RHM Editor Blake Scott's Interview with Lisa Keränen

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Blake: I'm happy to be here with Lisa Keränen at this Health Rhetoric and Social Justice Pre-conference Symposium, which you (Lisa) organized, and to recognize the influence of the 2018 Public Address Conference honoree Celeste M. Condit and her work in women's health rhetoric and the rhetoric of health and medicine.

Both you and Celeste serve as editorial board members of RHM and, as you know, the journal's inaugural issue was dedicated to the two of you along with other women who were instrumental in co-founding our field. Given your work illustrated by, but also extending far beyond, this pre-conference in advancing the rhetoric of public health, and given the journal’s forthcoming special issue on this theme to be published in Winter 2019, we (Lisa Meloncon, Jennifer Malkowski, and I) thought it would be an opportune occasion to get your perspective on this important thread of our field. I also want to note the importance of the 2014 special issue of the Journal of Medical Humanities that you edited. We see this issue’s generative influence in the citations in the manuscripts that we receive, and we see its influence in reviewers’ comments and our own editorial comments about how authors can better situate their work in the field. Indeed, some of the questions I'll be asking you are based on the discussion questions that you developed in that special issue, so thank you.

My first question is really about how you think a rhetorical perspective of health publics and public health differs from other views or perspectives; I'm thinking, in particular, here of the definition you offered in the introduction to that special issue in which you resisted defining rhetorical publics in a purely discursive manner. You additionally captured the way publics bring
together embodied people in discernable places and spaces and at particular times, so perhaps you could expand on what such a rhetorical notion of the public means for you.

Lisa: Yes, great. So, first, let me just say how humbled and honored I am to be here talking with you and how amazing it was to see people like Celeste Condit this morning being celebrated for her work on rhetorical formations, those broader sets of discourses and languages around health issues that I see as being directly linked to your question of how a rhetorical perspective might differ from other views of the public and what exactly it entails. When we look at public health we see that, at its core, it’s about prevention medicine in a populace, in their lived community. So, the public here is really that populace, and a rhetorical perspective treats the public not as one monolithic community but as a dynamic, emergent, ongoing, assemblage of people who come together around an issue of mutual concern. So, like you said, it is embodied and it is very much affected by the broader structures that can constrain or enable discourse, and that’s a topic I want us to come back to a bit later—the constraints on public life that we are facing now. And so a rhetorical perspective is really calling our attention to the roles of discourse, embodied discourse, in creating our visions of community and so that we can track how publics form around health and wellness issues and ask who benefits from those formations, who benefits from particular ways of framing debates, whose voices are included and excluded.

Blake: Yes, absolutely. One of the things that your special issue did for me was get me thinking more about how we, in rhetoric, can approach public theory in a more expansive set of ways. For example, I’m thinking about the notion of “local publics” that Lawrence at al. forwarded in their article. I also want to ask you what you think the rhetorical perspective on the public that you
just articulated can add to public health research and practice. We know how it’s already informing rhetorical work, but what do you think about its potential to inform other forms of public health work.

Lisa: I think one of the things that we heard about this morning from [Cerise Hunt](https://example.com), who is a public health practitioner and the director of our [Center for Public Health Practice](https://example.com), is the importance of partnerships that are interdisciplinary. And what I think that rhetoricians and Communication scholars and English scholars who are studying with rhetorical lenses can bring to the table is a set of vocabularies and theoretical constructs for really tracking how various messages can be received, how they can be taken up, how they can be mobilized, and for doing so not just in terms of texts, but also visual rhetorics. So one of the things that the notion of publics has really pushed me to think about—and I haven't yet achieved fully its potential in my own life and scholarship—is that instead of working as an isolated rhetorician doing textual analysis, what I’d really like to be doing is partnering with community groups already working on public issues; they would bring the richness of their local lived experience with the health problems they are engaging, and then I would bring the richness of the theoretical apparatus of rhetoric. And, in partnership, we could define the problem together, collect data together, define communicative solutions together, and ultimately try to intervene in some of these very community-based, public health issues. So, for me, what’s most exciting about this line of research is that it calls for critical participatory rhetoric, it calls for community-based participatory research. So many people in rhetoric right now are starting to or already have been engaged in these kinds of projects, but I think there’s a real opportunity to extend this work if we take seriously this idea of publics. Instead of studying these problems in a disengaged way, why
not use the productive art of rhetoric to engage with them, to partner reciprocally around them, and to add our voices to these very pressing public debates about health and wellness.

Blake: I'm really glad you mentioned your collaboration with Dr. Hunt, and I wanted to ask you a little bit more about that, in particular how what you brought to that partnership was not just your expertise as a communication studies scholar, but also a teacher of the communicative arts. Could you say more about how that second role helped shape the project, especially its service-learning component.

