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Learning from Practice

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Recently, immediately after completing a short yoga practice, I (Kim) watched a neighbor attempt to chisel his way through the three feet of ice and snow still on his drive from a snowstorm that had ended a few days prior. I mention this not to judge the neighbor, who may have been out of town or otherwise incapacitated since before the storm, and who has the additional bad luck of being on the "bad" side of the street, which is to say, the side that does not get afternoon sun—in a mountain town that gets over 100 inches of snow each winter, it definitely helps to have the sun on one's (driveway) side—but as a way of noticing the value of tackling tasks as a practice. Shoveling multiple feet of snow is very difficult and unrewarding, and can be physically dangerous, particularly when it has melted and frozen multiple times. Shoveling a few inches of snow, even while it is actively snowing, can be unpleasant, but is far less challenging—it can feel self-defeating, as it did when I shoveled three inches of slush one evening, only for it to rain for an hour and melt all the slush before the "real" snow came. But that instinct to move the inches, to practice shoveling when the task feels doable, even if progress is nonexistent, even if it has to be done over and over (and over), beats facing the seemingly insurmountable. Viewing shoveling as a practice—an activity one engages in repeatedly, even if sometimes there is very little visible effect, is instructive, though, and matters as much for physical projects like shoveling as it does for intellectual enterprises like research and writing. It matters, too, albeit in different ways, for professional practices like medicine.

"Practice" has myriad meanings, and for medicine, those definitions can be complex and legal, but here we want to focus not on those formal delineations, but on the more quotidian meanings of practice, including not only in the sense of repeated, habitual activities, but in the sense of practice as a form of learning by doing and by reflecting. To briefly indulge the snow-shoveling metaphor again: learning what kinds of snow can be gently scraped across the driveway and which kinds need to be lifted and tossed is important for budgeting time and energy as much as it is for preventing injury. Learning from practice matters. Opening up the concept of practice in these two senses can remind medical practitioners and RHM scholars alike of the scope of such practices, and what can be gained not only from the dedication to habitual practice, but also from the inevitable missteps inherent in the practices of medicine and scholarship alike. Understanding and allowing for imperfect applications as scholars and practitioners practice plying their trades, and building in time and space for reflection about what has been learned from a particular practice, allows for open-minded assessments and new possibilities.

As English-trained scholars, we turned to the *Oxford English Dictionary (OED)* for some historical definitions of "practice," and discovered "practic," a precursor to our modern "practice," and a valuable, if now-obsolete and primarily Scottish usage, which meant "[p]ractical experience; spec. practical knowledge or proficiency resulting from training or experience." Obsolete and Scottish, perhaps, but relevant now as we want to discuss deliberate reflection and attempts to learn from practice—not just in the sense of practicing repetition to get better at something in a rote manner, as the *OED*'s definition 2a puts it: "[t]o exercise oneself in a skill or art in order to acquire or maintain proficiency," but to deeply reflect and learn from/evolve one's practice well beyond what one comes to view as previous mistakes made.

An NPR article posted in the RHM Facebook group Flux earlier this year describes one such approach to practice in one doctor's fluctuating approach to her patients' weight over time. In the piece, Mara Gordon (2024) noted that her stance was initially that of a traditional doctor, advising weight loss as a boon for multiple situations, such as knee pain, for example, which she views in retrospect as unnecessary and damaging, writing, "As if my patients hadn't thought of that already. As if they hadn't already tried." Gordon reflected that her approach to "overweight" patients began to change as she read various memoirs describing how traumatic

doctors' visits are for those above a certain BMI—she asserted that the "change started for me, as many of my major realizations do, from reading." Gordon felt "unsettled" after reflecting on her advice through the lenses of these narratives, and began to change her practice: she stopped mentioning weight. Gordon's story further validates Martinia Bientzle et al.'s (2021) findings about the power of narrative in their study, titled "The impact of narrative writing on empathy, perspective-taking, and attitude." While their study focused on patient attitudes, physician attitudes can also be productively affected by narrative—if the physician is open to reflecting on her practice. That Gordon's approach was first affected not by anything her own patients did or said, but by exposure to everyday individuals' health narratives, demonstrates the value of narrative as well as an open-minded approach to practice that extends beyond the work day or work context.

