domains of their health. However, they expressed a concern in dealing with the rhetorics of efficiency that dominate corporatized medical settings, assembling "people and practices in robotic, restrictive ways" (Smart, 2023, p. 85). These rhetorics of efficiency were highlighted and exacerbated during the COVID-19 pandemic, when organizations were seen as sometimes prioritizing investment and gain at the expense of providers' experiences and perspectives (Smart, 2023); these issues, which were already contributing to provider burnout even before the pandemic, could be seen as potentially contributing to the 230,609 health care professionals who left the workforce in 2021 (Popowitz, 2023).

Ways to Mitigate Provider Burnout and Improve Patient Care

Patient Centered Care and Narrative Medicine

As will be discussed in more detail in chapter three, concepts such as patient-centered care (PCC) and narrative medicine are ways that medical think tanks and organizations have tried to improve patient care as well as mitigate provider burnout. These two movements in medicine aim to humanize patient-provider relations in ways that center the person and not the disease. Patient-centered care can be understood as a method by which to prioritize patients by acknowledging their roles in the clinical process, such as listening to patients' concerns and incorporating shared decision-making. Building on this idea, narrative medicine aims to change how dialogue takes place in clinical spaces, by focusing on how providers can use patients' narratives to more deeply understand patients and their diseases. These two concepts are analogous to the Therapeutic Partnership, and have gained significant ground over the decades, both in medical education and clinical spaces.

There are, however, two concerns regarding PCC and narrative medicine. For PCC, definitions about what being truly "patient-centered" vary widely, and may look different depending on the medical organization, clinic, or even the provider (Lusk and Fater, 2013). These varying understandings of what PCC means result in a lack of standardization across medical spaces, and may be implemented to varying degrees, also resulting in a lack of consistency. And with respect to narrative medicine, although the concept is generally theorized by founder Rita Charon as a clinical method, in practice it appears to mostly manifest in the form of helping medical students going through their training. As will be explored in chapter 3, research shows that it is being used to help medical school burnout (Stumbar et al., 2020; Lijoi and Tovar, 2020) and to help medical students maintain or increase levels of empathy (Collier, Gupta, and Vinson, 2022; Granat et al., 2023). Both PCC and narrative medicine aim to humanize medicine by moving it away from a disease-centric model, yet the lack of consistency, definition, and application are ways that complicate the methods from being reproduced on a wider scale. As mentioned, FM's Therapeutic Partnership is an analogous concept to PCC and narrative medicine, and incorporates many of the two concepts' basic elements. However, this study found that one edge that the Therapeutic Partnership has compared to PCC and narrative medicine is its ability to be standardized and defined more consistently among the FM providers who practice it. While the IFM is working with a smaller provider population, its providers are diverse in professional training and experience, yet still understand and implement Therapeutic Partnerships in a way that mirrors each others' approach; and each participant said this shared understanding has helps them to collaborate not only with patients but with each other, allowing them to have a more fulfilling professional experience.

CAM and Its Critics

The term CAM is used to define "medical products and practices that are not a part of standard care" (National Cancer Institute, 2023). The types of practices that fall into this category include: mind-body therapies, such as meditation, biofeedback and yoga; biologically-based practices, such as vitamin and botanical therapies, and dietary supplements; manipulative and body-based practices, such as chiropractic and massage therapy; and whole medical systems, such as Ayurvedic and Traditional Chinese Medicine, naturopathic medicine, and Functional Medicine. About 40% of US adults use some form of CAM therapy (Stubbe, 2018), and the reasons for the increase in use include: increased access to information, a decreased tolerance of what patients may perceive as paternalism conventional medical spaces, the perception of conventional doctors as overly reliant on prescription drugs, as well as patients' dissatisfied with conventional treatments because of "adverse effects, cost, lack of efficacy, erosion of doctor–patient relationships, or an impersonal health care system" (Ventola, 2010, p. 465). Of these reasons, greater interpersonal attention and improved patient-provider communication remain at the heart of why patients turn to CAM (Derkatch, 2016). Yet it is not only patients who are seeking CAM, according to IFM reports, each year they are training more and more providers in their approach and certifying providers at a steady rate (IFM, 2022b). As seen in the infographic below, providers, too, are seeking out FM, and it may not be coincidence that they are doing so during a time when the provider burnout rate is at its highest.

Despite the growing popularity, however, within professional medical spheres, CAM and FM face difficulty with lack of understanding, credibility within mainstream medicine, and challenges to research. These issues are explored in Derkatch's work (2016; 2022). In her book, *Bounding Biomedicine* (2016), Derkatch explores how biomedicine used rhetorical boundary work to create distinctions between biomedicine and CAM in order to both defend its authority

and position in professional and public spheres, as well as to work to delegitimize CAM practices and research. She writes,

> biomedicine is ultimately recognizable *as* biomedicine because of its association with scientific methods and procedures. Boundary work is a constituent element of medical research because the ways that researchers line up their work with those methods and procedures will either assert the researchers' membership within the professional community or declare them outsiders. (p. 192)

With respect to FM, the challenges it faces from critics include arguments that claim its practitioners use pseudoscience and quackery, as well as being guilty of using predatory marketing practices (Siegler, 2022; Hall, 2017). For example, one specific claim is that its "practitioners order reams of useless lab tests and then try to correct every abnormal level without considering (or even knowing) what these abnormalities mean, if anything. So they make up fake diagnoses and profit" (Gorski, 2018). Also of concern is that "it can be difficult to tell which of the providers are serious about using functional medicine and which providers are using it as a marketing tactic to get more patients" (Childs, 2022). Such concerns arise not in just FM settings, but in CAM as a whole, and the last report showed that Americans spent $30.2 billion in out-of-pocket costs for these types of therapies and treatments (National Center for Complementary and Integrative Health, 2016). These numbers connect to the growing trend of wellness culture and rhetoric which Derkatch (2022), described as discourse that "increasingly primes us to see ourselves as candidates for medical intervention" (p. 24). Wellness, in this context, can be seen as a never-ending journey, because one could seemingly always be better, making it easy for predatory providers to capitalize on such beliefs.

Despite these challenges, it is important to note that the founders and practitioners of FM have gone through traditional medical programs to obtain their licenses as medical providers

(MD, DO, NP, etc.), and the term "Functional Medicine Practitioner" means that they have additional training and have earned their certification in this approach.[4] In fact, many FM providers, including those interviewed for this study, spent many years in conventional medicine only to be left disillusioned with their inability to truly help patients heal (Li, 2019; Gupta, n.d.). In FM approaches, similar laboratory work is done, and sometimes medicines are prescribed that are in line with conventional medicine practices. The difference in FM lies in the scope and breadth of providers' investigations; lab work may go beyond basic panels, and pharmacological prescriptions are an option after other methods and treatments are exhausted. Recent FM research boasts significant success with patients who were otherwise stagnant in their disease (Strobel et al., 2022; Droz et al., 2020; Chaney et al., 2022; Beidelschies et al., 2019). For example, Beidelschies et al. (2019) study showed that after six months, FM patients scored higher on the PROMIS global physical health assessment compared to those seen in a primary care clinic. And in Droz et al.'s (2020) study, which looked at patients with rheumatoid arthritis and psoriatic arthritis, after just 12 weeks of FM care they were able to have improved markers on physical health, mental health, and pain levels (p.7). And in Strobel et al.'s (2022) study with inflammatory bowel disease, the authors stated that "as part of the patient's journey, self-discovery plays an important part in creating a personal map moving toward a healthy state of being" (p. 3). This research has been challenged by mainstream medical journals, such as *The Journal of Family Practice,* which stated that "functional medicine is an interesting, mostly unproven, approach to patient care" (Hickner, 2022, p.6). Despite these challenges, the number of FM practitioners and patients continues to increase, which makes its approach and goals worthy of a deeper look. Ultimately, FM providers stated that the goal with FM is not to establish relief from disease and its symptoms, but to treat what is causing the disease and to aid in holistic healing. As a result of this focus, the providers in this study said that they are now have

professional joy and decreased burnout because they are able to establish fulfilling patient relationships and have the clinical curiosity and freedom to explore the best ways to establish patient wellness; and these factors, they stated are founded on the opportunity to implement Therapeutic Partnerships in their practice.

Chapter Summaries

In Chapter 2, I present the theoretical foundation of the study, which is *techne*. After providing a brief look at how other RHM studies incorporate *techne,* I explain the historical development of *techne* as a concept in the ancient world, especially as it was debated and used in ancient rhetorical and medical texts. Through *techne*, I am able to understand and provide insights into how the Therapeutic Partnership envisions a rhetorical approach to the medical art. This approach connects providers with what they call "the healing arts," which mitigates burnout and improves patient relations and communication.

In Chapter 3, I present scholarly conversations and concepts that are relevant to the contextualization of this study. This includes an interdisciplinary look at topics such as physician burnout, issues surrounding patient-communication and relations, and analogous patient care concepts such as patient-centered care and narrative medicine. I also explore how patient-centered care and narrative medicine are used in medical education and clinical spaces. As a whole, these contexts and conversations provide the means by which to situate and better understanding how the Therapeutic Partnership functions and improves the clinical experience for providers.

In Chapter 4, I describe my methodology, constructivist grounded theory, and why it was chosen for this study. I also describe my data collection process, methods, and coding processes, which included conducting in-depth, semi-structured interviews with 16 FM providers, as well as collecting archival documents from the IFM website and training videos.

In Chapter 5, I present the results of my data, organized by theme and prominence in the data. The major themes of the data are: 1) the role of rhetoric in biopsychosocial medicine, 2) patient narrative, 3) teamwork, 4) cultural and systemic barriers to the Therapeutic Partnership, 5) healing versus treating, and 6) the Therapeutic Partnership provides resistance against provider burnout.

In this Chapter 6, I present my analysis of the interviews and archival/documentary data. In order to contextualize my analysis of the data results, I first explore the emergence of FM and its philosophy, focusing on their concept of the Therapeutic Partnership, which attends to both provider and patient well-being. I then explore how, for the participants, the Therapeutic Partnership first begins with providers' self-identification as being a "healer" and/or being a part of the "healing arts." These identifications mean caring for themselves first in order to be able to help their patients. Additionally, for the interviewed providers, this identification was a major reason why they felt burnout in conventional care settings, specifically because they felt they were not living out their values as healers in these spaces; conversely, this healer identification and its qualities contribute to why they feel joy when practicing FM methodology. I then explain how the concept of the Therapeutic Partnership also tends to patient care by transforming medical art into rhetorical *techne*, which means centering rhetorical awareness in the methodology; this rhetorical awareness creates a greater epistemological standing for the patient, potentially improving their clinical experience. This understanding of medical *techne*, providers stated, decreased their burnout and increased their professional joy and fulfillment.

In this Chapter 7, I explain how the results of this study contribute to other conversations both in medical spaces and RHM. Of significance includes how the Therapeutic Partnership contributes to conversations in epistemic injustice in clinical spaces and the way FM rhetorical *techne* builds on discussions in RHM regarding chronicity. I also describe the implications

regarding deeper connections between medicine and the humanities, in particular, with ancient Greek philosophy. And I end with practical takeaways for providers in any space to use rhetorical awareness and strategies to help transform their practice where possible to improve patient relations and potentially mitigate the effects of provider burnout.

Chapter Summary and Takeaways

In this chapter, the context and exigencies that surround Functional Medicine methodology, specifically the Therapeutic Partnership, were explored. Of importance are the rising rates of provider burnout, as well as its subsequent issues with patient care, in particular patient relations and communication, which are areas in which the Therapeutic Partnership can potentially mitigate and serve as an intervention. With respect to the rising rates of provider burnout, it is important to not only note how burnout affects provider performance, but also the moral distress it can lead to. This moral distress can lead to dissonance between the providers' values and their daily realities in their clinical settings. This means moving away from practices that align with their ideal professional identities and potentially underscoring the latent and culturally inherent issues that already exist in patient-provider relations. Some ways these issues have been challenged is through patient-centered care and narrative medicine, which help to decenter the disease in clinical methodology. However, these methods lack standardization and may be implemented in different ways depending on the clinic or provider. Building on these ideas, the Therapeutic Partnership works to encourage, and reinforce the patient-provider relationships by centering rhetorical awareness and practices. These practices are standardized by FM clinical methodology and tools that look beyond a scientific center when considering disease treatment, instead centering on the strategic use of Therapeutic Partnerships. These partnerships illustrate an approach to medicine that is in line with a *techne*, a rhetorical theory nuancing what

an art is. As a *techne*, the Therapeutic Partnership redefines what it means to practice the medical art, and does so in a way that aligns providers with their self-identification as healers and with the healing arts. As a result of this method, FM providers stated that they feel less burnout, more clinical joy, and improved patient-provider relations and communication.

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[1] In 2019, the Institute for Functional Medicine reported that more than 1,000 providers were IFM-certified (The Institute for Functional Medicine, 2019). Additionally, in 2021 276 providers attained IFM certification, and in 2022 the IFM expects to certify around 700 providers (Today.com, 2022).

[2] Although the focus of FM often trends toward helping persons with chronic illness, this does not mean that only the chronically ill can seek out such providers. The Institute for Functional Medicine states that FM helps to discover and treat the root causes of all diseases, not just chronic diseases (The Institute for Functional Medicine, 2021c).

[3] The PROMIS global physical health scale questionnaire is a survey that uses patients' self-reporting in areas including: overall health, quality of life, physical health, mental health, relationships, and social roles and activities.

[4] There is currently only one official accrediting body for Functional Medicine providers and it is called the "Institute for Functional Medicine."

CHAPTER II

THEORETICAL PERSPECTIVES: TECHNE, RHETORIC, AND MEDICINE

"Life is short; art is long; opportunity fugitive; experience is delusive; judgment difficult."

–*The Aphorisms of Hippocrates* (1982, p.1)

In this chapter, I explore the concept of *techne*, the theory that informs my analysis of FM providers' experiences working in Therapeutic Partnerships. I specifically explore this theory through classical understandings, as these texts and conversations most explicitly illustrate the connections between rhetoric and medicine while providing a historical foundation for RHM work. As a framework, *techne* provides a theoretical understanding that helps to illustrate and understand the rhetorical values and actions at play in FM communication. These values and actions are what helped the providers in this study connect with what they call "the healing arts," bringing them professional joy and mitigating burnout, while also improving their relationships and communication with patients. Through *techne*, I am able to nuance the idea of medicine as an art by illustrating how rhetorical understanding and medical action are inextricably linked, an idea that notably manifests during patient-provider communication that follows FM's Therapeutic Partnership principles.

The parallels between the ancient debates of rhetoric and medicine as *technai* cannot be overstated enough. Knowledge of this cultural and intellectual parallel adds an important layer to the understanding of the history of rhetoric; it is also relevant to RHM scholarship because these ancient works illustrate how rhetoric helped to establish an understanding of the medical profession as we see it today. While nowadays the details may be different, these early works show the philosophical foundations that are essential to understanding the *techne* of medicine and call attention to a deeper history of RHM as a field. In these ancient debates, we find the

seeds of cultural meaning regarding what it means to be an art and how to express and perform that art; and by applying this historical understanding of *techne* to the Therapeutic Partnership, we are able to understand how FM aims to nuance and redefine the medical art through a rhetorical means.

Techne in RHM Studies

Having deep roots in both rhetoric and medicine, *techne* is a rhetorical concept that easily fits into the work of RHM scholars. Notable examples of RHM scholarship that incorporates this concept includes Lora Arduser's *Living Chronic: Agency and Expertise in the Rhetoric of Diabetes* (2017) and Jennifer Edwell, Sarah Ann Singer, and Jordynn Jack's "Healing Arts: Rhetorical Techne as Medical (Humanities) Intervention" (2018). In both of these examples, *techne* is primarily discussed through the perspective of patients and their lived bodily experiences. Also, in these texts there are slightly different perspectives about what is incorporated in a *techne*. For example, in Arduser's work, she described *techne* as separate from episteme, stating that *techne* "deals with things that change" and that episteme deals with certainties (p. 86). In my understanding, however, episteme is just one part of what makes up a techne. Our understandings converge in the idea that techne requires a rhetorical frame of mind to be implemented. Similarly, Edwell, Singer, and Jack (2018) defined medical *techne* as "a realm of knowledge that was contingent upon the specific context, patient, and symptoms, which a physician would consider in relation to their prior experiences to determine the most appropriate healing practice for each case" (p. 52). This definition aligns with the definition of *techne* presented by the providers in this study.

One way that *techne* can be understood through patient bodily knowledge. With patients, the reality of their disease/s often demand daily interventions and considerations, making their

bodily knowledge an essential component of their management. For Edwell, Singer, and Jack (2018), this *techne* is defined as health *techne.* They wrote,

> Our conception of health *techne* differs from formal medical *techne* in two key ways. First, health *techne* takes the individual patient's body and its social, material context as the primary focus, and assumes that patients (and caregivers) must fully negotiate these particularities and contingencies in applying medical knowledge. Conversely, medical techne originates from a medical authority, who possesses a body of knowledge and seeks to apply that abstracted knowledge to the individual patient. (53).

In this study, I build on these ideas by illustrating differences in how medical *techne* can be conceived. In the aforementioned works, medical *techne* originates from a medical authority. In FM medical *techne*, patients are a deeply embedded part of the process, and meaning originates not from one party, but from the work of both provider and patient. This understanding complicates and furthers understandings of *techne*, while also emphasizing how this approach can improve provider wellness and patient relations.

Techne

Techne (τέχνη) is a Greek word that can be translated as, "craft," "art," or "skill." In Ancient Greece, calling knowledge a *techne* legitimized it by suggesting that the knowledge could exercise a sense of control over its subject; this control was not thought as being ultimate, but rather containing profound influence. Furthermore, to call knowledge a *techne*, was to believe that the knowledge itself contained methodical reasoning and skills that could be used, taught, and furthered through study. A *techne* was thought to have three elements: *episteme* (scientific knowledge), *phronesis* (practical wisdom), and *sophia* (wisdom). Therefore, a *techne* becomes more than just a skill set, but contained the virtues and elements needed to earn cultural

respect for one's knowledge and skill set (Nussbaum, 2001, p. 95). In ancient Greece, there were two significant debates surrounding the idea of *techne*: one directed toward rhetoric, and another aimed towards medicine. While rhetoric and medicine are both regularly understood as arts in the contemporary world, this understanding was hotly contested by ancient thinkers. Rhetoric as a *techne* is debated because ancient thinkers believed calling an art a *techne* endows it with a sense of legitimization and professionalization. In ancient debates, the aims of rhetoric were seen as less than noble because of its political uses, thus, to call rhetoric a *techne* would legitimize its use regardless of moral aim. However, not all thinkers subscribed to the belief that rhetoric is not an art solely because of how it is used. This key point hints at how the definitions of *techne* varied from thinker to thinker, in ancient times as well as modern.

Interestingly, as this debate about rhetoric was going on, physicians (*iatros*) in the classical world found themselves also debating and defending their art as legitimate. Prior to Hippocratic thought, medicine often relied on magic and superstition; this cultural norm led critics to believe that when physicians used reasoning and their understanding of natural processes to achieve results, they simply had luck (*tuche*) and took credit for a healing that would have naturally occurred anyway. While the Hippocratics did not completely dissociate themselves with divine elements, they did seek reasoning that went beyond magic and luck. Ultimately, the Hippocratics believed that "health is not entirely up to the gods; humans must take responsibility and action as well" (Wickkiser, 2008, p. 33). Although these debates seem parallel, they often intersect and show an intricate connection between rhetoric and medicine.

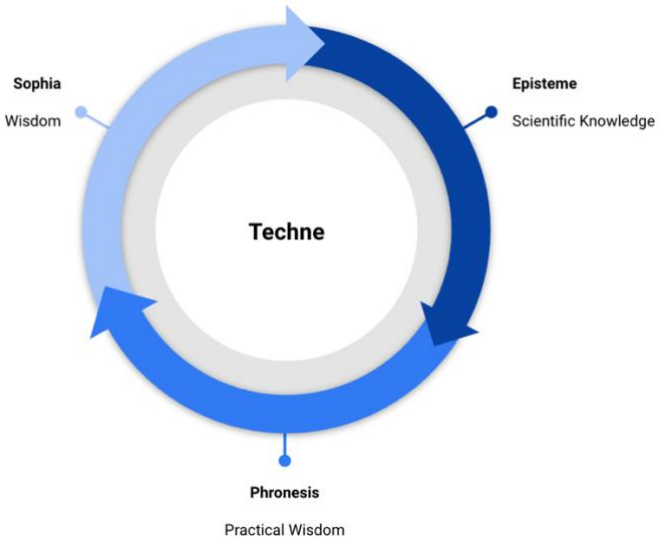

Figure 1 – Techne

The History of *Techne*

Techne has a long history in Greek culture and has uses that predate even the earliest Greek literature. The word first appears in Greek literature in book three of Homer's *Iliad.* In this passage, angered by his brother's cowardice, Hector rebukes his brother Paris, to which Paris states:

> Hector, seeing you have scolded me rightly, not beyond measure–
> still, your heart forever is weariless, like an axe-blade
> driven by a man's strength through the timber, one who, **well skilled (τέχνη)**,
> hews a piece for a ship, driven on by the force of a man's strength:
> Such is the heart in your breast, unshakeable: yet do not
> bring up against me the sweet favors of golden Aphrodite.
> (Homer, 2011, 3.59-64)

In this quote, I have bolded where *techne* appears; Homer uses *techne* to mean "well-skilled" in the arts of woodworking. This usage follows the preliterate definition and uses of the word, which specifically refer to someone who produces something from wood (Roochnik, 1996, p.19). As the Greek society and culture progressed, *techne* began to refer more generally to a craftsman (e.g. shoemaker, carpenter, smithing) but debates emerged regarding what constitutes a *techne*, especially as major thinkers and philosophers began to incorporate the word into their musings. Does it need to produce something? Must it be beneficial for society? Does it have a moral component? Must it be rational and teachable? At what point is a skill also an art? As thinkers began to question these elements of a *techne*, the path for a skill to become a *techne* became narrower and narrower.

Among the terms that began to complicate the cultural understanding of *techne* are *episteme* (scientific knowledge), *sophia* (wisdom), and *phronesis* (practical wisdom). While these words have their own complex history, throughout the chapter I will show how they helped to shape the varying understandings of *techne* and added meaningful layers to the word's use. As Jay Gordon (2002) states, the entering of these other elements meant that *techne* "could be used both abstractly for philosophical reflection on a given practice (e.g. is X a genuine *techne*?), and much more concretely as the name for handbooks containing rules and principles for guiding such practices (as in Aristotle's *On Rhetoric* (2007), the Greek title of which is *He Rhetorike Techne*)" (p. 147). Among ancient thinkers, one of the major areas of contention is what differentiates an art from mere skill. When considering this question, *episteme*, *sophia*, and *phronesis* all come into play. Scholars (Warnick 1989; Gordon 2002; Roochnik 1996; Nussbaum 1994, *The Therapy of Desire*) note that knowledge of guiding principles and ideals is what differentiates skill or imitation from a true art, which raises a question about the morals attached

to calling knowledge a *techne*. Should these guiding principles and ideals be connected with *sophia*? Also in question is whether or not a *techne* needs to promote virtue among men, especially given its relationship to *phronesis*. These parts of the debate are specifically where discussions about rhetoric become sticky, particularly because of its relationship with politics and the questionable practices of some sophists. Before moving into the relationship these debates have with medicine, we might first look at how rhetoric stood up to these philosophical tests.

Rhetoric as a *Techne*

The history of rhetoric in ancient Greece must begin with a discussion of the sophists, which was a group of itinerant teachers in the fifth and fourth centuries B.C.E. who would, for a fee, teach students a number of subjects, including philosophy and rhetoric and taught mainly by example and imitation (Kennedy, 1994, p. 19). They helped to expand literacy but are generally thought of as controversial because of their epistemological views. In general, the sophists argued that human knowledge relies on sense perception and that certainty and/or truth is inaccessible to humans (Bizzell, Herzberg, & Reames, 2020, p.22). This understanding of knowledge was seen as destabilizing and called into question how a society could sustain any kind of shared values and traditions that are typically seen as partly responsible for holding societies together. During the time, Athens was working under a radical democracy, which included *isegoria* (equal right to speech). As teachers of rhetoric, Sophists thrived in this radical democracy as many citizens saw their teachings as being politically useful. Thus, when the Assembly would meet, there could be up to 5,000 citizens in attendance, and because of *isegoria*, as long as a speaker could grab the attention of the audience, he was allowed to speak. This means that if a captivating speaker could sway the audience, he could have a direct impact on

policy decisions (Worthington, 2009, p.75). This made rhetoric as a *techne* incredibly important in order to have political influence. Rhetoric was seen as a powerful tool, yet as stated earlier, there was some moral ambivalence about its use. Citizens loved eloquent speeches, but they also feared its power, especially if this power moved people towards bad judgment (Ober, 2009, p. 188-189). The notable rhetorician Gorgias (2020) hints at this power in *The Encomium of Helen*, where he states that "the effect of speech upon the condition of the soul is comparable to the power of drugs over the nature of bodies" (p. 51). This ambivalent attitude towards rhetoric is clearly expressed in *Gorgias*, and Plato was not alone in his distrust. Part of the issue that made rhetoric so threatening was that the ancient Greeks believed that group wisdom and thought were trusted, so if a speaker went against group thought and persuaded people to decide against the group, the speaker was undermining a foundational belief in their political decision-making process.

Scholars of rhetoric are most familiar with the debate surrounding the legitimacy of rhetoric as an art through two Platonic texts that harshly denounce rhetoric; these two texts are *Gorgias* and *Phaedrus*. The general consensus in rhetorical studies is that Plato had a contentious relationship with rhetoric, because in his perspective, it lacked a virtuous element. It did not inherently promote wisdom and justice like philosophy did, so to call rhetoric an art called into question the validity of his own philosophical art. In *Gorgias*, a dialogue named after the notable rhetorician, we find a scathing attack on rhetoric that emerges as Socrates and Gorgias debate the merits of philosophical and rhetorical art. This dialogue characterizes rhetoric as a shameful craftiness that leads to only winning an argument, but not attaining or transmitting any "truth" (459C). And in *Gorgias*, we find the famous rhetoric and food analogy; Plato (1987) writes,

> …what cosmetics is to gymnastics, pastry baking is to medicine; or rather,

> like this: what cosmetics is to gymnastics, sophistry is to legislation, and
>
> what pastry baking is to medicine, oratory is to justice. (465C)

Plato's issue with rhetoric is that rhetoric was associated with empty persuasion, which did not necessarily align with good judgment. Rhetoric in this sense is related to the negative reputation of the sophists, who were believed to teach rhetoric for the sake of winning arguments, and at any cost. Thus, rhetoric is merely the semblance of wisdom and virtue, and has very little to do with the *sophia* the sophists' namesake claims to have. Isocrates, a sophist, openly refuted this position, writing that all of his work tends "toward virtue and justice" (Isocrates, *Antidosis*, p. 67). Ultimately, though, this attack on rhetoric "cast a long shadow in the history of the discipline" (Schiappa, 2017, p. 39), and is one that scholars in the history of rhetoric continue to discuss, especially when considering the merits and limits of a true *techne*.

In *Phaedrus*, we find a more accommodating Plato (1995), one who sees a path for rhetoric that aligns with his value system. In this dialogue, he presents a rhetorical battle on the nature of love and sex. Rhetoric is used to craft arguments that discuss the nature of sexual relationships with and without love, and instead of aiming for an agreed consensus, the dialogue is quite literally a game of rhetorical wit–who can deliver the better speech? And while it may seem that Plato is advocating for rhetoric in this dialogue, it comes down to the difference between a true rhetoric and a false rhetoric. False rhetoricians do not focus on "what is really just, but only what will seem just to the crowd who will act as judges. Nor again what is really good or noble, but only what will seem so. For that is what persuasion proceeds from, not truth" (260A). Furthermore, false rhetoric is not an art. To explain this point, Socrates makes an analogy of a man who knows musical skill but lacks harmony; he states,

> "[Artists] would react more like a musician confronted by a man

> who thought he had mastered harmony because he was able to produce the highest and lowest notes on his strings. The musician would say [...] what you know is what [is] necessary to learn before you study harmony, but not harmony itself" (268E).

In this passage, Plato (1995) marks a clear boundary for a proper *techne* and aligns it with "endless talk and ethereal speculation about nature" as well as a "lofty point of view and universal applicability" (270A). Despite these high standards, by the end of *Phaedrus* Plato does make room for a true, ethical rhetoric, provided that it is closely aligned with dialectic; in other words, true rhetoric is "best exemplified in the dialectic with which the philosopher persuades and ennobles the soul of his beloved" (Kennedy, 1994, p. 39). This true rhetoric is what separates rhetoric as a true *techne* from rhetoric as skill imitation, and the difference lies in the morality of the speaker's art.

Plato's belief that a true rhetorical *techne* contains a virtuous element is not challenged until Aristotle (2007) wrote *On Rhetoric*, where Aristotle defines rhetoric succinctly as "an ability, in each case, to see the available means of persuasion" (p. 37). Using this understanding of rhetoric renders it a *techne* that is neutral in terms of its moral character. While Aristotle did believe that rhetoric used logos, he believed that the product of rhetoric does not take away from the fact that it is an art. The art lies in its principles and processes, and, again, is not specific to the end product. This is not to say that Aristotle promoted unethical uses of rhetoric; he believed that rhetoric did rely on *logos* (logic), and for him, *logos* is a unique property of human beings. He writes "And it is a characteristic of man that he alone has any sense of good and evil, of just and unjust, and the like, and the association of living beings who have this sense makes a family and a state" (*Politics*, 1984, p. 1253a 15-18). Following this understanding, rhetoric then could

be seen as possibly containing virtue, however, this is not its art. Aristotle's definition of a rhetorical *techne* aligns more with modern interpretations of *techne*; take for example these two definitions by contemporary philosophers Martha Nussbaum and Brooke Holmes.

Martha Nussbaum (1994):

> A deliberate application of human intelligence to some part of the world, yielding some control over *tuche* [luck]; it is concerned with the management of need and with prediction and control concerning future contingencies. The person who lives by *techne* does not come to each new experience without foresight or resource. He possesses some sort of systematic grasp, some way of ordering the subject matter, that will take him to the new situation well prepared, removed, from blind dependence on what happens. (p. 95)

And Brooke Holmes' (2010) definition:

> a corpus of knowledge that enables our active intervention in the world to make it more amenable to our needs and desires, achieves predictable outcomes, explains why those outcomes occur or fail to occur, and may be communicated to others. (p. 25)

For these two scholars, a *techne* is reliant on having a systematic understanding that can be used and taught to others. This idea aligns with Aristotle's purpose in composing *On Rhetoric*, which essentially reads like a handbook of rhetorical principles and strategies. By writing such a text, he laid out "the principles of the art and render an account of it so that it could be studied systematically" and used to "achieve good for the state and its citizenry" (Warnick, 1989, p. 305).