Lisa: Absolutely, so the project with Dr. Hunt was a service-learning project, in partnership with a Community Action Network, the Families Forward Resources Center, and the Black Health Collaborative, here in Colorado. And the problem that they were struggling with was that infant mortality rates among Colorado’s black population are extraordinarily high, as they are throughout the nation and even broader globally. And so, they were looking for ways to deliver sets of influential health messages to communities who were vulnerable to differentially unequal health outcomes, such as having this ridiculously high infant mortality rate. And, so, I was at the time trying to teach myself some digital rhetorical skills because I felt like I wanted to be fresh and I wanted to be able to teach my students, not just to write papers, like I write, but to be able to produce meaningful rhetorical products that could intervene in contemporary health debates. We started visiting the Center for Public Health Practice where we would have meetings with our community partners. And they just kind of told us, here's the problem and here's what we need, and it turned out that they were having a summit with the Black Health Collaborative to address the problem of infant mortality. What they wanted from my class, which was a digital
health narratives class, was a series of videos that would highlight both the problem itself, but also some solutions. And so, safe sleep was a message that they were trying to emphasize across these four different community groups in Colorado.

So, our class went to the drawing board and wrote some proposals for how we were going to create these video products. We then took those proposals back to the groups, and with them we hashed over them, changed some things, until everybody was comfortable with what we were proposing. And then my class went and we organized, at the Families Forward Resource Center, a day where we did a video shoot and our community partner found authentic voices from the community that they wanted to speak about these issues. These included women who had lost pregnancies, women who had lost babies. And we were so fortunate that they were willing to share their stories with us. And so, you know, of course we had to do a lot of prep work with the students to be culturally sensitive, to think about the ethical issues of storytelling and voice and so forth. And we also knew that the people who were coming to the Families Forward Resource Center to speak with us were giving a gift of time that they didn't have. So, we arranged for child care for those who needed it and dinner for everybody who participated. In order to teach my students how to do a film shoot, or rather learn along with them, I hired a documentary filmmaker to come and be our director of photography. And so, we hauled out a whole Subaru full of camera equipment and consent forms and so on along with our pizza order. And we set up this studio at the Families Forward Resource Center and conducted these interviews. I have to say, for me and the students, at least for me, this was one of the most powerful learning opportunities that I’ve ever had, to bear witness to community struggle, community suffering, you know, the stories of these women, which were deeply intimate and heartfelt. It was just a
gift, you know. I felt so honored that they trusted us to share those stories and to make themselves so vulnerable.

So we spent hours recording these interviews with everybody and then kind of had to go back and do the editing and really face some ethical dilemmas, such as how much of the suffering we show without being manipulative, and so we really did a lot of reading about public health ethics and so on and then we made sure with the women that they were okay with the parts of their stories that we told. And it was hard for me sometimes as the educator because I had to also let the students edit the videos in teams. Then we previewed the videos and went back and made changes based on our community partners, and the students were very proud to see their videos shown at the Black Health Collaborative Summit. And the women who participated, I believe (I don’t want to speak for them), seemed happy that their stories were heard and that those stories could make an impact for other women in their communities. So that was how we did this as a service-learning project; ideally, if I could do this again, I would research the process and the public that we formed as we were working together on this project.

Blake: Thank you. I love that example because it so powerfully illustrates the importance of deliberating about the value-laden nature of public engagement and incorporating that into a teaching approach. And it was clear that you had students think about the ways of doing that, the ways of enacting responsive methodologies for public engagement.

I want to switch gears a little and ask a more conceptual kind of question. I’m coming back to this idea of the public as a lens for us to think about, in rhetorical studies, the groups of people
who are participating in these healthcare practices. Could you say a little bit about how a public lens might relate to other kinds of lenses that rhetoricians could be using like audience, stakeholder, community, population. What does public get us in terms of conceptualizing or maybe even broadening the kinds of inquiries we can make as rhetoricians of health and medicine.

Lisa: Yes, so I think it turns our attention to the broader ecology, just to use a familiar term, in which our rhetorics are produced. It also turns our attention away from, you know, single rhetors. If you think of some of the great early work in rhetoric of health and medicine, it analyzes the rhetoric of this great surgeon or scientist, right? So instead we can turn to the people in this broader environment and how they network with one another, leading to infrastructure questions about how they build coalitions, how they engage in advocacy, etc. So the notion of public really opens up our units of analysis, if you will, to these broader rhetorical formations that happen in and between and among various groups within society. It very much broadens our lens.

