Beyond the Science: Bioanxiety, Medical Ethos, and the Proxy Debate over Mandatory Vaccination Policy

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BEYOND THE SCIENCE: BIOANXIETY, MEDICAL ETHOS, AND THE PROXY DEBATE OVER MANDATORY VACCINATION POLICY

by

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has been approved for the Department of Communication

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The final copy of this dissertation has been examined by the signatories, and we find that both the content and the form meet acceptable presentation standards of scholarly work in the above-mentioned discipline.
Malkowski, Jennifer Ann (Ph.D., Department of Communication)

Beyond the Science: Bioanxiety, Medical Ethos, and the Proxy Debate over Mandatory Vaccination Policy

Dissertation directed by Professors Gerard A. Hauser & Lisa B. Keränen

This dissertation theorizes relationships among health publics, medical ethos, and vaccination hesitancy to consider the function of policy communication in relation to public perceptions of U.S. medicine. To do so, I conducted a comparative analysis of official and vernacular rhetorics comprising U.S. mandatory vaccination policy deliberation. In particular, I examined political and professional communication surrounding mandatory health-care worker influenza vaccinations at the national level—and the public backlash that issue generated—to consider the status of private health citizenship, public participation, and medical professionalism for a biotechnological era. As a pragmatic response to something I term biotechnological anxiety, or bioanxiety, this study articulates how concerns born from contextual, systemic factors are encoded into specific rhetorics of health and medicine in exacerbating ways, concerns that health-care workers express in communication about annual vaccinations as a “duty of care.” Insofar as vaccination communication functions as a proxy for other anxieties that undergird contemporary health-care experiences, I conclude that public trust in medicine and the success of this particular medical technology (vaccination) may wane.
Dedication

To my grandmother, Angela Malkowski
Acknowledgments

First and foremost, I would like to thank my “academic parents,” Jerry and Lisa. Over the past five years you have served as my sources of inspiration, of guidance, and of support and I have been honored to work with you both. I look forward to many more laughs, stories, and glasses of wine as I continue to learn how to become the type of welcoming, generous, impactful, patient, and thoughtful scholar (and human!) you each epitomize. Thank you so very much.

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supported and shaped my early research agenda, and who continues to partner with me to conduct applied, mixed-methods research.

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INTRODUCTION

Pandemics remind us of our morality in a way that modern biotechnology soothes us into forgetting.

—Donna Dickenson, *Me Medicine vs. We Medicine*

In an increasingly global and more scientifically saturated world, the nature of disease threat has achieved heightened significance. According to a National Intelligence Estimate (NIE) released in 2000, the overall number of U.S. infectious disease deaths has doubled since the 1980s. Despite the predicted likelihood of future pandemics, portions of the larger U.S. population willingly forgo protection offered by a now-robust U.S. public health-security plan (Boyles 2008). In recent years, interventions, such as vaccination, have become the foci of particularly impassioned public criticism. Public attention suggests that vaccination is situated at a particularly meaningful nexus where important political factors converge. Disproportionate public criticism directed at a particular medical technology may pose problems for the delivery of everyday U.S. health-care. Debates surrounding vaccination policies and practices, therefore, draw attention to how dominant rhetorics of health influence the overall course of medicine. As such, “vaccination rhetorics” provide an excellent vantage point from which to consider the relationship between medicine and its publics.

For some time now, rhetoricians of health and medicine have substantiated links between (bio)medical talk and (bio)medical behavior/experience. Within this body of literature, certain health and medical issues have been identified as debate triggers. For example, certain biotechnology processes and products, such as regenerative medicine, stem cell research, and
neonatal genetic testing, are widely understood to aggravate public backlash, private concern, and professional problems. In a recent edited volume titled *After the Genome: A Language for our Biotechnological Future*, contributors tackled issues, such as these, to consider rhetorical, religious, scientific, and ethical dilemmas that now characterize much of the biotechnological public debate (2013). What may be most interesting is that although biomedical technologies have progressed—we have, indeed, entered the new biotechnological era—the tone and tenor of public concern remains largely the same, at least that is what I argue in the pages to come.

Although new medical interventions have been introduced that challenge previously held beliefs about what is possible in terms of disease prevention and treatment, convincing members of the U.S. general public to trust a particular health technology, to adopt a particular health practice, or to purchase a particular health product presents familiar challenges for both health officials and medical consumers alike.

For instance, public health officials have long encouraged U.S. residents to vaccinate themselves and their children against easily communicable diseases. Despite these consistent, beneficent efforts, in consequential ways, members of the U.S. public have long regarded health as an individual practice that is informed by diverse commitments rather than as a collective project that is focused on the “greater good.” In his historical account of the smallpox epidemic that lasted from 1898 to 1903, Michael Willrich described how thousands of U.S. Americans resisted government authority over matters of public health, but who, nonetheless, ultimately lined up (sometimes by force) to get vaccinated per federal order. In *Pox: An American History*, Willrich asserted that because some people died or fell ill from mandatory smallpox vaccination, that historical incidence now marks the moment when U.S. Americans would, from then on, insist that “the liberty protected by the Constitution also encompassed the right of a free people
to take care of their own bodies and children according to their own medical beliefs and consciences” (2011). Thus, the resulting Supreme Court case Jacobson v. Massachusetts (1905) serves as a landmark example of how public dissent can successfully influence U.S. health policy on a national scale.

Today, the return of vaccine-preventable conditions that previously were deemed to be “under control” (e.g., measles) correlates with decreases in vaccination rates tied to voluntary opt-out mandatory vaccination clauses (Wiener 2011). This trend poses significant challenges for U.S. health professionals charged with the task of promoting medical interventions in the name of public health: For instance, how should pediatricians promote and defend childhood immunizations as part of their professional duty to advance public health-security and, simultaneously, to respect and accommodate parents’ decisions to decline vaccination for their children? This trend also complicates personal decisions made by medical professionals: For instance, should health-care workers be expected to “practice what they preach” and get themselves vaccinated, despite personal commitments that argue otherwise?2 These types of practical dilemmas suggest that, in the everyday medical context, health policy may be fundamentally at odds with health practice.

Unlike some approaches to the public’s opinion, the public’s good, or the public’s health that regard members of “the U.S. public” as homogenous in need and opinion, the rhetorical perspective considers the multiplicity of voices that constitute any generalizable notion of “public health.” This multiplicity of voices is an important consideration in the design and implementation of health policies and practices that are intended for widespread adoption. Furthermore, this multiplicity likely offers innovative flexibility with regard to how to amend health-care policies and practices in an era when change and uncertainty are imminent. Patterns
apparent in public argument raise practical questions for scholars interested in the persuasive
dimensions of collective life: namely, why does history seem to repeat itself when it comes to
certain matters of health and medicine? What is it about certain medical technologies that make
them particularly prone to heated public argument? Why has the institution of medicine become
a reoccurring stage for public unrest across U.S. history? This dissertation begins to answer these
questions.

Specifically, this study investigates rhetorical dimensions (a modality that I explain in
greater detail in chapter 3) of one biotechnological advancement: vaccination. Across history,
vaccinations have caused concern between various stakeholders occupying the public health
arena, and the current era proves no different in this regard. However, recent public uproar and
changes in U.S. health-care processes and practices suggest a unique environment in which
modern biotechnological concerns reside. The rise of informed health consumers, the fall of
public trust in experts, and the disappearance of some well-worn health-care funding and
decision-making structures (and their replacement with uncertain alternatives) have uniquely
positioned vaccination as a site where competing matters of public health collide. In a span of
merely 50 years, medicine has fallen from its apex of power and prestige, measurable, at least in
part, by the state of media images alone. We have shifted from the days of celebrities, like Elvis
Presley, proudly receiving vaccinations on the covers of daily newspapers to celebrities, like
Jenny McCarthy, gaining notoriety and amassing social movements by publicly discrediting
vaccinations. Although there are clear merits to the rise of the “novice expert,” when it comes to
matters of health and well being, from an epidemiological standpoint, such public health
upheaval causes concern for the management of contagious and deadly disease.
In the modern era, when and where science, arguably, is sounder than ever before, why do we find ourselves in the midst of one of the most heated public debates concerning the merits of modern medicine? Although vaccination has been a site of public concern for decades (and, therefore, is privy to investigation), what specific contextual features of the current era fuel the most virulent debate about public vaccination to date? I ask these questions with ameliorative intentions. Identifying rhetorical features of modern vaccination debates may offer insights into qualities of talk that preserve vaccination as a viable site where various publics compete for things, such as expertise and autonomy, and, in doing so, those features may offer insight into argumentative structures and qualities that are either beneficial or problematic for systems and communities that actively are combating disease.

Therefore, this dissertation examines the rhetorical nature of vaccination as a political process. In other words, I examine symbolic features of this particular technology as it is presented in public communication to consider why and how resistance amounts in relation to its adoption. As a rhetorician, I suspect, from the start, that symbolic features of vaccination have something to do with the public–private tension inherent in any and all medical endeavors. Furthermore, I assume that vaccinations punctuate uncertainties circulating around notions of “risk” and “responsibility,” and that they operate at the borders of medicine as a science, versus medicine as a business, versus medicine as a healing art. In the chapters to come, I tease out and defend these assumptions more clearly, and, in accordance with a rhetorical perspective, I offer that rhetorical sensibilities draw attention to persuasive features of biotechnology talk that act centrally in how and why certain medical interventions instigate public controversy. Beyond characterizing argumentative features of any one vaccine-specific controversy, in particular, however, I invoke a rhetorical perspective to move upstream to consider sources of all vaccine-
related public unrest. That is, if the resurgence of pertussis, for instance, represents a downstream effect of vaccination disloyalty, what prior contextual factors contributed to that outcome? To investigate such questions as fully as possible, both material and symbolic properties of vaccination must be considered.

Although vaccination certainly presents a ripe opportunity to study material rhetorics of everyday health citizenship, this project focuses on the other half of the persuasion equation: vaccination’s symbolic function. I do so guided by the assumption that concerns and complexities manifest in language that is used to describe and explain vaccination, and that that language operates at the center of this particular public storm. Furthermore, although I am convinced that vaccination talk impacts material conditions surrounding medical interventions and social, political, and cultural realities (an issue that I extrapolate on in more detail in chapter 3), this study begins from a place that entrusts the scientific method to move beyond the materiality of vaccination in modern debate. In this regard, and to illuminate the specifically symbolic function of vaccinations as a politically charged issue that is independent from the efficacy of any particular vaccine, this project begins from a place that understands science to deserve and hold widespread credibility for the majority of U.S. Americans when it comes to disease prevention.

Although the reputation of specific experts may waiver, when it comes to matters of health and wellness, by and large, the U.S. public generally acts in a manner that reflects science as influential and important when it comes to the management of disease. Although some specific groups actively reject Western medicine (e.g., Scientology) and other individuals simply do not pay attention to their health, as sociologist and author of The Vaccine Narrative, Jacob Heller, noted in the opening pages of his historical account, “Today, vaccines are highly
respected and compliance rates hover near all-time highs, despite a steady decline in attitudes
towards the health-care system” (2008, 3). Despite these reassuring trends, when it comes to the
study of many science-based controversies, distrust in institutions and characters of science tend
to dominate discussion. That is, the steady decline in public attitudes toward the health-care
system tends to overshadow any goodness about actual vaccination rates in the popular press,
which may be an artifact of sensational journalistic practices. Nonetheless, counter to assuming a
“watchdog” role regarding policies and practices of medicine, my project begins from a place
that accepts medical expertise as a necessary and trustworthy component of a successful U.S.
biotechnology apparatus. This position is not controversial or new, and, as will be shown in the
next chapter, it comes supported by research across academic disciplines. Increasing public
understandings of science, cultivating civic engagement with science, and addressing science-
based concerns and criticisms about emergent biotechnologies are certainly important parts of
the vaccination public approval equation; however, it is my contention that, sometimes, these
efforts overshadow factors or considerations that act as precursors to outward public dissent.
When it comes to vaccinations, in particular, the truisms “medicine is an art” and “medicine is a
business” imply that medicine is more than a science or its science. This trend indicates, to me,
that responses to public vaccination concerns stem from a variety of contextual features that do
not, simply, pit big science against lay individuals. One way to isolate and observe these “other
features” is to, essentially, control for the science.

For the purposes of this project, I begin from a vantage point that is aligned with science
to traverse, more readily, the commonly polarized terrain between scientific and lay processes.
However, rather than blindly trusting all advice offered by scientific, medical, and policy
experts, or adamantly denying those positions and ideologies that resound a mantra of private
rights, my project, instead, occupies the gray, ambiguous area somewhere between vaccination’s extreme crusaders and its opponents. I am interested in citizens who believe in their right to make decisions regarding their health and who also understand that those personal decisions hold consequence for communities of which they are members; citizens who, I suggest, represent an important and influential segment of the larger U.S. population that now identifies as “vaccine hesitant.” In matters of vaccine hesitancy, where boundaries concerning right and wrong, private and public, and patient and professional grow more blurry, pitting one side against the other is to be avoided, especially when any single individual embodies those contradictions as a term of employment.

In this project, I look at medical professionals’ responses to mandatory vaccination policies to make sense of vaccine hesitancy “beyond the science,” so to say. I do so to consider more nuanced features of the vaccination debate and to move beyond particulars of any one controversial vaccination profile to consider upstream factors that likely undergird or characterize all vaccination concerns alike. A now well-established field known as “the rhetoric of science” has demonstrated that science, like many other human endeavors, is prone to bias, error, and to making arguments in ways that are self-serving (see, e.g., Gross 1990; Myers 1990; Wander 1976). This claim has been cause for much debate between the fields of science and rhetoric, and it has, in some instances, shaken faith in the scientific project as a whole. However, if we trust science, as I do, I ask what we might learn about the symbolic nature of vaccination in relation to public perceptions of medicine. Beyond gauging public perceptions of scientific/medical authority, reliability, or efficacy, however, my project hinges on perceptions of medical expertise as paramount to the success of any institution of health or medicine, and medical interventions promoted therein. In this regard, I contend that if and when a new,
trustworthy biomedical science enters into public possibility, the qualities of medical personnel, as rhetorical figures, matters to individual health decision-making and biomedical adoption trends. Read another way, using persuasive communication, medical professionals can actively alleviate (or exacerbate) anxiety surrounding scientific advances and, thereby, serve prominently in matters of public health-security and private health-care.

Health-care personnel represent a complicated community of individuals that muddy clear-cut understandings of medical publics as being distinct from medical establishments. Acting simultaneously as private citizens and public servants, health-care deliverers and recipients, medical professionals constitute a community of individuals unique in their rhetorical positionality. From the outside looking in, it would seem that everyone professionally involved with disease prevention would be moving toward similar goals where, together, they, ideally, would create a world that is free of disease. After all, no individual would likely welcome the ravishes of disease into his or her body, and, furthermore, individuals who have taken oaths to protect the health of others likely would not wish disease on fellow community members. Nonetheless, from the inside looking out, communication about vaccination that is happening among health-care communities seems to express a more complicated story. To my knowledge, no humanities scholars have yet studied public effects of the vaccination debate that is happening within the walls of medicine. Doing so can provide an informative vantage point from which to consider vaccination hesitancy beyond the science. Configuring medical professionals as conduits between public and private life, official and vernacular rhetorics requires a much more complex notion of medical publics as fluid, intersecting, interlocutors who converge (and diverge) around health issues of mutual importance. For this study, I adopt the term “health publics” to do some of this work.
In this study, I invoke a theory of dialectical vernacular to complicate more traditional approaches to the study of public opinion, participation, and resistance. Considered in terms of its rhetorical features, a public can be comprised of conflicting ideas and individuals; however, although this point is widely known in both theory and practice, many studies treat publics as competing rather than intersecting entities. For example, in 2003, Phaedra Pezzullo published a study that examined the San Francisco-based Toxic Links Coalition’s (TLC) annual “Stop Cancer Where it Starts” tour in contention with official positions on breast cancer. Although her findings importantly advanced understanding of resistance in relation to the status quo, and it illuminated fault in normative assumptions and strategies about a world free from cancer, the study used an oppositional framework to organize and describe action to characterize competing groups as different publics. For my study, I focus on one unique subset of a larger medical public out of both convenience and manageability, but also because of the influential position that particular audience holds in relation to public perceptions of medicine: Health-care personnel who question, and sometimes reject, vaccination policy do not fit neatly into the oppositional framework that has been utilized in studies of counterpublic discourse.

Although vaccination rates remain consistently high in the United States, vaccine’s status as a continually contested public issue has left portions of the U.S. public vulnerable to disease and uncertain about science; the same can be said about segments of the health-care community. This lattermost trend is significant with regard to the delivery of effective and efficient health-care, because debates within medical communities can divide members of an organization and, thereby, compromise essential pillars of team-based medical practice. Furthermore, dissensus experienced within the institution of medicine likely permeates beyond the walls of health-care proper and may influence public deliberation concerning vaccination as a widespread public
health practice. In response, this project centers on expressions of uncertainty that are generated among an otherwise trusting segment of the U.S. public. Moreover, as an ameliorative measure, this project theorizes concepts, such as “medical ethos” and “proxy debate,” and their relationships, to consider how a complicated medical publics issue might be better leveraged to offset dwindling trust in medicine and to unite various stakeholders against the threat of contagious diseases.

To understand public perceptions of medicine, I suggest that a close look must be taken at rhetorical nuances of medical processes that surround particular medical products, and that a good place to start is within the walls of medicine at mandatory vaccinations. The better those symbolic functions of vaccination can be deciphered, the more likely vaccination communication may be deployed in helpful ways. In this regard, findings from this research study will likely help both policy officials and medical professionals to negotiate between the publicness of disease and the privateness of medical intervention in ways that regard patient-centered care and public health-security as complementary, as opposed to competing, health paradigms. Findings produced from this type of research agenda, therefore, will contribute to a growing body of scholarship that explores rhetorical dynamics of biotechnology policy communication.

Most humanities research addressing public dissent about vaccinations has focused on how controversial publics form, transform, or operate in opposition to medical practices and health policies; in contrast, I begin from within the institution of medicine and detail how actions adopted by a particular subset of a medical public, or, rather, by a set of public health officiates, work to influence public health participation writ large. By situating my emphasis there, I anticipate that findings from this study will enhance understanding of how rhetoric contributes (or does not) to the overall success of disease prevention on a national scale, and, thereby, add to
a growing body of work in the area of the rhetoric of health and medicine. More poignantly, the findings from this research may enhance abilities to navigate organizational, interpersonal, and medical terrain via vaccination communication; here, communication scholars equipped with humanist sensibilities arise as essential to determining “best practices” for a better biotechnological future.

Section and Chapter Overviews

Part I: Hesitant Health Publics

The first section describes and theorizes resistance as it relates to health issues and publics. In chapter 1, I offer an overview of the status of vaccination problems, policies, and practices within the United States to suggest that the U.S. public currently suffers from vaccination hesitancy, a condition that is characterized by intense experiences of uncertainty when faced with vaccination decisions. Given that reality, at the end of chapter 1, I pose three questions about the relationship between vaccination rhetoric and public perceptions of medicine: (a) How do rhetorics of health and medicine frame vaccination as a public problem? (b) What does public debate about mandatory vaccinations reveal about public perceptions of medicine? (c) What do competing rhetorics of vaccination suggest about the nature of medical professionalism in the United States?

In chapters 2 and 3, I highlight the rhetorical significance of public talk and lay a foundation from which to consider how vaccination policies and practices operate as sites where social, political, and cultural consideration collide to prompt public debate. Specifically, I introduce the theoretical and methodological frameworks that I use to investigate the current U.S. vaccination climate within the institution of medicine, to offer advice and relief on the outside. I review work of traditional and contemporary theorists, such as Jürgen Habermas,
Gerard Hauser, and Robert Howard, to explain the (ideal) function of public participation in relation to public problems. I then detail a rhetorical perspective, generally, and biocriticism and vernacular rhetoric, specifically. Each of the latter theories offers tools to locate and organize data according to qualities of rhetorics that health publics produce. Chapter 3, therefore, broadly distinguishes between official and vernacular rhetorics that comprise the mandatory vaccination policy debate before describing in chapter 4 the data that this study analyzed.

**Part II: An Ongoing Public Health Debate**

In part two, I introduce and describe one ongoing U.S. public health debate. Chapter 4 reviews the particular controversy—mandatory influenza vaccinations for health-care workers—to demonstrate the many audiences to which this issue speaks, to articulate distinct political inflections of the issue, and to warrant my investigation into, specifically, rhetorical dimensions of recent policy deliberation. I then review my data collection and analysis processes in detail and preview the framework that I use to organize and illuminate official and vernacular rhetorics of mandatory vaccination addressing seasonal influenza vaccination as a condition of medical employment.

In chapter 5, I present the results of my close textual analyses of deliberations about the vaccination of health-care personnel in relation to national public health-security standards. Specifically, I conduct a comparative analysis of argumentative strategies used by policy makers and health-care employees. I organize the presentation of data according to the type of rhetoric that it represents—official vs. vernacular—to maintain tension between competing elements of a larger vaccination rhetoric. Doing so intentionally maps out causality (in terms of rhetorical exigence), directionality (in terms of social influence), and intentionality (in terms of political impact) between instantiations of vaccination rhetoric, and it suggests a range of possibilities
regarding how vaccination policy informs relationships between medicine and its publics. I suggest, ultimately, that the issue of mandatory vaccinations for health-care workers serves as a proxy debate for concerns about U.S. citizenship for a biotechnological era.

**Part III: Vernacular Additions**

In part three, I consider official rhetorics of mandatory influenza vaccination (policy communication) in conversation with vernacular rhetorics of health (public pushback). In putting policy and pushback into conversation with one another, I identify two rhetorical features that currently characterize contemporary health-care experiences but that remain largely unaddressed or unarticulated in official rhetorics of health and medicine: bioanxiety and medical ethos. Each feature highlights a system-level attribute of health-care organizing that, I assert, vaccination debate highlights. In short, *bioanxiety* can be understood to describe the condition in which we (are made to) live, whereas *medical ethos* refers to the influence that medical professionals wield over public health insecurities. When put in conversation with these two rhetorical features, proxy debate, thus, offers a diagnostic framework for understanding why bioanxiety often goes untreated across public forums and how medical professionals might offset public anxieties moving forward. In chapters 6 and 7, I present findings from an in-depth analysis of public comment about mandatory vaccinations for health-care workers, to consider ways that the vernacular corpus may better enhance policy deliberations and outcomes.

**Part IV: Reimaging Rhetorics of Vaccination**

The last section of this dissertation revisits the notions of medical publics, medical ethos, and vaccination hesitancy in lieu of findings from my close analysis of mandatory vaccination policy and (resistant, rhetorical) practices. Specifically, I expand on the concepts of biotechnological anxiety (or bioanxiety), medical ethos, and proxy debate to foreground
rhetorical opportunities to study, understand, and intervene into public perceptions of medicine via vaccination policy communication. A theory of bioanxiety suggests that health messaging in this biotechnological era breeds emotional hostility about risks and responsibilities assumed to be associated with contemporary public health participation that interferes with abilities to make health decisions at both the individual and collective levels. A theory of proxy debate accounts for how bioanxiety relates to public forms of argument that trouble, in predictable and repetitive ways, medicine’s relationship to and reputation across various publics. A theory of medical ethos suggests new opportunities for medical professionalism amidst biotechnological advance and uncertainty.

Ultimately, I conclude, the lucidity generated by identification of productive vernacular tensions allows for consideration of how the language of common biotechnological anxieties may, in turn, be reappropriated to improve the overall structure and function of contemporary health-care systems. In this regard, I close by speculating about some benefits of understanding how a public, as opposed to a person, suffers from a particular biomedical disorder, such as anxiety. In doing so, I offer one possible technique to increase pharmaceutical policy literacy at the public level and, in so doing, to decrease experiences of bioanxiety that are exacerbated by un(der)addressed conflicts that are inherent to everyday health-care policies and practices. If we begin to publicly address bioanxiety and its causes using the language of both biology and sociology, and we talk publicly about cures in terms of both biomedical and behavioral interventions, might we begin to relieve anxiety undergirding policies and practices of health citizenship for this biotechnological era? In this manner, I position findings from this project as one step in a larger research agenda that is dedicated to identifying which and how dominant
biomedical models can better inform and inspire scholarly intervention into biotechnological problems, policies, and practices to improve public perceptions of medicine.

1 A word is needed about my use of the terms “citizen” and “America” throughout this study. Clearly, disease does not discriminate based on a person’s documented status while residing in or visiting the United States and, therefore, the issue of communicable diseases effects legal and undocumented Americans alike. Nonetheless, because I am interested in the health-care “workforce,” throughout this study I use the term “citizens” to signify a group of health-care employees who are legally working within the United States as, in most cases, credentialed medical professionals. Because this debate has spanned well over ten years, those most involved with the debate are likely not on visiting visas (visas would expire) or undocumented United States residents (feasibly, they would not be employed by reputable medical facilities without legal resident status). Additionally, throughout the study I elect to drop my descriptive “U.S.” before each mention of “American.” Although I recognized that all individuals whom identify as “American” might not be referring to North America and the United States, stylistically, I opted to drop the specifying adjective in each mention of the term. Unless otherwise specified, throughout this project, when I refer to “American” or “America,” I intend to communicate about the United States of America and the documented citizens therein.

2 Communication scholars John Lammers, Joshua Barbour, and Ashley Duggan noted the difficulty of assigning a label to “medical professionals” to best represent the dynamics of contemporary health-care: “Writers in health communication have struggled for years with terms that are inclusive enough to acknowledge that physicians are in the minority among those mainstream professionals who see patients, while avoiding the thorny problem of identifying just what distinguishes one caregiver from another. Problems with access to and costs of care have placed more and more registered nurses, physicians’ assistants, and nurse practitioners in front of patients” (2008, 335–336). For this study, I use the label health-care workers to indicate any employees of health institutions that have been trained to provide medical care and/or have regular contact with patients. Patients refer to individuals who are under the medical supervision of health-care workers. In this regard, I also use the term “medical professional” interchangeably to capture the communal identity (and responsibilities therein) bestowed on health-care workers as a condition of employment. Throughout the study, readers should expect to see the terms “health-care personnel” and “health-care employees” appear across policy communication as well. In this regard, as the authors of a commissioned report who reviewed literature on the issue and compared organizational definitions explained, “Because the healthcare workforce is diverse, employers and advisory groups have adopted varying definitions [and labels] to describe the individuals who will be included under influenza vaccination recommendations, policies, and programs. . . . The most inclusive definition includes all employees, volunteers and contract personnel (Stewart, Cox, and O’Connor, 2011, 5).

3 Much like the issue addressed in the footnote above, I also recognize that the widespread use of the term “patient” throughout my study, at times, may be used inappropriately. In this study I adopt the term patient to refer to any individual who may find himself or herself in contact with medical care systems and products now or in the future.

4 In chapter 2, I define the terms “official rhetoric” and “vernacular rhetoric” in closer detail, but vernacular rhetoric refers to everyday expressions produced by private individuals and official rhetoric refers to formal messages produced by public institutions.
PART ONE:

HESITANT HEALTH PUBLICS
CHAPTER I

DISEASE THREAT AND U.S. VACCINATION

An air of anxiety now typifies much public talk about vaccination, which is attributable, at least in part, to the evolving nature of viruses, the more elaborate and efficient modes of disease transmission in the current era than ever before, and the looming threat of biological warfare. In an era when viruses may spread and mutate more rapidly than ever before, preventive health behaviors and trust in expert advice remain essential to the success of a larger U.S. public health-security plan. On the one hand, the evolving disease threat could strengthen connections between medicine and various publics, such that individuals rally together against a common enemy—disease. On the other hand, uncertainty and fear that accompany disease threat may heightened underlying experiences of public distrust in medicine, exacerbate an already tense situation, and lead individuals to opt out of proactive preventative health measures. Unfortunately, some recent vaccination trends suggest that the latter scenario may be most likely.

Although national and state vaccination averages remains somewhat consistent despite increased media coverage and attention, in states that allow for philosophical exemption, vaccination rates remain among the lowest in the nation, and vaccination refusers tend to cluster in dangerous ways:

Based on national and state averages, the number of people who seek exemption from mandatory childhood vaccination is, on average, very low. There are “clusters” of exemptions in local communities that are much higher than the national or state averages. For example, while the percentage of people exempted from mandatory childhood
vaccination is only 0.64% nationally, Utah has a rate of exemption twice that percentage (1.2%). Furthermore, one county in Utah (Washington county), has an exemption rate nearly six times the national average (3.7%). This high exemption rate undermined herd immunity for this county, resulting in an outbreak of measles lasting 6 viral generations and 107 cases, half of which were contracted by people who had been vaccinated. (May and Silverman 2003, 1049)

Given the ambiguity surrounding, for instance, the spread of pertussis (colloquially known as “whooping cough”) through a community, the contingencies of a bioterrorist attack, or uncertainties associated with possible pandemic influenza strains, preemptive public health solutions rely heavily on public trust in and adherence to advice of public health officials in the absence of disease outbreak. “Given the growing numbers of exemptions, it is imperative that physicians and policy makers be vigilant for dangerous ‘clustering’ that might undermine herd immunity,” Drs. May and Silverman warned (2003, 1050). Advice that is given to inform and mobilize preparatory collective action, as these recent examples illustrate, may not be heeded regularly.

Given the disconnect between public health needs and public trust in medicine, in this dissertation, I consider specific features of contemporary medicine that likely proliferate the public’s uncertainty by actively troubling the relationship between medicine and its publics. In this first chapter, I investigate dimensions of contemporary disease management that likely perpetuate anxiety around health-security decision making. Specifically, I suggest that an increase in disease threat awareness and a decrease in public trust in medicine create complications for contemporary health-care events because the pairing breeds concern about medical policies and practices in relation to health-security. Together, I contend, these factors
have lent vaccines a symbolic prominence in recent years whereby most vaccine talk—public or private—is laden with ethical, social, cultural, and political anxieties that extend beyond concerns about the quality of medicine’s science, with the result being a largely vaccine-hesitant U.S. society. Following a brief discussion of vaccination hesitancy, the latter half of this chapter reviews literature that connects actions of health-care personnel to public perceptions and adoptions of vaccination. Although the influence of health-care professionals to larger public health-security initiatives is clear, more recent expressions of vaccination hesitancy generated from within the walls of medicine suggest that connections between health-care personnel and public perceptions of medicine and adoptions of vaccination remain in flux. I close this chapter by posing three research questions that are situated at the intersections of vaccine communication, medical professionalism, and rhetorical theory.

Public Health Challenges

It is a truism to say that people now live in an increasingly more globalized world, with patterns of travel and business putting people in contact with a plethora of other people and their ideas and germs. Although such interconnection presents many opportunities for social, political, and cultural growth, a more integrated world, conversely, presents problems for the management of disease. In places, such as the United States, unpredictable disease threat and complex patterns of social interaction complicate national disease defense systems.

In the history of disease control prior to vaccines, global travel spread the plague and many other conditions; more recent history has witnessed a hastening of the disease course/lifeline as these social ties have become more robust, intertwined, and longstanding. In 2003, for example, the sudden acute respiratory syndrome (SARS) travelled swiftly across the globe: between early March 2003 (when the first atypical pneumonia cases outside of China were
reported to the World Health Organization) through early July 2003, SARS cases had been reported in 32 countries (Ahmad, Krumkamp, and Reintjes 2009). The rapidity with which SARS spread was a direct result of cross-cultural interaction and international travel. In response to the 2003 SARS pandemic, China imposed government-sanctioned quarantines that, from an infectious disease standpoint, were very successful: Limiting social interaction and deliberately isolating individuals who may have been exposed to the virus did efficiently and effectively curb deadly outbreak outcomes. Similar precautions had been taken by Cuba during the early days of HIV and AIDS, and although HIV and AIDS now threaten every corner of the globe, Cuba’s rates of infection remain markedly low (McNeil 2012). Although there may have been a time when a lack of wide-reaching social interaction helped to quarantine and control naturally occurring disease outbreaks, amid a more globalized terrain, the intervention of government-led defense strategies have become more pronounced. In nations that regard health decision making as a process that is intimately bound to democratic freedoms, such as the United States, pervasive government control in the name of public health-security is hardly an option (Lakoff and Collier 2008), although authorizing government intrusion into private U.S. citizens’ lives in the name of public health-security is not altogether unfamiliar to U.S. audiences. For example, disease prevention measures were enforced on immigrants traveling through Ellis Island at the turn of 19th century, such as forced medical inspection and/or quarantine (Conway 2014).

However, across contemporary settings, similar means of disease control would be uncommon. Nonetheless, in an era when the threat of pandemic and bioterrorism loom large, these “freedoms” are increasingly being challenged.

The deliberate manufacturing and deploying of disease has long been of concern to U.S. national defense officials, and, to some extent, the threat of bioterrorism has existed in the U.S.
psyche for quite some time. Some fiction and nonfiction “bestsellers” that have helped to bring
the threat of disease emergence to the attention of the public include Laurie Garrett’s *The
and Stephen King’s *The Stand* (1978). In recent history, the 2001 Anthrax attacks largely
substantiated these previously fictitious fears when the prospect of disease warfare became a
domestic reality. In the aftermath of the now infamous September 11, 2001 attacks on the United
States, several letters containing anthrax spores were received by U.S. news offices and senators.
Timely reporting of the issue as a potential follow-up bioterrorist attack led to frenzied public
action that included taping windows, purchasing ventilation masks, and avoiding public places
and spaces: The United States, at that time, was vulnerable, alert, and ready to distrust its
neighbors (quite literally). “Amerithrax,” as the case was named by the Federal Bureau of
Investigation, bookmarks the moment in recent U.S. history when the need for a national public
health-security plan became solidified.

Since the early 2000s, a biodefense agenda has characterized discussions of homeland
security and has given rise to a burgeoning area of policy work that is dedicated to defining,
defending, and promoting “U.S. public health-security.” The “full suite” of U.S. public health-
security policy includes: *The Public Health-security and Bioterrorism Preparedness Response
Plan* (2012), and *Healthy People 2020* (2010). Across that policy documentation, vaccinations
have been configured notably as a “public health-security strategy,” a “medical countermeasure,”
and as a distinct weapon in a larger “arsenal” of national defense. Likewise, it seems not to
matter whether a disease outbreak is natural or intentional, as the U.S. public is coached to
regard both bioterrorism and naturally occurring disease as one and the same threat. In their 2007 report, titled *Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings*, for example, The Healthcare Infection Control Practices Advisory Committee (an arm of the larger U.S. government public health-security apparatus) claimed that “lessons from the SARS outbreaks are useful for planning to respond to future public health crises, such as pandemic influenza and bioterrorism events” (Siegel et al. 27). The unchallenged conflation of these two categories—seasonal flu and terrorist attack—raises concerns for scholars attuned to social and political consequences of persuasive language (Segal 2005).

In the last few decades, proscience coalitions, which include rhetoricians of health and medicine, have organized resources to improve public understanding of science and to interrogate discursive complacency. For example, members of Virginia Tech’s Vaccination Research Group have begun to foreground relationships among power, decision making, and social norms surrounding vaccination communication, to consider how public messages evoke ethical and moral concerns, as well as to mobilize public action. Although still a fairly new area of study, a focus on messages used to describe, explain, and promote vaccination (aka “vaccination communication”), now proliferate the pages of medical, social-scientific, and humanities journals alike. Through academic venues, the persuasive potency of vaccination communication can now be demonstrated by and for scholars, scientists, and public health advocates alike, although translating those findings for public consumption remains a challenge.

Spun from the works of rhetoricians, specifically, the recent blurring of a distinction between personal health choices and national security requirements via official public health policy language suggests that public understanding of vaccinations has been complicated, and perhaps intentionally so (see, e.g., Malkowski 2013). For instance, with regard to the issue of
health-security, in particular, should parents vaccinate their children to protect them from consequences of particular illnesses or because it is an act of civic duty that is required to build herd immunity that is needed to fend off disease threats across communities and nations? What are the consequences of either motivation in terms of long-term public health-security plans?

Amidst new, unforeseen biotechnological advances (and set-backs), expectations concerning what public trust can and should entail for 21st-century medicine remain unclear. Recent research suggests that public health officials can offset vaccine-hesitancy to help U.S. Americans evaluate emerging disease risk and mobilize accordingly, but disease risk, as was reviewed briefly, is a moving target that is complicated by complex systems of social interaction and “loaded” language. In a more integrated world, the proliferation of public access to information and distant others poses significant challenges for public health professionals who are determining and pursuing global, as well as national, health-security goals—goals for which vaccination technologies figure prominently.

**Public Health Risks**

Despite notable, time-tested successes, across contemporary U.S. settings, the business of infectious disease control, experienced at both private and public levels, remains wrought with uncertainty and gamble. When Edward Jenner discovered the first vaccine (against smallpox) in the 1790s, it set Western medicine on a powerful trajectory to minimize malady in the “developed” world. Whereas the term *vaccination* refers to a specific medical intervention technology that is used to confer immunity to a specific individual against a targeted pathogen, *immunization* is an umbrella term for inducing disease resistance in persons or populations, of which inoculation and vaccination are but two methods (Centers for Disease Control [CDC] 2013a). In the first half of the 20th century, public health witnessed and claimed many major
triumphs in the area of disease control and prevention (Plotkin 2005). For example, as described by medical sociologist Jacob Heller, the polio vaccine tells “a story of success against the odds: how the rational and systematic application of science in the hands of a dedicated scientist—a humble genius (Salk)—defeated the disease and prevented its horribly crippling effects, including its ultimate consequence, death” (2008, 5). With polio eradicated and the demise of many other diseases in range, the 1950s are often remembered fondly as the “golden age of medicine,” where medical experts earned prestige, funding for medicine was abundant, and the United States established itself as a model for international disease relief (Starr 1982). However, gains on the medical technology front were markedly uneven, and by the close of the 20th century, the reputation of public health and medicine waned, as the nature of viruses, themselves, troubled how medical officials understood and combated disease.

In February 1976, the first media coverage of swine flu likened the condition to the 1918 pandemic—“the most virulent influenza known to modern medicine” (Neustadt and Fineberg 1978, 6)—which created widespread concern and debate over proper government intervention. The National Influenza Immunization Program sought to inoculate every U.S. citizen before December 1976; inoculations began on October 1, 1976, and nearly 40 million civilians were inoculated over the next 10 weeks. However, on December 16, 1976, the program was brought to an immediate and permanent halt when the swine flu vaccine, known as the Victoria vaccine, was linked to Guillain-Barré syndrome, a paralyzing and occasionally fatal condition. “The swine flu caper” has been described as “a classic fiasco, replete with premature commitment, personal agendas, incomplete analysis, unspecified uncertainties, unstated assumptions, the neglect of implementation, and the failure to reconsider prior decisions” (Behn 1979–1980, 681). In hindsight, Neustadt and Fineberg verified that “the killer never came. The fact that it was
feared is one of the many things to show how little experts understand the flu, and thus how shaky are the health initiatives launched in its name” (1978, 1). Instances such as the “1976 Swine Flu debacle” have, unfortunately, substantiated public anxieties about public health’s premature acceptance and promotion of new biotechnologies in the name of national security. Indeed, the 1976 case illustrates how antsy public health tactics, ultimately, may misguide publics to pursue unnecessary or even dangerous health practices. Regardless of past lessons learned, the language used to mobilize prevention efforts against annual flu threat continues to evidence fear appeals.

In 2007, the World Health Organization (WHO) published a report, entitled “A Safer Future: Global Public Health-security in the 21st Century,” that identified pandemic influenza as “the most feared security threat” (45). The warning readied government and medical institutions to solicit militant means (including metaphors) to preemptively “combat” disease. Experience suggests that in a more globalized, scientifically savvy world, the manner in which disease threat gets described and explained within policy language influences public understandings and adoptions of certain medical practices. In this regard, I offer a brief example of how the WHO 2007 report mobilized actors (and more) to fend off “the most feared security threat.”

Vanderbilt University’s annual Flulapalooza is a widely advertised event that provides an opportunity for individuals to receive their influenza vaccination in an efficient, “fun,” and cheap manner. Furthermore, Flulapalooza serves as “a mass vaccination drill and simultaneous attempt to break the current Guinness World Record . . . [for] the most people vaccinated with the flu shot in an eight-hour period” (2011). Beyond these amusing features, the event also intentionally doubles as a means to test the medical center’s emergency mass vaccination plan in preparation for disease outbreak, including a bioterrorist attack. Despite this ulterior motive, many patrons
claim to line up each year out of convenience and competition, rather than because of civic duty. During simulations such as this, it can be argued that efficiency becomes the gold standard of security readiness. Although efficiency is important and laudable, prioritizing that goal may lead to oversight in other areas, including disease diagnostics (e.g., whether we projected an accurate disease threat lifespan and its viable impact across place and space) or intervention stockpiling (e.g., whether there are enough vaccinations to meet the demand that we are generating).

The 2009 Influenza A (H1N1) outbreak tested readied health-security infrastructures worldwide. Early media depictions referred to the threat as the “swine flu” and overemphasized its geographic origin (Mexico), which exacerbated international relations and misrepresented the threat. Furthermore, media coverage quickly likened the emerging threat to the 1918 Spanish Influenza, which wiped out one eighth of the world’s population a century earlier (Stein 2010). In doing so, many U.S. Americans found themselves in a state of emergency, fearful of their neighbors to the south and in line for vaccinations to fend off the second coming of the most destructive naturally occurring threat in memorable history. Despite successfully convincing publicity efforts that resulted in an adequately mobilized U.S. public, across the nation, providers ran out of vaccines, if even provided with them at all (Ruiz 2009). Thankfully, the forecasted “1918-like” pandemic never materialized. Harkening back to previous premature hype and policy mishap (ironically, under the same colloquial nomenclature “swine flu”), the lack of pandemic resulted in credibility set-backs for public health officials reliant on public trust in science, technology, and medicine. Indeed, the 2009 event has been regarded as an instance of “health-promotion theatre,” a reactionary response to a moral panic generated by a combination of an overly eager U.S. media and a substantially scared political system (Miko and Miller 2010). However, that assessment leads one to wonder whether medicine is in need of a full-
blown pandemic to restore the public’s faith in it. Many promedicine advocates claim that the success of public health may be leading to its demise because, as David Ozonoff, a longtime public health professor put it, “When public health works, nothing happens” (as cited in Klotz and Sylvester 2009, 172–173). “This,” bioethicist Donna Dickenson explained, “is the ‘vexing paradox’ about vaccines: ‘the more effective they are, the less necessary they seem’” (2013, 149, citing Mnookin 2011, 26).

Viruses, such as influenza, are notoriously unstable, and, thus, to some extent, they will always pose challenges for how U.S. citizens and public health officials understand and take action in response to disease threat. In a short informative video, The National Institute of Allergy and Infectious Diseases warned that

influenza viruses are always changing. . . . This means that the infection fighting antibodies that your body makes in response to the flu vaccine may only protect you for one flu season. After that, circulating flu strains may change and make the old vaccine ineffective. A new vaccine is needed to match the new viruses (2013).

No matter how well intentioned public health-security efforts are, these biological realities mean that some existing defense measures will never offer failsafe protection against annually predictable disease threat. In addition to naturally occurring virus variability, attributes of modern living seem to exacerbate issues of predictability and protection against emerging disease. For example, now, more than ever before, environmental changes are believed to expedite virus mutations. In particular, inappropriate uses of antibiotics and human-induced environmental changes (consider the causes and effects of global warming, for example) are credited with multiplying the potential for worldwide epidemics of all types of infectious diseases (North Carolina Division of Public Health 2010). As a brief example, the major
environmental source of gastrointestinal illness is water or food that has been contaminated with pathogenic microorganisms, pathogens that are now introduced both naturally and artificially into ecosystems (Basic Information 2013). Referencing Anthony Giddens, sociologist Ulrich Beck pointed out that a “risk society begins where nature ends, where we switch the focus of our anxieties from what nature can do to us to what we have done to nature” (1998, 10). Alarmingly, new vaccines are available for only 3 of the 50 newly emerging disease threats that have been identified since 1973 (Hoyt 2012). These realities suggest that disease threat has grown more unruly in this day and age, a status that requires science and public response systems to remain incredibly flexible and ripe to act, a task that grows increasingly difficult when responding to notoriously unpredictable and savvy viruses, such as influenza.

In earnest, risk and error are undoubtedly a part of good, even great, science. In a 2013 Nature commentary, contributors William J. Sutherland, David Spiegelhalter, and Mark A. Burgman compiled a list of 20 “tips” to help nonscientists grasp limitations of evidence. Among those tips, the authors clarified “the real world varies unpredictably. Science is mostly about discovering what causes the patterns we see,” that “practically all measurements have some error,” and even the best measurement tools may mislead:

Expressed as $P$, statistical significance is a measure of how likely a result is to occur by chance. Thus $P = 0.01$ means there is a 1-in-100 probability that what looks like an effect of the treatment could have occurred randomly, and in truth there was no effect at all. Typically, scientists report results as significant when the $P$-value of the test is less than 0.05 (1 in 20).

In his 1965 Presidential Address to the Royal Society of Medicine, Sir Austin Bradford Hill offered some thoughts about “statistical significance” and scientific error, concluding that
all scientific work is incomplete—whether it be observational or experimental. All scientific work is liable to be upset or modified by advancing knowledge. That does not confer upon us a freedom to ignore the knowledge we already have, or postpone the action that it appears to demand at a given time. (as cited in Griffin 2014, 59)

Unfortunately, a measure of U.S. Americans’ tolerance for margins of error in matters of preventive health would probably yield low rates.

For instance, in reference to the marginal risk assumed with childhood vaccinations, a parent explained, “I cannot deny that my [unvaccinated] children can put someone else at risk . . . [but] I refuse to sacrifice my children for the greater good” (Steinhauer and Harris, 2008, paras. 8, 10). Recently, in the opinion pages of The New York Times, physics and astronomy professor Adam Frank noted,  

Americans always expected their children to face a brighter economic future, and we scientists expected our students to inherit a world where science was embraced by an ever-larger fraction of the population. . . . But what has been lost is an understanding that science’s open-ended, evidence-based processes—rather than just its results—are essential to meeting those challenges. (2013, para. 12)

Discouragingly, U.S. citizens have experienced both the highs and lows of the scientific process that Frank detailed. Here, a “high” would be an instance when the CDC declared, “Thanks to effective vaccine, the United States has been polio-free since 1979” (2014); a “low” would be when the CDC (2007) admitted:

More than 98 million Americans received one or more doses of polio vaccine from 1955 to 1963 when a proportion of vaccine was contaminated with [Cancer, Simian Virus 40 (SV40)]; it has been estimated that 10–30 million Americans could have received an
SV40 contaminated dose of vaccine.

For vaccination, in particular, the status of this particular medical intervention remains contested despite notable successes (Baumel 1977). Given that potential, the failed Bush smallpox vaccine campaign for first responders demonstrates renewed public resistance to previously faith-based draconian measures (Richards, Rathbun, and Gold 2004), a resistance that gains prominence and, perhaps, justification in the wake of “Big Business Medicine,” an issue discussed in some depth in the next section.

**Public Distrust of Science**

The vacillating reputation of vaccination across time suggests that the tone and tenor of public deliberation concerning select related issues have also remained unstable. Amidst instability, however, some concerns seem to consistently characterize U.S. public vaccination talk: questionable public health practices, for-profit motivated advances, and specific science-based concerns. These complications likely interfere with everyday public health-security planning by harboring uncertainties that erode public trust in medical expertise. As a continually contested public health issue, vaccination calls attention to the science of new biotechnologies, motives driving medical advancement, and the logic informing public defense decisions, but it also, and, perhaps, most important, calls attention to the necessary and significant role that public trust plays in the overall success of science-based endeavors. Unfortunately, recent polls suggest that members of the U.S. public do not regard official health recommendations with as much enthusiasm as they once did (Jacobs 2004). In the contemporary U.S. setting, conflicting images of medicine in relation to real and/or perceived health threats remain troubled at best. In her review of scholarly literature and public polling results on the subject, linguist Louise Cummings noted,
It is clear that public health cannot command more confidence than the institutions—the health-care system and the media, predominantly—upon which it depends. And there can be little doubt that these have suffered a significant decline in public trust over a period of many years. (2014, 3)

Despite the realities of somewhat familiar, age-old disease threats, such as the seasonal flu, U.S. Americans remain largely tentative concerning who and what should be trusted in the politics of contagious disease. Mark Largent, a historian of science, recently traced how the issue of vaccination, in particular, has generated over the last decade public debate, parental confusion, and patient pushback. Andrew Wakefield’s now-infamous early 1990s publication, positing a link between the measles, mumps, and rubella (MMR) vaccine and the onset of autism, sent a ripple through lay and scientific audiences alike. Despite the study’s refutation as “an elaborate fraud” by the British Journal of Medicine, over time, the autism–vaccination link encouraged otherwise disparate medical publics in the United States to challenge the longstanding trust in science (Godlee, Smith, and Harvey 2011; Repeik 2011). Backed by celebrity endorsements from mothers of children with autism (most notably, Jenny McCarthy), the vaccine–autism connection successfully forged partnerships across groups of wary parents and longstanding antivaccinationists to generate widespread publicity about the potentially unsafe aspects of childhood vaccinations (Largent 2012). Beyond the MMR–autism accusations, for example, the autism–thimerosol connection publicly revealed hazardous materials in the composition of some vaccinations, which perpetuated vaccine fear across U.S. audiences, even though the medical community has refuted the connection (see, e.g., Price et al. 2010). Together, evidence suggests, the proliferation of false information paired with the disclosure of previously unknown
information scared publics, despite a much longer history of vaccine resistance, and, thereby, tempered longstanding public trust in science (Geier and Geier 2003).