Central to Aristotle's idea of rhetoric as a *techne* is its ability to be flexible to specific exigencies. This idea is present in his definition of rhetoric, as he states it is an ability to "see the available means of persuasion" (p. 37). Naturally, these available means will vary by situation and audience, and therein lies the *techne*. This idea aligns with his ethical philosophy that informs *On Rhetoric*. In *Nicomachean Ethics*, he writes that "virtue is an active condition that makes one apt at choosing, consisting in a mean condition in relation to us, which is determined by a proportion and by the means by which a person with practical judgment would determine it" (1107a). Thus, a *techne* is more defined by guiding principle than it is by its product. This idea was also explored by ancient medical writers when discussing the definition of a *techne*. Aristotle makes this connection between rhetoric and medicine by writing:

> The persuasive is persuasive to someone (and is either immediately plausible and believable in itself or seems to be shown by statements that are so), and since no art examines the particular–for example, the art of medicine does not specify what is healthful for Socrates or Callias but for persons of a certain sort (this is a matter of art, while particulars are limitless and not knowable)—neither does rhetoric theorize about each opinion [...] but about what seems true to people of a certain sort" (1.2.11).

This passage underscores the idea that for both the art of rhetoric and the art of medicine, its *techne* lies in its guiding principles that aim for what is plausible, not necessarily what may work in every situation. It is up to the rhetorician or physician to understand which principles make a positive outcome more likely. These Aristotelian ideas parallel the accusations and debates upon which medical writers founded their expositions.

Medicine as a *Techne*

In Ancient Greece, the title of physician (*iatros*) did not have the high standing it does today. They were more closely related to craftsmen and belonged to the lower social strata, especially because most physicians were itinerant. Interestingly, during the Roman Empire, most physicians were slaves (Carrick, 2001, p. 15). Medicine also had a remarkably close relationship with philosophy–James Longrigg (1998) even argues that philosophy was "directly responsible for the rise of rational [Hippocratic] medicine" (p. 2). This relationship between philosophy and medicine was largely because both arts had a common intellectual background, sharing the same general assumptions, concepts, categories, and modes of reasoning (Longrigg, 1998, p. 2). Also, medicine was often seen as paradigmatic to other arts. For example, Plato often referred to medicine, especially when considering the health of one's soul. Given these details about the rise of medicine, it seems ironic that the art had to defend itself at all. Nevertheless, there are two significant treatises in the Hippocratic Corpus that specifically aim to defend medical *techne*: *On Art* and *Ancient Medicine*. For the writers of these two treatises, their work centers around the critique that the art of medicine has no skill or guiding principles. The accusations they defended themselves against were the following: when patients receive medical care, they either 1) get lucky and find healing or 2) die anyway. Detractors believed that the so-called art of medicine had nothing to do with the patient's outcome (Jones, 1923, p. 186). Notably, these two treatises are both written in a sophistic style, and *The Art* is believed to have been written by a sophist (possibly Protagoras), which illustrates an early relationship between rhetoric and medicine (Jouanna and Allies, 2012, p. 4; Jones, 1923, p. 187).

The Art is a short treatise that provides an explicit defense of medicine as a *techne*. It begins with an attack on critics who deny the existence of an art for the sake of their own

virtuosity and for a "want of art" for themselves (p. 191). Thus, while the subject matter of *The Art* is clearly medicine, from the outset the author's opening lines suggest that to defend medicine is to defend any denounced art. And scholars argue that because the treatise was written by a sophist, it would not be a stretch to suggest the author was simultaneously making a claim for rhetoric itself (Roochnik, 1996, p. 56). This claim is noted by scholars particularly because the author of *The Art* often discusses the nature of a *techne* in general terms, with medicine being the example through which his arguments are filtered. For instance, the author writes that when patients are healed through the art of medicine, they are "freed from dependence on luck" (Hippocrates, 1923, p. 195). The author continues, "for in that [patients] committed themselves with confidence to the art, they thereby acknowledged also its reality, and when its work was accomplished they recognized its power" (Hippocrates, 1923, p. 195). In these lines, the author notes that the art of medicine does indeed have guiding principles which help to bring its power to fruition; luck is not a part of the *techne*, and more importantly, part of the *techne* lies in bringing both the physician's knowledge of the art and the patient's belief in the art to find healing (Bottalico et al., 2019, p. 3354). Just like in rhetoric, without an audience, a speaker cannot perform the art; in medicine, a physician cannot perform his art without a trusting patient. Both rhetoric and medicine contain *phronesis*, as such the human element of the *technai* (arts) cannot be denied but must be understood as essential to its performance.

However, entering human elements into a *techne* may yield unpredictable results–for rhetoric it may be an unpredictable audience, and for the physician it may be a wayward disease–and the author of *The Art* argues that one cannot judge the validity of art based on its outcome. He makes this statement when he defends the art of medicine even in the face of a patient for whom it did not help. He writes,

> For if a man demand from an art a power over what does not belong to the art, or from nature a power over what does not belong to nature, his ignorance is more allied to madness than to lack of knowledge. For in cases where we may have the mastery through the means afforded by a natural constitution or by an art, there we may be craftsmen, but nowhere else. (Hippocrates, 1923, p. 203)

All an art can do is improve the aim of the artist, but it cannot be universal in all forms and situations. Thus, an art cannot be defined by its outcomes but by the process. The idea that one cannot demand precision from an art harkens back to Aristotle's ideas in the *Nicomachean Ethics*, in book one, where he states that "there is not any good that is shared and comes under one form" (Aristotle, 2002, 1.6.23-24). The author of *Ancient Medicine* supports this point by stating that "perfectly exact truth is but rarely to be seen" (Hippocrates, 1923, p. 25). Hence, the idea here is that a *techne* is a flexible skill, like a rhetorician's ability to adjust his speech according to exigency, audience, and/or purpose. A physician, like a rhetorician, must have the "ability to see the available means" (Aristotle, 2007, p.37). This means while a *techne* can achieve a better aim, the limit of a *techne* lies in its ability to foretell an outcome with certainty.

As stated, Hippocratic medicine believed that diseases were caused by nature rather than the gods intervening in human affairs. Thus, "medicine was a matter of reason and understanding" (Arikha, 2007, p.7). And the *techne* arose out of a sympathetic concern and natural need to help "the sufferings of [...] ordinary folk when they are sick or in pain" (*Ancient Medicine*, 1923, p. 16-17). The author of *Ancient Medicine* states, there would have been no need for the art "if sick men had profited by the same mode of living and regimen as the food, drink, and mode of living of men in health" (p.17). Thus, despite the limitations of the *techne*, there is

still nobility in seeking an art for the aim of achieving a human good. Hippocratic physicians acknowledged that the limits of their art was bound to the limits of their knowledge (*Ancient Medicine*, 1923, 27). However, knowing that their art contained methodical research and understandings, these ancient physicians, much like today's physicians, know that that their art is built upon continuous discovery and that with each discovery, the limits of *techne* slowly edge outwards.

Modern understandings of medicine have swayed between imbalances of episteme, sophia, and phronesis; however, in the medical field there is now a trend to find balance between these three elements in order to redefine medicine as an art instead of a hard science. This effort is seen through the concepts of patient-centered medicine and narrative medicine, which are analogous concepts to the Therapeutic Partnership. In FM methodology, *episteme, sophia,* and *phronesis* are brought into balance through the Therapeutic Partnership, which is often touted as the most critical element of FM *techne*. As such, FM leaders lean on specific tools to teach and encourage Therapeutic Partnerships, and these tools illustrate that FM *techne* aims to blend knowledge (more widely defined) with the practical application of that knowledge in order to achieve whole health goals.

Chapter Summary and Takeaways

In this chapter, I explored the rhetorical concept of *techne*, focusing on its classical understandings and significance. Leaning on ancient texts, I consider how the concept of *techne* and its elements (*episteme*, *sophia*, and *phronesis*) are culturally debated through the lenses of rhetoric and medicine. Using texts from philosophers, sophists, and medical writers, I illustrate that these two fields parallel each other and also meaningfully intersect through the theory of *techne*. This intersection shows how rhetoric helps to establish an understanding and the

implementation of medicine as a *techne*. These conversations and understandings help to add to ongoing conversations in RHM regarding the role of *techne* for both providers and patients, and provides the means by which this study is contextualized, conducted, analyzed, and discussed.

CHAPTER III

LITERATURE REVIEW

Exigencies and Challenges

This chapter presents an overview of the exigencies, challenges, and scholarly conversations that surround this study of the Therapeutic Partnership. Beginning with research on medical provider burnout, I illustrate how burnout has affected provider wellness as well patient care, especially with respect to the patient-provider relationship and communication. Following these conversations, I illustrate the underlying and ever-present issues that lurk within patient-provider communication, showing how sociolinguists as well as RHM scholars consider these topics within their methodologies. Finally, I illustrate concepts that attempt to ameliorate these issues, namely, patient-centered care and narrative medicine. I present these concepts in theoretical form as well as how they are currently being conceived of and implemented in clinical settings. Overall, these conversations help to provide the informational and scholarly background needed to situate the current study in order to understand its impacts and contributions.

Medical Provider Burnout

Burnout research began with clinical psychologist Dr. Herbert Freudenberger, who volunteered at a drug addiction center in New York City during the 1970s. During his time at the clinic, he began to see the staff become emotionally depleted and begin to have accompanying physical and behavioral symptoms; borrowing the term from addiction slang, he called the phenomenon “burnout” (Heinemann and Heinemann, 2017; Reith, 2018). In this original 1974 article Dr. Freudenberger wrote that the physician symptoms are “easy to spot” (p. 160) and include exhaustion, fatigue, being unable to shake a lingering cold, suffering from frequent

headaches and gastrointestinal disturbances, sleeplessness and shortness of breath (p. 160). He describes the behavioral signs as the following:

> A staff member's quickness to anger and his instantaneous irritation and frustration responses are the signs. The burn-out candidate finds it just too difficult to hold in feelings. He cries too easily, the slightest pressure makes him feel overburdened and he yells and screams. With the ease of anger may come a suspicious attitude, a kind of suspicion and paranoia. The victim begins to feel that just about everyone is out to screw him, including other staff members. (p. 160)

Since Freudenberger's initial work on burnout, the study of it has moved beyond just the clinicians to incorporate teachers, social workers, and even those working in the financial sector (Heinemann and Heinemann, 2017). However, as an area of concern, medical provider burnout continues to elicit concerns and calls to action from major medical organizations and offices, such as the World Health Organization (WHO), the American Medical Association and the Surgeon General's offices. In 2019, the concern about the rising rates of provider burnout, which were hovering between 40-54% (NAM, 2019), led the World Health Organization to deem it a "syndrome" and added it to the International Classification of Diseases-11th Revision. It is defined as the following:

> Burnout is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterised by three dimensions: 1) feelings of energy depletion or exhaustion; 2) increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and 3) a sense of ineffectiveness and lack of accomplishment. Burn-out refers specifically to phenomena in the occupational

> context and should not be applied to describe experiences in other areas of life. (WHO, 2024)

For medical providers, burnout is the result of many factors, beginning with one's own workplace environment (e.g. lack of autonomy, limited time with patients), organizational concerns (e.g. disconnect between values and key decisions, lack of leadership support), systemic concerns (e.g. poor care coordination, burdensome administrative paperwork), and even societal and cultural issues (e.g. mental health stigmas, structural racism and health inequities) (Surgeon General's Advisory, 2022).

While there are many reasons for medical providers to feel burned out, administrative and bureaucratic tasks often remain high on the list of causal factors. In a 2023 Medscape survey of over 9,100 physicians, 61% of respondents said that "too many bureaucratic tasks" was one of the reasons for their burnout, topping the list of causal factors (Medscape, 2023). These tasks are often time consuming, and relate to systems that reward patient volume over quality care (Doggett, 2023); consequently, it results in limiting providers' ability to effectively address important areas, such as their patients' social determinants of health, which can help to contribute to a patient's well-being and security. As a result of these constraints, providers end up in a state of moral distress, where what they are doing and what they feel they should be doing are at odds (Surgeon General's Advisory, 2022).

How Burnout Affects Patient-Provider Relations and Communication

Moral distress is a significant concern when considering provider burnout, particularly because it can become an occupational hazard and reason for leaving the medical profession. It is believed to occur "when one has made a moral judgement but is unable to act upon it" (Morley et al., 2018). This dissonance can affect providers' perspective and attitude towards their work, which means it may affect the quality of care a patient receives. The ways that moral distress can

manifest in clinical settings include: providing potentially harmful or futile treatment, pressure to act against ethical standards, and witnessing clinicians give false hope. This factor can lead to what NAM calls "degraded patient-provider relationships" (NAM, 2019, p. 96). These degraded patient-provider relationships may result in patient safety incidents and low satisfaction ratings from patients. Panagioti, Geraghty, and Johnson (2018) found that physicians with burnout are twice as likely to be involved in patient safety incidents, show low professionalism, and over two times more likely to receive low satisfaction ratings from patients (Panagioti, Geraghty, and Johnson, 2018). Furthermore, in the 2023 Medscape survey, physician respondents said that burnout affects patient care and interactions in the following ways: "I become easily exasperated," "I am less careful with patient notes," "I express my frustration," and "I make uncharacteristic errors" (Medscape, 2023). These strained patient relations exacerbate moral distress because they are at odds with why clinicians entered the healing professions, which is to have the "opportunity to attend to and ease individual suffering" (NAM, 2019, p. 96).

Other Factors Contributing to Issues in Medical Communication

While burnout is cited as a reason for affecting patient-provider interactions and talk, it is important to recognize that from a socio-cultural rhetorical perspective, burnout can also be seen as a symptom and not a cause for decreased satisfaction in provider-patient communication; and this is because provider burnout allows the factors that inherently complicate medical communication come to the forefront. Patient-provider communication is a multifaceted rhetorical situation, and RHM scholar Elizabeth L. Angeli describes this rhetorical situation as one that is unstable and unpredictable, with high-stakes rhetorical work in action; she likens it to other high-stakes communication environments such as firefighting, legal trials, and public health campaigns (Angeli, 2019). Part of what complicates this specific rhetorical situation are the hierarchical power dynamics to contend with, issues regarding how the concept of ethos

affects what is being said and how it is being said, and negotiations regarding medical epistemology and who can judge what is "truth." These issues in communication can be ultimately tied to the social and cultural institutions that often dictate norms and expectations to be followed, which can lead to perceived rhetorical constraints and affordances. This "institutional talk" can be defined as,

> a reduction in the range of interactional practice deployed by the participants, restrictions in the contexts they can be deployed in, and it frequently involves some specialization and respecification of the interactional relevance of the practices that remain (Heritage & Clayman, 2010, p. 17).

Institutions, thus, circumscribe communication to protect existing structures, which ultimately protect specific epistemologies. The medical institution is one of the most long-standing and powerful institutions in the contemporary US as well as globally, and its influence is captured in the social order and prescribed rules that dominate its discursive practices. Michel Foucault (1994) captured this idea in *Archeology of Knowledge*, writing that "this status of the doctor is generally a rather special one in all forms of society and civilization: he is hardly ever an undifferentiated or interchangeable person. Medical statements cannot come from anybody" (p. 51). As such, physician discourse is often taken as unquestionable, leaving a patient's health vulnerable to their interpretations, and essentially deeming their discourse as fact.

This positivism in medical discourse is illustrative of a dramatic paradigmatic shift that occurred in the 19th century. During this period, medical philosophies, theories, and practices moved towards what Foucault called a "positive science" (1994, p. xviii). As a result of this shift, doctors moved away from observing a patient to deciphering a disease—the difference lies in wanting to discover a "truth" versus being a careful observer of disease and working with nature to help the patient. Thus, the reward of the medical gaze became this "synthetic truth"

established by language (1994, p. 60). The days of carefully, patiently examining a patient were over; the infirm were soon herded into clinics, allowing doctors minimal time with each person, focusing mostly on deciphering instead of analysis. The result of this setup changed medical discourse entirely, turning patients into a collective group of organs that, theoretically, could be considered individually and apart from the patient sitting in the room. Foucault wrote that the question from doctors' mouths changed from "what's the matter with you?" to "where does it hurt?" (1994, p. xviii). What these questions reveal is the sometimes objectifying nature of the modern physician's gaze. Patients may become collections of organs that need fixing, not persons who need healing.

Patient-Provider Communication as an Object of Study

Patient-provider communication is more than a verbal exchange between two people, it is a relationship and an expression of what medical care is and should look like. While this talk may have an "everydayness" quality, for better or worse, its outcomes impact patient health. Researchers in a variety of disciplines agree that there are a number of significant socio-cultural factors that impact this topic. Among these factors are socio demographics, such as race and gender, as well as cultural mis/understandings. Unfortunately, recent studies have shown that patients' perception of communication with their providers is poor, and perceptions are even worse when discussing ethnic minorities and the chronically ill (Spooner et al., 2016; Hall et al., 2017; Haywood et al., 2014). The consequences of poor communication in medical spaces are too costly to ignore. The American Medical Association reported that the United States spent $4,255.1 billion in healthcare costs, with physician services making up a significant portion of that number–$633.4 million (American Medical Association, 2023). However, the aim of improving patient-provider communication is more than just addressing the rising numbers; it is important to remember that these numbers represent individual people with health concerns that

impact their lives and the lives of their families. The aim of improving patient-provider communication is an aim toward bettering patient health and enhancing quality of life. These goals connect medical practice with the idea of *techne* in that it considers medical knowledge beyond scientific knowledge and have a rhetorical foundation. As such, goals begin at the level of doctor-patient talk and in these often brief exchanges–the average length of a primary care office visit is 15 minutes (Tai-Seale, 2007, p.1871)—patients and doctors can set the scene for better rapport, treatment, and outcomes (Ainsworth-Vaughn, 1998, p.190). These positive outcomes are not just for the patient. Dr. Emily Aaronson states that better patient-physician communication "decreases the risk of medical error and increases clinicians' joy at work" (Berg, 2017). Improving patient outcomes *and* mitigating physician burnout is necessary if we are to improve our current medical system.

As more Americans become affected by health concerns, doctor-patient talk continues to grow as a topic of conversation, especially in online spaces. In digital spaces, such as blogs, private patient forums, and even individual clinic websites, there are numerous resources that provide help to people who may be struggling to speak with their providers (a Google search of "how to talk to your doctor" yields thousands of results). For example, Rachel Hill, a patient advocate, notes ways to improve communication during a medical visit, and includes some interesting suggestions, such as bringing another person with you to the appointment so that you can be taken more seriously and looking at providers in the eye when talking to them to express confidence (Hill, 2018). While this topic may now seem ubiquitous, the reality is that academic researchers have been at the forefront of the conversations surrounding doctor-patient talk since the 1960s (Heritage and Maynard, 2006, p.2). Most of the major studies in this area emerged around the 1980s and 1990s, including Elliot George Mishler's well-known book, *The Discourse*

of Medicine: Dialectics of Medical Interviews (1984) and Nancy Ainsworth-Vaughn's book, *Claiming Power in Doctor-Patient Talk* (1998). For the most part, the disciplines that have extensive research in this topic of inquiry are sociolinguistics and health communication. Scholars in these disciplines have created a valuable research corpus which works to highlight and improve some of the major issues in patient-provider communication by "scrutinizing language in use" (Harvey and Koteyko, 2013, p.2), which helps to expose beliefs and practices that we might take for granted or overlook. To support the current study, as well any future research in this area, this chapter will discuss how medical art became an object of study within the academy, and will conclude with a discussion of issues and trends relating to doctor-patient talk and relations; specifically, the concepts of patient-centered care and narrative medicine. As a whole, these conversations and concepts help to provide a framework for situating how Functional Medicine's "Therapeutic Partnership" functions as a *techne*.

Although rhetoric and medicine are often topics of historical and contemporary academic debate, the idea of specifically looking at patient-provider communication as an object of study did not appear until the 1980s. Patient-provider communication research first emerged in sociolinguistics and health communications, and to understand how RHM work in this area complements the existing corpus, it is necessary to understand these fields' approaches. Following a traditional introduction, methods, results, and discussion (IMRAD) structure, studies in these fields focus on what occurs in exchanges, and then translate the results into a general understanding about how this type of talk works. Two of the major findings in existing literature are that patient-provider conversations: 1) co-construct realities and 2) usually separate the life world from the medical world. These two approaches dominate both foundational and current

research and provide meaningful ways of understanding what typically occurs in these medical spaces.

Co-constructing Realities

The nature of patient-provider talk is generally viewed as having a power differential that rests on the hierarchical superiority of the physician. Physicians are seen as having the upper hand in the relationship due to not only their social position, but also because of their scientific knowledge. Typically perceived as experts, both physicians and patients often enter exchanges with this power balance in mind, and what tips the scale is knowledge. For researchers studying these interactions, this point cannot be overstated, as "the whole nature of the doctor-patient relationship and the healing process rests on the unequal power balance and asymmetry of knowledge between patient and doctor" (Lupton, 1994, p.59). In this context, knowledge refers more to scientific knowledge, and physicians are seen more as applied bio scientists whose job is to collect and analyze technical information elicited from patients; this type of communication approach downgrades patient-provider communication, turning the patient from a person into "a passive object responding to the stimuli of a physician's queries" (Mishler, 1984, p. 10). This understanding of patient-provider communication is the general perception that not just scholars, but also the general population has regarding these exchanges. However, sociolinguistics argue that we cannot take such understandings for granted, because their research shows that these exchanges do not simply reflect the social order/perception, they create it, and both parties are involved in the creation (Harvey and Koteyko, 2013; Heritage and Clayman, 2010; Sarangi and Roberts, 1999).

The idea of co-constructing realities is a theory sociolinguistics apply more generally to language use, and it is particularly prominent when discussing patient-provider communication.

Sociolinguistics state that "the wider social order is not a given but is actively produced [..] in any workplace setting, participants will constantly define and redefine the situation as part of an ongoing interaction" (Sarangi and Roberts, 1999, p. 2). Thus, the social order is either constantly reaffirmed or negated, depending on the linguistic choices of the participants. Applying this idea to a medical setting, John Heritage and Douglas Maynard (2006) state that "physician and patient–with various levels of mutual understanding, conflict, cooperation, authority, and subordination–jointly construct the medical visit as a real-time interactional product" (p. 1). Given the overarching perception of doctor-patient talk as inherently imbalanced, it is thus possible that many physicians and patients have fallen into a trap of believing *this is just how it is*. Two theories that help clarify this idea are the "Bucket" and the "Yellow Brick Road." In the theory of the bucket, the idea is that interaction accommodates itself to fit in the context as water would fit into a bucket. Hence, we shape our language and action to fit what we believe is socially acceptable or appropriate. In the Yellow Brick Road theory, the image is that of a road that materializes and forms as a person walks. In this understanding, "persons are continuously creating, maintaining, or altering the social circumstances in which they are placed" (Heritage and Clayman, 2010, p. 21). No matter how oppressed or predefined, people are able to create their own reality through their actions and choices. Through these two theories, language is shown as the force that either maintains or alters social realities.

There are some scholars whose work pushes back against the idea of an ever-present asymmetry by showing how patients actively deconstruct these socio-linguistic norms. One notable work in this area is Nancy Ainsworth-Vaughn's (1998) book *Claiming Power in Doctor-Patient Talk*, which illustrates how patients actively assert power when communicating with their doctor. Using an ethnographic discourse analysis approach, she states that her data of 101

encounters in a private practice shows patients were more active in claiming power and doctors were more willing to share power than compared to the findings of previous literature (p.7). One of the ways in which this power is asserted and balanced is through storytelling that allows patients to co-construct the social and medical realities. Through storytelling, patients not only experience a cathartic release, but they also begin to construct meaning that adjuncts the physician's own technical knowledge, empowering them through a deeper ontological connection with their disease. This idea connects with philosopher Annemarie Mol's (2002) idea that no object, body, or disease is singular; if it is not removed from the practices that sustain it, its reality is multiple (p.6). She writes, "ontologies are brought into being, sustained, or allowed to wither away in common day-to-day, sociomaterial practices [such as medical practice]" (p.6-7). Understood thus, disease realities are more than the interpretation of one person (i.e. a physician), and grasping its reality requires the participation of the patient as well. The typical asymmetry of patient-provider communication, then, defies the reality of the disease. Furthermore, Mol writes that ontology is to be thought of as a highly topical matter, in that it is informed by bodies, healthcare systems, disease symptoms, and technology (p.7); as such, the environment creates the disease realities, rendering its emergence and manifestation far from an objective truth to be sought.

Life World and Medical World

Another important understanding sociolinguistics and health communications researchers highlight in patient-provider communication is the difference between the life world and medical world. Typically, the life world of the patient is not a part of the clinical conversation, as it is perceived as time consuming and irrelevant. However, negating this part of the patient's disease experience ignores not just the ontological relevance of the patient's understanding, but also

creates barriers for a working relationship. Elliot G. Mishler (1984) writes, "[a] physician's effort to impose a technocratic consciousness, to dominate the voice of the lifeworld by the voice of medicine, seriously impairs and distorts essential requirements for mutual dialogue and human interaction" (p.127). Patient research supports Mishler's view; take for example Laura L. Ellingson and Patrice M. Buzzanell's (1999) study with breast cancer patients. In this study, the researchers found that patients wanted physicians to identify with and understand their lives, and that rather than being known as individuals, they wanted to "connect with their physicians as whole, situated, fully contextualized persons" (p.169). Although connecting with physicians on this level is related to a deeply human dynamic, it also relates to a general idea of respect. When physicians ignore the patient's life world, they also negate the idea that both patient and physician are experts: one in the life world and one in the medical world, and both knowledges are relevant to the clinical conversation. Mol (2002) presents another way of understanding this idea, writing that disease is what is happening inside the body and illness is the patient's interpretation of living with the disease: the feelings that accompany it and the life events it leads to (p.9). Thus, both patients and providers provide epistemological views that create a more complete picture of the disease.

Patient-Provider Communication in RHM

Patient-provider communication is a complex and dynamic experience, and, of course, is deeply rhetorical; as Gouge (2016) stated, "clinical encounters with patients are communication events that do not simply communicate knowledge; they generate knowledge. They are complex, layered, and interpretive critical processes for which the goal is to produce knowledge and make meaning, meaning that is impossible to make with the presence and knowledge of the physician alone" (p. 539). The rhetoricity of patient-provider communication thus makes its study a natural

fit for RHM scholarship, and, working alongside patients as well as providers, scholars have explored this topic through various avenues, such as stigma and agency, and the role of credibility and persuasion (Bennett 2009; 2019; Molloy, 2020; Gouge, 2016; Cook et al., 2021; Kessler 2022). Stigma is a well-explored topic in RHM scholarship, and scholars looked into how stigma affects both patients as well as providers. From a patient perspective, stigma is a noted issue that can negatively affect a patient's experience with a provider, and can present in a variety of forms. In Bennett's work, he explores stigma through the lens of queer communities donating blood (2009) and through patients managing diabetes (2019). In these studies, stigma is shown to affect what patients are asked by providers and even how they see themselves as they navigate their own health. For example, in Bennett's (2019) book, *Banning Queer Blood: Rhetorics of Citizenship, Contagion, and Resistance*, he addresses the concerns providers and health officials have surrounding queer communities donating blood. These communities, he argued, want to donate blood and participate as full members of their community, but the question: "have you, as a male, since 1977, even one time had sex with another male?" lead to assumptions about a person's lifestyle and health that essentially banish an entire community; this singular question prohibits this community from the performative act of "civic engagement and nation building" (2009, p.6) through stigmatizing inquiries.

Stigmas, which can be understood as "the product of rhetorical practices" (Kessler, 2022, p. 177) not only affect communities across racial, gender, and sexuality lines, but also affect entire disease communities. Persons with diabetes, for instance, often have to deal with the public perceptions and stigmas surrounding management rhetorics, and can be seen as entirely responsible for their condition and its management; these rhetorics can make management difficult given that diabetes treatment is not formulaic. As a result, Bennett wrote, patients may

feel shame when discussing their care with providers; and a nurse practitioner said that "the hardest part of her job was convincing patients that having atypical blood sugars did not make them bad people" (Bennett, 2019, p. 19). This example connects to Kessler's idea that when illness and/or disability cannot be cured or does not normalize, stigma can result (2022, p. 22). Through the lens of chronic illnesses, namely GI conditions, Kessler argued that the western medical model ultimately aims to "prevent, minimize, invisiblize, overcome, and ideally eradicate disease/disability" (p. 20); as such, individuals who do not fit this mold or outcome can face issues because their conditions do not fit the mold or expectations. Some rhetorical strategies that patients have used to advocate for themselves include using "strategic inquiry" through "high quality textual research" and "assigning a credibility proxy" (Molloy, 2020). Through textual research, Molloy wrote, patients "arm themselves with high-quality information prior to and after diagnoses are made such that they can recover from the misconception that many believe their care providers, at first, had of them" (p. 61). And by using a credibility proxy, which can take the form of having a person with established *ethos* vouch for you, patient-provider communication can be improved, lowering levels of stigma (Molloy, 2020). Stigma, however, is not a one way street, and reiterating Kessler's point, occurs as the result of rhetorical practices, which means both patients and providers need to be proactive in working to combat it. In order to support this work, Blake Scott and Catherine Gouge are starting to engage in work to create training materials to providers through graphic medicine to make them more aware about how stigma can manifest in clinical interaction (Cook et al., 2021; Rhetoricians of Health and Medicine, 2022; Rhetoric of Health and Medicine, 2023). The current study aims to add to this body of research by understanding how providers' exigencies and challenges underscore the need for improved communication, not just for the sake of the patient, but for the provider as well.

Patient-Centered Care

When thinking about FM's Therapeutic Partnership, a comparable, analogous approach that most conventional medical practices would be familiar with is "patient-centered care." This approach is often used to describe a methodology that aims to prioritize the patient by acknowledging his/her role in the clinical process. This means listening genuinely and empathetically to the patient's needs and concerns, but also recognizing the value of the patient's understanding and decision-making abilities when it comes to treatment. The goal with this approach is to destabilize extant cultural notions about power and control in clinical settings. As Moira Stewart and W.Wayne Weston (1995) state,

> The hierarchical notion of the professional being in charge and the patient being passive does not hold here. To be patient-centered, the practitioner must be able to empower the patient, to share the power in the relationship; this means renouncing control that traditionally has been in the hands of the professional. This is the moral imperative of patient-centered practice. (xvi)

Thus, a significant aspect of a patient-centered approach means that providers must recognize a patient's agency and cultivate an environment in which that agency can flourish. This approach defies a scientific, positivistic approach to medicine because it recognizes the intricacies of working with a person who needs more than just a treatment. Advocates of the patient-centered approach argue that patients need a trusted connection that allows them to recognize their own capabilities when it comes to disease treatment and management (Frampton et al., 2013; Oldenburg, 2016; Griskewicz, 2016). Simply put, "[patients] want to be the owner of their care, not just a by-product of it" (Frampton, et al., 2013, xxvi).

