Just Walk/Walk with a Doc: Organizing for Health

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This dissertation titled
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ABSTRACT

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Just Walk/Walk with a Doc: Organizing for Health

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My dissertation project examines how participants and healthcare providers create meanings about health in an integrative healthcare program called, Just Walk/Walk with a Doc. Founded in 2005 by a local Cardiologist, JW is an organization that brings together healthcare professionals and community members to encourage healthy lifestyle behaviors while engaging in the exchange of health information. There is a need to attend to how participants of the JW program make sense of and socially construct their health concerns and appreciations outside of institutionalized establishments.

To position my descriptions, I draw upon phenomenology and pragmatism philosophies with a feminist approach. In doing so, I argue that we must attend to ways of being (e.g. embodied presence), doing (e.g. practical experiences), and becoming (e.g. a reflexive dimension rendered from the interplay of being and doing) to understand meanings we create about who we are as a healthy person and what we do in order to maintain our healthcare practices. Further, I suggest that health communication scholars explore embodiment as it complements the spoken word in health promotional campaigns. In this way, we are more able to attend to how embodied cues as well as discourse offer us insights into health values that underlie meanings and behaviors that we attribute to our health experiences. My methodological approach aligns with these efforts to emphasize embodiment in health campaigns as I describe how ethnography
served as my guide to attend to and interpret interactions that occurred at the JW program.

My ethnographic descriptions and reflections led me to explore answers to the following questions: 1.) How does storytelling in the Just Walk/Walk with a Doc program become meaningful? 2.) In what ways does culture inform meanings we create about our health in the Just Walk/Walk with a Doc program? 3.) In what ways does the Just Walk/Walk with a Doc program reproduce, disrupt, and/or redefine power within physician-participant/patient relationships? I conclude this dissertation by offering how what is learned can be embraced by, transformative for, and transferable to other healthcare movements.
To my father, Grove R. Field and my mother-in-law, Vicki L. Zsinko. May your teachings and love of life forever live on through your children.
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“Life isn’t about finding yourself. Life is about creating yourself”
-George Bernard Shaw

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“Can you share with me a story that illustrates what makes Just Walk/Walk with a Doc special?” I asked the Executive Director of the Just Walk organization. She responded, “There are so many people, so many stories. I received a phone call from a person who had heard about the walk. She has a son who is overweight. They had decided at the beginning of the year to make an effort to change their habits and she called me to ask more about the program. She said, ‘I want you to know that this is going to change our lives. And thank you.’” Without any further prodding on my part, she continued to share other stories that moved her. She said, “I can think of two gentlemen who have been taken off of medications because of joining the walk program. It is not just about the exercising either; these are the guys that will email you during the week and send you funny jokes. You can tell they are really passionate about the program.” “Then,” she continues, “There is a story of a woman who has a granddaughter in Florida who has been sick. We linked them up with a pediatrician who was able to provide them with medical advice for their baby. The baby is doing much better now and she always comes back to the walks and tells us how glad she is for the program.” She must have noticed the surprised expression that appeared across my face as she replied, “I mean there are countless stories like that. We are so thankful for the docs who are coming out to do this. They are all so very special because the majority of docs are still in bed.”

(Personal Interview, February 18, 2011)
My dissertation project explores how health meanings are created by participants involved in a program called, Just Walk/Walk with a Doc (JW), a program where community members can interact with healthcare professionals and each other while engaging in non-scripted health discussions. I engage questions informed by narrative inquiry, cultural/feminist theory, and critical theory in order to explore these unique interactions between participants and healthcare providers. Each of these frameworks provide a unique perspective for exploring health organizing in ways that differ from standard paradigms of health (i.e. the biomedical model), as well as standard institutionalized health contexts (i.e. hospitals). Using ethnography and narrative interviewing as my method of inquiry, I explore the situation specific-meanings that develop among participants at actual JW events. By examining these innovative processes and outcomes of health organizing, I hope to offer ways that integrative health-related practices like that of the JW program may contribute to health communication.

In this chapter, I first provide a rationale for why I chose to study the JW program followed by information about the program itself. I then offer an overview of the dissertation, previewing chapters that include: a meta-theoretical chapter exploring how phenomenology and pragmatism complement one another, a review of literature focusing upon embodiment as a taken for granted conception in health promotional campaigns, and a methods chapter discussing the investigative orientation/techniques that guide my interpretations. Next, I briefly outline my three interpretation chapters offering my reasons for addressing the questions that came to guide my inquiry. These questions involve: how we make sense of our own and others’ health experiences through narrative
accounts, how our cultural standpoints in the world shape what we value and what we do concerning our health, and how power has the potential to (re)negotiate relationships between healthcare providers and participants in integrative health organizing practices. I conclude this chapter with a brief description about the significant contributions this study offers for health communication campaigns.

To Educate, Exercise, and Empower: Rationale

What is the one activity that is free, we already do it almost every day, and it can greatly affect our health? The answer is walking. If walking were a prescription drug, the recommended dosage would be 150 minutes per week (CDC, 2012). This weekly commitment could reduce health risks for cardiovascular disease, type 2 diabetes, metabolic syndrome, and some cancers (CDC, 2011). In addition, walking for the recommended amount of time improves bone density, muscle mass, mental health, and balance (CDC, 2011). The benefits of walking are plentiful. But if this information still does not persuade you, walking also has been known to help with weight loss and increase the likelihood of living a longer life (CDC, 2011). So why are only 62 percent of Americans doing it (CDC, 2012)? Some research suggests it is because we do not have enough policies in place to promote walking (Lee & Buchner, 2008); others suggest we do not have enough public access to walk-friendly environments (CDC, 2012); and still others argue that an ecological approach (e.g. a focus on individual, community, and environment) is the only way to motivate an individual to sustain walking behaviors (Eyler, Brownson, Bacak, & Housemann, 2003).
This current project does not focus on reasons why individuals do not walk. Rather I explore reasons for why individuals who already participate in a walking program find it meaningful. The JW program offers an ecological approach including individual motivation (e.g. pedometers), social support (relationships with healthcare providers and participants), and public access to walking trails (e.g. public parks and malls). I could name numerous studies that suggest an ecological approach to modifying healthy behaviors is effective. Unfortunately, this is where the knowledge gap narrows and where my project begins to provide a significant contribution.

Strikingly absent is research descriptive of the socio-cultural dimensions among those who practice habitual preventive health behaviors (Curfman, 1993). It is important to examine the specific meanings arising from these socio-cultural dimensions because communicative actions in specific contexts come to constitute the meanings individuals attribute to their health practices. For instance, the ways we make sense of our own health is a process of reflection from past health experiences and a reciprocal exchange of health information (knowledge claims and anecdotal stories) with others. Therefore, JW offers a space where participants actively create and transform meanings that contribute to what it means for them to live a healthy life—to educate, exercise, and empower themselves through community.

Just Walk/Walk with a Doc: Background

JW, founded in 2005, brings together community members, physicians, medical students, and healthcare professionals to take steps for encouraging an active lifestyle. Yet walking about while simultaneously engaging in understanding can be traced back to
the peripatetic school. Here, Aristotle coined the term soul-faculty, a way of knowing that emphasizes the inseparability between body and mind (Sharples, 1999). In more recent times, the cardiologist of President Eisenhower advocated physical activity as a life philosophy, which arose from his own lifestyle practices and attention to his patients’ oral histories (Oglesby, 1986). The JW (2012) mission statement reads, “Our mission is to encourage healthy physical activity in people of all ages, and reverse the consequences of a sedentary lifestyle in order to improve the health and well-being of the country.” This mission corresponds to these embodied ways of knowing—encouraging both healthy lifestyle behaviors while creating a space for participants to seek advice from physicians.

Dr. Brooke, Cardiologist from Mount Carmel St. Anne’s Hospital in Columbus, Ohio initiated the idea of the JW program. Although originally organized out of Dr. Brooke’s personal garage, the program’s popularity rapidly generated enough interest for administrators at St. Anne’s to consider donating office space. In addition to office space, the walk hired an executive director who is responsible for daily operations and promoting the walk program. Now almost two years later, the program has added another staff member and has grown from five to over eighty walks located all across the U.S. and more recently the world.

JW events take place every Saturday morning at several different locations throughout the country and the world. At the beginning of each walk, the doctor responsible for the organization of the walk at that designated location gives a 10-minute presentation about current health educational trends. The walks take place in public parks during the fall, spring, and summer months, while the walks occur inside public malls
d during the winter months. Attendees are encouraged to walk park trails or mall pathways with each other at their own pace. Blood pressure checks, pedometers, healthy snacks and additional informative literature on health lifestyle changes are also provided at each location.

Overview of the Dissertation

This dissertation examines communication among members involved in JW, an integrative health program. The JW program provides an alternative path for health organizing that calls attention not only to discursive ways of knowing but also to “extra” discursive or embodied ways of knowing. The meanings that arise from situation specific walk events will be beneficial for examining the link between personal and societal understandings of health as well as insight into the promotion of healthy lifestyle changes. This project engages in a reflexive understanding of how both participants and healthcare providers actively partake in shaping health meanings that have implications for future health interactions.

Chapter 2, “Towards a Feminist Approach to Phenomenology and Pragmatism,” explores the meta-theoretical links between phenomenology and pragmatism in relation to our own and others’ embodiment in an integrative health-organizing program. Phenomenology provides a unique lens to understand our being (i.e., former patient, walk volunteer, healthy body) in the world. In comparison, pragmatism emphasizes how our actions come to inform our experiences of doing (i.e., walking, talking, sharing, caring). Both of these philosophies together allow us to explore the body and mind in ways that limit the essentializing of human activities. I argue that this process is social and informs
the notion of becoming, which offers us ways to envision a purpose that is meaningful to our existence.

Chapter 3, “A Review of Embodiment in Health Campaigns,” presents an argument for the inclusion of embodiment as a primary component in health communication campaigns. Bodies speak; yet, we often take for granted the symbolic health meanings that arise from spaces, places, and times that we ourselves inhabit. By exploring embodied health practices, we are more prepared to understand how embodied meanings take shape in health campaigns. This chapter will contribute knowledge to our understanding of health campaigns with an emphasis upon appreciating a health program that underscores listening to the body. These “extra” discursive health meanings that are created in and through the body remain implicit if left unattended. By the end of this chapter, I provide suggestions from the review of literature about how embodied health meanings among researchers, participants, and healthcare providers can be addressed in health communication campaigns.

An overview of contemporary health communication scholarship is provided in this chapter with an emphasis upon a value-centered approach to understanding health-related meanings (Guttman, 2000). Next, I offer information concerning: a) a (re)conceptualization of embodiment, b) how this affects the role of the researcher, and c) embodied persuasion. I strongly urge qualitative health researchers to attend to embodied meanings prior to, during, and following their work in the field – and – that these meanings offer us a healthful purpose for building relations with others.
Chapter 4, “Methodological Approach,” takes into account how my role as the researcher informs the ways I come to make sense of health meanings created in the JW program. Scholars have recently called our attention to exploring the role of the researcher in qualitative inquiry, but to what extent do we attend to the embodied stories of our participants—or even more so to ourselves? This chapter employs narrative ethnography and interviewing as a method for understanding the storied processes that guide our co-constructed meanings prior to, during, and after our entrance into and exit from the field. I share what I have learned from a reflexive process of co-created stories with other participants – whereby – the story-teller becomes a part of the story and the shared story becomes a purpose for the story-teller.

In this chapter, I explain how my methodological orientation including: a) reflexive embodied ethnography, b) narrative ethnographic reconstructions/reflections, and c) discourse-in-use and “extra” discursive practices (e.g. language and embodied meanings) serve as frames of reference guiding my interpretations of discourse. I provide information regarding my methods of discourse collection and analysis followed by an argument for methodological rigor. I conclude this chapter by sharing my story accounting for the decisions I made as a researcher to include and exclude certain observations and descriptions. This story unfolds with me divulging what I value and how I acted during different phases of the research process including: entering the field, becoming a co-participant, and writing as a method of inquiry.

Chapter 5, “Storytelling in an Integrative Health Program” examines health narratives both embodied and spoken during JW events. We tell stories on a daily basis
often either to explain to others or ourselves what is happening in our life (Bruner, 1990, 2002). Even so, narratives are lived and told with and about others who ultimately become a part of our story. Such stories shape the ways we come to make sense of our health as well as inform the ways we practice health behaviors with others. Meanwhile, these storied meanings created through dialogue with others also contribute to collective and societal understandings of health (Charon, 2009; Gubrium & Holstein, 2009; Harter, Japp, & Beck, 2005). And describing these shared stories allows us to examine underlying health values embedded within narrative accounts.

Charon (2009) explained, “Like all narrating situations, these instances of storytelling unite the teller and the listener in a shared world either recalled or imagined” (p. 120). Stories draw listeners into our worlds to serve as witnesses (Frank, 1997), to share our burdens and/or pleasures even at times when our stories do not cohere. This is often the case when referring to stories about health and illness where uncertainty abounds. Yet for some of us, living with uncertainty is better than knowing for certain when it comes to our health. This chapter further explores how and why participants continue to search for meaning through stories when we live in a world where each foot straddles both realms of health and illness.

Searching for meanings about our health is a fundamental aspect of the JW program. Accordingly, in this chapter, I share participants’ unique health stories that led them to join the program and continue to come back. I also provide insight into the interactions that have taken place between healthcare providers, members of the walk, and myself. The activity of storytelling provides new possibilities for accepting a
plurality of meanings concerning our own health and the health of others that may guide us in future healthcare encounters to come.

This chapter begins with an overview of narrative theory concerning: a) whether stories themselves should be solely conceptualized in the literary form or if we do indeed live out the stories we tell, and b) how diverse frames of reference contribute to our understanding of a particular story. The second part of the chapter presents ideas from scholars who employ narrative in a health context that are useful for understanding how JW participants enter into story. Next, I share participants’ stories as the following research question guides my interpretations: How does storytelling in the Just Walk/Walk with a Doc program become meaningful? Emergent themes that I discuss include: serving as a witness (and teller) of health stories; embodied meanings; health talk as a scaffold for dialogue; participant as patient; doctor as patient; the structure of the walks; friendships; and our search for meaning. I conclude this chapter by offering practical implications for each theme.

Chapter 6, “Cultural Meanings about our Health,” expands upon narrative theory to explore how our cultural positions inform what we consider to be of value when we talk about our health in a situation-specific context (e.g. a JW event). All stories are context-bound; without context meaning would cease to exist (Bateson, 1972; Marshall, 1993). In examining narratives-in-context we begin to learn the ways we come to form opinions with others about our health experiences. Simmel’s concept of culture that is inclusive of race, ethnicity, gender, age, and other unique and diverse positionalities served as my framework for this chapter. Meanwhile, I also attend to Guttman’s (2000)
value-centered approach to health promotional campaigns and feminist organizing practices. In doing so, I employ Mumby and Putnam’s (1992) ideas about bounded emotionality that involves understanding meanings that are intersubjective, tolerant of ambiguity, informed by both goals and values, molded by both self-identity and community, and relationally based rules (p. 474). Health meanings emergent from context account for the ways we engage in health processes and outcomes of organizing that make our culture important in adding to both discursive and “extra” discursive ways of knowing.

Fine (1993) argued, “a feminist perspective tells us why we study organizational communication—to create organizations that allow all people to express fully their human potential, and that allow them a genuine and free voice rather than a voice constrained by false ideology” (p. 132). In this chapter, I suggest that the JW program is transformational because every Saturday morning we leave with new information, resources, and stories we create with others about our health that we would otherwise keep suppressed from the public sphere. Members of the JW program (re)negotiate public and private domains informed by what Mumby (1993) after Laing (1967/1983) refers to as the politics of experience. When we bring to the forefront our own personal stories about health, we are redefining both public and private realms in an effort to narrow the gap between healthcare provider and participant. Yet I also suggest that this effort is guided by a feminist ethic of care and listening where participants of the JW program respect each other’s privacy.
This chapter examines the history of communication and culture as it relates to how our cultural backgrounds a) render health meanings shaped by codes, symbols, and rituals, and b) inform both discursive and embodied experiences about our health. I then explore how communication, culture, and health provide a lens to understand beliefs we attribute to private and public spheres as well as the potential for change. In doing so, I draw upon my observations to interpret cultural meanings about our health asking: In what ways does culture inform meanings we create about our health in the Just Walk/Walk with a Doc program? Themes developed in this chapter include: cultural meanings shared and unshared; from standpoints to dialogue; negotiating private and public; and bodies building boundaries. I draw this chapter to a close by providing practical implications for each theme.

Chapter 7, “Power Dynamics in Integrative Health Organizing Practices,” explores power within healthcare provider and participant relationships in the JW program as they are reproduced, disrupted, and/or redefined. The patient-provider encounter is complicated by a web of dilemmas entrenched within the relations among power, politics, and control (Waitzkin, 1991). Power within patient-provider models are examined in detail by scholars such as Lupton (2003), yet lacking is how power is conceptualized outside of a traditional health environment (e.g. a hospital). By exploring communication that takes place in a context unrelated to typical institutionalized medicine, we may encounter new possibilities for (re)negotiating power. I suggest these power dynamics in the JW program spawn both dialectical and dialogical moments where individual empowerment is fostered by communal support.
The study of health and illness from a socio-cultural perspective emphasizes the ways our cultural understandings of sickness and health are molded by values that when experienced through encounters with others, often reproduce notions of what it means to be healthy through the influences of physical, environmental, and social factors (Lorber and Moore, 2002). Yet, health information is a continually evolving process through the production of new information and the reproduction of previously established information. I argue that the knowledge production within the JW program involves a combination of both past and present technical, private, and public spheres.

This chapter also describes the ways space, place, and time shape and reflect power dynamics in the JW program. For instance, participants are afforded the opportunity to create a long and lasting relationship with healthcare providers in an informal setting on a weekly basis. This encounter can potentially serve to re-envision conventional patient-provider relationships allowing for broadened experiences, desires, and values to arise. Through a communal effort to understand what it means to live a healthy life, meanings are contested, negotiated, and understood in relation to self and other that permits alternative ways of knowing.

I first provide an overview of communication and power as their interrelationship has been conceptualized in terms of both positive and negative elements. Then, I turn to communication, power, and health to examine traditional patient-provider relationships in comparison to provider-participant relationships typical of a health promotional campaign. When addressing my observations, I ask: In what ways does the Just Walk/Walk with a Doc program reproduce, disrupt, and/or redefine power within
physician-participant/patient relationships? Specific themes in this chapter include: narrowing the healthcare divide; our dialogical imaginations—stories that glide; the spoken body—becoming embodied; the voice of the lifeworld; white coat syndrome; becoming empowered through dialogical exchanges; and something about place. I again offer practical implications to conclude the chapter.

Significant Contributions

This project aims to contribute descriptions about how participants ethically engage with stories about their health and pragmatically consider suggested practices concerning their own and others’ health behaviors in a facilitative setting. The JW program provides a bona fide alternative environment for exploring the communicative aspects of health organizing from a socio-cultural perspective. Foremost, the analysis provides a “thick” description of the interactional ways self-motivated participants make sense of health stories that come to inform the decision-making process concerning their own health practices in such a context. Second, my study’s focus on naturally occurring conversations between healthcare providers and participants—in conjunction with their spoken reflections on the process—will significantly enhance our understanding of how culture affects health communication in minimally hierarchical, non-institutional contexts. Thus, the results of this study will contribute to our knowledge about health organizing relations from a unique field setting involving voluntary participants with diverse backgrounds. Finally, this study examines ways that integrative health care interactions can transform patient-participant power structures within health promotional campaigns, thus providing insights to improve healthcare practices.
CHAPTER 2: TOWARDS A FEMINIST APPROACH TO PHENOMENOLOGY AND PRAGMATISM

This chapter outlines the philosophical perspectives informing my efforts to understand the communicative activities occurring at the JW program. My initial interest in combining these philosophies occurred when I myself was asked to define who I was as a scholar. During my own search for a meaningful answer, I realized that we, as human beings, creatively compose life. And during our compositional endeavors, we take many things for granted, which certain philosophical outlooks can highlight for us. To consider one such perspective, phenomenology is the study of essence or being (Merleau-Ponty, 1945/1962). Being is a mutually constituting presence, involving both subjectivity and intersubjectivity, where we come to explore and ascribe values to our experiences that occur prior to our creation of words. By comparison, another perspective, pragmatism, is the study of practical experiences or doing (James, 1967). Doing is the ways we embody values we both perceive and conceive during the unfolding of events. I maintain that there are key insights phenomenology offers that pragmatism overlooks. Meanwhile, pragmatism accounts for human activities that phenomenology is reluctant to venture beyond. Throughout this chapter, I explore how the strengths from each philosophy build upon the limitations of the other. In doing so, I rely upon philosophical contributions from the phenomenologist, Merleau-Ponty and the pragmatist, James.

Next, I discuss how a feminist approach towards phenomenology and pragmatism offers an additional framework for exploring the conditions of social structures (e.g. gender, race, ethnicity, sexual orientation, able-bodiness, age) entrenched within cultural
life. In this way a feminist approach lends itself to understanding becoming, that is, the reflexive dimension rendered from the interplay of being and doing. For example, when we become aware of the ways others tend to see ourselves, would we not possibly consider changing our course of direction in life? I suggest that such potential adaptation in recognizing alternative choices is often the case if a feminist approach provides a critical reading and supplement of the descriptions of experience guided by phenomenological and pragmatic philosophies.

Finally, I conclude this chapter by discussing the merits of using a feminist approach to phenomenology and pragmatism within an integrative healthcare organization, JW. Accordingly, I explore how the framework of being, doing, and becoming informs how I observe and interpret interactions between and among members of the JW program. In doing so, I suggest that the ways we learn to look at events as they unfold inform the ways we interpret the unfolding of events. This process guides my own inquiry in describing what becomes meaningful to JW participants who creatively compose the answer to James’ (1967) question, “What makes a life significant?”

Merleau-Ponty and James

In 1897, William James wrote a philosophical treatise entitled, “Radical Empiricism” that afterward served as the foundation for his later work entitled, “The Pragmatic Method.” James acknowledged the pragmatic rule in his writing for the first time in the essay, “Radical Empiricism” arguing that our perceptions in the world are inseparable from our conceptions or unique experiences. In other words, our particular position in the world will always affect what we believe to be significant. For example,
my education and training in communication studies has guided my development as a scholar and informs how I observe and interpret communication phenomenon. Even so, my unique experience as a health practitioner prior to continuing my education influences my selection, observation, and interpretation of health issues. James refers to his empirical foundation as “radical” because he parts with the rationalist tradition that argues our consciousness is separate from our experience. Rather, James prefers what he calls the “stream of consciousness,” in that thought and action are mutually contingent and intertwined as opposed to dualistic. In this way, James offers what he calls pluralism that defies Kant’s ideas about universal principles. Instead, he argues that our experiences are personal and that consciousness cannot be removed from these experiences (James, 1967).

In a somewhat similar vein, Merleau-Ponty in 1945 establishes what he calls the “Phenomenology of Perception,” arguing against Descartes’ ‘cognito,’ that suggests we know objects because our consciousness ventures out and returns back to our bodies. Rather Merleau-Ponty (1945/1962) asserts that all knowledge starts from “body-subjects” and that body and mind cannot be divorced from one another. Even more, Merleau-Ponty argues that our bodies inhabit objects that surround us in space and time. He holds firmly to the idea that consciousness or thought presupposes our perceptions of our surroundings, which we end up taking for granted. For instance, when I am at a JW event, my body guides my perceptions even as my body becomes an object to myself against the backdrop of all other surroundings including nature and people. In this way, my body
becomes my point of view in the world and it is this mind/body relation that guides my perceptions.

Thus, both philosophers emphasize the notion that our perceptions provide us with a unique position in the world; yet both also advocate that we need to relearn how to understand the relations among perception and conception. Even so, as each philosopher begins to unpack and create assertions about these relations, their ideas begin to diverge. For instance, Merleau-Ponty distinguishes between perception and action, whereas, James does not. This divergence in thought is largely driven by how each philosopher develops their definition of experience. For example, Merleau-Ponty (1945/1962) wrote, “We must discover the origin of the object at the very centre of our experience; we must describe the emergence of being and we must understand how, paradoxically, there is for us an in-itself” (pp. 82-83). In this way, Merleau-Ponty advises us to relearn how our being-in-the-world is only accomplished by acknowledging the infinite amount of ways the body expresses itself in our perceived world. In contrast, James (1967) wrote, “Experience, I believe, has no such inner duplicity; and the separation of it into consciousness and content comes, not by way of subtraction, but by way of addition—the addition, to a given concrete piece of it, of other sets of experiences, in connection with which severally its use or function may be of two different kinds” (p. 172). For James, perception is attention and attention is action and thus to know something is only accomplished by what he refers to as being-knowing-together or our ability to comprehend things in context. Considered in this way, Merleau-Ponty’s “Phenomenology of Perception” is a more reductionist approach and James’ “Radical Empiricism” is a
reconstructionist approach. Despite their differences, both perspectives provide useful insights when we attempt to observe and make sense of a communication phenomenon.

In my view communication means understanding how we make sense of meanings that we create and share together. In a healthcare context, I am particularly interested in how health meanings are negotiated while coming to inform both being and doing. Thus, underlying principles of phenomenology and pragmatism guide my inquiry to pay attention to and understand meanings that are both embodied and discursive.

Merleau-Ponty (1945/1962) wrote:

We become unaware of the contingent element in expression and communication, whether it be in the child learning to speak, or in the writer saying and thinking something for the first time, in short, in all who transform a certain kind of silence into speech. It is, however, quite clear that constituted speech, as it operates in daily life, assumes that the decisive step of expression has been taken. Our view of man will remain superficial so long as we fail to go back to that origin, so long as we fail to find, beneath the chatter of words, the primordial silence, and as long as we do not describe the action which breaks this silence. The spoken word is a gesture, and its meaning, a world. (p. 214)

Accordingly, we must not forget that the body speaks and inhabits objects in our world. And our embodied habituations are unique in that sometimes it is not what we say but how we say it that makes all the difference in the world (e.g. being apprehensive when speaking to a physician). Understanding this involves attending to what Merleau-Ponty (1945/1962) calls an embodied presence. Even so, James (1967) reminded us that things
have names because we give names to things contingent upon our relations to the things we experience. James (1967) wrote:

The pragmatic method starts from the postulate that there is no difference of truth that doesn’t make a difference of fact somewhere; and it seeks to determine the meaning of all differences of opinion by making the discussion hinge as soon as possible upon some practical or particular issue. (p. 279)

In this way, the words we use to communicate describe experiences that are not simply observable facts but connected to what we value. Our communication with one another is informed by our habits of perception and contingently bound in relation with one another (e.g. we value our health thus we exercise). This is what James (1967) refers to as practical experience. Both of these perspectives are invaluable for me as I desire to attend to and comprehend health values embedded within both nonverbal and verbal communicative acts.

**Feminist Epistemological Approach**

Keeping the above ideas in mind, both phenomenology and pragmatism share some familiar shortcomings, which is the reason I now turn to a feminist epistemological approach. I, before anything else, consider myself a feminist. In doing so, I do privilege lived experiences unique not only to women but also to persons who share with me experiences that differentiate from cultural hegemony—in other words—bound to a certain way of understanding the self in relation to experiencing the world. For instance, "masculinity" is a particular cultural condition of social structures that has different effects for both men and women. I do not hold firmly to or appropriate a specific type of
feminism(s). Rather I navigate a feminist life without labels partially due to personal experiences that I, in my own lifetime, have endured. In this way, I suggest that a feminist approach to phenomenology and pragmatism offers skepticism that neither “Continental” philosophies are answerable to when attending to the intersectionality of one’s unique experiences and conditions of cultural life.

The question thus becomes: how and to what extent does a feminist epistemological approach supplement phenomenology and pragmatism? To begin answering this question, it is necessary to identify some shortcomings of phenomenological and pragmatic thinking that a feminist approach has the potential to rectify. First, phenomenology and pragmatism originated from a cultural era rooted with a male bias (Fisher, 2010; Seigfried, 1996). Women’s experiences, be they the embodied conditions of the female “sexed body” or practices that would lead to transforming social conditions, were not a key consideration. Even so, we could turn to phenomenologist, Beauvoir, and pragmatist, Jane Addams, whose works often get neglected, to understand the social conditions of women and persons in this time period. This leads to the second shortcoming, gender neutrality. According to Fisher (2010), this outlook can become a question of essentialism or reducing all observations down to essence or being—thereby, failing to account for differences. For pragmatists, this uniform constitution of being becomes a question of reconstructing experiences that likewise fail to take into account diversity in our everyday practices or doing (Bardwell-Jones & Hamington, 2012). A feminist approach is therefore sensitive both to similarities and differences as these values inform both being and doing in relation to what I refer to as becoming—or the
ways in which we reflexively engage in understanding the self through the eyes of others routinely interwoven with transformative change. But before going into more detail about becoming, I turn to contemporary feminist thinkers who outline feminist approaches to phenomenology and pragmatism.

Feminist phenomenology is a descriptive account of interrelations among the lived body and social conditions that either constrain or enable being or subjectivity. Iris Marion Young (2005) is a contemporary thinker who develops a feminist phenomenology to approach the conditions of women’s experience (including embodiment during pregnancy). Young is widely known for her essay “Throwing like a Girl” where she discusses differences associated with facticity and transcendence. The former concept is understood in relation to how others judge and often constrain our bodily existence (e.g. in terms of race, ethnicity, health, age, etc.). The latter concept is understood in relation to our ability to define for ourselves how we project our bodies forward onto the world. In this essay, she illustrates the constraining elements of the facticity of girls largely due to societal pressures to “act like a girl,” which reacts back onto girls’ subjectivity influencing their freedom as an agent to act in society. Young (2005) defined the lived body as “a unified idea of a physical body acting and experiencing in a specific sociocultural context; it is body-in-situation” (p. 16). Thus, even though our “body-subjects” are unique to the ways we inhabit the world that surrounds us; we are still bound to socio-cultural conditions that influence our embodied presence.
Feminist pragmatism reclaims a political orientation during the process of examining values intertwined within the context of our experiences and actions. Charlene Haddock Seigfried (1996) is well recognized for developing this connection between feminism and pragmatism. Seigfried suggested that feminism and pragmatism are compatible due to pragmatists’ principles including “the relation of theory to praxis, takes the continuity of experience and nature as revealed through the outcome of directed action as the starting point for reflection” (p. 6). In other words, the personal is the political and the meanings that we ascribe in reflection emerge from our situation in specific contexts that can either help or hinder social conditions for persons in society. Thus, a feminist approach to pragmatism exposes social inequalities that lead to alternative possibilities for living in the world via our descriptions of practical experience.

At the center of a feminist approach to phenomenology and pragmatism is an interconnection among our descriptions of experience and how we interpret meanings that are not free from social conventions. For feminist scholars who approach the description of experience from a phenomenological lens, embodied dialogue is emphasized during the process of sensemaking (Kaufman-Osborn, 1993; Kruks, 2001; Young, 2005). By comparison, for feminist scholars who approach the description of experience from a pragmatic lens, discursive acts are the foundation for providing us with the means for redescribing social conditions for living in the world (Dieleman, 2010; Collins, 2000/2009; Seigfried, 1996). Feminist interpretation of experience interrogates underlying values that we reflexively engage with when describing and evaluating
meanings we attribute to self and society. A feminist approach also embraces the social construction of meanings that questions how values created from self and society inform biological, social, and environmental circumstances or the interplay among being and doing—becoming. For instance, we may decide to make healthy decisions because someone is there—present—listening to our needs and providing us with responsible feedback. Thus, in an integrative healthcare context, a feminist approach to phenomenology and pragmatism offers a framework for observing and understanding relations among being and doing while also offering insight into how we become a healthy person in an organization like JW that frequently challenges social conventions embedded within participant-provider relationships.

