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The Rhetoric of Health and Medicine as a "Teaching Subject": Lessons from the Medical Humanities and Simulation Pedagogy

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The Rhetoric of Health and Medicine has only begun to intervene in health pedagogy. In contrast, the Medical Humanities has spearheaded curriculum to address dehumanizing trends in medicine. This article argues that rhetorical scholars can align with Medical Humanities' initiatives and also uniquely contribute to health curriculum. Drawing on the author's research on clinical simulation, the article discusses rhetorical methodologies, genre theory, and critical lenses as areas for pedagogical collaboration between rhetoricians and health practitioners.

Key words: curriculum design, Health / medical communication, pedagogical theory, rhetorical theory

In her 2016 review of Rhetoric of Health and Medicine (RHM) scholarship, Reed (2016) argues that rhetoricians' critical orientation towards institutions of medicine has led to a lack of attention to medical professionals' "rhetorical disabilities" and limited pedagogical interventions (p. 19). In contrast, the Medical Humanities (MH) have successfully promoted curriculum to address medicine's limitations, positioning themselves as a humanizing force within coursework that they claim can desensitize its students. This article argues that rhetoricians can learn from MH's pedagogical interventions to better frame our contributions and argue for our relevance to health education. The two fields share commitments to critical thinking, patient-centered care, and empathy in educating health practitioners, as well as methodologies designed to unpack and intervene in communication practices. However, we should also learn from the limitations of MH curriculum and its often devalued role within medical institutions. Rather than positioning our curriculum in opposition to so-called dehumanizing medical education, we can value our alignments with pedagogy in the health sciences and frame ourselves as collaborators with health educators. I argue that we are uniquely positioned to take on this role given: 1) our ability to move flexibly between close reading methodologies and methodologies that attend to larger patterns across data sets; 2) our attention and interest in a range of pragmatic and pedagogical genres outside of narrative; and 3) critical engagement with communication practices that can be held accountable to practitioners'[1] aims and pedagogical applications.

As an example of these opportunities for collaboration, I turn to my experiences researching and contributing to simulation pedagogy in health education. Medical humanists tend to dismiss the use of simulation to teach medical communication, arguing that it is too focused on technical skills and promoting narrative medicine as an alternative (Bleakley & Marshall, 2013, p. 129; Arntfield et al., 2013, p. 280). However, research in the health sciences on

simulation (including nursing and social work, as well as medicine) shares pedagogical commitments with both MH and RHM to using simulation to teach empathy, collaborative communication, and patient-centered care (Levett-Jones & Lapkin, 2014; Bearman et al., 2015; Adib-Hajbaghery & Sharifi, 2017). Through my work as a rhetorician investigating clinical simulations, I have found ample opportunities to both collaborate and intervene in health pedagogy and to contribute to a growing understanding of health communication practices in RHM. For example, this research has led to a chapter for a nursing textbook that unpacks strategies for teaching writing practices during simulations; coordinating a writing center site at a medical college library and organizing writing workshops for faculty ranging from Orthotics to Public Health; as well as traditional scholarship on genre and gendered learning in nursing simulations (Campbell, 2017).

In this article, however, I focus on my experience working with health educators to write simulation scenarios as an apt example of the kind of research-based collaboration on health education that I envision becoming prominent in future RHM work. As I demonstrate, this work benefits from the unique methodological, theoretical, and critical lenses that we bring as rhetorical scholars and from alliances with health practitioners that are already fundamental to much of our research. As collaborators with health practitioners, RHM scholars can also help expand curricular interventions beyond just the purview of physicians to include nurses, social workers, health care aides, EMS and first-responders, and others who are frequently overlooked in MH programs (Barber & Moreno-Leguizamon, 2017). In this way, RHM can build upon its critical orientation towards medical institutions, to recognize the range of health practitioners' "rhetorical disabilities" and the multiple opportunities for intervention and change.

THE MEDICAL HUMANITIES IN PRE-HEALTH AND HEALTH CURRICULUM

Curriculum in MH goes by a number of names and can come in various instantiations—from an undergraduate course on social determinants of health (Martinez et al., 2015) to a reflective writing exercise that supplements medical students' clinical rotations (Shapiro, Kasman, & Shafer, 2006; Welch, 2000). These programs share a common commitment to employing methodologies, vocabularies, and material from one or more humanities disciplines (i.e., literature, history, visual and performing arts) in order to teach "health professions students how to better understand and critically reflect on their professions" (Shapiro et al., 2009, p. 192). Jones (2013) draws a distinction between programs that are more aesthetically oriented – focusing on literature's "practical immediacy in clinical work" – and those that are ethically oriented towards holistic development of the medical student (p. 418). Overall, MH has made a mark on both undergraduate and graduate health curriculum, attributed in part to efforts to correlate the outcomes of humanities coursework with the competencies of medical professionals. That said, MH pedagogy faces ongoing challenges in gaining legitimacy and funding within medical institutions. This section offers an overview of MH's successes and limitations with curricular intervention as a foundation for understanding the unique role that RHM can play in contributing to the training of health practitioners.