The historical roots of patient-centered care are often said to have begun as the brain-child of American psychologist Carl Rogers, who in the late 1940s and 1950s promoted his idea of "client-centered therapy" and the concept would eventually explode in the healthcare arena in the 1990s (Latimer et al., 2017; Jayadevappa and Chhatre, 2011). Rogers' client-centered therapy shares many key principles of contemporary patient-centered care; in particular, it asks the therapist to acknowledge the experience, strength, and capabilities of the client. Moving the role of the therapist from expert to a catalyst used to help the client discover these qualities in order to move his health forward. In a paper delivered at the Topeka Veteran's Hospital in 1946, Rogers stated that this approach is a "therapeutic process" that "releases the growth forces within the individual" (Rogers, 1946, 416). Key to this process is undermining the hierarchy culturally inscribed in healthcare. He writes,

> It seems to be genuinely disturbing to many professional people to entertain the thought that this client upon whom they have been exercising their professional skill actually knows more about his inner psychological self than they can possibly know, and that he possesses constructive strengths which make the constructive push by the therapist seem puny indeed by comparison. The willingness to fully accept this strength of the client […] is one of the ways in which client-centered therapy differs most sharply from other therapeutic approaches. (Rogers, 1946, 419)

Also key to client-centered therapy was to create an environment that allowed the client to express herself fully with warmth and understanding; this environment would thus lead to genuine, deep communication and understanding that would result in a more fruitful experience for both parties. For Rogers, this was one of the most important aspects of his approach. He

writes, “every little word is not so important if you have the correct accepting and permissive attitude toward the client” (420). Creating an environment of acceptance and respect is a key element of contemporary approaches to patient-centered care, and one that is crucial to FM’s Therapeutic Partnership.

Although Rogers was working within a mental health framework, health care policy makers took these ideals and placed them within the general healthcare system, and after a push for patients’ rights in the 1960s, this concept began to make waves in America (Nolte et al., 2020). It was not until the 1990s that patient-centered care would truly take off in the healthcare arena, with both healthcare policy leaders and physicians advocating for the approach. Its main opponent was medical practice that was divorced from the human experience, both for clinician and patient. And as physician Ian R. McWhinney (1995) penned, “one of medicine’s perennial moral problems—and one almost totally ignored by modern bioethics—is a failure to respond to suffering” (p. 10). With this problem in mind, the role of the physician becomes more than just an applied bio-scientist, she is a partner aiming to help and guide another fellow human being in need, and that requires more than textbook knowledge. “Our therapy is not divisible into biological, or psychological or social,” McWhinney expands, “It is all three together. We have switched out attention from the linear notions of cause and cure to the holistic notions of function, care, context, support, and healing” (p. 13-14). Healthcare policy leaders took these notions to heart and in the late 1990s and early 2000s, patient-centered care found its place firmly rooted (at least in policy, if not in action).

A notable landmark for patient-centered care came in 2001, when the Institute of Medicine, an authoritative independent organization, published a book length report that explicitly advocated for patient-centered care. The report, titled, *Crossing the Quality Chasm: A*

New Health System for the 21st Century, addressed issues in the quality of healthcare delivery. The report states, "quality problems are everywhere, affecting many patients. Between the health care we have and the care we should have lies not just a gap, but a chasm" (Institute of Medicine, 2001, p. 1). A major issue cited in the report deals exclusively with the chronically ill, particularly because their care requires an approach that is strikingly different from acute care (something American healthcare is often seen as doing well). Chronic conditions, the report states, are now the leading cause of illness, disability, and death; and they affect almost half of the U.S. population and account for the majority of health care expenditures (p. 3-4).

The approach the IOM's report advocates for is patient-centered medicine. Per the report, the defining elements of patient-centered medicine are:

1. Respect for patients' values, preferences, and expressed needs
2. Coordination and integration of care
3. Information, communication, and education
4. Physical comfort
5. Emotional support–relieving fear and anxiety
6. Involvement of family and friends. (p. 50-51)

While specific definitions for patient-centered care abound, varying from country and country and even clinic to clinic, the generally understanding is that care is rooted in and with the patient; as the report states: "the goal of patient-centeredness is to customize care to the specific needs and circumstances of each individual, that is, to modify care to respond to the person, not the person to the care" (p. 51).

Debra Roter, a notable scholar of patient-provider communication, studied the patient-centered care, specifically focusing on the communicative aspects of the approach. The focus of

her 2000 study was treatment decision-making, and in this study, she found that providers who were trained in the patient-centered approach were more likely to be emotionally supportive, ask open questions, ask patients' opinions, and be less verbally dominant (Roter, 2000, p. 23). Much like Rogers' envisioning for client-centered therapy, with these skills, Roter writes, physicians "provide an atmosphere in which confidence and competence is built, emotional support is given, and in which support for choice, control, and responsibility for health behaviour is recognized and reinforced" (p. 23). This atmosphere, she argues, provides the means by which patient follow-through on an action plan is more likely.

Roter's study also found that storytelling is vital to this approach, writing that it is "essential to being understood" (p. 21). These findings align with the existing literature on patient-centered care, which state that storytelling is part of what makes the connection between patient and provider therapeutic. For example, Oldenburg (2016) wrote,

> People are eager to tell their stories of health, illness, and recovery. Getting sick, whether with an acute, chronic, or terminal illness, forces people to take stock of who they are and how physical health factors into their sense of self. Telling the story helps people make sense of their illness, put it into context, and give it meaning. (p.3)

When patients are allowed to share their stories of illness, they are told that their understandings and experience matter not just for themselves, but to the future story of their treatment and healing. This perhaps unconscious realization, scholars state, can motivate patients to be highly activated, are happier with their care, and are less likely to have adverse health consequences (Oldenburg, 2016, p. 4). As Scott et al. (2008) state, the locus of healing is "neither in patient nor in healer, but rather in the space created by connections of the two" (p. 320). This liminal space

can be argued as being a rhetorical space that is afforded by the provider's values and ethics in clinical care. These values and ethics thus create a conscious approach to speaking with patients in a manner that develops human connection through hope, trust, and ultimately forming what scholars would call a "healing relationship" (Scott et al., 2008; Patterson, 2012).

While the term "patient-centered care" may be popular nowadays, the concept is not without its issues and controversies. One of the biggest issues that researchers note is the lack of a consistent definition, which inevitably means its application looks different from clinic to clinic or even provider to provider (Entwistle and Watt, 2013; Lusk and Fater, 2013). For example, Entwistle and Watt (2013) found eight different definitions for patient-centered care, and "each definition or characterization is also open to various interpretations, which can incorporate (often implicitly) a number of other concepts and assumptions" (p. 29). Ultimately, they stated, the main idea is that patients should be treated as persons, decentering the disease as the focal point in medical care. Also, a major part of patient-centered care is the idea of co-designing and managing care plans, which has been shown to improve health outcomes, quality of care, and patient safety (Santana et al., 2017). And while this idea of shared agency between provider and patient is foundationally the goal of patient-centered care, Gouge (2016) argues that biomedicine still focuses on patient compliance as a measure of success, seemingly going against the ethical values patient-centered care promotes, such as patients' needs and preferences. She wrote, "Some of the same texts that include patient-centered advice for medical communicators also cite compliance metrics as the best way to determine the most effective method of communication for individual patients" (p. 543). While the definitional issues have complicated patient-centered care, as a concept it holds steady in contemporary medical vernacular, and the idea has been

buttressed and nuanced through another health care delivery model that also aims to decenter disease and foreground patients: narrative medicine.

Narrative Medicine

In 1925, Virginia Woolf found herself ill, and in an attempt to make sense of her experience, penned the following words from her sickbed:

Incomprehensibility has an enormous power over us in illness, more legitimately perhaps than the upright will allow. In health meaning has encroached upon sound. Our intelligence domineers over our senses. But in illness, with the police off duty, we creep beneath some obscure poem by Mallarme, or Donne, some phrase in Latin or Greek, and the words give out their scent and distil their flavour, and then, if at least we grasp the meaning, it is all the richer for having come to us sensually first, by way of the palate and the nostrils, like some queer odour. Foreigners, to whom the tongue is strange, have us at a disadvantage. The Chinese must know the sound of *Antony and Cleopatra* than we do. (p. 21-22)

What she captures in these lines is what the ill, and especially the chronically ill, have known all along: the illness experience is one that is understood not through intellect, but through sense perception. In this space, the body is in power, following its own order, and often defying what we deem sensible and rational. Thus, for the person living this experience, it can often be hard to answer the question: “what brings you to the clinic today?” The answer to this question assumes a bodily logic is visible and, more importantly, comprehensible enough to be conveyed to another person. In this space, illness becomes not a line to be traced, but a story to be explored, a story whose logic and reason are trapped in the intensity of the patient’s sense experience. What then, is a well-intentioned provider to do? For the clinicians practicing narrative medicine, they would argue that the answer lies in the story itself; and the provider’s job to unlock healing by

enacting a therapeutic process that unburdens the patient while simultaneously teasing out its mysteries.

Narrative medicine advocate Rita Charon, an internist and professor of medicine, describes the practice of narrative medicine as one that defies the technocratic approach that dominates modern medical practice, and it does so by specifically relying on skills that are said to only have a home in the study of humanities: narrative skills. These narrative skills in medicine involve practicing medicine by "recognizing, absorbing, interpreting, and being moved by the stories of illness" (Charon, 2006, p. 4). By acknowledging the importance and utility of narrative skills in clinical settings, narrative medicine practitioners undermine the false belief that tools typically reserved for analyzing philosophy and literature have a place in the applied sciences. As Charon states,

> I came to understand that what my patients paid me to do was to listen expertly and attentively to extraordinarily complicated narratives—told in words, gestures, silences, tracings, images, laboratory test results, and changes in the body—and to cohere all these stories into something that made proverbial sense, enough sense, that is, on which to act. (Charon, 2006, p. 4)

Charon and other advocates for narrative medicine argue that practicing medicine is more than just discovering a treatment for a disease or symptom, it is a deeply human experience that understands medical practice as an art and that care and creativity is at its core. Medical encounters, Charon argues, "are not bureaucratic or technical encounters, but creative, singular, exposing human experiences" (Charon, 2013, p. 2). As a result, it is important for both patient and clinician to recognize the value of story within this encounter. For the patient, storytelling becomes a therapeutic space in which their frustration, confusion, and fears can be told without

fear of judgement, allowing herself to be unburdened of the weight that is an unresolved illness and possibly gain a valuable perspective (Egnew, 2018; Zaharias, 2018). For the provider, engaging in the patient narrative can help patients "refocus and reclaim important, meaningful, and generative aspects of their lives that foster growth through connection, transcendence, and healing" (Egnew, 2018, p. 160). This approach can help patients address the existential concerns of illness while also fostering a foundation for patient activation[1]—a major step in the healing process.

While many physicians may be in line with the intentions and goals of narrative medicine, its practical steps in the clinical setting may not be as obvious; however, it does come down to one simple understanding, and can be summed up by 19-century physician William Osler's famous words: "Listen to your patient. He is telling you the diagnosis."[2] Listening to the patient means more than just listening to the patient's response to a question, it means asking the right questions to elicit a meaningful narrative. Handbooks in narrative medicine approaches often state that the first step in enacting this approach is to ask open-ended questions and in a strategic way. Charon (2017) advises using an opening such as "I will be your doctor, and so I need to know a great deal about your body, your health, and your life. Please tell me what you think I should know about your situation" (p. 293). Another suggested way is to begin by taking a reverse patient history. Typically, medical students are taught to take a patient's history in the following order:

1)History of present complaint

2)Past medical history

3)Drug history and allergies

4)Family history

5)Social history

6)Systemic enquiry of systems (cardiovascular, respiratory, etc.)

7)Is there anything else we haven't covered? (Robertson and Clegg, 2017, p. 6-7)

Colin Robertson and Gareth Clegg suggest reversing this order and beginning with the family and social history. By showing interest in this part of the patient's life, "it conveys [the provider's] interest in the patient as an individual, fosters the doctor-patient relationship and the [provider's] understanding of their problem(s)" (p. 7). Complementary to this advice is using and interpreting body language; for the provider, this means being cognizant about how body language can either support or obstruct a patient telling her narrative. Environments should be noise and distraction-free (e.g. computer screens should not have the provider's attention). For the provider listening to the patient, body language should be seen as a part of the patient's narrative, placing careful attention to facial expressions and hand movements during certain parts of her story (Robertson and Clegg, 2017, p. 10). These details are considered the "close-reading" in narrative medicine, and contribute to the provider's understanding of the issues at-hand.

Two other major elements of practicing narrative medicine include not interrupting and examining one's own personal biases, expectations, and beliefs. The average doctor interrupts a patient after just 11 seconds (Phillips, Ospina, and Montori, 2019), which barely gives patients a chance to state their complaint(s), let alone any kind of revealing narrative. This tendency on the part of providers can possibly be attributed not just to a time constraint, but also a bias or the belief that they already know what is going on. Allan Peterkin, a M.D. practicing narrative medicine, writes that examining one's own assumptions and stereotypes can help break unhelpful narratives that hinder patient progress (Peterkin, 2012). Stereotypes, he writes, "are the unexamined stories we tell ourselves without realizing it" (p.63). Holding onto such beliefs,

especially as a provider, can prevent the patient from telling his story and filters the story through a lens that does not allow a therapeutic process to begin. As a whole, narrative medicine requires active participation from both patient and provider and works to actively subvert culturally held beliefs regarding what is “appropriate” for a medical visit and the roles of both patient and provider.

Narrative medicine is now recognized as being implemented more widely, but has a notable presence in medical education and burnout research, as it is seen as a tool that can serve to help cultivate empathy with patients while also mitigating provider burnout (Granat et al., 2023; Stumbar et al., 2020; Liao and Wang, 2023; Yuan et al., 2023); these two issues are notable concerns for the providers interviewed for this study, as well as the provider population in general. Narrative medicine is also being considered as a way to help providers with the secondary trauma and moral injury they might have experienced due to the COVID-19 pandemic (Low and Kowalsky, 2024; Association of American Medical Colleges, 2020). For example, one provider trained in narrative medicine said that “by releasing emotions through illness narratives, I come to understand that life, death, illness, and aging are part of the human experience and attempt to cope with them” (Liao and Wang, 2023, p. 12). In these settings, narrative medicine can take the form of reading and sharing a poem, prose, or visual image and then writing and sharing reflections with one another. This practice can “preserve empathy, enhance self-awareness and perspective taking, increase emotional regulation, facilitate grief processing, support trauma- informed care, and encourage teamwork” (Low and Kowalsky, 2024, p. 3), all of which can support providers who are experiencing burnout. With respect to cultivating empathy and language awareness, researchers note that medical students and providers who are trained in narrative medicine are generally able to connect better with their patients and become more

mindful of how they communicate with them. One study noted a "higher level of awareness at the bedside that corresponded with a more contemplative stage characterized by increased self-reflection and introspection with regards to their own language choice" (Collier, Gupta, and Vinson, 2022, p.4). This higher level of awareness meant actively choosing language that defied stereotypes and stigmas, and focusing on more compassionate language. As a tool, narrative medicine techniques are embedded in the Therapeutic Partnership and FM methodology, by foregrounding the patients' narratives and asking the provider to reflect on these narratives through a partnership that empowers both parties, ultimately supporting both provider and patient in a way that unites medicine with its most human elements.

Chapter Summary and Takeaways

The literature and concepts explored in this chapter present a number of the issues facing providers today, especially as they deal with unforeseen levels of burnout that exacerbate existing factors that complicate the patient-provider relationship and communication. Yet, what we can take away from this exploration is the knowledge that for millenia, the debate around what makes good medicine, for both provider and patient, circles back to Osler's observation that patients partly hold the key to unlock their potential for healing; thus meaning that in the rhetorical situation of a clinical encounter, a patient's agential power and epistemology are critical to re-establishing health. Contemporary studies in medical communication illustrate the consequences of downplaying the role of the patient, indicating that the socially-constructed hierarchy between patients and providers can hinder progress, burdening the provider who is expected to have all the answers, serving to exacerbate burnout and poor patient relations. Both patient-centered care and narrative medicine work to address the concerns of a non-rhetorical, technocratic approach to medicine, and Functional Medicine's Therapeutic Partnership folds

neatly into this conversation as it contains elements of these two approaches. As an intervention, the Therapeutic Partnership provides both patients and providers with an alternative approach that acknowledges medicine as a deeply human, rhetorical act.

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[1] Medical literature often refers to a patient following a treatment plan and/or provider recommendations as "patient adherence" or "treatment adherence." In line with the philosophy and values promoted by patient-centered medicine, narrative medicine, and, of course, Functional Medicine, I have chosen to use the term "clinical activation" as it moves away from the paternalistic language and attitudes often used in medicine. By "activation" I mean to express ideas similar to "adherence," but without the agency-stripping language. An activated patient is a patient who is motivated to act on treatment plans and recommendations via an intrinsic motivation to regain her health while being supported by a provider-partner.

[2] Although there is debate about whether or not Osler actually stated these words, medical literature often ascribes these words to him (Aronson, 2022).

CHAPTER IV

METHODOLOGY

This empirical study in rhetoric uses a constructivist grounded theory methodology to generate data that can illuminate a deeper understanding of the Therapeutic Partnership by illustrating how it demonstrates a *techne*. Essential to grounded theory methodology is the idea of listening for emergent insights into how the Therapeutic Partnership affects providers' rhetorical philosophies and practices, so that the knowledge created might aid in ameliorative new theories about patient-provider communication. This methodology was adopted because this study is deeply situated in its "social, historical, local, and interactional contexts" (Charmaz and Thornberg, 2021, p. 315). Given my intimate connection to Functional Medicine as a patient working within this medical space for many years, my positionality as a researcher cannot be understated. Furthermore, my understanding of medical communication contexts and rhetorical theory places my perceptions and understandings alongside the collected data. Combined, these elements affect how the research was conducted as well as my emergent insights. This context does not hinder the quality or validity of the research, it simply acknowledges the tools being used to create constant comparisons that result in the emergent insights. Grounded theory and its forms have been used by RHM scholars to explore topics such as patient credibility and Latinx experiences navigating medical systems (Molloy 2020; Pigozzi 2018). In Cathryn Molloy's (2020) study, she states that she uses aspects of grounded theory when studying patient credibility because her study is rooted in the interviews, observations, and archival materials from which the insights emerged (p. 16). And in Laura Maria Pigozzi's study (2018) on informed consent in clinical trials within Latino communities with little to no English ability, she stated that she used constructivist grounded theory because her research was a form of participatory

research and required the shared experiences and relationships of the researcher and the participants (p. 201). Like in Pigozzi's study, the interviewed providers and I often connected through our shared experiences in the Functional Medicine space, me as a patient and them as a provider. Additionally, constructivist grounded theory is popular with health-care related experiences, as it acknowledges the socio-cultural context of illness and medical care constructs (Wang, Zhang, Zhou, 2023; McKinlay and Donnelly, 2014; Varpio, et al, 2006; Scheffels, 2009). Because patient-provider communication is such a well-researched topic in the academy, a constructivist grounded theory approach also helps to recognize how the Therapeutic Partnership differentiates itself, avoiding replication of what has already been said and understood. Specifically, in the interviews for this study I looked for key terms and language that took previously studied ideas but brought them to new light or a different angle of understanding, especially within the context of the Therapeutic Partnership illustrating a *techne*. In this sense, a constructivist grounded theory approach helps foreground the participants' voices, but also allowing the possibility for new insights to emerge.

Grounded Theory

In 1967, sociologists Barney G. Glaser and Anselm L. Strauss published *The Discovery of Grounded Theory: Strategies for Qualitative Research*. This book proposed a new methodology for legitimizing the work of qualitative researchers, work which often came under scrutiny by quantitative researchers for being "impressionistic, anecdotal, unsystematic, and biased" (Charmaz, 2014, p.6). In defense, Glaser and Strauss (2017) argued that "there is no clash between the purposes and capacities of qualitative and quantitative data" (p. 17); rather, "each form of data is useful for both verification and generation of theory" (p.17-18). The key to

grounded theory methodology is that the work is systematized and logical, and therefore, an appropriate way to generate theory. The essential components of grounded theory include:

· Simultaneous involvement in data collection and analysis

· Constructing analytic codes and categories from data, not from preconceived logically deduced hypotheses

· Using the constant comparison method, which involves making comparisons during each stage of the analysis

· Advancing theory development during each step of data collection and analysis

· Memo-writing to elaborate categories, specify their properties, define relationships between categories, and identify gaps

· Sampling aimed toward theory construction (theoretical sampling), not for population representativeness

· Conducting the literature review after developing an independent analysis (Charmaz, 2014, p.7-8)

These strategies aimed for an approach to qualitative research that emphasized positivistic research, and today, it is used by quantitative researchers in mixed-methods studies (Charmaz, 2014).

In the 1990s, constructivist grounded theory emerged as a branch of grounded theory methodology in order to further emphasize we do not live in an "objective external reality" nor that the researcher is a "passive, neutral observer" (Charmaz, 2014, p. 13). Kathy Charmaz (2014) explains:

> The research reality arises within a situation and includes what researchers and participants bring to it and do within it. Thus, relativism characterizes the

> research endeavors rather than our objective, unproblematic prescriptions and procedures. Research acts are not given; they are constructed. Viewing the research as constructed rather than discovered fosters researchers' reflexivity about their actions and decisions. (p. 13)

The way that I employed constructivist grounded theory when coding the data was by specifically looking for the ways that providers understood and implemented their medical *techne*; for example, I focused aspects such as how they work with patients and why they made certain rhetorical moves. This methodology allowed me to hold a wealth of context, both experiential and academic, upon which I could lean on when listening to the providers speak about their experiences. This context helped me locate areas where their philosophies, values, and tactics either mirrored or diverged from what I know about patient-provider communication and *techne*.

Methods

Research Questions

Born out the context of both my first-hand experiences and the literature review, the research questions for this study were the following:

1. How are FM providers trained to foster a therapeutic partnership?
2. How do FM providers understand and describe the concept of the therapeutic partnership? How do they believe it serves their practice?
3. In what ways can the therapeutic partnership (in theory and practice), as articulated by FM providers, provide affordances for a kind of persuasion that engages the patient as a central figure of agency, both in the experience and narrative of their illness, and in the interpretation and practices that treat it?

Study Design

This study uses intensive, semi-structured interviews alongside documentary research to explore the knowledge and perspective FM providers have regarding the Therapeutic Partnership, centering on how they believe this concept affects their views on their profession and their clinical practices, especially with respect to burnout and patient care. This focus also means seeking their perspectives about how they understand what the medical art is and its value, as seen through the lens of Therapeutic Partnerships. Using intensive, semi-structured interviews as a method is in line with previous studies on medical experiences (Rebman et al., 2017; Armentor, 2017; Sowinska and Czachowski, 2018; De León-Menjivar, 2021); while these studies are focused on patient populations, the method can also be useful to assess providers' impressions when implementing Therapeutic Partnerships. The main thematic questions I explored in the interviews include:

- Describe how you were trained to foster Therapeutic Partnerships. What were your initial reactions and perceptions about the idea? Was your training enough preparation to implement it in your practice?
- Describe your communication practices with the patients before learning about the therapeutic partnership. Do they differ now? If so, how?
- How did you begin cultivating Therapeutic Partnerships with patients? Did it come naturally to you and your patients or did you find difficulties?
- How do you elicit and utilize patient narratives in your practice? How do you assess them as part of your clinical practice?
- Has the Therapeutic Partnership changed how you perceive patients? If so, how? And in what ways?

- How do you assess your patients' responses when cultivating Therapeutic Partnerships?
- Do you believe therapeutic partnerships serve your practice well when working with patients? Why or why not?
- Has the concept of Therapeutic Partnerships changed how you understand and practice medicine? If so, how?

Participant Recruitment

After receiving IRB-approval in spring 2023, I reached out to The Institute for Functional Medicine (IFM) to both inform them my study had been approved as well as to ask for assistance with participant recruitment. IFM leaders assisted with recruitment by sending out mass emails to providers and then connecting me with each interested provider individually. I was only connected with those providers who explicitly stated interest in the study. Because the IFM's Annual International Conference was being held just a couple months after my initial contact with the interested providers, I thought that attending the conference in-person in Orlando, Florida would be an ample opportunity to both interview providers and find other interested parties through in-person snowball sampling. Between the providers I met with in-person and those I interviewed via Zoom, I had a total of 16 providers participate in the study. I had five male providers and 11 female providers. 12 of these providers were M.D.s, and I had one D.O, one chiropractor, one nurse practitioner, and one physician's assistant. The racial breakdown was the following: 12 were white, two were Asian, one was Black, and one was Hispanic. The participants in this study are certified through the IFM and actively seeing patients, and their experience in FM ranged from newly certified to a senior faculty member who has been working for The Institute for Functional Medicine since 2007. In line with Charmaz's (2014)

recommendations, recruitment stopped after 16 providers as emergent codes were saturated at this point.

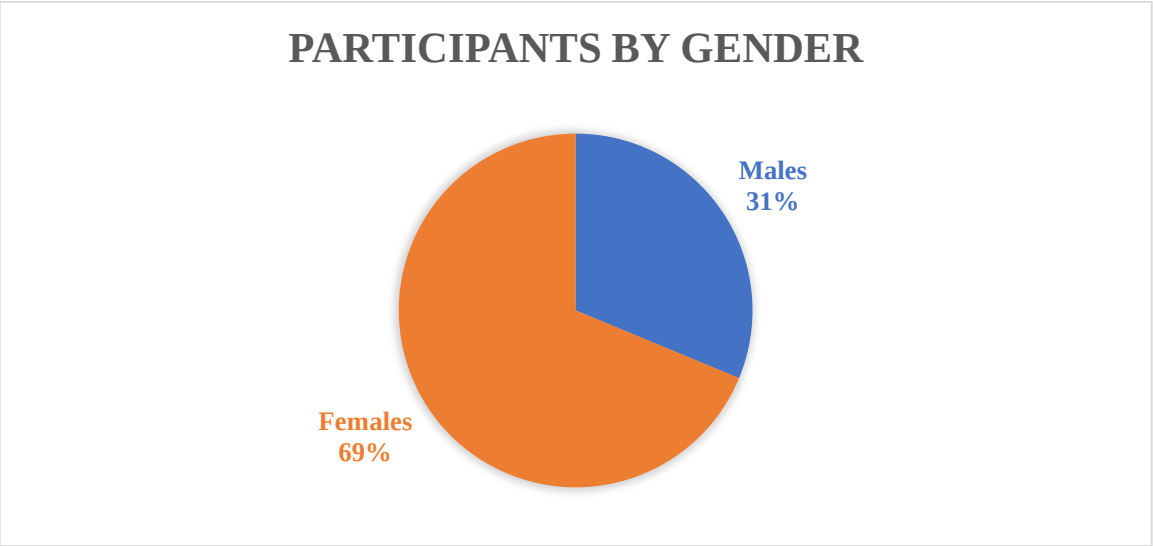

Figure 2 – Participants by Gender

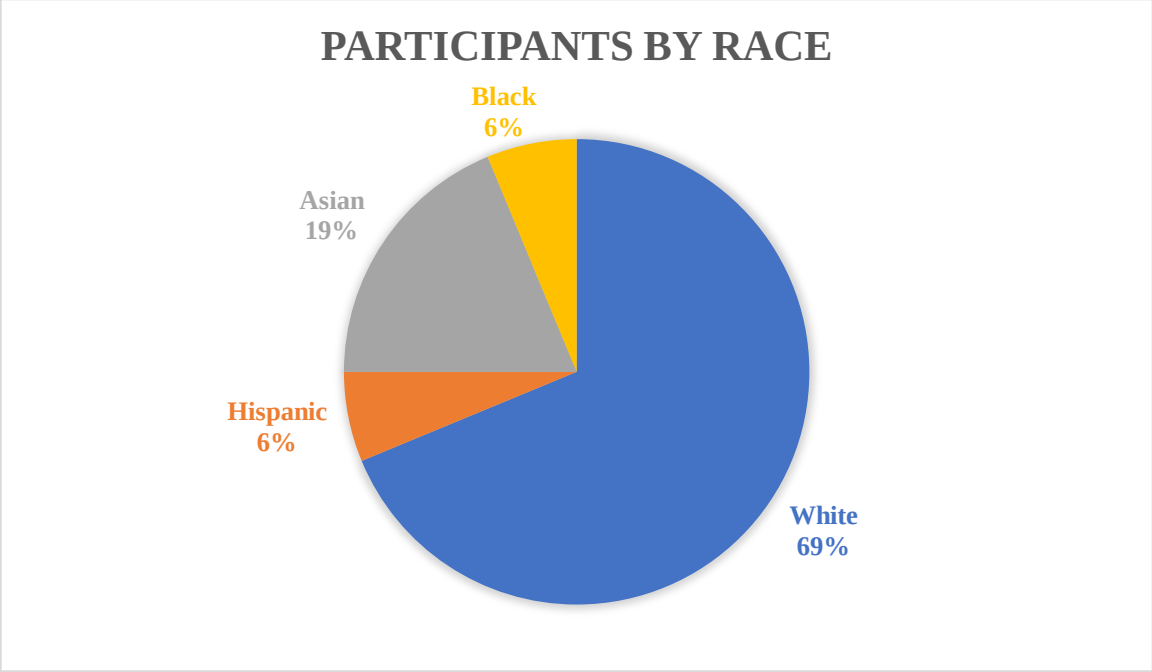

Figure 3 – Participants by Race

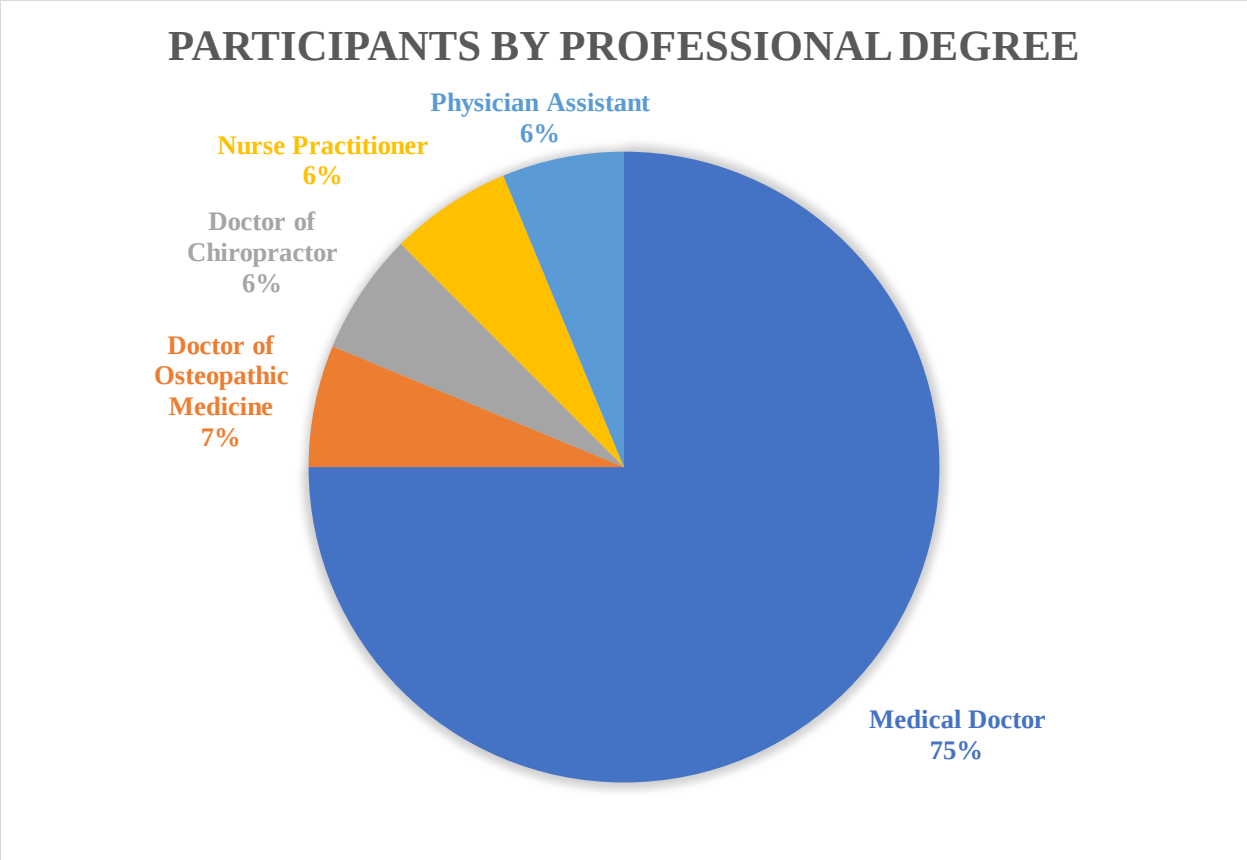

Figure 4 – Participants by Professional Degree

Data Collection

I attended the conference June 1-3, 2023, and connected with six providers to conduct in-person interviews. In line with grounded theory methods, I engaged in journaling and memo-writing to document my thoughts, connections, and experiences throughout the conference. In addition to using the conference to meet with providers, I took note of any documents or events that would add to my research. One notable find was a public board where providers were asked: "How do you hope your patients feel after meeting with you?" The responses (see figures 5-10), which were posted via Post-It notes on the board stated: "Heard," "Hopeful <3," "Hopeful! Excited! Ready!" and "Seen and heard."