Towards a Feminist Approach to Phenomenology and Pragmatism:

In an Integrative Healthcare Context

The ways in which health meanings are negotiated in an integrative healthcare context stems from and informs how we perceive ourselves as a healthy person and what we practice to maintain our health. In this section, I elaborate upon how being, doing, and becoming offer a unique framework that guides my observations and interpretations regarding the interactions that occur at the JW program. While I highlight distinctions in defining being, doing, and becoming and in describing their meta-theoretical assumptions, I must emphasize that they are not mutually exclusive communicative phenomena. These concepts actually interpenetrate one another in nuanced ways in phenomenological, pragmatist, and feminist descriptions and in the interpretive meanings I develop here about participation in the JW program.
On Being

A phenomenological perspective on being or essence accounts for how our particular projects inhabit the world. Merleau-Ponty (1945/1962) wrote, “I regard my body, which is my point of view upon the world, as one of the objects of that world” (p. 81). Therefore, the ways our bodies interact with our surroundings can perceivably communicate cues about what we value when it comes to our health. For instance, the ways we walk and talk (e.g. listening to music versus listening to each other) at the JW program can communicate certain values. Participants who listen to music while they walk may be motivated differently than participants who engage in eye contact during the walk. Paying attention to or relearning the meanings that our bodies communicate is thus an important aspect of attending to being.

In relearning how to attend to being within a healthcare context, we must also be sensitive to how medical narratives at times impose values onto our projects or body-subjects. For example, do we not want to be understood as a person first rather than a would-be healthy subject participating in a program? Young (2005) differentiates facticity by employing such terms as immanence (e.g. a fixed position of the body) and transcendence (e.g. a fluid position of the body). The biomedical paradigm has a habit of disregarding the humane domain of health communication and labeling people by means of the disease they carry. This is a classic example of immanence in medicalization that imposes definitions onto the body. Rather, the JW program is an integrative health care organization where members foster ongoing relationships that account for who they are in diverse contexts. For example, my involvement in conversations unrelated to my health
(e.g. relationships, education, extracurricular activities) suggests to me that my presence as a human being is valued foremost.

This embodied presence is fostered by listening and attending to embodied cues. Thus, our body-subject also symbolically responds to one another and this response is an intentional one according to Merleau-Ponty. We can then violate another’s sense of being if we do not attend to another with what Levinas (1974/1998) refers to as a listening eye. A listening eye actively avoids all thoughts that would lead to thematizing what another is saying. Rather we attend to another through our active silence and embodied cues. For example, someone may at some time need you to only listen and not speak. In this way, I am responding to another with silence so that they may have the opportunity to express what is meaningful to their existence.

On Doing

A pragmatic perspective on doing describes how our practices inform our experiences in the world. James (1967) wrote, “The knowledge about it is it with a context added. Undo it, and what is added cannot be context” (pp. 141-142, original emphasis). That is, our actions cannot be severed from our feelings during our efforts of describing experiences within a particular context. In other words, what we value informs what we do. Take for instance participants at the walk who form social bonds with other participants during their exercise routine. For some members, the social component—because of their experiences of loneliness outside of the walk program—is more valuable than the exercise itself.
These values embedded within an act constitute both subject and object (Seigfried, 1996). Thus, the ways we come to embody what we attend to and value about our health is dependent upon what health values an individual believes are important. In other words, health values are both abundant and diversely contingent upon an individual’s perspective in the world. For example, at this point in my life, because my partner and I are discussing starting a family, I will most likely ask health questions regarding fertility. In turn, I will in all probability decide to walk and talk with members who can provide the knowledge I need answers to about my health in relation to my own life circumstances.

These descriptions of practical experiences may offer knowledge about alternative possibilities for living in the world. For example, are we not able to conceive of a relationship with a physician that differs from the traditional patient-provider model? The JW program takes place in a public park on a weekly basis, which offers a unique context to explore how spatial and temporal elements of our experiences with healthcare professionals may inform how we make health decisions and change our health behaviors. As Rorty (1982) suggested, “Theory for pragmatists is when somebody has doubts about what everyone has always believed and suggests another way” (p. 25). The JW program in this way does provide a unique space where participants and healthcare providers share lived experiences that inform alternative possibilities for living what each individual believes is a healthy life.
On Becoming

While we observe and interpret being and doing, we begin to account for descriptions of experiences that begin to inform the interplay that guides us towards understanding becoming. Scholars from a phenomenological approach suggest that sometimes words escape us during our moments of experience in dialogue with one another and all we have is the memory that our bodies carry with us (Hamington, 2002; Kaufman-Osborn, 1993; Kruks, 2001). I know that I am unable to account for every embodied experience at the JW program. Yet these meanings will forever live on in my memory and guide me, however tacitly, during my reflections. And as Fisher (2010) argued, these meanings generate both specific and general understandings of being through what she terms three-dimensionality or of being bodily. In this way, our reflexive understanding of self is mutually constituted with other persons who may at times see us better than we see ourselves and thereby prompt us to think differently about who we desire to become.

On the other hand, scholars from a pragmatic approach are devoted to understanding how we embody these experiences. Bardwell-Jones and Hamington (2012) claimed that:

If we uncritically accept values, such as the subordination of women or other social groups, we acquiesce to these operative power structures and become passive participants in the formation of our lives. (p. 3)

We are responsible for and answerable to envisioning other possibilities not constrained by social conditions. The JW program is an integrative healthcare context that offers a
different way of valuing the participant-provider relationship. In this way, we engage
differently with healthcare providers, which is both empowering and communal, resulting
in different courses of action we might undertake about our healthcare decisions and
practices.

**Conclusion**

My goal for this chapter was to outline a feminist approach to phenomenology
and pragmatism. In doing so, I drew upon the works of Merleu-Ponty and James to
illustrate how embodied presence and practical experience together provide a more in-
depth analysis for describing communication experiences about health. I argued that by
attending to being (e.g. listening, being present, and responding to bodily cues) in a
health context, we can appreciate how others inhabit their perceived worlds. I also
suggested that by paying attention to doing (e.g. asking questions, making decisions, and
acting) in a health context, we are more attuned to how what one values creates meaning
about her/his health. Even so, I proposed that a feminist approach preserves our
skepticism about social conditions that constrain how we see ourselves and what we
desire to do. In this way, I suggested that becoming permits a reflexive dimension where
we can re-evaluate how we might see ourselves differently resulting in an alternative
course of action. I concluded this chapter by illustrating how these concepts (e.g. being,
doing, and becoming) may provide some foundational ways of thinking about health
communication in an integrative health organization.
CHAPTER 3: A REVIEW OF EMBODIMENT IN HEALTH CAMPAIGNS

This chapter offers a comprehensive review of the literature addressing embodied health experiences. By exploring embodied health practices, we are better prepared to understand how embodied meanings shape health campaign effectiveness. It is well known that the effectiveness of health campaigns has involved a trajectory from minimal effects to moderate effects to what is presently understood as a conditional effects era (Noar, 2006). Health campaigns applying current knowledge regarding planning, implementing, and evaluating the success of a health intervention in a particular context utilize a conditional-based approach (Atkin & Salmon, 2010; Noar, 2006; Silk, Atkin, & Salmon, 2011). Yet, health campaigns that emphasize these effects must expand their purview to include persons’ embodied health experiences. Shifting our focus towards the interpretive realm of understanding co-constructed health meanings provides vital information into how health campaigns contribute to our societal definitions of health. Thus, there is a need to reconceptualize what can be gained by health campaigns that include our embodied health experiences (Zook, 1994). Repositioning the body at the center of what constitutes a meaningful health interaction highlights how we make sense of the social, environmental, and physical attributes affecting our health practices in a given situation. Lack of such information is alarming, because these “extra” discursive health meanings that are created in and through the body remain implicit if left unexamined. For example, we often raise a hand if we have a question. However, we also use our bodies in different ways (i.e., waving, hovering, or stalking) in hopes of getting
someone’s attention. This is especially important to consider within a health-organizing context where participants are consistently seeking out health information.

This chapter contributes knowledge to our understanding of health campaigns with the associated goal of appreciating a health program that underscores listening to the body. I offer knowledge that creates a space for examining the role of the body in a health campaign context. Accordingly, this chapter investigates how embodied health meanings among researchers, participants, and healthcare providers are addressed in health communication campaigns. My purpose is to highlight embodied ways of knowing complementing the spoken word that have the potential to challenge and transform what it means to be healthy (Antelius, 2009; Gale, 2010). My reading of this available research argues that embodied health experiences offer us resources related to the outcomes of health interventions.

This chapter proceeds in the following way. First, I provide an overview of current health communication scholarship employing what Guttman (2000) refers to as a value-centered approach to understanding health campaign effectiveness. Next, I compare, contrast, and synthesize information guided by a (re)conceptualization of embodiment. Krieger (2005) defined embodiment as:

a concept referring to how we literally incorporate, biologically, the material and social world in which we live, from in utero to death; a corollary is that no aspect of our biology can be understood in the absence of knowledge of history and individual and societal ways of living. (p. 352)
This definition of embodiment guides my own understanding of how both mind and body contribute to the ways that health meanings are socially constructed, negotiated, and/or sustained. For example, an avid marathon runner, who runs 26.2 miles, conceptualizes a healthy body differently from a grandmother, who desires to bend over and pick up her grandchildren. Following this, I will discuss why embodiment is a salient issue for health communication scholars to attend to as this focus renders an additional layer of reflexivity through the role of the researcher (Friberg & Ohlen, 2010; Gale, 2010; Sharma, Reimer-Kirkham, & Cochrane, 2009). Finally, I will address the ways embodiment is related to the outcomes of health interventions. Research suggests that embodied accounts depict a significant relationship between intentions and behaviors (Sherman, Gangi, & White, 2009), and embodied health experiences afford more explanations for the complicated lives we live (Hudak, McKeever, & Wright, 2009). Since values underlie the fundamental choices we make and approaches we take in organizing health communication campaigns (Guttman, 2000), it is imperative that we deepen our understandings of embodied health experiences that contribute to outcomes of our health interventions.

Contemporary Health Communication Campaigns

The effectiveness of contemporary health communication campaigns depends upon numerous factors. Developing adequate planning, implementation, and evaluation strategies contributes to the success of an effective health campaign (Atkin & Salmon, 2010; Noar, 2006; Silk, Atkin, & Salmon, 2011). Within these broad categories, scholars narrow the field even more by recommending specific principles for campaign
practitioners to follow. These include formative research/needs assessments; theory and its relation to practice/context, audience segmentation, targeting, or tailoring; selection of specific messages including content, style, and format; identification of appropriate communication channels; and relevant evaluation design (Atkin & Salmon, 2010; Noar, 2006; Silk, Atkin, & Salmon, 2011). According to Silk, Atkin, and Salmon (2011), “Campaign effectiveness typically is defined in relative rather than absolute terms. If a campaign meets the objectives set by its planners, then it is labeled ‘effective,’ and if it does not, then it is labeled ‘ineffective’” (p. 216). Therefore, contemporary health campaign effectiveness is closely related to how well we as scholars and practitioners design interventions that yield commensurable findings between the underlying values embedded within our campaign principles and intervention outcomes.

Health campaign principles that drive our choices for a particular intervention are value-laden. According to Guttman (2000), “Values are embedded in all facets of the intervention process and both influence and serve as justifications for the choice of the intervention goals and objectives” (p. 1). The effectiveness of health campaigns depends upon whether or not the recommended principles are meeting the needs that are of value to the intended community as opposed to the health interventionist. For example, Zoller (2000) discovered that health practitioners who have good intentions to build healthy communities through the use of dialogue may hinder the process with preconceived notions of what a dialogic interaction should resemble. Zoller (2000) suggested that “When we want meaningful interaction, we have to meet people where they are, not where we want them to be” (p. 206). One way to meet people where they are is to
approach health interventions using a value-centered approach. Guttman (2000) refers to two distinctive types of health campaigns, strategy-centered and value-centered. Both campaigns involve analytical frameworks that address:

- the way the problem is defined or the goal of the intervention,
- the way the solution is defined or the locus of the solution,
- the strategies approach chosen, and
- the way the outcomes of the intervention are assessed. (Guttman, 2000, p. 221)

The difference between strategic and value-centered campaigns is that strategic campaigns often involve underlying assumptions that are taken for granted within each dimension of the analytical framework. For example, the strategic approach is most often monological in failing to account for multiple perspectives about the problem and the alternative possibilities in intervention and evaluation strategies informed by meanings that arise from a social context. Some primary health campaign principles such as theory-driven practices, needs assessments, channels of communication, and evaluation goals—offer us a lens to interrogate some of these ethical dilemmas.

Several scholars stress the importance of a theory-driven health campaign to serve as a guiding framework for formative research, implementation, and evaluation (Babrow & Mattson, 2011; Cameron, 2009; Fishbein & Cappella, 2006; Roberto, Murray-Johnson, & Witte, 2011). However, theories can assist us during our interpretation of events while also preventing us from visualizing any alternative possibilities. Most of the time we are told to carry with us multiple theoretical frameworks, yet, Cameron’s (2009) review of several health communication theories also included distinct limitations among their
many promises. Fishbein and Cappella (2006) emphasized the role of communication theory in shaping, changing, and/or reinforcing health attitudes, beliefs, and behaviors. Integrating theories will afford us the opportunity to examine specific populations who are likely to act upon certain messages we send. For example, Fishbein and Cappella (2006) discovered that antismoking messages aimed towards smokers who did not intend to quit smoking were less likely to impact attitudes, beliefs, and behaviors. Rather, antismoking messages aimed towards smokers who intended to quit smoking were more successful in their outcomes (Fishbein & Cappella, 2006). Similar results occurred for Vaughan and Rogers (2002) who employed Prochaska and DiClemente’s (1992) stages of change to guide family planning education-entertainment programs in Tanzania. This sentiment is an iteration of Zoller’s (2000) call to meet people where they are. This then leads us to question what types of communication channels work for whom and how?

Several scholars have argued that a mix between mass mediated messages and interpersonal communication channels is most effective (Harrison, Morgan, King, & Williams, 2011; Hwang, 2012; Vaughan & Rogers, 2002; Wakefield, Loken, & Hornik, 2010). For example, the Harrison et al. (2011) study showed that social support conveyed through interpersonal relationships increased the likelihood for African-Americans in the state of Michigan to become an organ donor. Hwang’s (2012) study provided support for interpersonal relationships as a mediator for the facilitation of health campaign conversations about smoking. Finally, Wakefield, Loken, and Hornik (2010) discussed mass media effects of health campaigns in relation to specific health issues and contexts (i.e. tobacco, alcohol, physical activity). Wakefield, Loken, and Hornik (2010) suggest
that the type of campaign strategy depends upon the type of desired health behavioral change (i.e., promotion of a one-time change, episodic, or habitual change). Mass mediated physical activity campaigns have generated short-term effects even when aimed at highly enthusiastic individuals (Wakefield, Loken, & Hornik, 2010). According to Wakefield, Loken, and Hornik (2010), community-initiated physical activity campaigns, like that of the Just Walk program, have been more effective in changing the behaviors of older adults and tweens. Walking campaigns that are sustainable appear to provide two significant elements. First, there is an investment into the social relations formed among community members, and second, an environment is provided for participants to engage in physical activity. Environmental engineering is salient to the success of walking programs like that of the Just Walk program.

Environmental engineering involves modifying one’s surroundings in order to increase a desired outcome, such as physical activity (Guttman, 2000). This type of campaign strategy brings together both individual and community oriented health concerns (Brownson, Haire-Joshu, & Luke, 2006; Santariano & McAuley, 2003). For example, Santariano and McAuley (2003) discussed how individuals, themselves, serve as resources for understanding their own care of the self (i.e., through self-efficacy behaviors and perceived control over one’s physical environment). According to Santariano and McAuley (2003), “An ecologic model assumes that health depends on the dynamic interaction of biological, behavioral, social, and environmental factors, factors that interact over the life course of individuals, families, neighborhoods, and communities” (p. 184). Therefore, the demands of both the individual and community
need to be met in order for this type of health campaign to succeed. Brownson, Haire-Joshu, and Luke’s (2006) review of literature discovered that physical activity was likely to increase if an area provided trails, transportation to workout facilities, and zoning policies that encouraged pedestrian transportation. Environmental engineering is salient for those health campaigns that desire to increase physical activity.

As I mentioned previously, there exist numerous factors that influence a campaign’s successful intervention. First, one needs to provide a framework for the locus of the problem (Guttman, 2000). According to Guttman (2000), “Social problems are time, place, and context bound” (p. 74). These underlying questions entertain diverse perspectives from different levels of involvement. From a meta-theoretical level, I draw upon feminist notions of phenomenology (Young, 2005) and pragmatism (Seigfried, 1996) to understand Just Walk/Walk with a Doc dynamics within the intersectionality of individual and community. I seek to understand the ways individuals make sense of their embodied health experience. In turn, these experiences come to inform the communal meanings one gains from the Just Walk organization, as well as guides Just Walk advocates to provide certain information tailored towards their walkers. Besides increasing an individual’s physical activity and creating community awareness about healthy lifestyle behaviors, the Just Walk program also seeks to empower their walkers by offering a space where participants and healthcare providers come together and converse about health issues specific to their own or others’ needs. This being so, participants often will walk with the doctor to discuss an ear infection that they themselves have recently experienced or a heart issue that a loved one is currently
experiencing. Individual level problems reflect the contextual layers of the person’s life prior to, during, and even after participating in the walk. Yet, communal meanings are co-created together with participants and healthcare providers who both actively engage in discussion with one another. Therefore, the locus of the problem for Just Walk involves increasing physical activity with an emphasis on relational processes that take place among individuals and members of the healthcare community.

Guttman (2000) also articulated the importance of understanding the locus of the solution, which provides resources for individuals that help guide communal understandings of how to attend to social problems. For example, at the beginning of every walk, the doctor presents information/education about a current health trend. This could include any topic from Trisomy 18 genetic chromosome malformations that Rick Santorum’s 3-year-old daughter’s experiences to healthy antioxidants found in grapefruit. Topics of discussion are dependent upon multiple factors. First, usually the doctor has some type of expertise in the area in which they prepare a presentation. Out of all of the walks I have attended, I have heard from a Geneticist, Cardiologist, Pediatrician, OB/GYN, Family Medicine, and OSU medical researcher. Another factor that influences the type of topic discussed is whether a health topic is currently in the news (i.e., popular culture print coverage like *The New York Times* or broadcast news coverage). Current literature in medical journals has also been discussed especially if the study correlates physical activity with preventive health outcomes. Topics may also arise depending upon the time of year. For example when summer was upon us, skin cancer prevention through the use of sun-screen and the ABCD’s of identifying mole problems was the topic
discussed at one of our previous walks. Finally, topics often arise from participants themselves who email the doctor beforehand with an interesting article or question. Sometimes topics may increase our knowledge about a health condition that we ourselves may never experience; while at other times, topics are highly relevant by providing us with the skills and resources (i.e., raising our own self-efficacy and perceived control) necessary for us to make healthy choices. Thus, the locus of the solution reflects whether or not community members’ needs are being met by the healthcare leaders of the walk.

Environmental engineering and providing educational resources are strategies that the Just Walk program implements in order to achieve a desired outcome (Guttman, 2000). This includes what Brownson, Haire-Joshu, and Luke (2006) discussed as physical, economic, and communicative conditions that enable participants to feel connected to one another while also accomplishing a goal related to physical activity. Public locations are updated weekly on the Just Walk website describing where walks will take place. During winter months, walks occur in a mall. During spring, summer, and fall months, the walks take place in public parks. The mileage for different trails located in the public parks is calculated beforehand as well as the level of difficulty for individual walkers. Most of the time, participants opt to walk the one-mile trail, which is a loop that connects the start and finish location. The Just Walk program also provides some material incentives such as: healthy snacks, coffee, blood pressure checks from OSU medical students, and free pedometers for the walkers. During these walks, the participants have the opportunity to walk and talk with the doctors on a more interpersonal level. These interpersonal connections increase one’s motivation and investment to participate in an
organization that listens and accounts for their own individual health needs. Just Walk strategies address both relational issues and environmental engineering in order to promote physical activity.

Locus of outcome or evaluation of a particular health intervention asks to what extent individuals benefited from the program (Guttman, 2000). According to Guttman (2000), how we examine the effects of a particular health campaign is dependent upon what we regard as valuable within a particular social context. For example, I can assess a campaign by quantifying health variables (i.e., blood pressure checks, decreases in calorie intake, or increases in physical activity) that identify whether or not certain health behaviors were adopted. Or, I may choose to appraise a health campaign by providing a thick description with an emphasis on embodiment as a process that contributes to our social understandings of what it means to be healthy and live a healthy life. The following section expands upon this notion of embodiment and addresses what is gained by (re)positioning our values towards understanding the processes of embodiment within health campaigns.

Embracing Embodiment in Health Campaigns

In order to answer my research question concerning the current application of embodiment in health campaigns, I conducted a keyword search of articles using: “embodiment and health,” “embodied health,” and “walking campaigns.” Because I desired to learn about a communicative approach to understanding embodiment in health campaigns, I excluded multiple search database engines such as MEDLINE, CINAHL, and Health Source. The articles that were included within this review can be retrieved
from Communication & Mass Media Complete as well as Academic Search Complete. Based on the articles gathered from my initial search, I conducted an extended search from bibliographical references that included book chapters and additional articles emphasizing embodiment in health communication campaigns.

I am concerned with the extent to which embodied knowledge in health campaigns is embraced by researchers, participants, and healthcare providers. With this goal in mind, I asked – how do we discern differences and similarities between embodied knowing and more traditional ways of knowing? A (re)conceptualization of embodiment in health campaigns most notably contrasts with traditional ways of knowing in a health context through recognizing the differences created in the stories that bodies tell us as well as the implications of these stories for healthcare providers and practitioners. For example, the ways we attend to whether or not a patient winces when bending a knee communicates to us that this action is painful. (Re)conceptualizing what embodiment means in relation to healthcare campaigns is therefore an important undertaking in this section.

The role of the researcher informs the ways that embodied health meanings are embraced in contemporary health campaigns. Attending to embodiment in health communication research lends itself to: (a) reflexively engaging with our interpretations in order to avoid essentializing mind and body; (b) providing thick descriptions in an effort to render potential heuristic ways for addressing embodiment; (c) rendering multiple layers and perspectives informed by the partial accounts composing our understanding; and (d) assuming an ethical framework of listening and care. Informed by
a review of how other qualitative health researchers have embraced embodiment, we are better equipped not to take for granted embodied knowledges that are created by our own bodies in the field.

Finally, the last part of this section provides a brief review of challenges and successes of contemporary walking campaigns. I provide evidence from research that suggests a link between embodiment and persuasion. This link may contribute to ways that we as health promoters and practitioners can address embodiment in future health campaigns. Specifically, I suggest that aspects of health communication campaign processes are inseparable from outcomes that determine the success of our health interventions.

(Re)conceptualizing Embodiment

(Re)conceptualizing embodiment in a healthcare context differs from traditional medical models in many ways. According to Zook (1994), embodied health does not derive from biomedical nor biopsychosocial models; rather, embodiment embraces ontological ways of knowing. Within a biomedical model, communication serves as merely an instrument whereby a physician objectifies the body and picks and chooses what to listen to based upon a priori biomedical knowledge that guides—his/her decisions about the patient’s treatment. Meanings that therefore could arise from listening to a patient’s body are preemptively foreclosed either verbally and/or nonverbally from the perspective of the practitioner. According to Zook (1994), healthcare decisions for a patient’s course of medical action that excludes other voices such as family, friends, and
neighbors is a major limitation of the biopsychosocial model. Rather, Zook (1994) argues that:

We need to recognize the reciprocal relation between conceptions of communication and health: A truly holistic conception of health is sustainable only through an appreciation of communication’s constitutive capability; conversely, an understanding of this constitutive function requires our advocacy for and adoption of a holistic conception of health. (p. 348)

Thus, a phenomenological approach to ontological health is embraced that supports both being and becoming in a world where our past health issues guide our future health choices and present health dilemmas (Zook, 1994).

This process of being and becoming embodied involves what Merleau-Ponty (1945/1962) addressed in that our perceptions of the world around us can never be fully detached from our corporeal body. And this is important to comprehend because as Kreiger (2005) so poignantly articulates:

(1) bodies tell stories about—and cannot be studied divorced from—the conditions of our existence; (2) bodies tell stories that often—but not always—match people’s stated accounts; and (3) bodies tell stories that people cannot or will not tell, either because they are unable, forbidden, or choose not to tell. (p. 350)

For example, a new member of the Just Walk program recently underwent knee replacement surgery. Her bodily condition matches not only her stated accounts of her medical procedure but also the way she paces herself around the park where we walk and
talk together. The story that she leaves for me to interpret is that her success in accomplishing many laps quickly is not a precursor to understanding who she is as a human being. In fact, attending to her achievement emphasizes being embodied can promote a sense of agency through the use of space and time whereby becoming is experienced in motion as opposed to stasis (Antelius, 2009; Low, 2003; MacPhee, 2003). She often uses the term “walker stalker” to define herself in opposition to others who are overly enthusiastic about walking. The ability to complete one lap is a successful, practical health venture informed by her previous experience and embodied self.

Therefore, when attending to embodied meanings, we can learn that bodies tell us stories about one’s identity, space, and place. According to Zook (1994), “biography supersedes biology, requiring greater appreciation of the narrative unfolding and recounting of one’s life” (p. 361). In Antelius’ (2009) study, we learn that persons with disabilities, who desire to move but need assistance, can create their own exigencies through the use of their body to garner attention from others and therefore enact agency. As Low (2003) suggests, bodies also can become embodied space, which is defined as “the location where human experience and consciousness take on material and spatial form” (p. 10). For example, I walked with a participant a couple of weeks ago that confided in me that she recently became a widow. Her intention to join the walk program was to create a human connection with others. Therefore, a public park is no longer understood as a space where recreation takes place, but rather for her a space where she goes to reflect upon past events and to cultivate social relationships. In addition, space is
marked by a temporal flow of events that can also contribute to how we understand our health in relation to others. MacPhee (2003) discussed:

Flow occurs within contexts that require the ordering of the body and the mind to be in harmony with an activity—to the point that action and awareness, mind and body, merge—such as in the performance of work, art, sport, or religious ritual. (p. 58)

Health meanings that arise from the Just Walk events are contextually bound and inevitably changing – and as such – these co-constructed meanings are informed by an alternative setting for exchanging health information. Zook (1994) argued that:

We have also overemphasized formal health care contexts (i.e., medical clinics and hospitals) to the exclusion of nonmedical settings, where we spend the vast majority of our time and where therefore most of our ‘health knowledge and behavior’ are formed and enacted. (p. 348)

In overemphasizing institutional contexts, patient-provider relationships are described with preconceived notions including compliance-gaining strategies, behavioral changes, and monetary constraints over therapeutic goals for the attainment of improved health. The Just Walk program recognizes the need to integrate formal education into informal contexts in order for participants to retain information that they deem significant to their particular circumstances. If the doctor does speak about a topic that piques the interest of a particular participant, in most cases the participant will confide in the doctor after the talk about the topic that was discussed that morning. Sometimes this occurs in smaller groups of a couple individuals who use the information as a talking point for the walk.
These embodied stories have serious implications for healthcare providers who seek to contribute to improving the health of others. Embodied epistemological notions according to Kreiger (2005) lead to “why and how historically contingent, spatial, temporal, and multilevel processes become embodied and generate population patterns of health, disease, and wellbeing, including social inequalities in health” (pp. 350-351). In (re)conceptualizing embodied ways of knowing, we are better able to address what Kreiger (2005) refers to as an integrated approach to understanding how patterns of health behaviors connect to our social existence as human beings, rather than relying upon morbidity rates to explain individuals attitudes, beliefs, and behaviors regarding health. This is accomplished by attending to the ways that embodiment produces its own knowledge about identity, temporality, spatiality, and social dimensions. For example, my own beliefs, values, and attitudes about health contribute to how I see myself as a healthy body. The environment that I am in contributes to temporal and spatial elements that may constrain or enable resources for me to live a healthy life. And finally, the relationships that I foster with others may allow me to reflect upon my own life – in comparison to – and different from – what is commonly accepted as healthy behaviors to adopt. Healthcare providers and practitioners who attend to these needs are able to provide better assistance in the form of healthcare options available for an individual while considering their immediate circumstances.

Role of the Researcher

Heedful of scholars’ advice, we must remain attentive to the ways we reflexively embrace embodiment in order to avoid essentializing (Ellingson, 2006; Gale, 2010;
Sharma et al., 2009). Gale (2010) provided helpful insights regarding motivation, immersion, and expression by employing descriptive accounts of her role as an embodied ethnographer in an alternative and complementary training institution for medical students. According to Gale (2010), motivation is how we as researchers employ our own knowledge and experiences in the world and creatively account for our surroundings while attending to the, “wordless bodily sensations, emotional empathy, intuition, spiritual experience, and subtle energetic fields” (p. 208). Immersion is described as an uneasy comfort that the ethnographer feels once he/she had spent a considerable amount of time in a particular setting. In turn, expression refers to how embodied knowledge is understood in words (Gale, 2010). Grasping these three concepts allows us to envision qualitative research as a process, whereby we can potentially become more attuned to contextual layers of meanings that guide our reflexive interpretations. My year and a half in the field guides my own inquiry through shaping the types of questions I ask, the specific events I pay close attention to, and the relationships kindled and crumbled between and among one another. As Friberg and Ohlen (2010) described, reflexivity is a “pendulation between being close and distanced, which can be compared to being in the natural attitude and breaking out of it by means of reflection to understand what is going on” (p. 277). In this way, the participant consummates the researcher’s experience of another just as the researcher consummates the participant’s experience of another.

Sharma et al. (2009) also provided an array of methodological reflections regarding how the researcher’s reflexive practices offer interpretations of emotions and
difference, thus, contributing to alternative ways of knowing. According to Sharma et al. (2009), researchers must attend to:

(a) how researchers can be more aware of their emotions and bodily states, (b) what these states can reveal about the researcher and possibly his or her participants, (c) how nonverbal communication is intersubjective and contributes to a coconstruction of knowledge, (d) how researchers’ identities are multiple and complex, and (e) how cultural difference can impact on the interactions between researchers and participants. (p. 1643)

In Sharma et al.’s (2009) study, Sonya described her interaction with the wife of a man recently diagnosed with a brain tumor and under the care of hospice. Sonya upon leaving felt fatigue and emotionally drained and during reflection realized that she embodied the wife’s emotions. Researchers in the field are prone to blurring emotions between ourselves and our participants (i.e., uniting both knower and known) and without this awareness we may be less able to understand our participants’ experiences. In another account, Sheryl while observing a Sikh religious service becomes aware of and accounts for difference through her skin color and clothing. Dress, which is often overlooked, can serve as a symbol for expression, identity, and even activity. At the Just Walk events, I can often tell by the way someone is dressed (i.e., golf shorts and shirt) whether or not they have plans following the walk. These methodological reflections provided by qualitative health scholars have the potential to guide our own frameworks as we enter into the field, are present with others during our participant-observations, and later reflect back upon what has occurred.
Qualitative health research lends itself well to providing thick descriptions detailing characteristics of people, places, and events as they unfold in narrative. Foremost, according to Friberg and Ohlen (2010), the choices researchers make need to be clearly articulated to the reader. As Gale (2010) professed, these choices include our own intentions, interpretations, and contributions to a body of knowledge. And according to Gale (2010):

> With a concern for embodiment, this is even more important as the body tends to be devalued and silenced in our culture. To write of embodied experiences it is important to notice and make aware where there are absences of language (silences) to describe what is going on. (p. 217)

During the writing phase of our research, it is often difficult to stumble upon the words that best depict what has occurred. This struggle becomes even more apparent when we attempt to describe events that often are communicated through our bodies. But if we are successful, we could potentially strive for what Sharma et al. (2009) recommend, “Embodied experiences can provide for connection and, as a result, serve as a heuristic approach to generating new insights into social relations” (p. 1648).