Across levels and programs, the visibility and growth of MH curriculum is clear. A 2016 report on Health Humanities Baccalaureate Programs found that curriculum had quadrupled since 2000, going from 14 programs to 58 (Berry, Lamb, & Jones, p. 5). At the post-baccalaureate level, 69 of 133 accredited schools in the United States required a course in MH (Banaszek, 2011). In addition to curriculum development, research on MH programs is widespread, with a growing presence in international scholarship (Ousager & Johannessen, 2010;

Dhakal et al., 2014; Supe, 2012).

Still, MH faces substantial challenges in moving out of what Bleakley and Marshall (2013) call a "weak version of inclusion" that positions coursework as supplemental and towards a "strong version" that integrates humanities curriculum with scientific material (p. 129). The inoculation view of MH curriculum – that a humanistic worldview can be acquired in a single, one-off course – sets unattainable goals and contributes to its devaluing among students, faculty, and administrators alike. On an institutional level, this perspective manifests through a lack of funding for MH curriculum, even as it might receive verbal commendation (Lehman et al., 2004). On a local level, students often question the relevance of MH and perceive it as "fluffy," suggesting that the curriculum should be elective (Shapiro et al., 2009; Arntfield et al., 2013). These perceptions can remain static as students transition into professional roles and view MH with ambiguity or contempt (Knight, 2006).

One method employed by MH to counter perceptions that it lacks rigor or relevance has been translating outcomes of humanities coursework into medical competences. MH scholars position their curriculum in relation to statements by accrediting agencies, aligning themselves with shifting standards for the MCAT exam and physician accreditation (Doukas et al., 2012; Zimmerman & Marfuggi, 2012). Scholars identify professionalism, communication, and collaboration as shared competencies (Arntfield et al., 2013). They emphasize how skills like empathy, critical reflection, and close reading and listening might address gaps in medical education, which have led to high instances of medical error (Bleakley & Marshall, 2013).

Of course, aligning curriculum with professional competencies also necessitates that MH scholars develop systems for assessing students' skill acquisition. The field appears to be split between calls for more comprehensive quantitative assessments of humanities outcomes and

arguments that such assessments are in direct conflict with the epistemological positioning of MH itself (Barber and Moreno-Leguizamon, 2017; Shapiro et al., 2009). Shapiro et al. (2009) assert that the humanities offer, "an understanding of attitudes, knowledge, and behaviors as dialogical […] incomplete, partial, and inevitably biased" (p. 195). The question remains how to persuasively measure this situational and dialogic knowledge for faculty and administrators in medicine. In short, MH still face what Holmboe (2016) has called "translational challenges" or what RHM might recognize as rhetorical challenges. And yet, rhetorical scholars are rarely included among those teaching or publishing on MH pedagogy, with a few exceptions like the *Journal of Medical Humanities* special issue on the rhetoric of biomedicine (Lyne, 2001).

MH's success in contributing courses to medical education and articulating connections to medical competencies offers RHM a model for engaging directly and persuasively with the health fields in course development and scholarship. Beyond critiquing medical practices, MH has positioned itself as a necessary supplement to medical curriculum and RHM scholars should look to their work as we develop and assess rhetoric courses designed for health practitioners. Meanwhile, rhetorical scholars are likely to find that curricular affiliations with MH programs can create a necessary foundation of visibility and recognition. However, it is important to look for opportunities to align with MH initiatives without trying to compete for limited space in medical student coursework. I offer specific suggestions for possible curricular alignments between RHM and MH in the conclusion. At the same time, I argue that RHM can look beyond developing one-off courses to humanize medical education and can aspire to widespread curricular collaborations with a range of health practitioners. As an example of a space with numerous opportunities for research-based curriculum design, I turn next to conversations about simulation pedagogy in both health education and MH scholarship.

CLINICAL SIMULATION AS A SITE FOR PEDAGOGICAL COLLABORATION

In the following scene from a clinical nursing simulation, a junior year nursing student is negotiating a conversation about delivering pain medication with an elderly female patient. Her instructor is responding as the patient through a voice box in a lifelike robotic manikin[2].