I met with participants at the conference and used a voice recorder to record the interviews. We met in common areas throughout the hotel space and for the providers who did not attend the conference, we met on Zoom. Interview lengths ranged from 45 minutes to two hours. The interview questions aimed to get at an understanding of how providers conceive of their medical practice, focusing on the theoretical underpinnings of what makes medical practice a *techne*. During the interviews, following Charmaz's (2014) recommendations, I paid attention to language and discourse, encouraging participants to "reflect upon their experiences during the interview in fruitful ways for advancing theory construction" (p. 95). I paid attention to language and discourse by listening for noteworthy word choices that were expressed when the providers discussed working with patients and their perceptions of medical art. Often, the verbs and adjectives used to describe their experiences could be connected to a greater understanding about their value system in the medical space. For example, when I heard such language, I would ask providers to explain more about the way they chose to express their views.

Archival Data

The archival portion of my data collection included a database of training materials and videos aimed solely for FM providers as well as documents that explain FM ideologies and heuristics. The training videos I gained access to specifically dealt with the biopsychosocial aspects of FM methodology, including topics within patient-provider communication. These topics included: the social determinants of health, how to create an "environment of insight," and of course, how to create and implement Therapeutic Partnerships. I used these videos to provide me appropriate context when discussing FM methodology with the providers. I also obtained documents and tools, such as the FM Timeline and Matrix, which helped to tangibly illustrate

how FM concepts are employed. I used these tools to ask providers deeper questions about how they use them and their value to Therapeutic Partnerships.

Study Limitations

Major study limitations are sample size as well as that this participant pool includes self-selected providers who entered the study with the idea that conventional medical paradigms and norms need to be either changed or built upon. Additionally, there is a gender disparity in the participant pool, with more than half of my participants being female providers.

Coding and Analysis

Grounded theory calls for constant comparisons, which means that researchers are actively analyzing and coding during every stage of the research process. Through these constant comparisons, which includes studying data, comparing them, and writing memos, I was able to "define ideas that best fit and interpret the data" (Charmaz, 2014, p.4), locating emergent codes that I would use to refine each subsequent interview. Coding began with the initial codes I noted in my memos and journals, giving special consideration to how the Therapeutic Partnership illustrates medical *techne* in theory and practice; then after the interviews were transcribed and anonymized, I proceeded to do another round of coding using the printed transcripts and journaling. As I read each transcript, I highlighted and annotated insights, then I proceeded to write a memo for each transcript, noting the emergent codes and comparing them across the collected data. My second round of coding used NVivo, a popular software program used to code qualitative data. NVivo was chosen for the second round of coding to help validate the findings of the first round of coding more efficiently. I specifically leaned on the program for its ease of use, as data easily coded, sorted, and organized into organized files, making connections and findings easier to locate. Once the data was coded, I assigned the providers a pseudonym and

then organized and analyzed the emergent codes into themes that will be explored in the next chapter. This grounded theory analysis method helped me achieve a nuanced, insightful look into the Therapeutic Partnership. While this study ultimately sought providers' experiences working within Therapeutic Partnerships, one surprising finding that helped to shape the analysis was that the providers were keen to discuss and explain their experiences with burnout and how it shaped their perceptions, and ultimately, their move to Functional Medicine. Moving to FM and implementing Therapeutic Partnerships, they stated, helped to bring back their professional joy and alignment with their values as self-identified "healers" and practitioners of the "healing arts." This finding ended up helping to frame the study as a way to further understand the value of Therapeutic Partnerships and rhetorical awareness.

Table 1 – Coding Scheme

Coding Scheme
The Role of Rhetoric in Biopsychosocial Medicine
Patient Narrative
Teamwork
Cultural and Systemic Barriers to the Therapeutic Partnership
Healing versus Treating
The Therapeutic Partnership Provides Resistance Against Burnout

Chapter Summary and Takeaways

This chapter reviewed constructivist grounded theory, the methodological approach of this study. This methodology was chosen for its acknowledgements and incorporation of

important contextual factors, namely, researcher positionality, and experiential and academic knowledge of the topic. I also reviewed the methods of the study, which are primarily founded on semi-structured interviews with 16 FM providers. The interview questions aimed to get at an understanding of how providers conceive of their medical practice, focusing on the theoretical underpinnings of what makes medical practice a *techne*. Archival data adjuncts the interview data and consists of training documents and videos that help FM providers implement Therapeutic Partnerships. The data was coded twice, with special consideration to how the Therapeutic Partnership illustrates medical *techne* in theory and practice. The codes resulted in emergent themes that help to demonstrate and explain how FM conceives of and implements its medical *techne*.

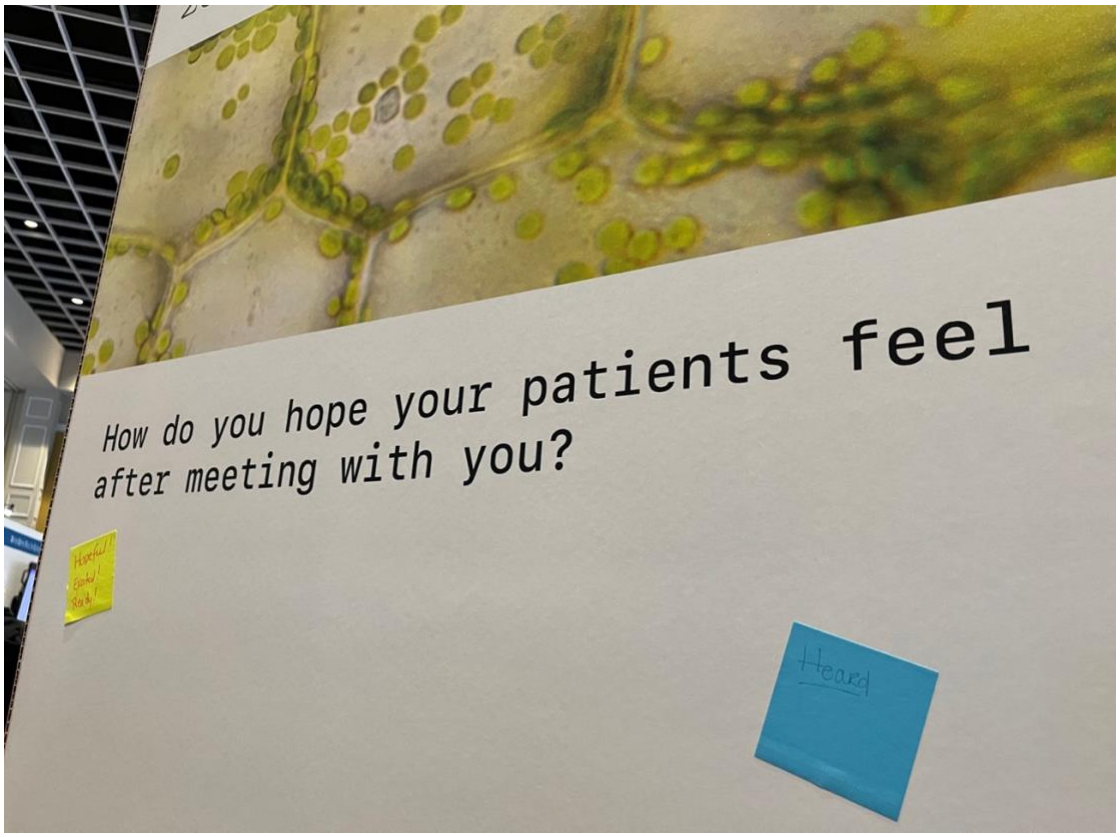

Figure 5 - Provider Question ("Photo taken by author")

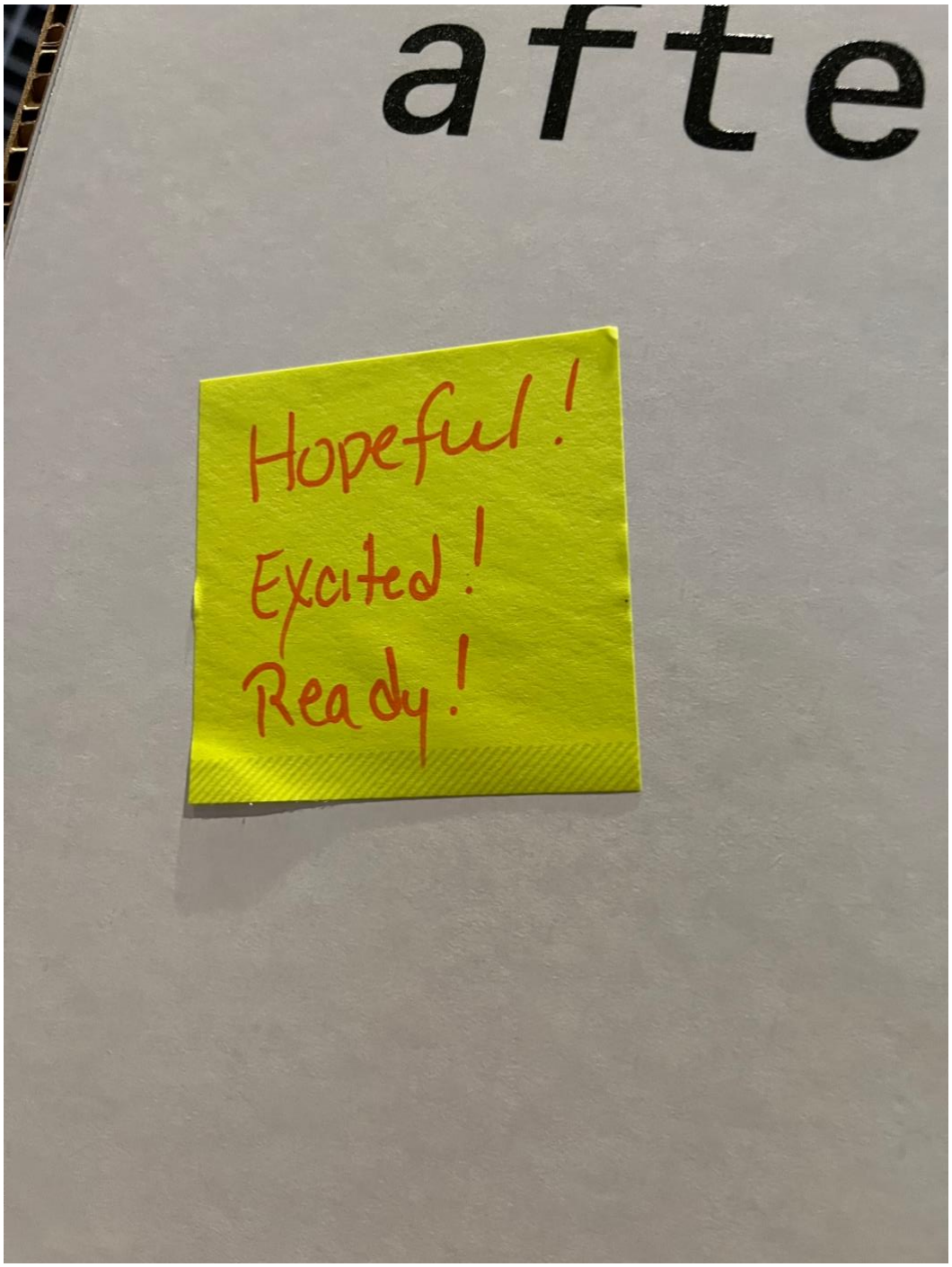

Figure 6 - Response 1 ("Photo taken by author")

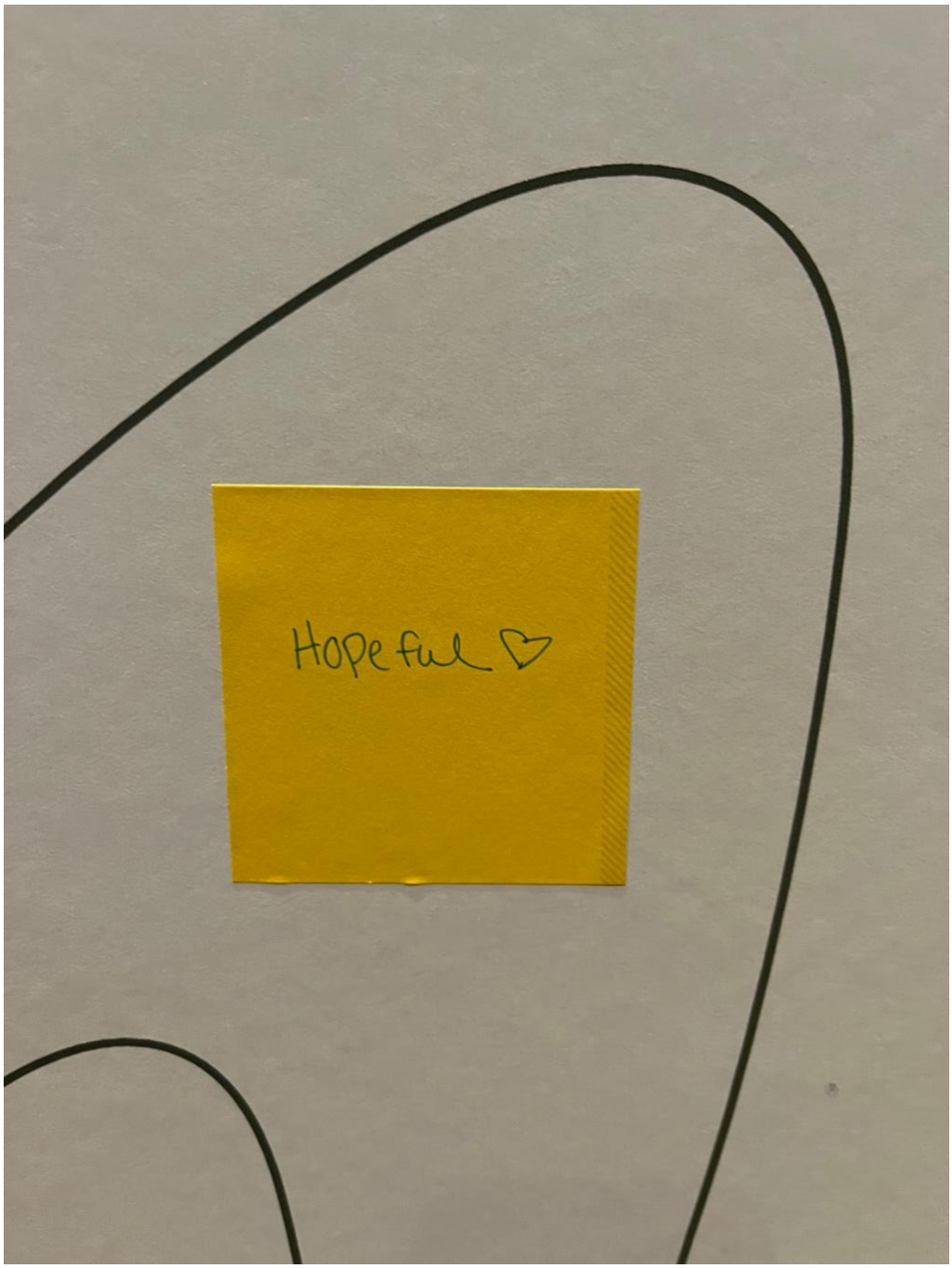

Figure 7 - Response 2 (“Photo taken by author”)

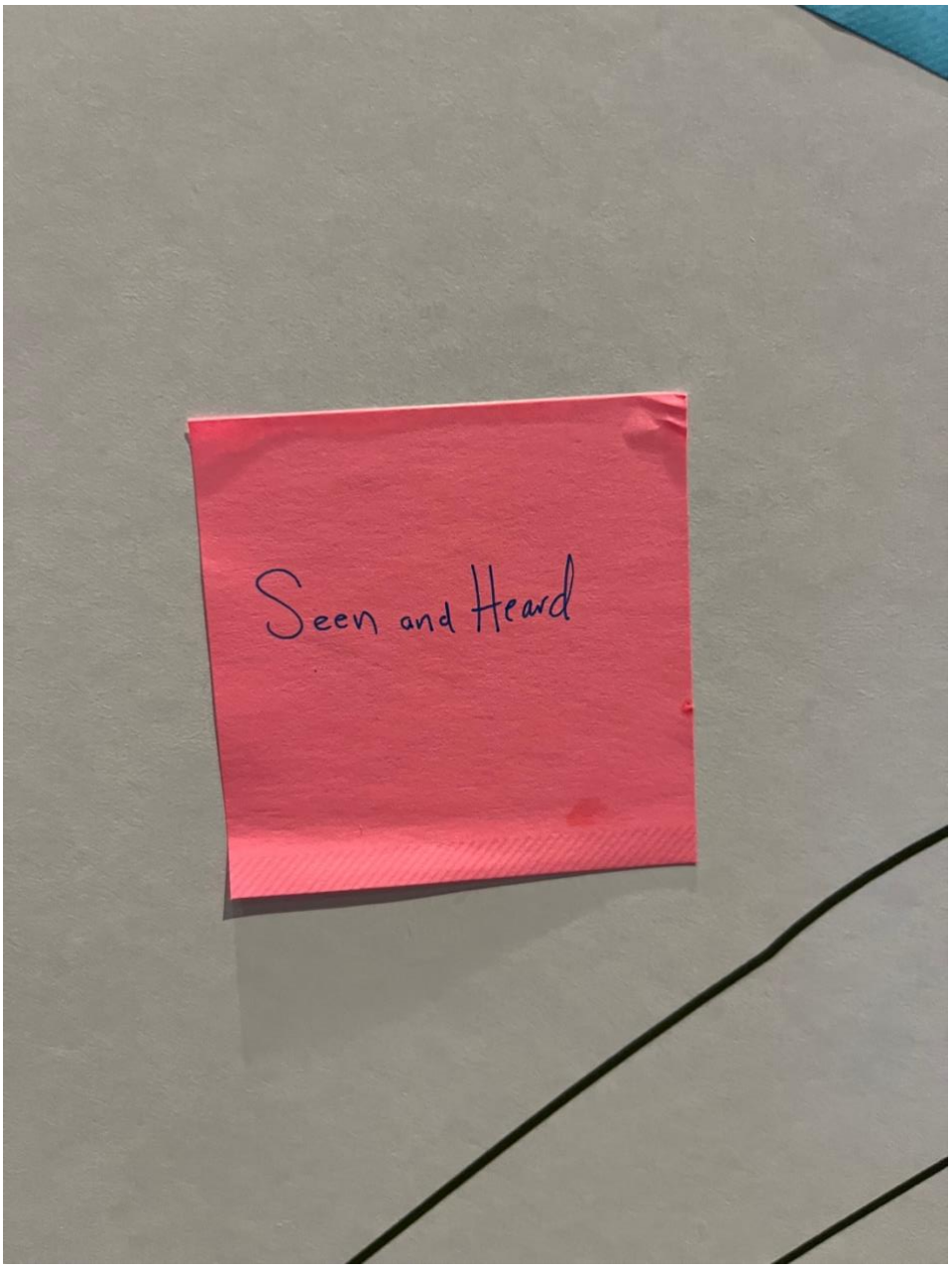

Figure 8 - Response 3 ("Photo taken by author")

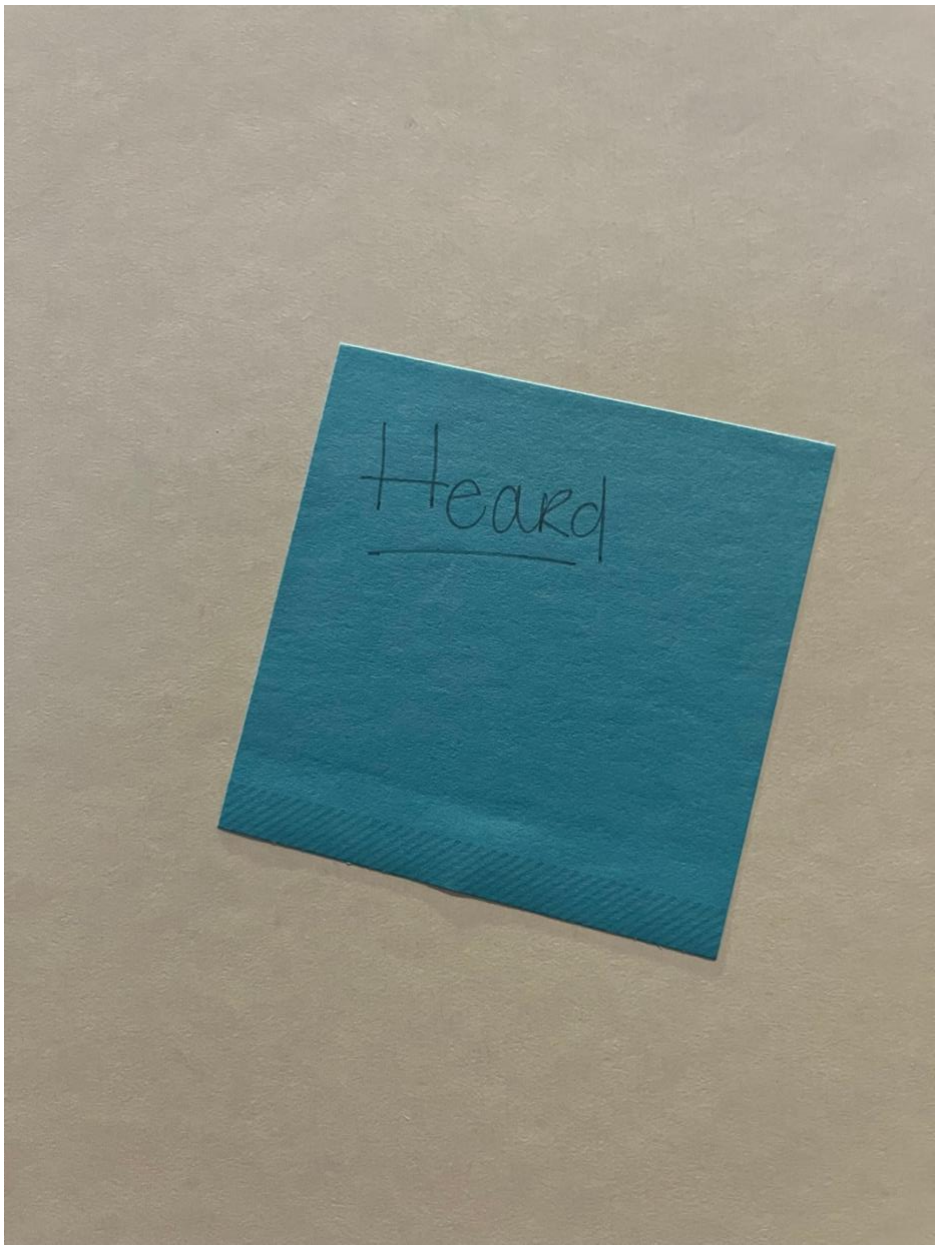

Figure 9 - Response 4 (“Photo taken by author”)

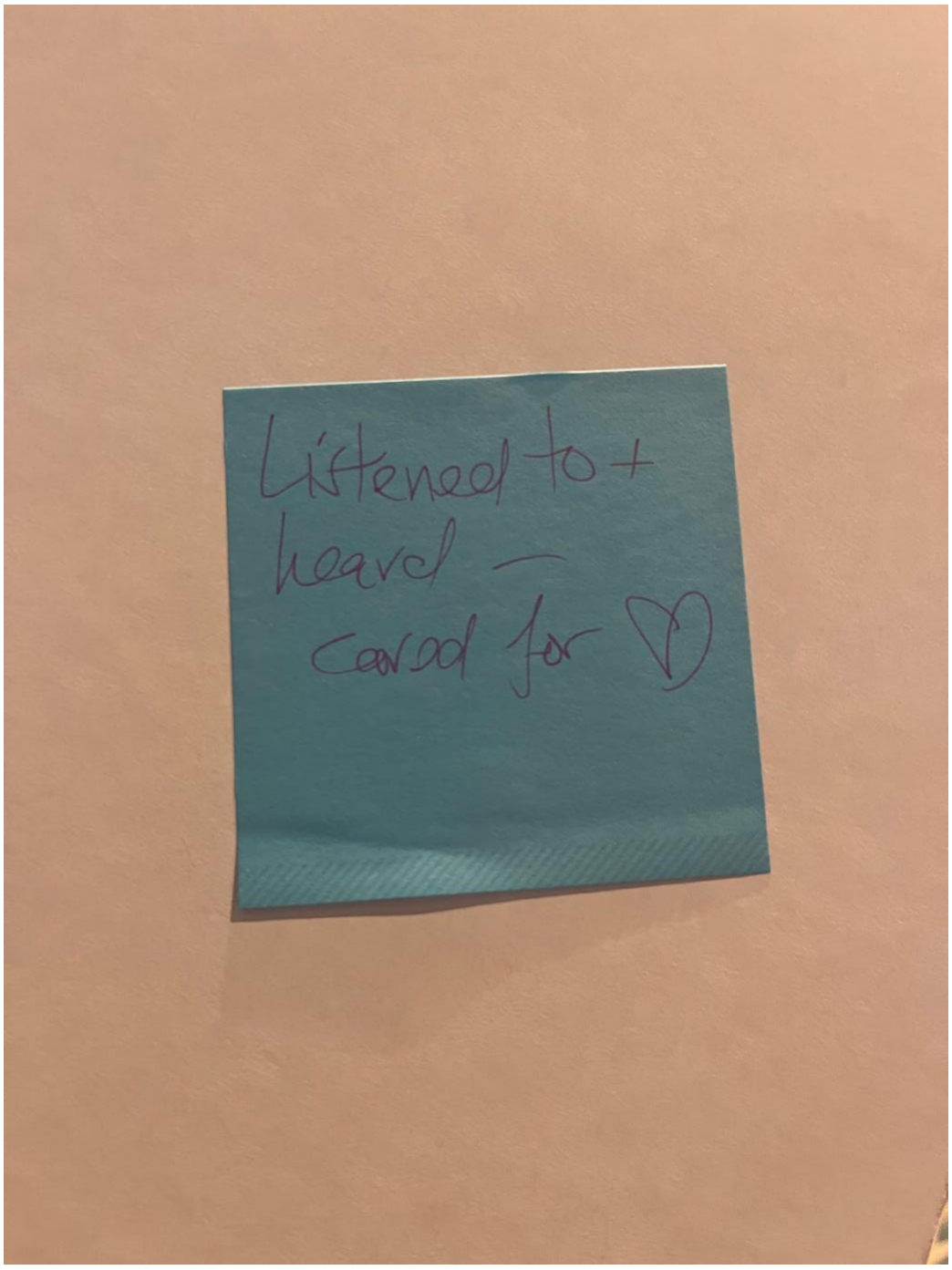

Figure 10 - Response 5 ("Photo taken by author")

CHAPTER V

RESULTS

One of Functional Medicine's main taglines is that it aims to discover the "root cause" of illness; this means that the goal when working with a provider becomes much more than a surface level conversation about symptoms. When aiming to discover the "root cause," there is an inherent understanding that the care a patient requires goes beyond the surface, and for FM providers, this is where medical practice turns into a *techne*. And as Dr. Brown states, "if you're going to help a human heal, it requires a much different story, it requires a much different intent." This intent to heal redefines the end of medicine in biopsychosocial terms, aiming for a wholeness that is physical, mental, and spiritual, and the process for that is through patient-provider teamwork and partnership, and notably healing applies not just to the patient but also to the provider. In FM, providers are encouraged to first take care of themselves in order to bring their best selves to their practice. The interviewed providers often self-identified as either being a "healer" or being a part of the "healing arts," and which for them meant practicing what they preach. These ideas are the major paradigm shift in FM *techne*, and it is why providers called their *techne* "an art based in science." With this different understanding of medical *techne* comes a different manifestation of clinical methodology, and for the providers in this study, it is encapsulated in the concept of the Therapeutic Partnership. Dr. Smith stated this point when she said in her interview, "although we might have great science behind things, unless people really feel engaged in the communication with their doctor, no matter what happens, no matter how great the technology, no matter how great the medication, they're never going to feel healed." Providers and the IFM archival data often noted that medical *techne* rests on what they considered the "art" of medicine: relating to and working with patients. Without this art, they

stated, the science loses its value: "…the tools without the art," stated Dr. Jones, "are kind of useless." In this study's data, the idea of creating a foundational relationship with patients is a prominent emergent theme, yet it is also noted that this relationship cannot occur unless the health and well-being of the provider is also prioritized. As FM providers reflected on their understanding of the Therapeutic Partnership, a number of elements that are foundational to this methodological approach with patients became apparent, and they related to caring for the physician and patient in order to enact a successful and fulfilling partnership with patients. These elements are:

- Actively and constantly caring for the self by creating appropriate boundaries and engaging in rejuvenating activities
- Being intentionally present with the patient
- Having clinical humility
- Foregrounding the patient's narrative
- Mirroring the patient's narrative
- Establishing a shared understanding and expressing empathy
- Working to establish hope
- Creating accountability and responsibility both for the patient and provider
- Creating an atmosphere of teamwork
- Creating an environment for healing and lasting wellness

In these elements, the building blocks of the Therapeutic Partnership are visible, and are what help create the dynamic that providers believe help patients regain and sustain their health and wellness, as well as what creates and maintains clinical curiosity and joy for the provider. In the

interviews, providers leaned on these 10 elements as they explained their views on the Therapeutic Partnership, and they will be detailed and expanded on in the following themes.