Blake: I think I heard you use the term “emergent” in the example of the service-learning partnership. There was a new collective that emerged through those interactions. I guess, for me, some of those other terms like “populations” can sometimes have a static connotation, whereas a public is something that is very much alive and well and shifting and merging.

Lisa: Yes, it’s dynamic and built through communication. We, as rhetoricians, very much have an important role to play in encouraging conditions that allow for more equitably community partnerships, emergent publics. And I also think it creates a place for us to comment on the
conditions of our publicity, for lack of a better term. And so, one of the things I wanted to make sure that we talked about here is that rhetoricians have vital roles to play right now in unpacking and unmasking the constraints to our public discourse. Whether those are constraints on free speech, whether those are budgetary constraints, you know, following the money. And one of the examples that I referenced last night in last night’s National Communication Association forum on the Art of Science Communication, which featured a group of rhetoricians of medicine, is the example of how the public discourse around the vaccine controversy in the United States has been infiltrated. I’m using the loaded term “infiltrated” deliberately to say that public health experts have found very credible evidence that this debate has been infiltrated by Russian agents, bots, and real-life trolls who are introducing discord and doubt into our vaccine science. An Something interesting about this practice is that these entities were not only promoting anti-vaccination rhetoric, which may not be so surprising, but also promoting pro-vaccination rhetoric. They were, in effect, kind of maximizing the conditions for doubt, distrust, disbelief. So the challenge for rhetoricians, in terms of thinking about publics and health and wellness, is how to create healthy community discourse that is built on transparency and relations of trust. And how we learn to find common ground, particularly when the conditions of our discourse in online social media fora are obscured in such a way that we may not realize, or realize too late, that these are not legitimate posts by authentic stakeholders from their subject positions but rather the work of agents who are deliberately trying to sow discord into our public sphere. That, I think, is a very pressing existential challenge

Blake: You kind of already anticipated, in some ways, the next question, which is really around challenges to studying publics when it comes to influencing health practices and outcomes, but
I'll take it in a slightly different direction. I'm wondering if you could talk a bit about any ethical dilemmas or constraints in approaching the study of these things through a public lens, around, say, labeling, describing, analyzing different groups as particular kinds of publics or counter publics. You know, we've seen terms like “vaccine skeptic,” “vaccine denier.” What do you see as some of those challenges?

Lisa: Yes, so all of those examples that you just named point to the politics of defining. Who gets to define? Is it the community itself, is it the researcher imposing some third position from above? How do we negotiate these different labels for communities—is it ethical even to call something a counterpublic? All of these questions are very much fraught, and I think one of the greatest challenges is that classic issue that Linda Alcoff wrote about in, I think, 1993, which is the problem of speaking for others. So, if I’m a rhetorician I’m partnering with a community and, let’s say that I come to agree with the community and their messages designed for the public sphere. At what point am I speaking for a potentially marginalized group, and in what ways is my privilege as an academic potentially overshadowing, harming, doing disservice to this group?

And so, one of the ethical challenges is setting up partnerships that are transparent in the beginning and that protect communities so that everybody is clear on what the stakes are, what the naming privileges might be, what we’re going to call things, how we’re going to share data, and so on. And, frankly, that takes a lot of work, it takes a lot of hard work, it involves many parts of institutions, so it involves, you know, the office of risk, it involves legal offices, it involves potentially their lawyers and so on. It adds a layer of complexity, but it also, when at its best, is not just an institutional CYA exercise, but rather a process of mutually creating a
community, a public, that is going to work together and, as we discussed this morning, be sustainable.

Blake: What you just said reminded me of something Dr. Hunt talked about this morning, this term she used—"infrastructures of engagement". We tend to think of infrastructures in terms of infrastructures of healthcare delivery etc., but the engagement of publics itself requires a set of infrastructures that are shaped in part by publics.

Lisa: Yes.

Blake: And I’m thinking beyond the initial engagement to the continued engagement, how their stories are subsequently reported and circulate.

Lisa: Yes, and one of the things I've seen in the digital story projects and research that many people are using in the health and digital storytelling realm is kind of setting up the initial agreements so that there are many places where communities can decide that they no longer want their stories to circulate. And, to some extent, you have to be very clear in the beginning, that once something is on the Internet, it’s extremely hard to pull out; but in the lead-up to that, how many places can we build into the structure so that people can say, “You know what, I’ve thought about this, and I'm not comfortable with that piece of my story going live yet on the Internet. You know, let’s reframe, let’s kind of edit.” So I think an important piece is creating opportunities for people to change their mind about their consent or to un-volunteer certain portions. You know, we had all kinds of check boxes for them to tell us about the images, the
audio, the combination, and so on. A related topic that Cerise discussed today was building in the sustainability structures and letting organizations decide how to do that, but also trying to make sure that there would be replacement board members so that the longevity of the projects can keep going.