Student: So this medication is actually going to be given rectally and so…
Patient: Excuse me?
Student: Yeah, I know. It's actually so that it works faster for you because it's surpassing you know, it's not going through all of your body. It's just going right in there.
Patient: Oh golly, dear…
Student: It's not going to hurt too much though. It's a pretty small pill.
Patient: But still…
Student: Yeah, I understand. If you're, just you know, let us know if you're feeling too uncomfortable.
Patient: Oh, I am feeling too uncomfortable.
Student: You're feeling too uncomfortable?
Patient: Yeah I've never allowed anything to go in that area. You know dear, I have some Tylenol right here in my purse. How about if I just take some of that?
Student: We can actually call the doctor and ask and see if that's alright.
Patient: Oh that would be…
Student: Would that be good with you?
Patient: That would be terrific. She's very reasonable.

During her phone conversation with the doctor (played by another instructor), this student will learn that patients are not authorized to take medications from home while in the hospital. She will also learn that the medication order can be changed from rectal to oral with doctor approval. In the debrief conversation that follows this group's care, instructors and fellow students praise the student for her willingness to be responsive to patient needs, but also point out how she had a tendency to interrupt the patient early on, talking over her obvious concerns.

This scene was one of hundreds that I observed during a year of ethnographic research on the nursing program at a mid-sized private university in the Northwest[3] and one of thousands that take place every year in health programs across the United States. A 2000 report from the

Institute of Medicine defines simulation as "a training and feedback method in which learners practice tasks and processes in lifelike circumstances using models or virtual reality, with feedback from observers, other team members, and video cameras to assist improvement of skill" (Kohn, 2000, p. 176). As such, clinical simulations can range in complexity from practicing technical skills on a model body part – like catheter insertion on a plastic model of a female pelvis – to interactive exchanges like this one. Simulation scenarios typically occur in life-like environments and include conversations with the patient and other providers, in addition to practice with technical skills like drug administration or wound care (Bradley, 2006; Nehring & Lashley, 2009). In fact, a growing area of interest and research within health fields is the use of simulations to teach interprofessional communication between physicians, nurses, social workers, and other healthcare providers (Booth & McMullen-Fix, 2012; Zhang, 2009).

In the short exchange described above, a nursing student is practicing the complexities of the practitioner-patient conversation and learning about how her relative power might silence patient concerns. She is coming to understand how clinical genres like the physician's orders inform patient-nurse conversations, but can also be flexible in response to patient needs. As this example suggests, current health sciences research on simulation focuses not only on teaching technical skills but also on fostering humanistic competencies. Nursing scholarship often evaluates student development of skills like empathy, critical thinking, close listening, and reflection using both qualitative and quantitative measures, including case studies, interviews, and surveys (Levett-Jones & Lapkin, 2014; Bearman et al., 2015; Adib-Hajbaghery & Sharifi, 2017). Given its investment in humanistic training, simulation pedagogy offers ample opportunities for collaboration between humanities scholars (from both RHM and MH) and health educators.

That said, a dominant response to simulation pedagogy in MH has been dismissive, positioning narrative medicine as an alternative for teaching ethics-based communication practices. Bleakley and Marshall (2013) claim that the increase in instances of medical error is evidence of the failure of simulation, reifying misconceptions that simulation practices teach only "technical skill." Meanwhile, Hanna and Fins (2006) argue against "exclusive reliance on simulation training," while proposing MH as an alternative pedagogical approach. This argument misrepresents the role of simulation in medical pedagogy, since simulations are used before and simultaneous with hospital training with real patients (Nehring & Lashley, 2009).

Overall, MH scholars argue that empathetic care is tied to internal self-development and thus, will be more effectively cultivated outside the confines of formalized professional training (Arntfield et al., 2013, p. 280). As Hanna and Fins (2006) claim, "If we want medical students to be able to *be* good doctors rather than merely to *act* like good doctors, then we need to also teach them to actually create authentic relationships with their patients, from inside themselves (from their hearts, so to speak)" (p. 267). The suggestion here that cultivating internal self-understanding will naturally translate into external relationships with patients is perhaps the most frustrating aspect of this position for me as a rhetorician who studies simulation. Looking back at the conversation that began this section, I feel confident in asserting that reading stories of illness alone will not adequately prepare nursing students to navigate this exchange.

