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## **East Carolina University**

## **Capstone Framing Document**

## **March 21, 2025**

I will complete my MA from East Carolina (ECU) in May 2025. At seventy-one years of age, I have lived up to the moniker *life-long learner,* or *professional student*, whichever you prefer. But the truth is that I love innovative ideas and ways of looking at aspects of the human condition. My time at ECU has furthered my knowledge of looking, listening, and participating in human interactions, and how they make meaning in the world. I love to hear people talking, and arguing, about ideas. Listening to diverse viewpoints on topics helps me to hash out my beliefs and opinions, and to develop a base of logic to compare new thoughts and ideas to previous knowledge. Many times, my logic base has been swayed by listening to the reasoning of others. Through this lifelong learning process, I have developed the ability to step outside of my consciousness and become aware of my biases and prejudices. Most importantly, I have learned during my time at ECU to find my own voice, and to speak it aloud. These things have made such a difference in the quality of my life.

In addition to becoming more self-aware, I learned practical techniques and tools to utilize in professional and technical communication arenas during my time at ECU. In the professional and technical writing program, I became proficient with online programs such as Canva, Google Docs, Word styles, Adobe In Design, Webador, and a variety of others. These tools typically have a learning curve, and I was always appreciative of the patient and caring professors who were available to help me gain the understanding that I needed to overcome the technical challenges I encountered in completing complex assignment projects. Without these dedicated professionals, I would not be completing this MA and graduating in May 2025. Thank you all.

This framing document introduces my capstone essay project to my professors and explains the rhetorical context in which it is written. I am a hybrid professional, meaning that I have spent my working years in both the medical field as a radiographer, as an educator of student radiographers, and after retirement as an English professor in the areas of reading and writing. While completing the coursework for the ECU MA degree, I read and heard rhetoric criticizing patient care practices in the medical field in which I spent over forty years of employment. During those years, I frequently witnessed situations in which health care workers went much further than reasonable to help patients heal, and to save lives. Health care workers are very compassionate people.

During my coursework at ECU, I had assignments from the article, *Cruel Pies:* *The Inhumanity of Technical Communications* by Dragga and Voss (2001). Graphs such as the one depicted below were criticized as being insensitive to the victims and their families. These graphs were developed for safety training programs for fishers. Trauma healthcare workers are so familiar with the causes of the fatalities that when they read the list, they can see, feel, and smell what these awful accidents do to the human body. To be effective in finding ways to prevent these accidents through education, cold hard facts are warranted.

Figure 8

 

*Note*. Adapted from *Cruel Pies:* *The Inhumanity of Technical Communications* Dragga and Voss (2001, p. 271).

A second graph pulled from *Cruel Pies …* depicts an effort to add empathy and sensitivity to a cold statistical graph that has been created for training and educational purposes. Health care workers know the reality of the look, texture, and smell of burned bodies. They have tremendous empathy for burn victims, but the best way to help is to educate the public regarding the statistics.

 Figure 10

*Note*. Adapted from *Cruel Pies:* *The Inhumanity of Technical Communications*, Dragga and Voss (2001, p. 272).

My capstone essay project was visualized and written to enlighten and convey understanding of the similarities and differences between traditional rhetorical communication practices and rhetorical communication practices in medicine. To better frame the context of the topics, I have written the text in sections with headings and will utilize these sections in the remaining part of my framing document.

## **Philosophical and Historical Perspectives of Rhetoric and Medicine**

For this section of the framing document, I researched the historical interconnection between rhetoric and medicine. Through studying Socrates and Plato, I discovered that initially Plato believed that the art of healing bodies to be far superior to the art of rhetoric. From my perspective, the two arts are different and there is no ground for comparing one as superior to the other. However, Plato’s perspective changed, and he began to allow space for the possibility of authentic rhetoric existing on a level playing field with the healing art of medicine (Roth, 2017).

Although Plato’s perspective is difficult for me to understand, I did grasp common themes between rhetoric and medicine through historical research. Rhetoric, by its nature, is meant to persuade its audience to believe and follow its directives. Physicians are in a similar position in patient care communication. When an illness has been diagnosed, the physician will attempt to persuade a patient of the right course of treatment. As I mentioned earlier in the document, I believe physicians are caring individuals who want the best care for their patients. I also believe rhetoricians to be honest and truthful in their efforts to persuade society to act from their better angels. The majority of the professors I have learned from during my time at ECU were examples of altruistic rhetoricians who always thrive to create a *call for* *action* when necessary to create a more equitable society.

## **Educational Models**

My decision to expound on the differences in the educational models of the medical profession as opposed to the rhetorical communication profession is meant to provide clarification. The way students are taught will directly affect the results of the professional’s communication approaches with both medical patients and rhetorical audiences. From my experiences in the medical field, the educational models all include action. The edict *see one, do one, teach one* continues to be one of the learning anchors in medical educational models. It is imperative for many medical professionals to think on their feet, and make quick, accurate decisions. In the beginning, new students are supervised to protect the patient, but the educational model expects students to practice and catch on quickly. From my viewpoint, traditional rhetorical communication is primarily concerned with thinking things out carefully and thoughtfully to comprehend subtle details that add to communication between people, and how these details are manipulating the overall message.