Gordon began to practice what she described as "'weight-neutral medicine,'" seeking community and support from like-minded practitioners who shared this new view. While she embraced this ethos of weight-acceptance, the drug Ozempic appeared, which again changed her perspective—not because she wanted her patients to use it to become thin, a path she resisted, but because as they increasingly asked for it, she "started to understand that it wasn't [her] job to withhold Ozempic from [her] patients simply because it didn't align with [her] ethos." Again reflecting on her practice, she began asking her patients *why* they wanted the drug, offering alternatives where they made sense, but often prescribing what the patients asked for when the reasons given were about quality of life. She explained that she realized that "[p]art of practicing weight-neutral medicine . . . is supporting my patients' own sense of what their bodies need."

While Gordon's initial weight-neutral shift in practice was sparked by narratives she encountered outside of work, her later shift, a way of practicing weight-neutral medicine while simultaneously prescribing weight-loss medication for patients who asked for it, came through her careful attention to her patients' own senses of their own bodies. This later adjustment could be considered an example of a narrative-based medicine practice physicians are increasingly embracing (Zaharias 2018) as an explicit part of their practice, endeavoring to learn from interactions with patients in their everyday practice. Megan Milota, Chislainie van Thiel, and Johannes van Delden (2019) conducted a systematic review of narrative medicine studies, finding that among the benefits of narrative medicine training is increased empathy, enhanced understanding, and better communication skills.

Our meditation on "practice" reminds us that many things rely on practice—as in rehearsal and preparation—and use reflection to identify where practices might need to shift. The reframing of practice—as in repetition meant to lead to proficiency—implies reflection and constant iteration. Scholars in RHM can also benefit from this kind of reorientation–away from research we are doing because it's part of what we do and part of research as a practice from which we are constantly learning based on reflection.

Writing in *Families, Systems & Health: The Journal of Collaborative Family Healthcare*, family medical physicians Colleen T. Fogarty and Larry B. Mauksch (2014) call for their fellow physicians to specifically "integrate practice and reflection into the learning," which they do through videos, role-plays, and observations of other practitioners (p. 365). They explained that watching others, in particular, helps one develop an "'observer self'" which "allows one to be mindful while seeing patients" (p. 366). Their article focused on the need for effective systems to include cycles of action and reflection and to "protect time for practice and learning" (p. 365).

The advice Fogarty and Mauksch offer for physicians can productively be mapped onto the work RHM scholars do: how are we as researchers and writers building in such cycles of action and reflection? When we finish a research project, do we simply move on to the next one, or do we take stock of what we learned, what mistakes or assumptions we might have made, and how we might grow as practitioners as a result? When we read scholarship with ideas that challenge us, do we note our disagreements and move on, or do we sit with the challenges to see if we might benefit from a reconsideration of shared practices and long-held beliefs, as Gordon did? We'd like to encourage our fellow RHM scholars to protect some of their time explicitly for such reflection.

Paul Saunders (2001) described caring for patients as an art that:

> should fluorish not merely in the theoretic or abstract gray zones where scientific evidence is incomplete or conflicting but also in the recognition that what is black and white in the abstract often becomes gray in practice, as clinicians seek to meet their patients' needs. In the practice of clinical medicine, the art is not merely part of the "medical humanities" but is integral to medicine as an applied science. p. 139)

We believe the same is true for RHM scholars—what seems black and white in theory often becomes much more gray in the moment of a research encounter or in the complications of writing for publication, and the lines between disciplines and practices become blurred as well. Participatory action research (Swacha 2022; Quintal 2023) seeks to blend reflecting on practice with including patients as knowledgeable participants—one path that encourages scholarship and medical practice to evolve together in ways that ultimately benefit patients, practitioners, and scholars alike. Practice is a deceptively complicated term, its definitions varied and at times contradictory, but one of the final offerings of the *OED*, definition 10a, is one to which medical practitioners and RHM scholars alike no doubt aspire—to themselves be practiced, "to be experienced or skilled through practice; to be skilled, versed, or proficient *in*" their chosen profession.