All storied accounts are partial. Because of qualitative researchers’ commitment to positionality, our insights often offer multiple layers of interpretation driven by diverse perspectives shared with us by our participants. How we come to terms with embodiment in relation to self and society is informed by how our participants communicate their own experiences to us. Hudak, McKeever, and Wright (2007) employed Gadow’s (1980) theoretical framework regarding phenomenological conceptualizations of embodiment to
explore patient satisfaction following hand surgery. According to this perspective, Gadow (1980) theorized that individuals understand the self in relation to their body by one of the following ways: (a) the lived body, whereby body and self are integrated but taken for granted; (b) the object body, whereby body and self are in opposition to one another; (c) cultivated immediacy, whereby body and self are divorced yet are meaningful; or (d) subject-body, whereby both body and self are positively meaningful. In Hudak, McKeever, and Wright’s (2007) analysis of patient satisfaction following hand surgery, several participants provided descriptions that fell into one of these four categories. However, two major limitations that Hudak, McKeever, and Wright (2007) ascertained was that the subject-body rendering may be negatively meaningful and meaning is not found but created. Hudak, McKeever, and Wright’s (2007) extended Gadow’s theory to include a body-self-society triadic, which:

account[s] for the ways in which the social context influences individual’s state of embodiment or for the value-laden nature of the body, which is shaped by societal views of beauty and physical fitness. An awareness of the symbolic meaning of body parts is important because of the potential influence these meanings have on individuals’ states of embodiment. (p. 41)

This understanding of the body is more in line with Frank’s (1997) communicative body and Young’s (2005) lived body, whereby meanings that arise from self, body, and society are enabling and constraining due to our individual freedoms of choice and societal conditions that bind these choices. Internal motivations and external conditions inform one’s embodied communicative acts. For example, a female walker may use her body as
a barrier to move a physician physically to a private space to ask questions related to her own reproductive health concerns. According to Sharma et al. (2009), “To encompass the fullness of what the researcher experiences in the field, an appreciation for how the body, self, and society interact and mutually inform each other can enrich qualitative inquiry” (p. 1647).

Finally, the role of the researcher in qualitative health scholarship is more predisposed to embrace an ethical framework of listening and care. Sharma et al. (2009) argued:

How identities are lived within the field requires consideration, especially in relation to, but not limited to, notions of power, class, age, and race. In being an embodied researcher, value-free, objective, stable, secure, and safe research is very much an illusion, as is the notion that one is just a “researcher” while in the field. (p. 1646)

For example, in Sharma et al.’s (2009) study, Marie, who was also a former nurse, conveyed an ethic of care when she decided to discontinue her research in order to show her participant how to use a picture reader. As qualitative researchers in the field, we often are confronted with choices about when and how to care for others. For example, on my second walk with the Just Walk program, I noticed an older man who was by himself. My role at the Just Walk event involved shadowing the doctor around while listening to conversations that take place between participants and the doctor during the walk. However, on this particular day, the lonely man requested a walking buddy. I made the choice to walk with him instead of the physician. An ethic of care also involves an
ethic of listening. For example, in Friberg and Ohlen’s (2010) study, one of the researchers embraced an ethic of listening by actively responding to and being present for a 70 year-old patient who has been diagnosed with colorectal cancer. An ethic of listening is an awareness and attention to another (Frank, 2000). And as we are guided by an ethic of care/listening, embodied ways of knowing open up new avenues for participating with others that we would have otherwise left unknown.

*Embodied Persuasion and Walking Campaigns*

Researchers for the most part are still uncertain as to what works well for increasing physical activity. Kahn, Ramsey, Brownson, Heath, Howze, & Powell et al. (2002) provided a systematic review of the effectiveness of physical activity campaigns. This study found strong evidence for increasing physical activity by use of educational information, communal social support, and environmental access to recreational sites. In addition, Kahn, Ramsey, Brownson, Heath, Howze, & Powell et al. (2002) recommended that “individually-adapted health behavior change and creation of and enhanced access to places for physical activity combined with informational outreach activities—point out the roles that policy and environmental approaches and behavioral and social approaches to increasing physical activity can play in combating inactivity in our culture” (p. 91). On the other hand, Sallis, Bauman, and Pratt (1998) recommend health practitioners measure community-level environmental factors as opposed to individual-level indicators of increasing physical activity. Other scholars reported the use of reminders and interpersonal communication as mediators of walking campaigns (Matson-Koffman, Brownstein, Neiner, & Greaney, 2005; Williams, Matthews, Rutt, Napolitano, & Marcus,
that physical activity interventions such as walking campaigns rendered long-term effects (Huhman, Potter, Duke, Judkins, Heitzler, & Wong, 2007; Huhman, Potter, Nolin, Piesse, Judkins, & Banspach, 2010), and that walking campaigns employing motivational prompts in combination with contingency plans were described as most effective (French, Stevenson, & Michie, 2012). To summarize these findings, it appears that walking campaigns are most effective when employing a human communication component within campaign strategies. Moreover, this human communication component brings forth an embodiment dimension that has the potential to influence individuals’ attitudes, beliefs, and behaviors about walking.

According to Briñol, and Petty (2008), embodiment can influence attitudes through association, inferences from bodily responses, postures, power, thinking, head motions, and arm flexion. For example, individuals who were lying down as opposed to standing were more inclined to accept strong persuasive arguments (Briñol & Petty, 2008). Interestingly, this article also offers support for embodied persuasion in the form of self-validation, which is similar to self-efficacy but with a social element added. According to Sherman, Gangi, and White, (2009), “The embodiment approach offers a unique perspective on intention-behavior consistency with two lines of research indirectly supporting the hypothesis that embodiment would facilitate intention-behavior consistency” (p. 461). One of the two studies conducted by Sherman, Gangi, and White, (2009) measured intentions to walk employing imagery and embodied cognition conditions. Findings indicated a significant link between intentions to walk and the act of walking providing evidence to support embodied intention-behavior consistency relations
(Sherman, Gangi, & White, 2009). These findings illustrate that we in fact may have been taking for granted meanings that arise from self, body, and society. As a result, qualitative health scholars must remain cognizant of the struggles that we as well as our participants experience in understanding meanings associated with the health of our bodies, the ways we understand the self in relation to health, and how society contributes to the meanings that we use to conceptualize our health.

Conclusion

For the purpose of this literature review, I first provided information concerning contemporary health campaigns including the relevancy of theory, the selection of specific communication channels, and campaign strategies. I then emphasized the need to focus upon embodiment as a process and outcome to identify whether or not a particular communication health intervention is effective. By (re)conceptualizing what embodiment means, we have learned that meanings that arise from self, body, and society can contribute to our experiences of adopting behaviors in order to live/maintain a healthy life. This is accomplished if we as healthcare practitioners recognize differences and similarities in alternative ways of knowing and pay close attention to the stories that bodies disclose. In paying close attention, we as researchers must be reflexive and limit essentializing notions of body and mind; offer thick descriptions of people, places, and events; provide multiple views of understanding; and assume an ethics of care and listening. Finally, I offered support that embodiment can in fact be a persuasive element in health communication campaigns; meanwhile, we seem to take for granted that which we often fail to see.
Practical Implications

Health interventions that focus merely on the biological determinants of health (i.e., biomedical) do not engender a meaningful health experience. According to Zook (1994):

We must embrace a definition of health that balances the concern of biological survival with concerns of personal and social, as well as societal, well-being. This is possible, however, only if we embrace as well a broader conception of communication wherein instrumental interests are balanced by emancipatory interests. This tandem action emphasizes the need for a concept of health (and health care) that answers to the human quest for meaningful rather than mere existence (as cited in Callahan, 1987). (p. 345)

For example, it is not the number of steps indicated on one’s pedometer at the end of a JW event that generate lasting impressions. Rather, it is the relationships that members create during those steps that provide a meaningful existence. Conversations fostered among and between members during this event suggest more meaningful ways for coming to understand their health in relation to their past experiences, present behaviors, and future actions. By focusing upon these communicative acts during the process of embodying health, we are better able to describe how one balances the personal (i.e., the series of health events that led one to the walk) and social conceptions (i.e., the health information offered by the doctor at the walk) that contribute to our broader understanding of health communication. This is what Zook (1994) means when redefining health communication as that which “is thus more appropriately defined as the
This literature review did advance some criteria for how we as scholars, practitioners, and healthcare providers can address embodiment in health communication campaigns in the way that Zook (1994) advocated. First, we must pay close attention to how bodies tell stories and how these stories matter. Implications of embodied stories may indicate a pattern of social disparities due to a geographical location or lack of resources available for certain communities. Stories that individuals tell through their bodies may also suggest that individuals are unfamiliar with healthcare options that are actually available to them. Second, our role as a researcher influences whether or not we listen to the stories that bodies tell us. For example, we must remain sensitive to the ways that others use or not use their bodies in certain situations. And when we are uncertain about meanings that arise from one’s conceptualization of embodiment, we need to find the courage to ask our participants to explain. Finally, embodiment in health campaigns can be a powerful link between processes and outcomes of campaign interventions. Paying attention to the body during health campaign interventions can indeed inform us about whether or not participants willingly were persuaded by some of the messages we send.

Keeping the above in mind, the following research questions guide this dissertation project:

RQ1: How does storytelling in the Just Walk/Walk with a Doc program become meaningful?
RQ2: In what ways does culture inform meanings we create about our health in the Just Walk/Walk with a Doc program?

RQ3: In what ways does the Just Walk/Walk with a Doc program reproduce, disrupt, and/or redefine power within physician-participant/patient relationships?
CHAPTER 4: METHODOLOGICAL APPROACH

In this chapter I describe the methodological orientation that has guided my reflections, reconstructions, and interpretations prior to, during, and after my work in the field. I previously concluded that health communication scholars need to pay particular attention to embodiment as such meanings contribute to: a) values that underlie messages we create about our health, b) different sensibilities on behalf of the role of the researcher, and c) health communication campaign effectiveness relating to both process and outcome. In an effort to follow my own advice, I share how different methodological perspectives have informed my observations, analysis, and writing processes. These include: a) reflexive embodied ethnography, b) narrative ethnographic reconstructions/reflections, and c) discourse-in-use and “extra” discursive practices. Next, I outline my methods of discourse collection and provide an argument for methodological rigor. Finally, I offer my story describing how the different stages of research unfolded including: entering the field, becoming a co-participant, and writing as a method of inquiry.

Methodological Orientation

Alvesson and Skoldberg (2000) claimed, “dedication to only one theory reduces reflexivity and different ways of seeing the world” (p. 250). The deeper we develop an understanding of cultural analysis, the more doubtful we grow and nebulous our thoughts become about what has been going on (Geertz, 1973). I carry with me multiple perspectives informed by meta-theoretical approaches ranging from phenomenology (being) and pragmatism (doing) to concrete theoretical assumptions such as literature
suggesting what does and does not work when implementing a health promotional campaign. These diverse theoretical perspectives helped to guide my judgments when I was in need of clarity. And if we carry with us multiple lenses for understanding the world, then, it is reasonable that we also carry with us multiple methodological dispositions. Ellingson (2009) terms this methodological orientation “crystallization,” or an integrative approach to analyzing multiple forms of a particular phenomenon. This practice provides thicker descriptions of a phenomenon in question by re-directing our attention to explore further the events that are occurring or to probe more deeply meanings that are constructed.

My methodological orientation is not necessarily novel in a sense that I am creating positionalities anew that will serve as my guidance for how I approach the phenomena in question. Rather my orientation for collecting, analyzing, and drawing assumptions has in some ways already been with me throughout the process. This is largely due to classes I have taken, discussions I have had with colleagues, advisors, and mentors, and my own personal journals I have kept throughout this project. Yet I am still in some ways pulling missing pieces of the puzzle together in accounting for why I made certain choices and what this means in light of a present that grows dimmer with each passing day. Three methodological forms that informed the way I came to understand the meanings created in the JW program are: a) reflexive embodied ethnography, b) narrative reflections/reconstructions, and c) discourse-in-use and “extra” discursive practices. Each form, in its own right, offers significant insights, yet together they offer a more nuanced
and complex version of how we come together to create meanings about our health within the JW program.

**Reflexive Embodied Ethnography**

The purpose of ethnography is descriptive in that ethnographers explore values that lie deep within lived experiences (Leeds-Hurwitz, 2005; Lindlof & Taylor, 2002). It was not until several months into my fieldwork with the JW program that I came to realize the word “descriptive” does not just mean detailing what is said among walkers. Rather I was recreating a scene with characters (including myself) and a plot full of unfolding mysteries exploring meanings concerning both health and illness. I embodied emotions, feelings, and thoughts that others shared with me as they too embodied mine. The more I came to realize how intense and intimate my relationships with others was becoming, the more I desired to express in words that which often is left without expression. Yet when we avoid observing, reflecting, and creating words that describe our embodied experiences with each other, we are refusing to acknowledge our existence as human beings living and experiencing the world corporeally. I was motivated to immerse myself into the field in order to express embodied ways of knowing, being, and doing in words (Gale, 2010). I was in a sense learning to learn a different kind of language—this language as Gale (2010) articulated, “is a challenge to the social scientist to explain with words that which is taught without” (p. 218). Reflexive embodied ethnography: a) recognizes that each experience changes how we come to perceive, understand, and act in the world, b) approaches receptively our own and others’
responses to extra-discursive experiences, and c) enhances our awareness that we are re-
constituting worlds with words.

Reflexivity has often been concerned with how the researcher herself comes to
interrogate her own standpoint and interpretive perspectives. At first, I really did not have
a good grasp of this concept. It was not until I distanced myself from the walk program
that I questioned what I was doing there in the first place. I learned that what I initially
believed was significant became less so as time passed. I started paying close attention to
certain moments that seemed more important in the eyes of my participants. Finlay
(2005) suggested, “The researcher’s capacity to understand can be enhanced through this
reflexive awareness” (p. 277). I believe we should take reflexivity one step further and
therefore argue that we (researchers) should strive to understand how others position us
during this process. Reflexivity is a mutual and reciprocal exchange of knowledge,
perception, and action. I am a member of this group because other walkers have accepted
me. On one particular occasion, I had a chat with a member who I had just learned takes
pictures at several of the walks. I mentioned to her that I doubted she would find any
pictures of me at the walks. That following Saturday she proudly brought me several
photographs featuring me at the walk. This experience changed the way I came to
understand my own participation at the walk—as an embodied subject.

This re-examination of who I was in relation to other walkers in the program led
me to re-evaluate what I believed was important about the program. I was not an invisible
figure or disembodied other; rather I was very much “present” in the eyes of other
walkers. I became receptive to how others viewed me as well as my embodied responses
to other walkers. Burns (2003) described this type of embodied reflexivity as “extra-discursive” effects and advocated for an approach that constructs, deconstructs, and reconstructs our embodied subjectivities (pp. 234-235). For example, we as researchers may decide to alter our own embodied subjectivity based upon how others perceive and act towards us. We negotiate their gaze by repositioning ourselves differently. For instance, I walk slower with those who may perceive me as intimating because of my youth, physicality, and dress. This action often is accompanied by me remarking how little time I have had to work out lately. However, there are others that I have misperceived as slower walkers, which often has not been the case.

Finally, reflexive embodied ethnography is about reminding ourselves that we are re-constituting worlds with words. Alvesson and Skoldberg (2000) summarized this idea when they wrote:

The research process constitutes a (re)construction of the social reality in which researchers both interact with the agents researched and, actively interpreting, continually create images for themselves and for others: images which selectively highlight certain claims as to how conditions and processes—experiences, situations, relations—can be understood, thus suppressing alternative interpretations. (p. 6)

For me these processes involved an ethical framework of listening to and care for other walkers in the JW program. At times, this stance may find me serving as a witness for someone who wants to share a story even if this means that I myself do not speak at all during our walk together. On the other hand, a walker may desire affirmation and/or
encouragement that what they are doing is a significant health benefit. Listening and an ethic of care forges a space for mutually meaningful interactions as well as thick descriptions to transpire. And these thick descriptions, although always partial, allow for multiple layers of interpretation and perspective. Reflexive embodied ethnography is a methodological orientation that emphasizes an ethnographic process of exploring not only what has been said but what has also been felt.

**Narrative Ethnographic Reconstructions and Reflections**

Atkinson, Delamont, and Housley (2008) claimed, “Narratives, stories, and accounts are—or should be—fundamental sources of data for the ethnographer of everyday life” (p. 90). Stories are invaluable to the ways we come to reconstruct who we are and reflect upon what we have been doing. During my time as a co-participant at the walk, I learned to listen to the stories that walkers shared with me. Some of these stories were short while other stories are still ongoing even to this day. These same stories also allowed me to understand what was meaningful for the life of an individual walker. I attended to narratives both as participants reconstructed them during walks and following the walks when I sat down with participants and asked them to share their story. This experience has taught me that stories are both lived and told, contextualized from diverse frames of reference, and that they offer health meanings for self, other, and society that are unique and often inconclusive.

Telling stories is a normal part of our everyday routine. Charon (2006) suggested that narrative is “an instrument for self-knowledge and communion, narrative is an irreplaceable—and often silent or at least transparent—partner to human beings as they
make and mark meaning, coping with the contingencies of moral and mortal life” (p. 40). Yet the unfolding of stories may be more reflective at some times than at other ones. Warren (2000), for instance, argued that narrative interviews as opposed to ethnographic methods provide participants space to reflect upon what they have been doing. Even though participants shared stories reflecting upon their lives with me during our walks together, these observations deepened our conversations that took place at a later date. I recognized that walkers reflected upon their participation when a person would respond, “Hmm, hold on; let me think about that question for a minute.” Some of the participants even mentioned to me how much they appreciated this time to reflect upon their participation at the walk. Storytelling is and always will be an intricate part of our complicated lives, whether we are telling the stories we live or living the stories we tell.

Discourse-In-Use and “Extra” Discursive Practices

As I previously mentioned, the first aim of ethnography is description, or the gathering of discourse in an effort to understand the significance of something that happened and why it is meaningful (Leeds-Hurwitz, 2005). The second aim of ethnography is analysis. Leeds-Hurwitz argued that at this stage we begin to reconstruct social worlds that both interest us as researchers and our participants. According to Gee (2011), description is one form of discourse analysis and “discourse analysis is the study of language-in-use” (p. 8). I also suggest that analysis for ethnographers also concerns “extra” discursive practices. Here, we come to understand how language and embodiment renders as Gee suggests connections among saying (e.g. informing), doing (e.g. action), and being (e.g. identity).
As I have recently discussed, storytelling is one method that I find particularly useful in understanding what discursive and “extra” discursive forms are doing. Gee (2011) suggested:

For any communication, we want to ask what typical stories or figured worlds the words and phrases of the communication are assuming and inviting listeners to assume. What participants, activities, ways of interacting, forms of language, people, objects, environments, and institutions, as well as values, are in these figured worlds? (p. 72)

I conclude each of my interpretation chapters by acknowledging that stories draw a listener or reader into their symbolic worlds. And these worlds have practical implications. The practical implication section induces the doing of discursive and “extra” discursive forms. The symbolic worldviews that we create at the walk, for instance, make us think about our health differently than we may have prior to our participation. Walkers act upon these conceptualizations. Participants’ actions are never divorced from how they come to understand who they are or might become as a healthy person.

The longer I spent in the field, the more I began to question what I thought was important to both the walkers and myself. The three methodological orientations reflexive embodied ethnography, narrative ethnographic reconstructions/reflectations, and discourse-in-use and “extra” discursive practices—guided my observations in ways that allowed me to remain open while also attending to and probing more deeply into the values walkers placed upon their health. My understanding of these underlying values provided me with
Methodological Practices

The purpose for outlining my methodological orientation was to illustrate how my methods correspond with that stance to develop a better understanding of the phenomena in question, or why the JW program is meaningful to its participants. I did employ certain practices that align with my methodological orientation that included: participant-observation, fieldnotes, and narrative interviews. In the following section, I describe these practices in relation to the JW program as well as make a case for methodological rigor.

Participant-Observation

Participant-observation is the negotiation of the type of role the researcher comes to occupy during the process of collecting information in the field. Some scholars refer to this role as the “professional stranger,” a more standoffish approach to gathering information (Agar, 1996). Others refer to this role as the “vulnerable observer,” a rather intimate process where the researcher ultimately shares private accounts including emotions and feelings that she has confided within herself during the fieldwork process (Behar, 1996). Lindlof and Taylor (2002) describe participant-observation as a range of possibilities a researcher can occupy from complete participation to complete observation. Yet the researcher’s intention is hidden in both of these positions. Throughout my project, I have tried to occupy a space that I refer to as co-participant. A co-participant inhabits a position that takes into account a reflexive approach where a
participant’s voice is as significant as the researcher’s voice. As Bakhtin (1929/1984) wrote, this is a type of double-voiced imitation, “Someone else’s words introduced into our own speech inevitably assume a new (our own) interpretation and become subject to our evaluation of them; that is they become double-voiced” (p. 195). What was important to participants ultimately became important to me. For example, several of my interview questions stemmed from participants who asked me to integrate some of their own interests into my research.

A co-participant also does not hide one’s intentions or motivations from fellow participants. Further, I did not bracket my own emotions, feelings, or insecurities during the project. I did however grow more intimate with participants who the JW program would refer to as “regulars.” Because my husband accompanied me on the walks, participants did not just perceive me as a “researcher” but also as a wife, student, and comrade. After receiving IRB approval and renewal (See Appendices A & B), I began attending the JW events. During the duration of this project, I participated in twenty-eight walks held between January of 2011 and August of 2012. I attended eight walks held at Antrim Park, which were led by Dr. Rathi, an OB/GYN. I attended twenty walks held at either Polaris Mall or Highbanks Park led by the founder of the walk, Dr. Brooke, a local Cardiologist. I conducted a total of 56 hours of observation.

Fieldnotes

According to Agar (1996), “Field notes are the record of an ethnographer’s observations, conversations, interpretations, and suggestions for future information to be gathered” (p. 161). This is a rather straightforward definition of what fieldnotes entail.
Even so a researcher’s relationship with fieldnotes varies to some degree with regard to form and function. For example, some ethnographers emphasize content while others may emphasize stories, performances, or their own reflections regarding the process of note taking. Researchers may even experience a love-hate relationship with fieldnotes (Jackson, 1990). This often occurs during the writing up phase following our participation in the field. I always understood this experience as both enlightening and exhausting in an effort to create a vivid account of a past that no longer existed. Yet I was never simply content with re-creating a scene with characters that occupied a space outside myself. Rather I desired to dig deeper into the underlying values that I and/or others placed upon our participation together at the walk. This involved describing, sensing, feeling, and being reflective about others’ concerns, interests, and appreciations.

Throughout my project, I began to compile thoughts about conducting fieldnotes that guided my observations in the field (See Appendix C). These thoughts focused on four main themes, including: a) interrogating my own assumptions, b) understanding accounts from multiple perspectives, c) understanding how context shapes histories, meanings, and subjective positions, and d) responding to an ethical code of conduct. Even so, these thoughts did not come about until after my participation at the walk increased, which served to alter the addition of questions and phrasing.

My fieldnotes were a combination of observations and personal reflections. Agar (1990) defined these personal reflections as “diaries,” which “focus more on the reactions of the ethnographer to the field setting and the informants, the general sense of how the research is going, feelings of detachment and involvement, and so on” (p. 163). If my
husband drove us to the walk, I would sometimes reflect during the two-hour drive time prior to the walk. I also spent time writing on the two-hour drive home. If I drove, most of my writing took place after I returned home. I had two journals dedicated to fieldnotes with the walk. Prior to the analysis and writing phase, I typed up all my fieldnotes from these two journals resulting in 97 typed single-space pages of notes.

*Narrative Interviews*

Apart from my ethnographic observations and gathering of information, I also sat down with members of the walk and conducted one-on-one narrative interviews. Warren (2000) suggested that qualitative interviews are constructed in an effort for the researcher to thematize areas of interest. These areas included such topics as narrative, gender, and power. Yet specific questions emerged because of my close involvement with participants in the field (e.g. questions regarding the cultural background or medical experience unique to that individual). Even though I followed a more traditional approach with a typed up interview protocol, I seldom held to the traditional back and forth question and answer interview format. Rather I approached these interviews as a more interactive, reflexive, and conversational process where I shared my own perceptions and interpretations (Ellis & Berger, 2002). For example, I often found myself answering specific questions that a participant had for me. In part, this is due to the structure of narrative interviewing where questions are left open-ended allowing for dialogue or mutual “telling” to occur (Reissman, 1993).

The opportunity for dialogue blurred the lines between narrative ethnography—the ethnographer’s account of stories *in situ* (Gubrium & Holstein, 2008; Lindlof &
Taylor, 2002), and narrative interviewing—explicating storied accounts of personal, organizational, and health meanings (Lindlof & Taylor, 2002). My ethnographic account of stories guided questions created and emerging during the narrative interview process. At times, it became less clear who was the researcher and who was the participant. Yet as I previously mentioned, the participants’ appreciation for their opportunity to reflect differed from my ethnographic observations. I suppose this is partly due to the timing of the interviews, which did not take place until the end of my fieldwork in July and August of 2012. I had a year and a half to build rapport with participants involved with the JW program.

In June of 2012 while I was still involved at the walk, I provided a sign-up sheet for those who were interested in scheduling a time to talk with me about their participation in the JW program. I contacted those willing to participate to schedule a time, place, and date to meet. I let the participants decide where they wanted to meet but provided some options including prior to or following a walk, at their homes, or at the JW office. However, I did meet participants in some unexpected places like a driving range and a restaurant. Once we set a time, place, and date, I called the participant the day before to confirm our meeting. I provided a description of the study, identified any discomforts (e.g. audio recording), and asked the participant/physician if they wanted to continue to sign an informed consent form (See Appendix D). In addition, each participant/physician was offered a copy of the informed consent description. Because of my extensive time in the field, I created questions unique to each individual participant in one section of the interview protocol (See Appendix E). I also dedicated a section of the
physician interview protocol to questions specific to that individual (See Appendix F). These questions stemmed from conversations I had experienced in the past with the person. I typically wrote 3-5 questions prior to the interview. Yet some of these questions also served as probes following the interview. I conducted a total of 26 interviews. Four of the interviews I conducted were with JW organizers (i.e. 3 physicians and the executive director). Twenty-two interviews were with participants of the JW program. The interviews lasted on average from forty-five minutes to one-hour—ranging from the longest interview of 2 hours to the shortest of 40 minutes. The interviews were recorded and transcribed resulting in 206 typed single-spaced pages.

**Interpretation of Discourse**

After all of the transcriptions and fieldnotes were typed up, I began engaging in a close reading of the discourse. Because of the blurring of the lines between ethnography and interviewing, I did not conduct an analysis separating the fieldnotes from the interview transcriptions. Rather I read all the materials in one sitting from cover to cover. As Charon (2006) suggested, I became the reader who “actively engaged in the matter of the book, agreeing to become in some way an agent for its use—whether to endorse it, condemn it, or join with it in finding meaning” (p.108). And during my second reading of the material, I began identifying rich points or storied accounts that would guide my interpretation of discourse reconstructing what the JW culture looks and feels like for those unfamiliar with the program (Agar, 1996). This kind of coding is a process where the researcher undergoes the sorting out of significant segments of discourse (Charmaz, 2006). Questions I entertained during the second reading included: What health values
are participants attributing to certain events, people, and places? What health meanings do I or other participants agree with, disagree with, or feel indifferent about during our conversations at the walk? What am I learning now that differs from what I thought I already knew? And in what ways does this program contribute to health communication (e.g. health promotional campaigns, discursive and “extra” discursive ways of knowing and being in the world)?

Prior to writing each interpretation chapter, I re-read all the materials once again and revisited my research question. Then I read books and articles that served to guide my reflections about the rich points I identified/coded. Next, I typed up pages of notes linking rich points or storied accounts to philosophies that corresponded to each other from the concrete to the abstract, or from the abstract to the concrete. In this way, I was able to better understand the phenomenon in question from diverse frames of reference. Thus, my analysis followed in the tradition of abductive logic. According to Agar (1996), “Abduction is about the imaginative construction of a \( p \) that implies an observed \( q \), or, to put it in our terms, about the modification or development of frames that explain rich points” (p. 35). For example, I read philosophical positions regarding a certain topic (narrative) while simultaneously re-reading rich points (stories) from my fieldnotes and interview transcriptions. In pursuing these investigative activities the philosophical ideas provide insight into the concrete practices I observed. Meanwhile, the narrated actions and storytelling experiences of participants in the walk dramatized the significance of particular philosophical and theoretical concepts for me. This reflexive process strengthened interpretations I began to draw upon from fieldnotes, weakened some of my
initial responses from observations, and/or brought to my attention different issues significant for my consideration. In this way, the recording, reading, and writing processes informed each other while I remained open to different ways of understanding and accountable to the arguments I ultimately put forth in the interpretation chapters that follow (Richardson & St. Pierre, 2005).

For this project, my methods of discourse collection and analysis align with a more qualitative tradition. For instance, I am reflexive about my interpretations of discourse, which is a (re)construction of events that have occurred in the past. Yet I also am a part of creating a socially constructed world wherein my opinions about the connections between theory and practice are disclosed. In the section that follows, I provide standards of rigor that apply to my methodological orientation, practices, and processes.

*Methodological Rigor*

Alvesson and Skoldberg (2000) claimed, “Empirical materials should be seen as an argument in efforts to make a case for a particular way of understanding social reality, in the context of a never-ending debate” (p. 276). Jackson (1989) promotes a similar claim suggesting that all knowledge constructions are rhetorical arguments. Therefore, I am not claiming that my interpretations of JW discourse mirrors some social reality that exists out there. Nor am I claiming that my interpretations of JW discourse do not offer any significant contributions to understanding health communication. My interpretations of JW discourse are limited to the ways I experience these observations and write up descriptions/reflections, my own philosophical sensibilities, and the relationships I built.
with others involved in the JW program. Yet, evaluating ethnography involves scrutinizing: a) whether the researcher spent enough time in the field, b) the connections created between theory and practice, and c) whether a contribution was made in the area of study (Leeds-Hurwitz, 2005).

Leeds-Hurwitz (2005) proposed assessing internal consistency or in what ways do the JW participants view their culture in a similar manner that I have described? After I completed the three interpretation chapters, I sent these to participants and physicians with whom I have created relationships during my time observing and gathering information at the JW program. I requested feedback, and specifically asked readers to consider: Does what is said make sense? In what ways does it move you? What do you find significant from each chapter? Do the stories embody what you value in the JW program? Are there any assumptions that are unclear? And, finally, in what ways do you feel what is said contributes to our understandings about health and communication?

The feedback that I received appreciated the emphasis upon social relationships and exercising as a valuable part of the JW program. Interestingly, some participants perceived this to be a more generalizable conception than I believe I am able to claim in this project. One participant valued, “showing how experiences come to life” through stories. Participants felt that the chapters contributed to health communication and offered additional suggestions about embodiment as part of a process and outcome. These suggested included such things as speaking louder at times to those who may be hard of hearing. At other times, conversations with a walker about certain medical conditions
may come to a halt altogether if other walkers were passing by. One participant wrote back:

I finally got time to sit down and read through the entire thing. There were several insights in here for me. I had never thought about the fact that this program removes the governance of the outside third party that is financially motivated to constrict dialog, access and information.

I really liked one of your comments about separating problem finding from problem solving. I have been wrestling with something at work and I am going to use this to prevent the dialog from jumping to problem solving without fully developing the problem finding stage first.

Overall a GREAT JOB. Very insightful.

The founder and leader of the walk wrote:

Kim—I'm terribly sorry for the crazy delay in getting back to you. It is amazing! I was blown away by the verbiage and your passion for communication. We are honored to have you so involved with the walk. I love it and hope to be able to attend on the 11th. Thank you so much for all you are doing.

In particular, they endorsed my observation that why and what we value (e.g. exercise, health answers, relationships) at the JW program are as two participants suggested “related, intertwined, and reciprocal.”

Internal consistency is one standard of rigor that Leeds-Hurwitz (2005) advocates for ethnography. Internal consistency also elicits new insights that may bring to bear “what it means to be human and the various ways people go about their lives” (Leeds-
Hurwitz, 2005, p. 339). The second standard of rigor Leeds-Hurwitz advocates in this context is whether a reader of the study grasps health values and behaviors important to JW members. Throughout this project, I remained committed to exploring why the JW program is meaningful to its members, including myself, and to provide these storied accounts in the chapters that follow. And finally, Leeds-Hurwitz proposes that a good ethnographer understands how to balance closeness (e.g. acting as a member of the group) and distance from (e.g. taking time for analysis) participants within the study.

