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### 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 I am to be here talking with you and how exciting it was to see Celeste Condit being celebrated this morning for her work, which 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 disease prevention and health promotion in a populace, in their lived community. So, the public in public health is really that populace, but a rhetorical perspective treats a public not as one monolithic community or group but as a dynamic, emergent, ongoing, assemblage of people who come together around an issue of mutual concern. Like you said, it is embodied and very much affected by the broader structures that can constrain or enable discourse, materials, and actions. A rhetorical perspective calls our attention to the roles of embodied discourse in creating our visions of community so that we can track how publics form around health and wellness issues, ask who benefits from those formations, who benefits from particular ways of framing issues, whose voices are included and excluded, and what are the overall consequences of all of these for health and wellbeing.

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 et 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: We heard this morning from [Cerise Hunt](#), who is a public health practitioner and the director of the [Center for Public Health Practice](#), about the importance of partnerships that are interdisciplinary. Rhetoricians and Communication scholars and English/Composition scholars who employ rhetorical lenses can bring to the table a set of vocabularies and theoretical constructs for tracking how various messages can be interpreted, how they can be taken up, how they can be mobilized, and for doing so not just in terms of texts, but also visual and social movement rhetorics. 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 or intertextual analysis, we can and should be partnering with community groups already working on public health issues; they would bring the richness of their local lived experience with the health problems they are engaging, and then we would bring the richness of the theoretical apparatus of rhetoric. And, in partnership, we would define the problem together, collect data together, identify 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, and 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 collaborative projects, and 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, textual, and largely analytic way, why not use the productive art of rhetoric to engage with publics, to partner reciprocally with them, and to add our voices to society's most pressing challenges about health and wellness? This encourages more rhetorical traction and sensitivity in collaborative public health projects.

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. The project with Dr. Hunt was a service-learning project, in partnership with a Community Action Network, the [Families Forward Resources Center](#), the [Black Health Collaborative](#), and the [Center for Public Health Practice at the Colorado School of Public Health](#).

The problem that they were struggling with was that [infant mortality rates](#) among Colorado's black population are extraordinarily high, as they are in black communities throughout the nation. And so, they were looking for ways to deliver impactful health messages to communities facing significant health disparities. At the time, I was trying to sharpen my digital rhetorical skills because I wanted to be able to teach my students, not just to write academic 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 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 in their communities. 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 articulate some solutions. Safe sleep was the message that they were trying to emphasize across these 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 and 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, people that wanted to speak about these issues. These included women who had lost pregnancies, women who had lost babies. We were so fortunate that they were willing to share their stories with us. 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 representation 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. We hauled out a whole Subaru full of camera equipment and consent forms and so on along with food. And we set up this studio at the Families Forward Resource Center and conducted interviews on camera. I have to say, for me, this was one of the most powerful learning opportunities that I've ever had, to bear witness to community struggle and suffering, the stories told by these women, which were deeply intimate and heartfelt. It was a gift. I felt deeply honored that they trusted us to share those stories and to open themselves up.

We spent hours recording these interviews and then had to go back and do the editing and really face some ethical dilemmas, such as how much of the story to show without being manipulative. We did a lot of reading about public health ethics and digital storytelling ethics and tried to make sure everyone was okay with the parts of their stories that we told. It was hard for me sometimes as the educator because I had to also let the students edit the videos in terms, instead of imposing my artistic vision for each of them. Then we previewed the videos and went back and made changes based on our community partners' desires. In the end, the students were very proud to see their videos shown at the Black Health Collaborative Summit that summer, when class had ended. And the women who participated, I believe (but I don't want to speak for them), seemed happy that their voices and stories were heard and that those stories could make an impact for others 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 emergent public that we formed as we were working together on this project and track the broader impacts of the intervention.

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, I think it turns our attention to the broader rhetorical ecology, just to use a familiar term, in which our rhetorics circulate. It also turns our attention away from single rhetors. If you think of some of the great early work in rhetoric of health and medicine, it analyzed the rhetoric of some great surgeon or scientist, right? And that was important work. But we can turn to the people in their broader environment and look at how people network with one another, leading to infrastructure questions about how they build coalitions, how they engage in advocacy, etc. So the notion of a public expands our focus and our units of analysis to these broader rhetorical formations and dynamics that happen in and between and among various groups and constraints.