Amidst a universal rise in internet health, an increase in celebrity and personal testimony concerning the “dark side” of vaccinations, and a mediated preoccupation with the potentially controversial aspects of vaccination, research now suggests that a growing number of U.S. Americans question the intentions of medical institutions and their government affiliates (Schelsinger 2002). On more than one recent occasion, members of the general public have rallied around accusations that the U.S. health-care system is corrupted by the for-profit intentions of a pharmaceutical industry. Public controversy surrounding the 2006 human papillomavirus (HPV) vaccination, for example, drew attention to how exaggeration and misinformation about particular health threats could be leveraged to sell health products and to gain political favor. In particular, in early 2007, Governor Rick Perry of Texas, an early proponent of mandating HPV vaccinations for all school age girls, was criticized publicly for his affiliations with Merck, the pharmaceutical creator (and lead beneficiary) of the vaccine. Consequently, heavy lobbying, private and public court hearings, and politicized debate demonstrated widespread public dissent concerning the for-profit backdrop of HPV-related health-care practices and policies. Many public health officials now attribute low\(^1\) HPV vaccination rates to this widespread public resistance, emphasizing ways that perceived ulterior motives directly influence public participation in vaccination effectiveness (Schwarts, Caplan, Faden and Sugarman 2007). With regard to effectively addressing public concerns about monetary realities of vaccination development, Centers for Disease Control Director Thomas Friedan recently claimed that the medical community is “dropping the ball” on HPV vaccination, in particular (Neale 2013, para. 5).
Within the United States, public health systems have expanded to include scientists, policy makers, national security strategists, health-care professionals, and community organizations and personnel. Indeed,

the public health system involves many players. Government health departments have legal responsibility for ensuring public health and employ professionals, such as physicians, epidemiologists, social workers, nurses, and inspectors. Public health departments also rely on medical professionals in private practice to perform public health functions and help patients practice prevention. Police and fire departments play a crucial role in ensuring public safety and well-being, and even architects, housing developers, city planners, and traffic design specialists contribute through their everyday work to the safety and health of our communities. Neighborhood and nonprofit organizations also are part of the public health partnership. (National League of Cities 2003, 3)

Undeniably, this compilation now includes for-profit partners as well; in a recent issue of the *Harvard Health Policy Review*, the pharmaceutical industry was described as “one of the biggest players in the crafting of health policy” (Heath 2013).

Given that most vaccines are developed in partnership with large pharmaceutical companies, questions and concerns about motives underlying medical advancement now pepper public conversations about certain biotechnologies, with people wondering whether a particular vaccination is introduced to the public because of a dire need or to create a profit margin. Widespread distrust in this element of medical intervention may be misguided:

Even with industry growth fueled by limited competition and the prospect of ‘blockbuster vaccines’ such as Prevnar and Gardasil, analysts expect vaccine profits to remain below
the margins of branded pharmaceuticals. Compared with pharmaceutical “blockbusters” capable of annual sales well over one billion dollars, most vaccines continue to yield more modest profits for manufacturers. (Prifti 2010, para. 3)

However, as U.S. Supreme Court Justice Antonin Scalia made clear during a 2011 Supreme Court case:

Vaccine manufacturers fund from their sales an informal, efficient compensation program for vaccine injuries. In exchange they avoid costly tort litigation, occasional disproportionate jury verdict . . . a way to provide compensation to injured children without driving drug manufacturers from the vaccine market, a no-fault system that spares drug companies the costs of defending against parents’ lawsuits. (Associated 2011, para. 9).

Regardless of fault or motive, the economics of vaccine development now figure prominently in most public considerations of vaccination.

**Vaccination Hesitancy**

In his recent book *Vaccine: The Modern Debate in America*, Mark Largent suggested that the unpredictable and evolving nature of disease has interacted with an uncertainty and distrust regarding policies and practices of U.S. medicine and government to create a largely vaccine-anxious U.S. public (2012). This anxiety, according to Largent, can lead to vaccine avoidance. For instance, although “immunization system issues are more commonly reported with under-vaccination . . . access to services, parental attitudes, knowledge and practices appear to play a greater role among children who have not received any vaccination” (World Health Organization [WHO] 2012 Report, 434, in reference to Rainey et al. 2011). In communities where there has been a rise in concerned parents opting out of vaccination for their children, disease rates have
risen. In 2008, for example, an intentionally unvaccinated boy unknowingly was infected with measles during a trip to Switzerland. He returned to his school in San Diego, California, to a cluster of other intentionally undervaccinated children; the result was the largest outbreak of measles in the United States in recent history (Sugerman et al. 2010). That example illustrates how vaccine hesitancy—substantiated or not—can leave members of the general public vulnerable to diseases that may otherwise be prevented by vaccination. Although childhood vaccination rates continue to hover around 90% nationwide (NIS 2012), the 2008 San Diego case suggests that vaccine hesitancy clusters in significant and dangerous ways. As such, that example may justify why “health authorities see intentionally unvaccinated children as threats to everyone” (Largent 2012, 18). The 2008 case in San Diego does not stand alone.

Just this past year, 2013, the Centers for Disease Control and Prevention (CDC) reported a threefold increase in measles outbreaks across the United States. In the early months of 2014, MedPage Today, a self-proclaimed “trusted news service for physicians that provides a clinical perspective on the breaking medical news that their patients are reading” ran an article, titled “Culture Shock: Hellooo Measles!”, that opened with, “After 500 years, we have come full circle—we're importing measles from Europe” (Smith 2014, para. 1). In related news, and directly linking low rates of vaccinations to recent measles scares, the CDC stated, “Fifty years after the approval of an extremely effective vaccine against measles, one of the world’s most contagious diseases, the virus still poses a threat to domestic and global health-security” (2013c, para. 1). Outbreak trends, such as the ones illustrated by modern measles, as Mark Largent’s conclusions suggested, raise legitimate questions about how vaccine hesitancy factors into public communication efforts that address real and imagined disease threat, how those factors likely
trouble the delivery of effective and efficient health-care, and how those factors taint the relationship between medicine and its publics.

Although commonly mentioned as a feature of contemporary health-care decision making, aside from Largent’s mention of the issue, very little research addresses vaccine hesitancy, specifically, as a variable of interest that influences relationships between health-care professionals and their publics. Some studies have investigated reasons for delayed childhood vaccinations (Green and Lee 2006), undervaccination (Luman, McCauley, Stokley, Chu and Pickering 2002), and hesitations attributed to vaccine safety concerns or access to health-care, specifically (Gust et al. 2004). Although the threat of an undervaccinated and/or a wholly unvaccinated public poses obvious problems for public health, the far more insidious threat that Largent’s research draws attention to is the emergence of an increasingly vaccine-hesitant U.S. public. As Largent warned, “Unless we address the fundamental problems inherent to the modern vaccination schedule, today’s vaccine-anxious parents may well become the parents of tomorrow’s under-vaccinated and unvaccinated children” (2012, 36). Authors of a study published in the Journal of Pediatric Health-care, who developed and administered “the hesitancy questionnaire,” found that two of the leading reasons parents reported vaccine avoidance were confusion about the vaccine schedule and concerns about trauma caused to their children during the vaccination process. These findings led the authors to conclude that “health-care providers may be missing opportunities to educate hesitant parents about immunizations” (Luthy, Beckstrand, and Peterson 2009, 388), an oversight that may be occurring with regard to adult vaccinations as well. Misperception about vaccine effectiveness and need continue to get noted across studies as a leading predictor for why adults avoid vaccination (see, e.g., Kempe et al. 2007).
Unrelenting public attention and debate concerning the safety and efficacy of vaccinations interferes with the success of vaccination writ large. In a vaccine-hesitant society, U.S. Americans publicly question the science, motives, and logic of certain biotechnologies more than was the case for previous generations of U.S. citizens. In and of itself, an increase in public engagement with matters of science, technology, and medicine is a commendable achievement that reflects ongoing efforts to increase public literacy in the sciences (see, e.g., the ongoing work of Dr. Jean Goodwin, which includes academic, popular, and online publications, annual conference proceedings, and academic–community partnerships). An (often inaccurate) overemphasis on the worrisome aspects of one component of the larger U.S. national public health-security plan, however, may be compromising the integrity of public health as a whole, a consequence that grows particularly alarming in an era when disease threat, arguably, has worsened. Insofar as vaccine-anxiety distracts from a critical citizenry’s ability to decide and act confidently against threats of emerging diseases, public debate about vaccinations matters to public perceptions of medicine (especially preventative medicine) and the subsequent overall health of its publics.

In this increasingly complicated environment, vaccination communication provides an enlightening entry point to consider how individuals organize around health issues and come to be represented and managed in the official language of health and medicine, and in the discourses that resist them within a larger public conversation. Health-care workers represent one segment of the larger U.S. population whose profession ties them directly to descriptions and explanations of disease prevention and management. Moreover, according to more recent legislation, health-care workers now represent a group that is targeted for vaccination in an attempt to increase nationwide immunity. Indeed, according to an ongoing strand of national
health-security policy, medical professionals may now consider personal vaccination to qualify as a “a duty of care.” However, professional expectations that require individuals to forfeit private rights in service of public goals, such as those suggested by mandatory vaccination policies for health-care workers, are not readily accepted or endorsed uniformly across the health-care community. In fact, a growing faction of medicine now publicly rejects efforts to mandate the annual influenza vaccination, and adoption rates within the health-care community continue to hover around 40%, a lower percentage than the national average (which is not much higher) of 45% (CDC 2013b). It seems, then, that the health-care community remains divided over whether certain medical interventions are necessary to personal, patient, and national health-security. Amidst current and anticipated proliferations in the availability of new biomedical prevention technologies for health-care personnel and patients alike, determining how biotechnology can and should factor into the delivery of effective U.S. health-care and the professionalization of the field arises as a pressing concern.

**Vaccination Communication Literature**

Unfortunately, the air of uncertainty surrounding the actors and factors of disease management (in a for-profit health-care context) contribute to an ongoing crisis of confidence experienced by members of the U.S. public with regard to perceptions of medical interventions, such as vaccinations, and their public health proponents. A growing body of research now investigates this issue. Within a larger body of “vaccination communication studies” more broadly, studies that have focused on stakeholders’ perspectives, policy interventions, risk assessments, and rhetorical arguments suggest that medical actors, such as health-care workers, operate as important intermediaries between the status of public health and individual vaccination behaviors.
Stakeholder Studies

A collection of vaccination communication studies focus on investigating and describing specific stakeholders’ perspectives. In that group of studies, parents, vaccine recipients, and health-care personnel arise as important actors in vaccination policies and practices (Downs 2001). The goal of studies in this category is to identify telling traits in each type of stakeholder that either predict or interfere with views of specific vaccinations as a viable medical intervention option. For example, a study concluded that narrative communication based on the extended parallel process model may persuade people aged 65 years or older to get an influenza vaccination (Prati, Pietrantoni, and Zani 2012). However, another investigation specified further differences between African American seniors and Hispanic White seniors’ perception of influenza, despite their similar age demographics (Cameron et al. 2009). Largely descriptive in nature, this collection of studies identifies demographic factors, such as age, race, and socioeconomic status, as predictors of vaccination behavior.

From this particular group of studies, the salient takeaways include recognition that opinions and behaviors surrounding vaccination differ across various commitments and map onto demographic characteristics in consistent ways. Specifically, socioeconomic status (as it relates to professional identities and levels of education) has been found to predict vaccine resistance tendencies (Streefland 2001) and health-care providers’ recommendations influence patients’ overall attitudes toward preventative technologies (Nichol, Mac Donald, and Hauge 1996). With regard to this lattermost strand of research, Moe Kyaw, Jonathan Nguyen-Van-Tam, and James Person conducted a study of hospitalized patients with “definite indications for pneumococcal vaccine” to identify motivations for vaccine adoption, with 85% of their survey respondents explaining that “advice received from their general practitioner” motivated them to
get vaccinated (1999, 589). In terms of this dissertation project, the findings surmised from this particular category of studies suggest that medical professionals play an influential role in the overall status of public understanding and acceptance of vaccination, especially among underserved and underprivileged segments of the U.S. population.

Policy Studies

An additional collection of vaccination communication studies contributes case studies and historical accounts of particular disease outbreaks and responses to advise future policy planning. In this group of studies, both successful and unsuccessful disease responses are evaluated in relation to social, political, and cultural considerations. For example, Cecelia Chen’s 2009 study, which examined reasons that rebellion occurred during WHO’s 1998 global polio eradication initiative in Nigeria, concluded that a bottom-up approach would have helped WHO’s policies and processes to succeed by allowing local leaders to empower themselves. Complimentarily, Amy Kaler’s 2009 article demonstrated how the inclusion of local authorities can affect the success of vaccine eradication initiatives by addressing head on culture-specific rumors. Overall, this particular group of studies views disease response as a complex, unpredictable endeavor that requires the cooperation of many organizations to react to disease threat in timely and effective manners.

Nearly all of the studies classified in this category claim that sustained investigation of past case studies can guide future public health-security planning. In her historical study, rhetorician Barbara Heifferon suggested that “smallpox vaccinations have a four-hundred-year-old history, and the insights gained from such historic studies can teach us much about our present course” (2006, 76). However, the adage “history repeats itself” resounds, as some infectious diseases, such the Swine Flu, reproduce eerily similar problems for policy makers and
health officials time and time again (e.g., compare Richard Neustadt and Harvey Fineberg’s 1978 study to Emma Teasdale and Lucy Yardley’s 2011 findings). In terms of general lessons learned, disease-specific policy studies identify distinct profiles for many individual health threats, and they specify ways that the biology of health conditions influences public perceptions of urgency in times of need.

In terms of vaccination policies and practices, in particular, this group of studies articulates some key concerns in the everyday assembly of public health-security that continue to trouble the effective and efficient delivery of health-care. Specifically, findings from these studies suggest that spontaneous disease outbreak trumps preparation and goodwill, no matter the era, because even in best-case scenarios, people die from infectious disease. Despite that claim, however, this group of studies offers assurance that remarkable strides have been made with regard to predicting and preventing disease outbreak from ever afflicting populations. For example, in a 2006 report, Colin Mathers and Dejan Loncar provided three visions of the future in relation to potential disease threat. With regard to their forecast, they assured audiences that despite the wide uncertainty ranges around future projections, they enable us to appreciate better the implications for health and health policy of currently observe trends, and the likely impact of fairly certain future trends, such as the ageing of the populations, the continued spread of HIV/AIDS in many regions, and the continuation of the epidemiological transition in developing countries. (2011)

With regard to the idea of imminent threat, this group of studies articulates what “the public” expects of politicians, scientists, and medical professionals for disease management; namely, individuals desire patient politics—that is, calm, collected, transparent political responses that are issued in a proactive, timely manner, to offset public anxiety and fear when
pandemic strikes (Quinn, Kumar, Freimuth, Kidwell, and Musa 2009). Similarly, patient politics can also preemptively amass the public trust that is needed to deal promptly with failure that is attributed to a scientific, medical, or policy intervention. As this category of studies demonstrates, the politics of vaccination is wrought with complications and complexities that range from social disparities with regard to access to health-care resources, to inadequate supplies of vaccination and/or the issuance of ineffective biotechnologies, to premature approval of public health interventions that later are deemed to be dangerous, to the proliferation of myths and conspiracy theories concerning the causality of disease that is exchanged among potential vaccine recipients. For my study, in particular, this group of studies punctuates the importance of health professionals in managing perceptions of disease threat before, during, and after public health-security breaches.

Risk Studies

A related body of vaccination communication research focuses on investigating potential and actual risk associated with specific vaccination technologies. By and large, the goal of such studies is to identify specific risks that are associated with particular vaccine technologies, to improve the overall capabilities of biomedicine. Hence, beyond the focus on provocative aspects of medical risk, investigations in this category assess the potential for vaccine-induced health injury that occurs at a statistically significant level. To name a few examples, Ascherio et al. investigated a potential link between Hepatitis B vaccination and multiple sclerosis (2001), Smeeth et al. considered risk of myocardial infarction (heart attack) and stroke after vaccination (2004), and members of the Vaccine Safety Datalink Team focused on risk of anaphylaxis (allergic reactions) after vaccination of children and adolescents (Bohlke et al. 2003). Although qualitative findings that report individual vaccine experiences often augment quantitative
findings in this category of study, for the most part, studies of vaccine efficacy either substantiate or deny claims of “widespread vaccine threat” by dispelling rumors originating at the individual patient level. In this category, public perceptions of vaccine risk (Hobson-West 2003), public understandings of vaccine safety (Stefanoff et al. 2010), and implementation and use of adverse effects reporting systems (Gust et al. 2004; Tatley et al. 2008) are considered to be in the service of larger public health-prevention initiatives. Studies conducted in this category also evaluate compensation structures that are put in place to respond to vaccine injury (see, e.g., Walker et al. 2011).

Most relevant to this dissertation project, findings from these studies suggest that the science is sound with regard to most vaccine technologies; that colloquial versus scientific definitions, and, thus, evaluations of risk, differ tremendously; and that stakeholders at every level of disease management are actively seeking reassurance concerning the risk–reward tradeoffs that are assumed to occur with adopting new biotechnologies. With regard to the last point, findings from many of these studies illustrate how vaccines readily symbolize both risk and reward across invested publics; that is, although many members of the public recognize the benefits of vaccination for the overall well-being of a population, at the individual level, the risk–reward ratio becomes less clear. In particular, there appears to be a disconnect between actual public knowledge and what public health authorities think that the public knows (Moran, Shickle, and Richardson 2008). As such, evaluations of vaccination remain suspended somewhere in between reliable and risky, necessary and superfluous, and good and bad. In terms of this dissertation study, this grey area calls attention to an inability for official rhetorics of health and medicine to adequately reassure individuals about vaccination risks through the language of science alone. Even if risk exists as “a very unlikely outcome” and benefits of
vaccination are determined to “outweigh any and all risks,” individuals need to be persuaded to consider vaccination as a viable and necessary health practice.

**Rhetorical Studies**

The final collection of vaccination communication studies that is directly relevant to the present study are research projects that are situated at the intersection of rhetorical studies and vaccination. In particular, the distinct connection between persuasive communication tactics (rhetoric) and vaccination serves as a distinct subset of a larger vaccination communication studies category that is expanding across disciplines. Scholars contributing to this specialized dimension of vaccination research include Monica Brown (2012), Carolina Fernandez Branson (2012), Barbara Heifferon (2006, noted above), Heidi Lawrence, Bernice Hausman, and Clare Dannenberg (2014), and Rachel Whidden (2012). By and large, findings generated by this group of rhetoric scholars suggest that talk about vaccination bears social, cultural, and/or political consequences for how everyday citizens come to understand and experience health at both the individual and collective levels. For example, as Whidden’s recent comparative analysis of two public vaccination controversies concluded:

The Gardasil example provides a case in which a corporation has infiltrated the personal sphere in order to affect public decision-making. This type of usurpation prevents public deliberation; the personal sphere arguments advanced by Merck use fear tactics and play on a mother’s desire to protect her child and provide only one real option to lessen that fear: vaccination. The case of the vaccine–autism connection shows another way in which usurpation is preventing educated decision-making. Parents, based on their own experience, challenge with conviction and an air of expertise scientific facts and theories. Here, personal arguments and agendas are entwined with arguably pseudo-scientific
In this manner, attention to public consequences of vaccination communication delineate rhetorical studies of the issues as a distinct thread of inquiry that is dedicated to uncovering (and sometimes intervening into) persuasive dimensions of this particular medical option to determine what persuasion means for policies and practices of health and medicine.

In sum, vaccination communication is studied most commonly in relation to preventative health outcomes; that is, from both a biological and sociological standpoint, vaccination communication is often investigated as being in the service of larger public health prevention goals. In this regard, many communication scholars study vaccination communication to improve processes and products of public health campaigning. Because vaccination has prompted public debate and social action across history (Poland and Jacobson 2011), rhetoricians of health and medicine have grown particularly interested in this issue. Specifically, rhetoricians have been active in foregrounding the specifically suasive dimensions of vaccination policy and practice. Rhetoricians of medicine (e.g., those associated with Virginia Tech’s Vaccination Research Group), thus, have begun to foreground relationships among power, decision making, and social norms surrounding vaccination communication, to consider how public messages evoke ethical and moral concerns, as well as mobilize public action. As such, although still a fairly new area of study, a focus on messages used to describe, explain, and promote vaccination (aka “vaccination communication”) now proliferate the pages of medical, social-scientific, and humanities journals alike. This study adds to that expanding line of inquiry.
Research Questions

Thus far, this chapter triangulated the U.S. vaccine problem. First, I argued that disease threats remain real but that the nature of these threats has changed significantly in the last few decades, which poses new challenges for how individual U.S. health citizens understand issues of risk and responsibility in a global setting. Second, I reviewed how vaccination policies and practices have experienced varied success and publicized failure, which perpetuate a crisis in confidence with regard to the status of medical experts. Third, I suggested that these two factors have resulted in vaccine hesitancy being experienced across the U.S. population. Together, I contend, these three conditions—emerging disease threat, a varied public health track record, and shifting public attitudes and behaviors regarding medical intervention—have lent vaccines a symbolic prominence in recent years whereby most vaccine talk—public or private—is laden with ethical, social, cultural, and political concerns that extend beyond doubts about the quality of medicine’s science. This “symbolic prominence” and its consequences for the status of the U.S. public (and its medical publics therein) are the foci of this study and they offer a unique contribution to the literature.

With this larger context in mind, and after consulting literature that has focused on public perceptions and vaccination, the following research questions have been crafted to address dimensions of the larger vaccine hesitancy problem that this chapter outlined. Specifically, I pursue three questions successively to highlight some initial features of public and policy vaccination communication that actively influence how members of health publics come to understand, manage, and/or express personal beliefs about health-security. Of particular interest, and by way of an entry point into a larger discussion about the reprofessionalization of U.S. health-care for a biotechnological era, I foreground the role of health-care professionals in their
position as liaisons between public and private health decision making. Therefore, the following research questions were posed:

RQ1: How do rhetorics of health and medicine frame vaccination as a public problem?

RQ2: What does public debate about vaccinations reveal about public perceptions of medicine?

RQ3: What do competing rhetorics of vaccination suggest about the nature of medical professionalism in the United States?

In line with Largent’s position, I, too, understand the widespread air of controversy surrounding U.S. vaccination discourse to act as a proxy for other issues troubling the U.S. public. Furthermore, I also worry about how anxiety factors into public communication efforts in lieu of real and imagined disease threat. Therefore, in the pages that follow, I expand Largent’s assessment of proxy considerations to include ways that vaccination—as a medical practice—punctuates some problems that are inherent to modern medicine, norms that may have not been as prevalent in years past when vaccination enjoyed widespread public approval. In this manner, I pick up the scholarly conversation where Largent left off, build on important questions that he raised, and then work to identify some problematic assumptions that likely underlie practices, policies, and representations of vaccination in the modern era. To make better sense of these contours in terms of public significance, I draw heavily from theory that is situated at the crossroads of rhetoric and medicine, with particular focus on the notion of “publics” as a dominant, organizing principle of contemporary health-care; commitments and assumptions that I describe in the next two chapters.
Conclusion

History suggests that social and political consequences accompany the persuasive language that is used to mobilize publics in the name of health (Wald 2008). History also suggests that U.S. citizens are well versed in the limits of disease control and prevention in the face of evolving disease threat. In lieu of prevalent uncertainty regarding both what exactly to fear and who and what exactly to trust in matters of disease management, many U.S. citizens now experience intense feelings of worry when faced with medical decisions. Encouragingly, research has also demonstrated that health-care interactions can offset concerns regarding vaccination (e.g., Luthy, Beckstrand and Peterson 2009). In this regard, health-care professionals, scholars, experts, and officials are uniquely positioned to help reconfigure public trust in medicine for the biotechnological era. The issue of emerging disease has long provided a site whereby disparate stakeholders converge productively to discuss matters of health and safety within the United States. Today, however, these conversations are often set against the backdrop of unrelenting public debate regarding the risk and responsibility that are assumed with vaccination as an essential intervention tool. Hence, overemphasis on, or over vilifying, one aspect of a larger U.S. public health-security apparatus may unnecessarily, destructively, or distractingly bog down public health delivery systems in ways that perpetuate hesitancy and distrust among members of the U.S. citizenry.

However, it is worth noting that “low” qualifies as around 85% coverage for the 13–17 age group, the CDC’s target demographic.

In the next chapter, I dive more deeply into what I mean by this term. In short, I use health publics to refer to groups of individuals who organize around issues of mutual importance and whose decisions about health directly impact the politics and practices of care.
CHAPTER II
RHETORICAL THEORY AND HEALTH PUBLICS

In this chapter, I trace how the field of rhetoric has theorized publics to evaluate the status of the rhetoric of medicine’s current approach and to identify how, specifically, this study fits into and extends that larger body of literature. Beginning with Habermas’s (1989) introduction of a bourgeois public sphere, I subsequently explore limitations of his ideal using Fraser’s (1992) theory of counterpublics (later taken up by Warner 2002) and Hauser’s (1999) rhetorical model of the public sphere. Following an introduction of vernacular rhetoric as both theory and praxis (a rhetorical tool that is revisited in chapter 3), I explore how scholarship from the field of the rhetoric of medicine, specifically, adds to the study of medicine and its publics. I then consider public policy as an official rhetoric of health and medicine, and its relationship to material health conditions.

Rhetoric and Public Problems

Rhetoric has been an important part of civic life since the fifth century BCE, when citizens of an emerging democracy had to speak convincingly to participate in both social and political life. In his Politics (350 BCE), Aristotle delineated public participation (often via speech) as a central component of democratic life:

If liberty and equality, as is thought by some, are chiefly to be found in democracy, they will be best attained when all persons alike share in the government to the utmost. And since the people are the majority, and the opinion of the majority is decisive, such a government must necessarily be a democracy. (Book IV, 1291.b34)
In this regard, since its beginnings, rhetoric, the practice and analysis of persuasion, and ideas about publics have been intimately linked. Since Aristotle’s Greece, however, conceptions of publics and public engagement have shifted and changed in response to social and political circumstances.

Participants in Greek’s ancient polis relied on public speaking to communicate messages to the masses. The oral tradition and public fora were used to inform, praise, or persuade others about issues of mutual importance. Sometimes, too, public speech was required of individual citizens in need of self-representation during legal disputes. Although that was a time when public speaking became a primary mode of entertainment, commerce, and politics alike, today, the oral tradition serves some of the same purposes, but available modes of communication have changed notably. In a more integrated and technologically savvy world, public participation in political, social, and cultural meaning making has expanded to challenge well-worn notions of publicness. Social media alone pose new problems, as well as opportunities, for public representation and participation across authors and audiences. Some scholars, such as Swedish social scientist Hans Wicklund, have noted limitations that are assumed with participating in democratic life via social mediated means. Specifically, Wicklund questioned the limited two-way communication of online fora, the many opportunities that it presents for authoritative surveillance, and numerous issues of inequality that accompany needs of participating in “e-democracy,” such as access to computers and issue literacy (2005). Others, such as Canadian media and communication scholar Kirsty Best, laud the proliferation of new modes of material and discourse as offering much-needed, nonhierarchical opportunities for organizing (2005). Either way, communication expectations and possibilities afforded to contemporary U.S. citizen
have, perhaps, never been more complex or more in need of illumination with regard to everyday democratic life.

That being said, the need to negotiate between private life and public life is an enduring attribute of civic society, no matter the era. Determining a healthy, productive, or reasonable balance between private and public life remains central to many conversations about civic life, perhaps especially in democratic societies, such as the United States, where an engaged citizenry is fundamental to operations of both government and commerce alike. However, as sociologist Joseph Gusfield noted, concern about the public–private tension is perspective- and need-dependent:

The hiatus between the public and private sides of reality is interesting or shocking or provocative only as the observer expects or demands a closer fit, assumes that public authority is a means to a private end—control of the behavior of persons. Suppose that instead, or in addition, public acts—laws, legislation, official speeches, mass media descriptions, brochures, and the other mechanisms of public action—can be considered sui generis, as events in and of themselves without reference to possible functions as means to ends? (1981, 20–21)

Here, Gusfield raised questions about potential concerning what public processes and consequences might be expected to contribute to private life, if anything at all. Although the notion of “public deliberation” that has been used to imagine, organize, and contest issues of communal living in service of private rights may be, by now, considered a banal aspect of modern life, theories concerning the ideal functions of such deliberative arrangements for social arrangements and problem solving continue to evolve in relation to emerging needs. Theorizing
publics remains at the forefront of scholarly conversation, especially as notions of publicness grow more and more diffuse.

**Publics Theory**

In the contemporary setting, positions and ideas about the public gained renewed scholarly attention in 1962, when *Strukturwandel der Öffentlichkeit (The Structural Transformation of the Public Sphere)* by Jürgen Habermas was published.¹ The Habermasian public sphere operates as an ideal situation when and where individuals come together to freely identify and discuss social problems to initiate change. Whereas in the past, a political monarch made decisions regarding public goods and services, in 18th-century France, Habermas argued, private individual concerns could be considered in public life, and a space was needed to deliberate about social and commercial considerations. Specifically, the *public sphere* is a space that is designed to help bourgeois elites negotiate common tensions that arise from the need to lead, simultaneously, a private and public life. For Habermas, the public sphere was *the* means to achieve a truly participatory democracy where debate and deliberation led to public consensus, and where public opinion resulted in political action; its key feature was its separation from the influence of both church and State. Habermas articulated three preconditions for the emergence of a public sphere that he called “institutional criteria”: a disregard of status, a domain of common concern, and a practice of inclusivity. If each criterion was met, according to Habermasian standards, mutual understanding and consensus freely formed by participants in interaction (something he coined “communicative action”) was achievable. Notably, his contribution largely preceded the technological revolution that now overwhelmingly and convincingly demonstrates communication as essential to public life. Nonetheless, Habermas’s theory of the public sphere continues to provide a vocabulary and framework for interpreting,
influencing, and theorizing modern conditions for public deliberation. Each of the Habermasian
criteria continue to attract debate and to provide fodder for critics interested in how publics can
and should contribute to everyday living (see, e.g., Best 2005; Wicklund 2005).

In 1992, Craig Calhoun edited *Habermas and the Public Sphere*, which brought together
scholars from across disciplines in the United States to evaluate and apply Habermas’s theory of
a bourgeois public sphere. Most notably, Fraser raised concerns about Habermas’s problematic
definition of “common concern,” the propensity for Habermas’s public sphere to perpetuate
hegemonic practices of dominance and exclusion with regard to public policy, and the tendency
for the theory to bracket off inequalities that should be, she argued, considered centrally in
conversations about the public good. Fraser claimed that marginalized groups, in response and
out of necessity, formed *subaltern counterpublics*, which she defined as “parallel discursive
arenas where members of subordinated social groups invent and circulate counterdiscourses to
formulate oppositional interpretations of their identities, interests, and needs” (1992, 123).
Fraser’s insights remain central to projects that configure dissent as an inevitable and necessary
part of a more inclusive public sphere, because her critique prioritized considerations of ways
that nonbourgeois publics actively participate in modern-day democracies; this initiative holds
particular consequence for interpreting the health of any public (or, as shall be shown later, for
guiding “public health”).

In 1999, Gerard Hauser entered the public sphere debate, “interested in the insights we
may gain into publics, public spheres, and public opinion when we regard discourse as the
predominant and authoritative data from which we infer how they form and function” (11).
Unlike Habermas, Hauser did not identify consensus as a desired end for public deliberation;
instead, he defined the public sphere as “a discursive space in which individuals and groups
associate to discuss matters of mutual interest and, where possible, to reach a common judgment about them. It is the locus of emergence for rhetorically salient meanings” (1999, 61). Hauser’s reticulate model of the public sphere requires that participants share *intersubjective meanings,* “ways of experiencing action in society which are expressed in the language and descriptions constitutive of institutions and practices” (1999, 67). Sometimes, shared meaning requires the inclusion of dissident, nonofficial voices. Indeed, a reticulate model of public participation provides guidelines and vocabularies for factoring in nontraditional modes of political expression that may, as Hauser concluded, more accurately represent the status of public opinion about any given topic as compared to official opinion polling data. At the very least, considerations of alternative, mostly marginalized forms of expression ensure a textured, nuanced, and, ultimately, more accurate representation of “the public” that constitutes public life.

In 2002, Michael Warner theorized the concept of a “counterpublic.” Specifically, he distinguished between *the* public (“a kind of social totality”) and *a* public (“a concrete audience, a crowd witnessing itself in visible space”) to introduce a third kind of public: “the public that comes into being only in relation to texts and their circulation” (413). This last type of public opens up space for the emergence of *counterpublics,* collections of individuals who recognize their subordinate status and make use of resistant discourses and identities to form and transform social situations. According to Warner, counterpublic discourses are far more than the expression of subaltern culture, which appears to extend Fraser’s introduction of *subaltern counterpublics.* In this manner, Warner’s reexamination of counterpublics operationalized Fraser’s (1992) concept for use by rhetorical critics investigating the medical context today. Whereas Fraser’s version of counterpublic discourse was tied to embodied collectives of people, Warner’s version of counterpublics suggests that publics can emerge in and through texts, whereby individuals
may never meet but experience a sense of camaraderie and spatial presence, nonetheless. It is from this discursive presence that counterpublics come to demand political attention. For Warner,

perhaps nothing demonstrates the fundamental importance of discursive publics in the modern social imaginary more than this—that even the counterpublics that challenge modernity’s social hierarchy of faculties do so by projecting the space of discursive circulation among strangers as a social entity, and in doing so fashion their own subjectivities around the requirements of public circulation and stranger sociability. (2002, 424)

Existing as such, counterpublics form and transform in direct response to political and social issues as they organically emerge. This conceptualization holds important consequence for the study of nonofficial public opinion in official health policy deliberation. Importantly, they emerge as outside the circulating dominant text and in counterpoise to it.

**Medical Publics**

In recent years, scholars working in the interdisciplinary field of the rhetoric of health and medicine (ROHM) have begun to examine how publics challenge, support, and engage biomedical/health knowledge and practice.³ In doing so, a small but growing body of literature now theorizes publics as a distinct type of health community that is equipped with rhetorical tenacity. For example, recently, Drs. Lisa Keränen and J. Blake Scott bookended a special issue of the *Journal of Medical Humanities* that is dedicated to what “a rhetorical understanding of publics offers conceptual, methodological, and practical benefits to health and medical humanities scholars” (2014, 103). In their separate introduction and conclusion, each scholar affirmed that publics theory adds something extremely valuable to the study of medicine, but that
it also complicates well-worn approaches to understanding the public of public health.

Specifically, Keränen suggested that

- a rhetorical perspective on publics thus advances a participatory, dialogic model wherein citizens self-organize around issues of interdependent concern in a public sphere that need not be limited to geographical space. . . . From this perspective, we can appreciate biomedical and health discourses and practices as the result of complex sets of interacting rhetorical performances that bridge public, private, institutional, and technical concern.
  
  (2014, 104)

The literature on medical publics, thus, draws on Hauser’s work to surmise: (a) a medical public is not comprised of like-minded people but of those engaged by a particular health issue; (b) although individuals may never meet, insofar as they identify a particular health-related issue as an important, action-worthy concern that ties them to larger discourses about health and larger practices of medicine, these individuals come to constitute a medical public; (c) a medical public can be contentious both internally and externally; (d) a medical public likely consists of complex networks that are comprised of people who individually intersect with medicine, but that, as a collective, can operate independently and unofficially with regard to policies and practices of Western medicine; and (e) medical publics are not medical establishments but they can include people who work in and with medical establishments. A rhetorical perspective on medical publics, thus, recognizes that variety exists across various health definitions and experiences; accepts that certain health conditions, issues, and controversies attract the attention of individuals who disagree with dominant understandings of health; and understands that contested sites of medical deliberation provide valuable resources for investigating how medical discourses operate in relation to the overall publicness of health.
In rhetorical scholarship, it has been common practice to locate medical publics via the resistance rhetorics that they produce in opposition to clear demands set by medical establishments. However, medical publics may not always operate as countercultures. Beyond countercultures, Amy Koerber (2006) studied rhetorical agency and resistance as they relate to official rhetorics of breastfeeding. Using in-depth interviews, Koerber examined how dominate breastfeeding discourse operated as a disciplinary rhetoric for new mothers. In particular, Koerber noted the contradictory nature of medical policy and practice that often left mothers with mixed messages about breastfeeding. According to Koerber’s participants:

To follow current official medical guidelines on breastfeeding, which advise that infants should be breastfed for at least 1 year . . . a woman has to resist various other elements of medical discourse and larger cultural perceptions that directly contradict these official guidelines. (88)

Thus, Koerber argued that resistance, as demonstrated by her participants, began as an active selection among discursive alternatives that were presented by medical rhetoric and emerged as practical disruptions that allowed women to transcend preexisting subject positions from within the grip of disciplinary power. In her examination of how dominant breastfeeding discourse operated as a disciplinary rhetoric for new mothers, one of Koerber’s interviewees “defied medical perceptions of what [was] possible” by breast feeding through her subsequent pregnancy (99). Breastfeeding while pregnant was never addressed explicitly by medical discourse, but its absence from discussion implied a stance about the value of its practice. This particular participant utilized this “oversight” in official discourse as a site for active resistance against breastfeeding norms. Koerber’s line of work, thus, has clarified that, in some cases, medical
publics may not stand in opposition to official rhetoric; rather, they settle into the gaps presented by official rhetoric.

Similarly, Phaedra Pezzullo’s (2003) work identified how oversights in official discourse could be used to organize collective resistance. Pezzullo analyzed the San Francisco-based Toxic Links Coalition’s (TLC) annual “Stop Cancer Where it Starts” tour. At face value, the goal of the organization—to eliminate breast cancer—aligned well with the missions of other organizations participating in “National Breast Cancer Awareness Month” (NBCAM). However, as Pezzullo’s analysis demonstrated, through collective action, TLC’s revealed the gap between the appearance of, and the practices enabled by, NBCAM and, therefore, actively resisted official positions on breast cancer. TLC created an alternative tour that actively and publicly claimed to resist the “pinkwashing” of breast cancer discourse. According to Pezzullo,

More than a visual or psychological argument, TLC’s tour created an affective and embodied theatre for rhetorical engagement . . . TLC’s toxic tour performed reverse hegemonic attitudes about breast cancer. Instead of asking why anyone would want to resist NBCAM, TLC asks why anyone would not. Instead of romanticizing detection, TLC reminds us of how horrifying the moment is when someone hears those three words, “You have cancer.” Instead of focusing on what cannot be changed, such as heredity, TLC asks, what can we change? (361)

Together, findings derived from the works of Koerber and Pezzullo demonstrate how oversights in official rhetorics of health and medicine can be mobilized to create alternative, additional perspectives that have been used to loudly resist single, limited depictions of health and medicine. An understanding of these unique (and largely successful) forms of resistance efforts—ones wherein individuals change systems from within or alongside oppressive rhetorics
they depend on—provides a necessary backdrop to consider the vernacularity of health-care workers who reject dominant health-care models and still remain wed to medical institutions and ideologies. Importantly, this model highlights and credits the roles of individuals that “resist from within” as important and necessary to the overhaul and advancement of powerful institutions writ large.

In this regard, perhaps one of the most well know health resistance efforts that successfully changed institutions is the Women’s Health Movement. Susan Wells’s work illustrated the iterative process that occurs between “behind the scenes” activities and “on the scenes” activities over the life course of that movement (2010). In particular, Wells examined the evolution of the book *Our Bodies, Our Selves*, the foundational text of the Women’s Health Movement. Tracing the evolution of the text over time, Wells described how a group of women, in the absence of information, created a language of women’s health that came to change biomedical discourse and practice. Wells referred to the text as a “labor of language” in that, over time and through revision, a collective of women “invented languages, narrative forms, and rhetoric that produced new identities and new practices; this work of writing, brought to birth in the social movements of the 1960s and 1970s, continues to be productive in a new century” (175). Significantly, Wells’ work demonstrated how a medical public could maintain an identity while engaging in constant processes of revision, how a medical public could cycle in and out members across generations, and how, given time and persistence, a controversial logic could become adopted by official institutions and enact widespread, lasting social change. In terms of theorizing about medical publics, Wells’s account articulates how collective action grows and matures in relation to shifting social situations and elucidates ways that medical publics can engage with medical establishments to get demands met. Vernacular rhetorics that express
opposition in manners that effectively intersect with and speak back to dominant medical models present channels for redemption and invention with regard to health policy revision; this style of resistance, perhaps, is most needed by medical professionals inspired to reject official rhetorics of health and medicine while still maintaining affiliation with (and employment by) the institutions from which the dominant rhetorics hail.

Medical publics, medical professionals, and medical establishments intersect in a number of interesting and complicated ways. I take the term “medical establishment” to refer to any institution that is officially recognized as an organizational partner of biomedicine. Medical publics are not medical establishments, however, medical publics can include members that work in and with medical establishments. In other words, medical publics consist of complex networks of people that individually intersect with medicine, but that, as a collective, operate independently and unofficially with regard to the policies and practices of western medicine. Medical professionals represent a unique subset of this larger configuration, unique in their ability to act as intermediaries between vernacular and official rhetorics of health and medicine. With regard to vaccination policy outcomes in particular, accounting for a range of rhetorics of health and medicine in matters of disease prevention and management arises as an essential thread of scholarship that holds practical application.

I adopt the more encompassing term “health public” for the remainder of this study to better capture the unfixed, intermediary status of medical professionals. Whereas the term “medical public” tends to narrow focus to a group of (sometimes dispersed) individuals that share a similar biological, sociological, or biomedical condition-related health identity and, in many instances, engage in alternative behaviors that stand in contrast to ‘Western medicine’ as an institution, the term health public indicates a group of individuals whose professional (and
thus public) status links them invariably to institutions of health but whose personal commitments may challenge the institutions they represent to the public. Furthermore, health publics readily and regularly engage with official policy and practice in both dialogue and action; they need not share similar health experiences with one another but do share similar ethics of health-care; and health publics, are invested in addressing larger assumptions about health as a public problem, rather than debated the operations of medicine as an organization or institution in relation to particular conditions. As Foucault famously noted, perceptions of publicness have much to do with the organization and control of bodies, and, therefore, perceptions hold consequence for how individuals experience health on an everyday basis (1973); to this I add, especially if individuals intersect with, constitute, represent, and challenge public institutions of health and medicine.

**Rhetoric and Public Health Policy**

By now, a number of studies have demonstrated that health policies mediate rhetorical and material experiences of health and illness. Scholars such as Robert Asen, William Kirkwood, Dan Brown, J. Blake Scott, Celeste Condit, Melissa Leach, Ian Scoones, and Brian Wynne, for example, have articulated the rhetorical quality of health policy debate, have demonstrated the material consequence of public policy language, and have suggested that the social context determines the range of discursive opportunities available to public officials who seek to amass particular kinds of public response. In particular, Asen claimed “the process of policymaking foregrounds the role of rhetoric as a constitutive force” (2010b, 129). With direct connections to debates about the material consequences of rhetoric, scholars have suggested that the relationship between rhetoric and material reality is both evident and critical to the politics of public health.
Material Outcomes

Rhetorician J. Blake Scott (2003) examined HIV testing rhetoric and suggested that policy language used to describe and promote testing diagnosed individuals and categorized them into contrasting groups. For Scott, the material consequence of talking about “risky” versus “normal” sexual activity was the stigmatization and alienation of certain medical publics that could have benefited from the advertised medical intervention if it had been framed in a socially sensitive manner. “Preventative education,” Scott argued, “has developed largely around testing rather than the other way around” (3); because of this tendency, language used to introduce testing tends to emerge from biomedical orientations toward health and illness that significantly bias the integration of prevention technologies in social structures. Scholars such as Celeste Condit (1999), Melissa Leach, Ian Scoones, and Brian Wynne (2005), and Kelly Happe (2013) have also studied public discourse about health to understand the material consequences of biomedically inflected health policy. Most recently, for example, Kelly Happe’s investigation of heredity as a scientific and political concept demonstrates how public talk about genes results in economic injustice, environmental pollution, racism, and sexism, consequences with very real implications for marginalized bodies. As Happe’s conclusions reveal, her study joins a growing collection of research that demonstrates the very material consequences of official rhetorics of health and medicine. Indeed, many authors in this area agree that official rhetorics of science, medicine, and technology (pre)determine quality of life at the individual level, a conclusion with poignant instruction for how to interpret vaccination policy communication in relation to everyday health experiences.

As part of a special issue of Rhetoric & Public Affairs (2010a) focused on the intersections of public policy and rhetoric, Asen introduced the claim that rhetoric and public
policy were inextricably linked. His personal contribution to the special journal issue explored ways that text and context intersect and necessitate public rhetorical response to demonstrate how, more often than not, public policy that emerges from health-related needs is a collective achievement. Issues like access to care and widespread adoption of prevention technologies represent material consequences of successfully rhetorical deliberation hosted by individuals that represent, and sometimes comprise, a health public. In this sense, Asen’s contribution uniquely articulated the kairotic nature of official health policy, the cross-institutional partnerships that represent a health public, and the rhetorical processes that take place to form, describe, and support members of a general public that cannot be present during deliberations about how to allocate resources. He reminded scholars, “no single participant can direct the course of a policy debate; instead, trajectories emerge as collective achievements” (2010b, 133). How those collective achievements (the material consequences of public policy deliberation) reach health consumers is an important dimension of the public health policy processes that raises issues for scholars convinced “Public authority is engaged in preserving the illusion of a predictable, consistent, and morally controlled universe” (Gusfield 1981, 22).

In their rhetorical study of disease responsibility attribution, for example, William Kirkwood and Dan Brown (1995) developed a model of public communication about causes of disease that traced the origin and impact of political language about health and illness. Their model highlighted the fallibility of political language, but it also highlighted how attributions for particular diseases get written into policy and therefore get embedded in public thinking about health and illness. As they suggested:

Beliefs about the causes of disease and hence about responsibility for disease are central to all cultural understands of the human condition. . . . We argue that although
attributions of responsibility may appear to be medical or scientific claims, such claims are better understood rhetorically, as a means of influencing attitudes and behaviors. (55)

Although rhetorics of public policy create and address intended health publics, Kirkwood and Brown’s contribution demonstrated how rhetorics of responsibility contribute to the emergence of, sometimes, unintended health communities motivated by attitudes and behaviors born from public communication about health and medicine. Significantly, Kirkwood and Brown unveiled a tendency for individuals to engage public health rhetorics in manners that distance audiences from certain health conditions. Kirkwood and Brown suggested that one effect of framing illness in health policy discourse like it’s a crime is that everyone that encounters the message thinks they are innocent. In this regard, rhetoricians have helped explain how and why health policy language matters to the formation and mobilization of medical publics and the rhetorics they produce.

As was previously mentioned, scholars, such as Robert Asen, have demonstrated that health policies (official rhetorics of health and medicine) mediate rhetorical and material experiences of health and illness. And complementary to this particular area of research, the works of rhetoricians of medicine, such as Lisa Keränen and J. Blake Scott, among others, more recently, have explored medical publics as unique groups of individuals that coalesce around a distinct set of health-related issues (2014). Although individuals may never meet, insofar as they identify vaccination as an important action-worthy issue they become tied to larger discourses of health and medicine thereby coming to constitute “a public.” Vaccination is one health issue that constructs a complex medical public because it requires that individuals consider health options and then take action (keep in mind that inaction, i.e. not getting vaccinated, is action in this context); these actions (i.e. “practices” or “performances”) further stratify notions of one unified
“vaccine public” into different, sometimes competing subsets. (In the next section, I outline how I approach each of this public issue’s “competing parts” with the intention of, by dissertation’s end, piecing them back together to understand vaccination rhetoric as one cohesive public health text.) Whereas resistance experienced in the health context many times signifies the existence of counterpublics and therefore represents barriers or challenges to a larger public health agenda, a rhetorical perspective can help redefine those acts of resistance as in conversation with official discourses of health and medicine and, as such, serve as opportunities for invention and partnership.  

In the contemporary health-care setting, an inclusive, rhetorical model of public interaction holds particular significance for how public health practices and policies are conceptualized on a larger scale because it recognizes that variety exists across different health definitions and experiences. Whereas Warner recognized counterpublics as a response to social and political circumstance, Hauser articulated their presence as politically relevant and sensible with regard to more formal democratic structures. The term “vernacular rhetoric” most readily translates as “the rhetoric of everyday.” And, according to Hauser’s theory, vernacular rhetoric represents a form of political communication that, in its colloquialness, invites and unites members of local, nonofficial publics in discourse-based shared meaning and purpose. In this manner, Hauser’s vernacular rhetoric model of public opinion carved out and justified space for what Fraser and Warner might term counterpublic discourse. Defining counterpublic discourses as intelligible was an important contribution for how rhetoricians conceptualize and interact with medical publics today. Moreover, these concepts advance understandings of how seemingly disruptive or unintelligible publics gain, maintain, and express dissent across contexts and circumstances.
Dissident Publics

A type of public that has become of particular interest to rhetoric of health and medicine scholars is the medical public that challenges official discourses of health and illness by engaging in alternative behaviors. For example, a recent edited volume entitled *Contested Illnesses: Citizens, Science, and Health Social Movements* explored the ways health identities intersect with and challenge official institutions. Truly vernacular discourses, resistance efforts founded in contested health identities oftentimes organize people and ideas around language that may drastically depart from dominant knowledge and practice (Brown, Morello-Frosch, and Zaverstoski 2011). Across health-care settings, rhetoricians of health and medicine conceptualize resistance in terms of larger power relations and can use the theory of vernacular rhetoric to understand public controversy. In the case of vaccinations in particular, for example, unlike the term “refusal” the term *resistance* is used to draw attention to collective action inspired by public debate about a particular health practices (Streefland 1990). Some political and social resistance materializes in action, others in language. Furthermore, some resistance rhetorics resist official rhetoric from within institutional logics, and others resist from without. This continuum of resistance has provided multiple points of entry for rhetoricians of health and medicine to consider resistance in relation to the concept of publics.