Finally, it is important for qualitative researchers to be answerable to the processes of interpretation (Alvesson & Skoldberg, 2000; Ellingson, 2009; Richardson & St. Pierre, 2005). Ellingson (2009) wrote, “Accounting for your process constitutes an important nod toward methodological rigor” (p. 119). As such, in the following section I provide my story as it relates to: entering the field, becoming a co-participant, and writing as a method of inquiry. I share moments of vulnerability as well as moments of reassurance; moments of isolation and moments of belonging; and finally moments of feeling lost and then again found.

The Story of My Participation at the JW

*Entering the Field*

It was winter quarter of 2011 when I decided to enroll in a class called critical ethnography. Prior to this class, I had no former training and only little knowledge about ethnography as a research method. I was excited to learn, but I never could escape feeling a bit overwhelmed. After reviewing the syllabus in class, I realized that our instructor was asking us to become a member of a group and conduct ethnography or to write grapho
about people—ethnos. I quickly began to panic. This was only my second year in the doctoral program and I still had not narrowed down a topic for my dissertation. Panic-struck, I suspect I did what others do—that is ask for advice, guidance, or any other useful information that might propel me in the right direction. In an effort to keep me from standing still, I consulted with professors, classmates, and finally the internet for any clues that might speak to me and/or spark my interest. I received feedback including several ideas about local groups to follow, but after every suggestion my heart started racing and my stomach became all tied up in knots. I always considered this a sign for me to keep exploring my options. I finally realized that if nothing locally piqued my interest, I had to look elsewhere. After perusing several websites dedicated to listing events happening in the Columbus area, I came across the JW event. I was curious to find out more information about this program and decided to explore the walkwithadoc.org website.

I began to watch a couple of YouTube videos interviewing the physician who founded the program in order to convince myself that following this group might be a good idea. As I began to learn more about the program, I remember thinking to myself, “Hmm, well isn’t this interesting.” All the years I have spent working with doctors, I remember how difficult it was for me just to secure their commitment to speak at an educational program. I could not imagine how challenging it must be to commit physicians to speak to and walk with community members on a weekly basis. I was so intrigued by the passion that the founder exhibited that I decided to email him about the possibility of my participation with the program. I shared with him that I was currently
enrolled in a class called ethnography where we were required to follow a group. Right before I hit the send button, I wondered, “Is he as passionate about the program as he is portrayed to be online and in the videos”? Click. It wasn’t even two full days when an email reply surfaced in my inbox. His response was both inviting and enthusiastic.

“Crap,” I thought. There is no turning back now.

The following Saturday, January 29, 2011, my husband and I attended our very first JW event. Because it was winter, the walk was held inside a local mall. We found a parking spot and entered the building through the heavy steel doors separating us from the cold outside and the warm inside. I paid particular attention to all sights, sounds, voices, and noises that morning. On this particular day the mall was hosting several charities, and tables full of silent auction items were set up all across the food court. The color red representing the stroll for epilepsy was scattered everywhere. My husband and I found ourselves smack dead in the middle of a food court panopticon trying desperately to figure out where this walk took place. We shortly realized that we were not alone.

As my husband and I waited for someone or something to direct us to the right place, we met three women who were feeling as lost as we were that morning. One of them asked my husband, “Hey, are you the doctor?” “Oh, no” I thought to myself. “Yeah,” he responded. Feeling as though she accomplished her mission, she enthusiastically squealed, “Yeah!” In order not to get her hopes up even more, I revealed that he was not the doctor but that we must be here for the same program. She said, “No, no, you’re not the doctor” and then began to laugh uncontrollably. As she continued to chuckle, her eyes began to hide into her face, and all I could see was her black spiky hair
swaying back and forth. My husband asked, “Have you done this before?” One of her friends chimed in, “No, this is our first time. I said, “This is our first time too.” Little did I know at the time that this was my first interaction with two women I would come to care for as my journey with the walk program continued.

The three women we were standing with finally spotted the place where the walk program gathered. My husband and I accompanied them to a small area fenced in with tables and chairs secluded from the rest of the food court. People had already been chatting with each other as coats were draped over chairs in the small, confined area. Then, I noticed a woman wearing a Just Walk tee-shirt who kept staring at my husband and me. I did not have anything planned that morning to say so in order to break the uncomfortable stare down I blurted out, “Are you Dr. Brooke’s wife?” “No, I am Kym, the Executive Director of the walk,” she said. “Insert foot into my mouth now,” I thought to myself. I introduced myself and my husband. She mentioned that she noticed us but thought we were here for the charity because we were so young. Kym loudly announced, “Oh, yeah. You are Kim who is doing the ethnography. You are the ethnographer.” “Shh,” I responded as my insecurities surfaced and my face turned a shade of red that matched the walls in the food court. At this time, I did not feel remotely ready to be called an ethnographer. Heck, I was still learning what ethnography is and what an ethnographer does. “What if I cannot fulfill this role?” I thought to myself. Secondly, I was hoping that I could be incognito that morning by simply observing the program and getting a feel for what it was like for someone new. Well, that would never be the case because my role as a researcher was revealed on the very first day. Finally, I thought to
myself, “What if I decide not to come back? Will they take it as abandonment?” If nobody knows who I am, then, I wouldn’t disappoint and could easily disappear into the abyss never to be seen of or heard from again. But that also would never be the case.

So, here I was the ethnographer with her husband at our very first walk. The awkward silence dissipated soon enough as Dr. Brooke gathered everyone around for a health talk. I did not even realize he had arrived until his announcement of “Dr. Winter broke her leg” which was followed with a big “Ohh,” from the audience. He brought a get-well card for people to sign. At this time, I had no idea who he was talking about and began to feel even more uncomfortable. Then, he began talking about the four main drugs for anyone experiencing heart conditions. These included beta-blockers, ace-inhibitors, statins, and aspirin. After his thorough list of medications included in each of these categories, he discussed the benefits of walking and then dismissed us.

My husband and I began to walk. We walked alone that morning, and I remember commenting that it felt lonely. I guess in some ways we were experiencing what it might feel like to be a new member of the program. That is, not having anyone or a group to walk and talk with that morning. I also took note of the ways different groups walked. Some groups power-walked while other groups simply strolled along. Time seemed to speed by as we found our way back to the meeting place where the walk began. We sat down at one of the tables to take in all the sights and sounds. Then, Dr. Brooke approached us, shot out his hand and said, “We’ve never met before, right?” “Right,” I said. I introduced myself and my husband. “Oh yeah, you are the ethnographer,” he said. “What is ethnography?” he asked. “Here we go again,” I thought to myself. I explained
ethnography in terms of a participant-observer or someone who becomes a member of a group and describes that experience. With an impressed look across his face, he asked, “And you drove all the way from Athens to Columbus this morning?” “Yes,” I replied. “Wow!” he said.

Soon after this experience, I realized that if I wanted to be taken seriously I needed to have answers to these questions. Questions such as: Who am I? What am I doing here? What is it that I want to learn? I also realized that I desired to become a member of this group more than to position myself as the “researcher who merely observes.” Thanks to Kym and Dr. Brooke, I was not given the opportunity to hide myself, and looking back I have learned to appreciate these interactions. I am thankful because this meant that I needed to be answerable to the role that I and other persons perceived me as occupying. It is funny how your own frame of reference changes when you begin to perceive yourself differently in light of what others say and do. It did not take long until most of the participants knew who I was and what I was doing there.

Becoming a Co-Participant

February 5, 2011 was the very next walk I attended and it was also my 30th birthday. I came alone which meant I had no choice but to find a companion to walk with that morning. I had decided that I would try to start shadowing the doctor and observe the interactions between the doctor and the participants. However, this did not go as planned. Shortly after I arrived, I realized I was not the only one who was without a partner. And following the doctor’s presentation a man named William began to ask me questions about the college inscribed on my jacket. He explained to me that his granddaughter was
finishing up her schooling there. “Well, should we get walking?” he asked. “Sure,” I replied.

As William and I walked, he began to share with me his entire life story. We talked about where he grew up, where he worked, what he liked to do for fun, and what caused him to become a member of the walk program. Then, William shared with me that he experienced a heart attack about 4 years ago. Dr. Brooke was one of the doctors assigned to William. Dr. Brooke also became his heart doctor and the one who introduced William to the walk. It finally dawned on me that since then William has been participating in the walk for about 4 years now and would be considered a “regular” attendee. I was walking with a legend, an insider, and an enthusiast of the program. I then found myself opening up to William, sharing with him my life story including that I was a student and it was my 30th birthday. “Wow, and you drove up all the way from Athens on your birthday?” he said. “Yes,” I replied. Since that day, William announces to everyone that I am the one who drives all the way from Athens to participate in the program.

Becoming a co-participant did not happen overnight, however my walk with William did make me feel much more comfortable, like a member of the group. But with any new relationship we try to foster, sustaining it and figuring out our roles as members takes time. I did shadow the doctors often at the walks but I also walked with participants who needed a walking buddy. I began to feel included as several groups welcomed me into their walking group and shared their health stories and close friendships with me. As time went on, my fieldnotes became more descriptive and my questions grew more
refined. I felt a sense of belonging. I had come to learn that it is this sense of belonging that participants, like myself, value that makes this program meaningful.

I grew closest to Kym, which in some ways makes sense because she became a key informant who answered questions I had during this project. Yet our more intimate relationship developed when we discovered that we have been through some similar experiences that we hope to write about together at a later date. I share a nickname with her and will always be known as the woman who “shushed” her, which Dr. Brooke still teases her about to this day. I have not been back to the walk since August, and participants continue to ask Kym how I am doing.

*Writing as a Method of Inquiry*

During the month of August 2012, I spent most of my time transcribing fieldnotes and interviews. At first, I felt relieved to give myself time away from the walk. But now, I have grown to miss my companions at the walk. Even so, the separation was needed; I guess distance in some ways makes the heart grow fonder, and hopefully perceptions keener. As I typed up my fieldnotes, I tried to pay particular attention not only to the descriptions I wrote but also to my reflections and the questions that guided my observations. Once all of the notes and interviews were typed, I began to read. After reading, I began to write notes to myself. Richardson and St. Pierre (2005) wrote, “writing is thinking, writing is analysis, writing is indeed a seductive and tangled method of discovery” (p. 967).

I realized that in some ways an ethnographer never stops writing. For instance, nine months into my project, I remember sitting down and having a conversation with
one of my committee members about where I was at in the project. This conversation helped me to narrow down my specific questions to include narrative, gender, and power. Yet, we do (re)discover some things when we pull ourselves out of the field. For instance, I began to realize how much I privileged the voice of women in the conversations I described at the walk. As one participant mentioned, gendered issues help both spouses to guide each other’s understandings of health interpretations and behaviors. I also came to recognize that the emphasis I had placed on gender blinded me to other major themes that I ought to think and write about. Carrillo Rowe (2008) wrote, “The sites of our belonging constitute how we see the world, what we value, who we are (becoming)” (p. 25). We enter these sites through diverse locations including positions other than gender. This is the reason I chose to change my original position on gender and expand that particular chapter to include the values we place on our health guided by our cultural backgrounds. I did however choose to continue writing about narrative and power. My authorial choices led me to exclude more descriptions about the structure of the JW program and an analysis of weekly emails sent by Dr. Brooke. I realized that there was something special I grew to value about the program—a program that carves out a space where ongoing relationships between healthcare providers and participants are fostered, which contributes to empowering ourselves through community to become the healthy person we desire to be.

Conclusion

This chapter provided a methodological framework for my research project. I discussed how my methodological orientation including—reflexive embodied
ethnography, narrative ethnographic reconstructions/reflections, and discourse-in-use and “extra” discursive practices—guided my perspectives for understanding meanings we create about our health in the JW program. I offered a description of my methodological practices that correspond to my methodological orientation and presented an argument for methodological rigor. I concluded this chapter by sharing a detailed and reflexive account of my story involving entering the field, becoming a co-participant, and writing as a method of inquiry. My intention was to provide a thick description of my own research methods accounting for the decisions I made in the following three interpretation chapters regarding narrative, culture, and power.
CHAPTER 5: STORYTELLING IN AN INTEGRATIVE HEALTH PROGRAM

This chapter examines health narratives both embodied and spoken during JW events. I discuss here ways that narrative discourse can contribute to health promotional campaigns as well as my own interpretations of past, present, and future JW events. In doing so, I address the following research question: How does storytelling in the Just Walk/Walk with a Doc program become meaningful?

The first section of this chapter begins with a brief overview of debates surrounding narrative analysis/inquiry. One issue concerns whether stories are told not lived—lived and then told—or simultaneously lived and told. My consideration of this debate is largely driven by Eakin’s (2006) question:

Should narrative stick to narrative narrowly conceived as a literary form or forms, or should it entertain a more adventurous approach to narrative as something to do with society, with identity, with the body? Is narrative only a function of language or is it rooted more deeply still in the bodies that we are? (p. 186)

I then explore how different frames of reference toward narrative (i.e., small, big, grand) offer diverse ways for understanding meaning making and how stories creatively become meaningful. The second section of this chapter introduces ideas from scholars who have explored narrative in a health context. I emphasize how stories in a health context offer us ways to think about embodied meanings, meanings informed by both health and illness, and the potential to bridge the healthcare divide between providers and participants. The chapter’s final section examines participants’ stories and my interpretations about meaning making in the JW program.
Communication and Narrative

It should come as no surprise that theorizing about human communication as narration began as a quest for truth. We find it difficult as human beings to live in a world full of uncertainty, chaos, and skepticism about our social reality. According to Georgakopoulou (2006), scholars studying historiography and literacy used narration as a tool, a means to an end, for understanding social reality. Fisher (1989), one of the first communication scholars to write a book on narrative, claimed that there is a clear difference between “good and less good accounts” of understanding our experiences in the world and that “narrative rationality” is the method for conceptualizing these differences (p. 193). Fisher rejected dialectical and dialogical notions of narrative sensemaking and argues for a logic of good reasons employing concepts such as coherence (i.e., internal consistency) and fidelity (i.e., probability and predictability). If there is such a continuum from narrative sensemaking to historical truth, Fisher’s ideas about narrative logic correspond to the arguments put forth by others who believe in narration as a means for discovering and rendering historical truths. My own view of narrative reality coincides more with what Rorty (1991) refers to as an antirepresentationalist “one that does not view knowledge as a matter of getting reality right, but rather as a matter of acquiring habits of action for coping with reality” (p. 1). Therefore, meanings are not found but created with others as an ongoing process of continual change through and by the stories we tell to make sense of self, other, and society.
In time, scholars moved beyond the idea of thinking about narration merely as a tool used to represent reality; rather, stories are created-in-context (Georgakopoulou, 2006), which contributes to the meanings that unfold in storytelling. Yet, there are scholars who employ both textual and contextual elements as a way for understanding social reality. For example, Gergen and Gergen (2006) favor narratives in action, which is a constructivist position suggesting that stories are created and thus render intersubjective meanings. Meanwhile, these meanings also produce and reproduce discursive orientations resulting in a sort of taxonomy of actions we choose from when acting in the world. Gergen and Gergen follow a pragmatic/discursive tradition in that meanings rendered from narratives create “discursive actions” that both constrain and enable our abilities to act in the world. Although, Gergen and Gergen favor a more pragmatist tradition, in my opinion their analysis of textual representation falls short and takes a deconstructivist turn (e.g., emphasizing an absence of presence) as opposed to a reconstructivist position. A reconstructivist would argue that texts do provide meaning; however, it is the context (e.g., presence with others) that contributes to making textual meaning significant (Rorty, 1991). For example, the doctors involved in the JW program offer health talks prior to the physical activity of walking. If we so desired, we could deconstruct the health talks in order to analyze particular questions, such as why did the doctor chose to speak about a particular topic on that particular day (e.g., skin cancer because it is the beginning of summer). However, if we chose to deconstruct the health talks, we would miss meanings that are created following the talk and at times during the walk. For example, as we started walking, one participant asked if age spots related to the
doctor’s discussion about skin cancer. Thus, a reconstructivist asks what new opportunities are possible for creating meaning with others.

Georgakopoulou (2006) argued that the new narrative turn takes this position one step further and asks in what ways does meaning created from context become relative to the individual asking the question. Therefore, the values embedded in stories that contribute to knowledge are as James suggested (1967) “relative to the lives that entertain them” (p. 656). In a sense we become the subject of our stories (Kerby, 1991).

Meanwhile, the new narrative turn also scrutinizes coherence, allowing for the potential to explore inconsistencies in meaning we attribute to our experiences because we ourselves are multifaceted and complicated beings. Thus, the ways we come to understand meaning created in stories involves being (i.e., values we ourselves attribute to our experiences), doing (i.e., the ways we embody these values during the unfolding of events), and becoming (i.e., the reflexive dimension rendered from the interplay of being and doing that may enable us of a different way of seeing ourselves possibly resulting in a different course of action). For example, the participant who asked about age spots pointed to his arm and asked, “Why do they get darker and how can I get rid of them?” The doctors at the walk that morning were family medicine physicians who were unable to answer this particular question. The doctors referred the participant to a dermatologist who has the ability to remove age spots with lasers, which is considered a cosmetic procedure and usually not covered under insurance. With this newfound information that age spots are not dangerous and are a natural part of aging, the participant decided to forgo the removal of the age spots due to costs. Values that are meaningful to us about
our health are therefore sometimes fleeting, at other times unalterable, and most of the
time inconsistent.

By tracing different conceptions of communication and narrative, we are better
able to understand how stories become meaningful in the JW program. Three major
conceptions of communication and narrative involve: a) narrative as representation of
reality, b) narrative-in-context, and c) narrative understandings of identity. In recognizing
that narrative meaning is created and not found, we realize that both context and identity
remain important conceptualizations in understanding communication and narrative.
First, meaning creation for self, other, and society involves contextual inferences that
contribute to temporal structures of storytelling. Scholars who debate temporal
dimensions of storytelling argue over whether stories are told and then lived or insist that
stories are lived and then told. Secondly, meaning creation involves identity, which is
informed by frame of reference. Scholars who explore meanings created from the frame
of reference have done so in terms of small, big, and grand stories that we tell and
construct to create meaning for self, other, and society. I argue that meaning creation
from temporal structures and various frames of reference are pertinent for understanding
stories lived and told in the JW program.

Those who believe stories are told, not lived impose temporal elements onto
storytelling. For example, Mink (1970) argued that narrative structure involves three
modes: theoretical (i.e., generalizations), categorial (i.e., comprehension through
common characteristics), and configurational (i.e., the structure of a whole and its parts).
Mink is concerned with meanings attributed from the end result or outcome of
storytelling suggesting that the act of storytelling itself is atemporal. Thus, storytelling for Mink becomes primarily the act of the human mind. Mink goes one step further and declares that anticipation and retrospection differ. In a sense he argues that we as human beings have difficulty understanding meaning when living in the moment where anticipation about what is to come meets reflection about what has already happened. Mink’s ideas about storytelling do account in some ways for our capacity as human beings to imagine ourselves living life differently. Even so, for Mink this imagination is largely trapped inside our minds as opposed to experienced through our bodies. Mink, therefore, returns us to narrative as purely literary form rather than a lived experience.

By comparison, there are those who believe stories are lived and then told. Whereas Mink conceptualized time as atemporal, MacIntyre (1984) conceptualized time as sequential. Stories are then shaped by a beginning, middle, and end. This “practical” unfolding of action is suspended in time until we can figure out how the pieces fit together providing meaning and/or an outcome. What supports MacIntyre’s idea of temporality as causality is the fact that our intentions and/or virtues are unknown unless otherwise asked or after we grasp the context of the story. For MacIntyre, the storyteller imposes a structured order of events that was not present at the time the story was lived. MacIntyre (1984) claimed that “We live out our lives, both individually and in our relationships with each other, in the light of certain conceptions of a possible shared future, a future in which certain possibilities beckon us forward and others repel us, some seem already foreclosed and other perhaps inevitable” (p. 215). I agree that we live our lives with a possible future in mind; yet, we also live our lives with lessons we have
learned from the past. In this moment, present, future, and past inform the decisions we are about to make for and about ourselves, others, and society.

At the end of the day, what we must ask ourselves is: does this mean that what we experience in a story we are unable to experience while it unfolds in the present moments of our lives? Certainty some scholars would suggest that this is the case. Others would claim that meanings from experience are deferred until the story unfolds. While still others would argue that stories lived complement and emerge in conjunction with stories told. Carr (1986) believes that narrative and historiography differ and that the former is not primarily sequential in order. Carr (1986) argues that when we live stories the process itself is endless; yet discrete events, experiences, and actions are those occurrences with beginnings and ends. For example, those who attend a JW event and have previously experienced a heart attack are living a storied life involving a past, present, and future (e.g., informed from a previous health issue, presently forming social relations while actively maintaining a healthy lifestyle, hoping to prevent another health issue in the future). Carr (1986) also believes that meaning comes from the experiencer who both acts in the world and reflects back upon these actions. Carr (1986) suggested that:

Deductive relations, relations of identity and difference, etc., may hold among propositions or objects in a quite timeless way, but here they obtain among events, both mental and physical, or they are reflected in the thoughts and experiences of persons as they live through events and perform actions. That is, they are temporally embodied. (p. 51)
Therefore, when we conceptualize narrative as both lived and told, we also account for meanings that are embodied. Stories do not simply unfold in our minds but are also lived through our bodies. As Rawlins (2010) suggested, it is “our discourses [with others that] address and constitute our lived experiences of temporal becoming” (p. 363). What this means is that although our experiences precede the telling of our stories, stories are also simultaneously lived because each beginning, middle, and end is arbitrary, and each informs the meanings we give to our experiences in recollection (Carr, 1986). I contend that much of what we experience in story, we most often either take for granted or have yet to experience in life.

Bodies tell stories; yet we often take for granted the symbolic meanings that arise from the contextual structures of the embodied speaking subject. Carr (1986) insisted that “narrative form is not a dress which covers something else but the structure inherent in human experience and action” (p. 65). We reflect upon the unfolding of stories while we are still living these stories. When we pay attention to embodied meanings, we are also paying attention to the layers of meanings that inform our story. For example, Tom, a participant at the walk, exclaimed that he hit his goal of weighing less than 200 pounds. Tom shared with us, “Well I have good news from the doctor. I don’t have to see him but once a year now!” Tom first began to walk several years ago after he was diagnosed with diabetes type II. Over the past couple years Tom went from weighing 262 pounds to 199 pounds. This is an example of an individual who is reflecting upon his body in a meaningful way from what used to be to what is today within the social context of the JW
program. Narrative in context accounts for what happened prior to, during, and after events take place as well as those involved with the telling of our stories.

As I have suggested previously, storytelling also becomes meaningful on behalf of the person who is telling the story. In coming to terms with how we explain and interpret stories, we must take into account two perspectives: the witnesses of stories and the teller of stories. Some witnesses of stories prefer to be called narrative analysts who consider small stories to be meaningful about the present effects of storytelling. Some witnesses of stories prefer to be called narrative inquirers, who are concerned with what big stories tell us about the storyteller (Georgakopoulou, 2006). Yet, there are still other scholars who examine the extent to which stories reproduce meaning and reinforce grand narratives that would constrain our choices to act in the world (Lyotard, 1984; Nelson, 2001; Phelan, 2005). I argue that each frame of reference potentially informs how storytelling becomes meaningful.

Georgakopoulou (2006) argued that small stories are those that account for local talk and that this local talk has implications for storytelling in *praxis*. For example, in theory we would appreciate spending more time with a doctor chatting about us in a context outside of our medical history and/or chart. The JW program offers a space where these types of discussions take place. The question then becomes in what ways do these conversations between participant and physician provide practical outcomes for making healthy choices and acting upon these choices? Georgakopoulou (2006) argued that small stories are those that often are taken for granted; but so are the stories that are not verbally communicated. For example, when I witness someone struggling to walk at the
pace I am walking, I slow down. This communicates that I am respecting another’s embodied meanings while the person I am walking with becomes more relaxed and comfortable with the pace we are walking together. In this small story I just shared, I am a serving as both a witness and teller of the story.

In defense of big stories, we invite meanings that account for when both the witness and teller of the story become one in the same. The difference between small and big stories is as Freeman (2006) noted, “Rather, they [small and big stories] tell about different regions of experience, one [small stories] that involves the quotidian workaday world of incidents and exchanges, of routine talk about this or that, and another [big stories] that involves a kind of holiday, in which one takes the time to consider what it is that’s being going on” (p. 137). For example, I can expand upon my interpretation of the above walking scenario by disclosing that I have often been referred to as the “skinny, running girl” by participants of the JW program. Participants range in age from 40s to 80s in the program. Many participants have confided in me that the “skinny running girl” can be intimidating to walk with at the program. Big stories allow us to explore poesis, which accounts for how meaning is created in reflection after we have distanced ourselves from the present. This big story can be interpreted in many ways. First, the participants do not want to feel judged for walking slower than another participant. Second, the participants share their present health conditions in comparison to a past self (e.g., younger self or self prior to a knee or hip replacement). Finally, there is a social element in big stories that may not be as easily interpreted from small stories (e.g., a person desires to walk with someone who embodies similar limitations that they see in themselves). As both the
witness and teller of the big story, I do not simply provide details of what I believed occurred; but I also interpret meanings created from layers of experience with others involved in the JW program.

Finally, there are those scholars who want to know how stories create or reproduce meanings that contribute to societal understandings. These grand narratives can be either colonizing or decolonizing in ways in which meaning is either reinforcing an ideological position that constrains choice or disrupts master stories to enable choice to act in the world. For example, over the past couple decades our healthcare system has introduced stricter guidelines for physicians to adhere to when providing information to patients. These guidelines are outlined in HIPPAA laws and then most often regulated by case management attorneys hospitals now have on staff. In order to avoid medical liability, physicians have started to refrain from community service activities. Physicians involved in the JW program invest their time back into their communities, fostering a deeper relationship with participants while also meeting their health needs. Yet, at the same time, this grand narrative can also reinforce the authorial influence we relinquish to physicians that does not necessarily serve a colonizing master narrative. For the purpose of this study, I will refer to grand narratives as metanarratives that offer a different perspective on how the walk is framed and what the structure means for physicians and participants of this program.

My intent in the above section was to provide an overview of the different ways storytelling becomes meaningful to ourselves and others in society. The JW program is a unique integrative health context that offers an opportunity to explore storytelling about
the relationships we create with others concerning our health. I will pay particular
attention to how stories are lived and told and the authorial choices I and others perform
that determine how we frame our stories. Friberg and Ohlen (2010) argued, “The space
embraces objects that mean something to the participants, whereas the objects
simultaneously create a general frame of reference. Time refers not only to the passage of
time in the chronological sense, but particularly to lived time” (p. 274). Stories render
descriptions of contextual meanings that are relative to the person who is telling the story,
and the person who is telling the story also comes to inform meanings about body, self,
other, and society. In the next section, I expand upon these notions to include scholarly
discussions about storytelling in a health context.

Communication, Narrative, and Health

This chapter probes how storytelling in the Just Walk/Walk with a Doc program
becomes meaningful. As I have previously discussed, both context and identity are
important conceptions for understanding meanings created through storytelling. Because
the context of this study is health related, I believe it is useful also to include narrative
scholars whose work emphasizes a health context. I argue that attending to stories in a
health context involves (a) listening to our bodies; (b) realizing that meanings regarding
both health and illness render multiple and often inconsistent endings; and (c) offering us
possibilities to bridge the healthcare divide. Attending to stories in a health context
provokes one another to responsibly witness each other’s health testimonials.

First and foremost, storytelling in a healthcare context involves listening to the
lived, embodied experiences of others. According to Frank (1997), “The body itself is the
message; humans commune through their bodies” (p. 50). Because we are most often confronted with bodies first and language second, I believe embodiment is often easier to take for granted. Perhaps even in the same way that we hurt those closer to us at times. Consider, for example, gathering places where members of JW come together to chat prior to and following the walk. These gatherings are not a planned element of the structure of the walk program; yet, they foster a site for personal and social connections among the JW members. Prior to the talk, this communion also serves as a site to negotiate with whom they will walk and talk on that particular morning. Some individuals even linger around the coffee dispenser to find someone to converse with at the beginning of the walk. Bodies impart meaning if we pay attention long enough to listen to what they tell us.

Health stories are both lived and told; yet, these stories are not exclusively about illness. Most health scholars have explored stories from an illness perspective within a traditional setting, for example, a hospital. Stories are most often told in a doctor’s office where a corporeal gap between description and understanding exists (Charon, 2006). However, the JW program offers a space where description and reflection about our bodies are continually shared and discussed. Dr. Brooke, for example, shared with me a story about an individual who began to feel faint at one of the walks. This participant was taking an ACE inhibitor called Lisinopril to lower her blood pressure. The medication often causes dizziness. In this account, action and perception propelled Dr. Brooke to step in and care for this participant as both a physician and a concerned citizen. Members of the JW program are in a sense experiencing what Frank (1997) refers to as a living
testimony that “implicates others in what they witness” (p. 143, original emphasis). These testimonies provide reciprocity in storytelling that serves to affirm meanings for self and others as members of a unique community. Yet this reciprocity can offer conflicting meanings at times because as Harter, Japp, and Beck (2005) explained, health stories involve living within the tension of knowing and being, continuity and disruption, creativity and constraint, and partial yet indeterminate endings. Storytelling in an integrative health context offers us possibilities to explore these conflicting stories that we sometimes tell ourselves and/or others.

Finally, storytelling in an integrative health context offers us possibilities to bridge the healthcare divide. We are living in a culture that values health; as such, talking about our personal health issues makes us vulnerable in ways that differ from other topics of conversation. Charon (2006) articulated that internal feelings of shame, guilt/blame, and fear may be some of the reasons why we are often reluctant to discuss our personal health issues with others. We may, for example, find ourselves powerless in health situations, which can stem from external feelings/pressures of anger, self-loathing, and/or panic. When a physician and participant are empathetic towards one another, we may be approaching what Charon (2006) advocated, “Only with the capacity to be open to genuine intersubjectivity can these two participants approach an authentic relation in which the suffering does not separate them but is shared. Once shared, the suffering is lessened” (p. 33).
Storytelling in an Integrative Health Organization

As I have related, my involvement with the JW program started a year and a half ago when I enrolled in an ethnography class my second year into my doctoral program. The instructor required us to find a group to follow, observe, and write about for our final assignment. At first I was terrified about the assignment. I asked myself what group would allow me to follow them, and would they ever accept me as a member? Looking back now, almost two years later, I believe that I have experienced what others feel when something strange slowly becomes familiar. And the feeling of being cast as an outsider faded in time. This acceptance by others partly may have been due to the fact that at the very first walk I attended I met several new attendees of the program who had similar questions. Questions such as: how does this work?; who is the doctor?; where do we start and end? In some ways meeting new people at the first walk increased my anxiety. Yet in other ways meeting new people allowed me to realize that I was not alone. As described above, during the second walk I walked with a “regular” attendee named William. In an hour he shared with me his health experiences and life story, the history of the JW program, and reasons for why I should continue to study the JW program. His story offered me inspiration when I was in doubt, and I offered him a listening ear. Keeping this in mind, I hope to illustrate in this following section that I am not just telling my story or their story but our story.

Serving as a Witness

When we share stories, we are as Frank (1997) argued calling upon others to witness our experiences in the world even if this means we ourselves do not speak much
at all. In some ways, I always knew what “being a good listener” meant, but I did not realize how powerful it can be for others until I walked with a new member named Peggy. On the morning of April 14, 2012, the rainy drizzle in the park made it a little uncomfortable for walkers, but the coffee quickly warmed us. Following the doctor’s health talk, I asked Peggy if she wanted to walk with me that morning. “As long as you don’t get me lost in the woods,” she said. As soon as we began walking, Peggy had no problem expressing to me what she believes is wrong with our healthcare system here in the U.S. Peggy recently moved back to the U.S. after living in Canada for almost 17 years where her previous partner was from and where they raised their children. I learned later that she got divorced and she was still hurting from this experience.