Exposure to medical narratives is a fantastic way to foster empathy for patient experience, but these narratives do not offer health care professionals practice with navigating unpredictable patient exchanges. What can help students to develop patient-centered conversational strategies is practice with a range of challenging and volatile conversations like the ones that happen everyday in trauma centers, hospital rooms, and healthcare clinics;

observing other students' attempts at navigation; and critical reflection. Or as Makoul (2006) explains in his response to Hanna and Fins, in simulations "students are learning to negotiate the nonlinear nature of human communication, the complexity of emotion, and the sometimes competing agendas of physicians and patients" (p. 273). MH scholars often relegate simulation pedagogy to the "technical issues of face-to-face encounters" while suggesting that the humanities are unique in fostering the complex habits of mind that contribute to ethical clinical practice (Bleakley & Marshall, 2013, p. 129). A more productive orientation to simulation, however, might recognize that "humanistic learning is likely to be most useful if combined with teaching and learning about clinical skills rather than offered as a stand-alone activity" and find opportunities for aligning curricular work (Makoul, 2006, p. 273). As the following example demonstrates, RHM scholars are well positioned to take on this work of collaboration and alignment, in simulation education and beyond.

A RHETORICIAN NAVIGATES SIMULATION EDUCATION

In my third year of graduate school, I received an email from the Center for Interprofessional Education and Simulation (CIES) at my graduate university. They were looking for someone with creative writing experience to help write several short narratives about conflicts in hospital workplaces to support discussion and critical reflection among physicians-in-training. They contacted me because my name was first alphabetically in an online list of English graduate students. Importantly, it was not my identity as a medical rhetorician or research on clinical simulation that made me visible; it was my location in an English department, which the medical faculty associated with affinities for humanistic skills like story telling. At the time, I was in the beginning stages of planning a year-long ethnographic study of

clinical nursing simulations. I replied enthusiastically, clarifying that I did not consider myself an expert in creative writing but that "I would bring to the project some knowledge of research on communication in healthcare settings." The researchers agreed that it was a good fit and we began a summer-long collaboration, with frequent meetings and opportunities for feedback on the three narratives I composed.

Prior to my involvement, a team of researchers at CIES had conducted over 100 semi-structured interviews with healthcare practitioners about conflict in hospital workplaces. They coded their data using discourse analysis methods to identify nine contributing factors and seven main consequences of conflict. My job, then, was to compose simulation narratives that accounted for a range of these contributing factors (e.g. interpersonal communication and institutional structure) and consequences (e.g. employee satisfaction and patient safety). The group also asked that these scenarios work against some of the common assumptions about power in hospital contexts. One researcher said to me, "The physician is always a male and a 'bad guy'; the nurse is always a female and the 'victim.' We want to mix that up." Thus, I had to think carefully about the choices I was making with gender, racialized names, and professional roles and how those choices were perpetuating or challenging assumptions in the field. During the process, team members (both clinicians and non-clinicians) would offer feedback on my scenarios and answer my procedural questions about the hospital context.

Previous RHM scholarship has called for rhetorical contributions to health pedagogy. Segal (1998) argues that while rhetoricians may encounter resistance or apathy in sharing their findings with practitioners broadly, "critical pedagogy" offers a site for collaboration: "Practitioners may be content with their own discursive practices and their own genres, but acknowledge difficulty in passing particular modes of writing on to students" (p. 86).

Specifically, Lingard (2007) argues that rhetoric has contributed insights in three domains of medical practice—the standardized genres used to teach novices, team communication and socialization, and communication errors (p. 124). Meanwhile, Landau and Thornton (2015) discuss two versions of an undergraduate RHM course, arguing that these courses help students to critically engage with and produce messages about health, foster interdisciplinary connection-making, and "affectively energize" students and teacher (p. 528). My own experiences as a rhetorician working within clinical simulation reinforce Lingard's emphasis on genre theory and Landau and Thornton's discussion of the critical lens as key rhetorical contributions. I also found rhetoric's methodological flexibility to be an important resource for shared meaning-making and collaborations with the medical sciences. Below, I offer three claims about the relationship between RHM scholarship and medical pedagogy, overviewing previous RHM scholarship on health practitioners and sharing anecdotes from my collaboration with CIES that demonstrate both possibilities and limitations. Overall, this experience offers one example for the kind of mutual learning I believe is possible through research-based RHM curriculum development in collaboration with health practitioners.

1. Ample opportunities exist for applying rhetorical methods – especially rhetorical analysis, discourse analysis, and qualitative assessment – toward developing pedagogical materials in healthcare.