In addition to helping elucidate the building blocks of the Therapeutic Partnership, the interviews and archival data resulted in six emergent themes (listed in order of prominence): 1) the role of rhetoric in biopsychosocial medicine, 2) patient narrative, 3) teamwork, 4) cultural and systemic barriers to the Therapeutic Partnership, 5) healing versus treating, and 6) the Therapeutic Partnership provides resistance against provider burnout.

The Role of Rhetoric in Biopsychosocial Medicine

For the providers in this study, the emphasis on creating an artful practice was the most important element of their clinical methodology. As stated, this art is specifically manifested in how they speak, relate, and work with patients; thus, their understanding of the medical art is rhetorical. As Dr. Jones states, “there’s the practice of medicine, there’s the science, and there’s the art. And without the art, there’s no joy. And so how we relate to patients is the art, and it is profoundly important.” This theme was the most prominent code in the data, and it was coded 133 times, nearly double the times the other themes were coded. This high number of instances suggests that an awareness of rhetoric is foundational and integral to FM methodology. In this coding category, I specifically looked for language and terms that move medicine away from a scientific center and more towards a balance of communicative art and knowledge (both scientific and "non-scientific"). Examples of words in this coding category include “art,” “listening,” “communicate,” and “inspire.” In particular, I looked for language that decenters the disease in favor of the person and for the specific rhetorical moves that support this approach.

When describing the *techne* of Functional Medicine, providers often used their experiences in conventional medicine to illustrate their foundationally different approach. They

often praised conventional medicine for its acute care success, saying that it does a "great job;" but recognized that in chronic care settings, the outcomes are not as promising. "When you look at health care costs and outcomes," Dr. Smith said, "There's no doubt we're failing the chronic care patients." For the physicians in this study, they believe that chronic care needs a biopsychosocial approach that understands the root cause of disease in light of working with a "whole person" (mind, body, and spirit); as such, providers acknowledged that from the start of the relationship, communicative strategies need to be adjusted to help patients become invested and partner with their providers to make changes for their entire wellbeing. In order to achieve these goals, they stated a top-down approach does not work because patients need to develop a sense of agency in their own healthcare, and as Dr. Davis said, "it's such a different mental game." In conventional settings, providers often stated, the *techne* is different. They are, as Dr. Garcia stated: "taught to do something to somebody, but not to do something with somebody." This idea of working *with* somebody flips the culturally inherent hierarchy found in patient-provider communication—"You're flipping it from the doctor being the expert to the doctor partnering," Garcia stated.

FM is often called "lifestyle medicine" because of its biopsychosocial approach that aims to treat patients as whole persons and not just as people living with a disease. As seen in the FM Matrix, all aspects of the patient's whole life are important, not just the bothersome symptoms. This approach, providers stated, is what helps them achieve lasting wellness, and it also admittedly the hardest part of their *techne* because it requires big changes from their patients, and this is where their rhetorical art comes into play, providers stated. "We're prioritizing different information and literally having conversations that others don't get to have without this training and that […] comes across as us getting to a different shared understanding than you would

typically get, especially in a conventionally trained medical setting," Dr. Davis said. With a biopsychosocial model, what a patient thinks, how they exercise, what they eat, their sleep habits, their social life, and life stressors all become part of what goes into the care and support they receive from FM providers, and these factors are often some of the first items that are addressed. "There's all this foundational stuff down here," Dr. Williams said, referencing the personal lifestyle factors in the FM matrix, "and if you're not doing this, all the supplements in the world are just kind of a waste of time."

Key Rhetorical Strategies for Operationalizing FM Techne

In order to operationalize the foundational elements of FM *techne*, providers stated, patients need to feel hopeful, motivated, and responsible. For FM providers, this challenge can be particularly difficult because patients often come to their offices after many failed attempts to regain their health. And what providers described in their interviews are uniquely challenging rhetorical situations for both the patient and provider just in that first visit. However, all the providers stated that although FM *techne* does have ambitious goals, the strategies for achieving them with patients are uncomplicated and rely entirely on a conscious rhetorical approach. This method relies on shifting the ethos of the doctor, from expert to partner and even coach, which means that there is equitable agential power and responsibility in meeting health goals. The first step to making a patient feel that agency and responsibility, providers stated, is making them feel like a valued part of their care. This means valuing everything they bring to the clinic, their history, their feelings, their intuition—ultimately, their epistemological and ontological understandings about how they got to where they are. As such, their stories matter in a way perhaps they have never felt before in a clinical visit. Providers acknowledged what Dr. Jones said, that "patients want to be heard, they want to be cared for, they want to be listened to, they

want to be validated." To get to that place of value and partnership, several key rhetorical strategies were brought up numerous times in the interviews.

The first step is to have a "palpable" presence and "listen deeply" so that the patient feels understood. "When they come to the first visit and they're listened to or you take them seriously, when you ask deeper questions, you change their inner narrative that nobody does that pretty quickly," Dr. Garcia stated. "And I say, 'Listen, what you say matters. Like you're in charge, and I'm here to facilitate your health and healing, but you're in charge, you know your body better than I do'." Acknowledging the patient's epistemology is often the first step in FM *techne*, and providers stated that this simple step of welcoming their knowledge often breaks down any initial barriers to establishing the Therapeutic Partnership. Once patients understand that their input is valuable, they can get to the next step: shared decision making. For Dr. Brown, this shared-decision making is directly the result of validating a patient's story. He says,

> If you look at all the research of what patients want, they want to be taken seriously […] and when we do that, we create that suspension of opportunity; and hopefully, from that space of liminality you fall into the best path, the best healing outcome.

Another key rhetorical strategy FM providers use is asking key open-ended questions. The questions that particularly stood out from the interviews were attributed to life purpose. For example, Dr. Wilson stated that she often asks: "What matters to you? Why do you want to feel better? What do you want to feel?" Having patients connect their health to a greater purpose, providers stated, helps patients achieve the intrinsic motivation needed to make the changes that lifestyle medicine requires of them, and to do so not just for a moment, but as a habit.

The final element to be discussed when operationalizing an artful practice is the simplest, but also the most difficult: entering the conversation with sincere humility. FM providers as a whole acknowledged that humility can be challenging simply because they are often tasked with needing to come up with an answer immediately, to be fixers under a deadline. However, in FM methodology, there is room for the unknown since the expectation is that restoring health is not a quick fix. Therefore, providers expressed being comfortable in the unknown for a while. "There's always going to be stuff, I don't know, right?" said Dr. Adams. "But let me focus on that connection with the person and figuring out where they're coming from and what they need, and I'll try to do the best I can." Furthermore, providers emphasized that because FM requires such deep involvement from the patient, any kind of provider-driven agendas often do not take root. Dr. Clark emphasized this point and stated: "it's hard to stay in the ego in Functional Medicine, because it's so patient-centered." Dr. Wilson developed this point, and stated:

> I don't mind not being the expert in the room, because I have plenty of other scaffolding to put it on. You might be expert of the research on that disease and how that disease is for you, and there's still a role for me in that […] and for most doctors, that's a turn off and it shuts down right there.

Ultimately, providers attributed good patient-provider relations as critical to moving the needle on diseases. "I think it all starts with the profound effect of feeling heard, and also feeling like they've got this kind of sacred bond with their clinicians," said Dr. Lopez. "That's the normal experience in integrative and Functional Medicine, where patients just feel touched, they feel deeply touched in ways they probably can't even completely articulate."

Through this information, the providers articulated a clear understanding of what good patient-provider relationships entail:

- Acknowledging the patient as more than a disease or a set of symptoms
- Distributing work and responsibility equilaterally
- Giving patients hope and motivation in order to feel invested in their own care
- Having a palpable presence and listen with intent to validate their epistemology
- Having a shared decision-making process
- Entering the conversation with clinical humility.

Patient Narrative

With 69 references, patient narrative was the second most coded theme, and it is not surprising due to the heavy involvement that FM methodology expects from patients. For patients, this involvement most significantly manifests in the telling of their story (i.e. their narrative). For this reason, the two main words that I looked for in this coding category included "story" and "narrative." The message promoted in IFM materials and in the provider interviews is that a patient's life story *is* their illness story, and following the expectations of biopsychosocial care, patients are encouraged to share what may otherwise be deemed unnecessary information for a clinical visit. Using the FM timeline tool, patients are encouraged to literally tell their story from birth, highlighting significant moments in their life and health history, and to look for moments from which they believe their health never recovered. Because the timeline is a staple in the FM toolbox, it encourages providers to dig deeper than they ever have before with patients, and to ask questions they have never asked before. Patient narratives are not only welcome in the Therapeutic Partnership, they are what providers deem "the most important part of this encounter." And these narratives are critical not just in the information that providers obtain but for the connections they help establish between the patient and the provider. Some providers even described this process as the "therapy" in the Therapeutic Partnership. "Just

understanding the patient, just opening up and saying 'Yes, I believe you,' that itself is therapy for the patient," Dr. Rodriguez states. Making patients feel heard is a common phrase that providers stated in the interviews, especially because of the type of patients that they see often come in with concerns that have either been dismissed or misunderstood. As a result of these experiences, patients may come into these initial visits with frustrations or "a chip on their shoulder." Dr. Evans acknowledged that some of these issues may stem from the paternalism in conventional medicine. "[The patient] comes in and you're like, 'this is what you have, and this is the medicine you take, or this is the treatment we're going to do.' And the patient doesn't really have that much input." The way that providers in this study said they disarm such patients is specifically by explicitly welcoming their narratives. As Dr. Harris said, "It's just a matter of making sure that you feel that they feel heard, and they're not alone." For some providers it starts with "tell me your story," and making sure that eye contact is always present and no interruptions are made unless absolutely necessary. Many providers said that the patient response to this approach is almost always positive, and that it's common to hear phrases such as, "you're actually the first person that ever listened to anything I had to say."

Listening to patients is not unusual advice, and medical schools often float around Dr. Williams Osler's famous quote, "listen to your patient, he is telling you the diagnosis." However, in FM *techne*, that advice is not just advice, it is an *expectation*. For the providers in this study, listening to the patient appeared to be second nature to their practice, and they continuously emphasized the importance placed on patient narrative. For example, Dr. Garcia stated,

> There's more to it than just prescribing Prozac for depression. You know, it's much more complicated, right? If you just take time to listen, and understand that unique story, the answer comes through, generally. And then if we use our

> expertise in service of that story, that's a different strategy.

Part of how the patient's narrative is used is not just in listening, but in achieving a shared understanding about what the patient understands to be true. For the providers in this study, this means putting away any kind of agendas and listening with an open mind and heart. Dr. Brown states, "if I'm going to help you, I have to take my lenses off and put yours on. And I need to see life through your life, develop some insight and understanding of who you are […] and only then do I put my expertise in service of you." The way that providers "put on" the patient's lenses is by mirroring their narratives, which simply put means re-telling the patient's story back to them to ensure that there is a shared understanding about the patient's knowledge and experiences are. In the process of re-telling the story, the patient may see that the provider is truly listening, and it also allows the patient to understand how their story fits into their health history. Dr. Adams said,

> The re-telling of the story is so powerful because it helped recognize their life experiences and how what they've been through may have contributed to their health. So whether witnessing a parent's divorce, traveling overseas and getting diarrhea, marital stress, stress with children…allowing that conversation and summarizing their health history, I think is so key to establishing a shared understanding.

Providers also stated that this shared understanding can be strategically used to help motivate patients to make positive actions toward their health goals. For example, Dr. Davis said that by understanding "what their truth and perception are" he can use that information to help build what is possible for the patient and find steps to make them get there. Dr. Garcia also emphasized this point, stating that she explicitly listens to the narrative to "point out moments of positivity and character strengths, and a lot of resilience, a lot of courage and a lot of fortitude." By

highlighting these moments, she said, she uses it to motivate her patients to make the big changes that lifestyle medicine requires. “If you can do that,” she said she tells patients, “I’m confident you can do this.”

Teamwork

As implied in the word “partnership,” the Therapeutic Partnership demands an inherent teamwork from both providers and patients, and with 68 references, this was the third most prominent code found in the data. In this coding category, I specifically looked for words that suggest teamwork, such as “working with patients,” “partnering,” and “team.” Just like the other aspects of FM that differentiate it from conventional medicine, such foregrounding patient-provider relations and the patient’s narrative, teamwork is another part of FM methodology that is expected from providers. When describing teamwork in the Therapeutic Partnership, providers often used words such as “together,” “ally,” and “team.” And when using these words, they would emphasize the role of the patient in active decision-making and taking action. In the interviews, providers discussed the various ways that teamwork manifests in the Therapeutic Partnership, and it most distinctly manifests as treatment decisions which are informed by the patient’s goals and the providers’ support and guidance. In a Therapeutic Partnership, Dr. Garcia stated, “you can’t be Dr. Dictator,” specifically because FM asks patients to make long-term, lifestyle changes that do not always come easily. She explains,

When you’re looking at permanent change and sustainability, you’ve got to

> engage the client in conversation, and they’ve got to tell you what they can do, what they can’t do, what their starting point is…if you’re just prescriptive, they going to walk out of your office and not follow your directions, not because they don’t like you, but because it’s hard to change a lifestyle, especially if you’re asking

> them to change what they're eating, start moving, stop smoking, stop drinking, whatever it is.

Acknowledging that lifestyle medicine is a long-haul commitment for both patient and provider, providers often stated in their interviews that they would focus on what is 1) most important to the patient (e.g. focusing on their most pressing symptoms), and 2) identifying achievable first steps. The process then becomes very much a patient-led treatment plan that only goes as slow or as fast as the patient. For many patients, providers stated, working in one domain at a time is usually the best route. Dr. Smith explained, "Then I learned, if we're going to improve things, we can work with your diet, we can work with stress, we can work with sleep, we can work with exercise. I can do it all at once, if you want. Most people can't […] which domain would you like to work in first?" By allowing the patient to decide what is most important and doable for them, they begin to feel what the providers in this study called "empowered," "responsible," and "accountable." These attributes of the relationship are what make the Therapeutic Partnership possible, specifically because it requires active, motivated participation from the patient. And providers noted that patients are the ones doing most of the heavy lifting when it comes to their care, but they stated they are there in order to support, guide, and coach the patient.

Patient empowerment in the Therapeutic Partnership begins with one simple question, "which domain would you like to work in first?" This question is simple, yet profound in that it makes the patient an agent in her care. What she thinks and can do is that first step, this is *her* treatment, guided and supported by her provider. In that sense, the Therapeutic Partnership becomes participatory medicine, and moves away from the culturally expected paternalism that may be found in healthcare settings. This move not only grants the patient agency, it also eases the burden of the provider. Dr. Garcia furthers,

> It's not all on our shoulders to make them better, they're participating in their own wellness, so it empowers [patients]. It takes them out of this kind of learned helplessness where the doctor is going to fix me, they're going to give me a pill, they're going to give me a prescription, and it's on them to make me better.

Providers also noted the way that this empowerment acts as an element of persuasion in order to help them activate patients. For, example, Dr. Cooper noted that putting the decision in the patient's hands also places responsibility in their hands, and if the connection with the provider is strong, that responsibility turns into accountability, then suddenly, there is a "level of seriousness for the patient" that is needed to achieve the long-term goals of Functional Medicine. This is what Dr. Cooper calls a "buy-in" and stated, "if there is no buy-in from the start point, then it just crumbles." This buy-in, however, occurs with the explicit support from providers, they stated in the interviews.

In the very real and common instance that a patient struggles to make the changes needed to improve their health, FM providers leaned on what their role is in this partnership, and it often took the form of a supportive coach. For example, providers would state that if a patient came in after months of not making any changes or progression, instead of admonishing them to get "back on track," they would address any barriers that may have caused the stagnation or set back. Dr. Harris stated, "[sometimes] they come in with their tail between their legs, and many of them will say: 'I'm so sorry to disappoint you.'" At that point, she said, she will encourage the patient and simply state: "Let's start over." Staying supportive is also a point Dr. Lee emphasized, stating that "it's really critical to understand where patients are coming from, and what their barriers are to making these changes, and not judging, of course, just understanding where they're at and taking a walk beside them." Walking beside patients is a metaphor that many

providers used in the interviews, and it captures the equitable nature that Therapeutic Partnership aims to achieve. Finding lasting healing can be a complicated, long-term process, and it requires patience and consistency from both patient and provider. And it boils down to what Dr. Brown stated: “In a healing relationship, you’re always exploring together. Even if I don’t know the answer, hey, I’m here with you.”

Cultural and Systemic Barriers to the Therapeutic Partnership

The interviewed providers and archival data often discussed a number of systemic and cultural barriers that often block or deter Therapeutic Partnerships with patients. This theme was coded 63 times, suggesting that it is a notable concern for FM providers, providers who admitted that they left conventional medicine because they felt they needed something different from their careers. In this coding category, I specifically looked for words, phrases, and experiences that made clinical partnership with patients difficult, such as when providers or IFM materials mentioned systemic demands, “algorithmic” or “mechanistic” models of medicine, and frustrations in conventional medicine. When providers began discussing the systemic and cultural barriers to developing Therapeutic Partnerships, they often began by discussing how these barriers began in medical school and continued into their professional careers working in allopathic settings. By moving their practices into FM settings, they stated, they feel able and free to develop the relationships with patients they desire, understanding that such relationships are critical to the healing process.

When considering their medical school training, the providers who discussed these barriers often connected on one central idea: the idea of doctors being “fixers.” This cultural idea, they stated, is embedded into their practices early on due to the expectations of their training. Dr. Garcia, explains: “doctors are trained that they are responsible to fix the patient. The

they are fixing something. It's a mechanistic model […] and they get kudos for doing that from their colleagues and patients." For many providers in this study, medical school did not often focus on communication or relations with patients, and they said they did not "get too much of that" in their training. The one exception was Dr. Evans, a D.O., who said that she took a course called "Doctor Patient Relationship," but this course, said explained, was "not nearly to the level of the Functional Medicine training." For Dr. Jones, who attended conventional medical school, patient-relations was addressed "a little bit," but it was not the standard. "People learn how to treat disease, they don't learn how to treat patients, they don't learn how to treat people," he said. The encouragement to focus on disease, providers stated, led to algorithmic thinking that did not take the patient's story into consideration, as much as how the details fit into their knowledge base. For example, Dr. Brown stated that when he first got out of residency he would "listen to stories until [he] could attach a drug to it." He describes this methodology as a projection of science that discards listening, leading to the "pill for every ill" model. Yet while this cultural expectation from providers does encourage a kind of algorithmic model that reduces patients to symptomatology, the fault is not on the providers, as they often said in their interviews that the pressure to perform is immense. Dr. Brown states, "…you come out of training thinking that you went to school for that many years, so you should be able to fix stuff. And if someone comes back and says 'sorry, you didn't fix me,' […] and when someone tells me I can't [fix them], I feel like a failure." Dr. Adams also emphasized this point, stating that medical school puts providers in "scary positions, every step of the way."

Providers stated that the need to "be the expert" would often lead to a hardening process that could begin as early as in medical school. Dr. Jones stated that for him, the experience was quite profound. "I always say I was this rich, lovely, wonderful, interesting person and then med

school sort of burned me down to nothing, like just this little essence, and then I had to build myself back up afterwards." And while he said his experience probably does not amount to the average person, other providers shared similar experiences, saying that when physicians are training, much of the compassion that drives them to become physicians ends up being lost. Dr. Adams explained,

> When you're talking about the physicians we're training, of course they lose empathy, because they're exhausted […] you're put into positions where you really, you know, it's way above what you can do. And so then, on top of it, you're working way too much, and you don't have enough time for yourself and your family.

The reality of being overworked is one that begins in training and extends into professional practice, providers stated, which led to another major obstacle for establishing Therapeutic Partnerships: corporate medicine.

Corporate medicine has no distinct definition, but generally refers to the idea that healthcare is "a discipline that encompasses both the clinical and the financial" (Gardner Cook, 1999). This idea received negative responses, especially from physicians such as Dr. Barbara Gardner Cook, who wrote that "as physicians, we are often at the mercy of corporate medicine. We are the ones left trying to deliver high-quality, patient-focused and family-focused care while the corporate side tries to ratchet down costs" (Gardner Cook, 1999). And while the American Medical Association (Norton, 2023) explicitly banned the corporate practice of medicine in 2023, the reality is that many medical organizations still find the need to balance clinical and financial demands, and that can make tangible differences in providers' day-to-day interactions. The expectations of balancing clinical and financial expectations were often cited by providers as

creating unrealistic measures and goals for practicing medicine. And the issue of having enough time with a patient was a concern that was stated numerous times by different providers. At one point, Dr. Jones, an OBGYN, said that he was down to five-minute belly checks with pregnant women. “In addition to being under a lot of stress,” he said, “I realized that the way I could talk to them was completely different. I mean, I had to basically go in and have an agenda…not really give them time to talk.” For these providers, they stated that what they felt was lost with such measures was the art of medicine, because the listening aspects of the art struggles to be relevant in these spaces. Dr. Martinez stated,

> It’s just such a shame because we’re driven by these productivity markers, and have to see 100 people per day and spend 7.3 minutes with them and there are these business markers we get measured by. And I famously say in my meetings with administration, ‘Look, you cannot measure what I do […] you have look at the outcomes, you have to look at the healing that happens, and medicine is inherently inefficient.’

When looking at the cultural and systemic barriers that obstruct Therapeutic Partnerships, providers acknowledged that the consequences are felt not just for patients, but also for providers. “I think we have to be talking about taking care of doctors, when we talk about this whole conversation,” Dr Adams said. “It’s a very special person who can maintain empathy with a full schedule […] with what insurance companies think should be our full schedule.”

IFM promotional materials, such as text and videos on their website, address the issue of provider burnout; and they suggest that a major reason for burnout is because providers are not aligned with their own professional values when working under systemic or corporate constraints. One of the values that is specifically mentioned on their website is the idea of truly

restoring health. In conventional settings, especially those like the ones mentioned by the interviewed providers, they stated they found little to no space afforded to work in a way that could get to the "root cause" of why a patient is ill. "Many factors are mitigating against us such that we do not have the ability to develop the relationships with patients that we need in order to implement these successful treatments," said IFM Executive Director of Medical Education, Dr. Robert Luby on the IFM website. This promotional information harkens back to FM's taglines, and argues that FM methodology is a way to mitigate and even prevent burnout. The interviewed providers supported these ideas through their own experiences, and stated that the FM approach renewed their sense of joy in their profession and that it rested on the idea of considering themselves in a different light, as well as their patients, which was enabled by the Therapeutic Partnership.

Healing versus Treating

As stated, Functional Medicine seeks to find the "root cause" of illness in order to help patients regain health and well-being, and for the providers in this study, this strategy encapsulates how they view themselves and their practice. Healing versus treating was coded 48 times, and providers often called practicing medicine a "healing profession." Other words that were part of this coding category included "healer," "root cause" and "wellness." As such, providers acknowledged that conventional care settings often did not allow them to practice as healers, due to the constraints of cultural and systemic expectations. In Functional Medicine spaces, though, which often work outside of corporate and insurance models, providers are free to practice medicine the way they feel is best and help to avoid what Dr. Smith calls "repeat customers." Dr. Smith, a nationally recognized cardiologist, said that although his work was often lauded and received many accolades, he felt there was a gap between what he was doing

and what he felt he should be doing. “In business, they always talk about repeat customers and how that’s a great thing. But in my line of work, it’s not right. That means we failed them in some way, because they’re now in a second major cardiac event.” The idea of being a healer, providers explained, means having a different mindset, and lies in the difference between treating disease and establishing health. For FM providers, the described “the art of their specialty” as focusing on a healing-oriented strategy, which is founded on the Therapeutic Partnership. As FM providers, they stated, they now have the mindset and tools to heal patients, by asking different questions such as “How do we create a buffer of health? How do we create resiliency? And how do we keep those symptoms from coming back?” Dr. Moore described that by practicing Functional Medicine, she is able to get “far more effective results” because she has “far more effective interventions to offer.” “It used to be I was just coming up with a drug that they’re willing to take,” she said. “Now, I get to come up with the behavioral changes that really get to the root cause of why they’re ill. So now I actually get people better, as opposed to having them get worse more slowly.”

The ability to facilitate and witness healing was also noted as being part of their experience practicing Functional Medicine. This aspect in particular, providers said, helps keep them motivated as professionals and as human beings working with complex cases. For Dr. Martinez, seeing people “actually resolve their issues” is what sparks his passion for medicine. He said,

> I’m playing a role in the healing. I’m not the healer, but the person is healing themselves, but I can assist, right? And I may know some things that can help them towards that end. But that’s what I find the most gratifying: participating in the healing process and seeing the actual result.

Dr. Davis furthered this idea by stating that witnessing healing is the "bright spot" in his day, and it is something he does not take for granted because in his conventional care setting, when seeing 16-20 patients a day, he stated that providers can find themselves doing the "minimum effective, necessary to be safe" care just to get through the day. "The goal is: 'what do you need right now?' Meet it and move on," he said. "That's not joy and fulfillment." Now, as a Functional Medicine provider, he said, his life is changed because he is able to create the healing outcomes he seeks as a "healing professional." And while the providers did say that achieving their wellness goals with patients is difficult in conventional care, they were also quick to defend its merits in acute care, saying that in reality, medicine needs both types of care: conventional and functional. But when discussing theories of disease, Dr. Rodriguez said, different questions need to be asked: "Why is this person feeling the way she is? Why are these manifestations happening? That something that cannot treat acutely, we have to get to the root of the problem."

The Therapeutic Partnership Provides Resistance Against Provider Burnout

The providers in this study stated that establishing Therapeutic Partnerships with patients was not only beneficial for patients, but also for themselves. This theme was coded 31 times, and while it was coded the least, providers had significant discussions surrounding this theme. In this coding category, I specifically looked for words, phrases, and experiences that suggest professional joy and fulfillment, such as "fun," "joy," and "motivated." In particular, providers highlighted that their art, defined as "how we relate to patients," is what makes their work fulfilling. Because Therapeutic Partnerships demand an intimacy that goes beyond traditional care settings, providers said that when they meet with patients, "there is so much joy." "It's like meeting an old friend when you a see a patient," said Dr. Lee. Additionally, providers noted that the deep level of patient engagement and agency makes the work and responsibility equally

distributed between patient and provider, providing resistance against the burden of being the "expert in the room." In Therapeutic Partnerships, all epistemologies are welcomed in order to achieve the end goal of healing.

Another way providers noted that Therapeutic Partnerships help with burnout resistance is through clinical curiosity and creativity. In Therapeutic Partnerships, providers are allowed to be "clinically curious," which means moving away from algorithmic thinking that can turn both providers and patients into automatons. Instead, providers said they recognize that 10 different people with depression will have 10 different reasons for depression. Dr. Garcia explains, "we have the opportunity to be incredibly creative and look at the whole tapestry of their life and how things weave together; and from that, we reverse engineer to [the patient] to health and well-being." This opportunity to be creative in partnership with the patient resists what providers called "mundane" and "boring" medical practice that does not take into account the bio-individuality of human beings. In Functional Medicine, providers emphasized, it is "never, ever boring or dull." Because of the vast array of options lifestyle medicine affords, options are never exhausted and care is specifically tailored with deep knowledge of the patient, they stated. Dr. Davis furthered,

> It's one thing to know what is possible and how things work. And it's a whole other thing to try and operationalize that to a conversation that means something to you, that we get to a shared understanding, and then lead to first steps and a tangible strategy that is simple and makes sense to you. And no doubt, others don't get to have these exciting conversations.

When emphasizing the joy in their practice, providers often cited the communication and partnerships they developed with their patients, and some providers even expressed a deep

gratitude for being able to work so closely and intimately with patients in these partnerships. It is important, however, to note that FM providers often work independently, outside of medical corporations and organizations, allowing them to break free from the constraints of insurance-based medical models. However, the interviewed providers stated that even though they are free from corporate constraints, implementing elements such as humility, purposeful questioning, and listening are often possible even in tightly structured settings, and patients are grateful for the slight, but meaningful communicative moves. Finally, providers noted that patient gratitude is often expressed in these partnerships, but that they also made it a point to mirror that gratitude back to the patient. In particular, Dr. Davis noted that when his patients make big breakthroughs and thank him, he mirrors the gratitude by thanking them back, saying: thank you "for the opportunity to witness and do this with you."

Chapter Summary and Takeaways

This chapter presented the data results organized by the most prominent theme to the least prominent theme. Prominence was determined by the number of times a theme was coded, and the six themes that resulted were: The Role of Rhetoric in Biopsychosocial Practice, Patient Narrative, Teamwork, Cultural and Systemic Barriers to the Therapeutic Partnership, Healing versus Treating, and Resistance Against Provider Burnout. The first three themes illustrate the ways that providers use rhetorical approaches to move medical practice away from a scientific center and more towards the principles of a *techne*; and they specifically address how knowledge is balanced with the presence of wisdom and practicality. The latter three themes mostly address how providers saw their medical *techne* in light of cultural and systemic constraints and affordances. As a whole, the results of the data illustrate how providers conceive of and implement medical *techne* through the Therapeutic Partnership.

Table 2 - Thematic Results with Sample Quotes

Theme	Number of Times Coded	Sample Quotes
The Role of Rhetoric in Biopsychosocial Medicine	133	"There's the practice of medicine, there's the science, and there's the art. And without the art, there's no joy. And so how we relate to patients is the art, and it is profoundly important." If you look at all the research of what patients want, they want to be taken seriously […] and when we do that, we create that suspension of opportunity; and hopefully, from that space of liminality you fall into the best path, the best healing outcome.
Patient Narrative	69	There's more to it than just prescribing Prozac for depression. You know, it's much more complicated, right? If you just take time to listen, and understand that unique story, the answer comes through, generally. And then if we use our expertise in service of that story, that's a different strategy. If I'm going to help you, I have to take my lenses off and put yours on. And I need to see life through your life, develop some insight and understanding of who you are […] and only then do I put my expertise in service of you.
Teamwork	68	When you're looking at permanent change and sustainability, you've got to engage the client in conversation, and they've got to tell you what they can do, what they can't do, what their starting point is…if you're just prescriptive, they going to walk out of your office and not follow your directions, not because they don't like you, but because it's hard to change a lifestyle, especially if you're asking them to change what they're eating, start moving, stop smoking, stop drinking, whatever it is. It's not all on our shoulders to make them better, they're participating in their own wellness, so it empowers [patients]. It takes them out of this kind of learned helplessness where the doctor is going to fix me, they're going to give me a pill, they're going to give me a prescription, and it's on them to make me better.

Table 2 - Continued

Theme	Number of Times Coded	Sample Quotes
Cultural and Systemic Barriers to the TP	63	Doctors are trained that they are responsible to fix the patient. The they are fixing something. It's a mechanistic model […] and they get kudos for doing that from their colleagues and patients. It's just such a shame because we're driven by these productivity markers and have to see 100 people per day and spend 7.3 minutes with them and there are these business markers we get measured by. And I famously say in my meetings with administration, 'Look, you cannot measure what I do […] you have look at the outcomes, you have to look at the healing that happens, and medicine is inherently inefficient.'
Healing versus Treating	48	In business, they always talk about repeat customers and how that's a great thing. But in my line of work, it's not right. That means we failed them in some way, because they're now in a second major cardiac event. It used to be I was just coming up with a drug that they're willing to take," she said. "Now, I get to come up with the behavioral changes that really get to the root cause of why they're ill. So now I actually get people better, as opposed to having them get worse more slowly.
The TP Provides Resistance Against Provider Burnout	31	We have the opportunity to be incredibly creative and look at the whole tapestry of their life and how things weave together; and from that, we reverse engineer to [the patient] to health and well-being. It's one thing to know what is possible and how things work. And it's a whole other thing to try and operationalize that to a conversation that means something to you, that we get to a shared understanding, and then lead to first steps and a tangible strategy that is simple and makes sense to you. And no doubt, others don't get to have these exciting conversations.