I learned further that her distrust for the medical system in the U.S. began with her father who was undergoing a work-up for knee surgery and the staff happened to discover an abdominal aneurysm. “It was a nightmare negotiating with medical staff members. He is the one who started the tradition,” she said. And then soon after, her mother was diagnosed with breast cancer. “Remember when you went in and they did not have all these work ups?” she asked. I just nodded my head in acknowledgement and listened. It was not necessarily the increase in the number of work-ups that frustrated her; it was the increase of technological advancements at the expense of patient care. And then Peggy talked to me about her knee replacement surgery. Prior to her surgery, she visited a surgeon who said, “We are going to talk and then I will answer any questions you have.” Peggy with a hint of sarcasm responded, “What, you are going to take time to answer my questions?” Then, the surgeon asked Peggy if she had seen the X-ray of her
knee. Peggy again with a cynical remark, “You mean; you are going to let me see my X-ray?” Her preoperative evaluation for surgery included an MRI and one last session with the surgeon to discuss pains, discomforts, and risks of surgery. Her surgery was scheduled for 7 o’clock in the morning and she was prepped (gown and hat on) and ready to go. Then, the medical staff told her they had discovered a blood clot. Peggy said, “Why didn’t you know that before I prepped? Isn’t that why I pay for the preoperative evaluation?” The medical staff contacted a Cardiologist to clear her for surgery, but 10 o’clock passed and then 11 o’clock passed. Peggy finally said, “Can I sign a paper stating to go ahead even with the newly discovered risks?” She ended up staying the entire day until they cleared her and she went in for surgery. Peggy ended up having a good recovery with the least amount of complications following surgery. She did however share her frustration when her doctor’s partner conducted the follow-up examination without her knowledge. Peggy said, “Who are you? Why didn’t they introduce us and tell me this before?” Before I knew it, Peggy and I were back at the pavilion where we started walking together.

Frank (2000) suggested that people tell stories to affirm relationships and to understand the self in relation to events that have happened to them. I felt that Peggy needed to be heard that day. Despite everything going on in her life (e.g., divorce after 30+ years of marriage, health issues, and her occupation as a teacher), she is always giving of herself. This was her time to live and tell her story. Peggy reminds all of us that sometimes we need to remember to care for each other and to listen with others, health-related or otherwise, rather than allow technology and medicine to speak for us. Peggy
implicated me as a witness and teller by drawing me into listening to her own standpoint as the storyteller (Frank, 2000) and then communicating our story. After we returned to the pavilion, Kym asked Peggy, “How did the walk go?” Peggy said, “It was nice and I talked a lot.” Kym said, “That’s great! Your walking buddy has good listening ears.” Peggy said, “Yeah, she didn’t get a word in edgewise!”

*Embodyed Meanings*

We must also pay attention to health stories told and lived through our bodies when we are in the presence of others. Before I started walking with Peggy that morning, Peggy and Dr. Winter positioned one foot onto the picnic table bench and squatted. They were comparing each other’s flexibility and how far they could bend—what Dr. Winter refers to as “the false knee,” which was not working to her liking that morning. This is an example of the object-body, when a part of the body becomes foreign to the self (Hudak, McKeever, & Wright, 2007). And sometimes we find ourselves talking about our own body parts as objects until we take the time to reflect and figure out what this means. I sprained my knee, for example, during one of the walks. However, I took for granted my lived body until I put weight onto my knee in order to transport a bag of clothes to the laundry mat. I knew my knee did not feel quite right following the walk. Even so, I began to feel frustrated when my knee communicated pain to myself when attempting to complete a weekly task. At the following walk I shared this story with a participant named Cheryl. She asked me if I fell on a twig and twisted my knee or bow-legged it somehow. Then, Cheryl shared her story about seeing a chiropractor for a sprained ankle. She said, “There’s nothing like your body not working like it should. We get so used to
our body working like it should. There's something about not feeling right.” At this moment, I realized what Hudak, McKeever, and Wright’s (2007) body-self-society triadic and Frank’s (1997) communicative body meant, the idea of accepting and appreciating both mind and body. I found myself trying to make sense of my body in relation to my sense of self (e.g., this young person who runs and should not have any problems with her knees), and Cheryl became my eyes and ears helping me to reflect upon and create an appreciative script about my embodied self.

On Saturday, June 9, 2012, I sat down at the picnic table, and Tom and I started to talk about health communication. I shared with him my interest in qualitative methods and meanings we create together in story. He said,

I think everything, everything in life is convoluted and so every little part has a need in life. So, it’s good. There is a need for every part in life. So nobody gets to put one person down over another. I think our bodies are our whole life. We embody our bodies.

As Tom continued to talk, he provided an exemplar for what “embodying our bodies” meant. Tom told me he went for a walk with his son over the weekend. The walk they went on was challenging and included a big hill that “gets your heart beating pretty fast.” He said that the hill is usually used for excursions for those who want to climb up to enjoy the view below. But all Tom’s son could see was how big the hill was and how much more he had to climb to get to the top. Tom said, “And I’m the one looking around, enjoying the view, and having fun. Then, mom calls and asks how is your dad? He tells her, dad is kicking my butt up this big hill. I said no, we are just walking trails.”
Bodies tell stories; yet while these stories are at times taken for granted, they never are divorced completely from our perceptions of embodiment. All Tom’s son could see is how much farther they had to go, while Tom embodied his surroundings taking in both the process and outcome of his health activity. Meanings shaped by our embodiment are, as Carr (1986) attests, significant to the experiencers of the world as this father and son’s activities and bond reveal.

*Health talk as a Scaffold for Dialogue*

On Saturday morning participants of the JW program wake up and drive to a JW location that is most convenient to where they currently reside. My partner, BG and I usually wake up about 2 hours earlier to drive to Columbus to meet everyone at the JW location. The physicians, however, begin preparing for the JW health talk a couple days prior to the walk. Sometimes the physicians will search through current events to select a health topic to discuss for the day. At other times the talks are prompted by participants’ emails and even patients the “docs” see in their office that week. The health talks that I have observed over the past year and a half have been as Bruner (2002) observed “an invitation to problem finding, not a lesson in problem solving” (p. 20). The physicians I have followed discuss the importance of raising awareness of issues but not necessarily solving these issues because every participant is different. The physicians will ask participants to seek more information from their primary care physician who can contextualize the issue for the patient. In this way, health talks allow us to reflect upon how we live between past and possible, creating and re-creating meaning about ourselves in order to understand our relation with others while simultaneously understanding our...
own agency (Bruner, 2002). Yet health talks serve as a scaffold for dialogue because this process is embodied, involving multiple perspectives for understanding our bodies, self, other, and societal meanings of health.

On February 12, 2012, Dr. Brooke shared a recent study suggesting the desirability of decreasing one’s intake of over-the-counter medicines like Ibuprofen and Alleve. He said these medications can increase chances of stroke and heart attack. Instead, he suggested sticking with baby aspirin. Following his talk, a male participant approached Dr. Brooke and asked about taking ibuprofen as a sleeping aid. The male participant said he takes 2 ibuprofen a night before he goes to bed because of joint pain. Dr. Brooke asked him if he has seen a Rheumatologist for joint pain who may be able to recommend something other than ibuprofen. After the walk a group of 5 participants, 4 female and 1 male, approached Dr. Brooke and asked several questions about medications they were taking. One question involved clarification regarding the 3 drugs that are not to be taken together. Another lady talked about her father who takes Menadol, which is a type of ibuprofen. She held out her hand to convey how many drugs her father is currently taking prescribed by 5 different doctors. She asked if checking with the pharmacy is the best way to make sure drugs are not dangerous when taken together. Dr. Brooke said yes and the woman thanked him.

As noted, some participants ask questions about themselves while others may ask questions about a loved one. At times, there is not a clear distinction between care of the self and of others and/or for that matter when we draw others into our conversations that take place outside walk perimeters. Our relationships inside and outside of the walk are
contingent upon who we are as mothers, fathers, sons, and daughters. Bakhtin (1990) argued that we are answerable to others by consummating another’s viewpoint within our own. Thus, the daughter who asks questions on behalf of her father has chosen to act upon this responsibility.

Dialogue also creates possibilities for alternative meanings about our health. A pediatrician named Dr. Nelson substituted for Dr. Brooke at one of the Polaris Mall walks located inside for the winter. Her talk that morning addressed what is called myplate.gov, which has replaced the former food pyramid. Dr. Nelson explained that “Myplate” is much easier to explain to children, more visually appealing, and easier for us to identify recommended servings per day. “Myplate” is literally a plate split into four sections with one small dairy section located in the upper right hand corner. Each section on the plate is listed as fruits, vegetables, grains, and protein. Vegetables and grains are shown as bigger portions from that of fruits and proteins. Following her talk, a participant named Lucy said, “I’m gluten free. Is the grain portion a problem for me?” Dr. Nelson asked, “Do you eat rice or wheat?” “No, I just eat vegetables,” Lucy replied. Dr. Nelson asked, “Is there a reason? Do you have celiac disease?” Lucy said, “The gene runs in my family and my niece does have the gene. I have been gluten free for almost a year now.” Dr. Nelson asked, “Do you notice a difference? Some people who switch notice a difference right away in their energy levels.” Lucy answered, “My bowels are not an issue for me anymore.” Dr. Nelson said, “It sounds as though you may have the gene if your bowels are not irritable anymore. There is a gluten free bakery that you may like up the road from here.” Lucy expressed gratitude for the information.
We continue to make sense of our health within the tension of what Harter, Japp, and Beck (2005) refer to as knowing and being. We do not know for certain that “Myplate” works for everyone in every circumstance. Harter, Japp, and Beck (2005) argued, “Meaning, thus, lies in the interface between stories, not in the mind or the words of any sole participant” (p.11). Lucy did not assume the health talk was directly related to her situation nor did she take these meanings at face value. Lucy diverged from the apparent goal of the authoritative discourse, and Dr. Nelson consummated Lucy’s experiences (e.g., her past health issues and family history) and offered her alternatives for someone who chooses to live a gluten free lifestyle.

Participants as Patients

On some occasions the physician leading the walk will have information about the participant because the participant may be one of his or her regular patients. These relationships render additional meanings that inform both narrative-in-context and identity. William, for example, is one of Dr. Brooke’s heart patients. On June 25, 2011, William and I walked together, and he shared with me the last question he asked Dr. Brooke at the walk. William told me that he takes aspirin every day due to his heart attack one year ago. He asked Dr. Brooke if he could skip an aspirin every once in a while because the medication was thinning his blood. William said his arms were getting black and blue. He said he hardly had to bump into something and his skin would change colors right away. Dr. Brooke told him that it would be okay to skip one every ten days.

On another occasion a patient of Dr. Nelson asked a question about her son’s fever and his difficulty sleeping because of a cough keeping him up at night. The patient
said that her son is prescribed penicillin but because of his waking up half the night, she has been giving him codeine to sleep. Dr. Nelson said, “I’m not going to say that you can do that, but….“ The mother said they are trying to avoid giving him painkillers, but she does not know what to do and does not want to see her child suffer anymore. Dr. Nelson suggested honey, tea, and delsym. The mother responded that she was already giving him delsym every 12 hours. Dr. Nelson said, “If he is not wheezing, you may need to call someone to get him tested if the cough persists.” The patient asked if she could try tessalon perles. Dr. Nelson said yeah, you can try those up to three times a day.

Following this interaction, I noticed how comfortable the woman was confiding in and asking Dr. Nelson questions. I asked Dr. Nelson if she knew her. Dr. Nelson confirmed that she indeed was one of her patients.

When I interviewed William and his wife, Jane, I asked, “What are some benefits of being a patient of the doctor who is leading the walk?” Jane said,

It gives you confidence that the doctor knows you and you are not just a number or a paragraph on a piece of paper. When they know you, they say hi in a different way. It is better. It is nicer. Dr. Brooke does that.

William nodded and added, “These doctors know us. When I go see my ophthalmologist once a year, he walks in a dark room, and he does not know me from Adam. But Dr. Brooke knows me personally and can relate to me.” Jane also explained that “When the doctor knows general things like you are dedicated and committed to health, that makes a difference in how the doctor approaches treatment.”
The JW program provides a space for bridging the healthcare divide between patients and doctors, especially if the participants themselves are patients of the doctor leading the walk. As Jane suggested above, members of the program who are also patients have access to consult their doctor on a weekly basis. Continual communication fosters empowerment and dialogue about current health concerns and future treatment plans. William, for example, prefers a physical stress test over a chemical test, and this diagnosis procedure was negotiated with Dr. Brooke during one of the walks. On some occasions participants become patients of the doctors who lead the walks. For example, Lucy, who is postmenopausal, began to see Dr. Singh, yet another leader of a walk, because her specialty is menopause. Some of us are fortunate to have access to healthcare professionals in our lives, who may be family members and friends. Others may not have anybody to rely on to ask questions or get second opinions about current health issues. When I asked Dr. Vallon, an Immunologist and participant of the walk, about the value of the program, she responded:

The older generation is from a generation where they do not necessarily question their physician. They can ask questions at the program and take the information back to their own physician. They can say I heard xyz and I want to talk to you about it. This gives them more confidence and a sense of comfort to discuss health issues. Because I think people like myself, we forget that the general population does not have the same access to information that we have. It is a nice way to start the process.
The JW program bridges the divide between patients and physicians by closing the gap between knowing and being which is informed by becoming, an intersubjective relationship fostered during events.

*Doctors as Patients*

At other times, the physician may reveal personal health challenges he or she experienced, blending the private with the public. If we desire to bridge the healthcare divide, perhaps transparency on behalf of the doctor leading the walk invites a narrative imagination that as Freeman (2010) suggested “is involved in our various efforts to make sense of the world, both outer and inner” (p. 43). However, Dr. Brooke has communicated to me that he often walks a very fine line between discussing personal and professional issues at the walk. His choice to self-disclose information depends upon circumstances surrounding what is occurring in his personal and professional life. For example, he only chose to disclose information about his vertigo, balance disorder, when participants asked about his absence during the walks. However, there are those who still look up to physicians for authority and a sense of certainty. When a doctor reveals uncertainty, even about their own personal health experiences, some people may lose faith in the messages communicated by the doctor. Physicians who chose to self-disclose health information or even insecurities have been highly aware of their surroundings and reflective about negotiating what to say and when to say it around other participants of the walk. Nonetheless, these interactions offer us a glimpse into how storytelling can become meaningful in the JW program.
For example, the present “small story” effect of a doctor sharing her or his personal story may invite dialogue among members of the JW program. If the story is personable and relates to someone else’s experience, a member may be more encouraged to begin a conversation with the doctor later on during the walk. Yet, as the doctor shares his or her story, we become a witness and journey with them in reflection. Stories like this call upon others to create meaning and new possibilities for understanding our health. We may, for instance, share with others how we as participants serve as witnesses to doctors who trust us enough to disclose their own personal health information. From a metanarrative standpoint, these instances create new possibilities for shifting power dynamics within the patient-provider relationship.

Structure of the Walk

When I asked participants to describe what an ordinary day at the walk looks like, participants offered descriptions that were both unique to their own individual circumstances and socially patterned. For instance, some members arrive at the park earlier and walk trails or walk their dog before the talk even begins. Other members I have interviewed have said they usually get up early in the morning but find so many things to do around the house that they almost always arrive late. Still other participants arrive early to help Kym unload the coffee and healthy snacks. Almost all of the participants I interviewed said that they try to arrive about 5-10 minutes before the presentation begins at 8:30 a.m. on Saturday mornings to socialize with new and former members of the program. Some of the participants confided in me that the coffee in the morning is their only motivator to get them out of bed to attend the walk. Further, not
every walk begins promptly at 8:30 a.m. in the morning or is held all year round. The Antrim walk, for example, begins at 10:00 a.m. and only runs during Spring, Summer, and Fall. The doctor leading the walk is influenced as well by participants who attend the walk. For example, Dr. Nelson, a pediatrician who only holds walks during Spring, Summer and Fall, starts at 9:00 a.m. on Saturday mornings at a park with a playground. Dr. Nelson explained, “It is hard to get kids dressed, fed, and out of the door by 8:30 in the morning.” The parents walk and talk with Dr. Nelson while their children play on the playground. Dr. Nelson’s walk is family-focused, whereas the Antrim walk led by Dr. Rathi, an OB/GYN, emphasizes gender-specific issues, and the Highbanks walk led by Dr. Brooke usually focuses on heart and other general health concerns.

Although one may believe members attend the walk to hear what the doctor has to say that day, on more than one occasion participants have explained to me that it is the social bond they continue to create with other members that tends to hold them accountable for showing up that morning. The doctor’s health talks provide important health information, but this information serves as an ancillary value coming in second to the friendships members have formed with others in the program. Some participants who attend the walk arrange every Saturday to meet friends or family members at the walk. The structure of the walk may serve as the foundation that provides a space for routine health behaviors, but the members are the glue that holds these social bonds together.

Friendships

At the end of every interview I conduct, I ask the participant if there is anything they would like to ask me. Sanjay, one participant, said, “You also walk, right? You also
participate in this program, so what are your thoughts on the program itself?” I responded:

I believe there is a lot of power in relationships. Social connections feed our souls and provide us with the motivation to become healthy and do something for ourselves and others. We make friendships here and people start relying on us and we rely upon them. Just like you have served as a witness for Tom over the past several years, watching his health change drastically. I think that is really powerful.

Sanjay replied, “Exactly how I feel also, and that is the reason why I look forward to Saturday morning.”

During my interviews with participants, I did not directly ask about how friendships in the JW program become meaningful to them even though I was aware of friendships I observed. At the end of an interview I conducted, a participant named Matt asked:

Why did you not ask about friendships and bonding with people? Some people who are seniors, their circle of friends have shrunk and this is one aspect that allows them to expand and make new friends. One guy I talked to two years ago; his wife passed and his children have moved away. So, he came out and walked with us because he did not associate with anyone throughout the week.

I responded, “I noticed that you have formed a close friendship with Penny. Can you talk about that?” Matt said, “That is really important to me. Penny is consistently there for me to walk with.” He also explained to me how his friendship with Penny extends beyond
the walks on Saturday mornings. Because they work in close vicinity of each other, Penny and Matt often go on walks daily during their lunch breaks. When I did ask what was most meaningful to participants about the JW program, several members including Matt mentioned social relationships. As Rawlins (2009) suggested, “What we experience individually as consciousness depends upon interaction, symbolic activity, communication with other human beings. Communication with others is essential to our humanity—to continually being and becoming human beings” (p. 202). Matt was right in asking about the meaningful relationships we form in the JW program. This human connection opens up a window into seeing ourselves through others’ eyes. And for some participants, this social connection helps us grow “whole” again.

In May of 2012, I walked with a woman named Tracy and her friend named Dan. Tracy shared with me that she was a recent widow and started to participate in the JW program to meet people. She first heard about the program after visiting a friend with Alzheimer’s in a nursing home. She told me that her first walk was with her daughter, and her daughter encouraged her to continue attending the walks. I asked Tracy what she felt she gained from the JW program. Tracy replied, “Serenity and peace. I enjoy being alone with my thoughts and nature and reflecting back on my life.” When I hear Tracy’s story, I cannot help but wonder how someone copes with this type of disruption in her life history. Harter, Japp, and Beck (2005) discuss the problematic of continuity and disruption in the stories we live and tell. It is my belief that when we lose someone so dear to our hearts, we continue to live with this disruption. Our world is forever changed without the other. Even so, we fill in the gaps by telling stories and creating new
friendships in order to make sense of our surroundings without the other. Harriet, another widow, explained:

It was more or less like when you get married, you become one. When you are left, you feel like a half instead of a whole. You have to work at making yourself feel like a whole again. Some people get stuck in the half and feel nothing. I know people who stay in that state. It is depressing. I know because I had to work myself out of it.

People whom we refer to and call our friends do not only meet us where we are but also encourage us to become the person we desire to be. Rawlins (2009) claimed, “We judge together and we judge each other in a spirit of compassionate objectivity” (p. 212). Friends who have developed deep connections with one another at the JW program care enough about one another to also hold each member accountable for continuing to maintain their health. Tom explained, “The walk has grown allowing us to meet a lot more people that come on a regular basis. This is great because then you have more accountability and more camaraderie at the same time.” I replied, “That’s fascinating, Tom. Can you explain a little more about what accountability and camaraderie mean to you?” Tom said:

Yeah, if I do not show up one week, Don or Jerry, sorry to call out some names, or Sanjay will say, ‘Hey where were you last week?’ Well, then I have to explain to them. Some mornings, I do not want to always get up, you know. I get mornings where I really do not want to walk. I say, ‘Well if I do not walk, I am going to get drilled next week with where were you?’ It is fun meeting people. I
am not really outgoing a lot of times. I will go into crowds but will not say hi.

They have built up a...we have developed a friendship. I can call them and it is kind of neat.

Friendships are not solely about accountability but also camaraderie. It is not, as Tom suggests, solely about how the JW program has grown but also how we have grown closer with others we come to call our friends. We learn about ourselves by listening to one another’s stories. Cheryl, for instance, shared, “I always want to listen to somebody intently about what they have to say about their life. You never know how important that can be.” There are some people in the world who have an intuition about others and always seem to know what to do and what to say in a situation; Cheryl is one of these people. On several occasions, we have talked about the significance of being a good listener. Because as Cheryl suggested earlier, we never know when we will find ourselves in a situation where we need to make a decision about our own health.

When we listen to one another, we might find that others have been through similar health experiences. When I asked Tom to share with me a story that made him re-examine his own health experiences, Tom said:

I got diagnosed with type II diabetes. Jerry has diabetes. I do not know if I should share that but I will anyway. And, he was talking to me and gave me some really good insight about what to do. It was really neat finding somebody else with a commonality. So, it was really nice when he talked to me about that and told me, ‘Hey you should carry your meter at all times, have it in your car at least, and get an extra one. They are not that expensive.’ You know, he was right. It only cost
me another 20 bucks to get an extra meter. So, now I have one for my car. And he said, ‘That way when you're walking, if you feel something, if you feel a little funny, you can check it right away.’ You know, why risk it? So, it was kind of neat and it was good that we talked about that.

Tom also shared with me that Jerry suggested talking to his doctor about how to alter his health habits. Tom acted on Jerry’s suggestion and called his doctor who set him up with a nutritionist and classes to learn about how to control diabetes. Tom told me that he is currently taking Metformin twice a day to control his diabetes. Tom, however, found out that his A1C levels were low and he may not need this medication anymore. Jerry, Tom, Don, and Sanjay have formed close friendships with each other from their participation at the JW program. These close friendships extend beyond the walk in other ways.

Some of the stories they share with one another at the walk are personal, while some of the things they do at the walk are for fun. For example, Jerry shared with me a time he brought The Big Lebowski “Dude” headbands for his friends to wear for fun during one of the walks. When I asked Jerry what his most memorable moment was, he said:

Friends are important people who care. If there is a problem, I get a phone call. I talk to them outside the walk and occasionally go for a beer with a couple people.

I am a Mason and Don is a Mason. We go to lodge together and have beer together. I met Sanjay and his family at the Nationwide golf tournament.

When I asked Tom about the meaningful friendships he has formed, he said, “Don and Jerry are just really good listeners and pretty fun to talk to. When we walk, we joke a
lot.” Tom shared that he wants to do more with his friends outside of the walk but he has not had the time due to his work schedule. Jerry, Tom, Don and Sanjay have become civic friends who live within what Rawlins (2009) referred to as “the spirit of both personal and political friendship to facilitate edifying individuation and participation through communicative action” (p. 204). They keep each other accountable for maintaining a healthy lifestyle yet they are also comrades who together create new meanings about health and friendship.

Our Search for Meaning

Some members of the JW program are motivated to show up because if they do not, friends will ask them where they have been. Still, there are other participants of the JW program who show up in a search for meaning about their own or others’ health care issues. Near the end of one of the talks, Dr. Brooke asked the crowd if anybody has read *Man’s Search for Meaning* by Victor Frankl? For those who nodded their heads yes, Dr. Brooke asked if they would recommend the book to others because he really enjoyed reading it. I thought to myself, how ironic, here we are trying to make sense of our health, and he turns our attention to this profound work. As Harter, Japp, and Beck (2005) assert, meanings about health and illness are both partial and indeterminate because of the fixed and fluid nature of meanings invited by narrative-in-context and our standpoint in the world. Even so, we cannot simply turn off our curiosity about what is unknown. In a way it is this curiosity that motivates us in the first place to communicate with one another about our health issues. We never find answers, but we are able to create meaning
because who we are and who we want to become depend upon our communication with others.

During one of the walks, a participant asked about calcium supplements and whether or not we should take them. Another participant answered her question, “Yes, Dr. Brooke has already talked about that.” Dr. Brooke responded, “Uh, no, no, it is okay. See those studies do this. Now if you read one study, calcium pills are the worst thing for you. I cannot imagine that is really the case. My answer is to get it from food.” “Uh, ok,” the woman said. Dr. Brooke continued:

What we see over and over again is that supplements such as green tea extract and others, we get the benefit if they are in our food, tea, or drink and that is for sure. But like getting it in a pill, that stuff just is not that great. Fish oil being the exception. Just like vitamin D, get it from the food. If you are taking calcium, do not freak out because the study will probably go back and say it is okay. It is too early to stop calcium supplements.

“It takes a very long time to work,” another participant responds. Then another participant asked, “What if you have high cholesterol and do not drink much milk or eat cheese?” Dr. Brooke said, “Try low fat. I think milk is nasty.” Another participant chimed, “Oh, no here we go again.” Everyone starts laughing. Dr. Brooke calls out, “Who loves walking a mile, raise your hand. Who thinks milk is nasty, raise your hand. Ok, not too many.” The crowd starts clapping and laughing and then we all start walking.

Several participants of the walk will bring questions with them to ask that morning. These questions stem from studies they have read, current events, personal
health concerns, and at times a little of all three. Karrie, for instance, talked with me about the calcium supplement debate during our interview. She said:

Well, Dr. Winter said she did not take vitamins and calcium supplements. Then, Dr. Brooke provided information about calcium and heart problems. I had been trying to find out more about that because I think we all should take vitamins. Apparently, that is maybe not the case. It was really reinforced by Dr. Brooke and Dr. Winter.

I replied, “So, did you do your own research and ask the doctors questions about vitamin and calcium supplements?” Karrie said:

I did find a study that stated women who took vitamins died quicker than women who did not take vitamins. The women who took vitamins looked like they were healthier, but they died sooner. Part of it was the thought that even though your body needs vitamins and minerals, it cannot take the doses in pills. I think that Dr. Winter started to say that and then Dr. Brooke said it does seem maybe those things are marketed to us. But if your body needs this, you can just make it, but then maybe it does not.

When I asked Karrie what made this interaction meaningful to her, she responded, “Well, I think Dr. Brooke and Dr. Winter are incredibly caring people.” When I asked Lucy, another participant who asks a lot of questions at the walk, this same question, she replied:

I asked Dr. Brooke once about what sugar to use for coffee. I wanted to make sure Splenda or Truvia are not the ones that cause cancer. I was worried about eating
this or putting it into my body. That it came from a doctor. It is important to me. It assures me that if someone else asks well, the doctor says I can do this.

With illness always on the horizon, we sometimes seek comfort in the assurance that what we are doing in the present moment positively affects our health to the best of our knowledge. Stories we engage in with others at the JW program are not solely about illness but are more concerned with living in the state in between health and illness. Members of this program are consciously aware of the uncertainties informed by what we think we know, what we know but cannot explain, and what we do not know about our health.

On one occasion when I shadowed Dr. Brooke, two female participants came up to walk with us. One participant explained that while she was walking this past weekend, she had experienced pains in her chest. This was the first time she has ever felt something like this. She began to discuss her brother and grandfather’s heart health history because they have experienced heart problems in the past. Dr. Brooke replied, “That does not necessarily mean much. You still need to get checked out. You need to get the screenings available for the heart.” On another occasion, a male participant asked Dr. Brooke about his recent stent procedure. The participant explained that he has previously had a stent and wants to know what causes lead to a stent procedure. Dr. Brooke asked, “What was it that brought you in?” He answered, “I was having chest pains and pulsing sensations. The doctor says go in and everything checks out fine.” “Even the stress test?” Dr. Brooke asked. “We did not do a stress test,” the man responds. “So as far as your question of what caused it, was your blood pressure disrupting the wall…So it could be plaque
buildup but…,” the participant cut Dr. Brooke off and said, “I got out on Saturday and went for a walk on Sunday.” These are just a few interactions where participants wanted answers to their health questions in order to calm their fear.

When I asked Dr. Brooke to share with me what an ordinary day at the JW program looks like from his perspective, he said:

You realize people are vulnerable because people have questions and they are probably nervous about asking them. Some people have driven good distances to attend. They pay for gas or they are supporting this and/or others indirectly and you want to give them information that is positive and worth getting out of bed for. They got out of bed and so it better be good. Then, there is a chance that they came to see you. You want to take away the fear because I think there is way too much fear in medicine and a lot of barriers and myths that are out there. Just corporate goes a little too far with scare tactics and you just want to be available and be yourself.

I asked Dr. Brooke if he thought that a certain amount of fear motivated participants to attend the walk in the first place? He said, “Some, I guess. For some people.”

For some of us who have experienced a major health concern, our search for meaning may not be too far off in the distance. We may be asking ourselves, why me, why this, and why now? On the other side of this coin is the provider who asks himself what is my responsibility to another in this situation? When I asked Dr. Brooke why he started the JW program, he replied:
I wanted to do something. I actually felt I was ineffective at getting patients out by talking about it in the office. I placed an extreme amount of importance on exercise as being a risk reducer for many components of people’s health. It seemed like the next step was to go to the park and walk. I am a big fan of accountability on both parties [patients and physicians]. As physicians, we have an opportunity, a window that other people do not have. For example, I can say it looks like you gained—I can ask a woman her weight—It looks like you gained or lost 10 pounds. If you are a doc and they get in and out of your office and you do not talk about something, and you always hesitate to talk about the numbers because then you sound like a zealot. But if you do not talk about something that reduces cancer and heart disease then or 40 + diseases, then you are not doing your job. So a lot of docs do, and then I realized talking about it for a long time in really meaningful interactions did not really produce the results I was looking for. I would say less than 5 % of people were getting out and doing something. Now I am looking at 30 people. Then, I am going to spend the rest of my career with you smiling and saying you know that I am going to join Urban Active when I leave and I see you again in 6 months and you have not. If that keeps repeating itself over and over, I am not going to feel good having that 20-30 minute conversation at the end of an office visit because I know it is going nowhere. So, yeah. So there needed to be something else out of necessity.

Frankl (1959/2006) argued, “A man who becomes conscious of the responsibility he bears toward a human being who affectionately waits for him, or to an unfinished work,
will never be able to throw away his life. He knows the ‘why’ for his existence, and will be able to bear almost any ‘how’” (p. 80). It is my belief that participants of the JW program consummate physicians’ experience just as physicians consummate participants’ experience (i.e., existence). Thus, the JW program affords a space for both participants and healthcare providers to continually explore and imaginatively create the why.

Conclusion

For the purpose of this narrative chapter, I intended to offer arguments that attend to (1) meanings created in stories as they are both lived and told in context; (2) ways the frame of reference relates to what we do, who we are, and the intersubjective becoming of self with others; and (3) recognition that stories in a health context render unique, multiple, and most often inconclusive findings. First, I suggest narrative ought not be strictly confined within the realm of a purely literary form and that bodies also tell stories when we listen. Bodies provide us cues when we are happy, sad, in pain, or recovering from health and/or illness. Embodiment accompanies the spoken word as these meanings guide our behaviors concerning when to ask questions, when to ask for clarification, and/or when we feel comfortable sharing personal information about our health with others.