Traditional rhetorical analysis often entails close reading of examples or case studies to understand how texts position and persuade their audience, "emphasiz[ing] the situatedness of discourse, consider[ing] stylistic components (i.e., metaphor, trope) as key to persuasion, and culminat[ing] with a judgment about the rhetorical practice(s) being considered" (Lynch &

Zoller, 2015, p. 498). Using textual analysis methods, scholars in RHM have unpacked the messages communicated to healthcare practitioners and considered implications for practitioner practices. The 2000 special issue of *TCQ* exemplifies this work, with critical rhetorical analyses of clinical drug protocols (Bell, Walch, & Katz); a breastfeeding guide for physicians (Hausman); references in French Medical Journals (Salager-Meyer); and EMS Run Reports (Munger). Similarly, Keränen's (2001) examination of the Hippocratic Oath as epideictic rhetoric, Spoel's (2008) analysis of Canadian midwifery websites, and Derkatch's (2012) study of categorizing in the American Medical Association journals rely on textual rhetorical analysis. While many of these authors discuss implications for medical practice, these are rarely based on observations of how texts are used in context. In part, this can be attributed to the fact that textual analyses do not necessitate direct conversation or interaction with health practitioners.

In contrast, recent work in RHM is shifting rhetorical methods towards greater flexibility in artifacts and analysis to access not just the texts but also practitioner communication in action. For example, Barton (2004) argues that discourse-based methods "have the potential to become the basis for productive critical engagement between practitioners and researchers in professional communication" (p. 67). Meanwhile, research like Mirel, Barton, and Ackerman's (2008) study on the discourse of telemedicine demonstrates the value of blending qualitative and quantitative methodologies to visualize physician-patient interaction. This methodological flexibility certainly comes with risks, both for our unified identity as a field and for proper implementation of methods that come with their own complex histories (Segal, 2005; Barton, 2001). However, it also enables RHM scholars to "work in problematic contexts where generalities are used to illuminate particular cases, and vice versa" (Lyne, 2001, p. 4). Overall, I found that my ability to move between methods that offer both specific, contextualized views of rhetorical cases and

larger, pattern-based perspectives on communicative action provided a groundwork for collaborating with health educators on pedagogy.

Immersed in a doctoral program in "Language and Rhetoric" during my collaboration with CIES, my methodological training included experience with traditional rhetorical analysis, practice with qualitative writing studies research, and coursework on discourse analysis and corpus linguistics. My background in discourse analysis provided context and experience with "semi-structured interviews" and "coding" that offered an entryway into engaging with the group's findings. My writing process, however, often entailed moving between their coding of patterns in conflict factors and consequences and close readings of individual narratives from their interviews to understand the nuances of how a conflict unfolded. In effect, rhetorical analysis of interview excerpts provided me with guidance for plotting and nuancing the scenarios. Thus, my writing process necessitated that I work across methodologies, from situated and contextualized textual rhetorical analysis to more systematized approaches to finding patterns in meaning, like discourse analysis. This experience is hardly unique in health education, which necessarily is always moving between teaching patterns of pathological symptoms and behaviors and having students engage with specific, contextualized cases.

Meanwile, a consistent criticism of MH curriculum has been the lack of evidence for its efficacy, especially in the form of longitudinal studies and evaluation of transfer across contexts. This is perhaps not surprising given that the methodological training for experts in fields such as narrative medicine "is underpinned by philosophical approaches such as phenomenology, postmodernism, and narratology… [with] tools of language such as metaphor, plot, character and temporality" (Barber & Moreno-Leguizamon, 2017, p. 1). RHM scholars, on the other hand, frequently wear "hats" in first year writing, writing in the disciplines, or professional and

technical communication, fields which have long relied on social science methodologies for research and assessment (Hughes & Hayhoe, 2009; Blakeslee & Fleischer, 2009; White, Elliot, & Peckham, 2015). Thus, RHM scholars often have experience speaking the language of administrators that value skill acquisition, while also advancing nuanced arguments that challenge this perspective on rhetorical learning. Leveraging this experience in qualitative assessment, we could serve effectively as mediators between calls in MH for more rigorous assessment and calls to problematize a checklist approach to complex skills like empathy and communication (Barber & Moreno-Leguizamon, 2017; Shapiro et al., 2009). In order to best facilitate methodological collaborations with both health educators and medical humanists, however, RHM scholars must both communicate what we can do across disciplinary lines and also understand and stay beholden to what our research can contribute back to rhetorical scholarship (Barton, 2001; Hartelius, 2009), as I discuss in more detail in the conclusion.

2. Genre offers a useful framework for understanding and teaching workplace communication practices in healthcare contexts.