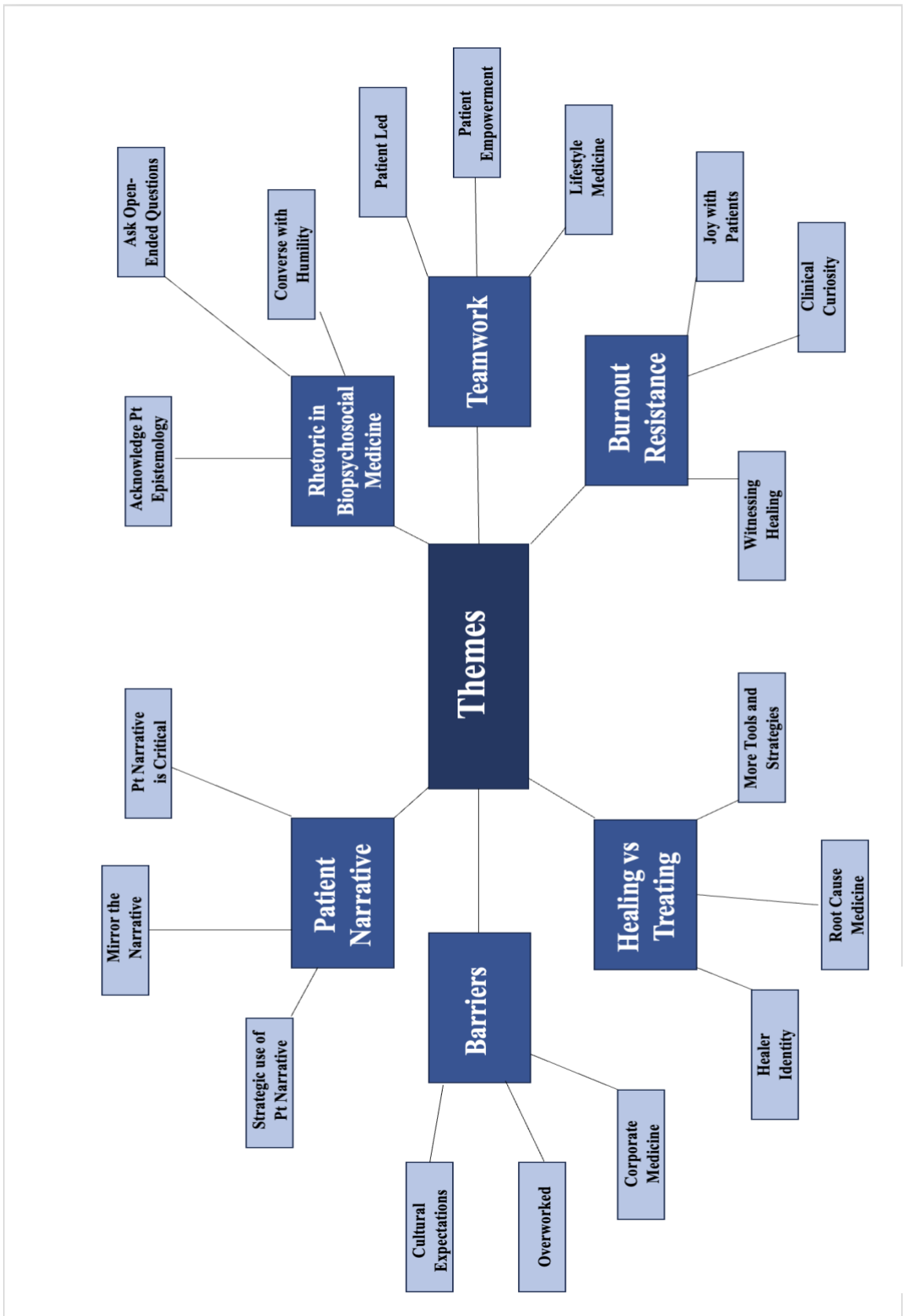

Figure 11 - Thematic Results

CHAPTER VI

ANALYSIS

Functional Medicine and the Therapeutic Partnership

Functional Medicine emerged in 1990, and its goal is to challenge and change how doctors and patients consider the etiology and persistence of disease, how to achieve complete healing and not just disease management, and the identity and roles of the patient and provider (The Institute for Functional Medicine, 2021c). Practitioners of FM often see patients who come to them after conventional medicine has left them frustrated, disillusioned, and perhaps feeling even more unwell (The Institute for Functional Medicine, 2021c). Additionally, FM providers often self-identify as being "healers" or a part of the "healing arts," which for them means entering into a clinical relationship with their patients as models of their approach. One of the main highlights of FM is that it approaches medicine with a whole systems approach, which essentially means that organs and ailments are considered in light of the whole body working as one system. Functional Medicine's tagline is that its providers consider the "root cause" of disease to achieve lasting healing (The Institute for Functional Medicine, 2021c). These approaches challenge the current paradigm of conventional medicine, which is often criticized as focusing on treating symptoms and not the disease (and on treating the patient, but not necessarily the person), and for treating organs and systems in isolation from the rest of the body, hence the large number of "specialty" providers (The Institute for Functional Medicine, 2021c). However, in FM, there are no specialists that focus on certain diseases or organs, as providers' expertise stems from a basic, yet important idea that the body acts and functions as one major system made up of smaller, but interrelated systems. Similarly, their approach challenges seeing a binary between the mind and the body, as their practice aims to understand "how important the

whole surrounding life of the patient is to their problem," (The Institute for Functional Medicine, "The Therapeutic Partnership," 2021). This understanding of medicine encapsulates FM providers' methodological approach, which they call "Therapeutic Partnership."

In the Therapeutic Partnership providers and patients are equally important, and training and promotional materials emphasize that both providers and patients are to be cared for. The health of the provider is understood as being just as important as the patient, and in fact, is seen as a foundation to creating patient wellness through a fulfilling clinical partnership. The idea is to engage the patient in a partnership that de-emphasizes the culturally expected hierarchy in patient-provider communication. Patients are seen as experts of their own experiences and these experiences are used by the provider to help determine the appropriate next steps as determined by both the patient and provider. Training modules in this approach tell FM providers: "our clients need to participate with us, they need to co-create with us, it's not a doctor/dictator telling them what to do; the engagement is crucial in FM" (The Institute for Functional Medicine, "Shifting the Therapeutic Encounter into an Environment of Insight," 2021). To support this communicative approach, FM trainers cite studies that illustrate how empathy and understanding positively affect not just patient experience, but also clinical outcomes. It also helps FM providers to achieve their goal of treating the root cause of patient illness, not simply treating symptoms, as they believe that disease etiology is the result of numerous factors that they address through a lifestyle, biopsychosocial approach.

Furthermore, FM providers acknowledge that despite our advanced medical technology, there will always be an inherent uncertainty in medical practice, and emphasize that medicine is an art. For example, FM views clinical practice guidelines as just that, guidelines, not definite answers that can and often do clash in this world of bio individuality. As such, a level of

uncertainty will persist in medicine, and FM founding member Dr. David S. Jones states that the "inherent uncertainty in our clinical science requires a different kind of relationship with our patients" (The Institute for Functional Medicine, "The Therapeutic Partnership," 2021). This is especially true for FM practitioners as they often deal with complex, difficult to solve cases. The idea is to know the patient accurately and include them in the process of the medical art, and this is partly done by teaching providers to be mindful and present when they are meeting with patients and listening intently to their narratives and descriptions. FM founding member Jeffrey Bland, Ph.D., and Dr. Jones state that "from the respectful and disciplined joint interrogation by both participants in this Therapeutic Partnership emerges the important factors for deeply knowing the integrated, quantified whole-patient and emerges, through the partnership, the pathways towards healing" (The Institute for Functional Medicine, "The Therapeutic Partnership," 2021). Such an understanding creates different demands and expectations for providers; and IFM training materials indicate the importance of the provider's own state and the self that they bring to the clinic. FM methodology essentially begins with the providers being healed herself, and then embodying and modeling that health for the patient. This means that to practice FM, burnout *must* be addressed, because as IFM materials state, "patient outcomes are not going to be optimal whenever we're burned out" (IFM, 2024).

Provider Burnout, Healer Identity, and the Therapeutic Partnership

While provider burnout was coded the least amount of times, an analysis of the data (both interview and archival) suggests that addressing burnout is a critical first step for providers to establish a successful Therapeutic Partnership. And although there was no explicit research or interview question regarding provider burnout, the interviewed providers were eager to relate their experiences with burnout and how it influenced their decision to move to FM. For some

interviewed providers, these experiences with burnout began as early as their medical school days, but for most, it began when they started practicing medicine professionally. Dr. Williams, for example, stated, “I always say I was this rich, lovely, wonderful, interesting person, and then med school burned me down to nothing, like just this little essence, and then I had to go back and build myself up afterwards.” For other providers, they pointed to the issue of corporate medicine, generally understood as the commercialization of medicine, as the reason why they experienced burnout. A heavy schedule, coupled with what they saw as unreasonable demands, led them to feel like their meaning and purpose waned and fell by the wayside. On this issue, Dr. Taylor said, “I’ve had burnout multiple times, and there are different things that are involved with the burnout. And I think that a lot of the problems in medicine [stem from] corporate medicine trying to calculate and dictate how long it should take for you to meet with the patient, how long or how many visits. That’s what’s causing the burnout. I think that’s the greatest contributor, because I think even doctors that are in allopathic medicine, they want to help the patients.” Wanting to help patients is often what providers say brings them into the medical field, and can even be understood as a calling. Seeing one’s profession as a calling thus demands meaning and purpose in work, and for providers, this meaning and purpose is directly tied to patient relations and care. Yet when business demands create obstacles to enacting fulfilling work through meaningful patient care, a dissonance is created, and “when dissonance arises between what clinicians find meaningful and the reality of their daily work tasks, they may experience increased work stress and burnout” (NAM, 2019). “I was drowning in the system,” said Dr. Lee. “A primary care office is underserved and fast-paced, so every 15 minutes you have to see a patient. So, how much time do I have to listen to your story and give you a little bit of what I think is happening?” Usually,

providers are paid based on production (defined as volume of work), and this productivity is measured in Relative Value Units (RVUs), and can be understood this way:

> RVUs reflect the relative level of time, skill, training and intensity required of a physician to provide a given service. RVUs therefore are a method for calculating the volume of work or effort expended by a physician in treating patients. A well patient visit, for example, would be assigned a lower RVU than an invasive surgical procedure. Given this relative scale, a physician seeing two or three complex or high acuity patients per day could accumulate more RVUs than a physician seeing ten or more low acuity patients per day. "Work," rather than number of patients or billings, is the behavior being measured and rewarded. (AMN Healthcare, 2021)

With this system and expectations, a provider would have to perform a higher number of lower RVU services to increase the revenue of the system they are working for. For the physicians interviewed in this study, this system created a dissonance in that it conflicted with their own self-identification as either being a "healer" or a part of the "healing arts." A healer's work, they stated, cannot be measured in units; as Dr. Taylor says, "they want the results, but they have no concern about how you get there. And they don't want to allow the amount of time or the education that it takes to get to that point."

For the interviewed providers, the identification of being a healer or part of the healing arts was the first step towards addressing their burnout because this identification provided the means by which they would change their own self-perceptions as professionals and how they enact medical practice. Simply put, healers try to heal, which means understanding medical practice from a different perspective. Dr. Martin stated, "Effectiveness means something

different when you perceive yourself as a professional and as a healing professional. You really have to start with that core understanding of what it is to heal, and what it means to witness healing or facilitate it." Facilitating that healing, as illustrated in the archival data, begins with healing oneself first so that the provider is in a physical and emotional state that allows therapeutic relationships to be established. For some interviewed providers, the only way to achieve this self-healing was to leave conventional medicine completely, but a handful of providers said that even within constraints, it is possible to embark on a professional healing journey that transforms both the provider and the care he gives to his patients; and it takes a conscious effort of taking note of your own professional identity and doing what you can in these spaces to better align one's identity with their with practice.

Of note, a couple of providers said that they were able to change their practice significantly even within systems such as active duty military clinics and Veterans Affairs hospitals by bringing a conscious rhetorical awareness to themselves and how they relate to patients. Dr. Moore, in particular, said that change can begin as simply as asking different questions during the visit, and her three questions were: 1) What did you learn? 2) What are you going to do? 3) What can you do? Building on this idea, Dr. Martin took the idea a step further, and stated that even when he was seeing 16-20 patients a day in a military hospital setting, he was able to transform his patient care and become more in alignment with his healer identity by coupling his Functional Medicine knowledge with rhetorical skill and strategy. He explained,

> once you learn the Functional Medicine framework, and you understand root causes of dysfunction, and you figure out ways to communicate, specifically focusing and drawing out on the most limiting, the most limiting the areas of dysfunction or disability, that are most limiting to the person based off of what they met what they

> care about, or the the symptoms that they care the most about, that are most embarrassing or limiting or that they seem to be focusing on [...] if you're able to figure out what they care about and what's relevant to them, or why they believe something to be true, then that shapes the conversation with how I can align what I'd like them to know. And ultimately, what we'd like to see them do with what they care about, or their most limiting perceptions or beliefs [...] the communication frameworks and the Functional Medicine concepts give you the ability to morph the conversation into an empowering one.

Dr. Martin said that this strategy was taught to other military providers and with it, he was able to transform the culture of care within his team. And even though the time with patients was not increased, the use of that time did, and did so by creatively constructing conversations with patients to target areas of importance and areas of hope. This strategy, he said, was an "epiphany in shifting in frameworks that allowed me to be more effective at facilitating that healing experience that I knew was possible." Facilitating healing experiences through therapeutic partnerships is a focal point for Functional Medicine providers, and they acknowledge these partnerships as partnerships that lead to better healing and as Dr. Jackson said, are "great hindrance to any type of burnout." And what was consistently emphasized in both the interviews and archival data is the importance that good patient care has on mitigating provider burnout; this idea aligns with Dr. Zohal Ghulam-Jelani's statement that "the patient is what is keeping the doctor from falling further into burnout. The physician-patient relationship and the desire for doctors to help their patients is the core of why physicians entered medicine."

The Healing Environment

In FM *techne*, the healing environment exists not just for the benefit of the patient, but also for the provider. FM *techne* argues that in order for the art of medicine to take place, it first begins with the provider being healed themselves. And according to the interviewed providers and archival data, this begins with the provider taking care of themselves, both modeling and embodying health, and this important distinction in their professional lives occurred when they moved to functional, integrative medicine. More importantly, providers noted that this distinction was made apparent in the FM training curriculum, and that without this self-awareness providers can't "see" patients because they do not know who they are; thus, providers are unable to "see this person, the human." Conventional settings, both as professionals and as medical students, they stated, did not afford them the opportunity and space to embody health in the way that is needed to have fulfilling and successful doctor-patient relationships. And a major part of transitioning from doctor to healer is being part of the Functional Medicine community, which they see as a caring, supportive peer community. A provider on the IFM website stated,

> I'm not just a productivity unit, and that's why many of us transition to Functional Medicine [...] we want a different quality of life and way of practicing and a medicine that reflects our values. I just want to pair those together. The mentoring and the applied training with the internal shift and paradigm shift and the health and honoring of ourselves, which really is necessary and goes hand-in-hand to fully transition to Functional Medicine. (IFM, 2024)

In FM *techne*, providers are asked to see themselves as their first patient. This is done by asking providers to consider their own lifestyle factors, which IFM materials state are "key factors of health for both patients and clinicians" (IFM, 2024). Taking care of themselves first so they can

be available to patients, setting healthy boundaries so patients know what to expect, and giving themselves time to replenish, whether that is meditating, being in nature, finding things that re-energizes them and fills them with joy, said IFM Educator Lisa M. (Perry) Portera (IFM, 2024). IFM materials stated: “One of the core lessons in the practice of Functional Medicine is to care for yourself while also caring for your patients. In sum, when personal satisfaction is increased, so too is professional satisfaction. Not only will your patients experience better care, you will feel more satisfaction with your practice and may be less likely to experience burnout. This mindset is what helps to create a healing environment for the provider, allowing the professional experience to become one of fulfillment, and allowing the ever-important patient-provider relationship to flourish.

Understanding that clinical practice is founded on patient-provider connection and mutual involvement means that in this healing environment, each element of the medical interaction (patient, provider, disease/nature) works together in unity and equilaterally to form the medical practice. IFM materials state: “the body doesn’t lie, and it’s not wrong. We’re not trying to fix it. We’re trying to inquire and to learn from each patient.” These ideas challenge conventional notions of medical practice, which typically place the provider atop a culturally-constructed hierarchical ladder, with the provider orchestrating and exercising control over the patient and disease. The providers in this study often stated that they humbled themselves, their knowledge, and their role. For example, Dr. Garcia said that patients are the “expert on themselves” and providers are “the experts on which tests to do.” Dr. Martinez furthered illustrated this idea by stating that he is “playing a role in the healing [but] I’m not the healer.” Understanding medicine as foundationally built on anti-hierarchical values provides the framework for understanding how a healing environment is created and enacted upon. Functional Medicine President Dr. David S.

Jones highlights that uncertainty is inherent to medical practice, so it follows that a hierarchical approach to medical practice and knowledge places a value judgment based on cultural understandings not necessarily medical truths. For the providers in this study, uncertainty in medicine was not shunned but rather embraced, because approaching medicine as a *techne* means understanding that the complexities of illness can and often extend beyond their own knowledge; however, what they did acknowledge and emphasize was that this uncertainty did not take away from their power to create what they stated is the most important element of their *techne*: a healing environment. FM trainers tell providers: "you are more powerful than the medicine you prescribe." And by this phrase, they are pointing to the potency of the healing environment, which the provider is ultimately responsible for creating.

To further create this healing environment, the interviews and archival data illustrated three elements: a therapeutic encounter, provider awareness, and the patient's narrative. As stated in the name, the Therapeutic Partnership, establishing a therapeutic presence and atmosphere is key to FM practice. The emphasis on being therapeutic acknowledges, the providers stated, that what they are witnessing in their daily practice is human suffering, as well as understanding that illness is an experience. To this end, empathy was noted as a primary element in their practice. Empathy in healthcare is a noted topic, and the provider interviewees as well as outside research indicates that patients want providers who listen with care, and who empathize with their health situation. For example, Dr. Jones stated in his interview that "if you're not communicating effectively, and showing patients how deeply you care about them, then you're not going to be a great clinician." Furthermore, in research from Churchill, Fanning, and Schenck (2013), they found that when patients rated positive clinician traits, they rated caring, empathy, and compassion as the top, with technical competence coming in last on their list (p. 34). This is not

to say that technical competence has no place in the healing environment, it simply points to the fact that for patients, illness is first and primarily a human experience, and they would like their providers to acknowledge that. Writing on this topic, Dagnone (2017) writes: “although medical training teaches us how to meet the needs of our patients, we actually learn more from our experiences of life and must leverage our own encounters to enhance the physician-patient dynamic” (p. e97). By focusing on empathy, providers are able to connect with patients in an authentic, human way, enacting a crucial element of the healing environment.

A second element of the healing environment that provider interviewees noted was provider awareness. By awareness, FM providers and training documents mean to emphasize an intentional presence and aiming to witness the patient’s story with presence and curiosity in order to facilitate insight and healing. Creating this intentional presence begins with what FM providers call “gathering one’s self,” which could take the form of a sacred pause before entering the room with the patient. Providers in the study also noted that other forms of “self-care” also help them create this awareness, such as taking care of their own bodies through healthy meals, and even taking a day or two to engage in a personal hobby. More formally, FM training materials noted the following steps to further cultivate this awareness:

- neither indulging or suppressing, just noticing,
- complete acceptance of what is, and
- realizing that the consciousness in which you gather your information is just as significant as the information you gather

(“Shifting the Therapeutic Encounter in an Environment of Insight,” 2021)

What is notable about these points of advice is there is a lack of moral judgement on both the patient and provider, information is accepted as just that, information, and there is no pressure on

the provider to perform the role of expert knower, undermining what is typically expected from providers. In the interviews, providers noted that because FM *techne* removes the pressure to provide immediate answers, they are able to take in the patient as a person and the information they relay with ease of mind, ultimately helping with potential burnout. This strategy also helps with developing the shared understanding that is needed to get to a place of partnership with patients, interviewees stated. By achieving shared understanding, patients begin to acknowledge their role in the healing process, and with that role comes the responsibility needed to make lasting change, which is why provider awareness is key to creating a healing environment.

The final element in FM *techne* is the patient's narrative, which is consistently foregrounded. When discussing patient narrative, interviewees stated that their first goal was to ensure that the patient felt heard, understood, and believed. For example, Dr. Rodriguez stated that "just understanding the patient, opening up and saying 'Yes, I believe you,' that itself is therapy for the patient." By making this goal primary, providers stated, it helps with the other aspects of the healing environment (therapeutic encounter and provider awareness) because it helps the patient understand that the provider is listening empathetically and re-telling the story back to the patient works towards helping provider awareness in the visit. A second goal, but just as valuable as the first, is to use the patient's narrative in a strategic way. Much like the practices of narrative medicine, FM providers are trained to be aware of metaphor, symbolism, and analogy in the patient's story. Training materials in this area state that if the patient says she is "drowning in a sea of grief," the response is: "what would it look like to swim?" Providers also noted that patient narratives can be areas where a patient's skills and confidence can be accessed and reflected back to them. Such as how Dr. Garcia said she uses the patient narrative to point out areas of positivity, character strengths, and resilience.

Put together, these three elements help to create a healing environment through constant and iterative engagement with one another. No one element is more important than the other, they work simultaneously between the provider and patient. What connects these elements is a rhetorical awareness of how the communication can either create and sustain these elements or fracture the power flow.

When speaking of this power, Churchill, Fanning, and Schenck (2013) write,

> We often speak of people who can "hold a room," meaning they are engaging, magnetic people who are able to sustain the focus and attention of others to an exceptional degree. This phrase is often used to describe political or other public figures, but it is also used in social, religious, and a variety of other contexts. Skilled clinicians have similar powers, but the setting and purpose of their work means that they can hold a space that is conducive to therapy, to a healing experience for their patients. (p. 27)

Holding this space is what allows the medical *techne* to create healing opportunities, as it empowers both patient and provider in the process. And while initiating this power does rest mostly on the provider, as she is responsible for first engaging in these elements, they help to encourage the patient to follow suit and become more involved in their treatment. With the goal being lasting change, such a healing environment is not only beneficial, it is necessary.

Medicine as a *Techne*

A central finding from this study is the idea of medicine as a *techne* as exemplified in the Therapeutic Partnership. In the Therapeutic Partnership, patients and providers work to counter imbalanced notions of medical practices that favor scientific knowledge over illness experiences and the context of etiology, tying back to the idea that Mol (2002) describes, which is that

ontologies are informed by not just our bodies, but by the organization of our healthcare systems, pains of disease, and technologies (p.7). “All of these, all at once, all intertwined, all in tension,” she writes (p.7). With this understanding, it comes to light that treatment must also be all encompassing, and not favor one element over another, thus favoring an approach that acknowledges the human experience of living with disease and how medical context influences its ontology. In this sense, a technocratic approach to medicine becomes a way to address just one dimension of disease, leaving the patient to possibly be rid of her symptom/s, but still feel unwell. In the Therapeutic Partnership, the various dimensions of disease are addressed through a biopsychosocial approach that acknowledges the role of human experience in disease processes, which means foregrounding a rhetorical approach that can not only acknowledge the human dimensions of disease but bring them into light through a methodology that understands medicine as than just *episteme*. With this approach, medicine becomes fused with elements of wisdom and virtue in that it seeks wholeness for patients (and providers), guiding them towards a path of self-discovery that can lead to wellness in the physical, mental, and spiritual domains. For the providers in this study, their understanding of wellness is in line with how the World Health Organization defines health, namely, “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity” (WHO, 2024). With this definition of health being the goal, the path towards healing looks different because it must be different. For FM providers, the path towards healing is inevitably fused with the social, understanding that we, as social beings, live out experiences and purposes more meaningfully when they are shared with others.

More importantly, medicine’s goal to relieve suffering inherently assumes a noble purpose, a purpose that extends beyond mere treatment but rather relation in the context of

illness. An example of this idea resides in Sir Luke Fildes' famous 1891 painting called *The Doctor*. In this painting, a physician is the central figure who is pictured at the beside of a sick child looking on with intent as the child recovers. In this moment, the physician is observing a child who is sick with an infection in pre-antibiotic days, and according to Jane Moore (2008), because "the effectiveness of medicine in the mid-19th century was limited, the doctor's contribution was unlikely to have had any influence on the recovery of the child" (p. 210). Yet despite his lack of medical aids, the physician stayed with the most important tool in his possession: his presence. The painting was painted in homage to the ideal physician, and it is important to note the lack of technology present in the image. What is foregrounded is the physician and the patient, as they and their connection become the most important elements in the picture of illness. Their connection is what makes the image noble and ideal. Likewise in the Therapeutic Partnership, the relationship between the physician and patient are what providers said is the most important element in the picture of illness, recessing the idea that medical progress requires technology and underscoring the virtuous element of medical *techne*.

Dimensions of Medical Techne in the Therapeutic Partnership

In order to further understand how medicine as *techne* functions within the Therapeutic Partnership, it is essential to understand how it encompasses the three dimensions of a *techne*: *episteme* (knowledge)*, sophia* (wisdom)*,* and *phronesis* (practical wisdom). Generally speaking, the Therapeutic Partnership does not diverge from conventional notions of *episteme* but complicates a purely scientific understanding of medical practice by incorporating other ways of knowing the body and disease etiology, and this understanding of *episteme* is only used in light of the other two *techne* dimensions: *sophia* and *phronesis.* Below I will explain how these three dimensions of medical *techne* manifest in the Therapeutic Partnership.

Episteme in the Therapeutic Partnership

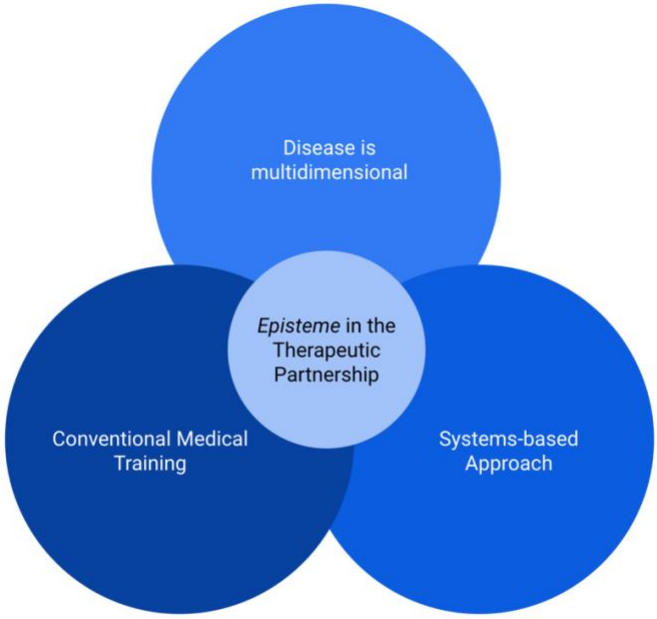

Figure 12 - Episteme in the Therapeutic Partnership

The way that providers understood *episteme* was expressed through three elements that all continuously work in sync with each other: their conventional medical training, the understanding that the body works as one unit with various systems working with each other, and the knowledge that disease is multidimensional. It is important to know that Functional Medicine providers all have completed conventional or traditional medical programs before coming into this space, and that the FM label is an add-on certification providers must obtain. Therefore, the knowledge that FM providers bring into the clinical space is a combination of conventional education and the knowledge they learned while completing their FM certification program. Secondly, in their certification program, they learn to view the body as a system comprised of

other systems that are constantly working with each, avoiding the typical medical silos of highly specialized providers. Instead, FM providers are taught to treat the body as one unit, which is nuanced by the third element of their *episteme*: the knowledge that disease is multidimensional. In FM, disease etiology is understood as more than just a physical infirmity, resulting in the aforementioned biopsychosocial approach that defines their *techne*. The multidimensions help to create a basis for the rhetorical work that is inevitably part of their methodology once the other two elements of their *techne* is implemented: *sophia* and *phronesis*.

Sophia in the Therapeutic Partnership

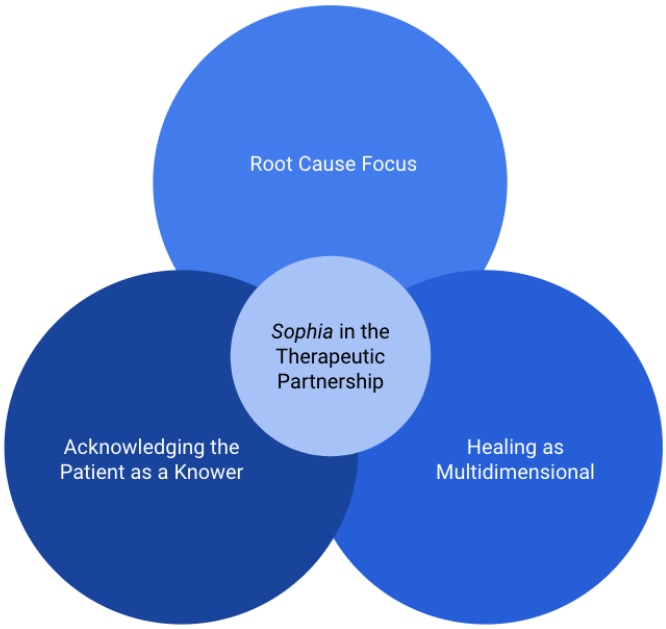

Figure 13 - Sophia in the Therapeutic Partnership

Drawn from the interview data, *sophia*, generally understood as philosophical wisdom, manifests in the Therapeutic Partnership through these three main elements: a root cause focus, healing as multidimensional, and acknowledging the patient as a knower. These three elements encompass the clinical wisdom of Functional Medicine and subsequently inform its practical elements (which will be discussed). When considering a root cause focus, providers said they move away from practices that treat only symptoms in order to seek a deeper level of wellness and medical progress. For example, the providers stated that their goal is to create a health "resilience" in their patients, and not to create endless "repeat customers." With this understanding the goal of medicine to relieve suffering presents itself in not just relief of suffering, but to try and stamp it out completely. Knowing that health means more than just physical health leads to the next point of FM clinical wisdom: seeing disease and healing as multidimensional, which subsequently means acknowledging the fluid, social, and dynamic aspects of illness; perhaps put another way, the parts that cannot be measured via technological means. The final but most critical part of FM clinical wisdom is understanding the patient as a knower. Validating patient epistemology is key to enacting FM methodology, and as such demands a presence and understanding that is reliant on rhetorical method and strategy, such as the idea of listening with intent and mirroring the patient's narrative. This epistemological validation serves not only as a therapeutic process for the patient that can help motivate them to step forward with their health goals, but also serves a tangible clinical purpose in unlocking their own health mysteries. As will be discussed, this tangible clinical purpose has an important connection to issues in medical epistemic justice that must be underscored.