Hauser’s model of the reticulate public sphere and his notion of a vernacular rhetoric model of public opinion contextualized Warner’s contribution to public health by articulating how expressions of dissent can and do speak back meaningfully to official institutions of health and medicine from within the same public context (1999; 2002). Given the publicness of issues related to disease management and the numerous disagreements that accompany “best practices” for individual health, a theory that accounts for how competing ideas about health and medicine
come to be conceptualized, communicated, and organized in public talk about vaccination arises as especially useful. Sociologist Joseph Gusfield reminds us:

There is more to the analysis of public issues than the idea of historicity . . . there is a pattern to how issues and problems arise, emerge, and evidence a structure. At any specific moment, all possible parties to the issue do not have equal abilities to indulge the public; they do not possess the same degree or kind of authority to be legitimate sources of definition of the reality of the problem, or to assume legitimate power to regulate, control, and innovate solutions. To describe the structures of public problems is to describe the ordered way in which ideas and activities emerge in the public arena (1981, 8–9).

To this end, Asen suggested that health policy writ large could benefit from rhetorical theory, criticism, and intervention (2010a).

With regard to matters of public and private heath citizenship in particular, theories of medical publics and vernacular rhetoric help speak to social and political responsibilities that are assumed with shaping policies and practices of health and medicine at the public, professional, and individual levels, and, simultaneously, highlight the distinctly useful attributes of resistant vaccination communication. Hauser insists that dissent need not indicate public divergence but, rather, that dissent be understood as a necessary component of any publicly deliberated issue that brings together diverse sets of stakeholders and interests. In this regard, Hauser’s designation between vernacular and official rhetorics provides a framework for studying how competing discourses of health and medicine intersect meaningfully under the shared banner of “public health.”
With members of health-care communities in mind, in this study I suggest that rhetoricians of medicine are uniquely positioned to access a tradition and vocabulary of publics that holds particular value for how individuals—both inside and outside of health-care contexts—understand and experience health citizenship in relation to everyday medicine. I do so convinced that theorizing about medicine in relation to its publics is still a relatively new endeavor that holds potential for how we understand and navigate an arguably more complicated biomedical terrain. And I also do so convinced that publics theory offers a method to influence and promote the “public good” in ways that matter considerably to the future of U.S. medicine. For example, from the corpus of public theorizing more broadly a theory of vernacular rhetoric articulates and justifies the need to account for everyday talk about health within the official policies and practices of medicine if the “public good” is to ever be achieved.

Although funding structures and access issues remain contested attributes of the public health sphere, public health policy is often conceptualized, mobilized, and addressed in terms of one united mission that positions humanity against disease. In this sense, our current national public health agenda is built on Habermasian foundations; however, in practice, this site is often populated by competing health practices, multiple publics, and resistant communication. In consideration of vaccination specifically, the concept of publics helps to account for symbolic and material relationships between health policy and medical practice, and to navigate between two senses of “a public”: the everyday sense of “a public response” and the rhetorical definition of publics as interdependent groups of people that form over issues of mutual concern. Because of the ways in which public health uses language to organize individuals in relation to one larger health agenda, rhetoricians of health and medicine have treated public policy debate as a site for observing the intersections of public participation (and formation) and official policy language.
Questions about the role of public health policy in relation to everyday experiences of health continue to feed a strand of rhetoric research to which the present study contributes.

**Conclusion**

This project sets as its primary goal to enhance understandings of medical publics—how they operate, who comprises them, and what they reveal—via close textual analysis of one important public health case and this chapter lays the foundation for doing so. Attention to rhetorical acts of resistance and ruptures in common principles and practices of health and medicine may signal important sites of cross-public significance. One such site known to prompt pushback across stakeholders in medicine hinges on efforts to professionalize the field, efforts intended to produce certain, ideal types of medical actors; these efforts include discussion about mandatory vaccination policy in relation to medical professionals and establishments.

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1. Although European scholars engaged his theory early on, his full work did not receive serious attention in the United States until its translation in 1989. Nonetheless, Habermas’s encyclopedia article that originally appeared in *New German Critique*, was published in 1974 and was known and cited in the English-speaking world.

2. Fraser did have an earlier publication in *Social Text* (1990) that has been widely cited and was the first well-known attack on Habermas’s formulation.

3. Rhetoricians since antiquity have considered relationships between rhetoric and audiences, but, current increased public framing of health and medicine have solicited attention to relationships among three concepts—rhetoric, audience, and publics—as a specialized subset within the broader discipline of rhetoric.

4. In his 2011 work, Hauser reviewed the origin of the term and theory across the disciplines of anthropology, communication, and rhetoric. Through an examination of the origins, implications, and methods used to observe, theorize, and make use of vernacular the appeal to the everyday instigated a turn in the overall study of rhetoric. Hauser located this “new turn” in the influential 1923 article by Ogden and Richard entitled *The Meaning of Meaning*. Through a review of this foundational piece, Hauser demonstrated how Ogden and Richard championed the idea that meaning is not static but situated and shaped by its usage. Conceptualizing meaning as derived from the culture and context within which action takes place, delimited vernacular as a site where ordinary citizens made sense of the world. This conception of the vernacular as a source of civic engagement continued to hold parity across 20th century theorizing. For example, findings from Malinowski’s (1946) influential essay *The Problem of Meaning in Primitive Languages* supported Ogden and Richard’s argument that words do not have a fixed meaning by demonstrating the comprehensible significance of the seemingly nonsensical communication patterns of Trobriand Islanders. Around that same time, Kenneth Burke (1945) developed his dramatistic theory of rhetoric that defined humans as “symbol using (misusing) animals” (1966), further substantiating Ogden and Richard’s claims to symbolic, context-bound existence. And during the mid-20th century, Bakhtin’s notion of *heteroglossia*, a theory that identified how several unofficial forms of symbolic exchange occur within an official language and that despite endorsed recognition become nonetheless influential in the operations of a community, spread across American
audiences (1935; 1981). Although written and spoken texts commonly constituted the core of early vernacular inquiry, the possibility of context-situated, unofficial modes of meaning helped the field of rhetoric to usher in nontraditional texts as worthy of critical study.

For example, at-risk medical publics may hedge recommended health behaviors because members do not identify with how policy language and practice defines their health experience, as Blake Scott’s work demonstrated, “at-risk” in and of itself is a label that has warranted consideration among rhetoricians of medicine. Similarly, Lisa Keränen’s (2012) examination of Morgellons illustrates how medical publics actively deny labels assigned to them by medical establishments and, alternately, develop new ways to talk about and treat health conditions.
CHAPTER III
RHETORICAL METHODS FOR MEDICINE STUDIES

To fill some of the gaps in the literature and theory that were noted in the previous chapters, this chapter examines rhetoric that is located at the nexus of disease and culture, private and public responsibility, and prevention and intervention in the contemporary U.S. public health arena, as guided by theories of biocriticism and vernacular rhetoric. I have designed this project to make sense of how upstream, system-level factors (issues of national health security) come to be represented and/or talked about in specific, downstream policies that delineate “best practices” for U.S. medical professionals (i.e., mandatory vaccination policies). I have elected to begin a programmatic line of research on that topic because of ways in which rhetorics of health of medicine explicitly organize medical publics according to public action. Emphasis on the publicness of vaccination debates highlights the rhetoricality of the health issue, whereby the successful coordination of various stakeholders depends on public communication about public health risk and personal responsibility. In particular, rhetorical theory aids in understanding vaccination communication/debate at a systems level. Drawing from various exemplars that have been published by other rhetoricians of health and medicine, this project uses the lens of persuasion and tools of humanistic rhetorical analysis to approach vaccination communication as a cohesive, public discourse. This chapter broadly details the rhetorical perspective and rhetorical methods that I used to locate and organize data presented in chapters five, six, and seven; the next chapter is dedicated entirely to detailing my case-specific methods for textual analysis.
Locating Public Health Texts

To study health contexts and issues, in particular, rhetoricians use rhetorical criticism to describe, analyze, interpret, and evaluate the persuasive force of messages that are tied to, in this case, practices and theories of health, assuming that all choices are strategic and purposeful. Whereas health can be understood as the more encompassing term, “medicine provides the set of terms through which health is primarily understood” (Segal 2005, 1). As Judy Segal explained in her field-mapping book, *Health and the Rhetoric of Medicine* (2005), “The defining feature of rhetorical study is that it isolates the persuasive elements in [health/medical] texts, genres, and discourses, and seeks to understand something about what they do, how they act in professional and public settings” (227). Through consideration of textual features of medicine, such as word choice, imagery, timing, and context, rhetorical criticism reveals how meanings are created and shared through messages, a perspective and research method with benefits for how health policies and practices come to be understood and promoted.

To adequately represent and examine contemporary health discourses, a growing number of rhetoricians of health and medicine weave together disparate strands of thought, speech, writing, and experience to construct a “text” for analysis. The process of locating a site for analysis is a creative, calculated endeavor that is guided by concepts that include fluidity, reasonability, and representation. “However systematic the gathering of data,” rhetorician Celeste Condit explained, “in the end, the critic is an artist, a rhetor, a theorist of the particular, a storyteller” (1999, 265). Next, I explain how I fuse the rhetorical method of biocriticism with the theory of vernacular rhetoric to gather in a systematic and practical way pieces of and assemble an otherwise unwieldy, vast mandatory vaccination policy terrain.
Biocriticism

Unlike traditional understandings of texts as finite artifacts that are used to capture (and situate) communication events in particular times and places, health discourses often are comprised of multidimensional components. For example, women who currently suffer from cervical cancer, men who have female family members and friends afflicted with cervical cancer, physicians who treat cervical cancer, and young girls interested in protecting themselves against cervical cancer can all come to be understood as part of the same health conversation: Despite differences across place, space, experience, age, media, and other important attributes, these individuals comprise one audience with vested interest in one health issue: cervical cancer. In this regard, as Segal explained, although “rhetoric is sometimes understood to suggest a procedure for analyzing a particular text . . . its theory requires no single procedure, and the object of analysis may be not a particular text but rather a discourse as a whole” (2005, 5). In this manner, the term text can refer to any artifact, set of artifacts, or pattern of talk that intentionally, or unintentionally, persuades audiences to think or act differently than they currently do.

In terms of setting a methodological example, Pricilla Wald’s work illustrated how a hunt for meaningful texts can be guided by one word, phrase, or central idea. In Contagious: Cultures, Carriers, and the Outbreak Narrative, Wald traced the role of pathogens in prompting cultural narratives that came to achieve widespread adoption (2008). Tracing narratives of disease and outbreak, she illustrated how contagion has acted as a recurring trope in analyses of social change across time. More specifically, Wald suggested that, much like disease, ideas about social reformation often are born in intimate settings, spread locally and then globally, and then get contained by dominant discourses and practices in a merger with the status quo. Her treatment of the issue demonstrated how those seemingly disparate texts can be woven together
to tell a comprehensive story about the social, political, and cultural implications of a rhetorical trope. Moving from description of rhetorical acts to applications of rhetoric theory requires that the issue under investigation hold significance on a public level. Here, too, Wald’s study serves as a good example. To mirror Wald’s successful process of text selection and analysis, I turn to a technique that was presented after Wald’s study was published, but that, in hindsight, offers a vocabulary to reinterpret Wald’s project as a biocritical investigation.

In 2011, Lisa Keränen introduced the term biocriticism to promote “a sustained and rigorous analysis of the artifacts, texts, discursive formations, visual representations, and material practices positioned at the nexus of disease and culture” (225). Keränen reviewed five books that served as initial exemplars to “sketch out an initial roadmap for considering emerging configurations of disease and security in a critical practice we may call biocriticism” (226). One of the books reviewed was Wald’s Contagious, a work that Keränen described as containing “impressive scope and meticulous research” (229). Through a comparative review, Keränen advocated for “communication and rhetoric scholars to take up the symbolic and material realities of germs, to intensify a nascent strand of scholarship I call biocriticism” strands of scholarship that, she suggested, deliberately sought to “better understand how germ rhetoric entangles anxieties about globalization, identity, and contamination into historically specific narratives that encode, revise, and challenge prevailing moral, aesthetic, epistemological, and political commitments” (225). By organizing a scholarly agenda around a set of ideas, Keränen, thus, outlined an opportunity and method to identify meaningful intersections that could then be approached in a number of intellectual manners.

For this study, in particular, I used “mandatory vaccination” as my Wald-inspired anchor to dip in and out, and through, various health experiences and health readings to piece together a
comprehensive story about the relationship between vaccination and public perceptions of medicine. To hone in on particular nodes of public consequence within that larger health discourse, I then utilized the biocritical perspective to conduct initial reviews of related artifacts. I did so to, specifically, hone in on variables in communication patterns and strategies that readily connected to public perceptions of biotechnological progress. The results of that targeted process yielded one health condition for which the possibility of mandatory vaccination stirs noteworthy, impassioned public response: the seasonal influenza (flu) vaccination. The annual flu vaccines have generated debate within health-care communities concerning mandatory vaccination measures. With general implications for public health writ large, and for specific policy recommendation for biosecurity and medical practices, in particular, I use the more specialized set of analytical tools afforded by a biocritical perspective (namely, the prioritization of language surrounding problems of biological security and medical ethos), in my construction of a comprehensive, yet targeted, health text for analysis and my subsequent study of vaccination rhetoric. In this manner, biocriticism, and methods and theories that it recommends, offers both practical and theoretical significance for an in-depth study of mandatory vaccination policy.

Conversation in and around vaccination, clearly, operates at the “nexus of disease and culture,” private and public responsibility, and prevention and intervention in the contemporary U.S. public health arena, and, therefore, is amenable to a biocritical approach. Guided by the methodological savvy offered via biocriticism, in the chapters that follow, I explore mandatory vaccination policy discussion surrounding influenza vaccination to illuminate material and symbolic dimensions of disease management. Although contestation prompted by specific biomedical issues rightly alerted me to entanglements of anxieties about globalization, identity, and contamination, entanglements that Keränen’s biocriticism prioritizes, in line with Celeste
Condit’s work, I also recognize that “rhetorics are always more or less contested, and at most times there is a range of discourses operating with the public sphere” (Condit 1999, 14).

To better identify nuances and ranges of talk that are involved with mandatory influenza vaccination, and to later describe and navigate the discursive terrain therein, I introduce Gerard Hauser’s theory of vernacular rhetoric into my data-collection strategy (1999). A theory of vernacular rhetoric provides tools to pare down and organize elements of public discourse by making a distinction between public and private, and official and vernacular expressions of participation; in doing so, as a method for data collection and analysis, vernacular rhetoric accounts for a range of perspectives constituting the populace. The value of this technique is, perhaps, best captured by Celeste Condit in her reflection on why rhetorical study matters to the fields of science and medicine: “Perhaps if we understand the range of ways in which we have addressed these issues in the past we will be better equipped to craft better understandings for the future. Only perhaps” (1999, 23). In the next section, I review a theory of vernacular rhetoric in relation to my process of data collection and analysis.

**Vernacular Rhetoric**

Whereas biocriticism turns attention to intersections of political, social, and cultural significance in the study of biosecurity, more generally, methodological assumptions delineated by Hauser’s theory of vernacular rhetoric foreground and operationalize considerations of that larger vaccination debate, more specifically. In particular, a theory of vernacular rhetoric offers suggestions for how to identify tensions at the core of public debate, tensions that foreground the relationship between public and private stakeholders, and official and vernacular rhetorics. The vectors identify tensions that then act as organizing principles for data management. In this manner, a theory of vernacular rhetoric provides a method to track public and private
experiences of health and medicine by observing communication that is produced by its intersecting stakeholders.

In the context of public health, a theory of vernacular rhetoric, thus, offers an alternative to reactively assessing public attitudes and opinions, and, instead, proactively gauges public opinion (and subsequent response) by systematically observing qualities of the communication produced by invested individuals and groups. As Hauser explained:

To learn what a public thinks, we first must monitor the social conversation within a reticulate public sphere to ascertain who is speaking to whom about what. And if we wish to get beyond the apparent volatility of opinion as reflected in the radical mood swings reported by opinion polls, we must locate the categories of assertion and response used by engaged members of society. Their rhetorical exchanges provide more than data; their narratives of common meaning, web of associations, and historicity each reveal the reference world of meaning they are co-constructing and provide the context for understanding their specific judgments. (1999, 279)

In this manner, a reticulate model of the public sphere—a model that treats discourse as evidence of public formation and engagement—becomes methodologically valuable because it establishes how language connects to the status of public opinion. Furthermore, it broadens consideration of what counts as valuable public contribution by ushering in everyday expressions of citizenship, and, thereby, advances a more inclusive conceptualization of Habermas’s public sphere. Inclusivity is a particularly valuable standard for the study of controversial health publics.

Currently, within the dominant vaccine narrative that is told by Western medical affiliates, vaccine opponents often come across as “ignorant” or as in support of “quackery,” at best (Heller 2008, 92); rhetorical sensitivity revisits those health participants to consider how
their contributions factor into the overall status of public life. In an era when “pseudoscience” and “probable myth” may spread further, faster, and more convincingly than does official public health messaging, addressing health fringes becomes essential to the health of public health. Rhetorical sensitivity extended toward citizen discontent becomes increasingly important when examining a population of individuals who challenge tenets of public health from within reputable structures of public health. In this regard, health-care workers provide an interesting site to examine means by which a particular public’s identity reverberates against public discourse about medicine. Furthermore, this segment of the broader U.S. public demonstrates how individual health citizens can speak back to dominant discourses about health and medicine, and remain affiliates of institutions and publics that created them. From a vernacular rhetoric perspective, health-care workers, thus, provide an embodied site wherein vernacular and official rhetorics of health and medicine coalesce constructively. Given the complexities that this enmeshing poses, in terms of understanding public versus private agendas, or public versus private responsibilities, the theory of vernacular rhetoric categorizes discourse according to its type—vernacular or official—and, in doing so, it sets the stage to examine tension as a necessary component of public life: No matter the issue, when it comes to making decisions, both private and public considerations must be considered. In terms of offering methodological direction, then, a theory of vernacular rhetoric encourages researchers to splice large, complicated health discourses according to their everyday expressions of public participation (their vernacular rhetorics) and their formal expressions of public organization (their official rhetorics).

In terms of my overall approach toward data collection and analysis, then, the theoretical sensitivity offered via a theory of vernacular rhetoric ensured that I remain attuned to persuasive mechanisms at work in public discourse; offered a vocabulary for assessing the influence and
intention of complicated medical publics that, initially, deemed unruly; and provided a platform to discuss consequences of representing people and institutions as invested publics amidst diverse commitments. Moreover, although a biocritical stance turned my attention to the investigation of mandatory vaccination communication as an important site where political and social issues converge, a theory of vernacular rhetoric offered a way to manage that larger discourse, that larger data set, through categories of official and vernacular rhetorics. Thus, after making use of mandatory vaccination to weave together artifacts and ready them for biocritical narrowing, I made use of the vernacular–official distinction to organize that data with attention to the publicness of vaccination communication. This eclectic method of data collection and organization, especially as it relates to representing professional identities of health-care workers, provides a valuable framework for understanding rhetoric in service of larger health-care goals.

With regard to the current U.S. vaccination climate in particular, attention to dissident voices, as well as to dominant voices, understands that public vaccination debate will and should continue in a democratic system wherein individual citizens interact with one another (and with messages) to actively shape experiences of health and illness. In this manner, and in terms of data collection and analysis, locating instances when individuals speak back to larger structures provides opportunities to observe how discursive tensions contribute to social change on a larger scale. In this regard, the concept of “dialectical vernacular” offers one method to locate and arrange competing vernacular and official rhetorics of health and medicine as comprising one medical public (albeit complicated and, sometimes, contradictory) working in tandem toward similar goals, a hopeful arrangement that informed my interrogation of mandatory vaccination
communication texts. Next, I detail the official and vernacular corpuses that this processes yielded.

**Managing Vaccination Rhetorics**

Health-care workers considering vaccination represent *both* an expert population *and* a patient population, and, for this reason, present some challenges in terms of categorizing rhetorics that they produce. Because I was dealing with an expert population, clear distinctions between vernacular expression and official jargon—a phenomenon that Michel Bakhtin (1981) might label *heterolglosia* or “double-speak”—a quality of health-care professionals’ communication style that, initially, drew my attention for ways in which it extends and troubles current theory about medical publics on the whole. If, as Hauser suggested, the existence of publics can be evidenced by the rhetoric that they produce, what type of public is one in which actors shift between the language of official institutions and everyday talk fluidly, willingly, and/or unknowingly? Although Kent Ono and John Sloop developed a very useful matrix to map relationship between official and vernacular rhetors (outlaw, civic, vernacular, and dominant), and Thomas Goodnight distinguished various spheres of influence (public, private, and technical) that produce various types of rhetoric and adopt one another’s “character” to argue across divisions (2002; 2012,), neither approach fully accounts for how health-care actors, simultaneously, are expert and lay; that is, how they are patient and provider when making vaccination decisions for themselves as a public advocates. In other words, health-care professionals are always already part vernacular and part official, and, therefore, they occupy the borders in between public and private spheres, vernacular and official rhetorics. Alternatively, perhaps instead of “occupy,” one could say that they “constitute” those regions of overlap. The rhetoric that health-care workers produce, therefore, evidences both official and vernacular
attributes. Health-care workers can make use of technical jargon alongside colloquialisms that would not be appropriate for the work setting, lending a vernacular flare to otherwise erudite topics. Descriptions offered by Ono and Sloop and by Goodnight of competing rhetorics suggest some intentionality behind moving from one sphere to another, one type of rhetoric to another, and one identity to another; for health-care workers, in particular, these distinctions appear to be less intentional, less of a choice for particular health interactions and more constitutive—that is, more of a defining quality of all health interactions.

**Dialectical Vernacular**

Identifying and elevating instances where the orchestration of vernacular and official rhetorics happens successfully (or, at the very least, necessarily) stands in contrast to what has been the typical approach to studying counterpublic discourse. To date, most research that explores controversial health discourses has focused on how resistance constitutes divergent, competing publics and public opinion, instead of focusing on instances where vernacular and official rhetorics intersect productively. Across scholarship, it has become common practice to think and talk about vernacular rhetoric as being in oppositional relation to official rhetoric. For instance, Hauser defined the *vernacular* as resisting the official discourse, where both vernacular and official rhetorics exist in a constant struggle for power (1999). Similarly, Kent Ono and John Sloop discussed the vernacular as being in opposition to official discourses, as subservient to official discourses, or as in danger of being usurped by official agendas (2002). For Ono and Sloop, the most productive form of vernacular was described as “outlaw civic,” but as they clarified:

No discourse or logic ever remains Outlaw Civic for long . . . for as it moves out of localized contexts into areas of the general culture, three possibilities emerge: (1) it
becomes popularized and then productively leads to social change, (2) it is disciplined to become part of the dominant discourse and thus loses what is resistant and challenging about it, thus rendering it unable to alter the status quo power relationship, or (3) it remains Outlaw, which means it never becomes part of the larger civic discourse and is, in a sense, remarginalized. (18)

In other words, although vernacular expressions constantly seek widespread influence, as soon as the vernacular achieves social authority, it necessarily transgresses into the domain of official rhetoric and acquires the power differential therein. Questions, thus, arise about the possibility of officially recognizing the vernacular but maintaining its function as an oppositional discourse.

Defining the vernacular via its opposite (the official) designates the two sources of meaning as always in contention, with the vernacular resisting the official, and the official discounting the vernacular. This assumed opposition raises questions about the possibility of missed opportunities with regard to in situ problem solving: How does a tendency to polarize vernacular and official rhetorics limit opportunities to explore alternative rhetorics? What promise might “the spaces in-between” vernacular and official discourse hold for social transformation? How might context work to delimit a more productive relationship between vernacular and official contributions? An oppositional approach to defining vernacular rhetoric, thus, may interfere with attempts to track how official and vernacular rhetorics interact and make use of difference for communal gain. Furthermore, maintaining the vernacular–official divide may cause considerable problems for health-care worker who must negotiate between vernacular and official rhetorics of health and medicine as a matter of profession and/or personal principle. With these considerations in mind, my analysis of data was guided by Robert Howard’s theory of dialectical vernacular.
Robert Howard offered a clean method to distinguish between vernacular and official rhetorics regardless of institutional affiliation: “At its base, the dialectical vernacular imagines a web of intentions moving along vectors of structural power that emerge as vernacular whenever they assert their alterity from the institutional” (2008, 497). That is, when pushback against official ideology occurs, regardless of the resistor’s institutional status, the resistant rhetoric that they produce may be read as vernacular expression. However, the notion of a dialectical vernacular, according to Howard, “resists a romanticizing or essentializing identification. It imagines agents as individuals or groups of individuals who in any given case may be acting through some institutional and/or some vernacular agency. Further, it imagines the locations of discourse made possible by institutional forces as harboring some vernacularity” (2008, 497).

Whereas Ono and Sloop (2002) and Hauser (1999) view definitions of vernacular in opposition, Howard’s definition presents vernacularity as everywhere and anywhere, but only noticeable in moments of disagreement. For the project at hand, adding the dimensions of fluidity and interconnectedness to a conception of the vernacular accounts for the complicated status of the resistance rhetorics that health-care workers produce.

Given the constraints and needs of the particular population being considered for this study, admittedly, the line of demarcation between vernacular and official status remains blurred. Health-care workers may willingly and functionally both reject and promote dominant health orthodoxies simultaneously, as is the case when a health-care worker refuses vaccination for her or himself as a patient, but who endorses vaccination for others as a provider. Mindful of the possibility for public status slippages or confusion among health-care workers as a quality of everyday employment, I opted to embrace a more flexible stance toward distinctions between vernacular and official rhetorics of mandatory vaccination debate. However, for purposes of
methodical investigation, I treated all policy communication as official rhetoric, and I considered all resistant responses produced by any health-care affiliate to be vernacular rhetoric.

In the pages to come, I show that noncompliance is, in many cases, deliberate political action. Whereas official institutions often treat or interpret noncompliance within the medical community as an oversight or as a product of busy schedules and accessibility, what the vernacular reveals is the intentional politicization of vaccination to communicate concern about and resistance to a number of trends unfolding across contemporary health settings. These considerations include an insider’s set of concerns, such as forced compliance or employer/employee relations, but they also likely reflect portions of an outsider’s set of concerns as well because of health-care workers’ statuses as both an expert population and a patient population. To better understand vaccination noncompliance as a form of political resistance, this study prioritizes and illuminates the margins of the public mandatory influenza for health-care workers debate. To do so, I pay careful attention to characteristics and nuances of official rhetorics of vaccination before turning to detail and comparing their vernacular counterpart. As Howard (2008) pointed out, the vernacular exists any time that it resists the official. In that sense, the official can act as a baseline for comparison to understand noncompliance as political action.

Representative Texts

Official rhetorics of vaccination likely set the tone for how medical professionals make sense of individual actions (personal responsibility) in terms of larger public health agendas (public health-security) and occupational identities (medical professionalism), and, therefore, they were central to my investigation. In chapters five, specifically, I outline findings from my close textual analysis of an “official rhetoric of mandatory vaccination for health-care workers
corpus.” The corpus consists of policy statements, calls to action, commissioned reports, monographs, published position papers, national survey results, and formal recommendations from nationally recognized U.S. institutions of health and medicine. Specifically, I consulted the following organizations’ policy statements regarding a move toward mandatory employee vaccination as a matter of U.S. health-care employment: the American Public Health Association; American College of Physicians; National League for Nursing; American Academy of Physician Assistants; American Pharmacist Association; Association of American Physicians and Surgeons; American Association of Medical Assistants; and the American Boards of Family Medicine, Pediatrics, Internal Medicine, and Medical Specialties. I focused on vaccination policy language because, at first glance, many of those organizations articulate similar stances toward vaccination adoption writ large, whereas responses to mandatory employee Influenza vaccination policies appear to be more textured. In other words, as prominent pillars of public health, the aforementioned organizations advocate for the widespread adoption of vaccination across the U.S. population, professionals included; however, whether employees’ job security depends on that decision still is under debate. This particular dimension of a larger vaccination discourse within the professional organization highlights a unique dilemma within medical institutions, a dilemma that often prompt public response.

In the end, a Call to Action, published in 2004 by the National Foundation for Infectious Disease and an official policy recommendation report published in 2012 by the National Vaccine Advisory Committee bookend nearly a decade’s worth of heated public deliberation about this issue. Key stakeholders formally partaking in this ongoing debate included national policy advisors, state policy leaders, hospital administrators, and professional organizations involved with medical accreditation; key stakeholders who were informally involved include members of
the health-care workforce (both medical and nonmedical), their representative labor unions and professional organizations, news media outlets, professional publications and journals, and a web of online social media contributors. Collectively, this multivoiced corpus spans over 10 years and represents a window into U.S. history where public attention turned considerably to the role of health-care workers in larger public health-security planning.

To construct a holistic view of mandatory health-care worker vaccinations as a public problem, and to better foreground voices of health-care workers, specifically, in chapters 5 through 7, I complement my investigation of official rhetorics of health and medicine with consideration of public feedback that was issued in direct response to segments of the official corpus. My larger “vernacular rhetoric of mandatory vaccination for health-care workers corpus” consisted of a variety of public response data, including blog posts, newspaper coverage, rally speeches, letters to the editor, rally posters, formal petitions, and open letters addressed to government officials. After consulting the full corpus and conducting a preliminary analysis, I identified several themes. One of the more recent public texts, a collection of responses submitted to the U.S. Federal Registry System, adequately captured each of the themes that I saw across the corpus. For purposes of close textual analysis, then, I elected to focus on this one representative “text” to craft my argument about the issue writ large. I did so to draw generously from a reasonable and representative window into the larger conversation that I tracked across a diverse array of media. Moreover, although the decision to focus on one representative text made the data set more manageable, it also allowed for in-depth analysis of one telling moment in the overall debate, as opposed to a more dispersed reading (and representation) of the entire corpus. In chapters 5 through 7, I prioritize findings from my in-depth analysis of that vernacular text. Next I offer an introduction into that limited data set before explaining why a focus on responses
to this particular document seems a good place to start theorizing about the rhetorical features of
the ongoing debate, more generally.

In 2012, the National Vaccination Advisory Committee (NVAC) authored an official
“recommendation” report instructing health-care employers to increase vaccination coverage
across health settings and offering methods to do so. Issuing a call for public review of the (then
titled) Recommendations on Strategies to Achieve the Healthy People 2020 Annual Goal of 90%
Influenza Vaccine Coverage for Health-care Personnel report, the NVAC published a call on the
U.S. Federal Registry System, an online public comment solicitation database run by the U.S.
government.2 The call read:

The National Vaccine Program Office (NVPO) is soliciting public comment on the
Healthcare Personnel Influenza Vaccination Subgroup draft report and draft
recommendations for increasing vaccination of health-care personnel to meet the Healthy
People 2020 goals. Individuals and organizations are encouraged to submit their
comments on the draft report and draft recommendations.

Between December 19, 2011 and January 16, 2012 (less than one month), 37 organizational
position papers and nearly 200 individual entries were submitted.3 Although the call was
addressed to the general public, the overwhelming majority of respondents self-identified as
members of the health-care profession. This trend in authorial submission type may have been
due to the exchange of the NVAC’s call via social media platforms that commonly are used to
keep members of the health-care community, writ large, connected. For example, the final
compiled report explained that “a compilation of blog entries from OSHA’s blog were submitted
by a single contributor”—this “compilation” included 79 individual contributions.4 Additionally,
this trend could have been caused by the exigency (Bitzer 1992) created for health-care
employees who would be directly affected by the policy outcome. For this lattermost reason, collectively, the individual public response statements comprised my limited and focused set of representative vernacular discourse, with priority given to respondents who clearly indicated their affiliation with the larger health-care institution. However, it is necessary to mention and keep in mind that contributors to the Federal Registry System represent a unique subset of the larger health-care community, and although sentiments expressed in this particular data set do illustrate trends that I observed across a wide variety of media and audiences, health-care workers who are opposed to being required to get vaccinated are, probably, more likely to submit responses to the Federal Registry than those who have no problem with the drafted report. Therefore, in terms of generalizability, this reveals a limitation of this study, a limitation I return to in the concluding chapter. Although in this text I speak “as if” this population represents health-care workers overall, this is merely a stylistic choice that is intended to convey one cohesiveness vernacular voice that is used to better compare and compete with the official institutions in question.

The vernacular, by mere virtue of its designation as such, tends to be less structured and less formulaic in its delivery of argument and resistance. Whereas official policy language makes use of institutional protocol and integrated means to communicate a seemingly unified position, the vernacular appears more stratified, diffuse, complicated, and, in some cases, internally conflicted over matters of health and medicine. Nonetheless, patterns can be observed across vernacular contributions that define disease threat, health protection, and personal obligation in unified ways that compete with official formulations of the influenza problem, its causes, and its solution. To better aid my ability to examine nuances of this vernacular rhetoric, I focused deeply on one representative sample (as opposed to focusing more shallowly across the
sprawling corpus). When contrasted against, compared to, and integrated in official policy deliberations, I suggest, the vernacular can complicate and extend collective understandings of vaccination in ways that become useful for public health-security writ large. Although diffuse in both its composition and delivery, when read as one complete narrative, the vernacular presents a compelling, coherent case in favor of mobilizing efforts to invest in the ideal of choice rather the immediacy of compliance because, the vernacular suggests, noble principles (rather than noble acts) can better direct health-care policy and participation for 21st-century medicine.

**Noncompliance as Resistance**

Research focused on oppositional discourse surrounding the issue of vaccination often showcases communicative practices that outright reject official discourses of health and medicine, and, therefore, exist in opposition to dominant medical knowledge. For example, much of the research about vaccination hesitancy has focused on attitudes, beliefs, and actions of antivaccinationists (e.g. Hofmann, Ferracin, Marsh, and Dumas 2006). Hence, although research has focused on oppositional vaccination communication, when people and ideas organize around behaviors that depart drastically from accepted biomedical knowledge and practice, methods that they use to collectively oppose dominant models of health and medicine constitute “health resistance rhetoric” (discussed in greater detail in chapter 2). Medical professionals who express concern about certain medical interventions present a unique group of individuals who have been understudied with respect to their ability to communicate professionalism in relation to vaccination practices, communication that requires health-care personnel to successfully navigate between competing roles as both health-care providers and health-care participants, and as both medical advocates and avid resistors. Complexities comprising and expressed in health-care professionals’ resistance efforts hosted within the
institution of medicine suggest a rich site for analysis, wherein issues of biomedical health citizenship are debated and determined. Insights gained from attention to the research questions posed in chapter 1 can illuminate expectations (and, ideally, “best practices”) for performances of medical professionalism amidst biotechnological advances, a contribution that foregrounds the rhetoricity of U.S. medical actors in relation to a more complicated global public health scene.

Compliance has been studied across health contexts and occurs when patient behaviors align with health directives. Compliance, according to Robert Cialdini and Noah Goldstein, is “a particular kind of response—acquiescence—to a particular kind of communication—request” (2004, 592). Research suggests that compliance is usually guided by perceptions of reward or punishment that are associated with a particular request, and, in most cases, individuals comply to gain approval or avoid disapproval from someone with power and influence. With regard to vaccination, then, when a physician recommends that a patient get vaccinated and that patient complies, the patient’s actions can be understood to be motivated, at least in part, by a desire to please his or her doctor and, at least in part, a desire to avoid punishments associated with nonvaccination (e.g., sickness). Conversely, this logic suggests that when noncompliance occurs, it may communicate an intentional disregard of the wishes and recommendations of a physician, or, worse, the invitation for punishment in the form of disease. Although sometimes assumptions about “the forgetful patient” accurately describes noncompliance as unintentional, more often than not, noncompliance may represent instances when patients exercise power over their health situation and, thus, intentionally communicate something meaningful to physicians and medical institutions. In a similar manner, deliberately boycotting vaccinations may intentionally communicate aversion to dominant medical ideologies and practices.
Insofar as certain uses of the body are understood, shared, and known to intentionally communicate resistance against prevailing views of official institutions, use of the body to resist official orthodoxy serves as a vernacular mode of expression. In this sense, boycotts are an expression of public opinion in opposition to official institutions and ideologies, and, therefore, they qualify as vernacular rhetoric that is privy to rhetorical theory and analysis. For example, in his recent book *Prisoners of Conscience*, Gerard Hauser detailed how hunger strikes were used in Ireland in the early 1980s to protest criminal statuses that were assigned to imprisoned political activists. Bobby Sands’s personal hunger strike (which resulted in his death) drew international press coverage and official comment from the then Prime Minister of Britain, Margaret Thatcher (2012). This represents a case when boycotting food communicated resistance. Although some boycotts may intentionally draw attention to sites of injustice, other forms of vernacular expression may intentionally resist official policies quietly, subtly, and go undetected. Such is the case when, for example, graffiti artists embed gang insignia or political commentary into colorfully distracting scenes appearing around a city. In politically contentious contexts, the function of vernacular rhetoric may be to allow individuals to live and operate at the margins of popular opinion and policy, a need that may be wholly essential to individuals whose livelihoods depend on institutions with which they disagree. In such situations, one useful characteristic of vernacular rhetorics is that those in power may not recognize the communication of a counterview.

For the case of health-care worker vaccinations, in particular, nonvaccinators have existed across health-care settings in dispersed, unorganized, and uneventful fashion for quite some time; subtleness on their part may have been necessary to ensure their good standing with the institutions in which they were employed. Indeed, before national attention to the issue,
nonvaccinators were previously able to quietly decline the medical intervention with which they disagreed (a form of undetected vernacular expression), and, thus, they were able to maintain an illusion of alignment with dominant institutions and ideologies on which their livelihoods depended. However, when official health policy began to promote standards for improved vaccination rates and dictate means to achieve those goals, previously undetected nonvaccinators could be revealed and categorized as “noncompliant.” From a shared title as “noncompliant,” nonvaccinators within the health-care community began to recognize themselves as a collective with political opinion and power. In other words, when nonvaccinators were directly targeted by official rhetorics of health and medicine, they were beckoned to “go public,” so to say, with their intentions, and they recognized themselves as “at the margins” of medicine. Exclusion is a clear marker for a counterpublic formation/existence, and it is through exclusion from official policies and practices that counterpublics become marginalized. It is through a designation of marginalization and exclusion that counterpublics are prompted to form alternative modes of communicating and acting in relation to certain issues. Through the formation and solidification of this type of ontological resistance, counterpublics materialize and can be understood as acting in opposition to another public.

Whereas institutions of medicine previously translated noncompliance as unintentional and apolitical, vocal public backlash organized in response to official policies clarified intentions behind abstaining from flu vaccination: inaction was clarified as political action for nonvaccinators. In a reflection on public debate about childhood vaccination policy, specifically, biomedical ethicist Pru Hobson-West noted:

At least some resistance functions as a critique which problematises the basic assumptions upon which vaccination rests, assumptions about the relationship between
the individual and community, citizen and state, and health and disease. These are undeniably political issues that deserve to be treated as such, and investigated using social and political analysis. (2003, 281)

Similar claims and charges, I suggest, can and should be considered in the case of mandatory influenza vaccinations for health-care workers.

Conclusion

Vaccination is a complex public health issue that calls attention to everyday obstacles for the practice of medicine and delivery of health-care. Specific insight into rhetorical dynamics surrounding vaccination communication may offer opportunities to better marry public health risk with private health responsibility via the language that is used to describe, explain, and promote new biotechnologies. From a biocritical vantage, and through the use of descriptive tools offered by a theory of vernacular rhetoric, this project analyzes mandatory vaccination discourse to detail a larger *rhetoric of vaccination*; that is, a set of linguistic maneuvers that are deployed to mobilize and manage individuals in relation to real or perceived public health threats. This rhetoric of vaccination, as shall be shown, is characterized by complex tensions that cluster into meaningful, rhetorical formations (Condit 1999) that offer suggestions for the maintenance of relationships between medicine and its publics. Moreover, this rhetoric of vaccination is necessarily both vernacular and official in authorship and composition.

From a practical standpoint, biocriticism serves as a method for data collection by targeting meaningful intersections of and formulating meaningful questions about problems and issues that hold public significance. Examining these intersections ensures that the U.S. public remains informed about and involved with the ongoing allocation of energy and resources to public health-security initiatives. As a nation that is built on an engaged citizenry, in both
principle and practice, public engagement in the United States with biodefense happenings is important. In terms of advancing the discipline of rhetoric, and the field of the rhetoric of health and medicine, specifically, underwriting humanities scholars into the larger biodefense project is also important. As Condit argued, “Foucault’s lesson was that all powerful social discourse is dangerous . . . dangerousness of any social discourse does not mean either that we can do without it or that some other discourse exists that is inherently not dangerous” (1999, 22; referencing Foucault, *Politics, Philosophy, Culture* 1990, 169). People may not be able to avoid all dangers associated with biodefense activities, but through a rhetorical perspective, they can manage how dangers come to matter and influence everyday practices and perceptions of U.S. health citizenship. With direct, political implications for the operations of U.S. defense systems, a biocritical perspective, thus, ensures that scholars, policy makers, and everyday citizens tend to the humanistic dimensions of disease management, in addition to the biomedical aspects of product development and system readiness. Assuming a biocritical stance identifies significant sources of public action and argument that warrant close, critical monitoring; the stance, thus, supports an engaged, interventionist approach to citizenship by targeting policy language and practices that can be improved by humanities-centered research, and a biocritical stance advances a strand of scholarship that demonstrates the centrality of the field of the rhetoric of medicine in matters of public health-security.

Findings derived from rhetorical criticism, if mindfully constructed, can present opportunities for meaningful engagement across audiences of public health. With regard to the vaccination debate, specifically, a particularly important and fruitful area where rhetoricians of medicine can contribute is helping diverse publics to better identify with one another for the sake of accomplishing larger public health goals. Rhetorical criticism, after all, is “a humanistic and
interpretive act,” whereby the critic “takes up a text and re-circulates it” to see the world from a different angle (Keränen 2010, 23). Through the process of contributing a unique perspective, the critic “asks the listener or reader to re-understand and re-evaluate the text, to see and judge it in a new way suggested by the critic” (Nothstine, Blair, and Copeland 1994, 3; as cited in Keränen 2010, 23). To eventually help competing stakeholders see their worlds from similar angles, it becomes necessary to understand individual positionalities before exploring possibilities for change. To this end, the focus of my reading of health texts—comprised of official and vernacular vaccination rhetorics—is guided by humanistic assumptions (Foss, 1996; Hart and Daughton 2005), broadly, and by the research questions raised at the end of chapter 1, specifically.

Vaccine resistance, hesitancy, and opposition challenge and may even undermine important tenets of public health; however, through a rhetorical approach, seemingly dangerous discourses, such as these, can be analyzed and interpreted for their public value. In a recent article, Louise Cummings evaluated predominant reasoning structures that currently characterize much public health policy, and she concluded “that lesson can be succinctly stated in the following terms: If public health can learn to trust the rational resources of the public, then perhaps the public will reciprocate by increasing its trust in public health” (2014, 13). For the study of the rhetorics of health and medicine, the theory of vernacular rhetoric grounds scholars in a collection of rhetorical theory that, due in no small part to Hauser’s work, situates even the most ill-understood, caustic, or dangerous publics as rhetorical phenomena that are amenable to respectful examination and, maybe, even rhetorical intervention. As previously noted, rhetoricians deal with communication at the level of the word, which makes unintelligible or worrisome health perspectives amenable to systematic, respectful investigation. In times of
medical crisis, this method of advancing understanding and action can become particularly useful to medical professionals and advocates charged with the task of addressing controversial health concerns at a public level in a timely manner. For the everyday practices of medicine, this method of reconciling tensions can become particularly useful to medical professionals making health decisions, who act, simultaneously, as both public and private citizens affiliated with institutions of medicine.

1Part of my analytic process is descriptive in nature. That is, when I examine official and vernacular vaccination rhetorics, I do so with the intention of detailing unique, discursive qualities of each type of communication as a stand-alone discourse to distinguish between them. This part of my analytic process is guided by what Gerard Hauser termed an “empirical attitude,” which “signifies more the attitude of an investigator who, cognizant of the intentional fallacy determines to go beyond the critics’ own sensibilities to the text and inquire into how those who appropriated it responded” (1999, 276). Beyond individual text-based descriptions, however, I also seek to understand how the two rhetorics interact to, eventually, offer proscriptive policy suggestions. For this part of my analytic process, I am guided by what Segal termed a “rhetorical subjectivity,” an analytic position “that is constructed in the terms and history of a tradition that has always been concerned with moral action” (2005, 16). Therefore, to develop findings that align with my applied research agenda, my empirical attitude attracts me to tensions observable in vernacular and official rhetorics in situ, and my rhetorical subjectivity entices me to consider context-adjusted, ameliorative social solutions. This is what is I mean when I use the phrase “rhetorical sensitivity.”

2The Federal Registry is a national database used to solicit and publish public feedback. Its intended audience is policy makers; however, in this case (and for many others), results of the Federal Registry response system have been published for public review.

3Although the 37 organizational position papers were, indeed, evaluated as “public comment” by the National Vaccination Advisory Committee seeking public response, in the context of my theoretical framework position, papers submitted by organizations qualify as a unique form of rhetoric that is distinct from both “official” and “vernacular” rhetorics of health and medicine. More affiliated with what Thomas Goodnight (1982) coined as the “technical sphere,” organizational position papers represent rhetorics that are produced by expert, specialized publics and, therefore, they stand distinct from either vernacular or official rhetorics in the traditional, Hausarian sense. Understood as either a refined reconstitution of vernacular expression or a resistant faction of a larger official ideology, in this case, organizational position papers are the result of a process wherein many voices get streamlined and expressed using generic forms of argument that are deemed to be intelligible and legitimate to official institutions of medicine. Because of the tendency for that process to intentionally rid resistance rhetorics of their emotive charge (to be understood and appreciated by official institutions wielding power over everyday citizens), for purposes of this study, these organizational statements were set aside for future research. Instead, full attention was turned to public responses that were submitted by individual health-care participants because of the emotive qualities that those submissions possessed.

4Although the final report—which was collated and published by the NVAC—considered these as one entry in its overall public response total, for purposes of analysis, I treated each of the 79 entries as stand-alone contributions and coded them as such. I did so because each entry included personal information and indicated separate e-mail addresses, although only one person (#22) submitted them to the federal registry. Each of these 79 contributions
were coded via decimal points added to #22, such that #22.1 indicates the first individual entry of the group of entries that comprise #22 according to the NVAC tally.
PART TWO:

AN ONGOING PUBLIC HEALTH DEBATE
CHAPTER IV
MANDATORY VACCINATIONS FOR HEALTH-CARE WORKERS

Using the mandatory vaccinations for health-care workers controversy, this chapter reviews discrepancies over expectations for compliance and choice in matters of disease threat and prevention. In addition to describing facts and figures that demonstrate the public significance of the issue, I review some ways in which the issue of mandatory influenza health-care personnel vaccinations has been taken up in policy and scholarship. I do so to demonstrate the many audiences to which this issue speaks, to articulate the distinct political inflections of the issue, and to warrant my investigation into the, specifically, rhetorical dimensions of recent mandatory vaccination policy communication. Following that review, I describe the representative texts selected for close examination, and I overview my analytic process. Preliminary review of the full data set produced three main themes that ran across public discourses addressing this issue. Therefore, following my discussion of method, I describe those three dominant rhetorical features and provide a preview of the argument that I develop more fully in the subsequent data analysis (chapters 5–7). First, however, I begin with a discussion of influenza and its significance as a site of public health intervention.

Influenza: A Public Problem

Most commonly known as “the flu,” influenza is a “highly infectious viral illness” that can be passed from person to person via aerosol droplets or direct contact (CDC 2012, 151). There are three types of the virus: Influenza type A causes moderate to severe illness, effects all age groups, and occurs in humans and other animals; type B occurs only in humans and is a
milder disease that primarily affects children; and influenza C has not been associated with epidemic disease because it is rarely reported as a cause of human illness. “Classic” influenza symptoms include abrupt onset of fever, muscles aches, sore throat, and “nonproductive cough,” and adults may transmit the virus to others for upwards of 10 days, 2 days of which are part of the incubation period that occurs before any symptoms actually manifest (CDC 2012, 154). The “flu season,” as most U.S. Americans colloquially call it, experiences peaks predictably between the months of December and March every year, although some flu seasons begin earlier and/or last longer. Although influenza may be regarded by some as routine, with common rituals used to confront it, such as when families “stock up” on vitamins and orange juice to keep from catching “whatever’s going around the office,” in 2014, a report noted that “an overwhelming majority of the influenza patients who required intensive care from Duke University Hospital during this year’s flu season had not been vaccinated,” a reality that led Dr. Wolfe, an assistant professor of medicine at Duke University, to conclude that “the public health implications are important, because not only could a potentially deadly infection be avoided with a $30 shot, but costly hospitalizations could also be reduced” (Duke 2014, para. 4). The Centers for Disease Control and Prevention noted that “an average of more than 200,000 hospitalizations per year are related to influenza. . . . The cost of a severe epidemic has been estimated to be $12 billion” (2012, 155). Influenza infection is associated with at least 36,000 deaths and 200,000 hospitalizations in the United States each year, and it remains the leading cause of vaccine-preventable death in the United States annually (Thompson et al. 2003, 2004).