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, publics are dynamic and built through communication. We, as rhetoricians, have important roles to play in encouraging conditions that allow for more equitable community partnerships and productive public dialogue. This focus creates a place for us to comment on the conditions of our publicity, for lack of a better term. One of the things I wanted to make sure that we talked about here is the roles rhetoric scholars can play right now in unpacking and unmasking the constraints on our public discourse--whether those are constraints on free speech or social media dynamics, whether those are budgetary constraints or enablers. One of the examples that I referenced last night in the [National Communication Association forum on the Art of Science Communication](#), which featured a group of rhetoricians of health and medicine, is the example of how the public discourse around the vaccine controversy in the United States has been co-opted. I'm using that term deliberately to say [that public health experts have found very credible evidence that this debate has been influenced by Russian agents](#), bots, and real-life trolls who are introducing discord and doubt into our public vaccine science conversations. Something striking 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, maximizing the conditions for doubt, distrust, disbelief. I do not find us/them rhetoric productive for society in general but do think anytime people are intentionally trying to sow discord, conditions for transparency and trust are undermined.

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. Relatedly, we have the skill set to promote the search for 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 those who are deliberately trying to sow chaos and dismantle the 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, all of those examples that you just named point to the politics—and ethics—of defining. Who gets to define? Is it the community itself, is it the researcher imposing some third position from above, someone else? How do we negotiate these different labels for communities—is it ethical even to call something a *counterpublic*? All of these questions are ethically fraught. And one of the greatest challenges is that classic issue that Linda Alcoff wrote about, which is the "problem of speaking for others." If I'm a rhetorician and I'm partnering with a community, at what point am I speaking *for* a potentially marginalized group, and in what ways might my privilege as an academic potentially overshadowing, harming, or doing disservice to this group?

One of the ethical challenges involves setting up partnerships that are transparent in the beginning and that protect participants so that everybody is clear on what the stakes are, what the naming privileges might be, how we're going to share data, and how we will create and implement interventions, and so on. And, frankly, that takes a lot of work, a lot of *hard* work, which involves many parts of many institutions, from the offices of risk management to legal counsel and beyond. It adds layers 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 with trust, openness, and as we discussed this morning, be sustainable over time.

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: 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 if not impossible to pull out; but in the lead-up to that, how

many places can we build into the structure of the project 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 edit”? An important piece is creating opportunities for people to change their mind about their consent or to un-volunteer certain portions. We had all kinds of check boxes on our consent and release forms for them to tell us what we could do with the images, the audio, the combination, and so on. A related topic that Dr. Hunt discussed today was building in sustainability structures and letting organizations decide how to do that, but also trying to make sure that there would be mechanisms for determining replacement board members to promote the longevity of the projects.

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. A recurrent challenge that many of us from the humanities and social sciences, those of us 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. I think, on the one hand, we can build on common ground because the case study historically was and remains in some quarters a tradition within the medical literature. But, on the other hand, I was also thinking this morning that we do have so many case studies: 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 Krall](#) (University of Utah) and [Berkley Conner](#) (University of Iowa) who gave fantastic presentations looking at resistance, which is where I think this health and public scholarship 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 Davi Thornton’s presentation, that echo some of what Celeste was saying. And I was wondering how could we build infrastructure so that we could start to extrapolate from these cases and start to compare data in such a way that would actually let us move to mid-range rhetorical theory where we’re describing, say, the major discursive strategies of resistance that we’re seeing on Tumblr or that we’re seeing in the health and wellness blogosphere? I think that’s a place where rhetoricians of health and medicine can partner together on digital humanities grants and projects and so on. While some rhetoric scholars believe this kind of work is beyond their purview, it’s clear many among our community have the social science background that they can create such things, but to date, we haven’t mobilized those kinds of resources and set up those infrastructures for ourselves as a scholarly community.

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: It's been very energizing to notice the uptake and resonance of the concept of publics in the health humanities since the special issue in the *Journal of Medical Humanities*. What's coming out of that is a set of studies that look at how people are talking to one another about health and wellness in their everyday lives, including online lives. These come from rhetoricians and from other humanities and social science scholars who are applying rhetorical lenses. Another set explores how various publics are collectively constructing biosocial identities online and in 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. The upcoming special issue of *RHM* will provide another piece of this work. Rhetoricians of health and medicine are also 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.

With another nod to Celeste Condit, I really think that the next frontier is and must be global. As Celeste has repeatedly noted, we have tended to be a pretty upper-middle-class and white and North American subfield, and so it's time for us to practice what we preach and be more inclusive and proactive in terms of nurturing 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 include more voices, and we should do this not only domestically but also internationally. Some rhetorical scholars 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, to recap, I see us doing more studies of how 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, infrastructures, and so on. I see us doing more work globally and also with both resistance and online rhetorics—areas 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 Meloncon, Celeste Condit, and so many others as well.

**Editor's Note:** We hyperlinked to Madison Krall and Berkley Conner's previous TED talks to show their public scholarship, but their talks at the Health Rhetoric and Social Justice preconference were entitled "Digital Networks and Rhetorical Invention: A New Line of Inquiry for Rhetorical Studies of Science, Technology, and Medicine" (Krall) and "Assembling Gynecology: The Potential for Assemblages for the Rhetoric of Health and Medicine" (Conner).