Phronesis in the Therapeutic Partnership

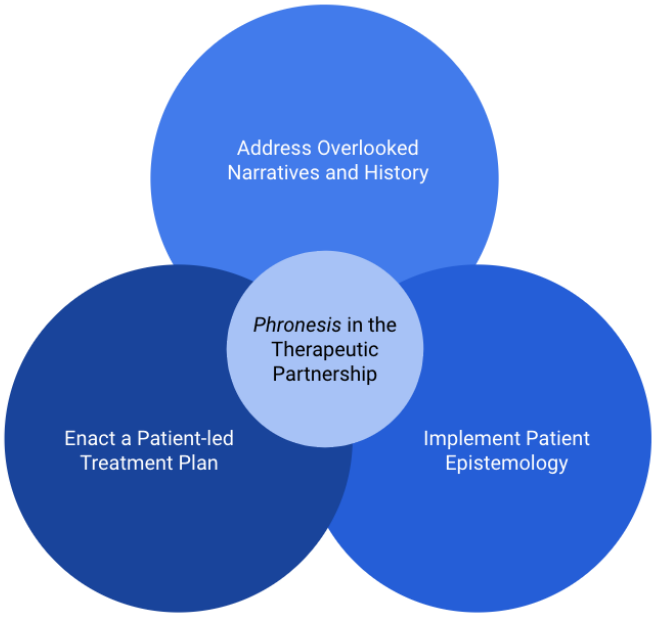

Figure 14 - Phronesis in the Therapeutic Partnership

Phronesis, understood as practical wisdom, manifests in the Therapeutic Partnership through three dimensions that stem from FM clinical wisdom: addressing conventionally overlooked narratives and history, implementing patient epistemology, and enacting a patient-led treatment plan into the clinical method. In the first element, providers stated that they address conventionally overlooked narratives and history through the FM Timeline tool, with these tools the provider and patient as partners tease out a detailed health history that begins literally from birth, highlighting areas from which the patient believes she has never recovered. Then, the life story is literally put to practical use by both provider and patient looking for areas of meaning that could possibly lead to insight into the patient's current state of health. Thus, the telling of the

patient's story becomes more than just therapy but becomes part of the clinical map upon which answers can possibly be found. The second element, implementing patient epistemology, stems from the idea of treating patients as knowers; this means trusting that they are experts of their own bodies and not putting technocratic tools such as labs ahead of what the patient already knows. The providers stated that this is often a difficult task for providers, as it requires a considerable degree of clinical humility. However, treating the patient as a knower is practical in the sense that it can eliminate unnecessary trial and error, possibly achieving health goals more efficiently. The final element is enacting a patient-led treatment plan; this element is related to implementing patient epistemology in that it respects what the patient knows about their capability to enact certain changes. Providers noted that practically speaking, if a patient does not lead the lifestyle changes and/or treatment plan, it can lead to failed attempts to regain their health at best, at worst, the patient becomes unmotivated and possibly even feel shame for not being able to keep up with the plan.

These three dimensions of medical *techne*, *episteme*, *sophia* and *phronesis*, all have rhetorical implications in that they require knowledge of the patient both in the context of medical practice and in the context of a human living in this world, the job of the provider, then, becomes learning how to use rhetorical skill to understand how these contexts impact the disease of the patient. This is a deeply intellectual task that demands more from providers than rote memorization of diagnostic criteria and relies on a rhetoric that can create a mutually fulfilling and open relationship in the pursuit of health.

Further Considerations

For rhetoricians, understanding medicine as a *techne* highlights the importance of a philosophical rhetoric in medical practice. Medicine as *techne* foregrounds the idea that medical

practice can be seen as a series of strategic communicative moves that can persuade the patient to health much in the same way that the *Gorgias* describes a moral rhetoric as being able to promote virtue in a listener. To reiterate, when FM researchers described their successes in working with patients with irritable bowel disease, they stated that "as part of the patient's journey, self-discovery plays an important part in creating a personal map moving toward a healthy state of being" (p. 3). What enables this personal map to be created, and more importantly, the patient to follow that map in a journey of self-discovery, boils down to an understanding of medicine as *techne*, with the *phronesis* or practical wisdom part of that techne being the rhetorical skill and understanding the provider brings to the visit.

In the interviews, FM providers understood medicine as *techne* through the way that they understood what it means to heal and what it means to enact healing processes. As shown in the data, the first step of unlocking this process is by entering the conversation with clinical humility. This humility creates a space for the medicine as *techne* to ensue because it allows rhetorical art to step in and moves away from algorithmic thinking that does not allow for wisdom and virtue to participate. While modern medicine attempts to discover positivistic ways to understand disease etiology, the reality is that disease experiences are different for every person, and providers expressed this sentiment when they said that 10 different people with depression have 10 different reasons for that depression. With this understanding, medicine must be more than *episteme*, it must become a *techne* that uses *phronesis* through rhetoric to tease out definition and meaning. Furthermore, understanding that health is not a destination, but a lifelong journey, the element of *sophia* (wisdom) must be promoted if wellness if to be experienced. This wisdom to teach the patient to know and do better is yet another virtuous element of medicine *techne*, and what is meant when I state that patients must be persuaded to health. The providers in this study

understood this element of medical *techne* by specifically linking health goals with life purpose. Without the attachment of health goals to life purpose, the impetus to make and maintain appropriate changes may be lost. And a medical practice void of such connections is not a *techne*, but rather a hard science. For patients with stagnant health challenges, approaching medicine as a *techne* becomes the answer specifically because a *techne* understands that disease is social, dynamic, and relational, and this idea is specifically enacted in the elements of the Therapeutic Partnership.

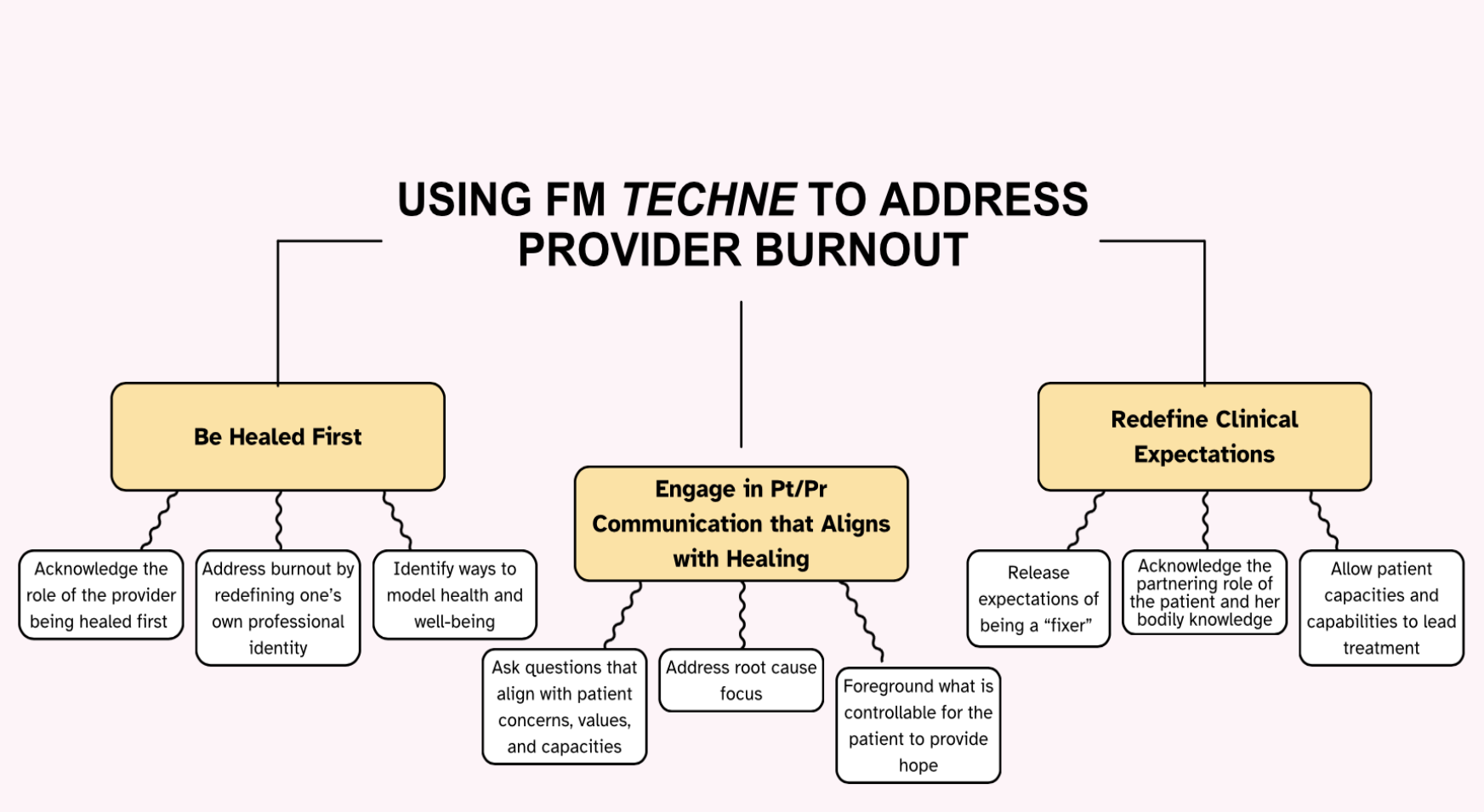

Figure 15 – Using FM Techne to Address Provider Burnout

Tools for Implementing Functional Medicine *Techne*

One of the very first tools FM providers learn to use is the "GO TO IT" model. The GO TO IT heuristic stands for:

G) Gather

O) Organize

T) Tell

O) Order

I) Initiate

T) Track

In the first step, providers are taught to "gather oneself," which translates to being mindfully present in the clinical encounter. This mindfulness provides the means towards "optimizing the therapeutic partnership" (The Institute for Functional Medicine, "GO TO IT," 2022). Secondly, they gather information from the patient through comprehensive intake forms that explore a biopsychosocial history; also part of this process includes the initial consultation, physical exam, and any objective data. In the "organize" stage, providers are to organize the patient's story, identifying any antecedents, triggers, and mediators (ATMs). Antecedents are understood as "those things that have set one up to develop an imbalance" (Jacobs, n.d.). Examples include one's genetics and/or environmental factors. Triggers are events which can cause an imbalance, such as traumatic events, serious infection, or chronic exposure to toxins or allergens in the environment. Mediators are things which "allow an imbalance to continue or worsen" (Jacobs, n.d.), such as person with diabetes continuing to eat a diet high in refined carbohydrates. Once these factors are explored, FM providers use the FM timeline to organize the information systematically. The timeline is pictured below in Figure 16:

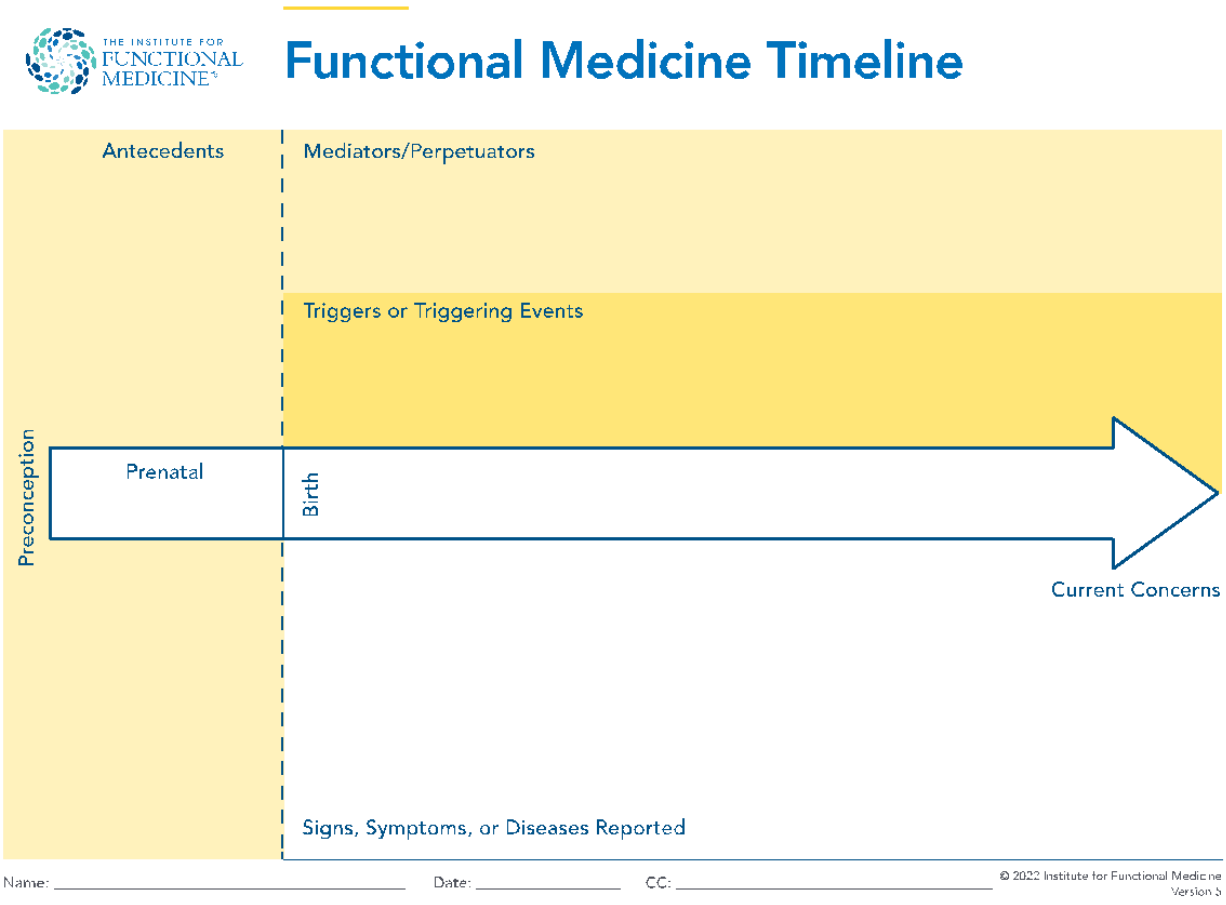

Figure 16 - The Functional Medicine Timeline ("Used with permission from IFM")

In this timeline, a patient's history is explored from birth and includes all ATM's. The goal with this timeline is not only to provide a visual, detailed history, but also to ensure that the patient's story is accurately told, with all important events listed. This leads into the next step, "Tell." In the tell step, providers are told to "tell the story back to the patient in your own words to ensure accuracy and understanding" and that the re-telling is supposed to be a "dialogue about the case highlights" (The Institute for Functional Medicine, "GO TO IT," 2022). Notably, two main elements in this step are to "acknowledge the patient's goals" and to "ask the patient to join

in correcting and amplifying the story, engendering a context of true partnership" ("GO TO IT," 2022). These steps foreground the rhetorical component of the therapeutic partnership, emphasizing the need to establish open and honest communication as patient and provider look towards a shared goal. Once complete, a timeline could look like the following example (Figure 17).

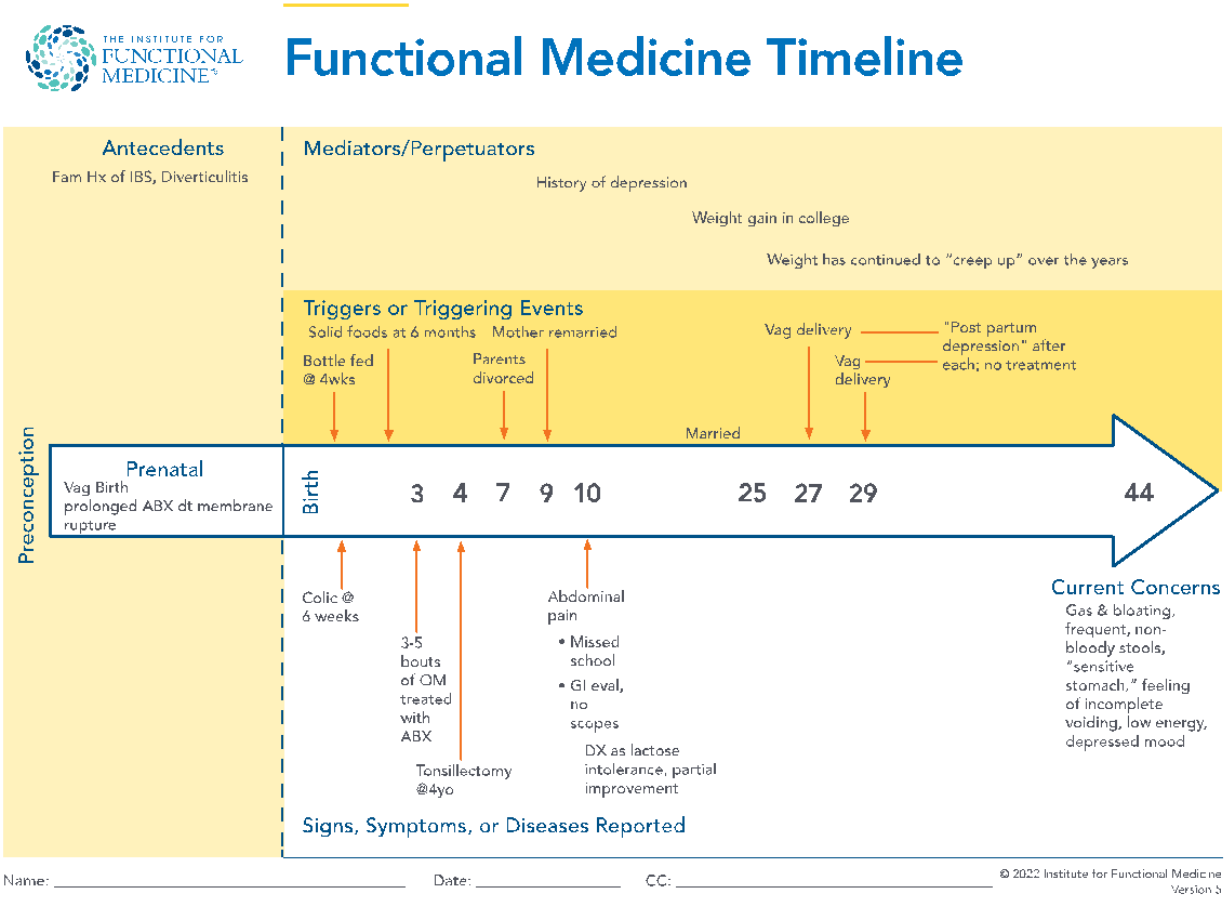

Figure 17 - A Completed FM Timeline ("Used with permission from IFM")

In this timeline, one can see a FM intake is considerably comprehensive, beginning at birth up until the present time. As stated, the above example illustrates how the patient's

information is organized by ATMs, with an emphasis on what is not only important biologically (e.g. family history of IBS), but psychosocially (e.g. parents' divorce at seven years old).

The next step in the FM heuristic is to "order." In this stage, providers are asked to order and prioritize information that emerges from the dialogue from the provider and patient. Notably, providers are asked to assess "the patient's mental, emotional, and spiritual perspective" because they are of "primary importance" (The Institute for Functional Medicine, "GO TO IT," 2022). To complete this step, providers use the FM Matrix, which is pictured below in Figure 18.

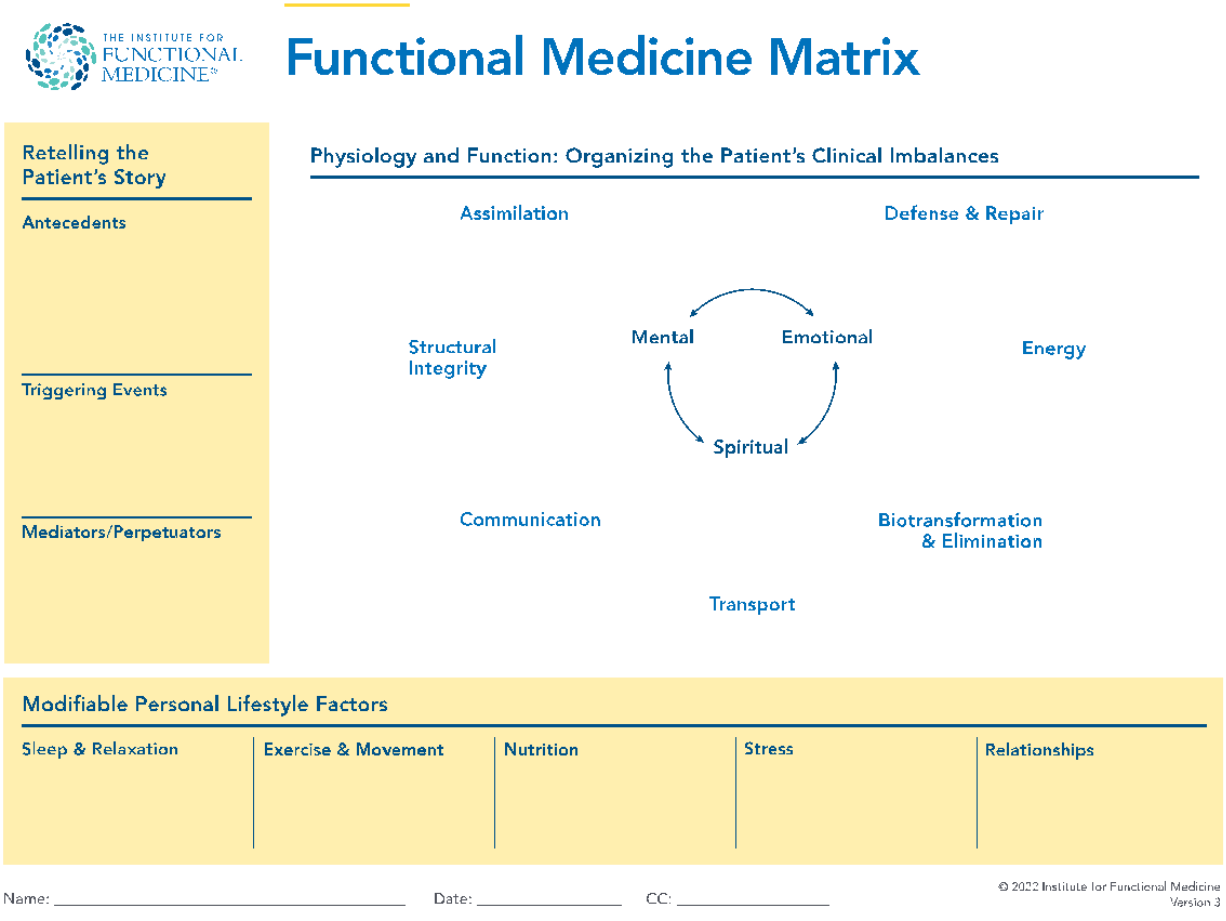

Figure 18 - FM Matrix ("Used with permission from IFM")

In this matrix, a full view of the patient's biopsychosocial history is captured. What is striking about this matrix is how it grounds one of the main values of the Therapeutic Partnership, and that is to truly *know* the patient. Because FM is often described as "lifestyle medicine," it requires knowing more than just the patient's physical symptoms; for example, as seen in the completed matrix below (Figure 19), elements that are taken into account are the patient's "modifiable personal lifestyle factors," such as his current social situation (divorced but has an active social life), sleep patterns (not enough since his 20s), and exercise and movement (low physical activity since his 20s).

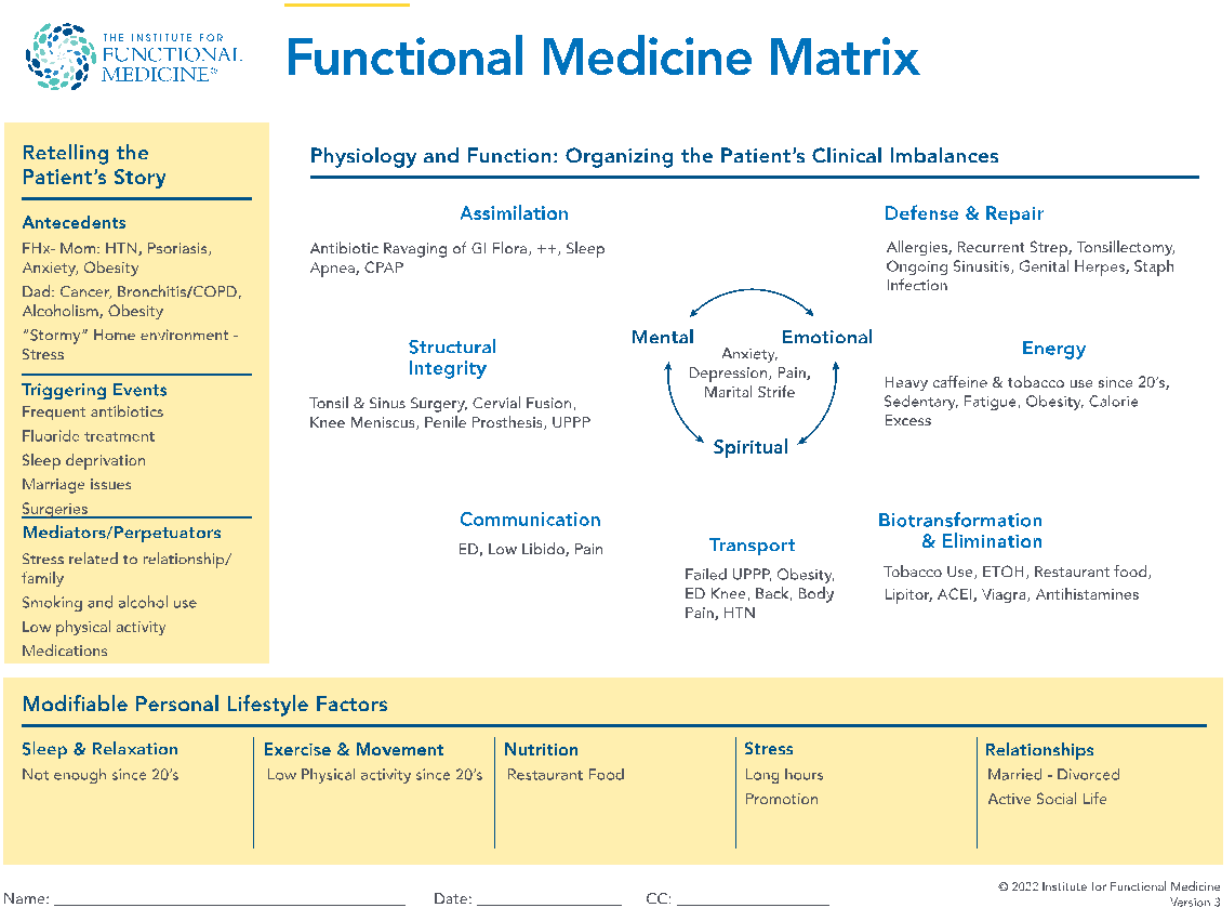

Figure 19 - Completed FM Matrix ("Used with permission from IFM")

Only until all of this information is collected, assessed, and validated by *both* patient and provider can the next stage begin, which is the "initiate" stage. In the initiate stage, providers can begin interventions; these interventions include patient education lifestyle change (e.g. working on nutrition, movement, and sleep) and keeping a journal regarding how these changes are working (or not working). Any appropriate prescriptions or other therapies are also recommended. In the final step, "track," providers are told to "track further assessments, note the effectiveness of the therapeutic approach, and identify clinical outcomes at each visit—*in partnership with the patient*" (my italics). Throughout each stage of the GOTOIT model, patient agency is emphasized, which means that providers must consistently use a communicative approach that not only acknowledges the patient's knowledge and experience but incorporates it into the next stages.

As seen in this heuristic, although what brings the patient to FM may be lasting and progressive physical symptoms, the model for helping the patient extends beyond symptom suppression, the focus is changing the patient's lifestyle to be more amenable towards health and healing; and with the intent to create lasting change, not temporary solutions. With this goal in mind, the provider becomes more than a doctor, she becomes a catalyst, a coach, a guide for an entire mind-body change in the patient. As such, an element of persuasion is inherently evident in this medical approach, patients must not only be willing and open to change, but truly motivated to act on the things that will help achieve their goals. Within the Therapeutic Partnership, the underlying principle is that motivating patients is not a top-down task; to achieve intrinsic motivation and move towards healing, patients must feel believed, understood, and supported. More importantly, they need to feel like responsible agents in their care, and the conventional medical model, especially within the realm of communication, makes this goal

difficult to support due to the rhetorical-cultural constraints that are only reinforced by its infrastructure. In FM, utilizing a rhetoric that values the epistemology of both patient and provider is not only used in the initiation of the healing process, it is also consistently necessary to keep the partnership thriving in order to achieve lasting wellness. A medicine that foregrounds rhetoric is a medicine that acknowledges the humanity of the medical art, and breaks away from the positivistic, technocratic thinking that currently dominates medical spaces. As FM founder Dr. Jeffrey Bland states, "Functional medicine is not a therapy. Functional medicine is a way of thinking" (The Institute for Functional Medicine, "The Therapeutic Partnership," 2021).

Chronicity in FM Tools

Both the timeline and matrix tools can also be further understood through concepts in chronicity studies. The most notable of which come from M.M. Bahktin's *The Dialogic Imagination* (1981). When discussing chronotypes, Bakhtin writes that it is important to note that both spatial and temporal elements are associated with time, creating a whole that illuminates our understanding. He writes,

> Time, as it were, thickens, takes on flesh, becomes artistically visible;
> likewise, space, becomes charged and responsive to the movements of time, plot and history. This intersection of axes and fusion of indicators characterizes the artistic chronotype. (p. 84)

In FM *techne*, the art of medicine, especially that of narrative medicine, is emphasized, and asks that the provider understand the temporal and spatial elements of illness in the course of their patient's life. IFM promotional materials describe the Timeline as such:

> This foundational tool enables the patient to detail their life and health history and the clinician to plot it chronologically, often revealing previously unseen relationships

> between various factors. Through retelling their own health stories, patients often see connections between life events, health behaviors, and current states of disease, which may motivate them toward change. What makes the Functional Medicine timeline different from other tools is that it has the effect of giving the patient insight into previous life events and validates for them that their story has been heard. (IFM, 2024a)

As seen through this description as well as through the sample completed Timeline, the Timeline tool helps FM providers make the patient's illness story take "on flesh" and become "artistically visible." It is thus the *techne* of the provider to see the axes and fusions that can reveal how these intersections create an understanding of the condition. This understanding reflects the understandings of chronicity that were expressed in the provider interviews, as they often stated the importance of the Timeline tool and how it serves to not only create a healing relationship, but also to fuse patient understanding with clinical methodology.