Blake: Yes, absolutely. I want to turn now to another methodological question that really came from Jennifer (Malkowski) and that I find really interesting: As you know, many rhetoricians of public health, including the two of us, have used a case study approach to rhetorical analysis. Regarding this approach, what concerns might we think through and address in articulating and helping others understand the potential of its broader applicability to practitioners and other stakeholders, particularly when considered alongside other kinds of research.

Lisa: Yes, I'm glad you brought that up. I think a challenge that many of us who come from the humanities and social sciences, who do case studies, face is that our standards of evidence may be different than those of the medical practitioners and public health practitioners with whom we partner. And so, I think, on the one hand, we can create common ground because the case study historically was and remains in some quarters a practice within the medical literature. But I was also thinking this morning that we do have so many case studies and at what point will we, as rhetoricians, start to build infrastructures where we move from cases to generalization.

Regarding this morning’s pre-conference, I want to give a “shout out” especially to our graduate students Madison Crawl and Berkeley O’Connor who gave fantastic presentations looking at resistive courses of action, which is where I think this public literature can lead. As I was listening to them and listening to Celeste Condit, I was noticing commonalities in the resistance
discourses used by Berkeley, Madison, and even Davie Thornton that echo some of what Celeste was saying. And I was thinking, wow, how could we build a structure so that we could start to extrapolate from these cases and start to compare data from these cases in such a way that would actually let us move to mid-range rhetorical theory where we’re describing the major discursive strategies of resistance that we’re seeing on Tumblr or that we’re seeing in the health and wellness blogosphere? And I really think that’s a place where rhetoricians of health and medicine can partner together on digital humanities grants and so on. I think many among our community have the social science background that they can do such a thing but, to date, we haven’t mobilized those kinds of resources and set up those infrastructures for ourselves. But I felt today like we were on the cusp of it with some of those presentations.

Blake: Exciting prospects. I think a lot of the younger scholars in our field are being cross-trained in social scientific research and can really take the lead in helping us, as a field, make this move.

Lisa: I think so, too.

Blake: Alright. We’re getting to kind of the last couple of questions and I want to return to the moment of today and thinking of the special issue you edited as a starting point or point of invention. From your perspective, how has rhetorical research on publics in health and medicine been extended or advanced since that special issue. What are some extensions you’ve noticed?
Lisa: Yes, well, it’s been very humbling to notice the uptake and resonance of the concept of publics in the *Journal of Medical Humanities*. What’s coming out of that are really a set of studies looking at how people are talking to one another about health and wellness in their everyday lives, including online lives. And how they’re collectively constructing, you know, biosocial identities online and in their everyday vernacular rhetorics. I've seen an explosion, if you will, of studies of resistance discourse, like those we heard this morning. Sometimes these are explicitly framed in terms of publics, and sometimes not. Yet they are still looking at ways that people are articulating subjectivities and positions that might run counter to dominant norms. So that would be another main area. I think the upcoming special issue of *RHM* will be another piece of that puzzle. Rhetoricians of health and medicine are engaging in some amazing research, including community-based participatory research and critical participatory rhetoric research, which is producing incredible results and gains for public health. And I really think that the next frontier is global. Also, Celeste Condit noted that we have tended to be a pretty upper-middle-class and white subfield, and so it’s time for us to practice what we preach and be more inclusive in terms of scholars entering our community. We can not only be more thoughtful, but also be more intentional about being welcoming and creating pipelines and infrastructures so that we have more voices, and we should do this not only domestically but also internationally. People are starting to do this work but it’s an important growth area that should continue.

Blake: I agree. Regarding the first part of my question, I think the rhetorical work around publics has given us an opportunity to think about how our interventions as rhetoricians of health and medicine are as much about our methodologies and *techne* of engaging others as they are about the conceptual tools that we bring. This seems to be one of the directions you see us going.
Lisa: Yes, so just to recap, I see us doing more studies of how the people and publics are actively constructing health identities. I see us doing more work to unpack the conditions through which healthy public discourses can happen, you know, creating fora, structures, and so on. I see us doing more work globally and also with both resistance and online rhetorics, areas I think the next generation of rhetoricians of health and medicine are already taking up in exciting ways.

Blake: Well they and all of us are deeply indebted to you in being able to take these next steps, so thank you for your work in shaping the field, and thank you for this interview today.

Lisa: Thank you so much. I think they’re indebted to you, Lisa, and so many others as well.