In terms of pandemic occurrence, at least four pandemics of influenza occurred in the 19th century, three in the 20th century (including the 1918 “Spanish flu”), and one, so far, in the 21st century (the 2009 “Swine Flu” scare). The worst flu outbreak in recorded history, the 1918
“Spanish” influenza pandemic, killed approximately 21 million people worldwide (CDC 2012, 151). Although the possibility for widespread pandemic certainly continues to loom large worldwide, annual influenza threat in places such as the United States, where influenza prevention and intervention have become medical priorities, is relatively well managed, considering the odds. The first pandemic of the 21st century, for example, caused nearly 60 million U.S. Americans to become ill but resulted in only 12,500 deaths, a mere fraction of the 1918 flu’s impact, which claimed nearly 500,000 U.S. lives (Congressional Budget Office 2008). Despite these notable improvements, overall, influenza-associated deaths have steadily increased since 1990 within the United States. Most of this rise has been attributed to a “substantial increase in the number of people aged 65 years or older, who are at increased risk for death from influenza complications” (Immunization Action Coalition 2013, 1). This fact means that although the United States has grown notably stronger as a nation in terms of fighting the flu, a significant portion of its populations has grown notably weaker in its abilities to biologically fend off disease. Suffering from a condition known as “immunosenescence,” the immune systems of the elderly are waning, which reduces their ability to respond to infection, which leads to more severe experiences of disease (Monto et al. 2009).

**Influenza-related Complications**

Every year, on average, close to 90% of “influenza associated deaths” occur among adults 65 years of age and older (Thompson et al. 2010). *Influenza-associated deaths* refers to secondary illnesses that occur because of the Influenza virus; examples include pneumonia, bronchitis, sinus infections, or ear infections (CDC 2014). The impact of influenza in the United States is quantified by measuring pneumonia and influenza deaths (CDC 2012, 157). To address commonly asked questions about the flu (and to promote the vaccination as well), the CDC
explained that “researchers have estimated that in most years 90% of flu-related deaths occur in people 65 and older, and the flu is a major contributor to hospitalizations in this age group” (2013a, para. 13). Furthermore, “data from statistical modeling studies looking at flu seasons from 1979 to 2001 estimate that as many as 60% of flu-related hospitalizations occur among people 65 and older” (CDC 2013a, para. 13). From an epidemiological standpoint, then, death by flu is as routine a feature of the flu season as are vitamins and orange juice; yet, despite a predictably dire outcome, rates of influenza vaccination continue to fall short of the coverage that is needed to boost herd immunity across the nation to protect the most vulnerable members of U.S. society that commonly contract and die from influenza related complications.

In theory, vaccination works by “herd immunity,” a phenomenon that requires a certain percentage of a given population be vaccinated to protect the unvaccinated among them. According to Kevin Malone and Alan Hinman:

An important characteristic of most vaccines is that they provide both individual and community protection. Most of the diseases against which we vaccinate are transmitted from person to person. When a sufficiently large proportion of individuals in a community is immunized, those persons serve as a protective barrier against the likelihood of transmission of the disease in the community, thus indirectly protecting those who are not immunized and those who received vaccine but are not protected (vaccine failures). (2003, 264)

According to the CDC, “on average, fewer than 20% of persons in high-risk groups receive influenza vaccine each year” (2012, 167). Thankfully, and with this unvaccinated group in mind, as long ago as 1970, researchers demonstrated indirect protection of older adults achieved through the vaccination of school children (Monto, Davenport, Napier, and Francis 1970).
Since 2003, there have been two methods of vaccination available to individuals: the trivalent inactivated influenza vaccine (TIV) and the live, attenuated influenza vaccine (LAIV). The former is administered through the intramuscular or the intradermal route (through “a shot”), and it contains virus strains that are “inactivated”; the latter is offered in a single-dose sprayer unit (half of the dose is sprayed into each nostril) and contains a “live” virus. Each version of the flu vaccine carries some risk, but the LAIV has only been “approved for use in health, nonpregnant persons 2 through 49 years of age,” a specific subset of those deemed to be “at-risk” (CDC 2012, 159). More generally, the nomenclature at-risk denotes children younger than 5 years of age (especially younger than 2 years old), adults 65 years of age and older, pregnant women, and American Indians and Alaskan Natives (CDC 2013a). Although there are some minimal risks for all vaccine recipients, such as “redness and swelling where the shot was given” (CDC 2013a), for some individuals for whom the vaccine is “contraindicated,” risks are deemed too high and, therefore, vaccination is not a preventative option. For example, individuals with severe egg allergies are ineligible to receive live, attenuated influenza vaccine (because eggs are an ingredient in the vaccine). Individuals for whom the flu vaccine is contraindicated must rely on members of their community to get vaccinated to reduce their likelihood of contracting the condition in the first place. Failing to sustain adequate vaccination rates at the population level means that vulnerable populations are at increased risk for influenza-related complications, and, as such, the intended benefit of this preventative medical technology cannot be realized.

Groups that are targeted for influenza vaccination (individuals for whom the influenza vaccination is not contraindicated) include otherwise healthy children, pregnant women, health-care workers, poultry workers, people living with those at higher risk, and those working in essential, military, and veterinary services (Mereckiene et al. 2008). Of those recommended for
vaccination during the 2010–2011 season—“the first season in which all adults were recommended for the influenza vaccination” (Lu et al. 2013, 1480)—approximately 38% of all eligible adult U.S. Americans got vaccinated against the flu; however, for adults aged 18–64 years, categorized, specifically, as “high-risk” only 45.6% received coverage (Lu et al. 2013). During the following flu season (2011–2012), 51.1% of individuals 6 months of age and older living in South Dakota got vaccinated; Nevada ranked lowest with only 32.6% of its eligible population receiving vaccination (MCT 2013). Questions as to why individuals refuse (or neglect) to line up for a vaccination that, potentially, could save their life, and why these rates vary across states continue to frustrate public health officials committed to the cause at the national level. In response, to increase vaccination uptake across the U.S. population, nonprofit and for profit partners have united efforts to raise awareness about the disease and to encourage individuals to proactively protect themselves and their communities.

Motivated by an outbreak of avian influenza (H5N1) in Asia and Europe in 2005, and still concerned with biosecurity after the anthrax attacks, under the direction of President George W. Bush, the Homeland Security Council published a report, titled the National Strategy for Pandemic Influenza (2009). In an opening letter, President Bush explained that the purpose of the report was to “[outline] how we intend to prepare, detect, and respond to a pandemic. It also outlines the important roles to be played not only by the Federal government, but also by State and local governments, private industry, our international partners, and most importantly individual citizens, including you and your families” (para. 5). The report set a number of state- and national-level legislative processes into motion. At the national level, in December 2006, the U.S. Congress passed The Pandemic and All-Hazards Preparedness Act to “improve the Nation’s public health and medical preparedness and response capabilities for emergencies,
whether deliberate, accidental, or natural” (Hodge, Gostin, Vernick 2007). In direct response to the President’s *National Strategy for Pandemic Influenza* plan, published in 2005, the CDC held two National Vaccine Summits with partners in 2006, and it hosted the first National Influenza Vaccination Week, which now occurs every year in December. In addition to year-round efforts that are hosted by a number of independent health-care organizations, the National Influenza Vaccination Week inspires a spike in media attention that is designed to raise awareness about influenza vaccination. These campaign materials, which include print, television, and online arenas, have been, perhaps, most concentrated in and around health-care settings where sick individuals go for care, to receive vaccines, and to interact with health-care professionals to learn about flu risks and treatment options. Ironically, health-care settings—where flu shots are commonly administered—may actually increase odds for patients to contract the flu. Despite concentrated efforts in health-care settings, vaccination rates remain low among patients and professionals alike, whereas rates of health-care-associated infections have risen.

**Health-care-associated Infections**

A recent report published in *Clinical Infectious Diseases* noted that “the influenza virus can spread up to 6 feet from a patient’s head via submicron particulars through routine hospital care” (Brown 2013), suggesting that traditional methods of flu avoidance, such as covering one’s mouth when coughing or sneezing, and washing hands frequently, may not readily protect against most flu transmission, especially in hospital settings. The National Healthcare Safety Network (NHSN), the CDC surveillance system for hospital infections, defined *health-care-associated infections* (HAIs) as “a localized or systemic condition resulting from an adverse reaction to the presence of an infectious agent(s) or its toxin(s). There must be no evidence that the infection was present or incubating at the time of admission to the acute care setting” (2009,
para. 1). In more colloquial terms, HAI refers to illnesses that patients catch from health-care settings and interactions.

According to the *Healthy People 2020* report, HAIs “are among the leading causes of preventable deaths in the United States and are associated with a substantial increase in health-care costs each year” (HHS 2011). Since early 2000, reducing HAI rates has risen as a national public health priority. Despite increases in national attention, survey results of a study published in the *New England Journal of Medicine* at the beginning of this year estimated there were approximately “648,000 patients with 721,800 health-care-associated infections in U.S. acute care hospitals in 2011 alone” (Magill et al. 2014, 1198). Of the 11,282 patients surveyed across 183 hospitals, 452 had 1 or more health-care-associated infections. Members of the Emerging Infections Program Healthcare-Associated Infections and Antimicrobial Use Prevalence Survey Team (the authors of the study and article) concluded that “our survey results indicate that on any given day approximately 1 of every 25 in-patients in U.S. acute care hospitals has at least one health-care-associated infection. Pneumonia and surgical-site infection were the most common infection types” (Magill et al. 2014, 1207). (Recall that pneumonia is a leading flu-related complication and is more often than not treated as being synonymously with influenza in most statistical data.) An unfortunate and startling statistic, medical institutions now formally factor in the health of health-care professionals as an important variable that is needed to reduce influenza-related complications for patients and professionals alike.

Formerly flagged as dangerous vectors in most hospital-incubated flu outbreak scenarios, health-care workers are now considered to be important intermediaries between the health of individual patients and the health of the U.S. public writ large. In 2004, the National Foundation for Infectious Diseases (NFID) published a “call to action,” whose subtitle read “Improving
Dismal Influenza Vaccination Rates among Health-care Workers Requires Comprehensive Approach, Institutional Commitment.” The following year, Gregory Poland, Pritish Tosha, and Robert Jacobson published an article, titled “Requiring Influenza Vaccination for Health-care Workers: Seven Truths we Must Accept,” whose sixth “truth” stated: “Health-care workers and health-care systems have an ethical and moral duty to protect vulnerable patients from transmissible diseases” (2005, 2253). Against the backdrop of a larger ongoing national biodefense discussion, wherein vaccinations were defined as medical countermeasures and health-care workers were identified as “important influential figures in the war on terror,” the issue of mandatory flu vaccines for health-care workers gained public attention and organized support. After all, in most worst-case scenarios, the threat of pandemic was treated similarly to a terrorist attack, thereby designating health-care workers as soldiers on the frontlines of the ongoing fight against easily communicable disease.

In her 2007 review of the CDC’s “ongoing domestic and international surveillance, other preparedness initiatives in 2006, and examples of CDC actions planned for 2007 and beyond,” Julie Gerberding, Director of the Centers for Disease Control and Prevention, reported on the agency’s progress toward meeting the President’s *National Strategy for Pandemic Influenza*, stating bluntly that “influenza pandemic would have a profound impact on almost every sector of society, both in the United States and globally (1). Informed by a similar conviction, the Infectious Diseases Society of America (IDSA) argued that “public health officials should think of seasonal flu as a dress rehearsal for pandemic flu,” raising the bar for what previously routine illness prevention meant for national health-security preparedness on a national stage (Schnirring, 1). Perhaps a reasonable expectation when juxtaposed against the threat of a deadly flu outbreak, such as the one in 1918, for the annual, somewhat routine and predictable, life
course of the flu, a notable mass of health-care employees took issue with being targeted for vaccination. Some health-care workers outwardly refused to vaccinate in protest of the mandates; others were forced to account for why they were “noncompliant” in the past. Published in 2010 in the journal of *Clinical Infectious Diseases*, a review of the issue stated bluntly that “mandatory vaccination was a controversial strategy that pits health-care worker autonomy against patient safety” (Babcock et al., 460). Despite pushback and controversy, national health policy sanctions continued to monitor HCW vaccination rates in fear of an unlikely—but forecasted—pandemic.

An aging population paired with a virulent strand of influenza threatens to almost certainly disturb life as usual within the United States in the coming century, especially if that population is undervaccinated. Disease occurrence can be predicted to occur in a cyclical fashion, and the next worldwide influenza pandemic is forecasted for 2021; “flu diligence,” one might say, is required for 21st-century public health organizing. Despite this prediction and charge, health-care workers’ vaccination rates remain around 40% (CDC 2013b). This rate varies across health-care settings and specialties, but it remains low no matter the division of medicine (CDC 2013b). Consistently low vaccination rates among health-care professionals are troublesome for a couple of reasons. From the perspective of public health officials, an undervaccinated health-care worker population introduces structural weaknesses into an otherwise (supposedly) robust health-security system. From patients’ perspective, unvaccinated health-care providers risk transmitting diseases that could infect them, especially if patients’ immune system is comprised during care. From health-care providers’ position, sick coworkers impose both biological and organizational stress on others. Because of the complicated emotions and competing perspectives that the issue invites, the status of health-care worker vaccinations, thus, is worthy of further investigation. Moreover, however, the issue may warrant closer
attention because of the somewhat counterintuitive reaction of the health-care workforce regarding the recommended precautionary measure, for here is a case where loyal actors in medicine reject the advice of medicine. It is the counterintuitive nature of the public health issue that inspired my closer look.

Health-care Workers: A Complicated Public

As a contested site wherein internal politics of medicine enter onto the public stage for discussion and debate, the issue of mandatory health-care worker vaccination raises some interesting questions about relationships among medical professionals and the patients and publics that they both serve and comprise. First, health-care professionals seem to administer vaccinations at a higher rate than they themselves receive them. Theories of cognitive dissonance (Festinger 1962) suggest that this finding is unusual, raising the question of why health-care workers would reject interventions for themselves but regularly recommend and administer them to others. Second, although distrust of science is commonly cited by members of the lay public as a reason for vaccine avoidance (Kahn 2013), in their agreement to train and work within the Western medical paradigm, in everyday actions and interactions, health-care workers seemingly endorse the scientific method and interventions that it promotes. In the absence of an overall distrust in science, what is it about vaccination that deters members of the medical community from adopting this particular recommendation? Third, as national attention about health-care-associated infections continues to demonstrate, health-care professionals work in environments with increased risk for disease contraction. Given that the nature of health-care work requires close contact with sick people, why would members of community that is committed to public health security willingly forgo an endorsed “first line of defense” against deadly disease?
As this line of reasoning suggests, persistently low rates of health-care worker vaccinations raises a slew of questions about what the flu vaccination means to members of the health-care community, how those individuals organize around issues of disease threat under both normal and heightening risk scenarios, and why policy centered on this issue continues to cause pushback amidst an audience of individuals who, largely, are aligned with Western medical ideals and who, by virtue of profession, intensify their risk of contracting the flu in everyday interactions. Understanding operations of this particular public health issue and the actors that it involves presents an opportunity to shift from specific to general, to theorize about medical publics on a larger scale. Given their indelible role as intermediaries between private lives and public good for themselves and others, health-care workers represent a unique segment of the larger U.S. population, a segment that represents, perhaps, the embodiment of many competing medical publics—and each public’s rhetoric—as a term of employment.

If certain members affiliated with official institutions are expressing concerns within the halls of medicine, it is likely that resistance in the form of intentional noncompliance communicates something outside of medicine as well. Vaccine-hesitant health-care workers may very well interact with and become part of the same “health public” as a parent who shares similar concerns. The difference between the two—a nurse and a parent, per say—is that the health-care professional’s opinion comes backed with his or her expertise as a public health professional. Professional expertise, in this situation, may prove to be very persuasive, especially if it confirms fears and hesitancies. In the case of vaccination, therefore, when members of the health-care community express concern about policies of medicine outside of the medical institution and within the larger medical public that they comprise, those reservations may carry across audiences who, otherwise, are unaffiliated with health institutions in professional and
daily life, and who hold more persuasive power over the opinion of others. The assumption here, that the study of a specific demographic becomes meaningful in generalizable ways, reflects a mode of reasoning known as the *a fortiori* argument. As such, my attention to what concerns are expressed by members of the scientific community regarding noncompliance with vaccination may provide valuable insight into concerns that move beyond the science of vaccination to shape public opinion about the issue on a public scale. What is at stake when disagreement about vaccination erupts within the health-care community? What, specifically, might debate indicate about low vaccination rates on the outside? In the process, how does vaccination act symbolically within, across, and outside of medical contexts to communicate public opinion about medicine?

Nearly a decade after the 2004 National Foundation of Infectious Disease’s original call to action that targeted health-care workers as in need of flu vaccination, much debate about mandatory policies continues to surge within the health-care community. With regard to health-care workers’ historical seasonal influenza vaccination coverage rates, the 2009–2010 season saw increased coverage estimated at 62%, and it should be noted that coverage of health-care workers has never exceeded 49% since the 1986 recommendation by the CDC for vaccination of that group (CDC, 2010). Since the early 2000s, and in lieu of continually low rates of health-care worker vaccination coverage, there has been a proliferation of both formal and informal communication about the issue on the pages of scholarly journals and the blogosphere alike. Scholarly attention to the issue has focused on explaining and challenging resistance within the health-care community to improve overall vaccination uptake. For example, a literature review of studies published between 1985 and 2002 that focused on health-care workers’ attitudes and beliefs about influenza vaccination concluded: “Two main *barriers* to *satisfactory* vaccine
uptake were consistently reported: (1) misperception of influenza, its risks, the role of HCW in its transmission to patients, and the importance and risks of vaccination (2) lack of (or perceived lack of) conveniently available vaccine” (142; italics added). On the basis of these findings, the authors recommend that “to overcome these barriers and increase uptake, vaccination campaigns must be carefully designed and implemented taking account of the specific needs at each healthcare institution” (Hofmann et al. 2006, 142; italics added). In other words, unvaccinated health-care workers were understood as being in need of intervention to “increase uptake” to “satisfactory” levels. Rarely has health-care worker resistance been studied as an opportunity to reconsider flu vaccination as a necessary precaution or to redirect prevention efforts already underway. Within this larger discourse, more often than not, pushback born from within the medical community gets framed as deviant and, as such, it remains at the margins of policy debate. Besides opinion pieces (see, e.g., Biton 2011; Bramstedt 2013; Pyrek 2010), the voices and experiences of medical professionals being targeted for vaccination remain notably absent from the official policy debate and its subsequent coverage and critique, an absence for which a theory of vernacular rhetoric turned my attention.

**A Research Plan**

I approached the tasks of data collection and analysis guided by theories of biocriticism and vernacular rhetoric (see chapter 3) that led me to seek out and foreground voices that, currently, are muted in the public record. Attention to experiences of health-care workers can round out both the scholarly and policy discussions alike. Although scholarship has consistently identified medical professionals as influential figures in public health and adequately recognizes their agentic role in influencing certain health-care practice trends (Frank et al. 2013), oftentimes, their allegiance is taken for granted as being in line with official policies and
practices of health and medicine. It has not been common practice, for example, to approach medical professionals as rhetorical actors who are equipped with skills and motivation needed to actively influence health behaviors, let alone resist official rhetorics of health and medicine in ways that influence larger public trends. Some scholars have sought to integrate medicine and rhetoric in theory and practice (see, e.g., the work of rhetorician Lorelei Lingaard), and others have conducted interviews with medical professionals to understand vaccination resistance in particular. By and large, however, the voices of resistant health-care professionals—the demographic for which influenza vaccinations are mainly targeted—remains underrepresented in both theory and practice. Better integrating the diverse voices and opinions of the health-care workforce may be necessary to craft reasonable, reliable public health policy (see, e.g., Malkowski 2014; Scott 2003). Furthermore, focusing on resistant vernacular rhetorics produced by health-care professionals may help advocates and scholars to better understand how vaccination communication intersects with and informs public perceptions of medicine from the inside out.

Data Analysis

In terms of analytic method, after gathering, organizing, and processing my large corpuses of mandatory vaccination communication to create representative vernacular and official texts I, first, conducted a traditional rhetorical criticism of both the official and the vernacular rhetoric of influenza vaccination. Specifically, I reviewed components of each text to look for terms and patterns across each distinct data set. (The interplay between official and vernacular rhetorics of mandatory vaccination was explored in subsequent steps in my analytic process.) In this first step, I engaged in a descriptive mode of analysis to identity formal devices because, in the words of Condit, “these devices constitute focal points for research because they
drive particular formulations of social practices and define the experiences of those practices” (1999, 252). This initial descriptive analysis was conducted while maintaining a separation between vernacular and official corpuses, with the process yielding evidence to suggest both differences and similarities in the manner in which official and vernacular discourses communicated about the issue of mandatory influenza vaccination. Explained in more detail in chapter 5, differences occurred between how official institutions of medicine defined the overall health threat and the “duty” of health-care professionals amidst health uncertainty. Conversely, similarities included establishing health-care professionals as essential to the overall national public health-security process and recognizing vaccination as an issue worth deliberating.

Whereas my initial descriptive analysis was conducted by maintaining a separation between vernacular and official rhetorics of mandatory vaccination, in the second step of my analytic process, I thought about each form of rhetoric in conversation with the other to consider how official rhetorics of health and medicine account for vernacular rhetorics of health and medicine, and vice versa. As Kenneth Burke observed, points of intersection and overlap between various rhetorics suggest meaningful opportunities for identification across diverse perspectives (1968). To identify and foreground official and vernacular similarities across difference in my second stage of analytic review, therefore, I organized and interpreted data with an eye toward connections and complementarities. The result of that step identified two rhetorical features, bioanxiety and medical ethos, on which both types of rhetoric focused. (Each feature is presented in detail in chapters 6 and 7, respectively, and each helps to describe the current medical moment more broadly.)

Whereas the first step of my analytic process could be described as descriptive and the second as interpretive and/or explanatory, the third and final step might be described as
exploratory, creative, or imaginative. Specifically, in step three of my analytic process, I was
guided by Thomas Lemke’s conceptualization of an “analytics of bio-politics,” which entails
a problematizing and creative task that links a diagnostics of the contemporary with an
orientation to the future, while at the same time destabilizing apparently natural or self-
evident modes of practice and thought—inviting us to live differently. As a result, an
analytics of biopolitics has a speculative and experimental dimension: it does not affirm
what is but anticipates what could be different. (2011, 123)

With this interventionist goal in mind, via the third step of my analytic process, I engaged with
the data in a manner that actively looked to and anticipated the future for biotechnological
health-care. For instance, if I noticed that a particular phrase or emotion appeared frequently
across the data, I thought about and interpreted topoi in lieu of the ongoing vaccination hesitancy
problem introduced in chapter 1. This third step yielded a far more nuanced understanding of
how talk hosted in relation to this particular issue acted as a staging site for other political, social,
and professional concerns to be debated. That is, whereas steps one and two of my analytic
process focused on describing and interpreting data, the third step speculated about recurrent
themes and patterns in lieu of what is known about contextual features of a biotechnological era
(outlined in chapter 1). For example, a statement such as “screw Big Pharma” extends beyond
considerations of the influenza vaccination, in particular, and, instead, gestures toward the
economic infrastructure of medicine and various stakeholders involved with vaccination
production and sales. Recall that “in 1950s America, twenty-six companies manufactured
various vaccines” and “by 2004, there were four” (Klotz and Sylvester 2009, 163), suggesting
that something, indeed, has changed regarding the business of public health-security. The
sentiment “screw Big Pharma,” thus, “indexes” (Pierce 1998) political, social, and professional concerns that now are readily embedded into everyday discourse about vaccination.

Aware that talk about vaccination, thus, is complex, I formulated the three research questions (posed in chapter 1) to guide my in-depth reading of this particular public health policy debate: (1) How do rhetorics of health and medicine frame vaccination as a public problem? (2) What does public debate about mandatory vaccinations reveal about public perceptions of medicine? (3) What do competing rhetorics of vaccination suggest about the nature of medical professionalism in the United States? These research questions were generated, in part, to respond to gaps in the current literature (see chapter 1), but they were also generated to advance theory about medical publics to describe and then shape the current medical moment (see chapter 2). Answering this particular sequence of research questions, potentially, could tell a compelling story about intersections of medical policy and medical practice, health-care and health professionalism, and biotechnology and biocitizenship. Similarly, it might reveal (with the intention of ameliorating) conditions under which the predominant health paradox continues to thrive, a paradox that often pits public against private health needs and prevention against intervention ideologies during the overall management and delivery of health-care in irreconcilable ways. Although each step of my analytic process emphasized a different relationship between vernacular and official rhetorics of vaccination—in contrast, in conversation, and in overlap—together, these three research question acted as touchstones throughout the overall project to lend continuity and direction to the overall study. After all, as Nikolas Rose noted, “When all is in flux, it seems to me that we need to emphasize continuities as much as change, and to attempt a more modest cartography of our present” (2007, 5). These three research questions were crafted with attention to the collective need to describe, interpret,
and ideally influence the story of medicine’s present. Although chapters 7 through 7 each take a different critical angle on the same data set, when woven together, in chapter 8, my sequenced research questions aid in telling a cohesive (albeit incomplete) narrative about contemporary U.S. medicine and its publics.

Ultimately, the result of my three-tier analytic process identified three key defining features of the current medical moment: proxy debate, bioanxiety, and medical ethos. Together, these three features account for the terms of contemporary public health argument, the emotional state in which public health decision are made, and key actors involved with shaping relationships between medicine and its publics. “Configuring new relations between citizens and science, in which the public is not only talked to but listened to,” scholars Emma Engdahl and Rolf Lidskog argued, “is the main path toward achieving public trust in science [where] trust is a modality of action that is relational, emotional, asymmetrical and anticipatory” (2012, 11). In the next section, I introduce each feature briefly to provide an overview of how chapters 5 through 7 unfold in line with the viewpoint expressed by Engdahl and Lidskog.

**Framework Overview**

A preliminary review of data, loosely guided by the three larger research questions posed, revealed three dominant rhetorical features across public vaccination discourse. I labeled these themes “proxy debate,” “bioanxiety,” and “medical ethos,” and I use each category to organize the findings over the next three chapters. In the closing section of each chapter, I provide a brief overview of each feature to better frame the presentation of data that follows. Together, these features provide a vocabulary and framework for describing persuasive particulars of the current (bio)medical moment and, thus, they tell a story about modern medicine that is nuanced and attuned to ways in which public perception matters to everyday health-care.
In brief, I use the term *proxy debate* to describe a public argument strategy whereby the language of one issue or topic stands in, for, and distracts from other larger, nebulous problems characterizing modern medicine. In the case of vaccination, specifically, this means that public scapegoating of one particular biotechnology is likely done because of what it symbolizes more than what it materializes. I use the term *bioanxiety* to refer to excessive worry that is generated by the large, nebulous problems that are affiliated with biotechnological advancement, specifically, attributable, in part, to public tendencies to talk around issues via public argument by proxy. Here, being bombarded by continuous heated debate about vaccination as a prevention option leaves members of various audiences with more questions than answers, with more concern than catharsis, and, thus, indelibly more anxious about future health decisions. Lastly, *medical ethos* is a term that I introduce to highlight rhetorical attributes of modern-day medical professionalism, a rhetorical skillset that includes a performative dimension that, currently, is underaddressed in theory and practice. Medical ethos, or the perceived professional status of health-care workers that is derived from observable behaviors, may serve as *either a cause or a cure* for collective experiences of bioanxiety, and, therefore, it warrants further investigation that requires future study. For the case of vaccinations, in particular, how health-care workers behave around vaccinations (e.g., what they say, what they adopt, and what they advocate) may sway public opinion about vaccinations more than is currently appreciated.

Conveniently, each rhetorical feature described above correlates with one of the three research questions posed in chapter 1. Furthermore, each theoretical construct uniquely illuminates a distinct relationship between official and vernacular rhetorics of mandatory influenza vaccination. In particular, the first construct, proxy debate, offers an answer to my first research question about vaccination as a public issue, and the construct emerged by considering
vernacular and official rhetorics of vaccination as opposing viewpoints. The second construct, bioanxiety, provides an answer to my research question addressing the status of medicine and its publics, and it illustrates, most clearly, what and how the vernacular of health and medicine can add to larger official policy process. In essence, investigation into everyday bioanxieties suggests that although official institutions of medicine promote only one way to quell concern (vaccination), vernacular contributors come equipped with a range of options to protect themselves and their communities against disease. In an era that is characterized by political gridlocks and standoffs, a range of options may be of interest. The third construct, medical ethos, suggests ways that vernacular and official rhetorics of vaccination see eye-to-eye, so to say, and, in doing so, it provides direction for what medical professionalism can and should look like moving forward; in this manner, a theory of medical ethos helps to answer the third research question. I, therefore, use these three concepts as an organizational schema for more presentation of data to follow. In the next three chapters (chapters 5–7), I dive deeply into each concept by drawing from evidence and examples from the official and vernacular corpuses of vaccination.

Conclusion

Via rhetorical analysis of primary texts, in the next three chapters, I analyze the language of vaccination mandates and institutional deliberation (official rhetoric) that are used to describe, explain, and promote vaccination within the medical community. Additionally, I investigate resistance to such official rhetorics of health and medicine through consideration of public backlash (vernacular rhetoric). Each type of rhetoric, introduced and unpacked across the following chapters, address similar questions concerning private rights and public service, and public health risks and personal responsibilities, but each interpretive angle highlights a unique attribute of the larger health-care context that, then, collectively, represent the current medical
moment. Admittedly, these three rhetorical features—proxy debate, bioanxiety, and medical ethos—do not provide an exhaustive list of possible analytic perspectives used to evaluate contemporary medicine; however, they provide a good start in terms of prompting a much-needed conversation about how public health is conducted and perceived in a biotechnological era. Although incomplete, the analytic framework introduced in and through this study for the first time provides a rhetorically complex lens through which to better consider more closely the deliberative, economic, and professional norms of modern medicine.

1See chapter 3 for an in-depth discussion of the process that I used to select this public health policy issue and its representative texts.
CHAPTER V
POLICY COMMUNICATION AND PROXY DEBATE

This chapter presents findings from my comparative analysis of official and vernacular rhetorics of mandatory influenza vaccinations. I begin by outlining findings from the official corpus to establish a baseline for how mandatory vaccination usually gets talked about and written into official health policy and practice. I conclude that official institutions of medicine largely argue via an enthymematic, deductive-reasoning method, whereby focus is maintained on particulars of the influenza problem and its single proposed solution. In the second half of the chapter, I present findings from my textual analysis of vernacular discourse surrounding the issue. When compared to the official mode of reasoning, the vernacular corpus exhibits inductive argument features that move from specifics of influenza vaccination to consideration of larger principles informing the health-care decision-making process in the modern United States. This debate is occurring in the midst of massive concerns about the Affordable Care Act and concerns that the U.S. government is inappropriately dictating health-care. Whether founded or not, when everyday citizens talk about vaccination, conversation, thus, is infused with concerns, opinions, and disagreements about the status of the U.S. bioeconomy (Rose 2007), and, thus, argues via proxy. Attention to these themes recasts ongoing deliberation focused on mandatory influenza vaccinations for health-care workers as a proxy debate, a public form of argument wherein individuals agree to come to the negotiating table to discuss the specifics of a particular health issue only to then use that issue to launch larger discussions about systemic problems for which that issue offers illustration. A theory of proxy debate is developed further in chapter 8; for now,
a comparative analysis demonstrates differences in reasoning styles used by medicine’s everyday citizens as compared to its authoritative officials. In everyday talk about vaccination, health-care workers seem to leverage the symbolicity of vaccination to express concerns about and reflect experiences about what it is like to live and work in the “marketplace” of contemporary health-care.

**Enthymematic Argument and Mandatory Vaccination Policy**

Official rhetorics of vaccination designed to increase vaccination rates among health-care workers, by and large, are part of a straightforward persuasive campaign aimed to incite increased rates of vaccination. In its “straightforwardness,” much official talk about vaccination follows a sequenced, predictable pattern that substantiates influenza vaccination as a necessary public health-security measure. The formula tends to contain these four elements: (a) policy communication *characterizes* influenza as an easily transmittable threat, (n) policy communication *translates* the toll of inaction to death counts and financial burdens, (c) policy communication *equates* health-care worker immunization practices into a patient safety standard, and (d) policy communication *criticizes* the low vaccination coverage rates among health-care workers. Below, I include three statements that illustrate use of this persuasive formula to better frame my argument:

Health-care–associated influenza outbreaks are a *common and serious* public health problem that contributes significantly to *patient morbidity and mortality* and creates a *financial burden* on health-care systems. Annual immunization of health-care personnel (HCP) is a *matter of patient safety* and necessary to significantly reduce health-care–associated influenza infections. Immunization rates of 80% or higher are essential for providing the “herd immunity” needed to have a significant impact on transmission of
influenza by HCP in medical settings, but overall immunization rates for HCP remain near 40%. (American Academy of Pediatrics 2010, italics added)

Transmission of influenza to patients by health-care personnel (HCP) is well documented. HCP may acquire influenza both in the health-care setting and in the community, and they can easily transmit the virus to patients in their care. Yet, the Centers for Disease Control and Prevention (CDC) estimates that only about 40% of HCP in the United States are vaccinated against influenza annually. With up to 20% of unvaccinated individuals developing influenza each year, a large proportion of unvaccinated HCP could succumb to influenza, thereby raising the risk of transmitting the virus to susceptible patients. Health-care organization leaders and staff need to mount a concerted effort to improve influenza immunization rates among HCP. Increasing influenza vaccination rates among HCP would reduce the burden of the disease and its associated health-care costs. (Joint Commission on Accreditation of Healthcare Organizations 2009; italics added)

A continued, concerted effort by health-care institutions, employers, insurers and allied professional organizations is essential to improve influenza vaccination rates among health-care personnel (HCP). Since the National Foundation for Infectious Diseases (NFID) published its first “Call to Action” on this topic in 2004, many health-care organizations have issued recommendations that HCP receive annual influenza vaccine. Despite these recommendations, influenza immunization rates among HCP have not greatly improved. Rates have fluctuated in recent years, but even at their highest (42 percent in 2004 and 2006), they remain unacceptably low. Health-care personnel can spread the highly contagious influenza virus to patients in their care. In fact, unvaccinated
workers can be a *key cause of outbreaks* in health-care settings. This is particularly troubling for the many *patients at high risk* for influenza-related *complications, hospitalization and death*. (National Foundation for Infectious Disease 2009; italics added)

These three organizations—the American Academy of Pediatrics (AAP), the Joint Commission on Accreditation of Healthcare Organizations (“the Joint Commission”), and the National Foundation for Infectious Disease (NFID)—are among a small group of leaders at the forefront of health policy design and implementation. In the first case, the AAP exemplified the formula in the way that I introduced: it *characterized* influenza as a “common” and “serious” threat; it then *translated* influenza occurrence into its consequences by stating that the virus “contributes significantly to patient morbidity and mortality and creates a financial burden on health-care systems”; it then *equated* health-care worker immunizations with a patient safety measure by stating directly that “annual immunization of health-care personnel (HCP) is a matter of patient safety”; and, finally, policy communication *criticized* the health-care workforce for low vaccination rates in juxtaposing the necessary “80% or higher” vaccination rate that is needed to ensure “herd immunity” against the consistently low 40% figure produced by health-care communities. In doing so, the AAP conveyed urgency and assigned culpability in matters of national influenza threat.

Likewise, the Joint Commission made use of a similar formula, but did so in a slightly different order. In the second case, the Joint Commission is a national organization that published a comprehensive monograph on the issue that continues to be cited across policy deliberation. This statement *characterized* influenza as “easily” transmittable and highlighted that “transmission of influenza to patients by health-care personnel (HCP) is well documented.”
Following explanation of the need for protection, the Joint Commission then critiqued the low 40% figure of vaccination coverage among health-care workers by emphasizing the likelihood that unvaccinated employees will “succumb to influenza” and infect patients. In this configuration, protecting “susceptible patients” is equated to the need to vaccinate where the toll of nonvaccination gets translated into “the burden of the disease and its associated health-care costs.” Although slightly reordered, here, too, each element of the enthymematic equation is accounted for, thus providing a full argument about the nature of threat and the necessary solution.

Uniquely, in the final case, the National Foundation for Infectious Disease (NFID) first contextualized the issue of health-care worker vaccinations by mentioning the issue’s longevity and the Foundation’s allied support before launching into the persuasive formula that it shares with other official institutions. Specifically, the NFID noted that there is “a continued, concerted effort” being undertaken by “many health-care organizations” that is directed at increasing vaccination rates among health-care workers. This discursive strategy, known as the “bandwagon appeal,” suggests that the NFID is supported by and speaks on behalf of the majority. After establishing this backdrop, the NFID made use of the identifiable characterize–translate–equate–critique formula. Most directly, NFID characterized influenza as “highly contagious” and criticized the health-care workforce for “unacceptably low” vaccination rates. More indirectly, the NFID mentioned that “unvaccinated workers can be a key cause of outbreaks in health-care settings” and claimed that this reality “is particularly troubling for the many patients at high risk for influenza-related complications, hospitalization and death.” These latter sentiments foreground patient health as the ultimate goal of raising health-care worker vaccination rates, with costly “complications, hospitalization, and death” serving as alternatives.
Although subtle in terms of translation and equation strategies, landing on complications, hospitalization, and death as undesirable outcomes implies that patients’ experience is at stake. Furthermore, although “complications” and “hospitalization” may be undesirable from patients’ perspective, from a system-level perspective, these two outcomes, more often than not, are used to communicate concern about cost of care in official policy language.

In general, then, policy communication aims to describe flu as serious, emphasize the cost of inaction, align vaccination with dominant ideologies, and condemn noncompliance across health-care communities. However, what is beneath the surface? How has this particular formula successfully mobilized an industry to take action and mandate despite backlash within the health-care community? Aristotle introduced the term “enthymeme” in his Rhetoric to describe an argument strategy, a linguistic template or pattern, whereby certain assumptions go unspoken because they are thought to be ubiquitous. Specifically, at the beginning of the Topics, Aristotle explained that enthymeme is a “kind of syllogism” or a “reasoning,” in which “certain things having been laid down, other things necessarily derive from them” (1.1 [100a]). Via their assumed ubiquity, unspoken assumptions gain persuasive force as, essentially, something that goes without saying.

Expanding and troubling this basic notion of enthymeme, in his article The Body of Persuasion: A Theory of the Enthymeme, rhetorician Jeffrey Walker traced another meaning for enthymeme that is complementary to but distinct from the predominant Aristotelian definition that gets commonly cited. Specifically, as Walker concluded:

We have . . . a double view of enthymemes: “enthymeme” as a complex structure of intuitive inference and affect that constitutes the substance of an argument; and “enthymeme” as a structural/stylistic turn that caps an exetasis, gives the
inferential/affective substance a particular realization with a particular salience for a particular discursive moment, and by doing so constructs or shapes its audience’s perception of just what “the argument” is. (1994, 63)

In the context of medicine, and with regard to the issue of mandatory vaccination, in particular, “enthymemizing” (Walker 1994, 61) likely requires both arguing in a manner that affirms insider statuses and arguing in a manner that effectively (re)shapes an audience’s perception about medicine in motion.

Below, I unpack the assumptions that each stage of the enthymemematic formula likely advances to consider how and why the institution of medicine feels confident enough to recommend, and, in some cases, mandate, health-care worker vaccination as part of a larger health-care revision plan. In doing so, I delineate a formula that is used by official medical rhetorics to shape and sustain medical authority amidst controversy. “The argument” that emerges makes use of the kairotic moment that influenza vaccination makes available to persuade its health-care workers that professionalism, in a biotechnological era, requires the adoption of particular medical interventions that are linked to the health of the public, more generally. In chapter 7, I revisit this appeal to authority to introduce the concept of “medical ethos,” the perceived professional status of a health-care worker that is derived from the adoption of certain, prescribed behaviors. For now, I speculate about how each unit of argument—characterization, translation, equation, and criticism—acts as a “device of emphasis” (Fahnestock 2011, 376) that is intended to persuade members of the health-care community to “perform medicine” in prescribed ways.

**Characterizing**
Across the official corpus, the threat of disease from the influenza virus is foregrounded and accentuated. Although colloquial discourse may frame the “flu” as “an annoyance” or as “a really bad cold,” official institutions of medicine make a concerted effort to challenge assumptions and colloquialisms about influenza as benign and survivable. By directly denouncing uneducated talk in their framing of influenza policy, officials insinuate that the medical audience shall not be privy to the same types of illogical, linguistic slippages as the “lay” publics that they serve. Sometimes, this insinuation is more direct, such as in the case of an “opinion” statement issued by the American Medical Association, which directly pronounced:

In the context of a highly transmissible disease that poses significant medical risk for vulnerable patients or colleagues, or threatens the availability of the health-care workforce, particularly a disease that has potential to become epidemic or pandemic, and for which there is an available, safe, and effective vaccine, physicians have an obligation to: (a) Accept immunization absent a recognized medical, religious, or philosophic reason to not be immunized. (b) Accept a decision of the medical staff leadership or health-care institution, or other appropriate authority to adjust practice activities if not immunized (e.g., wear masks or refrain from direct patient care). It may be appropriate in some circumstances to inform patients about immunization status. (2011, 1; italics added)

As this excerpt illustrates, through characterization, disease threat is defined as risky, easily transmittable, and, essentially, as “the quiet before the storm.” In this manner, policy language characterizes its enemy as somewhat surreptitious and savvy, if not inevitable, in matters of national panic and global pandemic. When faced with such realties, the medical community is granted authority over necessary precautions. In terms of underlying assumptions, this characterization of both disease and deterrent seems informed by an age-old arrangement that
pits disease against medicine, natural disaster against human innovation, and everyday chaos against authoritative control. Indeed, humanity’s “war on disease” continues and, the official rhetorics of health and medicine suggest, medical actors should be leading the fight.

By and large, this description of influenza falls in line with a trend to medicalize common and natural experiences. Medicalization refers to a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illness and disorders. According to Peter Conrad, the sociologist credited with issuing in the term into contemporary conversation, “It is important to remember that medicalization describes a process” (2008, 5), whereby a problem gets defined in medical terms, described using medical language, understood through the adoption of a medical framework, and then “treated” with medical intervention. Although “the flu” is certainly a medical condition, when its medicalized nature is amped up in public health talk (such as when disease is talked about as highly transmissible and as a significant medical risk), the consequence is that alternative methods used to prevent or treat the flu—or its relative, “the common cold”—frequently get looked down upon or disqualified altogether. In the case of the flu, in particular, efforts to talk about the condition in medicalized ways reaffirm a commitment to the Western medical profession by engaging in specialized talk among peers. Medicalizing the condition situates “the flu” as something other than an everyday experience that can be handled at home without medical intervention and expertise. Indeed, patients are described as “vulnerable,” whereas medicine’s officials are designated as “appropriate authorities.” Here, efforts to redefine flu likely encourage ownership over the condition by appealing to specialized knowledge that separates an “us” (medicine’s leaders) from a “them” (members of a lay public) in matters of disease management. In doing so, audiences of policy communication are encouraged to designate influenza, and the decision making and
treatment that it requires, to the realm of medicine, a realm that adequately understands the “significance” of the threats and consequences of the condition, which, as understood in this framing, necessarily requires medical intervention and expertise, a solution in which health-care workers are assumed to be both essential and dependable.

Policy communication makes hardly any mention of risks that vaccination may introduce into the health-care community. Although uncommon, there are documented risks associated with getting vaccinated. If mentioned in policy communication at all, risks, such as these, are often explained away as “rare” or of no concern to the “majority.” For example, in a *Morbidity and Mortality Weekly Report* that communicated recommendations of the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP) regarding influenza vaccinations for health-care workers, the CDC noted:

> Hypersensitivity reactions to any vaccine component can occur. Although exposure to vaccines containing thimerosal can lead to induction of hypersensitivity, the majority of patients do not have reactions to thimerosal when it is administered as a component of vaccines, even when patch or intradermal tests for thimerosal allergy indicate hypersensitivity. When reported, hypersensitivity to thimerosal typically has consisted of local, delayed hypersensitivity reactions. (2006, 10)

Emphasis on “local, delayed” reactions tempers the impact of listing documented reactions that include hives, swelling of the lips or tongue, acute respiratory distress, or collapse. In this manner, the official rhetoric of vaccination promotes a Pascalian wager: getting vaccinated allows individuals and institutions to bank on the lesser of two evils where compliance is necessary. Because medicine and the actors therein are experts at providing health-care services,
they gamble with their well-being to ensure the well-being of others because it is a sure bet and alternative actions (e.g., declining vaccination) are not. The only manner in which risk associated with vaccination gets consistently addressed in policy language is through inadvertent mention of “exemptions due to contraindication.” Here, psychological aversion to vaccination and/or experiences of other side effects that, currently, are “unrecognized” by the medical community are not evaluated as valid or “good” excuses for health-care workers to decline vaccination. Thus, linguistic strategies that medicalize flu also inadvertently undermine and dismiss “excuses” for declining vaccination if those reasons fall outside of the purview of “legitimate medical knowledge.” In line with tendencies to medicalize the overall condition of flu, such policy language medicalizes adverse effects to further promote vaccination; Only individuals for whom vaccination has been “contraindicated” due to a “preexisting” “diagnosed” health conditions may be readily excused from participating in health-care vaccination programs. This stipulation—at first appearing considerate toward alternative needs—contains exceptions to the rule within the logic of Western medicine; that is, the institution controlling the rules of the game controls the rules for not playing. Even when exemptions are granted for “legitimate” reasons, as shall be shown, the exemption welcomes other mandatory interventions for nonvaccinators due to the characterization of the overall condition as, inevitably, being serious.

Translating

Although Monto noted that “the clinical and economic burden of seasonal influenza is frequently underestimated, and is often overshadowed by the ever-present threat of an influenza pandemic” (2010, D34), mention of cost in relation to disease management appears consistently across the official register. Specifically, in terms of the threat of influenza outbreak, most policy language tries to quantify consequences of disease and does so in fairly unemotional ways. This
technique confirms medicalization theory in that it depersonalizes individuals’ experiences of health and sickness by adopting medical vocabulary and models. However, the depersonalization technique, commonly offered via medicalized language, gains an interesting dimension when applied to the issue of vaccination, in particular. Whereas the individual story or the individuation of flu is commonly talked about in terms of motivations to get vaccinated (e.g., to “protect yourself”), much policy language encourages health-care workers to measure the effects of disease at the system level. Sometimes, this measure involves the individual human experience, but even then, health-care workers are encouraged to consider “patient morbidity and mortality” instead of individual patients’ experience. Across the official register, the cost of disease is communicated in both dollars and deaths at the population level, which distances health-care workers from individual patients’ experiences.

For example, in a joint call to action, the Association for Professionals in Infection Control and Epidemiology (APIC), the Society for Healthcare Epidemiology of America (SHEA), the Infectious Diseases Society of America (IDSA), the Association of State and Territorial Health Officials (ASTHO), the Council of State and Territorial Epidemiologists (CSTE), Pediatric Infectious Diseases Society (PIDS), and the Centers for Disease Control and Prevention (CDC) claimed that HAIs “are an increasingly recognized problem. The number of people who are sickened or die and the financial impact from HAIs are unacceptably high” (1). More precisely, and citing a variety of sources in their 2006 recommendation report published in Morbidity and Mortality Weekly, the Healthcare Infection Control Practices Advisory Committee (HICPAC) and the Advisory Committee on Immunization Practices (ACIP) explained that
vaccination of [health-care personnel] reduces transmission of influenza in health-care settings, staff illness and absenteeism, and influenza-related morbidity and mortality among persons at increased risk for severe influenza illness. (3)

In both examples, “people” and “persons” are referenced, as opposed to individual patients. Similarly, the use of the combination of terms “morbidity and mortality” (which translates, roughly and colloquially, into “sickness and death”) emphasizes worst-case scenarios as they are measured at the population level. An individual patient cannot be both sick and dead, and, therefore, “patient morbidity and mortality” describes a phenomenon that shifts the focus from individuals to specific communities/publics; manipulating the rhetoric of epidemiology to shift the focus from individuals to communities—that is, from patients to populations—to incite medical attention and response has been a persuasive tactic tracked by other studies as well (see, e.g., Reeves 1990). Subtly, then, health-care workers are encouraged to think beyond individual patient cases toward a system-level measure. Moreover, after translating individual cases of flu into larger population rates, the discourse commonly mentioned the financial burden of the flu:

Immunizing health workers against influenza has an impact on the workers themselves and their coworkers and families, on patients in the healthcare facilities and community-based settings where they work, on overall communitywide immunity, and on the health system’s capacity to provide safe care and its readiness to meet both routine and emergent service demands. … Improving influenza vaccination rates in health workers provides benefits to workers, patients, and health service agencies. Preventing both community and workplace influenza transmission to health workers is essential both for maintaining a safe work environment in healthcare settings and for ensuring staffing capacity. ILI-related absenteeism can cause or exacerbate significant staffing shortages,
which can be especially problematic during influenza’s peak periods. *Staff immunization is highly cost-effective and can be cost saving.* (American Public Health Association, 2010; italics added)

Although the work of health-care is patient-centered, as shown, there is a concerted effort to quantify and depersonalize the toll of influenza outbreak. Individual health-care employees are encouraged to think about how their individual absenteeism burdens a system. Similarly, employees are encouraged to think about influenza treatment not in terms of an emotional burden, or as a burden of bodies, but, instead, as a drain of the financial resources that are needed to run a hospital. Although budgetary needs, undoubtedly, are a part of each individual health-care worker’s job—to remain mindful of the way that person fit into the larger system—this move appears emotionally unattached and business-oriented, two qualities of modern health-care that are denounced and buried in much contemporary ideologies that purport patient safety as the number one priority. In much current hospital talk, patient-centered care requires that medical professionals integrate patients’ wants and needs into every step of the medical process. That dominant discourse, however, is notably absent of the mention of finances. For the case of mandatory influenza vaccinations for health-care workers, where the intended audience of official rhetorics are members of the health-care community, finances are foregrounded in considerations of why action is required.