Second, I argued that diverse narrative frames of reference (e.g., small, big, grand) impart understandings concerning how perception and action guide what we do, who we are, and who we desire to become. Take, for instance, the ways small stories steer us towards examining praxis, the doing of making or not making choices and/or practices in a situation. Add another layer of meaning such as health communication and
we diverge down a path of re-examining the significance small stories contribute to health promotional campaigns. Big stories provide distance from the present, widening a space for *poesis* (i.e., reflection) about our health choices and practices informing our sense of what it means to be a healthy body. Grand stories or what I have referred to as metanarratives as they relate to the JW program convey ways that both structure and flexibility lend themselves to the creation of new cultural scripts about our healthcare practices and relationships.

Finally, scholars whose work emphasizes narrative medicine have made a concerted effort to broaden our scope in regards to how we conceptualize health promotional campaign effectiveness. Arthur Frank’s work, for example, has provided insight into ways the body is communicative by implicating others in the world of spoken and embodied stories. Yet these stories have the potential to offer meanings while we continue to live in a world between health and illness. And as Charon poignantly suggested, if we all claim a stake in the lessoning of suffering, then we have the opportunity to diminish the healthcare divide—narrowing the gap between knower and known.

**Practical Implications**

In this chapter, I set out to explore: How does storytelling in the Just Walk/Walk with a Doc program become meaningful? I anticipated offering both descriptive and interpretive findings from my participation as a member of the JW program and am encouraged that integrative health programs do make a significant contribution to our understandings of both health choices and practices. The themes that I discussed
Serving as a Witness. Sometimes stories call upon us to listen and at other times to share, and most of the time we find ourselves doing both. By telling and listening to each other’s health stories, we have the ability to affirm another’s life story, and we never know when we will find ourselves in a similar situation. Peggy’s story, for instance, draws the listener into her world. We feel angered and saddened to hear about how her voice was silenced underneath the noise of medical technologies and advancement. Yet medicalization has come a long way to avoid risks incurred from surgical procedures by conducting pre-admission testing. Even so, Peggy reminds us that medicalization cannot take the place of human communication in a healthcare setting. Further after we are drawn into another’s world, we always return back to our own world to re-examine what we have learned. And we may find ourselves with a number of options to choose from when making or enacting healthcare decisions for ourselves and/or others in our life.

Embodied Meanings. Because I approached this project as a glimpse into our story, I entertained one way that researcher and participant can become one in the same from an embodied perspective. Emphasis on embodied meanings during health promotional campaigns offer us new meanings for ways we cope with disruptions and reconciliation of body and mind, and appreciative understandings of how our embodied surroundings relate to our health practices. At the walk we cannot not attend to our bodies...
since physical movement with one another is inherent within the structure of the program. We are attuned to how our bodies and minds make us feel as we decide whether we desire to walk a longer or shorter trail each week. And sometimes, we are faced with re-evaluating why we so often take for granted our bodies when we call upon body parts like objects rather than interrelated parts of our being. Further, embodied meanings guide our perspectives in the world. For some of us, we perceive health practices as chores rather than accounting for our surroundings and the relationships we form when partaking in physical activities. JW is one example of a health promotional campaign that narrows the gap between process and outcome due to its emphasis upon embodiment.

Health talk as a Scaffold for Dialogue. Physicians prepare a topic to discuss at the beginning of each walk. These topics range from current events to new studies about our health, illness, and/or wellness. Yet these conversations continue long after the doctor presents information. Members participate in dialogue with one another and often diverge or converge from the original message presented by the doctor. Guided by conversations with healthcare providers and other walk members, participants have the capacity to contextualize health meanings for their own or their loved ones’ purposes and actions. As a result, we begin to entertain such questions as: what actions should I be taking, who should I consult about my healthcare practices, and/or how do I negotiate these concerns with my own healthcare practitioner?

Participant/Doctor as Patient. So many times, we walk into our doctor’s office longing for enough time to talk about what brought us there in the first place. We desire, as Jane eloquently put, to be seen as a person—not a number. Continuing relationships
with patients outside of the doctor’s office undoubtedly has its benefits. In this way patients become participants who are actively engaged in their own healthcare while physicians are seen as ordinary human beings. This process ultimately shifts power dynamics necessary for diminishing the healthcare divide because we become invested in each other’s healthcare at the JW events.

Structure of the Walk. In health promotional campaign literature, there exists an ongoing conversation about whether it is environmental manipulation that promotes physical activity or the social relationships people form that motivate us to become active. The JW program provides both an environment where people are able to choose how long they want to walk, and opportunities to meet with and choose persons with whom they would like to walk and talk during this time. The structure of the walk provides two primary implications for health promotional campaigns including, (a) a routine that leads to habitual weekly exercise activities, and (b) the strength of social membership that fosters involvement and engagement.

Friendships. In an effort to expand upon the strength of social ties formed at the walk, I discuss the power of friendships that serve as social support. As Jerry attests, “friends are people who care.” When I originally became involved in the JW program, I never thought I would be talking about the significant ways that friendships have shaped or informed either the health of ourselves or the health of others. When we think of the word healthcare, friendship is not usually one concept that readily comes to mind. However, after being a member of the group myself, I was not surprised by the emphasis participants placed upon friendship as I, myself, have created friendships that I believe
will last a lifetime. As Tom formerly pointed out, friendships make us *accountable* while offering us *camaraderie*. Tom, for example, became accountable for his insulin levels and learned from a friend that one way to do this is to have a meter readily available. Friendships also foster social support through camaraderie—knowing that if you do not show up at a walk, your friends will ask you where you were.

Our Search for Meaning. In a world today where nothing is known for certain about our healthcare, it is nice to know that we are not alone. As my own physician says, health is one part lifestyle, one part genetics, and one part luck. My understanding of our search for meaning as it relates to the JW program is, as Harter, Japp, and Beck (2005) argue, partial, indeterminate, and whimsical at best. Yet, what is certain is how our relationships with others create shared and tailored meanings for understanding our health. We are called into existence because we call others into existence.
CHAPTER 6: CULTURAL MEANINGS ABOUT OUR HEALTH

In the previous chapter, I argued that the stories we live and tell about our health become meaningful because these stories take place in a social context allowing us to reflect upon self and other in insightful ways. In this current chapter, I extend the conceptualizations of narrative-in-context and identity to explore how our cultural backgrounds inform what we consider meaningful interactions as members of an integrative health organizing program. Thus, the current chapter asks: In what ways does culture inform meanings we create about our health in the Just Walk/Walk with a Doc program?

The chapter begins with a brief overview of communication and culture and then examines how culture informs meanings about codes, symbols, and rituals we as ethnographers are interested in understanding (Collier, 2009; Philipsen, Coutu, & Covarrubias, 2005). I then explore how our identities arising from multiple social locations inform our embodied and discursive experiences. I conclude the first section by discussing how understanding health communication through a cultural lens provides us with the opportunity to explore underlying values, the relation between personal and political realms, and potentials for creative and transformative change. In the final section of the chapter I draw both upon conversations with my participants and fieldnotes to highlight cultural meanings about our health.

Communication and Culture

Formally studying interrelationships between communication and culture originally grew out of the British Foreign Service Institute where experts tried to discern
whether or not communication effectively took place between members of different cultures (Leeds-Hurwitz, 1990). Edward Hall (1959), on staff at FSI, was credited for recognizing that “Culture is communication and communication is culture” (p. 186). The study of communication and culture is rooted in pragmatics but over time has found its way into traditional paradigms such as social science (measurable behavior), interpretive accounts (localized knowledge), and critical work (systemic analysis). Rogers (1999) insisted that the term, “culture” has been more broadly defined by scholars in the past rather than how current scholars tend to operationalize culture as merely nation-states. Rogers recognized Simmel’s efforts to understand culture that broadens this scope because Simmel’s definition considers communication as the central focus for understanding ways cultural meanings are exchanged, created, and sustained in time. Rogers provided a useful summary of Levine, Carter, and Gorman’s (1976) account of Simmel’s ideas about communication and culture:

1) Society consists of communication among individuals, 2) All human communication consists of exchange that has reciprocal effects on the individuals involved, 3) Communication occurs among individuals who are at varying degrees of social distance from one another, 4) Communication satisfies certain basic human needs, such as for companionship, to express aggression, or to pursue certain desired goals, and 5) Certain types of communication become relatively stable over time, and thus represent culture and social structure. (p. 61).

This account of culture broadens our interpretations in allowing us to consider the many unique roles we play in relation to our imagined, collective communities. For example,
members of the JW program form a social community, yet its participating individuals come from different backgrounds shaped by experiences unique to them. Our differences inform what we may have in common with each other, and what we perceive we have in common also comes to inform our differences.

Martin and Nakayama (1999) later introduced a dialectical approach for studying culture that involves understanding communication as dynamic, relational, holistic, and tension-ridden. Martin and Nakayama argued that communication and culture consist of six dialectical approaches including: cultural-individual, personal-social, differences-similarities, static-dynamic, present/future-history/past, and privilege-disadvantage. Although these conceptualizations offer us insight into understanding communication and culture, the dialectical paradigm alone also narrows our approach to studying culture by perceiving the world solely through a lens that emphasizes contradictions in meanings. I prefer to conceptualize culture using Yep’s (2001) definition that “culture is an enabling fiction, characterized by the ongoing and shifting tension between the shared and the unshared, that creates, sustains, and renders meaning to the social world” (as cited in Collier et al., p. 231). This definition approaches a dialogical theory for understanding a hybridization of viewpoints that are edified through the ways we employ language in positioning our viewpoints in the world (Bakhtin, 1975/1981). Yep’s definition invites multidimensional understandings of culture that are not just focused on what the differences and similarities are, but rather make it possible for us to explore multiple perspectives and why these views are meaningful.
Prior to exploring why these views are significant for specific individuals, I explore differing opinions about how cultural constructs emerge and acquire meaning. In the following paragraphs, I address questions concerning how cultural meanings are constructed versus lived. On one hand, philosophers from a pragmatist tradition argue culture is socially constructed through the use of discourse. That is, meaning is constantly made and re-made because communication is conceptualized as a co-constructed coordination of activities, practices, and events. On the other hand, scholars turn to phenomenology to explain how culture is told and lived through the body. Young (2005), for instance, explained that (re)positioning our subjectivity entails embodying social conventions; we are at once enabled and limited to act in the world. I argue that those who desire to understand culture need to appreciate both ways for getting at meaning. We need to examine how meaning is created through our interactions with one another that shape and re-shape codes, symbols, and rituals—and how social, historical, and political locations inform meanings that emerge through our embodied experiences.

Rorty’s (1989) text entitled, *Contingency, Irony, and Solidarity*, articulates one way to understand how multidimensional perspectives become meaningful through the use of language. Rorty (1989) argues, “languages are made not found” (p. 7), and “to have a meaning is to have a place in the language game” (p. 18). Rorty’s idea of redescription is related to theories based upon symbolic convergence. For example, when I speak, the words I choose are appropriated from my position in the world (e.g., daughter, student, lover). Human beings do not acquire a certain nature based upon intrinsic truths, rather words are created and communicate a past, present, and possible
future. Rorty argues that language itself is neither neutral nor universal; yet, because languages are informed from a historical past, words themselves carry with them an embedded purpose. Because languages create meaning, Rorty expands his argument to illustrate how we are and are not a part of this process, which is the ironic part. Rorty (1989) defines an ironist as one who is: 1) always suspicious of a present vocabulary, 2) always doubtful of the arguments presented to support a present vocabulary, and 3) situationally-bound to realize that power is external. Rorty builds upon these ideas to conclude that moral progress is inherent within the words we use to create a common humanity where we accommodate as opposed to synthesize one another’s views in order to form a sense of solidarity. As a result, this is a solidarity based upon our similarities not differences—based upon language not embodiment. These ideas taken by themselves are useful for understanding stories told and how cultures come together to pragmatically create meanings about community. However, these ideas fail to shed light upon how our differences form solidarity and the unique ways our bodies also tell the stories we live.

Accordingly, if we desire to understand how culture is informed by stories lived, we should consider Kruks’ (2001) argument that discourse alone is inadequate for understanding our experiences. Kruks turns to phenomenology to understand how the lived body informs meanings we create from experience. Kruks points out that Rorty sides with the poet who “privileges the linguistically competent and denies a place for forms of experience, that may be non-discursive” (p. 136). Kruks suggests two ways that considering embodiment offers us knowledge. First, by paying attention to lived experience, we close the gap between the knower and known, which informs us about
what motivates us to act or not act in the world. Second, embodied experience discloses affective communication such as emotional feelings of pain, guilt, shame, suffering, hope, healing, compassion, and empathy that contribute to why we choose to act in the world. Kruks calls upon the work of Merleau-Ponty to argue that the conceptualization of body-subjects challenges mind/body duality. As a result, Kruks explores why the lived body can serve as a place of departure for understanding our commonalities as women. Kruks argues that meanings emerge from cultural and discursive elements that shape and inform understanding of self and other, not biological similarities per se (e.g., pressures of caring for the self during pregnancy). Kruks (2001) argues that “giving attention to commonalities of experience, even to the minimal ones of feminine embodiment, is one of the most important ways that we can become open to others different from ourselves” (p. 152).

Even so, Kruks does not articulate what she means by differences. If we, members of a community, approach each other from what we perceive to have in common, the only difference between Kruks and Rorty’s position is an emphasis based upon embodiment versus language. The question still remains: how do we approach each other at times when we perceive ourselves to have nothing in common? For example, I am currently voluntarily childless yet I still converse with persons with children. I sometimes find it difficult to relate to others when I am put in these situations, yet I come to realize that my friends’ love for their children convey how much they care for their family. Thus, we need to imagine a solidarity that invites understanding our respective subjective
positions in the world that involve, as Simmel suggests, both distance from and proximity to one another.

Another type of cultural lens we can engage with to understand and reflect upon our similarities and differences is a gendered lens. In order to explore multiple perspectives, we also need to account for how our backgrounds, for instance, social, political, and historical contexts, inform our decisions to act in the world. As Bakhtin (1986) would suggest, the place from which we speak plays an important role in determining what we say. Feminists have long argued that our standpoints provide an alternative way of knowing. Standpoint epistemology acknowledges that our social locations inform how we understand and communicate our experiences in the world (Collins, 2000/2009; Haraway, 1991/2004; Harding, 1986, 1991, 2007; Hartstock, 1987; Wood 2005). According to Harding (2007), standpoint epistemology is informed by how our realities become socially structured, which either enable or limit our abilities and choices to act in the world. Standpoint has the potential for understanding how discourse and embodied experiences of self and other merge together to create meanings concerning culture. Take, for example, that many middle class women seek out an OB/GYN for their health concerns. On most occasions, such women visit two physicians annually—their family practice physician and their OB/GYN. Women with the means to do so are conditioned in our society to seek health professionals in two areas of care, which constrains how we may feel about our self-care if we fail to act. Meanwhile, this practice enables possibilities for talking about certain health issues that at times would be uncomfortable with a family medicine physician. OB/GYN is a gender-specific
healthcare specialty that has met a need for women, yet at the same time can potentially limit ways we care for the self (e.g., if we cannot financially afford both healthcare visits).

In an effort to understand the ways culture informs meanings about our health, we must be reflexive about both language usage and embodied knowledge. Situated knowledges are both partial and embodied and have the potential to become emancipatory through the power of re-naming conditions that limit choice (Collins, 2000/2009). This process of naming or what Rorty calls re-description has the potential to offer a space where new possibilities to act in the world are encouraged, thus resisting habituations that become normalized through the social construction of reality. Just as words can serve as a useful tool for re-description and resistance, our bodies can also act in a similar way. For example, Haraway (1991/2004) suggested that embodied ways of knowing allow us to explore who is saying what and when, from what vantage point, and with what tools. Thus, we need to pay close attention not only to what someone else is saying but how they are saying it.

Communication, Culture, and Health

Scholars who have employed a critical/cultural approach to understanding communication and healthcare argue for alternative ways for attending to meanings about our health as opposed to more traditional ways of knowing (e.g., patient compliance). These scholars examine how health meanings are culturally constructed, the ways these meanings are contested, and the consequences that ensue from these meanings about our health (Dutta & de Souza, 2008; Dutta & Zoller, 2008). Dutta (2007) clearly delineates
the difference between culturally sensitive and culturally centered approaches to communicating about culture and health. Dutta argues that culturally sensitive initiatives: 1) determine needs outside of a community context; 2) make specific targets measurable; 3) tailor messages to meet specific cultural characteristics; and 4) evaluate objectives accordingly. According to Dutta, a culturally centered approach: 1) locates needs within the community informed by unique experiences; 2) pays particular attention to structural policies that inform choices available for particular community members; 3) ensures that power is redistributed to members of the community rather than the healthcare promoter; and 4) resists dominant ideologies about healthcare. A culturally centered approach is useful for attending to particular instances when co-created meanings emerge that resist dominant compliance-gaining strategies. Even so, it also may be considered irresponsible if a physician abstains from providing information that may be beneficial or harmful to our health (e.g., not discussing the harms of smoking to a tobacco farmer who smokes).

By comparison, Guttman (2000) outlines differences between strategic goal-oriented versus value-centered approaches to health promotional campaigns. The strategic goal-oriented approach is similar to Dutta’s culturally sensitive approach in that an expert outside of a community plans, implements, and evaluates a healthcare need without regard to underlying values informed by experiences of a particular culture. In contrast, according to Guttman, a value-centered approach acknowledges that all health interventions are value-laden. This includes choices made in the beginning of a health promotional campaign about defining the problem through choices made near the end of a campaign while also evaluating whether or not initiatives were successful. A value-
centered approach is useful for understanding the cultural dynamics at the JW organization because members embody discourses shaped from multiple perspectives (e.g., traditional medicine and/or complementary alternative medicine). A value-centered approach also invites alternative organizing principles that question the ethical dilemmas that conflict and/or are taken for granted during any and all health promotional campaigns.

Understanding health organizational communication principles from a feminist organizing perspective provides additional insights into ways culture informs meanings we create about our health. A feminist organizing perspective: 1) allows us to question underlying values that could potentially affect our healthcare practices; 2) investigates politics of representation in relation to personal health experiences; and 3) has the potential to bring about transformative change. For example, a feminist perspective would ask what values are assumed or implied that shape organizational communication (Marshall, 1993)? Mumby and Putnam (1992) argued that values embedded within organizing principles are also informed by what they refer to as either bounded rationality or bounded emotionality. Bounded rationality views organizational communication as a strategic approach to understanding rational human behavior. In contrast, “The concept of bounded emotionality refers to an alternative mode of organizing in which nurturance, caring, community, supportiveness, and interrelatedness are fused with individual responsibility to shape organizational experiences” (Mumby & Putnam, 1992, p. 474).

Many members of the JW program shared with me that they have grown to care for the friendships created with other members of the JW program. Doctors’ health talks,
which one could classify as a rational and strategic health approach with a goal of changing human behavior, are of secondary importance for many members. The JW program is also ideal for studying what Mumby (1993) refers to as the politics of experience, which refers to meanings we create about our health from personal experiences that we talk about in a public sphere. What remains unclear is “what issues ‘count’ as public versus private” (Mumby, 2000, p. 21) when we talk about our healthcare concerns. I believe that most people would contend that healthcare is a personal/private matter. That is, we generally do not disclose our health information in a public sphere. What may be lost is insight into the ways we negotiate health meanings and live out these meanings through practice. Further, I argue that the JW program is informative, educational, and thus transformative because meanings emerge every Saturday morning through discursive and embodied experiences that offer pragmatic implications (e.g., members who schedule follow-up consultations with a physician due to a conversation they have had with either a physician or participant).

Cultural Meanings about our Health

On the morning of Saturday June 9, 2012, my husband and I were relieved to be traveling up to Columbus on such a beautiful day. Because of the seasonal changes, the highway is visibly endless as opposed to its cramped horizons during the many dark days of winter. It is interesting when you find yourself living such a predictable routine that people, like the attendee at the gas station, begin to become a part of your story. They know who you are, what you are doing there, and where you are planning on going for the rest of the day. For some of us, these small interactions may mean the world,
especially if the world we know and the people we love are so far away. Such is the case for several participants of the JW program who have traveled to the United States (U.S.) with hopes for a better future.

On this morning, I decided to walk with Penny, Matt, and Dr. Winter. Dr. Winter is an 80-year-old woman who studies pediatric genetic disorders. Instead of taking the mile walk that circles the green meadows in the park, we strolled along the back part of the pavilion inside the woods. We all completed about half the trail and decided to take a short cut back to the pavilion because Dr. Winter needed to rest. When we returned to the picnic tables, I sat down with Dr. Winter and for the first time caught a glimpse into her past. Dr. Winter shared:

I have just had a slightly more interesting life than most people, and a tough life. Not really very much fun, because I came from a family and we were a reasonably well to do family when we were kids. And my mother did not do a thing but raise five kids, so we had a lady who did the cleaning, a lady who did the wash, and all this kind of stuff and my mother just took care of making sure we got to the gym because I was a gymnast when I was young. And we had our piano lessons and things like this, we went to the best schools possible and all this kind of stuff and then all of a sudden, Boom. The Russians kick you out and you are nothing, you are a refugee. I spent three months in a hospital because of malnutrition.

Dr. Winter began to talk about life as a refugee having no food, no money, and only the will to survive in order to care for family members. Her family started life over in East
Germany with the Russians. Dr. Winter said she applied to the university, but they would not accept her because she was not a communist. Her brother was accepted because he studied Slovak languages. One of her sisters was accepted because she became a Russian teacher. Her other brother became a doctor by happenstance after working as a male nurse for several years. Her youngest sister tried to escape, but it did not work out for her, and she ultimately became a CPA. Dr. Winter said, “I came over by myself. I escaped. I was shot at and they did not get me. I was running away from communism and Russians. But so, we all suffered quite a bit from living under the Russians. I suffered from it only because I escaped and for practical purposes severed ties with my family. Physical ties.”

Dr. Winter came to this country with her entire life in one small suitcase.

Life presents many challenges. After Dr. Winter arrived in the U.S., she faced another set of obstacles. I asked her how she got involved with the medical field. She said:

I knew what I wanted to do from the beginning and that is why I brought up my family. I found out when I was in New York that my High School diploma did not come, my Bachelor’s degree did not come, nothing did. I ended up getting a GED when I was in New York. And then, I applied to a college on the east coast and was told that I did not get accepted. I was criticized on the east coast and told I should try the Midwest. That is how I ended up at the College of Wittenberg. And then, it was difficult getting into medical school because there were very few women accepted into programs. I went there. I did not have any money or anything. I went to Ohio State University. I am a person who came from cleaning
lady to professor at OSU. Not bad. People think because I am a doctor; I am filthy rich. But I was an educator and did not make that much money 40,000 dollars a year is not very much for me. You know. But I like to do this work. Not having a family, my work gives me satisfaction.

I said, “It sounds like you have accomplished much even in the face of adversity. Do you feel like you have paved the way for others?” Dr. Winter replied:

It has been a very tough life. One thing I miss now is, number one, I never got married. Nobody wanted me. I was an immigrant from Germany nobody wanted me. And, number two, I do not have any family here. My brothers and sisters are over there. They swore they would never come again because they were badly mistreated here. They came here from New York. When they came over from Germany, they were treated like terrorists. They stood in line for over 3 hours and if you’re 70-years-old; it is not easy. Then, they took their suitcases and dumped them out, and then from there they stuffed it back in and fingerprinted and interrogated them. They felt that was under their dignity. And they said they would never ever come here again. So, if I want to see my family, I have to go there. Travelling does not get any easier.

Even though Dr. Winter refers to herself as the “default physician” when she has to prepare a talk at the walks, she considers herself a participant because this program is her social outlet. She has shared with me time and time again that she does not have any family in this country, and most of her interactions are with others in the medical profession. She said, “It is nice for me to be with somebody who, who does not know
about medicine. It is relaxing.” Dr. Winter continued to share with me why she continues to attend the walk program:

So you know what I mean, my biggest stress in some ways is the fact that I am lonely. That is not the right word, but I have no family here at all, and there is nobody in this house except my animal. When I come home in the evening after work, instead of being able to say, ‘Oh God, what a hellish day I have had, or to spit it out to somebody, I do not have anybody. That is not easy. People do not realize it, but that is a factor. My stress factor was last week, Saturday when I could not get out of my house because I had no power and I cannot lift my garage door. It is a two-car garage, it is a wooden door and I cannot lift it even if it is disconnected. I had to find someone to come over and lift the garage door so I did not feel trapped anymore.

I can imagine but never really know how difficult it must be to wake up every morning in another country so distant from loved ones and family members. For some of us who live close to loved ones, help when we need it is only a phone call away. We not only witness each other’s lives but we become involved by volunteering our resources, support, and labor.

Dr. Winter is not the only member of the walk who has come to the US from another country. Sanjay, another participant, came to the U.S. nineteen years ago from south central India to study a post doctorate in engineering at The Ohio State University. He has shared with me that all of his family still live in India and that he travels there once a year to visit. Sanjay introduced his friend and colleague Sahaj, who is also from
India, to the walk. Sahaj, however, has been living in the U.S. for 8 years, has resided in 3 different states, and loves to travel and meet new people. Sahaj, who is 31-years-old, joined the walk to increase his exercise activity because his doctor told him that he had a lung capacity of a 71-year-old. When I asked Sahaj why he continues to come, he said, “People are so happy, friendly, and share their thoughts and experiences with you.” The JW program emerges as a culture where members identify and share a common personal belief about maintaining a healthy lifestyle. Yet, our specific health experiences that motivate us to participate and the reasons why this participation is meaningful to us may be different from or similar to one another. Sahaj, for instance, joined because he wanted to improve his lung function and finds the program meaningful because he is able to continue to learn from other members’ stories and experiences. Sanjay joined the walk because the program provided structure that motivated him to continue to exercise even at times when work overwhelmed him. The walk for Sanjay is meaningful because of the friendships he has created with others whom he looks forward to meeting every Saturday morning. Dr. Winter joined the walk to meet people in order to reduce the stress of living alone. At times, when Dr. Winter does not feel obliged to assume the role of physician, she has the opportunity to put aside work and create meaningful conversations about one of her other hobbies and passions, photography. In fact, you will seldom see her on Saturday mornings without her camera at her side. What better to remind us of the places that are meaningful to us then to take pictures and preserve these moments and experiences.
Cultural Meanings Shared and Unshared

Walk participants are able to explore shared and unshared meanings about health every Saturday morning that can alter previous understandings of health and provide new possibilities. For example, on April 14, 2012, Dr. Winter presented a health talk about the trisomy 18 genetic disorder that affected politician Rick Santorum’s 3-year-old daughter. Dr. Winter concluded her talk with “And that’s all I am going to say today. But you can ask me anything you want. I do not know if I’ll have an answer.” A dialogue among participants and Dr. Winter quickly ensued. One participant asked, “What is her life expectancy?” Dr. Winter said, “Well, it is hard to say. I have had one patient that has lived to be 10-years-old. But I can tell you that she never learned to talk. She never learned to walk. The quality of life is limited.” Another participant asked, “How much pain was she in?” Dr. Winter said, “We do not think the patient herself suffers much but the family does.” He responded, “The caretaker suffers?” “Yes, the family suffers much,” Dr. Winter said. Another participant asked, “Where is the pituitary gland?” Dr. Winter pointed to her head and replied, “In the middle.” “On top,” he asked? Dr. Winter responded, “Yes, it is separated by two halves and you can even see it.” The participant asked, “Are you familiar with the chakra system?” “What? Can anybody answer his question,” Dr. Winter asked? The participant replied:

Anybody know what I am talking about? It is like the Western medicine talks about the heart, brain, and the gland. In Eastern medicine, we call it chakra. It is the energy center. That is why I asked you the question. It is basically called the
crowned center. And that is why we bow with our head pointed towards another.

In our religion, we bow in front of that.

Our cultural backgrounds from where we grew up to where we were trained and educated inform the ways we come to perceive the world. Dr. Winter’s training, for instance, was highly specialized. She had an NIH fellowship to study pediatric genetics from scholars across the U.S. who studied at highly reputable institutions such as, Johns Hopkins and Northwestern University. For many of us at the walk program, Dr. Winter speaks in such a different language that we lack the specialized training sometimes even to follow along in conversation. This is not at all unusual as Western medicine is dense with technical terminology about disease classifications, diagnostic procedures, and treatment options. So, when another participant begins to talk about Eastern medicine, we sometimes realize things that we have taken for granted about perspectives driven from a Western medical system (e.g., a system that is based upon science over religion, rationality over emotion, and outcome over process).

On June 16, 2012, I walked with a couple from China, Cuihua and Dagui. Cuihua is a nursing professor, who has taught in China near Shanghai for the past several years. Her partner Dagui came to the U.S. for business, but Cuihua shared that she presently travels back and forth from the U.S. to China. When I interviewed Cuihua and Dagui together, Dagui shared his reluctance to get up in the morning to attend the walk but his partner encourages him to participate. When I asked them to share how this program has changed their views of what society tells us about being healthy, Cuihua replied, “I heard somebody talking about aspirin preventing cancer and I was so surprised.” Dagui said,
“American people like to use aspirin so much, much more than Chinese people.” During the interview, Cuihua shared that originally “aspirin” sounded like “ice cream,” and we all laughed at the prospect that ice cream could reduce the prevalence of cancer. Cuihua continued, “I think in Eastern culture we more like nature. You can see a lot of people do regular exercise every day. I had a friend who visited China last year. They were so surprised a lot of people get together and do regular exercise. Very big group dancing, tai chi…” Dagui said, “Well people here are quite different.” Cuihua laughing said:

He is a lazy bones. But, I think American people like to enjoy life and ignore health somehow, you know. First time, I visited here in 2010. I was so surprised I saw a lot of people overweight. There is a different philosophy about our health. In China, we take nature method to keep or improve health like regularly exercise, and health food. It is hard to find health food in China. I think it is also related to the insurance systems. It is different. A lot of people cannot afford it.

What I consider intriguing about this dialogue is how Eastern philosophy is in some ways connected to the JW philosophy while varying to some degree. For example, JW leaders continue to use these messages about active lifestyles and healthy eating to motivate members to embrace these habits. Meanwhile, participants from Eastern cultures grew up with these messages already permeating their daily way of life.

When I asked Cuihua and Dagui if they have provided any advice for other participants along the walk, Cuihua said, “Well, my English is not good so I do not have the confidence to speak in front of others.” Later on, when I asked about how the JW program responded to personal values and beliefs, Dagui said, “She has language
problems and is nervous. We do not understand what they [doctors and participants] mean sometimes.” Cuihua said, “If they could provide us with the talk prior to the event, it would help us to be prepared.” I agreed with them and thought this was an excellent idea, especially since Dr. Brooke already sends out weekly emails to participants.

Both Dr. Winter and Cuihua have shared with me the intimidation they feel about talking with others due to cultural accents. Something that became painfully obvious for me during these interactions is how little patience we have for one another to listen and affirm another when speaking. Not once during our interactions did I feel that I could not understand Dr. Winter or Cuihua. One barrier to communication that we seldom embrace is patience for being present with another. We will never be able to create new worlds through language if we are not physically willing to acknowledge one another. For example, we can easily become distracted when speaking with one another by looking elsewhere or simply not positioning our bodies in line with the speaking subject. At other times, we tend to quickly assume that we cannot understand one another and/or have anything in common. As a result, we disregard and/or only passively listen to what someone else is saying to us. I, too, have struggled to avoid passive listening especially in motion when I am walking with another member of the JW program. In reflecting back upon our journey, I hope to continue working on being present with others even during times when I may feel preoccupied. Because if we long to render multiple perspectives shared and unshared in a meaningful way, we must embrace embodied meanings (e.g., being present with one another) that accompany the spoken word.
During the spring, summer, and fall, my partner (who was often the only male participant) and I would also attend a walk held later in the morning in the downtown Columbus area. Our Saturday routine during these months included waking up at 6 o’clock in the morning and driving to Highbanks to attend the walk led by Dr. Brooke at 8:30 am. Following the Highbanks walk, we rushed into our vehicle to drive to Antrim park to attend the 10 o’clock walk led by Dr. Rathi, a local OB/GYN. Dr. Rathi told me that the Antrim walk originally was intended to encourage women who were expecting to exercise during pregnancy because studies have shown that exercise correlates with better outcomes for the mother and baby (e.g., weight of baby/mother, risk of gestation diabetes). Unfortunately, the walk has had little success with the intended goal of reaching women carrying a child. In all the time that I have observed this walk, I did not come into contact with one pregnant woman. However, Dr. Rathi continued, “It is proven that there is two times in life when a woman gains weight. One is during pregnancy and the other is when a woman is approaching perimenopause, where your metabolism slows down and hormones are changing.” Although there was an occasional conversation about avoiding pregnancy, perimenopause, menopause, and postmenopause were frequently the topics of several conversations at this walk.