This issue of *RHM* includes various pieces that connect to the concept of practice in different ways, from Chad Wickman's analysis of reporting guidelines, and the practice of using guidelines and reflecting on that use to inspire new iterations, to Melissa Thomas' illuminating the ways Indigenous languages are inextricably linked to practices of sharing health and medical knowledge through storytelling.

First up, Chad Wickman examines the "genre-ing" activity of reporting guidelines in his contribution, "Standardizing Genres in Biomedicine: The Case of Reporting Guidelines." Through a detailed analysis of the CONSORT and SPIRIT guidelines, Wickman demonstrates the specific textual work such reporting guidelines do to ensure that research can be evaluated on clear, shared terms. Wickman teases out the ways these reporting genres create relationships between research reporting and the quality of that research reporting. These guidelines affect and "mediate different types of rhetorical work—from composition and peer review to the formation of communal ideals"—and thus serve as a rich resource, not only as a locus for shared scholarly commitments, but also a method for their creation and eventual revision.

In our next research article for this issue, Mariel Krupansky's "Intersections of Genre and Identity in Contraceptive Health Discourses" examines online contraception texts and interrogates the intersections of identity, inclusivity, and access in discourses surrounding contraception and reproductive health. Krupansky notes that while many contraceptive technologies are designed for and marketed towards "women" to prevent pregnancy,

users of and uses for contraception far exceed that purpose, and can involve sexuality, gender identity, socioeconomic status, ability, cultural and religious norms, and access to health care. Krupansky views contraception texts as a genre, and through coding and rhetorical analysis details how the genre features of these texts recognize—and/or don't—users' diverse identities and their equally diverse purposes for contraceptive use.

Mary Clinkenbeard and Sushil Oswaloffer "Corporate Rhetoric of Care and Nurse Identity in Times of COVID-19: A Study of a Johnson & Johnson Nursing Video Through the Lens of Althusserian Theory," which examines the ideology behind a Johnson & Johnson video that announces a competition for a technological innovation grant for nurses. The authors contend that the video builds on the pandemic-enhanced identity of nurses-as-heroes and enacts a vision of care that places nurses in various roles, such as the role of technological innovator, while simultaneously furthering its own corporate identity.

We are pleased to include a Commentary piece in this issue by Melissa Thomas: "The Loss of Indigenous Language Practices: Implications for Native Health, Healing, and Cultural Wellbeing." Thomas makes the compelling argument that the loss of Indigenous languages is directly responsible for a vast corresponding loss of Indigenous health knowledge, knowledge which is culturally rooted and traditionally only passed down orally. Thomas invites readers to learn how the storytelling practices of Indigenous communities conveys knowledge, and explains that most Indigenous terminology cannot simply be translated into English—because the words may not exist and because the cultural connotations are specific and distinct in each language. We are grateful for Thomas' voice on this important, underreported effect of Indigenous language loss.

The book review in this issue (which, as always, is accessible to anyone on the medical rhetoric website: https://medicalrhetoric.com/journal/vol-7-issue-3/) is Hua Wang's review of *Rhetorical Ethos in Health and Medicine: Patient Credibility, Stigma, and Misdiagnosis,* by Cathryn Molloy[1]. Wang notes that Molloy's book demonstrates how patients' vernacular ethos can be dismissed or compromised by various stigmas and biases based on mental and physical disabilities, gender, and/or race. Molloy shows how these effects can lead to disparities such as misdiagnosis and delayed

[1] *NB:* Book reviews that appear in *RHM* are solicited by and/or pitched to our reviews editor, Edzordzi Agbozo, not by journal co-editors.

treatment. Offering a vernacular approach to patient's ethos, which elevates patient credibility, the book provides both a theoretical and practical path away from disparities, holds the potential to empower the disenfranchised, and simultaneously offers a rich theoretical and interdisciplinary inquiry.

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