Rhetorical genre theory, which offers a framework for tying specific textual features like organization and language choice to larger group aims and institutional systems, has had a prominent role in RHM analyses of medical texts (Emmons, 2009; Teston 2009; Schuster et al., 2013). However, genre theory also offers an entryway for rhetoricians into the pedagogical project of initiating health students into the talk and texts of workplace communication. Segal (2005) identifies a trend towards genre analysis in Canadian RHM scholarship, which I would note often entails scholarly collaborations with health practitioners around pedagogical questions. Prime examples include research involving medical and rhetorical scholars studying

optometry students' case presentations (Spafford et al., 2004; Spafford et al., 2006) and electronic health records (Varpio et al., 2006). These scholarly collaborations frequently expand beyond physicians, in part because colleagues that value qualitative research approaches may be in adjacent fields such as Nursing, Social Work, Physical Therapy, Public Health, and Emergency Medical Services.

As Lingard (2007) explains, "a rhetorical approach draws attention to how generic rules of content and structure impart professional values, both values that can be essential to becoming an expert clinical communicator and those that the profession might not consciously wish to pass on" (p. 125). Ultimately, my understanding of how workplace genres reflect the institutional hierarchies in which they exist, mediate relationships between participants, and coordinate action helped me to innovate within the genre of simulation narratives to write a more nuanced and critical role for clinical genres during the CIES collaboration. I have also found genre theory to be one of the most impactful contributions in conversations with nursing faculty about supporting the teaching of writing in their field.

In my first email to the CIES, when I described my ability to contribute insights into "narrative pacing, structure, and language choices," I was talking about genre knowledge. Indeed, one of the reasons that I felt confident participating in their project was that I trusted my ability to read a variety of sample simulation narratives and decode their conventions. What I did not anticipate was that my rhetorical understanding of genre's role within the hospital context would be just as important to my writing for the CIES. This rhetorical perspective on genre first helped me to read the research interviews with an eye towards the role of verbal and written genres in creating or mediating conflict. It also enabled me to write scenarios that treated genres not as static texts but as reflections of organizational values and structures and as catalysts for

action. One scenario I composed was focused on a conflict between an experienced registered nurse and a new primary care resident about transferring their patient to intensive care. The scenario begins with the RN encountering "a long list of orders directing work up and treatment, but no order for transfer" after he has requested an evaluation of the patient to facilitate a transfer. Later on in the scenario, hospital guidelines for transfer act as a catalyst for a heated conversation between nurse and resident.

Overall, my background as a rhetorician helped me to see how verbal and textual genres in the scenario could play a critical role in conflict development and mediation. Certainly, writing nuanced and complex genre engagements into simulation scenarios is not going to alter medical pedagogy in the same way that teaching a genre-based course on health communication might. Still, the history of MH interventions in medical curriculum points to a need for greater integration across contexts and levels, rather than isolated courses or activities. In addition, a recurring critique of MH pedagogy, especially narrative medicine, has been its overemphasis on narrative forms without nuanced attention to diversity within that genre or to the many other genres of medical communication (Woods, 2011). As a rhetorician collaborating on the design of simulation training narratives, I had opportunities to innovate within that genre to highlight how conflict always exists in relation to typified modes of clinical communication.

As my research on simulation has continued to develop, one of my key contributions has been my insights into genre use in clinical simulations. In the clinical nursing simulations I studied, students documented patient care on a large white board in the center of the room using templates that they designed. Instructors initially saw this white board charting as a concession, necessitated because simulated electronic medical records are expensive and often ineffective. However, our conversations helped them to recognize its potential as a site for learning

professional values and to consider giving students more time to work through their experiences with charting during debriefs. In this way, my understanding of genre helped instructors to recognize new pedagogical opportunities within the simulation that did not necessitate dramatic shifts in practice. At the same time, their use of simulation genres helped me to imagine new ways of mobilizing classroom-based genre learning in my writing courses (Campbell, 2017).

3. Bringing a critical rhetorical lens to health curriculum can help counter assumptions about how power circulates in medical contexts for students, practitioners, and RHM scholars.

In her review of scholarship on RHM, Reed (2016) argues that most RHM articles take a critical stance towards medicine as a discipline, often portraying it as "a powerful, productive site of ideological construction" (17). This critical orientation, steeped in theoretical frameworks that help identify and describe how power circulates among individuals, is indeed part of what rhetoricians offer to health educational contexts. Previous scholarship has warned RHM not to lose this critical lens in collaborating with health practitioners, arguing that sometimes "critical perspectives become neutral descriptions" when rhetoric is used in the service of disciplinary understanding (Segal, 1998, p. 75). However, Reed is wary of the recent prominence of critique in our field, arguing that even as rhetoricians highlight the multiplicity and variation of medical discourse, they can offer one-dimensional views of medical authority. There is a tendency to underestimate the nuanced perspectives of those in the medical profession: "RHM scholars are not the only ones who recognize that medical knowledge is contested—physicians do too" (Reed, 2016, p. 18). I argue that collaborations with health educators necessitate that RHM's critical lens is both *accountable* and *applied.* That is, a view of power is held accountable to

experts in the field, who can nuance or challenge one-dimensional perspectives. At the same time, in pedagogical contexts RHM scholars must necessarily go beyond critiquing how power circulates to consider how educational practices could alter these practices, applying critiques to create change.