 I learned in my coursework at ECU that professional and technical writing can, and will, solicit a *call to action* in situations in which marginalized populations are being repressed. I argue that inherent in the communication process of rhetoricians is time for careful and thoughtful considerations when making persuasive points. However, I believe that with experience, both physicians and rhetoricians become more effective in their communication styles. From my perspective, this act of evolving brings each profession more to the center and creates more common practices.

## **Discordant Themes**

I chose to write this section to explain why healthcare professionals might be offended by the seeming critical reviews from rhetoricians regarding medical discourse. Healthcare professionals are trained to always put the patients’ needs first, but they are increasingly more constrained in the actions they take to care for patients. Although firmly based in science, the healthcare field practice is influenced and constrained by insurance companyreimbursements, AMA (American Medical Association) guidelines, political rhetoric, and now rhetoric stemming from professional and technical writers. In addition, healthcare personnel are inundated with their own text and data which entails a unique language that laypeople may not understand. My stance here is that when other entities comment rhetorically on the medical field, they should include someone from the medical field as part of communication. Alternatively, the group making assumptions about medical discourse needs to spend time with medical practitioners in the day-to-day physician- patient communications.

## **Medical Metaphors and Modules**

In this section, I argue that metaphors and models occur in every field that involves communication, not exclusively the medical field. For example, Martin (1991) questions whether “deeply held cultural beliefs about masculinity and femininity” result in gendered instruction regarding the union of the egg and the sperm (Derkak & Segal, 2023, p. 138). From my perspective, Martin is correct in her observation that the dominant culture influences the way communication occurs in any period, but that is true of all fields of writing. As a simple example, I remember instructions on how to make macaroni and cheese. After describing the steps, the serving size used to be described as for a *family of four.* In the current dominant culture, families can be in many configurations, and the macaroni and cheese instructions now say it provides *four servings.* With additional time, I know I would find other such examples of the dominant culture affecting communication.

Another issue to consider in the medical field is the level of professionals who are educated in the field. The levels range from certified nursing assistant (CNA) to physicians. Consider that the varying levels of medical professionals dictate the detail in which educational content is disseminated. High school students who are targeting the health field as a career will be taught less content detail. The goal in high school courses is to lay a foundation of knowledge to build on later. Certified nursing assistants require a high school diploma as a pre-requisite. They certainly need a basic idea of anatomy and patient care, but often the instruction given is reduced to more basic concepts for their current educational level. In comparison, higher levels of medical professionals, primarily physicians, are taught from a truly scientific standpoint because they must have more knowledge for *best practice* patient care.

## **Concordant Themes**

I chose to expand on similar themes here to lobby for common ground and respect. Some of the texts from rhetorical writing have made me as a former health care worker feel disrespected and belittled. I agree there are areas of communication in the medical field that need improvement, for example physician-patient interactions. I think most females have had the experience of not being heard and of being treated as if all female medical issues are parallel. I have personally had poor experiences with both male and female physicians who evaluate and treat my symptoms *by the book.* What I mean in saying *by the book* is that I have been treated as if my signs and symptoms are like other females when I know that all bodies have areas in which they are unique. However, I do not believe this happens most of the time, and I believe communication is improving over time as medical educational models emphasize patient education and empathy.

And shamefully, there is racial and economic prejudice in all people in all professions. I have seen this during my career in the medical profession, but I have always been a patient advocate. The best advice I can offer is to change physicians until you find one that you trust and have effective communication with; a physician who will listen to what you bring to the conversation.

## **Themes of Intersectionality**

In another attempt to find a common ground between the fields, I chose to include the field of Medical Humanities (MH) in this section. The MH field is more established in medical circles than the Rhetoric of Health and Medicine (RMH). The research and writing from the MH field has changed the way physicians are taught to create more inclusion and empathy in patient care. I believe the intersection of communication here would encourage MH, RMH, and the medical field to join efforts to improve patient communication and, resultingly, patient care and treatment.

## **Conclusion**

Finally, my goal in writing the final essay was to make a rebuttal from the perspective of a health care professional to what at times seemed to be a blatant disrespect for the medical profession. Rhetoric is a powerful tool as we have seen in current political administration in the talk against immunizations and the inherent right to personal choices in health care. Laypeople may be confused by this and make choices regarding whether to visit a physician, or not, based on incorrect rhetoric. I recommend that for the health of the public an alliance between the three fields forms to help to promote *best practice* in the treatment of patients. In other words, please include health care personnel when writing about the health care field.

Thank you for your time and attention in reviewing this framing document.

Pat Brannan