Equating

As was briefly noted above, patient-centered care is a prevailing framework for understanding the work of contemporary health-care (let alone individual health-care workers and their daily duties). *Patient-centered care* (PCC) denotes a method of health-care delivery that prioritizes patients’ needs and wants throughout the medical decision-making process via
inclusive communication. As Venetis, Robinson, Turkiewicz, and Allen (2009) explained, “Patient-centered communication attends to: (1) patients’ affective states (e.g., fear, vulnerability, hopelessness, uncertainty); (2) patients’ (vs. physicians’) values, needs, and preferences, including psychosocial (vs. biomedical) content; and (3) patient empowerment in terms of having control over topical directions, decision making, etc.” (380). Various iterations of this agenda now exist in health-care rhetoric. Although other nomenclatures are sometimes used, such as “participatory care” (Broadfoot and Candrian 2009), “whole person care” (Hutchinson, Hutchinson, and Arnaert 2009), and “relationship centered care” (Beach and Inui 2006), all of those terms communicate a similar, revised U.S. health-care ethic that recasts medical professionals as frontline enthusiasts of patient autonomy for medical decision making; PCC has emerged as the reigning orthodoxy for modern medical practice and training within the United States.

Studies have now confirmed that patient-centeredness is related to patients’ overall satisfaction (e.g., see, Brown et al. 1999), and measures have been put in place at both the national and local levels to communicate these standards. In vaccination policy language, specifically, decisions to vaccinate are commonly equated to “matters of patient safety.” Moreover, mandates or requirements to vaccinate often get defined as a “professional obligations” or a “duty of care.” In line with larger dominant PCC ideologies and communication standards, expectations of health-care workers vaccination are framed in terms of the good of the people who they serve. For example, as noted in the previous chapter, Gregory Poland, Pritish Tosh, and Robert Jacobsen declared that “health-care workers and health-care systems have an ethical and moral duty to protect vulnerable patients from transmissible diseases,” more explicitly:
Beyond government interventions, the medical community has an ethical obligation to act with the safety of its patients as its foremost interest. It is now known that health-care workers are vectors for the spread of influenza to vulnerable patients whom the disease would most jeopardize. It is also known that influenza vaccination of health-care workers protects patients from influenza infection and decreased mortality (2005, 2253; italics added).

Similarly, in an official “Opinion Statement,” titled “Routine Immunization of Physicians,” the American Medical Association stated:

As professionals committed to promoting the welfare of individual patients and the health of the public and to safeguarding their own and their colleagues’ well-being, physicians have an ethical responsibility to take appropriate measures to prevent the spread of infectious disease in health-care settings. Conscientious participation in routine infection control practices, such as hand washing and respiratory precautions is a basic expectation of the profession. In some situations, however, routine infection control is not sufficient to protect the interests of patients, the public, and fellow health-care workers. (2014, 1; italics added)

Each of these exemplar statements culled from the larger official corpus presumes that health-care workers take action in the service of individual patients. In fact, frequent across policy discourse are claims to “serving” patients and to the delivery of health-care “services,” terminology that reifies an orientation to the field as service oriented, and, in this way, an altogether altruistic endeavor. Many long-lasting traditions in medicine continue to reify assumptions about the connection between medical authority and best practice. The Hippocratic Oath, for example, is commonly referenced during ceremonial turning points in a medical career,
where articulating the “do no harm” sentiment aloud among peers demonstrates the Oath’s rhetorical work as both ritualistic and professional (Keränen 2001). As Keränen and Malkowski explained, “Viewed from the lens of epideictic, the Hippocratic Oath can thus be seen as a cultural touchstone that reminds health professionals and nonexperts about the far-reaching values of the profession, without providing specific precepts for action” (2012, 159). Although traditions, such as the Hippocratic Oath, pay homage to medicine’s humanistic commitments—age-old ethical principles of beneficence (doing good) and nonmaleficence (doing no harm)—they also actively assert physician authority over health and illness for the sake of their patients. Through resonance, appeals to service and serving, thus, draw from internally persuasive logics that professionals hold in common. In relation to vaccination, in particular, emphasis on obligation and duty as means to serve communities in need places a special kind of emotional burden on health-care workers in that it stirs dissonance in members who do not wish to get vaccinated but who, wholeheartedly, orient themselves toward the profession as a deliverer of health-care.

Centralizing talk about job expectations, professionalization of the field, and the need to manage public perceptions of quality health-care work are communicated via vaccination policy using patient-first language and framing that resonate with the currently predominant contemporary health-care model that delineates health-care workers as being in service to patients. In and of itself, prioritizing patients seems a noble quest. However, as my analysis makes clear, this premise contradicts the last premise. Namely, health-care workers are encouraged to think in terms of individual patients’ needs and safety, and yet, in the previous move, they are encouraged to translate cost via strategies of depersonalization. Contradiction within a logical argument raises questions about intention and audience. Although intended to
engage a shared ideal professional image to defend vaccination as a “duty of care,” the actions of health-care workers suggest that this persuasive appeal does not carry as much traction as messages that individuate the decision to vaccinate. In terms of revealing underlying assumptions, this faulty mode of persuasion may indicate more about the policy’s intended audience than it does motivations for action. In particular, appeals targeting medicine’s professional image are more likely to motivate hospital administrators and others directly in charge of public relations management than those already embedded in the system. Indeed, along these lines, there seems a disconnect between the dominant message being deployed across the official register—“get vaccinated to protect patients”—and what actually motivates health-care workers to consider vaccines: A number of studies now demonstrate that health-care workers decide to get vaccinated, first and foremost, “to protect themselves or their families,” not necessarily to protect the patients they serve (see, e.g., Norton, Scheifele, Bettinger, and West 2008).

**Criticizing**

Born from patient-first policy language, the explicit goal of policy formulation is to increase compliance among health-care workers to raise vaccination rates. More often than not, failure to demonstrate praiseworthy health-care worker vaccination rates across hospital systems gets described as “unacceptable,” which was previously illustrated in the NFID opening statement. Although in some places an 80% vaccination rate is quoted as essential to establish herd immunity (AAP), or the 90% *Healthy People 2020* mark is cited as an “acceptable” national health measure, there exist discrepancies within the health-care community about what constitutes an acceptable standard for vaccination coverage. After all, *Healthy People 2010* set the bar at 80% coverage and used the same arguments that later were recycled in the *Healthy
People 2020 policy documentation 10 years later to promote a higher goal. In the absence of an agreed-upon, evidence-based, “acceptable” standard for levels of health-care worker coverage, this descriptor likely lands uncomfortably across members of the health-care community, and it inspires action even among hospital systems whose levels of health-care worker vaccinations remain high. When to deem a hospital’s standard as “unacceptable” remains unclear, but policy documents suggest that anything below 90% coverage constitutes a failure. In this regard, rates are not described as “low,” “below expectations,” or even “too low”; instead, time and time again, across official rhetorics of mandatory vaccination, both a 40% rate of health-care workers vaccination coverage and an 80% coverage rate may get described as “unacceptable” if compared the Healthy People 2020 standard. In some sense, this label and subsequent framing of what is confers a sense of disappointment that qualifies immediate action at the institutional level. If something is “lagging” or “disappointing,” it gets addressed; if something is “unacceptable,” it must change. Moreover, because the measure against which performance gets evaluated was determined by policy makers and communicated via the official Healthy People 2020 report, it follows that officials in medicine should author and direct efforts to ensure that the situation changes.

As further argument for the need for institutional step-in, critical descriptions of low health-care workers vaccination rates are also commonly noted alongside mention that these “unacceptable” standards have occurred for quite some time, despite the consistent and admirable advice offered by policy officials. With regard to addressing the need to increase vaccination rates, nearly every policy document reviewed highlights the fact that health-care workers have failed to take initiative, and that this trend of inaction has occurred over a long
period of time. For example, the Society for Healthcare Epidemiology of America (SHEA) noted:

Influenza vaccination of HCP is an important and key component of infection prevention programs designed to reduce healthcare-associated influenza. As with any core patient safety practice, low rates of compliance that place patients and HCP at risk are unacceptable. Because HCP influenza vaccination rates in the setting of voluntary programs have remained low over the nearly 3 decades that HCP influenza vaccination has been recommended, SHEA endorses policies that require influenza vaccination as a condition of employment as part of a comprehensive influenza infection control program. (2010, 993; italics added)

In addition to condemning consistently low vaccination rates within the health-care community, this statement also described patience on the part of policy officials: a generous “3 decade”-long bout of patience has been afforded to health-care workers over which time policy officials allowed for health-care workers to rectify the problem themselves. Emphasis on the length of time that has been granted to health-care workers to fix the problem cast policy officials as something akin to patient parental figures who have given their dependents ample time to act in their best interest but who must now step in to protect those inactive dependents from themselves. Along these lines, in an editorial commentary offered in response to a pivotal article addressing the issue and promoting the need for institutions to mandate vaccination for the good of health-care workers and patients alike, Marie Griffin, MD, MPH, concluded:

Given the dire consequences that outbreaks of influenza can have in institutional settings, the known safety and efficacy of current influenza vaccines, and the strong evidence that vaccinating a segment of the population can protect unvaccinated persons who are in
contact with [vaccines], the meta-analysis by Ahmed et al. offers additional reassurance that the threshold for action has been reached or surpassed. Vaccination of healthcare workers to protect vulnerable patients and residents of long-term care facilities should be viewed as an evidence-based recommendation. (2014, 59; italics added)

The use of the term “threshold” here is interesting for the ways that it, much like the use of “unacceptable” to describe vaccination levels, is fairly nondescript and yet loaded with meaningful, action-oriented connotation. Via this wording, readers understand that officials have awaited a tipping point before necessarily stepping in to intervene. It would seem, then, that policy messages promote the patient nature of policy officials to justify intervention into employees’ health practices; after all, according to this framing, intervening into the lives of nonvaccinators is “for their own good.” Additionally, this framing seems to validate punitive responses to noncompliers; after all, health-care workers have been given ample opportunity to take action and “do what is right,” and yet some still insist on putting others at risk.

In terms of addressing noncompliers, most policy communication calls for disciplining health-care workers who refuse vaccination. The term “discipline,” in some cases, may be too strong, but I employ it here to reference Michel Foucault’s (1977) use of the term as a mechanism that is deployed to govern and control actions and reactions of a population. In this regard, the case of mandatory influenza vaccination for health-care workers could be talked about in terms of Foucault’s two mechanisms of biopower: disciplining the body via individual vaccinations and control of the population via official standards for herd immunity. The workplace vaccination policies use the rhetoric of individual health but do so to, ultimately, keep workers healthy. In this regard, both “mechanisms of control” produce bodies that are fit for the capitalist machine, and, in the process, create particular subjectivities: the subject who must
vaccinate (or resist) or the subject who becomes persuaded to vaccinate because that person becomes convinced it is the responsible thing to do.

In terms of advocating for disciplinary measures, health policy documents vary in extremes with regard to which actions get promoted as necessary to ensure the safety of the health-care workforce. Ranging anywhere from firing nonvaccinators, to prioritizing their quarantine in times of pandemic, to requiring alternative mandatory precautionary measures that they must exercise on a daily basis throughout flu season (e.g. wearing masks), to the signing and submission of official “declination forms,” nearly each of the policy documents promoted a swift and consistent response to noncompliers that signals to them and to the larger community that the institution of medicine is serious about raising vaccination rates to an “acceptable” level; after all, “the threshold for action has been reached.” The American Association of Pediatrics, for example, specifically claimed that

policies should be developed for the management of exempted [health-care personnel] during influenza season, including efforts to ensure patient staff and safety to identify ill [health-care personnel]. (809)

Along these same lines, the Joint Commission highlighted a number of exemplary programs throughout its monograph; one such exemplary case illustrates “reasonable” responses to nonvaccinators that include the use of formal declination procedures and formal tracking of noncompliers:

St. Louis University Hospital (Tenet) in St. Louis uses employee health clinic and mobile vaccination personnel to make the vaccination available to its 1,750 HCP. Beginning with the 2007 influenza season, the organization required HCP to either accept the vaccination or formally decline in person at the employee health office. Declinations are entered
electronically by the employee health nurse, so this process is centrally managed and controlled. Failure of HCP to accept the vaccination or complete the declination process by a preset deadline results in their payroll being locked down so they cannot “clock in” again until they do so. With this program, called “Not So Inclined to Decline,” the hospital’s vaccination rates have steadily improved from 34% in 2004–2005 to 67% in 2008–2009. (49; italics added)

The promotion of standards similar to the ones noted above evidence a mechanism of biopower in a few ways. First, it seems, privacy issues become a moot point when health-care administrators are encouraged—and, in many explicit ways, sanctioned—to keep tabs on the unvaccinated. For example, flagged as an “exemplary case,” the Joint Commission highlighted the following program in a text-box inlaid in its monograph:

Cleveland Clinic in Cleveland, Ohio, developed an intranet program to capture the organization’s influenza vaccination rates. Beginning with the 2005–2006 influenza season, HCP accessed the intranet and selected either “vaccine received,” “contraindicated,” or “declined.” The database permits real-time monitoring of vaccination rates by location, which facilitates targeted interventions in subgroups of HCP whose rates are lower. For example, when the infection preventionist noticed low participation and vaccination among staff in the solid organ transplant unit, she addressed the concern with senior transplant surgeons; as a result, a “catch-up” vaccination effort was provided in February 2006. (38)

Second, health-care personnel who decline vaccination are necessarily categorized as “unvaccinated,” regardless of reason for declination. In terms of intention and motivation, philosophically opposed nonvaccinators seem fundamentally different than want-to-be-
vaccinated-but-cannot-be health-care workers, and yet their exemption status is often regarded as the same in policy discourse and processes alike. Third, any expressed resistance to vaccination—medically honored or otherwise—welcomes additional, persuasive communication interventions that are intended to sway health-care personnel decisions. In this regard, the Joint Commission offered an example of this new norm. Fourth, regardless of reason, most policy language specifies that when disease outbreak occurs, nonvaccinators remain privy to quarantine. In other words, those who are unvaccinated are the first to forfeit their rights if and when a state of emergency is declared. In a recent research report prepared for members of the U.S. Congress that reviewed state and federal laws at the intersection of mandatory vaccination, medical exemption, and a state of emergency, Legislative Attorney Kathleen S. Swendiman explained:

> Many states also have laws providing for mandatory vaccinations during a public health emergency or outbreak of a communicable disease. Generally, the power to order such actions rests with the governor of the state or with a state health officer . . . exemptions may be provided for medical reasons or where objections are based on religion or conscience . . . however, if a person refuses to be vaccinated, he or she may be quarantined during the public health emergency giving rise to the vaccination order. (2011, 6)

With regard to setting standards of reaction to “non-compliers,” these assumptions about how to talk about and treat unvaccinated health-care workers sets a precedence that necessarily criticizes inaction with regard to the issue. Even when vaccination is contraindicated for specific members of the health-care community, those members’ privacy, reputation, and freedoms can be compromised via the official register’s framing of health threat as immanent and low vaccination rates as “unacceptable.”
In sum, official efforts to medicalize the influenza problem, to call upon medicine for disease management solutions, and to communicate medical excellence as being central to health security, in many ways, are not surprising. The discourse, by and large, adheres to medical health norms that, elsewhere, have been identified as important and essential. Somewhat surprising are the underlying assumptions that can be exposed with close consideration of the motivations behind each stage of the characterize–translate–equate–criticize policy communication argument formula. Namely, this equation (a) works to talk about the process and practice of vaccination as benign and routine when juxtaposed against the threat of an imminent disease; (b) mobilizes vaccination as a symbol of successful health-care in that vaccination gets defined as lifesaving and cost saving at a system level; (c) enfolds influenza vaccinations into larger, dominant, prevailing, and powerful patient-first ideologies; and (d) warrants action to be taken against nonvaccinators because individual decisions are evaluated as “unacceptable” in comparison to community needs. In this manner, official rhetorics of vaccination reflect a certain epistemology and ontology about the relationship between disease and vaccination: disease is bad, medicine is good; flu is deadly, vaccinations are lifesaving; and medicine is good and life-affirming, and non-vaccination is bad and deadly. Compliance, thus, communicates adherence to a logic and language of medicine that is noble, life-affirming, and good. Via deductive logic that combines implicit assumptions embedded in characterizations, translations, equations, and criticisms of the influenza threat and response, the official institutions of medicine argue effectively in favor of health-care worker vaccination compliance.

Since 2004, when the National Foundation for Infectious Disease published its introductory “Call to Action” that indicted health-care workers as a source for patient infection and promoted mandatory vaccinations, there has been a proliferation in the number of
organizations recommending the intervention and an increase in the overall number of health-care facilities willing to mandate the flu vaccine as a term of employment. At the start of 2012, 20\(^1\) states had enacted laws that required health-care institutions to develop and implement influenza vaccination programs that included data tracking and mandatory reporting (Stewart and Cox 2011). Mandates communicate a fully persuaded employer population who has considered statements, such as these, and has moved definitively toward options proposed. Mandates, thus, serve as evidence to suggest that this particular enthymematic argument structure and its depiction of the flu problem and the flu solution, indeed, have been persuasive.

**The Resistant Health Vernacular as Argument by Proxy**

From a bird’s eye view, vernacular rhetorics of influenza vaccination can be understood as one organized rebuttal that is designed to resist a “one-size fits all” health policy. By “one organized rebuttal,” I mean, even though the corpus is multivoiced and multimediated, prominent themes suggest that a common purpose unites diverse individuals in ways that craft one streamlined resistance message. Specifically, the vernacular narrative argues against formal recommendations and mandates for influenza vaccination of health-care workers because those types of policies fail to recognize and respond to the needs of individual health participants. Some individuals, the vernacular argues, have unique circumstances that increase individuals’ risk for adverse vaccination-induced outcomes that, currently, are underrecognized by medical institutions in charge of policy formulation. For example, individuals who are allergic to eggs (a biological limitation) may vary in their response to vaccinations and may, therefore, refuse to take the risk at all. However, beyond founding a case for individuated health-care decision making in biological considerations alone, more interestingly, across much of the vernacular’s rebuttal, consistent appeals to higher level principles, such as “democratic ideals,” “choice,”
“freedom” and “individual rights,” get prioritized over the containment of any one biological threat or any one particular biological limitation. Below, I include three examples selected from the vernacular corpus of online federal registry responses. Each was included because of the way that it highlights one (or more) of the dominant themes of *choice, freedom,* and *rights* that are evident across its vernacular rhetoric. These themes, I suggest, comprise a principle-focused vernacular argument about the relationship between medicine and its publics.

The first contribution was submitted by a Doctor of Chiropractic, who wrote:

I do not believe the government should have the right to force vaccination of any kind on anyone. *People’s approach to their own health is their choice,* and there are much better options than “shots” with much less risk of any side effects. I am 37 years old and have never had a flu vaccine . . . or the flu. As a health-care professional I have a much better understanding of the benefits and risks of vaccines in general, and a greater appreciation for the human body's inherent ability to protect itself the best way possible. If and when I “get sick” my immune system is doing its job and providing me with much better defenses against future illness than a vaccine. *That's my choice—and only my choice.*

(DC, #34; italics added)

An unidentified health-care affiliate authored a similar statement:

Please do not allow vaccines to become mandatory for health-care providers or for anyone. *Freedom in the realm of health and health-care is important.* Reactions to flu shots can be dangerous as you know and flu shots are often ineffective. A strain of flu of a different kind from the specific shot can still occur. There are still class action suits pending from flu shots administered in the sixties for those who were harmed or crippled by reactions to flu shots. The only guaranteed winners are the pharmaceutical companies.
Please protect the health and health freedom of Americans by stopping the move to make flu "immunizations" mandatory for health-care workers or for anyone. (HCA, #103; italics added)

The third was submitted by a Doctor of Dental Surgery, who claimed:

As a health practitioner, and a citizen of this nation, I abhor the idea for being forced into a process that I believe to be unnecessary medically and morally. I ask that the views of this department and the program be re-evaluated with respect to human and personal rights of all individual. Rights as you are aware, are derived from the idea of ownership, and our bodies are ours, this fact is irrefutable. Therefore no one is to be subjected to forced recommendations by others, or coercive tactics regarding health choices that is felt to be morally, personally, and religiously wrong. Please use your kind judgment in passing policies that affect the masses. (DDS, #64; italics added)

Together, these quotes illustrate how U.S. ideals of choice, freedom and rights map onto discourse patterns that, by now, have been widely recognized and critiqued by scholars tracking communication norms across the contemporary United States.

Communication scholars have argued that contemporary U.S. discourse is now dominated by themes of individualism and personal choice. Ultimately, scholars have concluded, these trends constitute a rhetoric that discourages citizens from contextualizing their personal problems within patriarchal power structures (Cloud 1996, 1998; Peck 1995; Rockler 2003, 2006). Rhetorician Dana Cloud referred to this no ubiquitous style of U.S. discourse as therapeutic rhetoric because of its ability to maintain the illusion that the overall system is fair despite personal troubles. This type of public rhetoric is characterized by themes of choice, freedom, and autonomy. Cloud explained that therapeutic rhetoric is especially compelling and
effective because it does not deny that injustices exist (1998); rather, it reframes widespread
discontent with social injustices as a personal “dis-ease” that individuals are responsible for
“curing,” through the alteration of individual behavior (Rockler, 2003, 100). Hence, for example,
if a patient is faced with a difficult health decision, that patient is encouraged to take charge, do
some research, evaluate her or his options, and then personally make the best decision for her of
his particular situation. The problem with promoting autonomous decision making, especially as
it relates to health, is that it presupposes, as another feminist ethicist noted, “articulate, intelligent
patients who are accustomed to making decisions about the courses of their lives and who
possess the resources necessary to allow them a range of options to choose among” (Sherwin
1998, 24). The conflation of health needs and consumer sensibilities is credited with how
therapeutic rhetorics often go unnoticed and acts persuasively to appease individuals in ways that
maintain the sometimes discriminatory and disempowering status quo.

In a related line of work, Phillippa Spoel, interrogated the now-assumed liberating
qualities of related “informed choice” rhetorics that are prevalent across health-care contexts.
From a rhetorical analysis of midwifery texts and through the channeling of a number of other
feminist scholars, Spoel ultimately concluded that “if not conflict and adversity, a consumerist
discourse of informed choice at the very least risks stressing the rhetorical distance and
disengagement, rather than proximity and engagement, between caregiver and care-receiver”
(2007, 17). Indeed, for health contexts, specifically, mantras of “choice” and “autonomy” lead to
disempowering, isolating arrangements more often than not. Part of the ongoing problem, and an
element for which the theory of therapeutic rhetoric most directly addresses, is that “the ‘healthy
living’ imperative that is currently dominating health policy agendas in many Western countries”
presents a “situation of choice” wherein “problems are framed as matters of choice and where
information and technologies are understood as neutral tools that can be used to aide decision-making in support of ‘correct’ choices” (Henwood, Harris, and Spoel 2011, 2031). Referred to as the “contemporary health empowerment discourse,” themes of choice, freedom, and autonomy now resound loudly across contemporary health-care settings, but they are faulty and misleading for the ways in which they perpetuate an illusion of empowerment more than “an enabling logic of care” (Henwood, Harris, and Spoel 2011, 2027; 2032).

Collectively, in the case of mandatory vaccinations for health-care workers, resistance rhetoric that pivot on themes of choice, freedom, and rights may be understood to comprise the vernacular of resistant health participants, a communication style that is characteristic of weary, market-mindful health participants navigating a biomedicalized United States. Although health-care workers represent a specialized (and, in some cases, expert) segment of the larger general public, the words in the Federal Registry represent talk about health, health-care, and medicine that reflect everyday sentiments about or commentary on life in a biotechnological society. Unlike policy statements that have been refined, edited, and represent a number of authorial voices, independent vernacular contributions speak to issues and concerns that, otherwise, would be deemed unprofessional if health-care workers were to voice such opinions in opposition to the institutions that they represent. In some ways, it is not surprising to see themes of choice, freedom, and rights pepper public health policy deliberation; however, insofar as vaccination becomes a discursive means to express concern about the larger political structures of the day, above and beyond the particulars of the biotechnology presumably being debated, these rhetorical topoi, or thematic commonplaces, suggest that debate about mandatory vaccinations for health-care workers, in fact, is a “proxy debate.”
Recall that I employ the term “proxy debate” to mean a public argument strategy whereby the language of one issue or topic stands in for and distracts from other, recurrent system-level problems. With regard to mandatory vaccination for health-care workers, specifically, the “resistant health vernacular” appears to advance commentary on the status of the current political moment in which and for which the health-care system currently functions. In this regard, the themes of choice, freedom, and rights certainly index only one dimension of a much more complicated landscape. For example, in the second quote above, the claim “The only guaranteed winners are the pharmaceutical companies” suggests a debate about ownership over medical authority and the influence of “Big Pharma” over so much of U.S. health-care practices. Furthermore, although I focus on nationalistic threads underwriting this dataset, there appear to be critiques of big government and government expansion implicit in the vernacular register as well. In chapter 6, I delve into some of these additional anxieties in further detail; for now, the themes of choice, freedom, and rights provide focus for theorizing proxy debate more broadly.

No matter the specific underlying concern, it can be said that when health-care workers talk about vaccination, they may really be talking about other things. In doing so, the discourse that they produce serves as an example of how argument by proxy operates as a public deliberation strategy. I speculate more about the function of this strategy in terms of public deliberation in chapter 8, but, for now, it is worth noting that health-care workers may make use of argument by proxy for very practical reasons. For example, speaking out against the larger health-care system may cost them their job, invite criticism from peers, feel futile, or create personal dissonance if the issue were to be addressed directly (e.g., in everyday work, health-care employees support the system that they may purport to critique). According to my close reading of vernacular texts, it seems that many health-care workers find themselves talking about
vaccination to also talk about the system struggles and everyday concerns that are assumed with living a biotechnological life. In doing so, I surmise, the resistant health vernacular makes use of *argument by proxy*, a rhetorical device that is used to create and convey meaning about large, nebulous problems via overt public attention that is paid to distinct individuals and/or particular issues within situated contexts, such that talk about vaccination stands in for talk about challenges of citizenship in a biotechnological era.

Unlike the official rhetorics of vaccination that reduce discussion to the particulars of influenza, as the three aforementioned excerpts illustrate, the vernacular corpus promotes choice, freedom, and individual rights as important expectations for contemporary patienthood on a larger scale. Choice, freedom, and rights, notably, are U.S.-centered “God-terms” (Burke 1970) that, in vernacular discussions of vaccination policy, are subtended by modernist liberal, autonomous individuals. Thus, the combination of principles exalted across the vernacular register appears to communicate a specific brand of uniquely U.S. health participation for which biology becomes one consideration among many in evaluations of vaccination candidacy. To better contextualize my in-depth discussion of these themes, I next consider excerpts from the vernacular register wherein health-care workers refer to their national identity directly. In terms of advancing an argument about proxy debate, more generally, direct mentions of “U.S. Americanisms” provide evidence of the specific system to which the resistant health vernacular refers. In this manner, talk about the influenza vaccination may be understood and reread as a rhetorical device that is used to critique the U.S. bioeconomy (of which health-care workers are a member) via participation in public policy deliberation.
U.S. Americanisms

Offering evidence of their power and appeal across U.S. audiences, in addition to direct invocation of recognizable ideals such as choice, freedom, and individual rights, on many occasions throughout the vernacular corpus, mandatory vaccination is commonly talked about as a direct infringement on “what it means to be a U.S. American.” By equating choice, freedom, and rights with U.S. Americanism, any challenge to those principles is decidedly a challenge to what it means to live a life in the United States. Many vernacular expressions capture the surprise and disgust of health-care workers evaluating mandatory medical procedures according to their identities as U.S. citizens. For example, a registered nurse contributed:

*The last time I checked, I lived in the United States of America. The land of choice,*

including the choice to make health-care decisions for my own body. I will never turn over that decision making to the government (RN, #132; italics added)

Another registered nurse similarly stated:

*Last I knew, we lived in the UNITED STATES of AMERICA! Freedom of CHOICE* (RN, #22.65; italics added)

The “last I knew/checked” quip is interesting for its recognizably colloquial nature and for the emotion that it conveys. The entre into these nurses’ statements appears a bit snarky and a bit accusatory, and it does some persuasive work in shifting attention from the issue at hand (vaccination) to communicating a larger “we’re onto you” type of sentiment. Here, mandating vaccination would stand in opposition to the “land of choice” in which they “supposedly” live; at least this is what the sarcastic undertones seem to suggest. In terms of advancing a statement about the relationship between vaccination and U.S. Americanism, then, this technique translates a violation of health rights into an affront to what it means to live in the United States.
It also is interesting that statements, such as these, make direct reference to *living* in the United States. As opposed to appeals to citizenship (forthcoming), many entries submitted to the public register made reference to freedoms acquired by merely residing in the United States. In terms of advancing contemporary standards for biocitizenship, these types of gestures lay important groundwork, in my opinion, for understanding that quality of life is directly related to where one lives, and that, perhaps, when it comes to matters of disease management, health decisions transcend traditional notions of nationhood. Sociologists of health have formerly connected geographic location with health status (see, e.g., Mojola 2011) and, here, the resistant health vernacular gestures similarly. The United States becomes synonymous with a “*land of choice*.” Attention to place and space as indicators of health freedom are interesting for both communicating a familiar U.S. Americanism (e.g., “we live in the land of the free”) and how they reference the natural world as an important way to gauge how one should live and what that means in terms of health status and expectations.

Conversely, some contributors made use of place and space references but did so to reaffirm their rights as citizens. Unlike some appeals to citizenship, wherein reference to country of origin was implicit, these next examples made use of explicit U.S. Americanisms. For instance, a health-care worker stated:

I am a health-care worker. I feel that “*mandatory*” vaccination that can cause me to [lose] my job is an assault on my personal freedoms. *I live in the greatest country on earth because of the civil liberties that the American Constitution defends.* My request to you is that you use your powers and position to enforce our constitutional rights when many of those rights are being eroded. Please stand for *the right to life, Liberty, and the*
pursuit of happiness and say no to mandatory vaccination in the work place (HCW, #105; italics added)

Similarly, a respiratory therapist wrote:

*I enjoy my freedom here in the United States of America! I enjoy how I have been raised for my entire life and pray that it continues for all of us Americans. The freedom here in the U.S. is something that many others in other nations don’t have. We are blessed to have our rights as U.S. citizens* (Respiratory Therapist, #133; italics added)

Similar to previous contributions, the first entry made reference to place and space in noting, “I live in the greatest country on earth.” Unlike the previous contributions, however, these two entries link life in the United States directly to governing processes. Mention of “civil liberties,” the “American Constitution,” and “rights as U.S. citizens” suggests that above and beyond mere residence in a place, health rights are bestowed upon legal residents. Here, health-care workers are noting that this aspect of living in the United States—being protected by governing documents and processes—helps the United States to stand out from other nations. Delineating the United States as “the greatest country on Earth” and as distinct from “other nations” appeals to notions of U.S. Americanism, wherein a violation of a health right would directly go against not only implicit rules of the land but also the explicit documents used to distinguish the United States as an admirable, unique nation state. Here, direct appeals to national pride are intended to mobilize the symbolic function of health decisions as a marker of the U.S. way of life.

Further teasing out a connection to the formation of this distinct nation, other health-care workers make appeals to the past. For example, a health-care worker pleaded:

Please include my voice and opinion that all medical treatment is a personal choice and freedom. These two concepts are intrinsic components to America and democracy.
Forcing flu vaccinations on anyone violates some of the basic freedoms that are a foundation in this great country (AP, DOM, Dipl. A C., #88; italics added)

Similarly, a hospital kitchen staff employee questioned:

On a philosophical level, the idea that the Federal Government can force its citizens to receive vaccine is abhorrent to a free Republic. What would the founders have thought of such a law? (Hospital kitchen staff, #121; italics added)

The United States is a fairly new nation when compared to much of the Western world. Assuming that some pride can be derived from both the newness of a nation, as well as from its novel form of governance, appeals to the United States’ “foundation” and its “founders” deliberately turns attention to ideals that were determined when it, as a nation, had a fresh start. Providing some distance from the immediate needs of a here-and-now situation, reflection on the foundations of a nation suggests that decisions about vaccination should align with practices and principles that built the United States. Posing the question, “What would the founders have thought?” infuses discussions of the past with a guilt appeal. That is, questions that turn to consider what the U.S founders intended, and how they might disagree with where the country has ended up, add a persuasive, paternalistic element to the discussion that hone in on the fact that the United States is a land that is built on ideals that citizens now have an obligation to defend and uphold.

In terms of offering a succinct evaluation of what those founders might think, another health-care worker stated succinctly:

I was just informed today about the fact that healthcare workers may be required (i.e. forced) to get flu vaccines. This is wholly un-American and also unnecessary (Licensed acupuncturist, #89; italics added)
Accusations that a particular health-related policy is “un-American” suggest that it violates the intentions of the U.S. “founding fathers,” rights earned by each citizen of the United States, and any grace extended to individuals residing in this great nation. As such, “U.S. Americanisms,” or direct appeals to ideal life in the United States, offer a means by which health-care workers argue against mandatory vaccinations from a situated place via an idealized public identity.

**Personal Choice**

Related to, but somewhat distinct from, the U.S. Americanisms outlined above, other respondents to the Federal Registry made reference to specific types of freedom that are associated with claiming a U.S. identity. For instance, a health-care personnel member wrote:

*The bottom line is our FREEDOM. Our countrymen fought for these rights we have today and I am old enough to have watched groups, politicians, individuals try to take these freedoms away. . . . I personally will not adhere to mandatory vaccines and I work in a top 100 hospital. I fought the mandatory policy this year and won, and I will campaign and fight for *freedom to choose* for all individuals* (HCP, #113; italics added)

Whereas individuals noted in the previous section referenced U.S. ideals more broadly, respondents, such as this one, equated the United States to freedom, and a particular type of freedom, for that matter. Here, the respondent specified that the particular type of freedom that “our countrymen fought for” was, in fact, the “freedom to choose.” This version of freedom implies action on the part of U.S. Americans in that citizens are not simply granted freedom to live passively but time and time again, across the vernacular corpus, individuals made reference to acting on our freedom by “choosing” among reasonable options. In this regard, a Licensed Acupuncturist noted:
I am a healthcare worker in the alternative medicine field. Specifically, I am a licensed acupuncturist in New York State. I have been in practice for 10 years. I provide a valuable service to patients. I also provide something very dear to most Americans which is freedom to choose an alternative (Licensed acupuncturist, #89; italics added)

This orientation toward choice—the active choosing among alternatives—imparts a certain level of agency on individuals and suggests that actively choosing becomes a way to communicate U.S. freedom across diverse audiences. Hence, according to these quotes and others like them, there is a “freedom to choose,” as opposed to a more passive orientation toward ownership over choice.

Other quotes, however, reveal some slippage between an active notion of choosing and a more passive notion of choice. For instance, a health-care personnel stated:

PLEASE, PLEASE, PLEASE stop this mandatory flu policy! We didn’t give anyone consent to make our health decisions for us! We have freedom rights and being able to choose our own health is OUR choice not anyone else’s nor should it be their business!!! (HCP, #139; italics added)

Similarly another health-care affiliate contributed:

I’m writing to state that how a person chooses to take care of one’s health is a personal choice—as is the type of profession one chooses. I am against mandatory vaccines in any profession. It violates personal freedom. (HCA, #82; italics added)

Here, outward expressions of health citizenship seem to require active choosing; however, when there is a shift to talk about “our choice” or “personal choice,” the authors imply a different orientation or reading of the freedom that U.S. Americans share. In particular, the lattermost deployment of the term “choice” suggests passivity and privacy, something that active choosing
may omit.

These quotes, and many others like them across the Federal Registry database, demonstrate how choice becomes synonymous with freedom. In this particular configuration, choice/freedom does not necessarily require action on the part of the individual; in fact, perhaps the purest expression of U.S. freedom would be to refrain from choosing anything at all and to be content just with knowing that a choice could be made if needed. Along these lines, another health-care affiliate wrote:

Choice is what makes us free citizens. I have never and will never get the flu vaccine. My choice (HCA, #22.15; italics added)

Another added:

This is a free country. Mandatory flu vaccinations is an OUTRAGEOUS violation of that. Every person should have the choice to make for themselves and their health and should not be forced into it or reprimanded for not choosing it. (HCA, #22.38; italics added)

In each of these quotes, choice is talked about as if it were an item that people own and can possess. That is, inaction can be understood as a method of preserving and, thus, affirming one’s ability to choose. In this manner, evidence of freedom exists in one’s ability to point to areas or situations in life wherein a choice still remains.

Whereas some of the quotes given above suggested a much more impassioned position on the issues of choice/choosing, many other contributors expressed polite reserve, as well as slippage, concerning how choice and choosing relate to freedoms within the United States. For example, a nurse simply stated:

PLEASE stop this insanity. Allow choice. (MSN, #22.73; italics added)
Another pleaded:

Please support health-care workers in letting them choose their own health-care choices

(LRN, #11; italics added)

The use of “please” in both instances stands out as remarkably polite. In fact, across the resistant health vernacular, the use of the term “please” is a fairly common turn-of-phrase that is used to open statements in a rather submissive and polite manner. “Please” also can be a firm admonition to stop; a prefatory exclamation point inserted by the polite form, such as when a mother says “please stop it” to unruly children who know that there is no other option but to stop. With this nuance in mind, the first quote conveys an argument style that is similar to the admonishing mom just described. The first “please” statement is directed at authorities; the second “please” clause seems to convey an earnest request for support. Either way, in contrast to some contributors who used declarative statements and a generous amount of capital letters and exclamation points in their entries to signify aggressive stances toward the issue of choice, authors such as these last two seem to convey a different type of emotive energy. Specifically, I am struck by their “reasonable” tone, even if it is deliberatively suggestive and insincere.

Furthermore, far from prescribing a particular counteraction, these last two entries focus on simply maintaining the status quo or, in other words, inaction on the policy front. The last entry that—perhaps intentionally or unintentionally—entangle the verb and noun forms of choice in a way that suggests that in all its iterations and complications, choice/choosing is something worth supporting and defending. Rather than a declaration of their “right to choose” or their need to uphold their “freedom of choice,” authors, such as these last two, reconfigured the mantras to promote, perhaps, the need to “choose choice.” This last mantra, admittedly, is clunky but perhaps that is the point. Pleas to let health-care workers “choose their own choice” may be
intentionally redundant and clunky as to drive home the need to maintain options in health-care processes.

Citizens’ Rights

Across the vernacular corpus, there are also direct appeals to rights as they are defined and granted via U.S. citizenship. Captured bluntly, a health-care worker concluded:

Mandatory influenza vaccines are to me, an aberration of civil rights and complete disregard of one’s personal health choices (HCP, #134; italics added)

In this section, I present common references to citizenship from the vernacular corpus that appear to do slightly different persuasive work. In particular, when citizenship or citizen rights are invoked in the following excerpts, they seem to articulate a relationship to the State to argue for a bodily-related issue (Petryna 2004). In other words, unlike more general appeals to citizenship as a symbol of ideal ways of living, here, individual contributors draw on the vocabulary of citizenship to define and then defend boundaries as they relate to the actual human body. As citizens, U.S. Americans are equipped with documented rules (constitutional rights) that dictate how the State can and should interact with individual biological bodies via reference to those documents, and health-care workers readily invoke rights as reason to reject mandatory vaccination. Unlike the last two subsections that demonstrated the use of appeals to nationhood or ideal ways of living and acting, talk about “citizen rights” or “civil rights” gestures to policy processes and outcomes that comprise civic life.

One common method used to incite dissonance via reference to essential policy documents involved talk about vaccination as a violation of the biological body. For example, a Respiratory Therapist said:

I don’t understand how you can make it mandatory for someone to inject them with
anything (matter being the flu vaccination)! Especially if they don’t have a choice! This is their body, and not the government’s body! How is this right? I would feel this being deceitful and unconstitutional to us health-care works. This would be violating us on many different levels of rights (Respiratory Therapist, #133; italics added)

Here, there is a struggle over who owns the biological body; additionally, there is a conflation of “health institutions” with “the government” (a revealing slippage that I revisit later). More than a mere symbol of political ideals, this contribution suggests that vaccination actually, physically violates the human body and, thus, infringes on protections ensured via citizenship. Similarly, another health-care worker wrote:

I feel that the central issue here is of individual freedom. The uncertainty, or risk, of freedom is that your neighbor may choose something that you yourself are opposed to;

Please support a citizen’s right to choose what gets injected into one's own body! Please stand with those of us who are fighting this on the front lines! (HCW, #92; italics added)

Here, the phrase “gets injected” highlights how the process of vaccination requires passivity on the part of a vaccine recipient. Clearly, medical protocol would not condone individual citizens administering their vaccinations; however, this sentence construction shows that the process of vaccination as intrusive, forceful, and in violation of “one’s own body”; this is especially true if an individual does not want to be vaccinated in the first place. Distinct from a definition of individual bodies as constituents of a larger nation State, statements such as the one above emphasize the personal and private nature of the biological body. In this regard, others appeal to the operations of the human body as entirely distinct from or devoid of governance altogether.
For example, another respondent stated:

_It’s my body and I want my rights protected. . . . I want to maintain our right to honor the sanctity of the human body_ and right to choose what level of healthcare we deem best for ourselves. Period. (HCA, #22.23; italics added)

Here, the “right” referenced may be earmarking a civil right, a natural right, or a religious right, but in all cases, the human body gets talked about as a sanctified site that is worthy of honor and peace. Referring to the body as an independently operating system stands in stark contrast to the operations of a State wherein political processes, such as mandatory vaccination, assume a forceful, fabricated role in ensuring certain outcomes. Descriptions, such as the one included above, turn attention to how the human body operates as an independent entity, one that may or may not benefit from State intervention, depending on its “owner’s” predilections.

A similar reference to honoring the biological body was contributed by a registered nurse who requested:

_Please do not assume that all of us that are questioning the efficacy of the flu shot are doing so out of fear or ignorance. We have researched the subject carefully and are requesting respectfully that our right to autonomy be honored_ (RN, #2; italics added)

In this statement, as was the case in the previous statement, the body is understood as carrying with it an autonomy that is worthy of being honored. In this way, talk about the body as distinct from statehood may work to establish the biological body as an apolitical entity. However, in the same breath, the means used to do so point directly to a political document. Situating the vernacular argument in citizens’ rights suggests that the body is being deliberately politicized to ensure/enforce/protect autonomous personhood. In this regard, many respondents who
contributed in this manner reference constitutional rights as protecting the version of the body that they highlight. For example, one health-care worker writes:

*As an RN of 29 years I am extremely concerned!* So far in the battle of research, there is not a convincing argument that flu vaccines are effective, let alone effective enough to want to *violate individual citizen's rights* by making mandatory requirements *to take the vaccine*, or lose employment and tenure. (HCA, #68; italics added)

In this quote, “individual citizen’s rights” is employed to politicize the body in that the citizen reserves the right to decide whether “to take the vaccine” that is, whether to “get injected” with the vaccine. The body, thus, becomes a political terrain wherein the rights to govern get negotiated. As an extension of an overall effort to politicalize the human body, contributors to the vernacular corpus made concerted efforts to remind policy officials that health-care workers are individual citizens, not an arm of medicine as an institution. For example, a contribution explained:

*Healthcare workers are also individual citizens* who SHOULD be protected by the same US Constitution that many fought to protect. (HCA, #73; italics added)

Similarly, another respondent wrote:

*Health-care workers are citizens*, and deserve the right to choose what is best for them.

*You cannot legislate health.* (HCA, #22.43; italics added)

It appears both interesting and odd that a concerted effort is made across the resistant health vernacular to remind policy officials that health-care workers—potential vaccine recipients—are U.S. citizens and, thus, entitled to the same rights as the patients they serve. In many ways, this assumption may seem obvious: To work within the United States, one must obtain the legal status to do so (at least over any long period of time). In other ways, this
assumption may speak to the embodied experience of what it is like to work for and within the institution of health-care and the United States. In particular, these reminders may indicate that health-care workers, as parts of a larger medical institution, more often than not, are made to feel as if they are simply pieces of a larger governmental body. Many hospitals and the medical associations crafting mandatory vaccination policies, however, are not actually governmental agencies. Emphasis on health-care workers as citizens, thus, suggests a desire (and perhaps necessity) to define and defend clear divides between government and industry, because, in the biotechnological era, this border has become less clear. In this regard, another respondent specified:

*Health-care workers, as well as others, have the constitutional right to choose what happens to their body. It is NOT the right of any agency, governmental or otherwise, to impose a potentially life threatening or illness potentiating anything without their express permission, without fear of loss of employment if they fail not [to] exercise that choice* (HCA, #95; italics added)

Significantly, then, vaccination serves as an impetus for health-care workers to remind themselves as they remind others that a line needs to be drawn—a boundary defended—between institution and individual, system and self, nation and biological body. Competition between citizenship and employment, nation and institution highlights a potential transfer of power occurring in the debate about mandatory vaccination policy. Specifically, arguments in support of constitutional rights in relation to hospital mandates pushback against efforts of nongovernment agencies (private health-care facilities) to wield power over populations as if they were official governmental agencies. A shifting sense of governable rights seems to
undergird the debate at hand and, thus, may indicate ways that vaccination serves to symbolize disagreements about responsible citizenship for a biotechnological era.

Adriana Petryna introduced the term “biological citizenship” to describe how norms of citizenship are created via everyday scientific understandings and medical practices in relation to illness. In her examination of the Ukraine political environment after a nuclear fallout, she defined biological citizenship as “a demand for, but limited access to, a form of social welfare based on medical, scientific, and legal criteria that recognize injury and compensate for it” (2004, 261). In the case of mandatory vaccination, the resistant health vernacular seems to draw from legal criteria to recognize and defend against requirements of the state. Here, unlike Petryna’s case study, the government “aid” that is sought after by health-care workers is to be left alone. Indeed, as action taken against illness, individuals in this subset of the discourse suggest that government exclusion—as defined and defended by citizen rights—can ensure the sanctity of the biological body by preserving it as an apolitical, uninjected site. Similar to Petryna’s depiction of biological citizenship, the State’s duty is to protect and preserve the biological sanctity of each individual citizen. If and when it fails to do so, compensation and active aid may be required. In the case of vaccination, however, preemptive action is cast as a violation of the biological body, or at least that is what seems to be suggested across the vernacular corpus.

In sum, across the vernacular corpus, thematic talk referencing personal choice, U.S. freedoms, and individual rights abound. As distinct types of persuasive appeals that challenge official rhetorics of vaccination more generally, comments clustered around themes of choice, freedom, and rights prioritize principles above patients, and philosophies above policies. With a focus on the principles of good, fair, and just healthy decision making, the resistant health
vernacular concludes that the weight of the burden of public health decision making should *and* lay on the shoulders of individual health participants who, when equipped with the right resources and protected by constitutional rights, can *and will* make the best decisions for themselves and their communities. Idealistic in its impulses, this conviction appears notably U.S. American. However, as scholars have pointed out, more often than not, perceptions of control that are founded in bioeconomic vocabularies may disable individuals in an oppressive system more than enable them to change their current situation. Perhaps this disempowering undertow of the resistant health vernacular is why the mandatory vaccination for health-care workers debate has seemed to gain momentum only over the last decade. Indeed, as an argument strategy, appeals to choice, and freedom, and rights may leverage vaccination as a symbol used to comment on the bioeconomic infrastructure of the day, but as a politically persuasive change tactic, its use of communicative indirection may undermine efforts to adequately stall the policies in question.

**Conclusion**

Whereas official rhetorics of vaccination take great efforts to host public debate at the level of the issue at hand, the vernacular uses vaccination as a launching point to address larger issues that extend beyond the politics of any one particular vaccination and, instead, address the system in which those health issues reside. In particular, everyday talk captured in this data set suggests that vaccination deliberation is characterized by appeals to higher level principles of what it means to be a U.S. American; namely, principles of choice, freedom and individual rights are worthy standards to uphold regardless of any individual biological threat. Choice, freedom, and rights represent universal—albeit U.S.-branded—standards for health citizenship. Shifts from particulars to universals, according to Aristotle, illustrates an argument from example or
paradigm (except in Aristotle it moves from particular to particular). As a public argument strategy, then, the resistant health vernacular moves from the particular to the universal, and, therefore, stands in contrast to the enthymematic mode of argument that is used by institutions of medicine. Specifically, principles of choice, freedom, and individual rights trump considerations of influenza as a particular threat with a targeted message to communicate about patient safety, and, instead, remind onlookers of larger, dominant principles that guide U.S. health-care as an institution. Shifting from the focus on one particular vaccination to a larger discussion about principles of contemporary health-care, thus, offers commentary on systemic issues that are unique to this biotechnological generation of U.S. medicine. As such, health-care workers (at least in this sample) make use of vaccination as a proxy for addressing larger, systemic issues that undergird all contemporary health-care decisions regardless of particular pathologies.