As previously mentioned, questions about the influence of gender, race, and professional role on conflict in the hospital were at the forefront of conversations with the CIES collaborators. To counter stereotypical portrayals, I worked to write scenarios that contextualized each participant's experience so that the resident's frustration with a nurse, for example, is understood as a response to her isolation from the care team and the sense that hospital policies are being neglected. Still, I frequently encountered my own biases about how power is distributed and who is to blame in conversation with the other contributors to the project. For example, in one scenario I had written a resident saying to a nurse, "You come to me," after the nurse had circumnavigated her to initiate an action. All three clinicians identified this as an odd moment and pointed out that the nurse reports to a number of people including nurses above her, the resident, and the attending. Therefore, they found it strange for a resident to suggest she was the only point of contact. I left this conversation with a better understanding of the ambiguous chains of command that exist in any clinical setting and revised the conversation to reflect that ambiguity. The accountability to health practitioners provided opportunities for me to recognize my own tendencies towards a monolithic view of hospital authority, even as I worked to challenge stereotypical portrayals for future students and practitioners.

My ongoing work with clinical simulation pedagogy has necessitated that I toggle between a critical rhetorical orientation and my positioning as a collaborator with nursing staff and teachers. I have aimed to take a critical view of social forces influencing simulation

practices—cultural attitudes towards illness, perceptions of the gendered body, assumptions about power relationships between patient and practitioner—while still viewing simulations as sites for supporting productive communication practices and reflection. In doing so, I found I am able to call attention to how power distribution is challenged or reified in unexpected ways in the simulation context, for example by examining subtle lessons about how nurses should perform and orient to gender. I have also been continually struck by how receptive nursing faculty and staff are to this critical framework. This aligns with Segal's (2005) claim that rhetoricians may find allied professionals to be more receptive to critique: "Physicians may feel comfortable with the genres that create the knowledge they need, but nurses, patients, and allied professionals who are caught up in or influenced by those genres may relish the opportunity for dissent that rhetorical critique provides" (p. 79). I argue that by engaging with health practitioners in conversations about power rather than orienting against them, rhetoricians are both more likely to gain nuanced understandings of how power circulates and to find opportunities for change within existing educational practices.

These examples from my collaboration with CIES and research on clinical nursing simulation all highlight the complex positioning of the RHM scholar in relation to both MH and healthcare fields. It was my role in an English department that provided the initial visibility and recognition that helped me to become involved in the CIES project, but only at a stage when much of the qualitative analysis had already been completed. In addition, because my work was consistently in collaboration with medical researchers and accountable to their disciplinary mandates and institutional structures, I could advocate for different kinds of rhetorical interventions but was frequently redirected. I had to be satisfied with contributing when and how

the other researchers saw fit and accepting that I might misrepresent communication or misunderstand the role of a genre. There is quite a bit of discomfort in these collaborations, similar to the discomforts that Gottschalk Druschke (2017) describes for rhetoric of science scholars collaborating in transdisciplinary community engagement. But also in line with her argument, there were opportunities to create and do: "To embrace the radical insufficiency of tentative answers. And to build anyway. To act as if. To hope. To do" (Gottschalk Druschke, 2017, p. 3). As we look to the future of RHM scholarship, my hope is that RHM scholars will continue to find opportunities like clinical simulation pedagogy to collaborate with health educators on shared concerns and to build more humanistic and patient-centered curriculum together.

CONCLUSION

In describing a recent creative non-fiction course based on Charon's narrative medicine model, MH scholar and psychiatrist Hellerstein (2015) offers the caustic aside: "thank God I wasn't being asked to give one of the all-too-sadly needed classes in 'writing in the electronic health record' (i.e., how to type something reasonably coherent in the lonely free-text fields set among thickets of check-boxes and numerical data-fields)" (p. 270). His, I believe, represents a common attitude in MH scholarship towards healthcare pedagogy. To teach the "whole medical student," MH has argued they need to operate outside the bounds of the everyday genres and practices of medical practitioners and educators; these are seen as too constraining and pragmatic to engage a humanist perspective. Thus, while MH scholars have successfully justified their curriculum and approach, making their way into medical curriculum across the country, they are still often consigned to one-off courses and reaching primarily pre-medical and medical students

rather than a wide range of health practitioners. Overall, several barriers have kept MH from positioning itself more centrally in the design of health curriculum – methodologies focused exclusively on close reading, foregrounding of medical narrative above all other genres, and critique and dismissal of educational initiatives like clinical simulation.