On August 6, 2011, I walked with a group of women ranging in age from their late 40s to early 60s. Lucy, a participant who also attends the Highbanks walk, asked, “Why do hot flashes occur and where do they come from in the body?” Dr. Rathi replied:
Hot flashes are not just symptoms of menopause but can also be a symptom of thyroid disease, leukemia, lymphoma, cancer, and diabetes. We should be careful not to make hasty conclusions about hot flashes because it could result from a serious health issue. Hot flashes occur because of hormone changes to estrogen levels. They call it your internal thermostat, which gets deregulated and reset because the brain receives hormones differently. The brain is a receptor of hormonal changes and the process causes sweating to occur. Once you stop getting your period, hot flashes usually last about two years.

This is when one participant laughed and responded, “Hot flashes lasted a lot longer than two years for me.” Dr. Rathí explained that several women have shared that hot flashes have lasted longer but the worse is right after the period stops. This has not been the only time we have talked about menopause at this particular walk. On August 20, 2011, I walked with Dr. Rathí’s partner, Dr. Singh who specializes in women experiencing issues during menopause. Dr. Singh explained to me that often by the time a patient comes to see her it is “too late.” Dr. Singh further illustrated, “I mean ‘lateness’ in a sense that women often go to menopause ‘gurus’ like Oprah prior to discussing experiences with a physician. Sometimes, five years have passed before patients find me.” Dr. Singh said, “Patients are so surprised by the time they find me. They say to me, ‘You specialize in menopause and you are an MD.’ Often by this time their minds have been polluted into thinking aging is a grueling process for women in our culture.” We then began to talk about the aging process in our culture and more specifically the expectation and pressure for woman to maintain their youth. This is when Dr. Singh shared with me that she came
to the US from India and how her cultural background informs her own views about aging. “It is so different here in the US. In India, aging is a natural process and a woman is thrown a big party when she turns 60,” she said. This conversation made me wonder how and in what ways the culture I grew up in would look like if the process of aging were embraced as a natural one.

Yep (2001) offered four meta-theoretical concerns for intercultural scholars to consider including the nature of knowledge(s), values, voice(s), and our aim of inquiry (as cited in Collier et al.). Yep calls upon us to practice reflexivity and acknowledge how our own values and the inclusion of multiple voices inform the decisions we make in our scholarship. After conversing with Dr. Singh, I came to realize just how much the cultures we grow up in influence our personal views concerning the practice of medicine as natural and/or traditional. This conversation also made me recognize that what Dr. Singh practices professionally, she is personally passionate about. Even so, it is complicated; for example, how does one embrace the natural process of aging while introducing traditional Western medicine? I have asked several participants and physicians this question time and time again, and each person provides an interesting answer worth noting. Dr. Singh, for instance, stated that alternative medicine runs parallel to traditional medicine because the same pharmaceutical company often owns these industries. Yet, I have learned from a participant, who is her patient, that Dr. Singh does suggest vitamin supplements. And still, alternative medicine is not covered under insurance. Dr. Rathi said that she has seen success in the case of fertility when patients use both traditional and alternative practices together.
When I asked Dr. Brooke this question, he responded “I think people feel I am more of a tree hugger than I actually am.” “I never thought that,” I said. Now curious about how I perceived him, he inquired, “You think I am a white, coat Westernized medicine?” “No, not exactly. I think that medical training has probably provided you with a unique vocabulary that informs your perspective, meanings, and practices about health,” I replied. Then, Dr. Brooke began to explain where he stands on this issue by employing the example of those who take red yeast rice as an alternative for Lipitor, a statin. Dr. Brooke said, “If it is not proven, I just cannot back it. Red yeast rice, the equivalence is supposed to be 10 milligrams of Mevacor, which is a Lipitor type statin. But some pills have one milligram and some may have 25. It is not a regulated industry.” Dr. Brooke explained to me that he is still willing to listen to others who take alternative medicine. I was a bit wary, but another participant named Harriet has shared with me her initial trepidation about talking to Dr. Brooke about alternative medicine. Harriet, who takes natural supplements instead of Valtrex for Rheumatoid Arthritis, told me that she feels comfortable talking about this experience with Dr. Brooke. What we value about our health often stems from personal experiences and our standpoints. Yet, when we share these experiences through dialogue, we are able to appreciate each other’s perspective. My personal position on this matter is more in line with Dr. Rathi, who speculated that maybe we should not completely reject traditional medicine, and neither should we completely reject alternative medicine.

As I continued conversing about this topic with Dr. Brooke, I realized that we were talking about health practices that take place usually after someone reevaluates their
own healthcare. The choices we make about our health practices (i.e., alternative and/or traditional) are sometimes due to circumstances that precede our actions—although they are never detached from our experiences. That is when, Dr. Brooke exclaimed, “I believe in the power of exercise. You are getting 1000 times more antioxidants. I fear the mindset that I can fix something with a supplement.” “Or, a pill,” I chimed in. Interestingly, the JW program promotes that which is often unseen—preventive medicine. Preventive medicine according to the *Merriam-Webster, Medline Plus* (n.d.) dictionary is “a branch of medical science dealing with methods (such as vaccination) of preventing the occurrence of disease.” On the other hand, when we seek medical attention, we seek answers or outcomes to a problem, often overlooking alternatives where we would likely have to make lifelong adjustments. The process to commit to living a healthy lifestyle is time-consuming; the benefits to our health are often indeterminable yet potentially substantial, and not covered under most insurance plans.

*Negotiating Private and Public*

When I sat down one-on-one with participants and asked if the gender of the physician influenced the conversations they had during the walk, most participants answered no. I learned from participants who attend both Antrim and the Highbanks walk that it is more often the physician’s specialty that influences the questions they asked and the conversations they have had with other members. However, over the course of the last two years, I also observed how the gender of the participants influenced the physician’s selection of topics for conversation during the walk. For example, in the beginning, Dr. Rathi’s routine for gathering health information to discuss at the walk was gender-
specific, targeting female audiences. These topics ranged from ovarian cancer to hormone replacement therapy. Because Dr. Rathi noticed more men attending the walk, she discussed topics more inclusive of both genders concerning preventive practices like vitamins, nutrition, stretching, and exercise. Moreover, Dr. Rathi shared with me that her previous health talk covered the five most common cancers that occur in both men and women (e.g., colon and prostate for men, breast and ovarian for women, and lung cancer that affects both genders). Our standpoints in the world do influence which healthcare topics the doctor decides to talk about in the morning (e.g., Dr. Rathi who trained as an OB/GYN). Even so, Dr. Rathi was able to adapt information suitable for an audience composed of both genders, inclusive of multiple standpoints or positionalities in the world. With that said, I have observed both similarities and differences in discussions that have taken place at Antrim and Highbanks.

When I sat down to talk to Dr. Rathi one-on-one, she asked me, “Were you there when Dr. Brooke and I both talked about the new weight loss drug recently approved by the FDA called Qysmia?” “No,” I replied. Then she explained, “It is a combination of two old drugs Topamax which is an anesthetic medication, and Adipex which is a stimulant. Both are anti-depressants.” Because the FDA just approved the drug, various news networks and stations recently covered the topic. Dr. Rathi said that when she started to talk about the new drug, participants who drove from the Highbanks walk shared with her that Dr. Brooke also held a discussion about the topic. Dr. Rathi continued, “You know everyone wants a quick fix for weight loss, so when new drugs are out there, it is easy to talk about.” It is however unsurprising that at times both walks held
similar conversations because the overall JW philosophy is driven by an emphasis on prevention such as exercise and nutrition.

Another similarity I observed was an increase in dialogue among new participants who started to attend the walk on a regular basis. For example, I have often been asked if members of this program are already health-conscious and take an active approach in their own efforts to live a healthy life. There are indeed some participants who have a list of questions from an article they have read during the week. However, I have noticed and been told by participants that the program has motivated them more to research healthcare practices that work best for them. Dr. Rathi conveyed, “When I first started, I asked people what they wanted to talk about. Then, I would talk off the cuff. Then, people started asking questions about things that I did not know a lot about. So, I decided, well maybe, I should start planning for something to talk about.” As time passed, I even found myself getting more involved by emailing topics to Dr. Brooke and asking questions to spawn discussion with other members. When we begin to communicate topics important to us, we bring our private concerns into the public sphere—from finding ourselves invested in the creation of dialogue about our healthcare needs.

Even so, there have been significant differences among the ways participants interact with different physicians. I had a couple of participants mention that they enjoy talking to Dr. Winter because of her gender, age, and love of dogs. Joan, for example, shared that she enjoys conversations with Dr. Winter and had previously asked her about whether she should continue taking calcium supplements. Harriet, who has been known to win prizes for being one of the oldest participants at the walk, shared with me her
intimate conversation with Dr. Winter about a friend who had recently passed. Harriet said, “I asked about a friend who had a heart condition. She was 95 years old. Dr. Winter was open when I approached her and provided details about how the health issue affected my friend. Dr. Winter said it was bad.” Harriet confided in me that this meaningful interaction changed the way she later approached her visits with her friend in the hospital. There are at least three participants that I know of that have discussed knee replacement surgery with Dr. Winter because of her own previous experience undergoing this surgery. These encounters are often based upon a perception of similarity that participants feel when interacting with Dr. Winter and the time they have had to foster a relationship. For example, Dr. Rathi’s walk is in its second year and only occurs during the warm months of Ohio. Dr. Rathi will sometimes substitute for Dr. Brooke at the walk held in Polaris during the winter months and mentioned to me how close participants seem to be with Dr. Winter.

If we take into consideration that most of the participants at the Antrim walk were the same group of women, and the topics emphasized were related to women’s health issues, when we walked with an OB/GYN, we were bound to strike up conversations about some personal gender-specific issues. When I asked Dr. Rathi if walking with a male or female participant affected conversations that took place at the walk, she responded, “I have only had like two guys at our walks. Tom, I think really talks about his personal health issues; whereas, others do not talk much about themselves at all and are just there to walk. I feel like with women, there is a lot more interactive conversation.”
Although I did observe some similarities between the Highbanks and Antrim walk, there were significant differences. On January 29, 2011, my partner and I attended our first walk event indoors. It is hard to fathom that a couple named JR and Joy began this journey with us at the exact same time. During our first introduction, my partner, Bg pulled JR’s leg and told her he was the doctor. When JR and Joy realized that he was joking, we all laughed. However, we did not really get to know each other until the Antrim walk led by Dr. Rathi. On these particular mornings, JR would arrive with her dog, Happy, which Bg always called Kujo because the small dog attempted to go after dogs much bigger than himself. During our walks together, I learned that JR was an Ohio State Lady Buckeyes’ basketball player and a health educator for several years. JR also shared with me that she experienced a brain aneurism. And when I later sat down to talk with JR and Joy, I learned that JR has now been diagnosed with Non-Hodgkin’s stage one lymphoma. During our conversation, JR also shared with me that she had “dandy sports conversations” with Bg during the walks. Most of the time we talked about our daily lives, including everything from what we did last weekend to what we planned on doing in the upcoming weekend. If I could describe JR and Joy in words, I would employ adjectives like spunky, funky, loveable, and always welcoming. As one can imagine, some of these talks were very personal.

JR and Joy are leaders of a local Lavender chapter in the area and had arranged for Dr. Rathi to come and speak at one of their group meetings. Joy said, “I asked her if she could talk to my group about menopause and post-menopausal health concerns. And, she did. It was very interesting.” Joy explained that she had members write down their
most embarrassing questions anonymously for Dr. Rathi to answer. When I asked what was discussed, Joy said:

Well, they asked about low sex drive. First of all, you have to understand these are all women. They talked about low sex drive during menopause, and dryness, and ‘bed death,’ meaning they do not feel like having sex with their partner or their partner does not feel like having sex with them because of the low sex drive.

I asked if she could share with me what Dr. Rathi recommended but she could not remember. JR said, “I told her I wanted some male sex hormones so I could get more muscular definition.” “We talked a little bit about this during our walks together,” I said. “I remember that we also discussed issues faced by members of the LGBTQ community in regards to obtaining access to medical care services.” I then asked, “Do you feel programs like the JW create a space where discussions can take place about these concerns?” Joy said:

Yeah, I feel comfortable discussing any of these issues. I did discuss some of those issues with Dr. Rathi, especially, when talking about my group. But, I personally have never had any obstacles in that area. I just walk in and say this is my wife and I need to be there for her care. If it is my health issue, I say can you please bring my wife in? I feel sorry for the young ones; it is much easier now for them. I was 50 when I came out. But my granddaughter is 17, and it is so much easier for them. Except for her father, my son in law, he detested Jessie Rae and me. When we had our union, my daughter was in the wedding; he called here
night and day and tortured us. Now, he has a teenage daughter who says, ‘I am gay. What are you going to do about it?’

JR chimes in, “karma, karma.” “I was thinking the same thing,” I said. “I was just letting you go there,” JR says to me. Joy continued:

The young people will have it so much easier. The older people will still have that stigma. They are afraid to say anything because of their jobs and to say something to a doctor. Which is not the way it is for us, her doctor has always accepted us. And if there was anything wrong, she would call me. You just got to be open and honest and that is the way it is. She [doctor] would say, ‘Okay Joy, now I need to talk to you. You need to do this, and this, and this for her.’

“What do you mean by this and this for her?” I asked. Joy replied, “Most people do not realize that she suffered from a brain aneurism. And there are things that she cannot remember. So, they say to me, ‘You need to listen so that if she forgets, you will remember.’ And, we chose a doctor who is a lesbian, and it makes it much easier.” I have had some great moments with JR and Joy. They remind me of Bg and I, that is, they enjoy ragging on each other as much as loving one another. Maybe, if we all lived by the phrase “when one forgets, the other will remember,” we will find ourselves witnessing a life of another in a meaningful way.

Of course, the topics we discussed at the walk were personal. We were living what Mumby and Putnam (1992) refer to as bounded emotionality every Saturday morning at the walks—we shared our personal stories and created connections with one another. As Woodward (2009) explained, “feminists, among others, have shown how the
emotions, shaped by cultural norms and practices, can be collective as well as personal, thus underscoring the mutually constitutive nature of subjectivity and sociality” (p. 21).

Prior to my participation at the walk, I did not realize how much members of the LGBTQ community are discriminated against within the medical field. Even though JR and Joy have always been accepted when in need of medical attention, I learned from JR and Joy that many of their friends have had to present documentation in order to be accompanied by their loved one. When I asked Dr. Rathi about her experience speaking at the Lavender group meeting, she replied:

There is always that concern with physicians and they are reluctant because they feel they will be identified with this group. You could go speak to a runner's group and people might not identify with you. But I think from a healthcare perspective, just because you speak to a lesbian group, does not mean you are a lesbian. I think it was an opportunity to share healthcare information with a group who often do not go to doctor's office.

In this way the JW program has provided a pocket of resistance when it comes to re-naming and re-describing issues of discrimination in the healthcare field. Through dialogue with one another, we share intimate details about our health that are situationally located and embodied. This is both informative and educational offering awareness and transformation into the ways we should practice medicine.

_Bodies Building Boundaries_

Scholars familiar with the spoken and written word (e.g., Bakhtin and Rorty) argue that there is indeed a moral imagination that underscores the constitutive nature of
language usage. Begging the question, what about unspoken words? Hamington (2002) argues for an embodied imagination that takes into consideration that “Beyond, and independent of, our verbal consciousness, our bodies carry on a dialogue with the world around us” (p. 278). Sometimes we journey to that place through reflection (e.g., when we no longer have the option to hear the words of loved ones who have passed;) and at other times we fail to listen (e.g., in moments present when bodies speak louder than words). Hamington suggests that embodied knowledges have the capacity for reciprocity through habitualization, even at times when we are not aware that these moral imaginations are taking place. Hamington (2002) explained:

The flesh is the paradoxical locus of both human individuation and continuity. Corporeal existence comes with specific time and space dimensions that do not allow the sharing of identical experiences; it is impossible to have ‘perfect’ empathy for another’s situation. However, corporeal existence provides the basis for intersubjective continuity through the flesh of the world. Bodies have definite limitations and potentialities that are shared by members of the species; however, the complex workings of the embodied imagination enable perceptual extensions of the flesh. Tacit and explicit knowledge can be transformed such that real insight, drawn from the body, exists, allowing people to care for one another. (p. 281)

Hamington also communicates that embodied knowledge still must be answerable to agency and choice. For example, we can choose to care or not to care for another member of our community. I draw upon Hamington’s notion of embodied imagination, because
over the past couple of years, I have taken notice of how individuals use their bodies to communicate their healthcare concerns to others at the JW program. In particular, bodies are employed to build boundaries when discussing more private concerns that take place in the public sphere.

During conversations with other participants, I have asked why they have or have not felt comfortable sharing personal health information with the physician at the walk. Cheryl, a participant, answered, “When I talked to Dr. Brooke about my cholesterol, I did it individually. I do not do it in a big group.” “Can I ask you, how you did that,” I asked. Cheryl said, “You wait until he finishes up the conversation. If the people are going to take off for the walk, some people stay back and ask questions. If they do not ask too many questions, then, you just stand in line. Then, you just move closer to him, and when it is over you can be the first person to speak with him.” “So, there is sometimes a line,” I asked. Cheryl explained:

I guess. I can see that at Polaris. It is kind of hard to detect because it is open. And most people like, if it is something kind of general people kind of hang around. If it is more personal, they will back up. It depends on the question. We are probably maybe 2-3 feet, a little further than that of an ATM, about 3 feet away. I will drop back if it is a little more personal.

Other participants also mentioned that the health talks are public; yet, members have the opportunity for private talk.

When I asked this question to another participant, Karrie, she answered, “It depends whether the question is specific or general and if a lot of people are around.”
Karrie shared with me her private encounter with Dr. Brooke when she asked about how to get the anesthetic out of the body following a DNC, a procedure that dilates the cervix to remove curettage. Karrie underwent the procedure because her doctor was checking for cancer due to bleeding. And when I asked a member, Penny, who has not shared personal information, why she might consider doing so in the future, she responded, “Because I have an ongoing relationship with the doctor.” Participants who do decide to disclose personal health information often create a physical space to do so prior to or following the health talk. Participants and physicians of the program appear to acknowledge that this type of disclosure is private and personal and respect the space of others at times when these conversations take place. I have, however, also observed how participants use their bodies to build boundaries to seek health information prior to, during, and following the walks.

On February 5, 2011, Dr. Smith, an OB/GYN, stepped in to lead a walk for Dr. Brooke during the one of the winter months. When we finally made our way back to the gathering place where the talk was held, a woman approached Dr. Smith and pulled her aside. Using her body, she turned her back towards the group and led Dr. Smith away to create distance between the group. She shared with Dr. Smith that she is concerned about a vaginal discharge and thinks it might be related to drinking soy milk. She explained that soy milk was recommended to her as one way to reduce menopausal symptoms, such as hot flashes. The participant and Dr. Smith exchanged contact information in order to discuss the issue at a later time and in more detail. Following this experience, I felt a sense of discomfort during the sharing of information between the participant and Dr.
Smith. I overheard this conversation because my body was positioned between two parties, the participant and Dr. Smith and the rest of the walkers. I have noticed participants waiting around a corner to ensnare and engage the physician privately. I have also observed participants walking faster to catch up with a physician to talk about their healthcare needs. And when I first started to shadow the physicians, I felt a certain sense of discomfort about privacy when these situations emerged. I could feel myself back off and walk slower to allow a participant to converse with the physician if it was specific to her or his own healthcare needs. Over time, when my relationships with participants changed and we grew to care for one another, my level of discomfort changed. Yet, even to this day, if I pick up on embodied clues that a participant (especially those who I have yet to create a close relationship with) desires to have a private interaction, I will back away from the interaction.

These types of embodied interactions do not only occur when participants share health information with physicians. Respecting the privacy of participants who want to share their personal health testimonials with other participants during the walk has also taken place. For example, after one of my last walks, Kym shared with me that she walked with a new participant who opened up to her about his heart attack experience. When Kym and this participant were walking around the loop, others began to join them. Cheryl, a member of the group that joined them, shared that she felt the participant shut down. Cheryl suggested to her group that they continue down a different path—leaving Kym and the new participant to continue their private conversation. According to Hamington, we can gain insight from the embodied imagination when we learn to listen
even at times when words are unspoken. This embodied imagination does, in my opinion, engender a moral respect for one another when it comes to communicating about our health.

Conclusion

In this chapter, I explored the ways culture informs meanings we create about our health in the Just Walk/Walk with a Doc program. I employed Simmel’s concept of culture in relation to communication as this definition includes race, ethnicity, gender, age, and other unique and diverse positionalities. In order to expand upon how culture informs meanings within the JW context, I argue that scholars who render ethnographic descriptions are in a position to study cultural codes, symbols, and rituals as well as embodied and discursive experiences. Ethnographers are in a unique position to examine cultures, *in situ*, or within the community where communication emerges (Collier, 2009). The JW program is a unique culture in that meanings shared and unshared about our health (e.g., Western/Eastern, traditional/alternative) are constantly contested. Further, I argue that language is not the only means for creating new worlds; our embodied experiences also urge us onward into exploring cultural meanings. Further, I argue that meaning is informed by what we perceive to have in common as well as what we do not. For example, participants of the JW program arrive with diverse life histories that alter how we come to understand meanings surrounding health, life, love, pain, happiness and sadness.

In an effort to understand, communication, culture, and health, I am guided by Guttman’s (2000) value-centered approach to health promotional campaigns. That is,
values underlie the choices we make, the actions we take, and the outcomes that may result from our communication about health. Guttman’s (2000) ideas are in line with feminist organizing principles that suggest that what we value will inform our actions. Moreover, what we value stems from our personal health experiences. For example, JR and Joy chose to visit a lesbian physician for their healthcare needs because as Joy suggested, “It makes it much easier.” Yet, these ongoing and changing cultural scripts that emerge in the JW program offer informative and educational knowledge that has the potential to bring about transformative change (e.g., closing the divide between medical personnel and LGBTQ communities).

Practical Implications

In this section, I offer some practical implications for ways we can better attend to how culture informs meanings about our health. How we understand our health is contingent upon past historical, social, and political backgrounds. Even so, we sometimes better understand where we have been when we begin to share where we are (e.g., conceptualizations of aging that differ with culture). The cultural themes developed in this chapter from conversations I have had with fellow “walkers” include: cultural meanings shared and unshared, from standpoints to dialogue, negotiating private and public, and bodies building boundaries.

Cultural Meanings Shared and Unshared. I have learned that the ways we come to understand what it means to be healthy involves our cultural backgrounds, embodied knowledges, and our abilities to re-create cultural scripts. For some of us understanding what it means to be and live a healthy life may be difficult to grasp for several reasons
including: (a) our inability to comprehend terminology about medicalization in a Western culture; (b) Western medicine’s lack of accepting and valuing a holistic understanding about our health; and (c) Westernized beliefs that contribute to emphasizing health outcomes over process. Thus, health does not become a priority because we become distant from understanding the self in relation to meanings about our health. Eastern medicine closes this gap between the knower and known because from birth health is imbued within cultural beliefs as a way of life.

Further, I suggest that the ways we are trained and educated inform how we practice medicine. We may, for instance, arrive to the U.S. with different cultural beliefs about medicine but then begin training where these beliefs become negotiated and re-evaluated (e.g., Dr. Winter’s specialized training through an NIH fellowship). I also maintain that our impatience to listen to one another may impede upon our ability to understand cultural meanings shared and unshared. One way to overcome language barriers and embrace our differences is to open up dialogue prior to the walk event. This can be accomplished by providing information about the talk presentation inside the weekly email that is sent out on behalf of the walk leader for that Saturday. In this way, participants have the opportunity to read, learn, reflect, and bring questions or comments that they would like to share and/or address at the walk.

From Standpoints to Dialogue. I argue that our standpoints in the world can and do allow us to foster conversations about our health, even if we disagree with each other’s position. Our standpoints guide us into dialogue, encouraging us to learn to appreciate our differences while offering us insights from fellow participants’ reflections.
on embodied knowledge. Take, for instance, our discussions regarding gender-specific health topics like menopause. I have come to learn that even though I have not yet experienced issues related to menopause, this experience affects everyone differently. That is, there are multiple options that women can choose from to cope with symptoms of menopause (e.g., estrogen supplements, hormone replacement therapy, cooling pillows and fans). Further, our discussions regarding alternative and traditional medicine open up dialogue about our different positions concerning what we put into our bodies. Some people may not be able to afford prescription medication or may not like the way it makes them feel and decide to use supplements. Meanwhile, there are still others who do not desire to use either prescription or supplements and would rather receive nutrients and antioxidants from food and exercise.

Negotiating Private and Public. I argued that the medical specialty of the leader of the walk as well as the gender of the participants influenced topics of conversations during the walk. There were both similarities and differences among conversations that took place between the walks I attended at Highbanks and Antrim. However because I spent a great deal of time walking and talking with participants at both walk locations, I grew intimate with participants who did share with me their private health stories. I also grew particularly close with a couple named JR and Joy who led me to realize how important talking about personal health experiences are to challenging public misperceptions and in some cases discrimination. In this way, we can raise awareness by bringing together healthcare professionals and members of marginalized communities about issues that may affect the treatment of persons in a healthcare setting.
Bodies Building Boundaries. This theme expanded upon how we negotiate private and public talk about our health by using our bodies as boundaries. I have learned from my co-participation that the amount of health disclosure depends upon several things: (a) the participant’s personality, (b) whether they have established an ongoing relationship with the physician, and (c) if they are provided the space and time to interact. There is an embodied imagination that fosters mutual respect among participants of the JW culture to back away if someone is trying to share information with the physician in order to obtain advice. This practice of providing space for others to speak upon private matters performs an ethic of care.

By describing how culture informs communication about our health, we are better able to understand the values that we attribute to certain health beliefs we hold and actions we take. Further, the exploration of these underlying values informs personal and political efforts which ultimately can engender transformative change. The next chapter will describe in more detail how this change is possible through the (re)negotiation of power within an integrative health organization.
CHAPTER 7: POWER DYNAMICS IN INTEGRATIVE HEALTH ORGANIZING PRACTICES

In the previous chapters, I explored how we create meanings about our health through stories informed by both social contexts as well as our unique positions in the world. More specifically, I argued that the JW program is transformative in some ways because it provides members information and education that raises their awareness and offers them additional choices for making informed decisions about their healthcare practices. However, I have also argued that metanarratives, the conventions embedded within storytelling, reproduce power in ways that are either productive or unproductive. Thus, power has been an underlying element in both of the preceding chapters, which is the reason I now turn to it in this chapter. This chapter questions: In what ways does the Just Walk/Walk with a Doc program reproduce, disrupt, and/or redefine power within physician-participant/patient relationships?

I first conceptualize communication and power relations as they involve reproducing and disrupting social constructions of reality through spatial and temporal dimensions. Then I probe how power relations can be redefined as providing alternative scripts for understanding health, wellness, and illness. Next, I discuss communication, power, and health from a traditional patient-provider lens while also attending to health promotional campaigns that offer alternative meanings within the participant-provider relationship. The final section of the chapter provides a reflexive account of how power dynamics shape and redefine meanings within an integrative health-organizing context.
Communication and Power

All of us, to some extent have in one way or another been curious about or affected by the relations among communication and power. We have seen how power can be used for destruction specifically when the purpose is to harm others and the consequences negatively affect the lives of many innocent people. We also have witnessed power employed with good intent that is misguided and/or ill-informed with disastrous consequences. To this point I have argued that the words we use are not exempt from some sort of influence of power whether good, bad, or indifferent. Yet I have also argued that human beings yearn to make sense of our world by constructing social realities that serve to inform who we are and what we do. I further contend that we often have failed in our efforts to understand communication and power in positive terms. Foucault (1977) argued:

We must cease once and for all to describe the effects of power in negative terms: it ‘excludes’, it ‘represses’, it ‘censors’, it ‘abstracts’, it ‘masks’, it ‘conceals’. In fact power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production. (p 194)

Power has both negative and positive attributes. Yet we tend to describe power in negative as opposed to positive terms. First, we reproduce both positive and negative power through our constructions of social reality. Yet these constructions are created and reproduced both discursively and through embodied activity. Because we hold fast to certain knowledge we are, as Foucault argued, a part of its production. But it is during the
process where intersubjective construction of social realities occurs that we often take for
granted power dynamics that render productive as opposed to solely destructive
outcomes. Take, for instance, our embodied doing of physical activities that discursively
reproduces medical knowledge (e.g. increasing physical activity is beneficial), also can
provide positive meaning to participants’ sense of self and health practices. Secondly,
these experiences that offer discursive constructions that reproduce power may be
disrupted through spatial and temporal dimensions. Consider how the JW program takes
place in a public space rather than a private office visit where participants are permitted
to come and go as they please. In this setting, power dynamics are constantly being
negotiated and redefined to varying degrees. This process in turn creates new possibilities
for how we describe participant-provider interaction. As a result, consider how social
constructions about our health may be redefined through the creation of a public sphere
that offers an overlap among private, technical, and public health concerns and
appreciations.

Power is deeply embedded within the words we use to communicate with one
another and these words at times can be hurtful or healing. As I have previously
discussed, the words we use are informed by our lived experiences that are both unique to
us as well as derive from cultural-historical contexts that shape how we make sense of
our multiple position(s) in the world. According to Lupton (2003), the term discourse
“can be described as a pattern of words, figures of speech, concepts, values and symbols”
(p. 20). The “discourse” I consult with in this project to develop my reflexive
interpretations of social constructions includes the transcripts from one-on-one interviews
with JW participants and the fieldnotes descriptive of conversations that have occurred at the JW events. Such JW discourse offers multiple perspectives. These perspectives range from participants whose worldview has been informed by an intense educational fellowship within the medical establishment (e.g. technical sphere) to participants whose worldview has been shaped by personal medical conditions and friendships (e.g. private sphere) they have created within the JW program. Lupton also claimed that when discourse is analyzed within a socio-cultural context, we have the opportunity to understand how we as a culture create and make sense of social constructions related to diagnoses, diseases, and treatments. Accordingly, the words (e.g. layperson terminology to explain medical phenomena) used to understand how we make sense of medical conditions and practices may enable us to better understand our own individual health experiences.

Yet power is not reproduced through language usage alone; power also is embodied. From a social construction perspective, Lupton (2003) argued, “emphasis has moved from examining medical power as an oppressive, highly visible, sovereign-based power, to a conceptualization of medicine as producing knowledges which change in time and space” (p. 13). Take, for instance, how difficult it is at times to describe how another embodies their body, especially when we ourselves have preconceived notions of how this occurs. When I remember back to my first experience at the walk, I was initially unable to discern the doctor who was leading the walk. I was so used to seeing a doctor in scrubs or a white coat that I became somewhat obsessed with describing the doctor’s dress at the walks in my fieldnotes because this performance violated my own
expectations. Dr. Brooke, for example, wore running pants, a tee shirt, and tucked his curly dark hair underneath a baseball cap. Given enough time, I came to recognize the doctor who was leading the walk. Even so, our expectations surrounding the reproduction of power from within the participant-provider relationship change when we take into account characteristics of embodiment like that of dress.

Embodied meanings are also shaped and informed by spatial and temporal elements that have the potential to disrupt how we may have conceptualized negative and positive power dynamics within the participant-provider relationship. Bodies come in all shapes and sizes. However, how our bodies interact within the physical, environmental, and social world around us is what helps us to make sense of embodied meanings (McDowell, 1999). McDowell (1999) reminds us, “our bodies are more fluid and flexible than we often realize” (p. 34). The plasticity of our bodies is what gives rise to disruptions that alert us to the possibilities to understand “being, consciousness, and action” redressed through spatial and temporal praxis (Soja, 1989, p. 137). It is the experience of becoming embodied through actions in space and time when power is disrupted and meanings are then locally situated that the JW program offers.