Prominent themes in the vernacular register map onto other recognizable patterns in everyday speech associated with the current medical moment, a trend noted as a distinct phenomenon. Distinct from official rhetorics of mandatory vaccination for health-care workers, the contemporary resistant vernacular of health does not aim to persuade individuals to take a specific action regarding vaccination, necessarily; instead, the resistant, health vernacular seems to aim to express concern about principles of interaction necessary to live a U.S. life in a biotechnological era. In this manner, talk about vaccination addresses a larger ongoing paradox observable at the national level: The United States is a nation that is comprised of autonomous individuals equipped with a language of choice, rights, and freedom who, nonetheless, are expected to make certain decisions on behalf of others and in service to the health of the public writ large. There seems no immediate remedy for this paradox and, consequently, it seems, many health-care workers make use of vaccination deliberation as an opportunity to express grievances
and confusion about what mandatory health policy is intended to communicate about U.S. life amidst biotechnological advance. In the current biotechnological era, the vernacular corpus seems to suggest that more is at stake in discussions about mandatory vaccination than the distribution or efficacy of any one particular medical intervention. Indeed, when mandatory vaccination is being debated as a public health issue, it serves as a proxy for many other contentious issues that may be founded on noble principles but which remain in contradictory standing to everyday medical policies.

1 The 20 states as of June 2011 were Alabama, Arkansas, California, District of Columbia, Illinois, Kentucky, Maine, Maryland, Massachusetts, New Hampshire, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Utah, and Virginia.

2 It is worth noting that chiropractors are commonly regarded to be “marginalized voices” within the larger health-care community. This marginalization stems from contentious demarcations made in the mid-to-late 1800s during the professionalization of medicine as licensed practice (see Largent 2012, 41–51). Indeed, many of the contributors to the public comment database could be categorized alongside chiropractors as marginalized medical actors, when compared to other medical actors. For example, the next quote that I include comes from a Doctor of Dental Surgery, and throughout the vernacular corpus, registered nurses authored a notable number of comments. Registered nurses, like chiropractors, tend to be ranked lower on the medical hierarchy than their physician or surgeon counterparts. (Although surgeons have not always enjoyed the prestige that they currently claim, For in ancient Greece, surgeons were commonly discredited as the “plumbers” of the human body. Surgeons’ rise in rank and status can be attributed to their rhetorical savvy in rebranding their skillset as elite and important.) I revisit the issue of medical rank and vaccine hesitancy in the concluding chapter.

3 A clarification on my citations of public registry responses: For each public response submitted to the registry, I assigned a number. In each in-text citation, I include this individual, assigned number. Additionally, I include a brief description (or acronym to indicate a medical licensing) of the person’s professional affiliation to health-care. I elected to be very generous with regard to what I considered to be a health-care worker to include in this data set, because the grand majority of legislation being proposed in relation to mandatory influenza vaccinations would require that any affiliate of a health setting who might have contact with a patient needs to get vaccinated; this definition includes nonmedical and unpaid personnel, as well as more traditional medical professionals. The Federal Registry system included a field where individuals could state their title and affiliation to health-care, and, more often than not, respondents filled in that field. In instances where the field was left blank, but from the context of the entry, I could determine that the individual was formally embedded in the health-care community somehow, I opted to include that person’s testimony as part of the vernacular corpus represented in this study. In these latter cases, the acronym “HCA,” standing for “health-care affiliate,” was assigned for in-text citation purposes.

4 According to official policy recommendations, all hospital employees, including nonmedical staff, would be required to get vaccinated as a condition of employment. I elected to include this voice among the others because it complicates the issue further and evidences additional means by which controversies in medicine influence the “general public.” However, this was the only self-identified, nonmedical hospital affiliate to contribute to the public register, and, consequently, I use only a portion of his or her comment in this one instance for this study.
PART THREE:

VERNACULAR ADDITIONS
CHAPTER VI
EVERYDAY EXPRESSIONS OF BIOANXIETY

In this chapter, via close textual analysis of the mandatory vaccination issue, I describe how health-care workers become active and direct in communicating unease about mandatory influenza vaccination policy. Specifically, my analysis focuses on accusations of concern within the public register to prioritize moments wherein individuals express emotion about vaccination adoption and policy, and, thereby, capture a tone of conversation that, otherwise, is minimized in the official register. Following a description of the official representation of the vernacular, I present findings from that close analysis of vernacular rhetoric. I find that vernacular expressions of emotion cluster around three common issues of concern, or topoi, that suggest worry beyond the science of vaccination as a medical technology. In particular, health-care workers express anxiety about ways that mandatory vaccination policy infringes on human rights, exposes inequities in health-care, and troubles medicine’s relationship with nature. I conclude that emotion—specifically, what I term “bioanxiety”—figures prominently in this public health debate. In this manner, and in addition to delineating certain concerns or anxieties expressed by members of the health-care community that are represented in this corpus, I offer an in-depth look at collective expressions of anxiety about mandatory influenza vaccinations to further hone the proxy debate concept introduced in the previous chapter. I suggest that when expressions of bioanxiety are tracked, evidence suggests that vaccination speaks to larger stresses that extend beyond any particular vaccination to biomedicine writ large. In particular, bioanxiety is a reflection of a troubled, multifaceted contemporary U.S. health-care system. In this regard,
whereas proxy debate may describe the overall structure and function of public argument about vaccination in relation to larger system level issues, bioanxiety marks a manifestation of those unresolved problems. In other words, because system-level problems are not addressed head-on, anxiety abounds. As such, I suggest that, moving forward, emotion should be accounted for more regularly in official rhetorics of health and medicine that are intended to represent and influence individual- and system-level health-care practices and outcomes, especially as emotion relates to public argument strategies that are intended to increase health-care worker vaccination rates.

**Official–Vernacular Interplay**

To best hone the interplay between official and vernacular rhetorics of vaccination, I examined the National Vaccine Advisory Committee’s most recent policy recommendation document and the public response that it invited. As noted previously, in 2012, the National Vaccination Advisory Committee (NVAC) authored an official “recommendation” report, titled *Recommendations on Strategies to Achieve the Healthy People 2020 Annual Goal of 90% Influenza Vaccine Coverage for Health-care Personnel*. The “draft” report outlined five “recommendations” for how health-care employers could increase vaccination coverage across its workforce. The report was open for public comment for a total of 29 days via the U.S. Federal Registry System, and the final report, titled *Recommendations on Strategies to Achieve the Healthy People 2020 Annual Influenza Vaccine Coverage Goal for Health-care Personnel*, was published 23 days after the online comment solicitation interface closed on February 8, 2012. Despite nearly 200 individual entries and 37 organizational statements suggesting a wide array of changes be made to the draft, the final version of the report appeared significantly unchanged. The most notable difference was an addition made to the fourth recommendation; Specifically, the following clause was added: “In addition to medical exemptions, [health-care employers]
may consider other exemptions in their requirement policies.” Notably absent from the first version of the report, this opt-out clause was added in direct response to the NVAC’s summation of public comments, which it evaluated as “almost exclusively in response to Recommendation 4.” Indeed, many of the individuals offering responses to the report took issue with Recommendation 4, and a significant number of individuals did advocate for an opt-out clause; however, many more contributors rejected Recommendation 4 altogether. How public comments were summarized and then enfolded into the final report by the NVAC is interesting for understanding how the process reduced and neutralized public concern.

By and large, the official institution of medicine (represented here via the NVAC) characterized the vernacular as “expressing concern” about the issue of mandatory vaccination policy. In one sense, “expressing concern” served as a fair descriptor of the vernacular register; indeed, health-care workers contributing to the Federal Registry readily conveyed hesitancy about mandatory influenza vaccination policy and, thus, did “express concern” about the issue at hand. In another sense, however, describing the vernacular register in its entirety as mere “expressions of concern” failed to capture important and telling threads of emotion that were observable across the vernacular corpus. Exclamations such as “Go to Hell!” and “Shame on you!” peppered the public record, and yet, the official corpus remained largely immune to any such emotional outburst in its summation of public comment. Instead, all of the 145\textsuperscript{1} individual submissions were condensed into a one-page, single-spaced “Executive Summary” that appeared in outline form. In this sense, the official document gave lists, rather than narratives, and came up with categories that distorted the picture of a nuanced, emotional public registry. The result was a representation of the responsive public as passive and a dissipation of the worldview in which the narrative resided. Perhaps part product of the public health policy report genre, in
general, or part product of a sanitizing, scientific public deliberation process, in particular, regardless, although emotion figured prominently across public opinion, it remained largely absent from the official records of the overall public debate. Indeed, the official register distilled, leveled, quantified, and neutralized vernacular contributions. Unlike the official characterizations of vernacular rhetoric that relayed a summary of the public register as more passive in its “expression of concern” about the science of influenza vaccination, an in-depth look at vernacular patterns reveals a much more emotional undertone characterizing the public register.

Vernacular theory suggests that, in certain matters of everyday living, emotion figures prominently as a sense-making tool that is used to consolidate and mobilize individuals and ideas. Eighteenth-century Scottish rhetorician George Campbell, for example, linked moral reasoning (rhetoric) with empirical evidence (sensory experience) as central to the process that is needed to merge thought with action: “Evidence from experience was rhetorically effective because it reminded people of the way in which they garner knowledge everyday of their lives” (as cited in Crowley 1990, 47). For Campbell, emotional reactions to contextual features mattered significantly to how individuals construct and relate to commonsense. Specifically, his work *Philosophy of Rhetoric* (1776), deemed “the consummate modern rhetoric” (Crowley 1993, 32), articulated that “the stuff of invention—subjects, ideas, knowledge, discoveries, and thoughts, as well as aims or intentions—[precedes] discourse; it [exists] in some coherent and knowable way prior to and outside of discourse” (Crowley 1990, 42). For Campbell, commonsense was “an original source of knowledge” (38–39) and rhetorical argument hinged on the ability to imitate audience members experiential process by which they acquired their everyday knowledge. The emotional element of experience gave way to everyday systems of
knowing. Campbell’s account, although contextualized in the epistemology of the Scottish Enlightenment, captures a basic mechanism of rhetoric: the centrality of emotional attachments to human experience as an influence on conduct.

For the case of vaccination, in particular, I suggest that a certain type of emotion is evidenced. I introduce the term bioanxiety (short for “biotechnological anxiety”) to describe the overall type of emotional response that health-care workers exhibit in relation to influenza vaccination as a public health issue. According to the Oxford English Dictionary, the term “anxiety” refers to “The quality or state of being anxious; uneasiness or trouble of mind about some uncertain event; solicitude, concern.” Bioanxiety, then, denotes a more targeted version of anxiety disorder and a discursive condition, rather than a biological condition. Specifically, I use the term to refer to excessive worry about “the business” of public health participation in a biotechnological era. “The business” may include factors, such as evaluation of risks, negotiation of responsibilities, transparency in personal decision making, or accountability for adverse health outcomes, each of which is being shifted, more and more, to individual patients per larger medical initiative, such as the patient-centered care movement mentioned in the previous chapter. More broadly, then, the term is intended to address an ongoing state of affairs and interactions that characterizes the overall U.S. biomedical industry. In this sense, the term reflects an ongoing effort to turn attention to material consequences of biomedical talk and better emphasize and integrate—in critical, conscientious ways—the recognition that collective, everyday health experiences cannot be divorced from the bioeconomy in which they are situated. Bioanxiety, thus, also can be used to describe, more generally, an overall emotional state that is experienced by health publics considering biotechnological intervention. In chapter 8, I dive more deeply into a notion of bioanxiety and what it may offer in terms of theorizing about health
publics, such as health-care workers, and what it might recommend in terms of reconfiguring public vaccination communication; for now, bioanxiety aids in describing the overall emotional reactions of health-care workers as represented in the public registry and outlined in this chapter, with speculations about how the concept might be generalized to make decisions at the public level explored in subsequent chapters.

For matters of health and medicine, in particular, a domain where emotion figures prominently, I suggest that emotion should not be extracted from public debate. This position is partly informed by the work of science and technology studies scholars Emma Engdahl and Rolf Lidskog, who argued:

Emotions are part of the evaluation of risk. Hence, trust is not the opposite of reflexivity or rationality but rather an emotionally based strategy that bridges the gap between the present and the future by anticipating the result that trust may create. . . . Trust concerns’ confidence not only in other actors and systems, but also in their own ability to evaluate and judge other actors and systems. Trust . . . necessarily involves a self-referential component . . . which means that public distrust may also be caused by a lack of confidence in one’s understanding and evaluation of these organizations (2012, 12)

Although Engdahl and Lidskog considered public perceptions of science, specifically, given the intimate link between science and medicine, I believe a reasonable and informative parallel can be drawn. Rather than simple outbursts, via a rhetorical lens, emotion can be reread and reintegrated as important and necessary. This being said, as Engdahl and Lidskog argued, “Current discussions on public trust, as well as on risk communication, have a restricted rationalistic bias that does not do justice to the emotional character of [public] trust” (2012, 11).

If vernacular captures informational emotions associated with everyday practices of health and
medicine, close attention to vernacular in its rawest of forms may offer valuable insight into dimensions of public health debate and scholarship that, otherwise, is neglected in official policy communication.

Significantly, some common symptoms of anxiety experienced at the individual level include emotion. For example, Drs. Aaron Beck and Gary Emery suggested that “generalized anxiety disorder” is sustained by “basic fears,” such as fear of losing control, fear of not being able to cope, fear of failure, fear of rejection or abandonment, or fear of death and disease (as cited in Bourne 2010, 18). These fears, in turn, result in irritability, difficulty concentrating, tense feelings, fatigue, muscle tightness, and difficulties sleeping. Although these symptoms may definitely include underlying biological causes, most treatments for anxiety address psychological triggers in a person’s environment that are anxiety provoking by addressing directly “any situation that heightens your perception of danger or threat” (Bourne 2010, 19).

Perceived threat paired with physical and psychological (emotional) symptoms can, and usually does, lead to inaction or hasty decision making on the part of the person experiencing anxiety. Although inaction may certainly be interpreted as action—such is the case, for example, when noncompliance is infused with deliberate political purpose—sometimes, inaction may indicate an inability to decide at all: an avoidance of decisions-to-be-made because of feelings of anxiety that accompany them. With the possibility of inaction being unintentional and, indeed, an emotional reaction to particular environmental circumstances, vaccine avoidance, in and of itself, may operate as a marker of anxiety at the individual level. In this same vein, groups of unvaccinated individuals may evidence collective or shared experiences of anxiety. In both cases—when anxiety leads to vaccination avoidance at either the individual or public level—I use “bioanxiety to describe one possible culprit. However, mindful that noncompliance can serve
as deliberate political action, during my analysis, I sought out other markers of anxiety in addition to resistance to the policy. I affix “bio” to anxiety to emphasize the now banal qualities of anxiety that are triggered by discussions of biotechnology. “Bio,” in Greek, means “life”; “bio” in the contemporary medical era signals a shift toward.6

During my analysis of the vernacular corpus, I sought to identify anxiety “triggers” and “manifestations” as expressed in individual talk about mandatory vaccinations. Specifically, I took note of moments in the register where agitation and anger could be tracked alongside contradiction and/or confusion, as the pairing suggested expressions of anxiety. This assumption is based on a definition of anxiety as “a state of vague apprehension, a coloration of experience in which much seems at stake but which lacks clear paths of action” (Brodwin 2000, 9). When individual expressions could be grouped meaningfully, I understood certain trends in talk to signify similarities in emotional experience that was shared by members of the health-care community speaking out against mandatory influenza vaccinations. Recall that, according to Hauser’s theory of vernacular rhetoric, collective acts of resistance indicate the existence of a public; recall also that the term “public” denotes a collection of individuals who come together to discuss an issue of mutual importance, and for the health context, in particular, with the term “health public” underscoring the publicness of decisions made about particular health-related issues based on the status of the participants implicated in deliberation processes and outcomes. Insofar as public health policy, as an institution, wishes to frame needs of the public good as “commonsense” to inspire action at the individual level (in this case, to get people to line up and be vaccinated), a range of emotions, it seems, must be better accounted for in the policy process and record.
Whereas the official register foregrounds “concerns” about the science/efficacy of vaccines, a closer look at the public record reveals other insecurities being considered and expressed by members of the health-care community. Beyond worries about whether the vaccine is good or effective, members also address issues of moral obligation, economic equity, and natural order. (These lattermost considerations resonate with the personal rights sentiments expressed in the previous chapter.) To better represent the conviction that health-care workers convey about mandatory influenza vaccinations (as opposed to the more passive “expressions of concern” denoted by the official corpus), the following sections present findings from my close textual analysis. In particular, I organize my observations of vernacular warnings, challenges, offerings, and other active expressions of emotion into three larger categories: the moral vernacular of health, hierarchies of care and compensation in biomedicine, and medicine’s war on immunity. Each larger common theme, or topoi, is further categorized into distinct emotional threads that illuminate ways that obligation, equity, and order come to be negotiated and expressed across the vernacular registry. Beyond “concern over adverse effects” or “concerns over vaccine safety,” health-care workers collectively express anxieties about universal rights and historical mishaps, about unequal treatment and inconsistencies in care, and about tension between Western medicine and natural remedy. In the end, I conclude that these emotional threads collectively evidence a chronic emotional condition prompted by unresolved public talk about biotechnological intervention; that is, the condition of “bioanxiety.”

The Moral Vernacular of Health Citizenship

In an essay titled “The Moral Vernacular of Human Rights Discourse” (2009), Gerard Hauser sketched “a conceptual frame for understanding the nature and function of the culturally and socially specific moral vernaculars that mark human rights rhetoric” (132). Inspired by the
work of Michael Ignatieff (2001), who suggested that human rights be understood and approached as a dynamic discourse, Hauser distinguished between two forms of vernacular argument: a thin form known as “human rights talk” and a thick form that gets “enacted by those whose rights have been violated” and, thus, serves as a “mode of resistance” and a “form of moral empowerment” (133). Examining prisoners of war, Hauser demonstrate the difference between the two, concluding that “thick moral vernacular is more combative; it is always a critique of power” (148). In the immediate subsections that follow, I review two prominent threads running across the vernacular registry using the headings “human rights” and “slippery slopes.” The former, I suggest, most closely illustrates the thin moral vernacular that Hauser outlined because it “does not seek convergence on values but agreement on consequences for which there is accountability” (133). The latter thread suggests a thicker version of a moral vernacular because it readily makes use of collective memories of past tragedy to incite emotion for insiders and outsiders alike. Via the lens of human rights rhetoric, I, thus, consider how each type of appeal, or moral vernacular, advances health-care workers’ position against mandatory vaccination and how each appeal communicates underlying emotions, specifically, anxiety, associated with symbolic repercussions of any mandatory vaccination of health-care workers.

**Human Rights**

Across the vernacular register appeared appeals to higher level principles and callings wherein a decision about mandatory vaccinations for health-care workers would, in fact, signify an overall stance toward human rights. In this regard, two types of argument threads were advanced. The first type referenced “human rights” as a well-known, universal code of conduct that prohibited certain behaviors. Although no edict was ever specified, multiple contributors
explicitly defined mandatory vaccination as either a “violation” or a “crime,” which insinuated that formal policy or language exists. For example, a health-care worker wrote:

It is absurd that EMPLOYERS (healthcare or otherwise) are allowed to require MEDICAL PROCEDURES of employees or they are DISCRIMINATED AGAINST. What kind of world are we coming to? Everyone thinks they can PLAY DOCTOR making medical decisions for others without having ANY KNOWLEDGE of the employee’s health history or risks and WITHOUT ANY LIABILITY in the game. It also engenders a discriminatory attitude against those who have a MORAL CONFLICT with vaccination. This is a very slippery slope kind of thing and SHAME ON YOU for pushing this flawed premise that everyone can and should be vaccinated with impunity. This IS A TYRANNY OF MEDICINE. This DENIES healthcare freedom, religious freedom, informed consent rights and the DIGNITY of the human person. Vaccine MANDATES and employer “required” vaccines—is a CRIME against humanity. (MP #40; italics added)

Here, the crime is “against humanity” and vaccines deny the dignity of “the human person,” a base-level human right argument that allows the appropriation of human rights as a rhetorical topos in the most general and universally acknowledged terms. The appeal lacks specificity of exactly what is being talked about, such that the rhetor might use it to indict any practice that she or he disapproves of that, in some way, can be construed as imposing a choice on others. The manner in which this message gets conveyed is also worth mention, as this style is indicative of emotional expression that is common across the vernacular corpus. This contributor, as was the case with many other contributors, used a generous amount of capital letters, which connoted extreme emphasis and emotion—its served as an orthographic display of emotion. This author
(like others) also made use of evaluative phrases, such as “absurd” and “shame on you,” and, additionally, accused policy makers of “playing doctor” free from “liability,” and, as such, acting as “tyrants.” Together, use of punctuation to deliberately offset loaded accusations and evaluations suggested an emotional reaction to the prospect of mandatory vaccinations. This emotional response was not represented in official rhetorics of health and medicine, and was further bolstered when contributors linked this emotion to morality.

In line with the lengthy quote above, throughout the vernacular corpus, individual health-care workers made poignant references to vaccination as a violation of human rights. For example, a registered Nurse wrote:

> It is a human right to be in charge of your own body and dictate what goes into it (RN, #49; italics added)

Beyond individual, U.S. rights, such as the ones noted in the previous chapter, a mandatory vaccination of any single health-care worker symbolizes a universal violation of human rights more broadly. Moreover, as many health-care workers have suggested, these universal “natural” rights stand in contrast to situated, man-made rules. In this regard, as a physical therapist noted:

> I do not feel that it is the government’s right to infringe upon my right as a human being to make a choice regarding whether or not I receive the influenza vaccine (Physical Therapist, #25; italics added)

Another health-care professional also claimed:

> For the government to step in and make this mandatory for healthcare workers to get this vaccine would be against our rights as healthy human beings to let our immunity do its job as nature intended it too (HCP, #76; italics added)
In each of these cases, human rights are pitted against governing rights, a juxtaposition that implies certain embodied freedoms that are available to any “healthy human beings,” rights that transcend the politics of public good. The mention of certain types of human beings in the lattermost quote—*healthy* human beings—leaves open the possibility that certain types of bodies forgo those universal human rights previously mention. For matters of disease management, in particular, endowing rights to *healthy* human beings suggests that if those bodies transition into *sick* human beings, rights may be necessarily forfeited and government may be able to step in. Concerns around if, when, or should government officials step in with regard to matters of disease management remain contested territory across the vernacular register. For example, another health-care administrator noted:

Vaccination is a *medical procedure*. Forcing a *medical procedure* on anyone is a *violation of basic human rights*. Period. (President & Co-founder Health Advocacy in the Public Interest, #26; italics added)

Another registered nurse wrote:

I have a right as a human, to decline a *medical procedure* that carries risks… Mandating such is *a total violation of human rights in every way*. (RN, #8; italics added)

Again, these responses employ appeals to “human rights” leveraged as a deliberative trump card. However, unlike the previous quotes, these last two additions emphasized *medical procedures* as the impetus for pushback. It is not a mere violation of human choice that is at issue for these health-care workers; it is the mechanism of control that worries them--namely, “forced” medical procedures are in direct violation of human rights. Whereas the earlier quotes took issue with government stepping in at any time as a violation of choice over the body, these lattermost contributors specified that forceful medicine violate universal laws of humanity. Members in the
former argument camp would likely resist quarantine even during a disease outbreak, whereas members of the second camp might understand the measure to be reasonable given the correct circumstances. Differences present within this particular health public may matter significantly to how relationships among government, disease, and the body get managed, relationships that, we shall see, are configured by and through memorable instances in medicine’s history where human rights were violated.

**Slippery Slopes**

The second argument thread works in conjunction with the above claim to speak to universal truths about how to treat the human body. Specifically, the second thread of argument readily references moments in history when bodily rights were violated and, thus, resulted in overwhelming atrocities. In this regard, and as also exhibited in the opening quote in this subsection, references to a “slippery slope” instigated by mandatory vaccination policy were common across the vernacular register. Reference to a “slippery slope” communicates concern about future, inevitable consequences affiliated with mandatory vaccination in the present. As a logical fallacy, slippery slope appeals depend heavily on *pathos*, or emotional appeal, to persuade audiences to consider, seriously, potential consequences of policy action based on what they know to be true about the past. In terms of the second argument thread, a handful of contributors made direct reference to World War II and Nazi experimentation, whereas others implied such outcomes if vaccination mandates are enforced. Although not fully performative in the embodied, sacrificial ways that Hauser’s ‘prisoners of conscience’ (2012) exhibited their thick moral vernacular, at the very least, this form of health-care worker vernacular expression seems *thicker* than the human rights talk noted above. “A thick moral vernacular,” Hauser
explained, “summons cultural memory embedded in a people’s language, national history and significant expressions of tradition and belief to inspire allegiance and support” (148).

According to Arthur Neal, “Both triumphs and tragedies are inherent in social living. The triumphs verify the assumption that plans can be made and implemented, while the traumas remind us that hopes and intentions have their limits” (1998, 197). Timothy Kubal addressed the recalcitrant nature of history in concluding that although the past is pliable, “powerful people cannot erase bad collective memories” (2008, 170). It is in the telling and retelling of these past triumphs and tragedies that those events become strategically distorted, as they become part of a larger collective memory. “Collective memory,” rhetorician Maegan Parker asserted, “is more than a social process of reconstructing the past; it is argumentative in the sense that public memory is evoked both selectively and purposefully” (2004, 278). With regard to the issue of mandatory vaccination for health-care workers, mention of past tragedy is common. In particular, reference to World War II and Nazi Germany activated a collective memory of what can happen if human rights are violated “in the name of medicine.” Indeed, parallels between eugenics medicine and mandatory vaccination policies frequented the vernacular register to suggest that what did happen in the past will happen again in the future if universal human rights get violated, especially if those violations come in the form of “forced medical procedures.”

Some health-care workers made direct reference to human rights violations that were associated with World War II. For example, a former health-care service employee claimed:

By forcing vaccines on the health-care personnel, the US government will behave like Nazi regime, which murdered people in concentrations camps with "medicines" (Ph.D. and former HHS employee, who has suffered severe vaccine-related injury and observed horrific effects of toxic vaccinations in others, #115; italics added)
Another health-care worker noted:

Do NOT take Americans rights away and force them sacrifice one person for the “welfare of the many”. Haven’t we been through this already with the Nuremberg Trials? (MP #22.11; italics added)

In each of these cases, historical mishaps or human rights retributions were directly referenced. Accusing the U.S. government of acting like the “Nazi regime” carries with it symbolic power that troubles the identity of most U.S. Americans: the United States fought against and defeated the evil Nazis, or so the collective memory goes. Thus, the dissonance created by drawing parallels between the United States and Nazi Germany is intentionally unnerving. Additionally, mention of the Nuremberg Trials moves one step further to remember international agreements that were made concerning human rights and lessons learned from World War II. Here, too, a violation of an international peace treaty rubs against the U.S. identity as a country that was founded on fair and equal treatment. As a result of the Nuremberg trials, a series of military tribunals were held after the end of World War II to hold the worst violators of human rights accountable for their actions, and the Universal Declaration of Human Rights was created, an international treaty that was designed to preserve and protect the sanctity of life, with the United States, along with many other countries, publicly vowing to never let anything like the Holocaust happen again. Therefore, a warning concerning a slippery slope that leads to such outcomes resonates with honorable public commitments and ideals. Appeals to the “slippery slope fallacy,” thus, frequented the public comments.

For example, as a health-care worker warned:

Though centralized control may have its appeal while you are one of those in control, it won’t be long before someone else’s will, will target one of your belief systems. A
handful should not decide for the masses, what is injected into one’s own body. I hope that you will side with all of us who may soon be forced to choose between our jobs and a sincerely held belief about the safety and efficacy of vaccines, and against the powers that be which are attempting to *seize far more control than they have any business claiming* (HCW, #92; italics added)

The old adage that warns “Give an inch, take a mile” rung true across this contributor’s entry. Warning that it “won’t be long” before the reader’s freedoms are compromised is motivating on both a personal and national level; indeed, a famous quote from a Holocaust survivor that frequents U.S. textbooks conveys a similar point and has, thus, become one of the most frequently employed colloquialism of World War II. This particular “lesson learned”—the slippery slope from the one to the many, from inaction to atrocity—is recognizable and, thus, persuasive to many U.S. Americans. Along similar lines, another health-care worker wrote:

*This is a violation of personal rights! It's plan and simple, vaccination of any kind should be a choice for the individual. Your trying to take away a person's right to choose. Go down this path . . . . What will be next?* (MP #19; italics added)

In terms of the emotional charge that accompanies most slippery slope warnings, for this last quote, I elected to keep the typos intact. This particular health-care worker appeared to have written quickly and haphazardly in response to the issue. Although parts of the contribution are edited properly, and ending with a question suggests a desire to entice a listener to interact with the ideas being expressed, an overall lack of editing at the beginning suggests that communication of the author’s concern—“getting it out there”—may have been prioritized over how the message would be received by readers. This type of grammatical pacing—transitioning from exclamation points and typos to a well-paced rhetorical question—suggests an outburst of
emotion that is tempered as the contribution goes on. In this case, it seems as if the author was reminded of past historical atrocities and, in the process of expressing concerns, was made somber by the collective memory. Although text-based communication typically loses many important nonverbal cues that accompany oral expression, in this particular case, emotional cues, such as the use of exclamation points, the failure to edit properly, incriminating accusations, and the use of probing questions, convey an emotional undertone that extends beyond “expressing concern” in a calm, cool, collected manner. I suggest that these types of textured emotions illuminate much about how a health-care worker feels, not just what a health-care worker feels, regarding mandatory vaccination as a public health issue.

In some notable ways, drawing a parallel between current U.S. mandatory flu vaccinations for health-care workers and the Holocaust could be deemed in bad taste, an exaggeration, or an altogether false equivalent. Indeed, the fact that public debate about the issue of vaccination occurs within the United States suggests important differences between how modern-day U.S. health-care operates in comparison to Nazi Germany. Nonetheless, an appeal the historical atrocity indexed by the Nazis frequented the vernacular register. As a persuasive strategy, health-care workers may intentionally draw parallels between the two health histories to ensure that mandatory vaccination as a public health issue gets remembered in a “strategically distorted” way to advance their counterargument. Conversely, however, this parallel may be drawn unintentionally, serving as a real and impending “worst-case-scenario” that each health-care worker considers in relation to individual choice. Acting as both a symbol of triumph (the Nazis, ultimately, were defeated) and of tragedy (millions died in the name of bad medicine), the collective memory of World War II and the mixed emotions it conjures may be inscribed on the U.S. psyche in ways that sit dormant in most everyday encounters but that surface when certain
demands are made. In this regard, health-care workers’ efforts to recall past historical atrocity for use in current day decision making may be an impulse more than an intention. When paired with the emotional cues that run across the vernacular register (such as the use of capitalization, exclamation points, and rhetorical questions), appeals to historical atrocity evidence latent emotion associated with mandatory medical procedures.

Hierarchies of Care and Compensation in Biomedicine

To counterbalance a history of prioritizing physicians’ perspectives, recently, patient-centered communication has emerged as the dominant health-care model guiding recommendations for physician–patient interaction (see, e.g., Venetis, Robinson, Turkiewicz, and Allen 2009). Although a number of studies have confirmed that patient-centeredness is related to patients’ overall satisfaction with their health-care, concern exists among scholars about the potentially distracting effects of championing patient-centered communication. An overemphasis on promises of patient-centeredness may underemphasize other important factors known to contribute to social disparities in health. In his 2011 bestseller Seeing Patient: Unconscious Bias in Health-care, for example, Augustus White III, M.D., warned:

In recent years, the idea of patient-centered medicine has gained increasing traction among doctors. Incorporating patient input and considering patients as partners in their health-care is an evolving counterweight to the prescriptive, ‘medical gaze’ approach most physicians have been conditioned to. The Institute of Medicine, the Robert Wood Johnson Foundation, the Kellogg Foundation, the American Hospital Association, the American Academy of Orthopedic Surgeons, and other leading health-care organizations all have programs designed to increase patient engagement. These programs reflect the generally accepted understanding that effective communication involves patients equally
with doctors. But the racial barriers to a more egalitarian concept of the doctor–patient relationship remain very high and very persistent. (228)

White went on to outline gender and socioeconomic barriers that continue to interfere with an ideal notion of truly equitable care, despite good intentions that are embedded in patient-first language.

Another feature of inequity that is often overlooked but, nonetheless, is important to ideal standards of health-care surrounds the now-inverted hierarchy between patients and health-care workers. Indeed, across the vernacular corpus, questions concerning why patients and providers are treated unequally, despite the fact that “disease affects us all equally,” were common. Specifically, inconsistencies between vaccination expectations for patients versus those required for health-care workers highlighted the blurry and contentious line that health-care workers must navigate acting as everyday expert-patients. Furthermore, double standards between how health-care workers get compensated for vaccination mistakes as compared to other stakeholders involved in the process further emphasized faulty, questionable logic used to, at once, convince health-care workers to line up and get vaccinated as vectors of disease, and, simultaneously, be asked to do so without the patient protection clauses that are afforded to all other vaccine recipients. Concerns about inconsistency in status and treatment with regard to vaccination expectations and compensation highlight another node of contradiction wherein health-care workers’ frustration, confusion, and anger (thus, emotion), clustered together in relation to the issue of mandatory vaccination policy overall.

**Inconsistent Care**

In terms of expressing concerns about inconsistencies in care with regard to freedom of choice and patient autonomy, a registered nurse stated succinctly:
If patients are allowed a choice of whether they choose to be vaccinated, so should their health-care workers who are providing care for them (RN, #124; italics added)

At face value, this assertion seems reasonable; after all, when a health-care worker is getting vaccinated, is that person not a patient of some kind? In this vein, many health-care workers highlight inabilities to separate patients from providers in matters of disease management. For example, a future health-care worker questioned:

When approaching the idea of a mandated flu shot, the nurse in effect also becomes the patient. So now it is the nurse who is on the receiving end of the ethical principle of autonomy. What about his/her rights to refuse a treatment, even after informed consent?

Nurses encourage their patients to “participate in informed decision making” (Morrison-Valfre, 2009) these same rights must be extended to nurses should they make the choice not to receive the influenza vaccine (Nursing student, #142; italics added)

Another nurse noted:

As healthcare workers, we are patients as well, and we should be able to retain the right to refuse certain treatments/care just like our patients can- especially when it is done conscientiously, while implementing other wellness activities such as vitamin supplementation that strengthens immunity (Nurse, #14; italics added)

The conflicting relationship between professional obligations and identities and health behaviors that affirm patienthood complicate clear distinctions between private and public health. In terms of critiquing policy communication, in general, pointing to this gray area pokes holes in the logic founding official rhetorics of health and medicine. Moreover, as was the case with the last quote, expressing an ability to be both/and a patient or provider complicates the vaccination terrain considerably. By and large, policy communication addresses health-care
workers as professionals; time and time again, across the vernacular corpus, the messages reaffirmed that health-care workers are always already patients themselves. If anything, some individuals suggested, this both/and status might just be a reason to offer better treatment for members of the health-care community who act as exert-patients among lay audiences. A contributor asked bluntly:

Why should HCWs have fewer rights than patients, especially when they become the patient? (HCA, #22.37; italics added)

Another future health-care worker explained:

We must remember that HCP are also patients at some time or another themselves, needing care for their own conditions or simply going for well visits. Patients have the autonomy to refuse vaccines; why deny HCP? We should also have this right to make informed decisions, based on our research, studies, and experiences. (LPN/ student RN, #45; italics added)

In both cases, the somewhat extraordinary status of health-care workers was emphasized. In the first case, the term “especially” set health-care workers who become patients apart from a more lay audience. In the second case, emphasis on health-care worker’s abilities to make “informed decisions” and to consult “research, studies, and experiences” suggested that health-care workers who become patients are an elite brand of vaccine recipient who may deserve better treatment altogether. In any case, when it comes to health decision making, they certainly do not deserve to be treated as inferior to patients they serve; at least that was the impression that most public comments suggested.
Further extending this line of argument, there were many mentions of the fact that patients may actually be more risky than their providers as vectors of disease. For instance, a health-care worker stated:

Notably missing from the draft is the topic of visitors in the general hospitalized population (protocol regarding immunocompromised patients were already addressed). Visitors sometimes come in with illness, and they do not always wash hands/ use sanitizer/ proper cough & sneeze hygiene, whereas HCP are already versed in these preventative strategies and are actively employing them. The risk of spreading an illness would be much greater from the general public rather than HCP! Why aren't we educating & screening visitors for s/s illness? Would this be more cost-effective than mandating vaccines? (LPN/student RN, #45; italics added)

Similarly, a health promotion hospital employee argued:

The majority of patients coming into our outpatient clinic are sick, not the healthcare providers. I questioned our employee health department as to why patients that come in the clinic aren’t required to have a flu shot or wear a mask since they are in just as close proximity to patients in the waiting room as providers would be treating them. Those that decline the flu shot are mandated to wear a mask with patient care which is fine with me. I was told that those providers that teach exercise classes we offer to the general public do not have to wear masks. Very inconsistent! (Doctorate, PT Health Promotion, #100; italics added)

I highlight argument strategies that pit health-care workers against patients they serve for two reasons. The first reason is to demonstrate one way that the vernacular corpus actively undermined the logic of official rhetorics of health and medicine. The second reason is to
highlight a somewhat desperate strategy that was used by health-care workers to argue a point when, in fact, caring for their patients was communicated time and time again as a top priority. In other words, it seems that health-care workers were driven to pick a fight against the patients they care for based on circumstances laid via public debate. In most instances, when health-care workers questioned the treatment of their patient in relation to themselves, they affirmed their ethical obligations and recognize inconsistencies in overall health-care philosophies. In this regard, for example, a health-care worker clarified:

Ethically, HCP’s have an obligation to protect and defend those they care for, however, they do not give up their right of self-determination because of that obligation. In a free country we should educate HCP’s about the risks and benefits of influenza vaccination, and allow the individual to choose his or her own healthcare. Each medication we deal with on a daily basis in my practice has risks and benefits, side effects and positive effects. If a patient of mine refuses to take a medication, ethically I must respect that right to choose, even if that choice will cause a delay his healing, causing increased burden and cost to the healthcare system (HCW, #137; italics added)

I do not highlight the juxtaposition between patients and providers to suggest that health-care workers were promoting reversal to patriarchal medicine and/or were suggesting worse treatment for their patients. Slipping into this logical fallacy would be a misrepresentation of what health-care workers seemed to convey across the public docket. Conversely, much of the health-care worker’s heavy handedness with regard to making use of an us-versus-them persuasion strategy may be read as an attempt to make a point dramatically. I say this because, across the corpus, reaffirmations of their professional identity as altruistic caregivers was reaffirmed to remind policy makers that equity in care is also their duty of care.
Special Treatments

Another different but related us-versus-them dichotomy that gets articulated across the vernacular corpus was set up between health-care workers and vaccination manufacturers. Because health-care workers, as noted above, understand themselves to move fluidly between patient and provider statuses when considering the issue of vaccination, across the public comments, health-care workers raised questions about compensation for adverse effects. Recall that adverse effects refers to unintended medical consequences that are prompted by the receipt of a vaccine, and that since 1986, the United States has tracked and compensated for vaccine-related adverse effects via The National Vaccine Injury Compensation Program, if specific effects can be directly linked to a particular vaccinations (a legal clause that has left many sufferers without retribution). With this system in mind, identifying as vaccine recipients (or “patients”) many health-care workers raised questions, such as the following:

\textit{Who will be liable} for damages if a health-care worker is forced to take a flu shot or lose their job and they suffer an adverse reaction? (LRN #11; italics added)

In addition to not knowing if or how compensation would be handled in the event of adverse effects, health-care workers also raised concerns about what the compensation process does or does not communicate about the safety of the vaccines that are being mandated. In this regard, as a health-care employee commented:

\textit{I do not believe the vaccine is completely safe}. There are both known and unknown adverse side effects to the vaccine itself and there are health risks associated with manufacturing, storing and administering the vaccine. \textit{The fact that there are organizations set up to collect data on adverse effects and to compensate people who develop serious complications attests to these claims} (HCP #134; italics added)
In this example, the health-care worker indicted policy norms as implicitly communicating concern about the quality of vaccinations being offered. Indeed, when a government agency is created, it usually indicates that some social, political, cultural thresholds have been reached, and that organized, government intervention is needed. For the case of vaccination compensation, in particular, the existence of a policy process suggests that vaccines have injured enough people in the past and, thus, policy structures intended to address adverse effects and compensation needs communicate that vaccines are unsafe.

However, beyond questions about if, how, or why compensation occurs, the very issue of compensation was frequently brought up in the public register to expose unfair bioeconomic practices. Recall that including the prefix “bio” in my framing of anxiety marks a shift for contemporary medicine that now formally weds biotechnology, and, thus, its bioeconomic infrastructure, to everyday experiences of health and wellness. With this new arrangement in mind, questions about compensation commonly were raised to interrogate the “special treatment” of pharmaceutical manufacturers and medical institutions in relation to issues of vaccination accountability. For instance, a health-care employee wrote:

> We’re not told here that *neither the doctor nor the vaccine maker is liable for any adverse reactions* to a vaccine. Injured parties have to instead go through a long and arduous process called Vaccine Court where claimants are up against government lawyers defending a government program using government money. Few people ever get their day in court (HCA, #22.18; italics added)

Further pointing to fault in legal proceedings, a registered nurse added:

> Mandating a pharmaceutical product that is *protected from direct liability* in court is unjust. Vaccines, like drugs, have adverse reactions. . . . I have no right to sue for vaccine
damage should I become injured by a vaccine, forced upon me, as a condition of employment. (RN, BSN, #114; italics added)

Here, too, as was the case with public structures evidencing public problems, legal clauses that explicitly protect vaccine manufacturers suggest that vaccine injury occurs. Moreover, protection from direct liability conveys that vaccination manufacturers are untrustworthy because they, in essence, are not required to stand behind the product that they create. Harkening back to the personal rights sensibilities expressed in the previous chapter, a consumer status equips health-care workers with a vocabulary to question any manufacturer that cannot ensure product satisfaction. Much like other consumer-driven industries, it is not just the manufacturer that can be held accountable; the merchants who “sell” the product should also be liable. For instance, another health-care workers explains:

I cannot imagine anything more un-American than forcing a medical procedure with known risks, with NO liability by anyone in the chain of command (government that mandates, pharmaceutical company that made it, doctor that ordered it, nurse that gave it) to pay for the disability or death of those victims who had no right to refuse it. Also, there is a near conspiracy of sorts to call any sickness, disease, adverse reaction, disability or death that occurs after vaccination anything except a vaccine reaction. It is unbelievable! So of course it’s easy to think vaccines are great and cause nothing but a bit of soreness or slight fever when every other reaction that happens is always “just a coincidence”

(RN, #127; italics added)

In terms of a persuasive strategy, claiming that no one in a chain of command accepts responsibility conveys a general legal mentality of culpability for unintended consequences, and it suggests that this particular health-care worker is being reasonable. After all, this registered
nurse was not looking to accuse a particular individual; she or he just believed that accountability should be built into the vaccination system because accountability is essential to good medicine. Unfortunately, shifting accountability from individuals to systems may actually do less for processes of retribution than would pinning the success of vaccination to one particular segment of the overall system. Nonetheless, dispersed confrontational remarks, such as the one illustrated above, may intentionally establish health-care workers as reasonable stakeholders in the overall vaccination debate.

In a similarly savvy persuasive move, the president & cofounder of the Health Advocacy in the Public Interest group dispersed blame concerning issues of accountability and injury in relation to vaccination. Included as a “P.S.” at the end of her or his contribution, she or he noted:

The amount of unreported vaccine injury is shocking. DO NOT trust the medical profession, pharma industry or government numbers of reported vaccine injury as these are completely unreliable *feel good* numbers and so under-reported as to be meaningless. (don’t believe me . . . again see link below; President & Co-founder Health Advocacy in the Public Interest, #26; italics added)

Here, the vaccine system was indicted as untrustworthy because it is interested only in self-serving “feel-good” data. Via the quip, “don’t believe me . . . again see link below,” this particular health-care affiliate intentionally deferred personal expertise to another source. In terms of a persuasive, trust-building strategy, by exhibiting deference and humility, this contributor, thus, positioned him or herself in opposition to the unaccountable and, thus, haughty “pharma industry” that refuses to take responsibility for adverse effects.
The final quote that I include in this section similarly highlighted the haughty nature of those in charge of vaccination manufacturing and distribution through the use of the term “special.” A registered nurse simply asked:

If vaccines are so safe, then why did congress give manufacturers *special legal immunity*? (LRN, #11; italics added)

Notably, this quote manipulated language in a way that turns biomedicine on its head. The phrase “special legal immunity” is interesting for the ways in which it adopts epidemiological nomenclatures to chastise policy processes. In this quote, “immune” was deployed to connotate a negative outcome, which stands in contrast to the manner in which the entire public conversation about mandatory influenza vaccinations for health-care workers is founded. Moreover, “special” as an adjective that is used to describe official legal and political processes, which pride themselves on objectivity and formality, can be interpreted only as backhanded. As such, this turn of phrase offers metacommentary on biomedical talk and it suggests that immunity may not always be possible or desirable if equitable health outcomes are to be desired. This alternative stance on immunity is further explored in the next section.

**Medicine’s War on Immunity**

Across the vernacular corpus, there was mention of “nature” or “natural” in relation to vaccination. In particular, many health-care workers suggested that the ingredients in vaccination or the introduction of artificial immunity compromise health. Part of this persuasive occasion required the identification of vaccinations as “toxins,” “poisons,” or as altogether “unnatural”; the other part of the equation required the exaltation of “nature” or “natural immunity” as superior to medical intervention. Each of these emphases troubled a health-care worker’s identity as a professional working in and for Western medicine. Thus, contributions that spoke to this
particular tension suggested a bit of unease about how, exactly, nature and medicine fit together. Efforts to establish a hierarchy between the two paired with efforts to use one to undermine the other suggested that this relationship was complicated for health-care workers who may administer vaccinations but who choose not to get vaccinated themselves. (This lattermost concern is one that I follow up on in detail in the next chapter.) Unresolved tensions between how medicine should relate to “nature” and to “the natural” course of disease may trouble everyday abilities to talk and act around vaccinations and, thus, indicate a site of emotional distress for some health-care workers. In this section, I consider ways that toxins were talked about in juxtaposition to other “natural” solutions.

**Toxic Interventions**

In her book *Toxic Tourism*, rhetorician and environmental justice scholar Phaedra Pezzullo noted:

Toxins have made our wildest dreams come true. They are as integral to our economy as money or natural resources. Since the inception of the chemical revolution, human-made chemicals have become used in almost every facet of our lives, including pharmaceuticals, solvents, adhesives, dyes, paints, preservatives, plastics, electronics, and aerospace industries. It is not an exaggeration to say that over the past one hundred years the [U.S.] nation has fallen in love with chemicals, making chemistry with chemistry.

(2007, 55–56)

In relation to the case of mandatory influenza vaccination for health-care workers, this so-called “love affair with toxins” was leveraged deliberately to suggest that such an affair, indeed, was “toxic” at both the personal- and system- levels alike. Ranging from the identification of certain toxins as particularly dangerous, to labeling vaccinations as entirely toxic for the human body,
contributors to the vernacular register seemed to agree that vaccination was, at least, unnatural and, at most, threatening.

For example, a registered nurse’s contribution included, simply, a list of dangerous substances that most vaccines contain:

There’s the list of toxic ingredients causing a wide range of mild to severe side effects and complications:

- Dangerous levels of mercury in the form of thimerosal, a deadly preservative that is 50 times more toxic than regular mercury
- Ethylene glycol (antifreeze)
- Formaldehyde—a known cancer-causing agent
- Neomycin and streptomycin (antibiotics)
- Aluminum—a neurotoxin linked to Alzheimer’s disease
- Polysorbate 80 (Tween80TM)—which can cause severe allergic reactions, including anaphylaxis
- Phenol (carbolic acid)
- Resin and gelatin—known to cause allergic reactions
- Triton X100 (detergent) (RN, #68)

In this entry, this Registered Nurse raised awareness about the issue via bullet points, a stylistic choice that mimics official rhetorics of health and medicine. The staccato style of bullet points hits the reader with dire concerns in rapid-fire order that leaves no room for questioning. In addition to including technical names of toxic ingredients, she or he made an effort to translate those dangers into either lay language or recognizable side effects. The combination of rapid fire style and pervasive risk may encourage an anxious response from the reader. According to this
entry, there is not just one thing people should worry about collectively when it comes to toxins in vaccinations (e.g., a predominate focus on thimerosol); there is a list of things to worry about. Moreover, many of these “toxic” ingredients are ubiquitous to daily life. In terms of inciting emotion in the reader (and reflecting emotion her or himself), an expanding list of toxic ingredients with articulated dangerous raises levels of worry and anxiety about vaccination as a “best option” for matters of disease management. Unlike some public conversations about toxin exposure, such as those investigated by Pezzullo in her 2003 ethnographic study, vaccination introduces toxins into the human body knowingly and willingly—at least this, too, is what health-care workers emphasized across the vernacular corpus.

For example, a health-care worker wrote:

I would refuse vaccination during a “legitimate epidemic” (which we have not had in the last several decades despite mass hysteria in the media) because I would rather actively support and defend my God given immune system than poison it while my body was trying to fight off disease. There is not a disease on earth for which I would submit to a vaccination, as I don’t believe injecting sickness ever creates better health. We were created by God, designed for health and should be cooperating with the healing power in our bodies, not blocking it at every turn (RN, #127; italics added)

Agency over toxicity avoidance may not be available to individuals living in a region wherein their environment is contaminated; however, options are available to individual patients concerning whether to introduce vaccination toxins into the body. This decision over toxic exposure mattered much to how some health-care workers oriented themselves toward disease management, which was especially true when vaccinations, as a category of preventative medicine, got labeled as “toxic” or “poison” altogether.
In this regard, a Registered Nurse wrote:

Flu shots are not making people healthy. You cannot inject noxious, toxic and biological elements into someone and pretend to improve their health (RN, #127; italics added)

Similarly, another RN argued:

No one should be forced to put poison into their bodies to keep their jobs (RN, #22.39; italics added)

Here, the line between toxins in vaccination become blurred with a conflation of vaccinations as toxins/poison. It is worth mentioning that many of the contributors to the Federal Registry who warned against the connections between vaccines and toxins were registered nurses. Although in this project, health-care workers were treated as one homologous group with regard to the issue of influenza vaccination, a review of the Federal Registry suggested clear correlations between professional rank and type of concern, a nuance that future studies should unpack.