In contrast, most RHM scholars would immediately complicate Hellerstein's description of the EMR as a series of textboxes and checkboxes as well as his notion that charting entails nothing more than "typ[ing] something coherent." Perhaps more importantly, many of us would be enthused about the prospect of investigating EMR documentation with students – recognizing these systems as complex, rapidly changing rhetorical contexts in which social knowledge and power relationships are being negotiated. While we might not envision a class exclusively devoted to writing in the EMR, we could likely imagine workshops on the topic through writing centers situated at medical colleges or in collaboration with an interdisciplinary center, like the CIES (Ariail et al., 2013; Nilsen, 2007). In addition, prior work already demonstrates the possibilities for collaborative research on the EMR with health practitioners, research with direct potential for pedagogical cross-over (Varpio et al., 2006; Mirel et al., 2008). Thus, while RHM should advocate for and participate in pedagogical initiatives in MH, it can also seek out opportunities to research and contribute to the training of a diverse range of health professionals.

In aligning our curricular initiatives with MH programs, it is important that RHM does not pit itself against MH to compete for limited space in medical student coursework. Instead, interdisciplinary affiliations with our own required undergraduate courses may be an effective entryway for facilitating connections between RHM and MH curriculum. For example, Zerbe (2007) and Rubens (2017) both offer examples of health humanities curriculum appropriate for first year composition. Meanwhile, Landau and Thornton (2015) describe two variations of

undergraduate courses in the RHM that fulfilled distribution requirements and enrolled a range of majors. Thornton's course existed as part of an interdisciplinary "cluster"; these are spaces where rhetoricians can authentically enter into conversation with MH scholars about curriculum design and aims. As previously discussed, assessment may also be an ideal entry point for collaborating on curriculum with MH; RHM scholars can contribute insights from decades of work translating the value of rhetorical learning to administrators that value skill acquisition.

In addition, as my experiences with simulation pedagogy demonstrate, RHM scholars are well-equipped to collaborate with a range of health practitioners in researching and designing health curriculum – a contribution outside the purview of MH's current work. Health education is a rapidly changing field, invested in innovative pedagogy to address pragmatic challenges like distance education and professional limitations like interprofessional communication (Booth & McMullen-Fix, 2012; Ochs, 2017; Zhang, 2009). Whether collaborating to design a virtual training module on hospital documentation or designing a course as part of an interdisciplinary cluster on a health topic, RHM methods can contribute to developing effective educational materials and experiences that are situated, communication-focused, and can create change in healthcare practice. In these contexts, leveraging our methodological positioning, understandings of genre, and critical lenses to engage in research-based, collaborative curriculum design will be crucial.

Of course, in moving forwards with collaborations with both MH and health educators, RHM scholars risk losing site of how this work contributes back to the study of rhetoric. Other scholars have warned about the neutralizing effects of collaborating across disciplines (Segal, 1998) and called for RHM scholars to articulate the relevance of their work for the continuing development of rhetorical scholarship (Hartelius, 2009). If my experience is any indication,

however, these collaborations will benefit our understanding of rhetorical practice as well – pushing us to understand the strengths and limitations of our methodological flexibility; helping us recognize pragmatic implications of theoretical lenses like genre theory; and making our critical approach to analysis both accountable and applied. Ultimately, all three groups—MH, RHM, and health educators—will have opportunities for reciprocal learning and development.

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[1] I use "practitioners" throughout this article to refer to possible collaborators in health education such as faculty, clinical instructors, and practicing health care providers in a range of disciplines including Medicine, Nursing, Social Work, Emergency Medical Services, and more. In contrast, when I discuss MH literature, scholars in that field frequently refer to "physicians" as their target audience, reflecting a tendency to prioritize medical students and curriculum over other health disciplines (Barber & Moreno-Leguizamon, 2017). RHM scholarship can play a role in countering this trend through pedagogical collaborations with a range of practitioners and fields.

[2] Companies such as Laerdal and Gaumard that design and market robotic simulators refer to them as "manikins," so that term is used throughout despite the author's preference for "mannequin." The manikins are technologically designed to respond to treatments and can exhibit symptoms including dilated eyes, spiking a fever, changes in skin tone, and wheezing. They are capable of receiving shots, giving birth, and even dying as a result of student interventions.

[3] This research was exempted by the human subjects review at my home institution and the institution where it took place on the grounds that it did not interfere with normal classroom practices.