These intentional acts and understandings centered in chronicity fuse literary and rhetorical elements of FM *techne*, making the provider's tasks deeply and inherently steeped in the arts of language. Building on these ideas, on the IFM website they describe the Timeline tool as a key part of decoding the chronicity of disease, writing that,

> The Functional Medicine Timeline is a graphical representation that allows clinicians to identify factors that predispose, provoke, and contribute to pathological changes and dysfunctional processes in the patient's physiology. In this way, both practitioners and patients can identify cause-effect relationships that might otherwise go unnoticed. By covering the period from preconception to the present, the timeline reflects the connection between the whole lifespan and one's current health. (IFM, 2024b)

What is described here is the specific way chronicity is understood in FM *techne*, and that is through the concepts of Antecedents, Triggers, and Mediators. As described earlier, antecedents are what predispose a person to disease, triggers cause the imbalance, and mediators perpetuate or worsen the imbalance. Thus, conditions are seen through a temporal lens but also through identification of these life events as ATMs. This idea resonates with Singer and Jack's (2020) idea that chronicity relates to a rhetoric of identification; and the identification of these ATMs is rhetorical in that it relies on an interpersonal, contextual understanding of the patient's unique situation in relation to the course of their life and illness. Furthermore, through this explicit focus on chronicity, the idea is to understand the disease in depth in order to address the root cause of disease and not simply delay a worsening of symptoms. With health resilience being one of the goals of FM medicine, it relates back to a Bakhtinian chronotype called "the life course of one seeking true knowledge" (Bakhtin, 1981, p. 130). This true knowledge is not only to inform the provider about the patient's illness story, but also to help the patient better understand how the course of their life may have contributed to their illness, making chronicity both a clinical and educational tool. In an article written by FM providers, Lamb et al. (2022), write that "programs aimed both at defining an individual's authentic self and at providing patient education using Functional Medicine's philosophy, are uniquely suited to the re-creating, visioning, and new behavior adaptation that is the work of successful behavioral change" (p. 38). In FM spaces, this philosophy towards chronicity may result in the patient reclaiming her life's purpose by choosing wellness in all domains of their life: mental, physical, and spiritual.

Chapter Summary and Takeaways

This chapter presented an analysis of the interview and archival data, specifically centering on themes regarding provider burnout, the healer identity and healing environment, and

how medical practice is conceived of as a *techne* through FM clinical methodology. Although provider burnout was coded the least amount of times, this finding in relation to the data illustrates that addressing provider burnout is a critical first step in implementing Therapeutic Partnerships. Additionally, it is important to note that FM methodology, through the Therapeutic Partnership, accounts for the well-being of the patient *and* the provider. And one of the main ways the interviewed providers accounted for their well-being is by aligning their values as self-identified "healers" with their medical practice. The main strategy for creating this alignment was through FM methodology, specifically, Therapeutic Partnerships; however, some providers noted that this change could also be done outside of FM spaces. This included bringing a different type of awareness to the clinical conversation, one that foregrounds FM principles in a way that gets to what is meaningful to patients in order to create lifestyle change. Another area of consideration for the data included how FM tools conceive of chronicity as a way to create wellness in all domains of a patient's life, adding yet another purposeful layer to FM *techne*.

CHAPTER VII

DISCUSSION

The results of this study add to various discussions regarding the current issues facing medical providers as they navigate burnout and work to actively create a medical practice that is understood as an art rooted in the principles of *techne*. It is important to note that although this study initially sought to focus solely on providers' perspectives on how the Therapeutic Partnership transformed their conceptions and the manifestation of the medical art, the interview results showed the importance of discussion provider burnout when considering this topic. Because, as Dr. Lewis said, "we have to be talking about taking care of doctors, when we talk about this whole conversation. How do we take care of them? How do we train them? How do we allow them the time to get to know their patients?" Ultimately, this study suggests that incorporating a rhetorical philosophy in clinical practice helps to produce an awareness that can transform the provider's own professional perception and identity to help produce a medical *techne* that works better for providers and patients. This medical *techne* is founded on provider *and* patient-centered ethics to create an understanding of the medical art through its communicative aspects, resulting in a dynamic healing environment and creating opportunities to combat epistemic injustices. Ultimately, these discussions point to the need for an increased awareness and incorporation regarding the role of rhetoric in medical spaces, especially as it relates to providers seeking ways to mitigate and prevent burnout.

Techne **and Provider Burnout**

An important takeaway from this study is the way that conceiving of and practicing medicine as a *techne* can help mitigate and prevent burnout by aligning providers with their own professional identity and values. Medicine as a *techne,* as evidenced in the Therapeutic

Partnership, foregrounds provider health and professionalism in a way that uses rhetorical awareness and strategies in order to promote provider health and more in-depth patient care through partnership. As shown, the providers in this study specifically pointed to rhetorical awareness in order to combat burnout, and it began with first identifying with being a "healer" or part of the "healing arts." This identification then leads to a different conception of what it means to practice medicine, one that foregrounds both the provider and the patient in a partnership with equal respect and footing in order to get at the root cause of illness. These findings add to discussions in provider burnout studies by highlighting the role of rhetoric as a way to mitigate and prevent burnout. And while it is important to note that FM providers often do work outside of conventional models that usually allow for more time and more clinical freedom and creativity, some providers noted that even the smaller elements of their *techne* can be utilized in constrained settings to help mitigate some aspects of burnout. Examples include consciously utilizing self-care strategies with the intent of being "healed" in order to enter clinical conversations as a model of their lifestyle medicine approach and using questions that are focused on the root cause of illness and that aim towards the patient's concerns and capacities. These findings also relate to the issue of finding meaning and purpose in one's profession, which is an aspect in mitigating burnout (NAM, 2019). For providers, especially those in this study, meaning and purpose was drawn from their relations in patient care as it relates to helping them achieve healing. For them, these experiences helped to provide them with professional joy that made their work as providers meaningful on new levels. As Dr. Martin explained, using this approach in medical practice creates "exciting conversations." "It's one thing to know what's possible and how things work. And it's a whole other thing to try and operationalize that to a conversation that means something to [the patient], that we get to a shared understanding, and

then leads to first steps and tangible strategy that is simple and makes sense to [the patient]. It is such a different mental game," he said.

Epistemic Injustice

Another area of research that this study adds to is the idea of epistemic injustice in medical spaces. In 1984, Beckman and Frankel's research on clinical encounters found that the average amount of time between a patient speaking and a doctor interrupting her was 18 seconds (Beckman and Frankel, 1984). Recently, Phillips, Ospina and Montori (2019) found that the average number of seconds before a patient was interrupted by a physician had gone down to just 11 seconds (p. 1965). Scholars in healthcare ethics highlight these striking numbers as a way to illustrate why discussions surrounding epistemic injustice matters (Carel and Kidd, 2014; Pot, 2022). The idea of epistemic injustice, first introduced by Miranda Fricker (2007) in her influential book *Epistemic Injustice: The Power and Ethics of Knowing*, is defined as "a wrong done to someone in their capacity as a knower" (p.1). Since her book was published, epistemic injustice has been a lens used by healthcare and clinic ethics scholars to study the power imbalances between providers and patients, and in particular, with chronically ill patients. In healthcare settings, epistemic injustice occurs when "healthcare professionals disregard patients' knowledge as relevant to understanding their afflictions and the care they receive and opt instead to act solely on the basis of their own knowledge and expertise" (p. 688). Numerous studies illustrate the issues chronically ill patients have regarding not just communication, but specifically, communication that acknowledges their epistemic standing in medical spaces (Blease, Carel, and Geraghty, 2017;). For example when assessing the experiences of patients with chronic pain, Buchman, Ho, and Goldberg (2017) state that these patients often have trouble

being taken seriously, in particular because of the epistemic hierarchies that exist within Western medicine. They write,

> When chronic pain impedes the production of clinical knowledge by defying the easy objectification that is at the core of the epistemology of Western biomedicine, it becomes subject to doubt and scepticism. Epistemic agents cannot see the visible pathologies that correlate with this particular illness complaint. Often enough, this epistemic problem leads to metaphysical doubt regarding the existence of the illness itself. (p. 34)

Valuing objective reports and visible pathologies over illness experiences is a concept that most would agree is a staple in conventional medical thought. However, when these epistemic hierarchies override patients' epistemology and experiences within the clinical space, scholars note that it can lead to consequences that go against the intended goal of medicine (to relieve suffering, and potentially heal) due to a lack of human connection and meaningful relationship. Kidd and Carel (2017) note that some of these consequences include an "unwillingness or inability of ill persons to give complete or accurate reports of their symptoms and adherence to treatment" which can turn into more testing or referrals to other providers (p. 173). The providers in this study, who foreground patient illness and epistemology as part of their clinical method acknowledged these pitfalls. For example, Dr. Cooper stated in his interview that he works to get into patients' "hearts and minds," always showing that they are "in it together" because if there is no "buy in from the start point, then it just crumbles." But for the provider interviewees, welcoming patients' narratives and epistemologies is not just an empty gesture to get patients onboard with treatment plans; in fact, providers often stated in their interviews that a patient's story is "the most important part of this encounter."

As seen through the various FM tools, such as the matrix and timeline, a patient's experience has clinical and epistemic relevancy in these spaces and works in conjunction with FM providers' scientific training to get a more complete picture of the issues at hand. These tools go beyond the values and strategies presented by patient-centered care and narrative medicine models and illustrate what Mirjam Pot (2022) describes as "epistemic solidarity" (Pot, 2022). Scholars have tried to push back against epistemic injustices advocating for epistemic humility, but Pot argues that this approach not enough because humility is only an attitude and not an act, instead epistemic solidarity is a practice of "supporting others (with whom one recognizes similarity in a relevant aspect) as knowers. To qualify as solidarity, these practices must involve particular costs (such as spending time, giving up a privilege, or accepting risk for oneself)" (p. 685). For the providers in this study, epistemic solidarity best characterizes their approach to patient epistemology because it requires providers to not just solicit patients' narratives, but to incorporate it into their clinical methodology. This act requires epistemic humility as well as a sincerity when accepting patients' knowledge and understanding, which gives patients a moral standing in medical spaces. But as Churchill, Fanning, and Schenck (2013) write, this can only be done with the provider in agreement; they write: "the patient's moral authority is finally not just the authority to refuse care or the right to be treated with respect and dignity. The real authority of patients is having their framework of experience taken seriously as a basic normative structure for shaping the moral imagination of those who are committed to helping them heal" (p. 136). Furthermore, the concept of epistemic solidarity recognizes that patients and providers are in a shared experience from which they can learn and grow together. To illustrate, Dr. Cooper stated in his interview that he tells patients, "As we do this work together, you're not the only one who is going to heal from it. I'm also going to start to heal from it." He furthered, "when

patients start to have this connection, where both of us are getting something from what we're doing, they feel that they have a responsibility not just to themselves, but to their practitioners." This responsibility, providers stated, can turn not only into agency and power, but into the motivation needed to create a lifestyle that works against illness.

FM *techne* also furthers conversations in epistemic injustice by addressing what Kidd and Carel (2017) note as two main concerns in this area: patient complaints and provider complaints. The patient complaints, they write, often look like reports that healthcare professionals "do not listen to their concerns, or that their reportage about their medical condition is ignored or marginalized, or that they encounter substantive difficulties in their efforts to make themselves understood" (p.173). And the physician complaints are that patients provide "medically irrelevant information, make odd statements and superfluous remarks about their condition, or otherwise fail to contribute epistemically to the collection of medical data (p. 173). With respect to patient concerns, FM approaches address these concerns by working to validate and truly listen to patients. In the interviews, the providers stated that their intention is to "listen deeply with an open heart." The listening is thus, not an empty act, but a therapeutic one with the intent to validate their epistemologies. And with respect to providers' concerns, it reframes the idea about what information is "odd" or "superfluous." In FM *techne*, information from the patient is valued as a whole because it helps to contribute to the understanding of the patient as a person living with a specific condition. The provider interviewees acknowledged that their questions are different; for example, Dr. Evans stated in her interview that patients have told her, "I've never had a doctor ask me that" or "No one's ever listened to this before." Understanding that illness exists in the context of a person's life, these different questions elicit and contribute to a different methodology, one that engages epistemologies equally. And this methodology allows both

provider and patient, as Dr. Moore said in her interview, to ruminate on what they discussed in relation to their condition. She said patients will tell her, "I never put all this together." "So they start piecing it together themselves, like they start seeing that there's a correlation between their illness and things that happen to them," Moore stated. In FM spaces, epistemic injustice is directly challenged through a manifestation of Pot's theory of epistemic solidarity, especially as it is grounded in a biopsychosocial approach that acknowledges the dualism of being a human. Just as humans do not exist outside of their context, neither does disease. And with this perspective, FM patients and providers work collaboratively through rhetorical work that foregrounds and values all of the knowledge and experience brought to the clinical encounter; this method allows patients to feel engaged and validated and allows providers to further their understandings of illness as a lived reality that requires a multi-epistemic approach.

Implications

Humanities, Medicine, and Rhetoric

The provider interviewees indicated the importance of the role of the humanities in medical practice by distinctly prioritizing communication and relations between providers and patients. This important relationship between the humanities and medical practice is often cited by RHM scholars and adds to the overall discussion about how and where the humanities fit in medical practice and spaces. RHM Scholar Cathryn Molloy (2020) writes that we need to "interrogate and work on the edges of the arbitrary borders between the humanities, social, and hard sciences" (p. 9). Furthermore, RHM scholarship "advocates for productive hybrid scholarship that engages meaningfully with (rather than dismissing as irrelevant) basic epistemological assumptions of other disciplines" (p. 9). For scholars in the humanities as well as medical providers who acknowledge medicine's human connection, assuming and

acknowledging the inherent connection medicine has with the humanities may come easily; and definitions of medicine often trend toward what surgeon and writer Atul Gawande (2014) noted in his Reith Lectures, which is that "the central act of medicine [is] that moment when another human being turns to another human being for help" (Gawande, 2014). However, as medical practice, technology, and science begin to fuse ever more closely, there are a number of physicians—in addition to the Functional Medicine providers interviewed in this study—who are pushing back against these technocratic approaches to medicine that can make human connection wane. For example, Abraham Verghese (2011) warns against the "iPatient," a concept that suggests the patient is no longer a person but an electronic version of herself that is the composition of electronic notes and test results. "The iPatient gets wonderful care all across America," he stated in a lecture. "And the real patient often suffers just a little bit" (10:51). The idea of the iPatient highlights the potential downfalls of technocratic medicine as it can transform patients into pages of data and doctors into mere interpreters of this information. Dr. Bernard Lown (1999), a cardiologist, also acknowledged this threat, and wrote that the more technology is foregrounded the more there is a danger to the art of medicine. He states,

> a three-thousand-year tradition, which bonded doctor and patient in a special affinity of trust, is being traded for a new type of relationship. Healing is being replaced with treating, caring is supplanted by managing, and the art of listening is taken over by technological procedures. Doctors no longer minister to a distinctive person but concern themselves with fragmented, malfunctioning biologic parts. The distressed human being is frequently absent from the transaction (p. xiv).

Much like the problem that Foucault notes in *The Birth of the Clinic,* the results of this study indicate that the issue facing modern medicine lies in the fracturing of philosophy and medicine,

the fracturing of what Lown describes as a "3,000 year tradition" (p. xiv). This tradition that he notes relates to the Hippocratic ideal that "philosophy should be embedded in medicine, and medicine should be embedded in philosophy." When medical practice is understood as such, it aligns with what medical philosophers He and Lang (2017) and the providers interviewed in this study note: that "medicine is not a pure science; instead it is an evolving elusive system of knowledge, technique, and consciousness because it serves living beings with thought, motion, mentality, will, and related roles in family and society" (p. 255). This conception of medicine describes a postmodern understanding of the medical art that allows for a plurality of epistemologies, embracing the complexities of illness and disease in order to partner with nature and the patient as opposed to attempting to dominate them; and it manifests in the communicative values and rhetorical strategies that make up Functional Medicine's Therapeutic Partnership.

Rhetoric and the Philosophy of Medicine

As stated, for the providers in this study, their philosophy of medicine is rooted in an understanding of medical *techne* that underscores the doctor-patient relationship. By highlighting the intimate and intricate connection between art and science, the Therapeutic Partnership reflects an ancient understanding of the art of medicine that has withstood the test of time. The ancients, especially Hippocrates and Plato, noted the importance of moral and ethical philosophy in medicine as manifested in the doctor-patient relationship, and it is implemented through a rhetoric that emphasizes these values. Notably, in Plato's *Laws* (2016), there is a strikingly analogous description of the interviewed providers' understanding of the Therapeutic Partnership. Plato writes,

> The freeborn doctor spends most of his time treating and keeping an eye on

> the diseases of the free-born. He investigates the origin of the disease, in the light of his study of the natural order, taking the patient himself and his friends into partnership. This allows him to both learn from those who are sick, and at the same time to teach the invalid himself, to the best of his ability; and he prescribes no treatment without first getting the patient's consent. Only then, and all the time using his powers of persuasion to keep the patient cooperative, does he attempt to complete the task of bringing him back to health. (720 D-E)

In this description of the doctor-patient relationship, there is equity and agency that flows through both parties, and the main goal is to work together, in sync and agreement, taking into account the patient's biopsychosocial factors to re-establish health through "powers of persuasion." The emphasis here on persuasion illustrates that the power of rhetoric in clinical spaces is an inherent and important factor in achieving not only better health outcomes but healing, specifically because healing requires the deep involvement of the patient. As the providers in this study noted, when patients are passive recipients of care or are treated as such, they lack the most important element to achieving good health: their own investment. Plato and the FM providers in this study understand patients as more than a physical body, and getting a patient's spirit in alignment with their health goals is where the *techne* requires an understanding of rhetoric. This idea was not lost on Plato, nor is it lost on the providers interviewed for this study.

Because FM providers work in a *techne* that emphasizes whole health over symptom management, the value system underlying the technique is different. For FM providers, their understanding of healing is in line with how Pellegrino (1998) defines healing. He writes,

> Healing means 'to make whole again.' Therefore, ascertaining and enhancing

> all four realms of the patient's good are involved in healing–the patient's biomedical good, his own conception of the good for him as an individual, his good as a member of the human species (i.e. the good for humans), and his good as a spiritual being (i.e. the good for the soul). The concept of wholeness, together with its asymptotic attainment through relationships between, and among, persons is the specific end of medicine. (p. 330)

This definition of healing describes a biopsychosocial approach to healing, which understands that patients are more than the symptoms their bodies exhibit. Furthermore, by emphasizing a patient's connection to not just his provider but also his world in relation to his health, providers express an understanding that healing is beyond the doctor alone: the patient must not only be involved but be responsible. This idea was emphasized by the providers in this study, and they said the responsibility for achieving better health lies on *both* patient and doctor. This idea also resonates with Platonic philosophy of medicine, illustrating an ancient, foundational principle in the art of medicine. Moes (2001) writes,

> According to Plato's conception of the nature of the doctor-patient and philosopher-interlocutor relationships, a good doctor views his patients as agents who are able to cooperate with him in the healing process and who can accept, when appropriate, some responsibility for their condition. The doctor as Plato understands him is neither a mere servant of the patient's wishes–a mere scalpel or pharmacist for hire–nor a despotic master, but rather himself a co-worker with nature and with the patient. (p. 365-366)

What the data in relation to the literature indicates is that FM's understanding of the medical practice, defined as a *techne* that emphasizes the rhetorical art, is in line with a philosophy of

medicine that has lasted through millennia. Although there have been push backs to this approach through the centuries, this study's interviews illustrate a desire to go back to the foundational roots of medical practice. And the results of this study spotlight that one aspect of medicine that will never change is that it requires deep, intimate work between two humans aiming to discover nature's mysteries in order to relieve suffering and allow the body and mind to flourish. The connection of FM *techne* to discussions in philosophy of medicine help to emphasize rhetoric's standing in the medical art. Simply put, rhetoric *is* the medical art and while the science may change, the value system that emphasizes this human connection through communication and partnership is the bedrock upon which medicine is practiced.

Communication in Medical School Curricula

The interviewed providers stated that they received minimal training in communication while pursuing their medical degrees, for some providers communication education was just a one semester class, and for others, this skill was highlighted during their work with standardized patients. But overall, the consensus was that they did not receive enough training in communication during their education. For example, Dr. Jones said in his interview that the deep communication and partnership that FM requires is not taught in medical school. "It may be addressed a little bit, but it's not the standard," he said. "People learn how to treat disease, they don't learn how to treat patients, they don't learn how to treat people." Additionally, Dr. Adams said in her interview that regarding patient-provider relationships, she did not get "too much" of that during her school or residency. As a whole, the provider interviewees stated that once they received the in-depth communication training from FM through the Therapeutic Partnership model, it helped them achieve a depth of practice with patients that allowed them to see health markers move in positive directions; these experiences buttress recent research that illustrates the

FM approach as being more successful in moving the needle with stagnant conditions (Strobel et al., 2022; Droz et al., 2020; Chaney et al., 2022; Beidelschies et al., 2019). In light of these findings, the current study helps illuminate how communication fits within the noted success of FM methodology. The success extends beyond a biopsychosocial, whole-person approach; much like what Mirjam Pot (2022) argues with epistemic solidarity, these two approaches must be more than just an attitude or goal, they must go beyond internal clinic or policy memos, they must be truly implemented into daily clinical practice, and this is done with a conscious approach to communication and patient epistemology.

Study Summary

This study considered how the Therapeutic Partnership encapsulates the idea of medicine as a *techne* by inquiring how Functional Medicine providers conceive of and work within these partnerships to form a different understanding of medical practice. This understanding underscores the main theoretical finding of this study, which is that medicine as *techne* requires a philosophical rhetoric because it encompasses the idea of *episteme* (scientific knowledge), *sophia* (wisdom), and *phronesis* (practical wisdom). The context and exigencies for this study included the rising rates of provider burnout, as well as concerns about poor medical communication and what counts as truth within the clinical space. Functional Medicine is a growing sector of complementary and alternative care, with thousands of new providers being certified yearly, and this approach is steadily showing progress with providers who are seeking different areas and ways to practice medicine, which may be partially due to the corporatization of medical practice, which is a major factor in the increasing provider burnout rates.

Because the underpinning of their clinical methodology is forming Therapeutic Partnerships to find a root cause and achieve whole health, their approach moves beyond a

technocratic center in favor of the patient and her epistemology. Notably, with the Therapeutic Partnership, both provider and patient health is foregrounded, and works from the understanding that the provider must first be healed in order to do his job well. This methodology renders a different understanding of medicine that falls in line with ancient Greek understanding of medicine as a *techne*, which means an art, craft, or skill that has achieved cultural reverence because of its association with moral virtue. Understandings and controversies surrounding rhetoric parallel the debates within the medical sphere, but both are united through the idea that a philosophical rhetoric is what makes them a *techne*. For medical practice, this philosophical rhetoric manifests in patient-provider relation as they seek to make the sick whole again (in mind, body, and spirit); for rhetoric, the moral aim lies in using its power to promote virtue within the speaker. Thus, the rhetorician and the physician become analogous to each other in that they use their respective role to promote good.

With this theoretical background, a constructivist grounded methodology was used to analyze how Functional Medicine providers conceive of their art as a *techne* through the concept of the Therapeutic Partnership. Using semi-structured, intensive interviews, 16 providers were recruited, ranging from newly certified FM providers to senior faculty members. From these interviews, six themes emerged: The Role of Rhetoric in Biopsychosocial Medicine, Patient Narrative, Teamwork, Cultural and Systemic Barriers to the Therapeutic Partnership, Healing versus Treating, and Resistance Against Provider Burnout. Ultimately, these themes illustrate medicine as a *techne* in that they foreground the health and relationship of the provider and patient in order to promote multidimensional healing. And this *techne* is tangibly illustrated in the FM Timeline and Matrix tools. These tools promote a biopsychosocial approach to medicine by asking the patient for a detailed narrative about their life's health history, beginning with birth

and highlighting notable areas where the patient believes their health has never recovered. In the Matrix, lifestyle and relationship factors are explored, underpinning the idea that disease etiology and its continuous existence belong to multiple dimensions. These specific clinical tools demand a rhetorical approach that encourages openness for the patient and clinical humility from the provider, rendering their art more than technical knowledge, but an art with goals that extend beyond the disease, a *techne*.

Thus conceived, medicine as a *techne* becomes fused with rhetorical skill and power, and the interviewed providers often circled back to their relations with patients as not only their art, but the source of their professional joy and fulfillment. Understanding that FM providers often work outside of medical organizations and usually in private practice does allow the freedom to do such work, however, they noted that simple rhetorical approaches that align with their medical *techne* can be implemented regardless of the constraints and demands. For example, asking patients to connect their health goals to their life's purpose was noted as a simple way to connect the patient with what can inspire him to make appropriate changes for his good. Ultimately, this study's findings help to illustrate that medicine as *techne* is an important concept which can be used to improve the health of both providers and patients, as well as to deepen the connection between rhetoric and medicine.

Future Directions

As stated, this study intentionally focused on the perspectives of FM providers with respect to medicine as a *techne*, but the issues and topics that arose regarding provider burnout illustrate a need for a more in-depth, and focused study on this topic, especially as it relates to providers working outside of conventional settings. Such a study could both complement and deepen the knowledge found in this project and potentially provide even more ways to discuss

and address issues of burnout. Additionally, because this work focused on the communicative aspects of the Therapeutic Partnership from a provider perspective, a follow up study with patients would help provide a fuller picture for the findings of this work; thus, I suggest that the perspective of FM patients on the Therapeutic Partnership through the lens of medical *techne* be considered. Scholars in RHM and social scientists would be best suited to do this work as it demands deep knowledge of rhetorical theory and practices, as well as an understanding of patient-provider communication literature. To be able to make parallel comparisons, I recommend following a similar study structure using semi-structured, intensive interviews.

Also, this study's findings indicate an intimate connection between complementary and alternative medicine practices and philosophy, especially as it relates to ancient medical philosophy. Future scholarship in this area could explore the connections between ancient medical ethics, especially those of Hippocrates and Galen, as they relate to CAM rhetorical practices. Scholars in RHM, medical historians, and classical scholars would be best suited to do this work as it demands an understanding of classical texts in relation to rhetoric and medicine. Exploring these connections could help to further the argument that the humanities (and rhetoric, in particular) and medicine have been falsely divided and may reveal that they are more necessary to one another than believed. Generally speaking, ancient and contemporary alternative physicians view medicine as an art that enlists *both* science and philosophy. For example, the Hippocratic triangle contains three elements: the disease, the patient, and the physician. These three elements make up the medical relationship with no one element being hierarchically superior to the other. Galenic ethics are also of note, as he was a prolific ancient medical writer whose works are credited as influencing medical practice up until the mid-17th century. In addition to writing extensively about anatomy, he often wrote about his major heroes:

Hippocrates and Plato, and his writings are a deeply rhetorical blend of philosophy and medicine. When Galen writes about his influences, he often focused on not just scientific knowledge, but also ethical approaches to medicine. These ideas nuance the relationship between medicine, philosophy, and rhetoric, and when combining these thoughts with that of other ancient Greek philosophers, such as Plato and Aristotle, it may help provide a comprehensive view that details how—even at its infancy—medicine was understood as an art that combines philosophy, rhetoric, and scientific knowledge.

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APPENDIX

"Agreement")

"Licensor") and ("Licensee").

the Accreditation Council for Continuing Medical Education ("ACCME")

related to functional medicine (hereinafter, collectively referred to as the "IFM Material")

Licensee understands and agrees that the IFM Material is provided on an "as is"

any implied warranties of merchantability of fitness for a particular purpose. Licensor shall not be liable for any claims related to or arising out of Licensee's use of the IFM Material.

4. **Limitation of Liability**
   a. TO THE EXTENT ALLOWED BY APPLICABLE LAW, NEITHER PARTY SHALL BE LIABLE FOR AY INDIRECT, CONSEQUENTIAL, INCIDENTAL, SPECIAL, PUNITIVE OR STATUTORY DAMAGES ARISING FROM LICENSEE'S USE OR INABILITY TO USE THE IFM MATERIAL.
5. **Indemnification**
   a. Licensee will indemnify and hold harmless Licensor, its officers, employees and agents against any injury, loss, damages, or other liability resulting from Licensee's use of the IFM Material.
6. **Termination**
   a. This Agreement shall be effective as of the date first above written and shall continue through December 31, 2024, unless terminated by Licensor for Licensee's breach of the license granted herein or other use in violation of this Agreement.
7. **Governing Law**
   a. This Agreement shall be governed by the laws of the state of Washington without reference to its conflicts of law principles.
   b. The parties hereby agree that any action arising out of this Agreement will be brought solely in federal court located in Washington, King County. Both parties hereby submit to the exclusive jurisdiction and venue of any such court.
8. **Entire Agreement, Modification; Waiver**
   a. This Agreement, and any exhibits attached hereto, is the entire agreement between the parties with respect to the subject matter hereof and supersedes any prior agreement or communications between the parties, whether written, oral, electronic or otherwise. No change, modification, amendment, or addition of or to this Agreement or any part thereof shall be valid unless in writing and signed by authorized representatives of the Parties. No waiver of any term or right in this Agreement shall be effective unless in writing, signed by an authorized representative of the waiving Party.

IN WITNESS WHEREOF, the Parties hereto have executed this Services Agreement on the date set forth below.

The Institute for Functional Medicine	**Cristina De Leon-Menjivar**
Signature: DocuSigned by: Brian Clintworth 95E059BBF80E417...	Signature: DocuSigned by: Cristina De Leon-Menjivar 01EA90F34E7D4DC...
Name: Brian Clintworth	Name: Cristina De Leon-Menjivar
Title: Chief Finance Officer	Title:

Date: 3/1/2024 | 10:25 AM PST	Date: 2/23/2024 | 2:49 PM PST

VITA

Cristina Elena De León-Menjivar
English Department, Old Dominion University,
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Education
PhD English, Old Dominion University, August 2024
M.A. English, California State University, June 2011
B.A. English, University of California, Los Angeles, June 2005

Publications
De León-Menjivar, Cristina. "A Review of: The Invisible Kingdom: Reimagining Chronic Illness by Meghan O'Rourke." *Rhetoric of Health and Medicine.* June 2023.

De León-Menjivar, Cristina. "Dear Spoonie Mom: Digital Open Letters as Counter Narratives for Chronically Ill Mothers." *Constellations: A Cultural Rhetorics Publishing Space*. 29 November 2022.

De León-Menjivar, Cristina. "Understanding the Experience of Puerto Rican Women with Fibromyalgia: An Intersectional Analysis." *Hispanic Health Care International*. 7 December 2021.

Professional Experience
CHRISTOPHER NEWPORT UNIVERSITY, Newport News, VA August 2024 – Present
Visiting Assistant Professor, Department of English

- Teach college-level English composition courses at a 4/4 load, which includes teaching basic writing, composition, critical thinking, and the research process.
- Develop and implement a curriculum that helps students improve their writing and critical thinking skills.
- Work with college faculty and administration to ensure course quality and student achievement.
- Use technology to further student understanding and achievement.
- Utilize both student and administrator reviews to improve teaching practices and standards.

CHRISTOPHER NEWPORT UNIVERSITY, Newport News, VA August 2023 – June 2024
Adjunct Instructor of English, Department of English

- Teach college-level English composition courses, which includes teaching basic writing, composition, critical thinking, and the research process.
- Develop and implement a curriculum that helps students improve their writing and critical thinking skills.
- Work with college faculty and administration to ensure course quality and student achievement.