Regardless, in terms of tracking emotion that was related to the threat of toxins, the use of capitalization, exclamation points, and rhetorical questions were deployed to communicate exasperation about mandatory vaccinations. For example, a health-care worker in internal medicine exclaimed:

I had problems getting pregnant and when I finally did I was FORCED to get the vaccine! I am not YOUR test subject and should not be forced to be!! How would you feel if you were having problems getting pregnant and didn’t want to do anything unnatural to make sure your pregnancy is viable and was forced to get the flu vaccine with poisons in it against your beliefs? (HCP- Internal Medicine, #139; italics added)

Harkening back to nature of the medical procedure as being “forced” upon an unwilling participant paired with emphasis on vaccination as an “unnatural” “poison” suggests a true
violation of human rights, as discussed earlier. The statement that “I am not YOUR test subject” is compelling for the ways that it implicitly communicates concerns that are tied to collective memories of Nazi Germany, for ways that it implicitly labels vaccination as a technology-in-process, and for ways that it reinstates the pregnant female body as a sacred site worthy of being preserved and protected.

**Natural Remedies**

Working in tandem with emphasis on toxic/poison ingestion of unnatural hinges, the vernacular readily pitted medicine against nature in configurations of disease prevention. Stated simply, a registered nurse wrote:

Don’t force me to inject *toxins* into my body which can interfere with my beautiful functioning *immune system* and could alter my status of *good health* (RN, BSN, #96)

An emergency medicine technician claimed:

The flu shot is not effective. It contains ingredients *never meant to be in the human body*. (EMT, #32; italics added)

Another licensed nurse noted:

Vaccines have *harmful toxins* in them and are causing many people lifelong diseases that could have been prevented by going the *natural route* (LRN, #11; italics added)

In each of these contributions, there was a deliberate pitting of preventative medicine against the natural course of things. Instead of enhancing the immune system, according to these health-care workers and many others, vaccinations actually interfere with the immune system. As a health-care worker wrote:

Our immune systems are not designed to function properly with intramuscular injection – in fact, our *immune systems require being challenged* from time to time with viruses in
order to evolve and remain healthy. We go to great lengths to actually *destroy our bodies’ abilities* to adapt and respond to pathogens (HCA, #22.23; italics added)

This possibility—of vaccinations undermining an otherwise healthy immune system—has been noted in other recent studies as well; however, those studies focused on reactions of lay audiences, not members of the health-care community (e.g., Lawrence, Hausman and Dannenberg, 2014).

For health-care workers, in particular, an appeal to natural immunity implicitly undermined the identity of medicine as a preventative, intervention industry. In other words, appeals to natural immunity suggested that medicine should fix problems but that they should not interfere with otherwise healthy individuals, even to prevent future problems. In many ways, this emphasis “cuts to the chase,” so to say, with regard to the menacing tension that confronts contemporary medical professionals acting as stewards of public health: The issue of vaccination as a public health problem draws attention to the dual functions of medicine as both a reactive and proactive curative system. In this regard, some health-care workers who contributed to the public registry conveyed frustration about vaccination because it tampered with an otherwise healthy body, as expressed by one worker:

> Real health-care workers focus on the more natural wellness areas and I am just thankful that we have many real professionals in our life that understand the importance of individual health-care and *WELLNESS* decisions . . . It is not one size fits all and no health procedure including any vaccine, should be mandated on anyone. (RN, #27; italics added)

An emphasis on “real” in this quote suggests standards for medical professionalism that require that health-care workers stand back and allow nature to run its course. As stewards of public
health, prevention behaviors should work alongside natural remedies that are used to fend off disease. This passive stance, however, rubs up against medicine as an institution that is equipped with proactive tools that are used to manage disease at the population level. This tension, between patient, natural remedy and proactive artificial intervention, suggests problems for health-care workers who are asked to identify as both medical professionals and public health advocates.

Health-care workers, on a daily basis, may be expected to at least marry medicine with nature, and, at most, to prioritize medicine over nature, especially when disease is upon them. When considering this tension, health-care workers responding to mandatory vaccination policy, more often than not, sided with nature if an ultimatum was forced. The following quotes illustrated the conviction with which many respondents communicated rejection of vaccination as the only alternative. Likewise, the following quotes offered emotional cues that add texture to the public debate that, otherwise, is underrepresented in the official register.

A health-care worker noted:

I use alternative, more healthy, natural methods of healthcare and resent this proposal

(HCP, #79; italics added)

Similarly, another wrote:

Hopefully this committee will rethink this ridiculous mandate that needs be put in the hands of each individual person to decide and get the word out that the best way to prevent the spread of illness, including the flu, is good, old fashioned hand washing, good hygiene, and keeping yourself healthy with diet and exercise! (HCP, #76; italics added)

Words such as “resent” and “ridiculous” feel far from neutral with regard to conveying emotion about this issue. Instead, these types of terms suggested that some health-care workers find the
logic of vaccination policy to be flawed, at best, and overzealous, at worst. Reference to “good, old fashioned” solutions suggests that medicine introduces unnecessary risk into the disease management equation. Along these same lines, another health-care worker exclaimed:

The best way to prevent the flu is to eat right, not be lazy and get some exercise and WASH our hands! *It’s that simple!* (HCP—Internal Medicine, #139; italics added)

Finally, another asked a bold, accusatory question:

*Why don’t you put more time and effort into promoting hand washing, healthy eating and exercise so the whole country would benefit?* (RN, BSN, #96; italics added)

Overall, arguments that link toxic choices and natural remedies, such as these, consistently included alternative suggestions to contradict assumptions about vaccines as the only preventative option. Moreover, as these last few quotes illustrated, health-care workers expressed frustration and contempt for medical procedures that interfered with or replaced simpler remedies.

This subsection considered how talk about vaccination draws forth a tension between nature and medicine. The next chapter considers how health-care workers pull from personal experience to challenge claims of vaccine efficacy and, in so doing, advance understanding of the expert patient.

**Conclusion**

In sum, members of the public are actively testifying and, in doing so, they are constructing an action-oriented narrative of what mandatory vaccinations communicate about profession, citizenship, and community in a biotechnological era. The way that this narrative gets interpreted and represented in the official language of health and medicine, at most, misrepresents or obscures intentions of the public talk about vaccination, and, at least, misses an
opportunity to make use of how vernacular rhetorics can and should speak back to official policies and practices. Here is a case where space was provided for vernacular expression but the process failed to fully consider or integrate public comment. In particular, official representations of public comment neglects important, telling emotional cues that add texture to public debate and suggest that certain tensions associated with vaccination conjure more emotion than do others. Emotion, as an instrument of commonsense, likely compels some health-care workers to act and react in certain ways when presented with vaccination as a mandatory measure. Recognizing patterns across emotional expression may indicate areas of vaccination policy deliberation that require careful consideration.

Experiences of health threat and illness are often complicated by and conjure up uncertainty and emotion across audiences. Change-inducing acts of public resistance, such as those illustrated by vaccination refusal, offer an opportunity to account for the more nuanced emotionally charged side of the public health debate. In situations that require acute decision making amidst emotions that include fear and worry, perhaps vernacular rhetorics offer a more realistic insight into challenges of modern health, medical, and health-care decision making. At the very least, they complement the official record of public health by accounting for and documenting an emotive dimension of public health decision making that likely influences public health practices. Unlike more formal (or “official) rhetorics of health and medicine, which often appear more polished and action oriented, vernacular rhetorics of health and medicine appear to be much more emotionally charged and conflicted.

This chapter reviewed emotions prompted by discussion about competing standards for personal and public health citizenship, recognition of inconsistencies in health-care policies and practices, and in questions concerning an ideal and operable relationship between medicine and
nature. These tensions are likely not going to go away, as the U.S. health-care system is dynamic and complex. Nonetheless, vaccination calls attention to these tensions and then asks health-care workers to make a judgment and to take action. “Judgment,” Hauser wrote, “is a form of knowledge constituted by the very performance and appraisal of discourse in terms of the world our collective activity promises to frame” (Hauser 1999, 100). Beyond evaluating decisions about individuals’ health behaviors, important conversations need to be hosted about what medical professionalism can and should look like as a collective activity amidst biotechnological advance, and how emotion figures into joint abilities to judge and act efficiently and effectively with regard to impending disease threat. This chapter illuminated the emotional toll that such a task requires; the next chapter outlines strategies that medical professionals currently report using to respond to the everyday, anxiety-provoking quandaries that comprise contemporary U.S. health-care.

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1 This is a questionable figure. See footnote 4 in chapter 3 for explanation.

2 For example, the official vernacular claimed that “these comments are almost exclusively in response to Recommendation 4 and represent opinions and personal accounts,” which stands in contrast to describing contributions as “facts” or “evidence.”

3 For example, each contribution is counted equally in an overall account and, yet, some submissions span for pages, are submitted by medical experts, and are well cited, as opposed to others, which are five words or less.

4 For example, the official report claimed that “the majority of individual comments can be categorized into themes (themes represent >5 common responses),” and then reduced and organized individual responses into categories using counts.

5 For example, all “Individuals that [sic] oppose Recommendation 4” are reduced to nine bullet points, seven of which begin with the word “concern” or “concerns” as representative of what the opposition looked like.

6 I describe these commitments in further detail in chapter 8.

7 Tension between “the natural” and “the manufactured” is closely related to and significant in light of ongoing enhancement, genetic modification, and bioengineering debates. Therefore, I revisit the nature–manufacturing divide in my discussion of “medicine’s war on immunity” in a forthcoming section.
CHAPTER VII
BEST PRACTICES FOR MEDICAL ETHOS

This chapter investigates medical professionalism as a site of overlap, or “complementarity,” between policy makers and health-care employees. Following a description of my analytic orientation toward rereading the vernacular and official corpuses with a standard of complementarity in mind, I outline “best practices” for medical professionalism as suggested by the vernacular register. I find that health-care workers responding to the possibility of mandatory influenza vaccinations champion standards for medical professionalism that far exceed the adoption of any particular biotechnology. Whereas the official corpus streamlines methods used to communicate quality care (“get vaccinated”), health-care workers detail a range of options that are available to medical professionals wishing to communicate trustworthy care amidst disease threat. Beyond expertise and acquisition and expression of “books smarts,” health-care workers extend standards of medical professionalism to include daily observable behaviors that convey “street smarts” to patients they serve. In line with an Aristotelian notion of ethos, health-care professionals contributing to this public register highlight practical wisdom, or phronesis, as being essential to the delivery of quality care. Additionally, my analysis of public responses to the recent NVAC recommendation report suggests that health-care workers also factor in daily performances of care and public perceptions of policy into their everyday management of disease. These three “best practices” or standards for medical professionalism in
a biotechnological era—*performance, phronesis,* and *perception*—reveal the rhetoricality of contemporary medical practice, a quality that I call *medical ethos.*

**Official–Vernacular Overlap**

In contexts that require the orchestration of competing elements of human experience, such as U.S. health-care, tension necessarily characterizes decision-making processes. Balancing issues of patient autonomy with public health-security measures, approaching medicine as a caring art and a profitable business, or adopting an individual therapeutic position on health intervention, as opposed to a more collective, system-level preventative paradigm, are just a few examples of the types of tensions that likely accompany vaccine decisions, specifically, and contemporary U.S. health-care experiences, more generally. For these types of tension-prone situations, a rhetorical perspective offers a framework to understand how tension operates in everyday interactions, sometimes productively, sometimes unproductively. Couched in ongoing uncertainty about how to best manage communicable disease, investigating tensions inherent in mandatory vaccination policy communication allows rhetorical analysts to consider the array of tensions that might be expressed if and when private health agendas compete with public health initiatives. With direct implications for how to map out complex relationships between persuasive elements in public health discourse, Segal noted, “Rhetorical study suggests countless opportunities to reflect on health and medicine’s complexity” (2005, 156–157). Indeed, across rhetorical studies, expectations concerning complexity abound. Condit, for example, in reference to her study of public debate surrounding gene therapy, affirmed, “To study rhetoric is not to seek for a single unifying principle. It is to seek for the important discursive units that recur in discussions of an era and to explore their interactions” (1999, 253). For the case of mandatory
influenza vaccinations for health-care workers, specifically, one meaningful “discursive unit”
cuts across official and vernacular rhetorics of medicine alike: medical professionalism.

According to the field-mapping handbook *Medical Communication: Defining the
Discipline*, editors E. Phillips Polack and Theodore A. Avtgis defined *medical professionalism* as
“the degree to which a person exhibits and exceeds those standards and expectations set forth by
the publics they serve and the governing bodies that set such standards and expectations” (2011,
358). This definition reveals a dual acknowledgement of the need for professional behaviors to
be evaluated as such by both expert (official) and lay (vernacular) audiences alike. This
perspective on professionalism has proliferated across medical education curriculum in recent
years. As Tim Swanwick, editor of the volume *Understanding Medical Education*, explained:

Very recently, the whole question of professionalism and how it is acquired has gripped
the professional and its educational institutions worldwide. Such issues have arisen from
a series of trigger crises that the profession itself experienced in standards of practice and
in changing practices, as well as in the changing role of doctors in society, market forces
and accountability within the healthcare system, and society’s changing relationship with
the profession in the light of greater universal education and wider access to previously
protected knowledge. Each of these ideas has its direct effect on the design of [medical]
curriculum. (2010, 8)

Indeed, the rise of the expert-patient paired with a litany of infrastructure changes has advanced
and complicated expectations for medical professionals among lay and expert audiences alike. To
better leverage overlaps between official and vernacular rhetorics of vaccination around the issue
of influenza vaccination, and to add to a growing body of work that is interested in shifting
notions of medical professionalism for the contemporary era, I examined the National Vaccine
Advisory Committee’s most recent policy recommendation document and the public response that it invited, with attention to considerations of medical professionalism.

Advantageously, findings from this analysis suggest that considerations of the future of medicine emerged as a space where both official and vernacular positions align. Although ranges of emotion remained largely absent from the official rhetorics of health and medicine, considerations of professional identity maintenance and its link to patient safety and perceptions were foregrounded in both the official and vernacular corpuses alike. What this finding indicates, perhaps, is that the issue of professionalism exists on the forefront of the mind of both official and vernacular actors alike, and, moreover, this discursive unit indicates an opportunity to host a productive conversation despite differences of opinion and need. Although particular duties of care (i.e., getting vaccinated or not) are contested with some regularity between official and vernacular publics, the undercurrent for sustaining conversation about what constitutes professional behavior amidst biotechnological revolution seems to be strong. This particular case does not present a situation wherein an institution is in denial concerning its need to change or its shortcomings in terms of promoting a successful image of itself to others. Conversely, both official and vernacular participants agree that professional behaviors for a biotechnological era must be determined to restore the reputation of a field.

Official institutions of medicine regard vaccination as the gold standard of protection against disease, with this belief rooted in a history of notable vaccination success that have become intimately linked to the reputation of medicine and, therefore, pride for the profession. In this manner, vaccinations symbolize professional success, as well as pragmatic ritual. In matters of influenza control, then, official health policy language configures vaccination as an important reflection of medical professionalism across health settings and audiences. This is not to say that
other preventative options go completely unrecognized by official policy communication but other options are deemphasized in official public health policy. Beyond identifying “best practices” for health-care professionals (which tend to serve as the “go-to” method for intervening on behavior via policy), vernacular rhetorics introduce new standards to communicate medical professionalism amidst biotechnological advance. In particular, attention to patterns across the vernacular corpus suggests a range of options that are available to modern-day health-care professionals wishing to foster trust amidst threat. This range of options can be grouped into three “priorities” for medical professionalism in relation to disease management, more generally, and influenza vaccination, in particular: performance, phronesis, and perception. Each priority points to a rhetorical attribute of medical professionalism that, otherwise, has been overlooked by official rhetorics of medicine, which are focused solely on promoting vaccination as the “gold standard” for mindful disease management. Instead, the vernacular corpus suggests that medical ethos, the perceived professional status of health-care workers derived from observations of behaviors, requires attention to audience (via “performance”), impromptu, situated decision making (via “phronesis”), and attention to public image and context (via “perception”) to successfully move patients and their providers to healthful action.

In relation to concepts introduced in previous chapters, whereas proxy debate describes symbolic qualities of vaccination for public argument and bioanxiety evidences unresolved problems or sites of agitation for contemporary health-care, medical ethos highlights rhetorical actors in medicine who influence (and, ideally, may offset) now mundane attributes of U.S. health-care. However, rhetorical “best practices” for modern medicine solicit health-care workers as, potentially, both cause and cure for bioanxiety, more generally. As a daily work requirement, medical professionals must navigate a complex environment, and, in many cases, they do so
consistently and effectively. Observing professional poise and resolve amidst complexity and chaos may actively offset patients’ experiences of bioanxiety because they see their health-care providers negotiate anxiety-provoking factors effectively. Conversely, however, theorizing medical ethos also highlights the possibility of these same factors contributing to ongoing anxieties for patients. For example, if a health-care professional fixates on influenza vaccination in conversations with a patient and fails to recognize what that issue symbolizes on a larger scale, that health-care professional engages in argument by proxy, potentially scapegoats a valuable health intervention tool, and fails to address a system-level node of concern currently agitating patients. Similarly, if a health-care worker is unable to communicate directly about vaccination or to act definitively when faced with disease threat at the personal level, that health-care worker may perpetuate experiences of bioanxiety for patients and publics, because they are influential figures in disease management apparatus. Therefore, acting as nodes of influence, the manner in which health-care professionals orient themselves to certain symbol-rich biotechnologies, such as vaccination, likely matters to overall public health-security outcomes. With this implication in mind, the best practices for medical ethos outlined next—performance, phronesis, and perception—may identify essential tools that are needed to both understand and foster future relationships between medicine and its publics from the perspective of those on the ground.

**Rhetorical Health-care**

Communicating poise and resolve amidst disease threat shows a level of training and experience among health-care workers that is required to gain the public’s trust for times of need. In *The Rhetoric of Expertise*, Joanna Hartelius examined rhetorical aspects of expertise across four contexts (political, historical, medical, and informational). As Hartelius explained:
A rhetorical point of view explains why experts face similar exigencies regardless of subject matter. These exigencies, which are ubiquitous in modern culture, contain certain expectations of what experts must be and do in and through language in order to be received as experts. (2011, 1)

In this regard, via textual analysis, Hartelius identified four rhetorical concepts (or concept pairs) as being essential to understanding the discourse of experts, regardless of field or training: *invention and performance* (the knowledge that an expert offers and the means by which the expert offers it), *ethos* (the perceived character of the expert), *identity and identification* (the expert’s performance of belonging to an audience and profession), and *audience* (the successful recognition of an expert’s status by intended message consumers). Each concept emphasizes ways that expertise—as a persuasive characteristic—requires both relational and substantial considerations. As Hartelius explained:

> The question of expertise as an individual quality versus an attribution made by others becomes moot as a rhetorical perspective reveals that it is necessarily and simultaneously a function of both. Specifically, source credibility, or *ethos*, redefines expertise as a combination of the expert's knowledge and competence and her perceived trustworthiness and goodwill. (2011, 11)

Hartelius examined expertise in and for the medical context, claiming, specifically, that “medical expertise is a long-contested cultural phenomenon” (17). Via a comparative analysis of two publications (an authored and an edited book), she considered how a psychiatrist presented his clinical expertise on depression in comparison to how patients living with depression present expertise on the subject. For health contexts and issues, in particular, her findings suggested, claims to expertise require more than mere technical training; indeed, for matters of health and
medicine, in particular, embodied experiences matter greatly to the ownership over expert status. Hartelius explained that experience-based expertise may be acquired through long-term exposure, repeated practices, or access to limited events. Experiences, such as these, offer specialized knowledge that can compete with (or complement) expertise acquired through traditional, technical training.

For the case of mandatory influenza vaccinations for health-care workers, specifically, it seems, both relational and substantial dimensions of expertise are required to effectively convey trustworthy care across diverse audiences. Contributors to the public registry did frequently note technical expertise as needed to ensure patient safety, but they did so in a way that seemed to convey that expertise—in the technical sense—is obvious. In this regard, many respondents began their contributions by stating their credentials. For example, a health-care worker claimed:

As well-educated, licensed, healthcare professionals we are about to be denied the opportunity to do our own research, speak with our own physician, and make the decision

(Registered Respiratory Therapist, #9; italics added)

By opening statements in this, or a similar, manner, most health-care workers mentioned their credentials early to establish initial, technical credibility before diving into deeper, relational arguments about standards for high-quality health-care. Indeed, in many cases, it appeared as if technical expertise was a baseline requirement to join the conversation about mandatory vaccinations in the first place. (Perhaps this is why the vast majority of respondents to the “public” register self-identified as credentialed, active members of the health-care community.) Nonetheless, in addition to more substantive know-how required to ensure patient safety standards (e.g., making sure one is licensed), a notable number of respondents also mentioned behaviors that extend beyond credentialing as a necessary standard for ensuring patient safety.
Therefore, whereas official rhetorics of health and medicine tended to stress the “substantial” requirements of expertise (e.g., “a professional gets vaccinated”), across the mandatory vaccination for health-care workers’ vernacular data set, contributors mentioned technical credentialing before launching conversations about “relational” dimensions of medical expertise.

Establishing patients’ trust, oftentimes, was presented as a precursor to, or, at the very least, associated with, patients’ safety goals. A need for patients’ trust suggests both a relational dimension of effective health-care delivery and attention to audience as important for overall assessments of expertise. Health-care workers contributing to this public debate illuminated three dimensions of contemporary health-care delivery processes that are involved with communicating medical expertise via disease management: performance, phronesis, and perception. In short, above and beyond mere vaccination—which might be understood, in a substantive sense, as checking an expert duty off a credentialing list—health-care workers attested to a number of observable behaviors required of them across time and place.

Specifically, attention to daily performances of healthy living, demonstrations of practical wisdom founded in past experiences, and recognition of public perception as key to long-term disease management strategy suggest that modern-day medical professionalism is rhetorical, all the way down. Below, I review each of these conditions for contemporary medical professionalism—performance, phronesis, and perception—via vernacular testimony to advance a theory of medical ethos, more broadly.

**Performance**

Expanding on how and why audience perception matters centrally to the function of medical expertise, with specific focus on rhetorical aspects of medical expertise, in particular, Hartelius suggested that expert status is earned via particular skills _and_ successful claims to
ownership and legitimacy. These lattermost factors, she maintained, are acquired by and through persuasive exchanges that define how experience factors into knowledge claims. Specifically, she claimed:

The artistic aspect of expertise is that which is invented rhetorically. Herein lies the importance of the expert’s performance. Thus, in this context, performance is not a matter of theatrics or artifice, but a vital part of rhetorical success. The expert is required to enact her position, knowledge, and experience in a public manner while considering audience and context. This means that neither ‘knowing your stuff’ nor having an official title is enough. . . A rhetorical perspective on expertise combines artistic and inartistic means of persuasion. It reveals how an expert uses both invented and “preexisting” forms of proof. (2011, 9–10)

This rhetorical approach highlights the performative dimension of medical expertise and extends traditional understandings of ethos by describing the process through which medical actors communicate expertise via everyday performance, performance that is visible to and evaluated by the members of the publics they serve (aka patients).

Across the vernacular corpus, mention of particular behaviors as necessary for establishing perceptions of medical professionalism was frequent. In terms of identifiable traits, contributors responding to the NVAC draft proposal stressed that health-care workers must be role models, responsible, and risk takers. Each of these attributes, many vernacular contributors suggested, should be observable during everyday interactions and through lifestyle choices that are made by medical professionals at work and at home.

In terms of role modeling, many nurses mentioned their personal commitment to leading healthy lives. For example, a registered nurse wrote:
I am proud to say that I wash my hands, take Vit D3, eat healthy and organic, and most of all exercise hard (RN, #8; italics added)

Another Registered Nurse noted:

I am in impeccable condition, leave a very clean and disciplined life, and I take no medication (RN, #132; italics added)

Hence, health-care workers explained that just because they have knowledge about the type of lifestyle to lead, for them to recommend certain behaviors to patients, they must draw from the lifestyle that they do lead. For these health-care workers, alignment between knowledge and personal behavior seemed essential to claiming expert status. Mention of “exercising hard” and being in “impeccable condition” suggested that, as part of their performance of professionalism, the lifestyle that they lead outside of work carries with it certain physical markers that are observable by patients they serve. For instance, at the very least, washing hands in front of patients may communicate personal healthy lifestyle choices and, thereby, build credibility between provider and patient. Along these same lines, another health-care worker wrote:

Educating health-care workers to adopt a more whole food diet, practice lifestyle activities such as exercise and proper rest and supplementing with Vitamin D3 will all boost their natural immunities without the toxic overload vaccines have to offer (RN, #49; italics added)

Here, too, a commitment to a lifestyle, rather than the adoption of a one-time annual intervention, suggested that long-term performance is required to speak convincingly about health and health-care. Moreover, again, there was a mention of “toxic overload” positioned as being counter to healthy living, and education about the issue was promoted as necessary for living healthfully.
Another registered nurse posed a rhetorical question about alternative solutions:

How about recommending that people be more healthy and take a little extra vitamin D during flu season? (RN, #28; italics added)

Requests to recommend that health-care workers “be more healthy” suggested the promotion of patterned behaviors that extend beyond the adoption of any particular medical intervention. In this regard, other health-care workers promoted lifelong learning as essential to “staying healthy.” For example a registered nurse wrote:

*Educating yourself* does include knowing your responsibilities of *staying healthy*, keeping your immune system optimal, and not infecting anyone, especially your patients by working when you’re not well. *That is our responsibility* (MS, RN, L.Ac., #101; italics added)

Another health-care worker stated:

*I take responsibility to keep my body healthy* and, as far as I can remember, *not had a Sick Day in the last 5 years* (RN, #30; italics added)

In addition to being role models through the life they lead, medical professionals are also responsible for the outcomes of their health-related decisions; that is, they “take responsibility” to keep their bodies healthy. One measure of accountability, as exemplified by this last quote, is to come to work. In terms of performance, above and beyond leading a certain lifestyle outside of work that allows for health-care workers to draw from experiential knowledge to then recommend health behaviors to patients at work, health-care workers mentioned the need to come to work healthy and consistently as a standard of medical professionalism. Indeed, noting a lack of “sick days” appeared more than once across the public register, suggesting that attendance at work is required for health-care professionals, even if risks loom.
With regard to risk in the workplace, in particular, a health-care worker explained:

As a nurse in a major university hospital, I expose myself to deadly viruses, bacteria and disease on a daily basis. *It is a risk I am aware of and willing to take* in order to provide care to the patients who need my help. While I can use protective measures to avoid contracting most of these, there is never a 100% guaranteed safety measure available to protect me from these diseases. *It is a risk I am willing to take and I fully consent to.* I have the right to work somewhere else if I feel the risk is too great. The federal government does not have the power to protect me from 100% of these risks. It also does not have the authority to mandate I work at that hospital. *It is a choice I exercise because of the rights provided to me in the constitution.* In turn, because the government does not offer 100% protection to me against any possible side effect from the flu vaccine, it should not have the authority to mandate *I take this risk, which violates my personal rights of liberty and freedom set in the constitution.* (RN, BSN, #96; italics added)

In this quote, again, appeals to personal rights and choice were made (themes that were discussed in chapter 5). Moreover, however, the word “risk” was mentioned three times. In terms of performance, this quote suggests that taking risks—whether that be treating a sick person or reporting for duty during a pandemic—communicates professionalism among patients and colleagues alike. “Exposure to deadly viruses” . . . “on a daily basis” . . . “to provide care to the patients who need . . . help” is a charge that suggests contemporary health-care professionals routinely communicate care to their patients via reporting for duty, regardless of risk to self. Moreover, when in the health-care setting, many health-care workers, as indicated by the following quote, also noted the adoption of preventative behaviors that communicate safety amidst risk:
I, as well as my fellow healthcare professionals, protect my patients by following *protocols* regarding *minimizing exposure and transmission* of the influenza virus via personal *protective equipment and hygiene*. These protocols are in place in all healthcare facilities, and these should be recognized in order to maintain my, and my fellow healthcare workers’, personal right to refuse the influenza vaccine (Physical Therapist, #25; italics added)

As this last statement illustrated, protocols are in place because risk is almost certainly a part of medical work. Showing up for work healthy and willing “to provide care to the patients who need . . . help” suggest observable qualities that communicate professionalism above and beyond personal protection via vaccination. Indeed, many health-care workers poked holes in logic that assumed vaccination is a measure of professionalism, and, instead, they highlight long-term, observable behaviors that evidence commitments to professionalism and patient safety on a daily basis.

In sum, many respondents to the public registry noted actions taken outside of work and inside the halls of medicine to communicate a healthy lifestyle. In addition to modeling ideal behaviors, health-care workers noted a need to be accountable for their health outcomes, and those of others, by showing up to work and adopting behaviors (such as hand-washing) that minimize risk for self and others. In this sense, health-care workers denoted a range of methods to ensure patient safety and well-being that transcend the adoption of any one biotechnology.

**Phronesis**

Aristotle’s *Rhetoric* introduced the term *ethos* to indicate the key influence that character has on people’s perceptions of others’ expertise. According to Aristotle, ethos is comprised of three components, each essential to effectively shaping public perceptions of a speaker:
phronesis (practical wisdom), arête (virtue), and eunoia (goodwill). In her 2004 aptly titled book How Doctors Think, Kathryn Montgomery demonstrated how effective health-care practice requires medical professionals to combine knowledge and skills with a keen sense of timing to intervene on health effectively. Montgomery argued that “clinical medicine is neither a science nor art but practical reasoning, an account that takes into consideration the uncertainties inherent in the physician’s task of diagnosing and treating sick people” (9). Practical reasoning refers to medical professionals’ ability to consider patterns in past patient experiences to determine how and when to act most appropriately in the present. The lattermost half of this equation, which emphasizes timing as essential to effective rhetorical action, is known as kairos. With regard to communicating expertise across health settings and in relation to disease threat, a number of health-care workers noted personal abilities to exercise judgment and individuate care based on needs of a particular situation.

Throughout the vernacular corpus, health-care providers made reference to their abilities to act and react across a variety of situated incidences. Moreover, they noted dimensions of practical wisdom that required nuance and patience with regard to the delivery of care. For example, a health-care worker wrote:

I understand that we as healthcare workers have a requirement to protect our patients, but we are capable of doing that within the restraints of our judgment as well (Physical Therapist, #25; italics added)

Appeals to judgment or an ability to judge amidst limited resources and information were notable across the vernacular corpus. In most cases, appeals to personal judgment were made after mention of a commitment to patient safety. In a similar manner to which mention of credentials was included as an opening line across entries, affirmation of a commitment to patients’ safety

seemed to be included as an almost obvious, yet necessary, aside. In this vein, a health-care worker noted:

I am very concerned about patient safety and will never endanger my patients in this way.

What I see, is the vaccine creates a false sense of security that patients are protected if everyone gets the shot. It has not been the most important measure to prevent respiratory febrile illnesses in my hospital this year (CRNA, MSN, #120; italics added)

The claim, “[I] will never endanger my patients,” implicitly speaks to the practicality of the professional. As opposed to a statement, such as “I will never harm my patient,” the term “endanger” suggests management of contextual features to ensure safety. Distinct from introducing danger into a scenario, this statement suggests that health-care workers routinely assess situations and patients’ needs to evaluate risk/danger according to the particulars of each scenario. An ability to transition from one patient to the next and to tailor environments and care as to not endanger patients “in any way” suggests that health-care workers remain savvy and flexible to respond to the needs of individual, unique patients. This type of flexibility requires practical knowledge, as there is no way that technical knowledge could prepare health-care workers for every single scenario they might face. Additionally, the contributor above was worried that vaccination may create “a false sense of security” for patients in his or her care. Referencing an ability to identify a “false sense of security” implicitly suggests that health-care providers are keen to “true” or “real” senses of security that are required to ensure patients’ safety. Discerning between “appeals to safety” versus “actual safety” details reasonable and informed judgment on the part of health-care professionals to assess danger and to identify reasonable and effective modes of protection. This skill resonates with the practical wisdom that Aristotle outlined as being essential to communicating expertise across settings and audiences.
In addition to rising to the contextual particulars of each occasion, health-care workers across this registry communicated a discerning quality about health-care work that appears to stand outside of the technical realm. More akin to the experience-based expertise that Hartelius promoted, many health-care workers used the phrase “one size does not fit all” to communicate unique qualities of each patient relationship that they keep and each patient’s body who they treat. For example, a nurse exclaimed bluntly:

*ONE SIZE DOES NOT FIT ALL!* (Nurse, #22.7; italics added)

Similarly, another health-care affiliate stated:

*Medicine isn’t ONE SIZE FITS ALL—even for vaccines.* (HCA, #66; italics added)

As noted above, technical know-how can provide health-care workers with only so much preparation for how to respond to the particulars of each patient’s situation. Affirmation that “one size does not fit all” suggests that, from experience, health-care providers understand that medical care cannot treat everybody the same. Whereas a “one size does not fit all” mantra could represent an evaluation of one particular biotechnology, in this case of vaccination, the lattermost quote specifies, “*Medicine isn’t ONE SIZE FITS ALL*” (italics added). This wording implicates the institution, and policies and practices therein, as not operating according to a “one size fits all” logic. This emphasis differs from claiming that the science of a particular biomedical technology may not be conducive for the biological body of a particular patient and, instead, shifts focus to ways that a system or organization slips into practices that assume a “one size fits all” logic. Indeed, many policies (and mandates in particular) assume the “one size fits all” solutions to variable problems. In denouncing that common strategy/logic, health-care workers implicitly suggest that another technique is necessary to deliver quality care: Medical
professionals must treat each patient as unique, a skillset that requires attentive care and recognizes variability as a precondition for health.

In this regard, a registered nurse noted:

Real health-care workers focus on the more natural wellness areas and I am just thankful that we have many real professionals in our life that understand the importance of individual health-care and WELNESS decisions . . . It is not one size fits all and no health procedure including any vaccine, should be mandated on anyone (RN, #27; italics added)

Here, the words “real,” “natural,” and “wellness” are emphasized in addition to the “not one size fits all” refrain. Combining elements of performance and phronesis, then, this particular quote delineated that “real” medical professionals prioritize healthy lifestyle choices and recognize that those choices require a keen ability to assess and respond to the needs of particular patients.

Beyond treatment of immediate ailments, an emphasis on wellness, once again (as was the case in the last chapter), communicates medical professionals’ focus on long-term plans and goals. Developing wellness plans alongside patients is decidedly a creatively tailored task. Being able to “read” a situation to decide which course of action would be best for this particular patient at this particular time suggests the need for medical professionals to remain mindful of timing and to remain poised to act, two skills that align with experience-based practical wisdom.

An ability to weave together personal experience with technical knowledge suggests that the two dimensions of expertise—substantive and relational—work hand-in-hand to communicate trustworthy medical care. In this regard, a medical professional disclosed:

My father died of polio in 1950 and we were all glad to get vaccinated against polio. The flu is another matter, however. Very little is known about how each individual's immune
system will respond to a flu vaccine, and whether it will be effective. The lesson I learned from this relative to mass immunization is “one size does not fit all.” (HCP, #144; italics added)

The idea that a takeaway lesson can be learned from a personal tragedy and that lesson then can be used to inform professional interactions years later indexes the experience-based expertise that Hartelius outlined. In this case, as was the case with many other health-care workers who infused their contributions with personal accounts of successes or tragedies, rejecting approaches to medicine as “one size fit all” asks health-care workers to adapt to the needs of particular situations at particular times, a skillset for which technical knowledge can support a worker only so far.

To adequately meet the needs of each patient, this data set suggests that contemporary health-care professionals must trust and make use of experience-based practical knowledge to deliver quality care. Each time that medical professionals successfully keep a patient safe or solve a patient’s particular problem, they affirm ability to exercise judgment in situ. Situated decision making and a “show up and rise-to-the-occasion work ethic” convey that medical professionalism surrounding disease management requires more than one-size-fits-all interventions or interactions. Indeed, health-care workers in this particular sample suggested that professionalism entails assessing a situation and adjusting according to the needs of individual patients, a skillset that cannot and will not be communicated through the sole adoption of a vaccination.

Public Perception

In terms of public health-security writ large, distrust in experts significantly weakens the U.S. national systems of disease management and preparedness, because preemptive risk
response systems require that audiences perceive threat and take action in advance of an actual pandemic. The frontlines for communicating health threats and promoting preventative behaviors includes health-care employees, which means that public distrust of those actors could compromise an entire public health system. Rhetorician of science James Wynne argued that it is wholly rational for the public to link risk and trust: Because surprises will occur, the issue becomes whether the public has confidence in the systems and experts ready to deal with problems when they arise (2001). Unfortunately, as was detailed in the first chapter of this dissertation, public perceptions of medicine, and trust in medical expertise, in particular, have been declining steadily across the U.S. landscape. This trend holds repercussions for the everyday operations of health-care, because, as The Institute of Medicine (IOM) specified, “The public will support science only if it can trust the scientists and institutions that conduct research” (1). For the modern biotechnological era, this trust, at least in part, is contingent on public understandings of medicine as a legitimate, honest business. For the science of medicine to advance, this IOM quote suggests, significant portions of the U.S. public must trust their public health leaders and workers when it comes to vaccination research, development, and deployment. This task, literature suggests, may end up being intimately tied to public health policy communication that takes place in health settings. However, “the idea that more scientific research and further risk communication from experts will positively influence public attitudes and behavior,” social scientist Pru Hobson-West warned, “is part of the deficit model of the public understanding of science” (2003, 279). Improving public perceptions of medicine and trust in medical experts will require more than the delivery of information.

Thus far, the corpus has revealed mechanisms to establish trust in medicine operationalized through a focus on everyday performances of health and experience-based, with
situated decision making used to benefit particular patients at particular times. The last category of responses broadens the scope a bit to communicate about perception as essential to modern medical professionalism. In addition to performing professionalism by living healthfully, and demonstrating situation-specific savvy derived from experience, the other element of medical professionalism that was conveyed consistently across the vernacular register concerned audience approval. In particular, health-care workers made multiple efforts to remind policy makers that public perception of medicine matters to the functions and successes of medicine. In terms of communicating this message effectively, health-care workers advanced two types of appeals that demonstrated a keen awareness for the rhetorical concern of audience. First, there were direct appeals to public perceptions of medicine that were founded on consonant talk and action. Second, there were pragmatic warnings about the maintenance of a professional identity as educated and discerning. Across both strands of argument, health-care workers communicated that trust is essential for successful daily medical practice, as well as for worst-case scenario response situations. (Trust, keep in mind, refers to a relational dimension of expertise that extends beyond substantive/technical know-how.)

With regard to the first strand of argument, a register nurse pleaded:

Please consider the image that will be portrayed to the general public as HCP are forced to take the flu vaccine to keep their job. We are an educated bunch, and the public trusts us (read the surveys, it’s true). And who does the public not trust? The big government folks, that’s you (read the survey’s, it’s true). Once you force HCP to vaccinate, I believe the talk on a grass roots level will be such that the public will wonder why this vaccination had to be mandated. I feel this will decrease the strides made in vaccinating the general public. Trust in this safety and efficacy of this vaccine will be eroded (RN,
Here, there was another mention of “forced” vaccinations and negative connotations that it carries in terms of human rights, more generally. Uniquely, in this particular quote, the contributor juxtaposes “force” against “trust.” In doing so, the author tapped into some of the emotion inspired by the moral health vernacular, previously discussed, but then targeted that emotion at a particular unwelcomed consequence: erosion of public trust. In particular, this author suggested that, problematically, a forced medical procedure depletes public trust that is associated with whichever medical procedure/product is being mandated. This technique of linking mandates to distrust in medicine is persuasive because vaccinating the health-care workforce is really only a small percentage of the overall national population that needs to get vaccinated to establish herd immunity across the U.S. nation. In other words, many more non-health-care workers must get vaccinated to methodically fend off disease threat. Essentially, what the above quote asked is whether forcing health-care workers to vaccinate was worth the risk of deterring the general public from adopting the behavior themselves.

Similarly, another nurse wrote:

The goal of controlling infectious disease must be kept in mind. Mandating a variable and problematic vaccine will undermine the faith/trust the people have in their governing agencies . . . . HCWs are a group of highly experienced and educated people; while you may win this single battle the damage that will follow will far outweigh any potential good. Consider how the general public will respond when the HCW in their circle of family/friends speaks about being forced to receive an unwanted vaccine. That same HCW that may have never discussed the vaccine before will now talk. Many times the
family, church or nurse friend’s opinion is held in higher regard then that of the CDC or FDA (RN, #7; italics added).

Here, an appeal to “the risk is too great” was deployed. As a gesture toward reassuring the public health officials about his or her ability to make reasonable assessments concerning connections among public perceptions, trust, and mandatory vaccination, this particular contributor explained that health-care workers are “highly experienced and educated.” The author then went on to, basically, threaten the image of the profession by providing readers with a hypothetical scenario. The scenario provided was reasonable and further extended “the risk is too great” appeal by suggesting that one disgruntled health-care worker may contribute a ripple effect that extends beyond the halls of medicine into the surrounding public. Making use of the “slippery slope” appeal, this contributor claimed, “while you may win this single battle the damage that will follow will far outweigh any potential good.” Although, technically, a logical fallacy, this argumentative device compellingly reminds policy makers that health-care workers are a small but significant portion of the population who wield personal, persuasive power over national vaccination trends. Given what is known about health-care workers’ influential status across various communities, this particular threat carried with it some factual support that bolstered the slippery slope appeal as a reasonable conjecture.

In addition to threatening how forced medicine might negatively impact public perceptions of medicine, in general, and about how this particular mandate might undermine the success of this vaccination, authors also pointed out dissonance as a potential breeding ground for public distrust. For example, a health-care worker wrote:
If you trust us with taking care of you or your family members when you’re not well, sick, or injured, shouldn’t you trust us to take care of ourselves and not spread disease and illness to you and your families (MS, RN, L.Ac., #101; italics added)

With regard to observable performance, assigning the care of the nation’s most vulnerable populations to health-care workers communicates trust in their altruistic nature and ability to care for the ill. Conversely, mandates communicate distrust in health-care workers’ abilities to make tough and necessary decision regarding health. The disconnect between the responsibilities that U.S. society bestows on health-care workers on behalf of others and responsibilities that U.S. policy makers wish to withhold from them with regard to personal health decision making suggests a mixed message at the public level with regard to trusting medical professionals in matters of disease. Similarly, another health-care worker wrote:

We are trusted with the lives of people we care for in the hospital, but can't be trusted to make an educated decision about whether we should receive the flu shot?? Do we really want healthcare providers who don't research issues, but instead just follow orders?

(Registered Respiratory Therapist, #9; italics added)

Posing this rhetorical question punctuated inconsistencies in the overall logic and practices of public health. Moreover, in terms of illuminating something about medical professionalism more broadly, this last quote suggested that desirable health-care workers do not blindly follow orders but think for themselves and do research to inform personal choices. Denying health-care workers the ability to exercise this dimension of professional duty risks sending the wrong message to various publics about the type of health-care professional who is admired across contemporary health-care settings. Contrary to what the question implies, following orders is not what is desired of medical professionals for a biotechnological era; instead, as the last subsection
outlined, the need to tailor medicine to specific needs and unpredictable situations is required for the delivery of high-quality health-care. As a trustworthy, observable behavior, when health-care workers conduct research and make educated decisions concerning their and others’ health, they communicate professionalism in the contemporary era. In this regard, I revisit a quote that was included above:

As well-educated, licensed, healthcare professionals we are about to be denied the opportunity to do our own research, speak with our own physician, and make the decision

(Registered Respiratory Therapist, #9; italics added)

This particular quote suggested that a mandate will actually detract from health-care workers’ ability, indeed motivation, to conduct research concerning health options. In this sense, not only will mandates convey that ideal health-care professionals follow orders but it will actually deter health-care professionals from acting agentially with regard to personal and patient health decision making. Harkening back to calls for health-care workers to act as role models for the patients they serve (recall that this is a performative measure for modern medical professionalism), conducting personal research and engaging in informed, critical discussions with their physicians models ideal patient behavior for others. Forgoing opportunities to model good behavior or to develop experience-based expertise, inevitably, will detract from a health-care workers’ ability to shape public perceptions of medicine favorably.

With regard to image management, in a very practical sense, in addition to linking mandatory vaccinations with decreased perceptions of public trust and decreased agentic participation among health-care workers, mandates may also lead to staffing shortages. As a health-care worker commented, the mandate
will cause less people to be in healthcare, knowing our personal choices have been taken from us (EMT, #32; italics added)

Another health-care worker provided evidence for such speculation, claiming:

I am in the process of going for my RN, but if this passes. I will not finish the course. I will quit nursing altogether (LRN, #11; italics added)

A poorly staffed field, according to public comment, will deliver substandard medical care and will deter others from joining the field. Packaging contempt as a threat about what this mandate will do to the entire field of health-care is provocative for how it, too, made successful use of the slippery slope appeal by providing matter-of-fact commentary on what will likely happen if a mandate were to pass. A registered nurse agreed:

I am a registered nurse and know many other nurses who say they will leave nursing, and some have, if they are forced to vaccinate. So this will affect the health-care (er uh sick care) industry in many ways if these mandates are enforced (RN, #27; italics added)

Beyond simple expressions of concern or rejections of the mandate altogether, multiple contributors to the vernacular corpus framed resistance as in defense of their profession. With attention to both public perceptions of medicine as a trustworthy and consistent institution and a need for well-staffed health-care institutions ready to serve that public when needed, health-care workers emphasized their audience’s perception as being central to decisions about the mandate. In foregrounding audience as essential to policy deliberation health-care workers, thus, demonstrates the rhetoricality of medical professionalism in relation to vaccination decision making.
Conclusion

This chapter demonstrated how a turn toward tension via the identification of discursive units can forge common ground between otherwise competing rhetorics of health and medicine. The value in doing so is to facilitate identification (Burke, 1969) across difference to advance a larger agenda; in this case, that larger agenda is public health-security. Although often perceived as in opposition to one another, vernacular and official rhetorics of health and medicine are necessarily connected. As Howard explained:

Because the vernacular comes into meaning as a result of being rendered distinct from that to which it is a subordinate, it can never be a complete alternate to the institutional. As a result, it is never completely separate from institutions. Instead, the institutional authorizes the vernacular in the sense that all vernacularity relies on the institutional to create the grounds on which the vernacular can enact its distinction. In this way, the vernacular emerges only when it imagines its dialectical twin as prior: the institutional. At this structural level, the vernacular is necessarily hybrid in that it must contain the institutional from which to express alterity. (2010, 251)

The present study demonstrates the reverse of Howard’s equation, in that an institutional system is only as effective as its vernacular participants embrace it to be. For public health, in particular, official rhetorics of health and medicine depend on vernacular arrangements to adopt preventative behaviors at the local level. In the face of complex issues, the logic of both is likely needed to adequately prepare and protect a public at risk. This type of project—one that understands vernacular and official rhetorics as intimately wed and open to complementary arrangements—allows scholars to seek out and validate instances of vernacularity in official practice, and vice versa. As illustrated by Howard’s theory of dialectical vernacular (2010),
rhetoricians have long considered tension and contradiction to be signifiers of persuasive truths at work in public life. Indeed, “most of the time . . . the discourse in the public arena is faced by both external and internal contradictions. Rhetoricians study these challenges and contradictions rather than focusing solely on the infirmities” (Condit 1999, 254).

For the case of mandatory influenza for health-care workers, specifically, prioritizing complementarity in my analysis of both corpuses led to identifying medical professionalism as an issue wherein both vernacular and official actors converge in (potentially) productive ways. Although official rhetorics of health and medicine convey a specific set of “best practices” for medical professionalism that require vaccination, health-care workers reveal a far more nuanced understanding of how their everyday actions foster and maintain favorable images of medicine among patients they serve. Beyond a “one size fits all” policy, careful attention to vernacular contributions suggests a willingness on the part of health-care workers to pursue a range of observable behaviors that are intended to communicate trust and enhance patient safety. For example, some health-care professionals suggested that providers’ washing their hands in front of each patient every time would do more to communicate patient safety standards than would a vaccination, a medical procedure that goes unseen by patients they serve (in other words, when providers get vaccinated, there are no patient witnesses to the act). Therefore, whereas official rhetorics of health and medicine designated certain health behaviors, in this case, vaccination, as “essential patient safety standards,” resistant health-care workers advocated for a combination of everyday health-care delivery behaviors that would communicate a commitment to patients’ safety across patient interactions.

Performances of everyday medical professionalism, as suggested by the vernacular, reveal a rhetorical dimension to health-care delivery and a rhetorical prerequisite to medical
expertise that, currently, remains unaddressed by much health-care policy, and is especially underaddressed by health policies that are focused on mandatory health-care worker vaccinations, specifically. A standard such, as washing hands, arguably, involves much more work on the part of health-care providers than would receiving one shot, one time, each year, as hand washing is an action that must be carried out multiple times each and every day. Therefore, petitioning for this type of standard behavior could be seen as somewhat surprising. Rhetorically informed speculation about what a series of behaviors likely communicates to patients about professionalism, however, suggests that the vernacular may be investing in techniques that better sustain perceptions of medical professionalism over the long run.

In closing, resistant health-care providers are unconvinced that getting vaccinated will secure public perceptions of safety and goodwill; instead, resistant health-care workers represented in this sample outlined a series of behaviors or performances that must occur on a daily basis for each patient each time to forge and secure a link between medical professionalism and patients’ safety in the minds of the individuals they serve. Prioritizing everyday performances, demonstrations of practical wisdom, and respect for public perception as key to trustworthy care suggests a rhetoricality to everyday health-care delivery that is account for only minimally in official policy and scholarship alike.
PART FOUR:

REIMAGINING HEALTH PUBLICS
CHAPTER VIII

ADVANCING THE STUDY OF PUBLIC HEALTH RHETORICS AND HEALTH PUBLICS

To discover the coordinates of anxiety in its locally and globally material manifestations, rhetoric will have to reflexively imagine itself outside of fixations on the discursive supplement within the logos-sphere.

—John Ackerman and David Coogan, The Public Work of Rhetoric

By further illuminating one particular ongoing public health debate, in this chapter, I also suggest how competing discourses of health and medicine intersect in meaningful and promising ways. Conflicts abound between official and vernacular institutions of health and medicine, official and vernacular actors, and even within particular individuals who are asked to shift seamlessly between the needs of self and other, between patient and nation. As one step in the right direction, I next tie together the results of my previous three in-depth analyses to consider how these findings may advance collective understandings of rhetoric, public health, and publics theory, more broadly. Using the collective results of my textual analyses, I dive into the three constructs of proxy debate, bioanxiety, and medical ethos that framed the previous three chapters. I do so, first, to suggest succinctly how each theoretical construct emerged from close consideration of health policy texts; second, to rearticulate the importance of interplay between vernacular and official rhetorics for the future of medicine; and third, to suggest ways that this tri-part framework might be applied to other complex public health problems to influence policies and practices moving forward. In closing, I move to suggest where to go from here and some chances we should be willing to take if restoration of the “public good” as a disease
management resource is to be desired.

Adopting a Critical Lens for Public Health Rhetoric Studies

In a time when both biological threats and medical options abound, decisions about how to manage everyday life amidst the proliferation of health choices exist at the forefront of many U.S. Americans’ minds. I suggest that diverse stakeholders make use of the vocabulary and imagery offered by certain health issues because those issues incite public deliberation across otherwise dispersed and divided audiences, address common concerns and contradictions associated with contemporary public participation, and express deep-seated (and often otherwise ineffable) concerns about what it means to act as a healthy citizen in a more biotechnologically advanced world. In addition to enhancing current theory about medicine and its publics, thus, in this section, I offer direction regarding how policy communication might better address the issue of vaccination across health settings, I offer insight into which dimensions of the current medical moment contribute to ongoing experiences of vaccine hesitancy within the health-care community (and, therefore, are likely outside of that community as well), and I offer strategies for reimaging medical professionalism for a more biotechnologically saturated world. Together, the three-part interpretative framework outlined here speaks to social and political responsibilities assumed with shaping policies and practices of health and medicine at the public, professional, and individual levels, and it highlights some distinctly rhetorical attributes of vaccination communication. Each perspective offers a lens through which scholars and practitioners may approach public health problems from different, inventive angles. Complex problems calls for complex answers; perhaps a three-part looking glass offers both a metaphor and an analytic device for thinking about complicated public health issues in multiplex ways.
The first organizing construct, proxy debate, responds most directly to the first research question posed for consideration: How do rhetorics of health and medicine engage vaccination as a public problem? The concept of proxy debate turns attention to patterns in public argument that may contribute to gridlocks and standstills more than to qualities of the actual issues being considered. Thus, my answer to the first question could read succinctly: Rhetorics of health and medicine engage vaccination strategically, suggestively, and sometimes distractingly.

Based on findings from this study, when health-care practitioners argue about vaccination, they seem to be addressing larger sociological and political structures that interfere with everyday abilities to distinguish, clearly, between private and public health needs and expectations. In this sense, everyday talk about vaccination expresses concern about structural, political, or cultural issues of the time. Whereas official rhetorics of medicine seem to consistently address and come back to the science and efficacy of one particular biotechnology (vaccination), and, thus, engage vaccination as a public problem in relation to a particular disease threat, vernacular rhetorics of medicine use vaccination as a discursive launching point to address larger ongoing public health problems that extend beyond any one biotechnological intervention. In short, whereas official rhetorics of medicine seek to host a particular debate about a particular issue, vernacular rhetorics make use of the particular vocabularies and scenarios offered via vaccination conversation and debate to address a variety of sociological, political, cultural, and moral issues now associated with biotechnological life. In doing so, everyday citizens make use of proxy argument to engage with public health policy leaders and
creators, to contest ongoing disparities in health, and, ultimately, to shift definitions of the public health issue.

In his book-length treatment of the U.S. vaccination debate, Mark Largent concluded that vaccination, as a contested public issue, serves as “a proxy” for larger issues that are troubling public perceptions of science (2012). Largent drew attention to a number of probable conditions of contemporary health experiences, which vaccination punctuates. Specifically, he used the autism controversy to demonstrate how historically embedded social, cultural, and political anxieties surrounding the organization and implementation of medicine come to be expressed in public discourse about vaccination. For example, when members of the U.S. population argue about limits of clinical trial evidence concerning the safety of Merck’s human papillomavirus (HPV) vaccine, they also question the relationship between federal and state governments and the pharmaceutical industry—arguably, a much more complicated and complex dimension of U.S. medicine for which the HPV vaccine acts as one specific illustration. In line with Largent’s findings, and in lieu of a changing medical landscape, my close examination of health-care worker vernacular has led me to agree that the issue of vaccination likely stands in for other tensions that typify the U.S. health-care experience; namely, sentiments that reflect U.S. consumer sensibilities. Therefore, when health-care workers, for example, argue about the policies of any particular vaccine, they are, in effect, using that issue to express concerns about larger, and, arguably, more consequential and perhaps even more complicated problems facing the everyday practice of health and medicine. I suggest that, at any given time in history, the status of vaccination communication within health-care communities may act as a gauge for how well tensions inherent to policies and practices of medicine are being managed across the broader U.S. general public. The case of mandatory vaccinations for health-care workers, specifically,
highlights tensions between patient autonomy and public health-security, medicine as a caring art and a profitable business, and individualized therapeutic health-care versus a more collective, system-level preventative model. Insofar as this proxy debate interferes with tackling larger problems facing medicine, its rhetorical potency in relation to vaccination, in particular, and biotechnological progress, more broadly, warrants further investigation.

Thus far, few scholars (if any) have studied proxy debate as a feature of policy discourse, especially within the health context. In the colloquial sense, according to the Oxford English Dictionary, the denotative meaning of proxy refers to “senses relating to representation” or “the agency of a person appointed to act in place of another.” Where the term “proxy” comes up in practice is in relation to the field of computer science, where it refers to a system that enables indirect exchanges of data between networked computers (e.g., “a proxy server”); in science and economics, where it signifies an estimation technique where one variable is used as an indicator of another (usually inaccessible) variable; or in health-care decision-making models wherein one person speaks on behalf of another (“so-and-so acts as a proxy for . . .”).

The latter application offers a great illustration for how I conceptualize its function in public argument. In the health-care setting, an application that more directly applies to how I employ the term, a proxy decision-maker is part of a larger end-of-life medical directive and refers to the person who would make decisions in the event of another individual becoming mentally incompetent. This modus operandi—using one person to speak for another—resonates with my preliminary conjectures concerning how vaccination talk operates as proxy: I imagine that individuals use specific rhetorics of vaccination to speak about other biotechnological anxieties, more generally. Although initially, some existent concepts seem to capture that
discursive strategy, none quite capture the dynamic that I see represented in the decision by proxy, health-care decision-making model articulated in this work.

For example, the rhetorical term *synecdoche* refers to a figure of speech for which a part is used to represent the whole, or vice versa. Although vaccinations can be thought of as a part of the larger biomedical complex, acting as proxy, in my mind, the focus on vaccination in public talk *distracts* more than it clearly *represents*. Another concept that appears closely related to but slightly different from proxy debate is the *association fallacy*, a faulty mode of reasoning wherein the qualities of one thing are assumed to be the inherent qualities of another (a common example would be the use of the phrase “guilt by association”). Although this slip in reasoning occurred frequently in the public register when and where one problematic vaccine (e.g., a “bad batch” of the smallpox vaccine) became representative of all other vaccinations (or even other injectable prevention measures, for that matter), the *association fallacy* does not seem to capture how a set of items gets substituted for a set of problems in public deliberation about vaccinations. Finally, a growing body of work now focuses on the deployment of scientific controversy to influence political processes and outcomes. In particular, as Leah Cecarelli explained, “A scientific controversy is ‘manufactured’ in the public sphere when an arguer announces that there is ongoing scientific debate in the technical sphere about a matter for which there is actually an overwhelming consensus” (2011, 196). With regard to the larger vaccination issue, scholars have identified ongoing debate about a vaccination–autism link, for example, to be a manufactured controversy because of the overall lack of scientific evidence to support such a connection (see, e.g., Mnookin 2011). Although that proxy debate likely distracts from effective policy processes and/or sways public opinion about the specific issue on which it fixates (in this case, vaccination), the overall system-level problems that it communicates about
are verifiably real. That is, there is scientific, political, economic, social, and other evidence of problematic disparities in health-care and reason for concern about so-called “hidden curriculums” (Snyder 1971) that are embedded in U.S. medical education. Therefore, despite reasonable, functional parallels between the two, proxy debate seems distinct from manufactured controversy as it is currently theorized. In the absence of a fully satisfyingly and wholly inclusive theory, I now turn to Sigmund Freud, Gerard Hauser, and Barry Brummett for their discussions of displacement, rhetoric by indirection, and rhetorical homologies, respectively, to begin fleshing out a theory of argument by proxy, specifically (1953; 2012; 2009).

In brief, the Freudian psychology term *displacement* refers to a process by which the mind substitutes a new object for another, more threatening one (1938). *Indirection* refers to a rhetorical strategy used to denaturalize the status quo “by addressing power in a manner intended more to move an audience of onlookers than authority itself” (Hauser and McClellan 2009, 40). Finally, a *rhetorical homology* is a discursive characteristic and/or structure that formally draws a parallel across different objects, actions, modes of experience, and so forth (Brummett 2004). Together, the perspectives and vocabularies offered by those concepts provide a means to tease out and to describe how proxy debate may be operating in and around practices and policies of Western medicine. Specifically, this combination of concepts suggests that everyday talk about vaccination signifies a lateral move whereby individuals (often) unknowingly substitute a focus on a particular biotechnology for other more threatening and worrisome problems associated with that technology, and, in talking about vaccinations to talk about currently unaddressed system-level issues, individuals are confronting the status quo (or “business as usual”) via public participation. Although the combination of these three concepts describes dimensions of the phenomenon that I see unfolding at the public policy level, each seems incomplete on its own,
and even together, they still fall short of fully capturing the notion of proxy debate being advanced. In particular, there may be more intentionality involved with arguing via proxy than the notion of displacement credits, publicized vaccination hesitancy is intended to speak directly to authority and currently does so via an (un)intentional indirection, and, although rhetorical homology provides a way to understand how “the biotechnological industry,” as a whole, becomes regarded as one integrated web in the public’s mind, the concept does not adequately articulate why, on a consistent basis, one particular object, action, or mode of experience (in this case, vaccination) assumes argumentative parity with the homologous structure of which it is a part. Given the unique and evolving circumstance of U.S. health-care, I suggest that a more robust explanation for the function of argumentative diversions is needed to more fully account for how such structures advance or impede participation at the public level. In this vein, this study combines and expands the work of Hauser, Freud, and Brummett to, perhaps, advance ongoing theorizing about the relationship between medicine and its publics, and to improve the status of public deliberation about biotechnologies moving forward. More research will be needed to fully understand argument by proxy as a rhetorical feature of public health debate, but this study provides a suitable foundation from which to advance such a discussion.

*Bioanxiety* (n): concern about “the business” of public health participation in a biotechnological era; a chronic condition experienced by members of a risk

The second organizing construct, *bioanxiety*, provides an answer to the second research question number posed for consideration: What does public debate about mandatory vaccinations reveal about public perceptions of medicine? Specifically, bioanxiety turns attention to commonplace emotional experiences that now are instigated by talk about health decisions and responsibilities, a widespread state that overlays processes and practices of contemporary health-
care, and, thereby, interferes with individual and collective abilities to speak, act, and interact in relation to imagined and impending health threats. Thus, in short, my answer to this question is: Health publics are anxious about health-care decision making at both the individual and system levels, and that anxiety complicates public perceptions of and relationships to medicine.

In line with other scholars who worry that prolific public talk about risk and uncertainty has contributed to an arguably less secure nation (see, e.g., Klotz and Sylvester 2009), I suggest that talk about particular biotechnologies incites concern across the U.S. public that results in an overall rise in awareness about that which threatens people and an overall decrease in perceptions of control over everyday risks. The result is a largely anxious U.S. public that is equipped with knowledge but devoid of know-how, or, rather, the result is a public that now suffers from “bioanxiety.” Anxiety refers to “a state of vague apprehension, a coloration of experience in which much seems at stake but which lacks clear paths of action” (Brodwin 2000, 9). Beyond individual diagnoses, anxiety can also be used to describe the state of a situation or experience, as is the case in an expression, such as “It was an anxious time for both of us.” In both regards, anxiety communicates unrequited emotional reactions to life lived in a biotechnological era and, thus, indexes an instance wherein biomedical language is used to make sense of everyday life. For a rhetorician of medicine, the normalization of this emotional state in relation to biotechnological progress as a public health issue is cause for concern, or, at the very least, cause for curiosity.

To my knowledge, the concept of “biotechnological anxiety” is a new endeavor. The closest study, to date, was an edited book series, titled Biotechnology and Culture: Bodies, Anxieties, Ethics, that was produced as a result of 1997 postdoctoral research institute at the University of Wisconsin-Milwaukee that was hosted by the Center for 21st Century Studies. In
the introduction to the collection, the editor, Paul Brodwin, explained:

The binding of anxiety is a psychoanalytic notion, but here it rears to both a personal and collective process. In American society and elsewhere anxieties over the reformulation of birth, illness, and death motivate rich debates about social duties and prohibitions. The debates exhibit an intensity and popularity fare out of proportion to the number of people who actually make surrogacy contracts, receive donated organs, or are affected buy the other currently controversial procedures. Moreover, the language which people use in such debates varies enormously. . . . Local ethical dialects which are calibrated to specific technologies and their immediate social stakes. These emerge from the moral imagination of a given time and place as well as the conjunctures of interests, values, and resources particular producers and user of biotechnology face. (2000, 10)

The volume, thus, explored ethical dimensions of many localized health cases spanning from specific reproductive technologies to new modes of health-care, such as telemedicine. Beyond connections between experiences of anxiety and biomedical intervention that have been made between individual technologies and individual experiences of anxiety with regard to health decision making, however, formally linking a state of public anxiety with a biotechnological discourse that promotes technologies of self for the betterment of community is not yet fully recognized, let alone understood; therefore, a notion of bioanxiety would extend the ongoing conversation. In particular, a rhetorical notion of bioanxiety would emphasize context and exigency in relation to health publics and problems to consider ways that public biotechnology talk materializes in an emotional state that is common across audiences and stakeholders.

Thus, I introduce the term “bio-technological anxiety,” or “bioanxiety,” to both capture and critique a state of affairs now commonplace for life lived in a risk society.¹ Different from
the vaccine-hesitant U.S. society described in chapter 1, shifting the focus to diagnosing the U.S. public as suffering from anxiety highlights the larger, chronic condition for which vaccine-hesitancy serves as one manifestation. I attach the prefix “bio” to anxiety to, first, highlight anxiety as a common attribute of everyday U.S. life, and, second, to align my work with a growing body of scholarship that is committed to investigating the politics of life itself (see, e.g., Rose, 2007). Critical scholarship focused on “biopolitics” has proliferated in recent decades as more material and symbolic connections among the human body, governing power, and public health are identified, with much of that lineage attributable to the work of Michel Foucault.

In 1976, Michel Foucault introduced the concept of “biopower” to academic audiences in his first volume of The History of Sexuality (2012), which was followed by a series of lectures on biopolitics conducted between 1978 and 1979 (translated in English in 2008). In short, the term biopower was used by Foucault to retroactively describe a number of political strategies that were used at the end of the 18th century to intervene upon collective existence in the name of life and health. Since Foucault’s introduction of the concept, there has been a proliferation of interest in the study of biopolitics, which theorizes the relationship between two types of power: disciplinary power, concerned with practices of the self, which aim to render the body productive or docile; and regulatory power, policies that govern and manage the population at the level of species (with public health interventions representing an example of the latter). An array of studies have emerged across disciplines, inspired by a distinctly Foucauldian sense of biopolitics that is grounded in the concept of biopower, which understands both types of power—disciplinary and regulatory—as acting fluidly and simultaneously at multiple points on the body; these include biosecurity studies (see, e.g., Lakoff and Collier’s 2008 edited collection), bioinsecurity studies (see Keränen, 2011; Klotz and Sylvester 2009), studies of biocitizenship
(see, e.g., the programmatic line of research by Nikolas Rose and Carlos Novas), and theories of biomedicalization (see, e.g., Clarke et al. 2010). Each of these offshoots remains tethered to the conviction that power over the body is central to practices and policies of governmentality.

In their essay on “Biological Citizenship,” sociologists Nikolas Rose and Carlos Novas introduced the term “biocitizenship” to describe new connections being made between biology and self-identity that have reshaped what it means to be human in a global marketplace (2003). They argued that the human body has become disconnected from national politics and is now a biotechnologically exploitable consumer object. Similarly, in her book *Body Shopping*, bioethicist Donna Dickenson tracked a series of biotechnological goods and services that have successfully commoditized—and created an international shopping market for—the human body (2008). Each of these projects suggests that an era has been entered wherein complications between the biological private body and the needs of a public “body” compete for limited and exploitable resources (with private bodies, sometimes, becoming those exploitable resources). The patient-as-consumer or citizen-as-consumer metaphors, thus, reflect game-changing trends toward understanding health within the frame of a larger bioeconomy. In part commenting on that state of affairs, and, in another sense, providing an analytic framework to critique that new normal, Adele Clarke et al. claimed that people have moved beyond medicalization into an era where the enhancement of private life now trumps the preservation of public life. “The shift from medicalization to biomedicalization,” Clarke et al. wrote, “manifests the epistemic shift from the clinical gaze initiated in the eighteenth century (Foucault 1973) to the emergent molecular gaze of today” (2010, 4). Indeed, it seems that humanity has entered an era that is characterized by the emergence of new, and perhaps dangerous, apparatuses of Foucauldian biopower. “Emergence” denotes uncertainty about the claims, directions, intentions, and consequences of the
contemporary molecular gaze—one that is unfolding and that is tightly wed to biotechnological advances—and, thus, indicates a context ripe for breeding the type of bioanxiety that I have described.

**Medical Ethos** *(n): A term used to highlight the rhetorical features of modern-day medical professionalism; the perceived professional status of a health-care worker*

Finally, the third organizing construct, *medical ethos*, provides an answer to the last research question posed: What do competing rhetorics of vaccination suggest about the nature of medical professionalism in the United States? Medical ethos turns attention to essential features of biomedicine that are required to communicate across diverse stakeholders and to communicate convincingly about the intentions of medicine as a caring profession. The vernacular register suggests that a range of performance possibilities exist wherein biotechnological adoptions become one option—among many—to communicate medical professionalism across diverse audiences. Thus, in brief, my answer to this question could read: Standards for medical professionalism are currently evolving and differ across patient, professional, and policy maker perspectives.

Based on findings from this study, the reputation of the overall medical profession is linked closely to “the ought” of how health-care professionals should act. In particular, given the widespread public dependence on medical expertise (especially in times of health crisis, such as H1N1), it is important to consider how health-care actors successfully convey reliable, trustworthy, and professional leadership amidst widespread uncertainty and public concern. According to Drs. Ronald Epstein and Edward Hundert, “Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being
served” (2002, 226). A rhetorical perspective explains how and why expert status is awarded to medical professionals when they convince attending publics of their legitimacy as competent professionals. As rhetoricians of science John Lyne and Henry Howe observed, “The ‘expert’ is a pivot point for the intersection of discursive domains, in that he or she makes it possible for nonspecialized publics to tap knowledge they do not directly possess. Expertise is not only a matter of the relationship of a specialist to a body of knowledge; it is also a matter of the relationship to the audience” (1990, 52). Thus, a rhetorical perspective on medical professionalism foregrounds persuasion—more specifically, persuasive performances of professionalism—as an important consideration for how everyday health-care work influences individuals’ (and, later, the public’s) health decisions.

I have introduced medical ethos to highlight the process used by professionals to engage with various publics, to determine mutually intelligible standards for medical expertise, and to then perform medical duties accordingly. Medical ethos, therefore, is not something that medical professionals acquire or occupy but, instead, is a rhetorical process that is dependent on public perceptions of medicine and the performative abilities of individual medical actors to satisfy these public perceptions. Although medical professionalism and scientific ethos, or even “ethos in medicine,” have been explored by many scholars (see, e.g., Keränen 2010), accounting for medical ethos as a standalone concept has yet to be fully explored. In 2001, Dr. Charles Francis, published an article in the Journal of the National Medical Association, titled “The Medical Ethos and Social Responsibility in Clinical Medicine,” in which he claimed that “the challenge facing the medical profession in the new millennium is to establish an equilibrium between the responsibility to assure quality health-care for the individual patient while affecting societal changes to achieve ‘health for all’ (157). Although the article uniquely referenced a rich history
shared between the study of rhetoric and the practice of ancient medicine, it largely positioned medical ethos as a somewhat stationary source of credibility that was credited to a longstanding profession founded in ethical practices. I agree that this sense of “good character” can be attributed to a larger professional identity that extends beyond particular cases and individuals to, instead, comprise a somewhat stable locale for medical credibility and influence to percolate. This lattermost attribute—a “stable locale”—was culled from the edited collection *The Ethos of Rhetoric*, in which Michael Hyde explained in the foreword that “Ethos antedates specific ethical prescriptions and prohibitions and marks out a region of knowing and working together in advance of strategies to achieve consensus in the public forum” (2004). In that sense, medical ethos, at least in part, refers to widely shared cultural values or implied norms that create a dwelling place where medical professionals converge to shape a collective image as trustworthy representatives of the institution of medicine. However, final evaluation of that image remains the task of medicine’s publics and, hence, medical ethos may be better thought of as a “caused perception” rather than a “stable locale.” As the findings in chapter 7 suggested, medical ethos is caused by specific communicative acts that are taken as signs of character qualities; those communicative acts include performance, phronesis, and perception.

In a reworking of Aristotelian ethos, Keränen suggested that trust in science depends deeply on perceptions of character established by individuals who are central to scientific processes (2010). Specifically, Keränen treated “ethos as the widely shared cultural values or implied norms that characterize a group of people” (27). In doing so, she highlighted situated audience perception as key to earning the status of expertise and influence. For my study, a parallel argument can be drawn to suggest that public trust in medicine, writ large, depends on perceptions of character established by individuals who are central to (bio)medical processes.
Via Hartelius’s (2011) rhetorical take on expertise (introduced in the previous chapter), medical ethos uniquely emphasizes the unstable nature of any medical professionals’ influential status, and it suggests, alternatively, that expert knowledge must merge with performances that are taken to be expert by patients those professionals serve. Within health contexts, in particular, evaluations of expertise lie in the eye of the beholder, with professionalism becoming a matter of showing a trait that the public understands as a sign of medical expertise.

Recall that one important observable component of ethos, to revisit Aristotle, is *phronesis*, which refers to a person’s ability to use sound reasoning to guide action rather than (or in addition to) technical or theoretical knowledge. In discussing practical wisdom, Gerard Hauser noted, that “the ancient Greeks considered our ability to engage in this type of public moral discussion a virtue” (1999, 94). Channeling Hauser, in their investigation of local vaccination talk, as Heidi Lawrence, Bernice Hausman and Clare Dannenberg explained:

Publics function as practitioners of *phronesis*, or practical reasoning that “is not governed by the true/false logic of propositional statements; it is concerned with beliefs and actions that have traction on the moral and pragmatic registers of those who are being addressed and asked to judge.” As these “questions of ‘ought’” are debated, they are fundamentally rhetorical judgments—arguments formed, evaluated, and finally decided upon based on responses to a wide range of discourses and in the midst of competing values and even truths under consideration by a public. (2014, 94)

Researchers in bioethics and the history of medicine have long demonstrated the central role that morality plays in the delivery of health-care (see, e.g., Hyde and King 2010), and, in doing so, they have demonstrated why moral judgments for medicine require a skillset that extends beyond traditional, Aristotelian definitions of *phronesis* as “practical wisdom.” For the context of
medicine, in particular, both peers and patients alike must receive expressions of practical wisdom as expert. In this sense, the vocabulary and perspective offered via the concept of phronesis sharpens definitions of medical professionalism to highlight the role of contextual factors and timing in medical action.

Accounting for rhetorical attributes of medical professionalism demonstrates the function of language in creating and (re)shaping a collective frame of what medicine should look like in the contemporary era. A combination of ethos, expertise, and phronesis advances a specifically rhetorical theory of medical ethos to account for how language and action (or a combination of both) contribute to public perceptions of medicine. Specifically, a rhetorical perspective on medical ethos stipulates that medical professionals must not only interface with publics convincingly (ethos) and must not only have the knowledge, skills, and performative savvy to diagnosis and treat illness effectively (expertise) but they also must demonstrate practical wisdom (phronesis) by adapting to conditions of each unique health circumstance (those “imperfections marked by urgency”) to intervene at the right place at the right time (kairos). Advancing a rhetorical take on medical ethos as both an individual and professional resources for trust, and both a stable and dynamic locale for credibility, may allow individuals to better strategize the image and function of medical actors in relation to contentious contemporary health issues that demand a unified public front amidst uncertain variability. To develop a specifically rhetorical explanation for the operations of medical professionalism in relation to public perception—that is, medical ethos—I, thus, have drawn from the works of Keränen, Hartelius, and Montgomery to formulate a preliminary base from which to further theorize the concept (2010; 2011; 2004).
Addressing Future Public Health Problems

To date, biotechnologies that call attention to the public consequences of health-care interactions are understudied with regard to their ability to instigate resistance and to complicate health assumptions among individuals who, otherwise, would align themselves with larger Western medical ideals. Because of the value that health-care professionals can offer in terms of influencing larger disease outcomes and goals, investigation into rhetorical facets of medical professionals as related to vaccination holds both theoretical and pragmatic value. Unrelenting public attention and debate concerning the safety and efficacy of vaccinations has interfered with the success of vaccination writ large, as more U.S. Americans publicly question the science, motives, and logic of certain biotechnologies than was the case for previous generations. An overemphasis on concerning aspects of one component of the larger U.S. national public health-security plan may be compromising the integrity of public health as a whole, a consequence that grows particularly alarming in an era when disease threat, arguably, has worsened. Insofar as proxy debate distracts from and/or minimizes larger organizational issues, it likely perpetuates the “vaccine problem” that the opening chapter outlined. In response, this study was designed to critically consider features of public participation for 21st-century health organizing in lieu of a larger public health-security agenda.

This study offered a streamlined evaluation of one ongoing national public health debate and an analytic framework for interacting with similar public health texts. Specifically, findings from this study revealed three dominant rhetorical features of current discourse about mandatory influenza vaccination for health-care workers: proxy debate, bioanxiety, and medical ethos. In a very practical sense, the tripartite critical lens that emerged from examination of both vernacular and official corpuses of mandatory vaccination public discourse likely also provides a framework
and vocabulary for describing the current medical moment, more broadly. In turning attention to voices of health-care workers, I have begun to demonstrate how marginalized perspectives come to compete with (or not) fundamental ideologies on which official rhetorics of health and medicines function. In doing so, I suggest that alternative means of communicating and organizing change issues to mean and do something else when it comes to life at the margins of policy making and in the halls of medicine. In an era when news about controversial health issues and positions gain widespread public attention across media outlets, understanding (and, eventually, addressing) medicine’s resistors may prove essential in ongoing efforts to mobilize diverse publics in the name of health-security, especially if these resistors influentially represent medicine as an institution across diverse publics. Interpreting resistance efforts as valuable and complementary to ongoing official health policy processes—as opposed to ignoring or rejecting them—may better account for and respond to the anxiety-provoking, chronic conditions that characterize everyday medicine and that continue to elude official health policy efforts and rhetoric alike.

By and large, the “official rhetorics of influenza vaccination” denote a nation that is plagued by annual disease threat, equipped with prevention technologies, yet bogged down by lazy, albeit well-intentioned, health-care workers who are central to the needs and goals of public health-security. This depiction, and policies that it upholds and defends, is challenged by “vernacular rhetorics of influenza vaccination” that, collectively, reject presumptions of imminent doom, failsafe medical interventions, and lackadaisical health-care worker decision making. With regard to influenza, in particular, policy communication about “the health problem” centers on individuals’ susceptibility to acquiring and spreading illness, with the goal of health-care policy being to protect individuals from undue health threats, and, sometimes, that
threat is themselves. Conversely, because vaccination is not an assumed solution, across vernacular rhetorics addressing the issue, discourses of choice, freedom, and rights shift the focus to ideals guiding the collective approach to health-care, rather than the focus being on any one measure of individual health. These standards—choice, freedom, and rights—however, remain difficult to comprehend, let alone operationalize, amidst biotechnological proliferation. Where official policies intend to persuade health-care employers to enforce health-care worker vaccinations as a matter of patient safety, vernacular rhetorics may reaffirm principles of autonomous health-care but, at the same time, also express concern and complication accompanying abilities to simultaneously live a communal, autonomous life. These irreconcilable difference between public and private responsibility are cause for anxiety across health publics and, perhaps, across the United States’ general public as well.

Today, the business of infectious disease control, experienced at both private and public levels, remains wrought with uncertainty and gamble. Emergent discursive, social, and biological disease realities undoubtedly complicate the relationship between private rights and civic duty, and between medicine and its publics. Practically speaking, the effectiveness of vaccination as a medical intervention that is used to eradicate disease depends on the successful negotiation of private and public interests, whereby members of various public spheres (e.g., politicians, health-care employees, and individual patients) all become stakeholders in how particular communicable diseases come to be understood and managed. Unfortunately, much public debate tends to pit one side against the other or to exaggerate positions with attention to opposite ends of the spectrum. In doing so, gray areas in between often get overlooked (or are taken for granted). Such is the case when, for example, a mother who asks questions about vaccination safety is labeled and treated as “antivaccination” or when a health-care employee is assumed to
align indefinitely with the institution that she or he represents because she or he is “promedicine.” Such totalizing tendencies in action and language problematize abilities to successfully understand and intermingle diverse stakeholders with diverse needs and interests. These insights force public health advocates to think critically and honestly about complex arrangements that now comprise U.S. health-care. In part, this project makes clear that business and medicine are now intimately wed, and that vaccination punctuates this connection.

Encouragingly, findings from this analysis suggest that official and vernacular rhetorics of health and medicine are not hosting entirely different or even competing arguments about connections among patient safety, vaccination, and medical professionalism; instead, each side emphasizes different entry points into the national health-security discussion. Vernacular rhetorics of vaccination produced from members of the health-care community outwardly defend individual rights and needs in matters of health and medicine, and, in doing so, they reframe the national conversation about vaccination to be one that requires individual authorization. Unlike official policy communication, which emphasizes a connection between patient safety and vaccination, the vernacular foregrounds the role of autonomy as a mitigating factor in the overall success of health processes, let alone the practice of vaccination, specifically. Whereas official policies of vaccination connect a patient-centered focus to improved health outcomes and, thereby, builds an argument on assumptions about the means of ensuring population-level influenza protection (compliance), the vernacular centers on the mitigating factor between patients and desirable health outcomes—autonomy—to build a case that is founded on personalized health-care (choice). In this manner, the vernacular prioritizes a focus on autonomy as a principle of quality health-care that, when upheld and supported, connects patient-centered safety needs with good health outcomes. In this sense, the vernacular appeals to the higher
calling of individuating health-care and promoting autonomous decision making in matters of health and illness, life and death. Importantly, this higher level calling is distinct from but, nonetheless, essential to the official policies with which it competes; therefore, the difference between the official and vernacular, it seems, is a matter of emphasis. As illustrated previously, emphasis is based on different forms of evidence that lead to different levels of conviction about immediate actions and “acceptable” public health goals. Although, independently, each type of rhetoric may prove incapable of fully addressing perpetual problems for contemporary health-care, weaving together the best parts of each may provide direction for improving public health policy overall.

Interpretations

Patterns in talk about mandatory vaccination policy, I suggest, constitute a proxy debate in which emerging biotechnological anxieties surface. Medical ethos serves, ideally, to offset bioanxiety and, at worst, to perpetuate cause for concern. What is at stake in matters of public anxiety management is the success of one particular medical technology—vaccination—and, perhaps, more important, the reputation of a field that is central to a U.S. public health-security agenda—medicine. Stepping back from the particularities of either the vernacular or the official, public health advocates may conjecture that what is at stake in talk about vaccination is the reputation of a field. For quite some time now, vaccination has served as a benchmark of good science, reputable medicine, and effective collaboration among government agencies and their for-profit partners. According to a 2013 survey published in *The Atlantic*, vaccinations rank eighth among the “50 greatest breakthroughs since the wheel” (Fallows). In many ways, then, talk about vaccination conjures a noble image of the medical profession, an image that harkens back to a time when the field was thriving, reputable, and respected; a time, too, when U.S.
Americans experienced the highs of post-World War victory and the consumer-driven expansion of domestic life. Arguably, the medical field continues to thrive and earn the respect of the publics that it serves; however, in a more integrated world, with more complicated disease threats, and a more savvy, critical, and, sometimes, more jaded patient population, medicine no longer boasts unquestioned and unshakeable authority over matters of health and illness. With contemporary challenges in mind, it is possible that vaccination reminds medicine of better days for medicine. Similarly, vaccination may leave some members of the U.S. general public longing for medical experts they can trust and depend on, both in times of crisis and in times of calm. As such, there is much at stake in medicine abandoning its steadfast hold to the vaccination project; namely, loosening its grip means that the field distances itself from a moment in history that will be fondly remembered by medical professionals and participants alike as the apex of modern science. Both symbolically—and quite literally—the success of vaccination carries with it the reputation of medicine as victorious over disease, and, thus, the victories of humans over threat as well.

Fortunately, it seems that the underlying message in both official and vernacular rhetorics of influenza vaccination is the need to protect and care for the nation’s public. Unfortunately, in official policy communication about vaccination, this admirable priority gets convoluted in talk about the need for professionals to put the nation before self, and to put patient before private interests. A more nuanced read suggests just the opposite: Official institutions of medicine, first and foremost, want to, have to, keep each individual member of the health-care workforce healthy for them to think in terms of nation and community. In this regard, both sides of this debate appear to share confidence in the assumption that health-care personnel are important agents in other people’s health. In other words, health-care personnel wield agency over health
outcomes for others, and, by and large, both sides believe that health-care personnel do so admirably. However, the mandatory influenza vaccination for health-care workers’ debate highlights disagreements concerning professionals’ ability to effectively communicate trust to the publics they serve. How successful health-care professionals are perceived to be in managing their health matters to how successful the health-care profession conveys its ability to manage the health of others. Indeed, healthy professionals must precede healthy patients, both actually and perceptually. Therefore, discrepancies over “best practices” for medical professionals highlight important distinctions between how the official and the vernacular each define and then mobilize individual professionals in relation to public health.

When it comes to flu season, official institutions of medicine do not trust that health-care workers will act in their best interest and take precautions to protect themselves to then protect their patients, or at least this seems to be the predominant, implicit sentiment that is expressed across official health messages promoting flu vaccinations. From the perspective of health-care professionals, too much emphasis placed on the need to get vaccinated “for the patient’s sake” may inadvertently communicate distrust regarding professionals’ commitment to the safety and well-being of the patients for which they care. For many professionals, vaccination does not measure concern about and commitment to patients’ safety; instead, commitments to patients’ safety occur in the daily routines of medicine: Hand washing between patient visits, resting and avoiding work if one feels ill, and wearing a mask around highly susceptible patients all represent daily, mundane routines where care for patients’ safety is communicated. These few examples illustrate how flu prevention becomes part and parcel of daily medical practice and professional routine, rituals for which the one-shot deal of flu vaccination will not communicate to every patient, every interaction, and every day. For many professionals, it seems, getting
vaccinated does not communicate care as effectively or as convincingly as do their daily efforts and expressions of disease prevention. To communicate care through vaccination, then, health-care personnel likely need help framing, embracing, and communicating about vaccination as an expression of care for both self and others.

Nurturing and supporting the need for health-care personnel to take good care of themselves to then take good care of patients seems essential to larger public health goals, and, yet, it is a sentiment that remains starkly missing from most public policy language. Instead, patient-first language, policy, and initiatives dominate much health-care policy and practice. Fundamentally, the patient-first focus denounces professional-first behaviors that must, nonetheless, precede good, effective health-care. Professionals act as mitigating factors in the health outcomes of patients, and, yet, their health and well-being remain largely unaccounted for in the larger patient-safety equation (aside from its conflation with profit margins, as detailed in chapter 5). Left without the means to express professional-first needs in relation to patients’ safety, many health-care professionals are left at a loss. Unable to draw from a discourse and framework that understands, promotes, and translates the needs of professionals in terms of overall patient health outcomes, as this study revealed, many members of the health-care community speak out against mandatory vaccination policy, claiming that it “denies personal freedoms.” Discourses of citizenship and personal rights are aggressive and essentialist because they are often words of war and pride and defense. Health-care professionals may borrow from the language of citizenship and personal rights because those are the discourses that are available to them to communicate about how the need to care for self matters to the health of a community. Perhaps health-care personnel, and communities in which they work, may be better
served by developing a discourse and framework that account for and defend the need for self-care in relation to a community’s or a nation’s overall well-being.

Admirably, translating (let alone pursuing) self-care in terms of caring for others seems foreign to professionals who are committed to a life of service. Indeed, the words of many professionals convey sincere efforts wherein personal health takes a back seat to patients’ needs. With this tendency in mind, perhaps a more concerted effort to talk about and promote vaccination as an opportunity to work harder for patients they serve may better speak to the altruistic nature of all health-care personnel. Along these same lines, however, addressing intersections of new biology and individualized medicine—something that Drs. Gregory Poland, Robert Jacobson and Inna Ovsyannikova called “vaccinomics” (2008)—seems essential.

**Future Studies**

In recent years, changes to the infrastructure of the U.S. health-care system have spurred debate and concern within the institution of medicine. The passing of legislation, such as the Patient Protection and Affordable Care Act (2010), has caused alarm for many medical professionals faced with uncertainty regarding what new policy changes entail for the everyday delivery of health-care. That particular law, novel in its scope and goals, distinctly promises “quality, affordable health-care for all U.S. Americans.” In principle, many health-care professionals may agree with the goal, but, in practice, they may not be able to imagine introducing more actors into an already overburdened U.S. health-care system. In a comprehensive review of the U.S. health-care system, published as part of the international *Health Systems in Transition* (HiT) series, editors Thomas Rice et al. argued:

The U.S. health system has both considerable strengths and notable weaknesses. It has a large and well-trained health workforce, a wide range of high-quality medical specialists
as well as secondary and tertiary institutions, a robust health sector research program and, for selected services, among the best medical outcomes in the world. But it suffers from incomplete coverage of its citizenry, health expenditure levels per person far exceeding all other countries, poor measures on many objective and subjective measures of quality and outcomes, an unequal distribution of resources and outcomes across the country and among different population groups, and lagging efforts to introduce health information technology. It is difficult to determine the extent to which deficiencies are health-system related, though it seems that at least some of the problems are a result of poor access to care. Because of the adoption of the Affordable Care Act in 2010, the United States is facing a period of enormous potential change. (2013, xix)

In lieu of this unfolding change, expectations concerning what any medical professional looks like or acts like amidst biotechnological advances and emergent legislation remains largely in flux and unknown, two qualities of modern medicine that, likely, provoke anxieties for patients and health-care workers alike.

In his edited volume addressing, in part, intersections of biotechnology and anxiety, Paul Brodwin suggested,

Certain biotechnologies become powerful public symbols even for those who never directly encounter them. In the contemporary United States, for instance, surrogacy and organ transplantations are highly charged terms in various cultural debates. They provide a convenient, tangible focus for arguments about the fundamental qualities of human nature as well as specific contradictions of gender, class, and professional authority (compare Woolgar). Biotechnologies thus become collective representations, encoding diverse anxieties and motivating political action (2000, 2; italics added).
From a public health perspective, reoccurring patterns in public talk suggest unresolved business concerning vaccination, specifically, and they highlight an opportunity to inquire about how the value and meaning of particular biotechnologies evolves (or does not) across place and space. To Brodwin’s aforementioned list of “powerful public symbols,” I have added vaccination, and I encourage future rhetoricians of public health to investigate this lead, as diagnosing the current state of the relationship between medicine and its publics may prove essential for successful U.S. disease management infrastructure.

Ultimately, my textual analysis of one ongoing public health debate yielded three theoretical constructs that extend current understandings of medical/health publics theory more broadly: proxy debate, bioanxiety, and medical ethos. In a very practical sense, these constructs can be used to illuminate rhetorical dimensions of unfolding public health problems that pose barriers (and, possibly, opportunities) to addressing controversial health issues across the public arena. In addition to identifying key actors and emotions surrounding this particular public health debate, I have suggested that these three constructs offer a set of conceptual tools that can be used to unpack and analyze a variety of public health issues, in addition to the issue of vaccination to further overall understandings of how, as Brodwin articulated, “certain biotechnologies become powerful public symbols” that represent “diverse anxieties” (2000, 2). The utility of such an approach will, undoubtedly, require additional in-depth case studies of a wide variety of public health problems to be conducted, and, for this reason, it may seem premature to state. Nonetheless, in framing my study as a first step in a much larger programmatic line of research, I position findings from this project as both explanatory and exploratory in scope. Over the previous pages, I have offered one preliminary model for how to unpack a public health issue from a variety of critical angles using a set of theoretical constructs
that are grounded in the rhetorical tradition. In doing so, I offer a first step toward detailing a larger rhetoric of public health and the rhetorics of mandatory vaccination, more specifically.

Admittedly, in hindsight, there are limitations to this particular study, which point to new directions for future research. First, methodologically, theories of medical publics and vernacular rhetoric guided a search for meaningful texts, and a rhetorical perspective (namely, biocriticism, complemented by an analytics of biopolitics) alerted me to variables and relationships that hold political consequences for the everyday practice of medicine. It is more than likely that other variables, which a rhetorical perspective may not illuminate, also actively trouble the relationship between medicine and its publics. Future study of this same issue via different critical lenses, thus, would help to identify variables of concern that this study, undoubtedly, had overlooked. For instance, the organizational communication perspective might be particularly beneficial for exploring in further detail issues of professionalism and institutional identity.

Second, as a complementary note, another limitation of this study was my treatment of “health-care workers” as if they constitute one homologous group. This depiction is far from the truth, as medicine operates notoriously as a hierarchical system. As an initial step to understand types of issues being raised in the halls of medicine, and given that an array of health-care professionals did respond to the National Vaccine Advisory Committee’s public registry call, coding health-care worker responses as one group was useful, because, in some ways, it collapsed power hierarchies that may normally operate to exclude certain voices and prioritize others. In this regard, treating resistant health-care workers as all contributing to one narrative about the status of medicine allowed me to look beyond rank and to focus on rhetorical features of conversation. Nonetheless, an overwhelming majority of public respondents to the NVAC database and, for that matter, to the entire vernacular corpus that was consulted, were registered
nurses. More research should be done to investigate anxieties according to health worker rank, as, I am certain, power differentials inform evaluations of what vaccination can and does symbolize in the larger scheme of medical practice. Similarly, access to unions (for which nurses are well known) likely also plays a big part in why and how vaccination gets leveraged as a site for pushback and collective organizing. In addition to rank, other studies have noted that socioeconomic status matters to health-care workers vaccination-adoption patterns (see, e.g., Frew et al. 2012). Thus, future study should follow these leads to better understand the health-care workforce as a diverse population of individuals.

As a third limitation of this study, I believe more can and should be done to understand and define health-care workers as a unique type of public. Health-care workers seem to be a true intermediary between public, private, and technical spheres; between official, vernacular, and expert rhetorics; and between professional, public, and lay identities. Additionally, health-care workers, as seen in this study, are able to resist from within institutions of which they remain a part; that is, they stay affiliated with groups with which they vehemently disagree. This skill sets them apart from a counterpublic as it is currently theorized (Warner 2002): Health-care workers are not positioned as counter-to official institutions but, nonetheless, produce resistant rhetorics that are intended to counter dominant ideologies. Similarly, health-care workers seem distinct from expert patients as they are currently being theorized in the field of the rhetoric of health and medicine (see, e.g., Heritage and Maynard 2006). Unlike the experience-based expertise that Hartelius detailed, which focused on expertise grounded in embodied experiences of illness, health-care workers may find themselves dealing with personal health decisions or issues about which they know very little (both technically and experientially), and, yet, within the halls of medicine, they still occupy an expert status compared to other patients. The term interpublic⁴
may better capture their intermediary status, and I look forward to expanding on this notion in future research.

**Final Thoughts**

Man’s guilt in history and in the tides of his own blood has been complicated by technology, the daily seeping falsehearted death.

—Don Dilillo, *White Noise*

There is something, at once, both foreign and familiar about public health debate. Although the specifics of biomedical technologies may change across time and place, a closer look at the vaccination debate suggests familiar patterns across modes of public argument (Stern and Markel 2005). Convinced that I saw footsteps in the sand—patterned ways of speaking that suggested organized modes of identification and action—this study sought to make a tacit community out of disparate public health communication that, otherwise, at first glance, would suggest division and disunity. In doing so, I aimed to tell a story about and through data that look to the future.

Overwhelmingly, public discourse about flu avoidance affirms the health-care profession’s commitment to protect the safety and well-being of patients. Because this commitment is shared by both official institutions of medicine and actors therein alike, in some ways, connections between flu avoidance and patients’ safety is a moot point, as both sides understand and support the idea that health-care personnel care about and must protect the health of patients. It would seem, then, that arguments founded on this ideal would act persuasively for both official and vernacular actors in medicine alike. As has been shown, however, this last point does not seem to be the case. The U.S. medical context is awash with complexities that require the deliberate and efficient orchestration of competing agendas, and, I suggest, vaccination
serves as a prima facie instance within which those tensions come to the fore. Because vaccination has prompted public debate and social action across history, and it will likely require integrated responsive systems to change behaviors in line with larger biosecurity plans, rhetoricians may be particularly well positioned to foreground the specifically suasive dimensions of vaccination policy in relation to medical practice and bio-(in)security. Research focused on understanding private rights and public service, public health risks, and personal responsibilities becomes particularly useful, especially for medical professionals asked to manage commitments as both stewards of public health and patient-centered health-care advocates. Moreover, designing public health messages that better resonate with and respond to the vernacular experiences of health-care communication can help medicine to better act against aspects of the human condition that escape reason. Indeed, I suggest that enfolding everyday concerns into the policies of medicine may highlight and mobilize the common experiences of humanity that both patients and physicians, and both policymakers and scholars, share to recognize the important in the ordinary, to implicate us all in a common quest to overcome pain and suffering, and to utilize discursive tension in ways that mobilize us to discover creative and novel ways to better the overall human condition.

As bioethicist Donna Dickenson provocatively noted, “Pandemics remind us of our morality in a way that modern biotechnology soothes us into forgetting” (2013, 144). Although the soothing function of public talk about biotechnology may provide valuable solace, the soothing qualities of biotechnological scapegoating may also distract from the critical conversations that are needed to monitor biomedical advancement. As an initial method of observation and intervention, to better tend to the multifaceted vaccine problem, this study turned away from framing vaccination communication as inherently controversial and, instead,
turned toward vaccination debate as an indicator of underlying tensions characterizing the current, shared “medical moment.” Specifically, I focused on mandatory vaccination talk in relation to perceptions of medical professionalism because asking questions about that connection might sidestep familiar political stalemates to reveal something about the common condition. As Drs. Joan Leach and Deborah Dysart-Gale argued, there is value in asking “prior questions” about health and medicine, because “rhetorical questions sponsor a prescribed way of viewing problems and potential solutions in a way that bypasses debate or even conscious deliberation” (2011, 2). In an era when biotechnological advancement progresses faster than informed, inclusive policy deliberation processes can accommodate, crafting questions that transcend difference and that consider the preamble to public debate might be of utter importance and utility.

1 A risk society, according to sociologist Anthony Giddens, is “a society increasingly preoccupied with the future (and also with safety), which generates the notion of risk” (1999, 3).

2 As one recent example of “game-changing” efforts, in April 2012, the Obama White House announced its “National Bioeconomy Blueprint,” which “outlines steps that agencies can take to drive the bioeconomy” in a time of economic uncertainty.

3 I label this contribution “unique” because, when compared to other articles, Francis offered a fairly in-depth historical account of the rhetorical tradition. Attention to the humanistic beginnings of medicine as a source for current professional credibility remains fairly uncommon across most mainstream medical journals. Although the Hippocratic Oath or Hippocrates get frequently mentioned across PubMed searches, attention to peripheral rhetorical figures or foundational rhetorical concepts remains rare. Even so, in Francis’s article, Aristotle’s notion of ethos is never mentioned nor explored, which seems a problematic oversight.

4 I thank J. Blake Scott for providing me with this term in response to questions I raised during my presentation at the 2014 Rhetoric Society of America Conference, San Antonio, TX.
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