The biomedical paradigm has contributed to defining through naming spatial and temporal locations, inscribed upon the body, that have led to repressing patient autonomy (Lupton, 1995, 2003). Foucault (1972/1980) said:

The return of the hospitals, and more particularly the projects for their architectural, institutional and technical reorganization, owed its importance in the eighteenth century to this set of problems relating to the urban space, the mass of
the population with its biological characteristics, the close-knit family cell and the bodies of individuals. It is in the history of these materialities, which are at once political and economic, that the ‘physical’ process of transformation of the hospitals is inscribed. (p. 182)

The manipulation of spatial and temporal dimensions (e.g. the hospital setting or institution) has helped to create and sustain a technical sphere. The spatial and temporal dimension where medical knowledge is accumulated shapes the social contract between the patient and the provider. This social contract is a balance between the extremes from the practice of medicine by “quacks” and the patient who is reduced to the “medical gaze” (Foucault, 1973). The practice of medicine throughout history has undergone a transformation where knowledge, experience, and training have become a specialized trade that is imposed upon by the body politic (Foucault, 1973; Lupton, 1995). This reproduction of knowledge is a social process and as Massey (1994) argued therefore, “space is by its very nature full of power and symbolism, a complex web of relations of domination and subordination, of solidarity and co-operation” (p. 265). Yet I argue we should consider how power dynamics in the JW program provides what Foucault (1972/1980) terms an “inverse energy” that disrupts and reproduces alternative systems of power relations that may (re)negotiate power within our current ideological systems.

Dimensions of space-time shape, mold, and inform these embedded meanings that occur between patients and their providers—and these social relations in turn shape, mold, and inform space-time dimensions (Massey, 1994). Yet, as Massey (1994) suggested, “Space is not static, nor time spaceless” (p. 264). But what happens when this
space-time dimension is ruptured by inversing the same social practices that have historically characterized the embodied experience of a patient? At what point do we become aware of our embodied health experiences by breaking away from naturalizing modes of being (Smith, 1970)? What would the state of our healthcare look like if doctors were no longer solely the specialist of the space we call our bodies? The JW program offers different types of spatial and temporal dimensions that allow us to explore how technical, public, and private spheres interact. Thus health knowledges that arise in the JW program are not simply a “will to truth” but are negotiated among participants’ private experiences, values, and beliefs, the physician’s health talk, and the social interactions that take place at the walk offering possibilities for the creation of alternative health knowledges.

These alternative health knowledges provide redefinitions and a new vocabulary for what it means to be healthy and live a healthy life through the co-constructions of a public sphere that offers multiple perspectives. I agree with Mumby (2000) that the public sphere is:

a discursively constructed space for argument in which different interest groups compete to articulate conflicting worldviews. The boundaries of the public sphere are both conventional (i.e., humanly constructed) and permeable, so the relationship between the public and private spheres is continuously open to contestation. (p. 10)

Yet these spaces are not solely discursively constructed; they also are embodied. Because ethnography permits me to become a co-participant with the participants of the JW
program, I am continually engaged, embodied, and present during the redefinition of alternative health knowledges. I also argue that my participation from one walking group to another has provoked me to reflect on how these multiple perspectives are organized. To some extent, Fraser’s (1989) emphasis on a shared vocabulary, structure, and identification that counters ideologies about health is present. Yet because health knowledges are steeped within a technical sphere that offers evidence-based medical claims, we can never fully escape the power inherent within these relations. But we can (re)negotiate these claims by comparing, contrasting, and synthesizing our own health experiences in relation to ourselves and with others. In this way we can inverse the energy that evidence-based medical claims often impose upon us in a generalized manner. Rather, JW participants are reflexive during the process of resituating health education and information that will best explain their own circumstances. Take for instance, the two walking buddies who talk about their experience with diabetes type II. These participants employ both their own experiences (e.g. public and private) and medical claims (e.g. technical) suggesting that they can never “beat” the disease but neither will they allow themselves to be defined by it. Conceptualizing power through multiple sites of location and interests provides opportunities for us to learn about how perspectives (e.g. private, public, and technical) merge.

Power can be reproduced in both positive and negative terms, yet we are a part of this reproduction. These social constructions are neither necessarily always discursive (e.g. we become embodied through a routine of physical activity) nor negative (e.g. if we tell ourselves this is what is happening, we can sometimes alleviate our fear of the
unknown). The reproduction of power can be disrupted through spatial and temporal dimensions by interrogating and being reflexive about our environmental and physical surroundings that contribute to understanding health, wellness, and illness meanings. Finally, power may be redefined through an emergent public sphere that blurs the lines between public, technical, and private realms. The following section expands upon these notions of power and communication by describing how power dynamics from both traditional and alternative patient-participant-provider interactions inform these relationships.

Communication, Power, and Health

The JW program provides a context for exploring reflexive understandings that differ from traditional understandings of the patient-provider care model. I have referred to this group as an integrative health organization because of the physicians’ willingness to get involved with the community despite bureaucratic programs like managed care. Managed care according to the *Merriam-Webster, Medline Plus* (n.d.) dictionary is:

> a system of providing health care (as by an HMO or a PPO) that is designed to control costs through managed programs in which the physician accepts constraints on the amount charged for medical care and the patient is limited in the choice of a physician. (para 1)

Access and cost are two of the major obstacles physicians and patients face in today’s consumer economy (Apker, 2012). This is due in large part to a third party payer who sets demands for medical services that often constrain a physician’s time spent with the patient in order to reduce costs. However at the JW program, participants are afforded the
opportunity to ask a physician questions concerning their health while also partaking in forging relationships with others in the program. What makes the JW program different is the emphasis on a holistic vision of healthcare over the biomedical paradigm. Even so, the biomedical paradigm is still most often the preference practiced in major medical facilities today.

In a Western context, medicine is a systematic process of determining symptoms and treatments of a disease or illness in order to return the body to its healthy stabilizing function (Mishler, 1981). The systematic application of describing, naming, and prescribing stabilizes health meanings, strengthening hierarchies of power embedded within the biomedical paradigm (Lupton, 1995, 2003). This has led several scholars to be suspicious of health encounters between patients and providers. For example, Lupton (2003) discussed three specific models for studying power: functionalist, political economy, and poststructuralist/postmodern. The functionalist perspective is a micro, consensus-gaining practice between patient and provider where participants within this interaction are performing specific roles. The etymology of the word patient is “one who suffers” and the functionalist perspective often reinforces these power differences. The political economy perspective examines patient-provider disagreements and explores macro, systematic structures in place that constrain agency. As such, this macro perspective understands patient-provider interactions as undermining agency. Lupton advocated the poststructuralist/postmodern perspective, which explores the historical and political circumstances that lead to practices within a particular situation. Lupton explained, “Power is therefore not only repressive, but also productive, producing
knowledge and subjectivity” (p. 120). For Lupton, power within the medical encounter is viewed as a dialectical tension involving both individual and society. Yet, this understanding of the medical encounter limits some possibilities for understanding multiple locations of meanings within an integrative health-organizing context. For example, embodied dialogic moments between patient-provider interactions offer possibilities where dialectical tensions such as vulnerability and control can contribute to positive encounters that privilege the voice of the lifeworld over the voice of medicine during conversations (Mishler, 1981).

As Waitzkin (1991) explained, power is not one-sided but stems from the social context where interaction takes place. Scholars who study power within the medical field often employ a socio-cultural lens. The study of health and illness from a socio-cultural perspective attempts to make sense of public and private values of health and illness as these personal and cultural conceptions are informed from experience influenced by physical, environmental, and social factors (Lorber and Moore, 2002). This perspective has led scholars like Lupton (1995, 2003) to explore power within a medical context as a dialectical tension between agency and institutions. However, other scholars have examined power through participatory action (Dutta & de Souza, 2008; Dutta & Zoller, 2008), narrative medicine (Charon, 2006; Harter, Japp, & Beck, 2005; Pennebaker, 2000, Sharf, 2009) the voice of the lifeworld (Ellingson, 2005; Mishler 1984; Frank, 1995, 2002), and dialogic/aesthetic/performance perspectives (Geist-Martin & Dreyer, 1993; Harter, 2009; Langellier, 2009; Rawlins, 2005). These perspectives often overlap simultaneously criticizing dominant meanings about health and illness bounded from
within our culture while engaging in reflexive interpretations that offer alternative understandings of health and illness. Power understood within these models also highlights the embedded meanings that emerge from the social context where medical information is created and sustained.

From a health promotional campaign perspective, participant-provider encounters would most likely cultivate alternative understandings of dialectical and dialogical health communication. Guttman (2000) claimed, “If we accept agency as a necessary aspect of responsibility, intervention models that stress responsibility as a goal need to include activities that enable agency in its full sense” (p. 117). Yet within this definition, agency only is enabled through participatory or community involvement health campaign goals. Guttman (2000) developed two types of health intervention typologies, personal responsibility and community involvement. I argue that within the context of the JW program these typologies are not independent from one another. Rather, they overlap in providing a more complex and nuanced account of ongoing events. Guttman advances three major constructs to analyze the personal responsibility and community involvement health intervention typologies including: content (e.g. open or closed messages), relationships (e.g. ongoing or closed interactions), and context (open or closed structures). I argue that health promotional campaigns that focus on (a) increasing personal responsibility as a strategy and goal is a form of dialectical health communication, and (b) these types of interventions necessarily need a component that embraces community involvement as a form of dialogical health communication.
Personal responsibility as both a goal and strategy places an emphasis upon choices, decisions, and actions while these conversations are continually reproduced in discourse (Guttman, 2000). The personal responsibility interventions view content as opened and shared among members of the program. For instance, JW participants are provided clarifications in response to questions by providers. Meanwhile, ensuing discussions render possible options that may differ from person to person yet serve the interest of the individual asking the question. On some occasions, the physician may respond that he/she does not know the answer and call upon another participant for clarification or a response to an individual’s inquiry. This practice differs quite a bit from my experience observing educational seminars that take place in a hospital setting. If a physician during these events, for instance, does not know the answer to the question, the physician will find the answer later and send a response rather than invite a dialogue with members of the audience. Personal responsibility interventions view relationships as ongoing where these continual mutual exchanges are possible. The context defined within the personal responsibility intervention is a site where access to adopting behavioral changes is available. Even so, a health promotional campaign that values personal responsibility cannot escape the traditional patient-provider interaction where a social contract is negotiated. This stems from the socio-historical context that reproduces traditional power relations between the patient and provider (e.g. provider is the educator and patient is the learner). This discourse then reproduces the dialectical tension that Lupton (1995) discussed between individual (e.g. governmentality of the self) and society (e.g. public health education/policies).
Yet at times, because the patient becomes the educator and the provider the learner, moments arise that welcome dialogical exchanges of information. Without these dialogical moments, agency and empowerment that are the underlying values of personal responsibility are limited. Guttman (2000) explained that a community involvement typology high in both goal and strategy (a) introduces the program and messages to those uninvolved; (b) provides possibilities for recreating a script that changes how we prioritize problems and solutions; (c) permits conflict and disagreements; and (d) assists in the creation of new vocabularies. Take, for instance, the many times I have witnessed participants prematurely interrupt the physician during her/his talk to introduce a study that offers a different point of view about the topic at hand. In such cases, there is a striking resemblance to that of dialogical communication that values an underlying ethic of listening, reciprocity, and diverse interpretations of health, wellness, and illness. In the next section, I offer detailed descriptions about how power dynamics in the JW program inform meanings participants create about health.

Power Dynamics in Health Organizing Practices

“So, we are all friends here,” Dr. Brooke said as he began to tell his story. Dr. Brooke shared that a few weeks ago he had trouble hearing some of the questions voiced by participants of the JW program. Rather than repeating the question and providing a response for all JW audience members to hear, he realized that his reactions were more delayed than usual. After some time reflecting upon his interactions with participants, he recognized that he had to physically move closer to a participant in order for him to hear her/his question. He continued, “And as my father-in-law cautioned me, there is a ‘fine
line between self-deprecation and self-destruction.’ Yet since we are all friends, I hope that you will find this story more along the lines of self-deprecating as opposed to self-destruction.”

Several weeks ago, Dr. Brooke took a trip to Miami to participate in a run. Half-way through the run, one of his ear-pieces fell out of his right earlobe. He explained that these particular ear buds were designed for runners and had rubber attachments that were very expensive. He mentioned his frustration losing one of the ear buds and leaving him with only half of the capacity to listen to the music that kept him moving down the path. A couple miles later, the other ear bud fell out of his ear. At this time, he realized that the special rubber attachment to the ear bud was missing. However, he was unable to stop to search for the rubber attachment as there were 100 people running behind him. “It’s not that I’m fast,” he said. He explained that there were about 1000 participants running in the race that day, which conveyed how unlikely one actually would be able to stop and pick up a rubber ear bud attachment. Following the race, he had made dinner plans with family and friends. Later that evening, he noticed that he was having problems hearing his family and friends.

During the following week, his ears began to hurt and he felt water swishing and swashing inside his earlobes. He mentioned that he had never experienced an ear infection before in his life. “So, this is what it must feel like,” he said. He prided himself for not ever having to visit his pediatrician when he was younger to treat an ear infection. His ear continued to hurt that following week, and then he realized that he was walking up to JW participants to ask them to repeat their questions. “So, then I get it,” he said. His
coworker, one of the JW organizers, told him that he had an ear infection and should get antibiotics. He said, “Oh, yeah you’re probably right. Why is it that I have to get the non-medical person to tell me what’s going on?” Everyone laughs. He said that he had his partner write him a script and went straight to the pharmacy to get it filled. Then, he mumbled under his breath that he probably shouldn’t have shared the information about his partner prescribing him medication. He waited in line for an hour to get Z-pack, Zithromax. Zithromax is an antibiotic used to treat bacterial infections in the body. He took the antibiotic but still seemed to experience pain in his ears.

Shortly after he had returned from Miami, he had unexpectedly bumped into a friend who is an ENT. His friend offered to look into his ears. In hindsight, “I guess I should have done that then,” he said. The next day after taking the antibiotics, blood started to ooze out of his ears. The bleeding gave rise to an exigency impelling him to make an appointment to visit his ENT friend. His friend used a microscope to look into his ear and said, “Oh, I see the problem.” “I knew I busted an eardrum and should have come to see you earlier,” Dr. Brooke said. Then, his ENT friend pulled out the rubber attachment to his ear bud. Dr. Brooke exclaimed, “All of the sudden, I could hear again. Although, it felt all the while like an ear infection.” Then, his friend pulled out the other rubber attachment from his other earlobe. Shortly thereafter, Dr. Brooke concluded his story, “There is a reason I did not go into ENT and I hope you guys see me on the self-deprecating side as opposed to the self-destruction side.”
In a world today where our stories are constantly in motion, words spoken from our bodies open up a space where multiple meanings for self and other become possible. While we bear witness to these stories, we also become characters of these stories that shape, mold, and carry them onward. By exploring both discursive formations and lived experiences that are storied from the spoken body, we may better understand how health meanings are reproduced, disrupted, and/or redefined in an integrative health context. In the particular story I shared above, the doctor used his own body as a site for reference provoking his audience members to think, feel, and listen to the body as a site for engaging health meanings.

The exploration of our lived experiences provoke multiple meanings that are contingently bound to a temporal dimension that collapses the past, present, and future and gives rise to an embodied subjectivity. Yet, meaning becomes disruptive by permeating spatial boundaries that often have been understood as a container of time. What appears to remain relatively fixed is actually moving throughout space and time. Embodied meanings of one’s health experience provide a moment for one’s exploration of positionality. This is the disruption process that engenders transformation by opening up the dimensions of space-time to encourage and engage with others socially in a symbolic response. These responses are interwoven from what Mishler (1984) refers to as the voice of the lifeworld and that of medicine (e.g. physician’s combination of private, technical, and public spheres) that render the dialogical imagination possible. This
dialogical imagination is what fosters the (re)negotiation of the perception of doctors as the sole authority figure in understanding our individual healthcare practices.

Discursive formations position doctors as the medical expert because of the ways our society has legitimized the historical and cultural production of medical knowledge. However Dr. Brooke surrenders this power by emphasizing a humanistic frame of reference while traversing the ambivalent terrain of a dual citizenship of both health and illness (Sontag, 1996). At times in his story, situated meanings served as a metacommunicative frame differentiated from and privileged over expert knowledge. During this struggle towards certainty, he was told by a nonmedical person to get medication for his ear infection. While Dr. Brooke attempts to understand what an ear infection must feel like, he does not have any previous knowledge to compare to his current experience. He is at once healthy and unhealthy. Through his narrative, he disrupts the historical and cultural legitimizing of expert knowledge and provides a space that is relatable to an audience that manages these uncertainties about health and illness in their own lives. The doctor is at once constrained by the role that others place upon him yet is enabled to perform this role in ways that challenge dominant meanings surrounding how we understand our health encounters with healthcare providers.

The doctor’s story imports emotions through the lived body that serve to reassemble mind/body duality. This impels audience members to engage in a thinking/feeling mode of self-reflexivity concerning their own health. For example, the ways in which we also engage in self-deprecation and self-destructive behaviors allow us to make sense of the ways we respond to ourselves and to others in a health situation. Our
health is uncontrollable, yet, we have a choice to respond. On one end of this continuum (e.g. self-deprecation), we make a decision to surrender to the chaos that surrounds us, leaving us in a state where we relinquish our own agency to act. On the other end of this continuum (e.g. self-destruction), we may react preemptively without thinking about the consequences of our actions. The doctor’s story negotiates power that we often reproduce within patient-provider relations because he positions himself as the patient or “one who suffers,” thereby narrowing the gap between the healthcare divide. Near the end of his story, he still allows the audience to draw their own conclusions about where they feel his behaviors should be located along the continuum.

Dr. Brooke’s story also renegotiates spatial and temporal meanings that are positioned through the body while also disruptive of space-time dimensions. In this way, one’s lived body is open to historical and culturally conditioned interpretations, yet the ways in which the lived body speaks is unique to how the body responds and acts within these constraints (Young, 2005). For example, health meanings negotiated throughout the doctor’s story rendered an overlay of situated, non-medical (e.g. private) and expert (e.g. technical) knowledge. The doctor’s lived body is positioned as the focal point for narrating the story he shares with the audience. Meanwhile, the audience conforms to these spatial power dynamics by the way their gaze is centered upon the doctor. On one hand, the doctor’s body becomes a vulnerable site for the location of health meanings. The medical gaze is inversed—away from the participant and now directed towards the doctor. On the other hand, the distinction between knower and known is inherent within these spatial and temporal dynamics because power is afforded to the doctor who
communicates his medical knowledge to the participants. One could argue that power is therefore reproduced in both positive and negative terms informed from previous systems of power while also open to emergent forms of power.

Montgomery (2006) wrote, “A physician’s diagnosis is a plot summary of a socially constructed pathophysiological sequence of events” (p. 13). What happens when the physician is faced with unsuccessfully diagnosing himself as he becomes the patient? How does the physician negotiate his own private, public, and technical knowledge surrounding his own circumstance? Mishler (1984) defined “the voice of medicine” as that which attends to “technical-scientific assumptions of medicine” and “the voice of the lifeworld” as that which attends to the “natural attitude of everyday life” (p. 14). When these worlds collide, a story is created that repositions power in a way that encourages us to acknowledge that others may provide more insight about our own body than we could imagine ourselves. But the doctor whose perspective is guided by the voice of medicine asks: how can that be? Dr. Brooke was transparent during the telling of his story when he talked about his feelings of anxiety and uncertainty about visiting a physician to check his ears. He also discussed how difficult it can be to even follow his own advice, for instance, encouraging walk participants to schedule a follow up appointment with a doctor if something does not feel quite right. It was not until the actual sight of blood that scared him enough to set up an appointment with his ENT friend. Herein lies the climax of the story that leads him down a different path. It is a path where he faces his own mortality and must be receptive to listening, discussing, and following interpretations that others and himself create about his health. The unfolding of Dr. Brooke’s story provides
insight into how a medical diagnosis is socially constructed, embodied, and dialogically imaginable. In narrowing the healthcare divide, we ought to strive for the creation of new symbolic worldviews where power relations are renegotiated.

*Our Dialogical Imaginations: Stories that Glide*

As we began to walk around a bend that morning, a man approached us, (directing his attention to Dr. Brooke), and said, “Hey I can sympathize with your story this morning.” The doctor replied, “You can?” The participant said that 20 years ago he was ordered to wear earplugs and his doctor told him he should not be wearing earplugs as frequently. He said it took him six years to get over the layer of wax that built up in his ear because of this practice. His ears became sensitive which he refers to as “complements of Uncle Sam.” The doctor said, “Gotcha.” Then, the participant discussed the sensitivity from the medications that he was taking for 6 years off and on now. I asked how the doctor got the ear-wax out. He responded that they sucked out the wax because his ears were sensitive to water and then finally gave him a prescription. The prescription was actually some expensive eye drops that finally cured him of his ear sensitivities. Because we were standing still for a while, the doctor asked us if we wanted to walk in the opposite direction of the walkers. We nodded our heads yes and went along our way. Then, the doctor and the participant began to discuss the local sports scene.

A dialogical perspective of medicine breaks down the biomedical paradigm, offering up meanings of experience created from and sensitive to fulfilling the patient’s need (Geist-Martin & Dreyer, 1993). Harter (2009) argued, “a dialogic perspective ought to reveal shifts in meaning that occur through the ongoing exigencies of relational work
and participants’ retrospective sensemaking” (p. 142). For example, the participant relived his own experience with an ear infection that differed from the doctor’s story. The story however prompted this participant to reflect about his own health experience. A story that glides is a story, which is owned by no one yet is told by someone. A story that glides is a story that through someone else’s eyes carries with it a difference of interpretation that matters. A story that glides is a story that (dis)locates power dynamics built into the culturally conditioned relationship between patient and provider. Stories that glide in the JW program offer a space where power relations are constantly in flux thus (de)stabilizing oppressive meanings generated by historical/cultural space-time dimensions (Massey, 1994). These spaces for potential moments of dialogical interactions offer resistance for engaging in health information not bound by biomedical discourses.

_The Spoken Body: Becoming Embodied_

It’s a New Year! I had not been back to the walk for a while, and I looked forward to again being surrounded by some familiar faces. The walk is led by Dr. Brooke and is inside a local mall due to the winter months that make the outdoors in the Midwest unbearable. I ended up arriving just on time. It sounded like from the chatter of “How was your holiday?” that several of the participants also took a break from the walk over the holiday season.

The doctor interrupted conversation with an exuberant, “Happy New Year!” He shared a rather personal story about his son’s holey underwear and everybody chimed in with laughter. Then, he dramatized a restaurant connoisseur persona and performed a
review of a sandwich place in New Albany. He said that “the restaurant had the most
amazing sandwiches for a great price and the fries were incredible.” He mentioned to the
participants that indulging in fried foods when in moderation is about enjoying life. This
was not the first time he advocated consumption in moderation of food and drink that
have often been considered unhealthy. I remembered the time he had talked about wine in
moderation. And then, there was the time he had talked about doughnuts. It seems to me
that he has some sort of sweet tooth and these pleasure-seeking behaviors give his life
some sense of meaning. He mentioned emailing a soup recipe that is fool proof for those
who may not be the best at following directions and cooking (indicating himself among
this group).

The health topic for this morning’s walk was ripped straight from the headlines.
The doctor said, “According to this study I read, the brain age declines at the age of 45
instead of 65. But exercise and crossword puzzles were shown to stimulate the brain and
improve cognitive dysfunction decreasing the risks of an aging brain.” He followed this
information with another major headline that indicated that Weight Watchers was ranked
the top of among 22 diets nationwide. Then, he reported reading that “by combining and
measuring the intake of fat/carbs/protein calories, we are more able to keep calories
down.” He asked if anyone had any questions. I remembered it was a small crowd this
morning and no one had raised any questions for the doctor. He ended his discussion
with, “Have a great weekend!” (applause).

As the doctor and I began to walk, I noticed that we quickly waddled up to
another couple strolling around the mall. When the doctor initiated conversation, I felt
that we might have caught them off-guard. The woman jumped a bit and a startled flash of terror swept across her face when the doctor crept up beside her on the left. He initiated conversation by asking, “So, how were your holidays?” The woman mentioned that their holidays were enjoyable but that they were struggling with losing the extra weight gained from indulging in the “food-filled festivities of the holiday season.” I was surprised she was worried about her weight for someone who seemed to evidence her petite curves. The doctor mentioned the success of the Weight Watchers program that he reiterated from his short discussion at the beginning of the walk. Then, he said, “I always recommend the goal of losing 10 pounds over 10 weeks as a healthy weight loss practice.”

As we began to bend around a corner, a woman anxiously and abruptly interrupted the conversation to ask the doctor a question. She appeared to be hovering and pacing in the corner waiting for the opportune time to ambush the doctor. She exclaimed with a stern look on her face, “I bet you are the Cardiologist who told me to lose 20 pounds.” The doctor replied, “If it was me, I bet I said it nicely.” They both laughed. She wanted to learn more about the lap band procedure and asked the doctor what he knew about the process. He replied that he was not very knowledgeable about that procedure because it was not his area of specialty. He said, “I am not familiar with that procedure, however the Cleveland Clinic is well known for the lap band surgery.” She said that her friends have mentioned to her people who undergo the surgery and then over eat until they “throw up.” He said that he has heard of familiar cases but he has also heard that several other people have benefited from the procedure when the circumstance
arises. He asked about her holidays. She responded that her holidays were nice and she spent time at a hockey game, reading, and going to the movies. He asked her about the last book she read. She said she recently finished reading *The Girl with the Dragon Tattoo*, which was about empowering women to stand up for themselves. I thought to myself, how interesting in light of the way she demanded answers to her health questions!

The body speaks to us if we listen and clues exist everywhere—if we only learn how to attend to them. There are fast walkers; there are slow walkers. There are social walkers and then there are walkers who want to be left alone. There are walkers who desire partners; there are walkers who bring their own. Some walkers like to talk while others like to listen. Some walkers want solace while others only aim to complete their steps for the day. This becomes a process of embodiment, a speaking through the body where others are compelled to listen. Charon (2006) wrote that “what is required is the skill of stereophonic listening, the ability to hear the body and the person who inhabits it” (p. 97). And Langellier (2009) further argued, “Stereophonic listening resists textualization which ignores the body, disguises its performance, or turns its participation into something that can be transcribed” (p. 154). The JW program invites a space that enables doctors to listen for the clues the body leaks. This means paying attention to times when spontaneity is necessary—especially when initiating a conversation with a participant that is caught off-guard. Or this might mean attending to the needs of a participant who is anxiously anticipating medical advice. Montgomery (2006) reminded us that,
The body is there: alive, beyond construction or representation, although unknown without those human acts. Bodies bear our identity, are our selves; they are socially constructed but not out of nothing. Bodies are language, mute appeal for recognition, for attention and care. Knowledge may be contingent, and existence may be too, but bodies are given: needy, playful, pleasurable, healthy, ill. (p. 26)

Our bodies are in need of acknowledgment even if this means a quick glance or smile of encouragement.

Participants of JW speak from their bodies in multiple ways which give rise to spatial and temporal locations and (dis)locations of meaning. These relationships serve to recreate space and time, which Massey (1994) argued, “introduce[s] into the concept of space that element of dislocation/freedom/possibility, enabl[ing] the politicization of space/space-time” (p. 263). The fourth dimension of space/space-time is the point of view relative to our own experience (Massey, 1994). The body becomes a site of localized meaning when a walker uses the body to disrupt the spatial and temporal boundaries in order to call attention to his or her needs. The body can become a site of (dis)localized meaning when the doctor is abruptly startled by the participants. Embodiment is central to the JW program and provides a space where health needs are (re)politicized.

*The Voice of the Lifeworld*

It was a cold Saturday morning, which was normal for winter months in the Midwestern states. The weather during my drive to the Columbus mall where the walk was held was a gloomy mix of rain, sleet, and snow. Because this was my second
appearance at the JW program, I still considered myself an outsider of this organization. I had originally planned to shadow the doctor who was assigned to walk at this location; however, plans never seem to work out the way one intends. Following the doctor’s 10-minute presentation about the benefits of sleep in balancing our insulin levels, an 86-year old man approached me. His eyes were gentle, which was enhanced by the wrinkles he expressed between his brows. He is a tall, frail man who I later came to understand embodies a history of wisdom from his own unique health story.

I accepted William’s invitation to walk, and I quickly began to realize that he is a veteran of the program. William shared with me that he had experienced a heart attack five years ago. When William was admitted into the hospital for his heart attack, he was assigned a group of Cardiologists. During this time, William had to undergo angioplasty surgery. Angioplasty is an invasive procedure that requires cutting open the body and inserting a stent. A stent is a small tube that opens up blood vessels in order for blood to flow from the heart to different areas of the body. Following the surgery, William explained to me that he was assigned to Dr. Brooke as his Cardiologist. Dr. Brooke became William’s primary physician who monitors his heart health. William confided in me that he had learned about and had been encouraged to join the Just Walk program through his visits with Dr. Brooke. William has been walking with the Just Walk program as an intervention strategy per Dr. Brooke’s advice ever since.

William sees Dr. Brooke both privately and publically for advice about his heart. During my last walk with William in June, I asked him about his heart health. William said he takes aspirin once a day due to his heart attack; however, the frequent dosage has
been causing his blood to thin. William informed me that his arms were turning black and blue when he was not even bumping into anything at all. As a result, Dr. Brooke told him to lower his dosage by skipping one aspirin every ten days. William also mentioned that he would visit the hospital soon for his annual heart check-up. Since William has become a regular attendee at the Just Walk program, he requested a walking test as opposed to the chemical test. Dr. Brooke had joined us during our walk at this time. Dr. Brooke told William that the hospital would probably automatically schedule him for a chemical test due to his age. Dr. Brooke said that since he is familiar with William’s health habits he would change the order to a walking test.

Attending to the voice of the lifeworld opens up a space where power is able to be negotiated. For example, meanings William attributes to his own health involves his ongoing practice of living a healthy lifestyle. Recently, William has been carrying a cane to the walks and has confided in my husband that he no longer is able to walk the golf course. Since I rarely walk the golf course, I could not understand the logic behind this news that upset William. I asked my husband why this was a big deal to William. My husband said that William’s close friend who was recently unable to walk the golf course passed away within a year.

William confided in me that he feels more vulnerable about his health now than ever before. Meanings between William and Dr. Brooke are negotiated and saturated with the voice of the lifeworld that has been conceptualized as contextual, humane, and contingent (Mishler, 1984). William is guided by the expert knowledge that Dr. Brooke’s provides yet also is afforded a space to reinterpret what this knowledge means for his
own care of the self. Because William is knowledgeable in this sense, his request to take a walking test rather than chemical test is an implication born out of the ongoing relationships fostered at the JW program.

**White Coat Syndrome**

When I sat down and asked participants what they believed they had gained from the JW program, several participants mentioned the ability to carry on intimate conversations. Tom expanded upon this:

I think the doctors that are involved with the JW program are often more personable. Maybe it's why they are committed to it. So, maybe they're more personable so they are able to listen easier and they're easier to talk to. It's outside of a regular physician's office so you don't get that…what I call the white coat syndrome.

“And, what exactly is white coat syndrome?” I asked. Tom said:

White coat syndrome, as my primary care doctor calls it, is when my blood pressure gets higher every time I visit her in the office. I think in reality that’s what it is…being in a formal atmosphere instead of an informal atmosphere with a doctor.

Several walk participants mentioned how the informal atmosphere at the JW program makes them feel more relaxed, comfortable, and at ease when asking questions. Karrie, another walk participant, even said, “The informal setting allows you not to worry about having a fifty dollar question.” As I sit here and ponder these comments and answers to my questions, I wonder how many times participants felt that they could not ask their
primary care physicians questions because they did not feel comfortable—in addition to not having the time, money, or access to their physician. Further it seemed to me that participants censored themselves when in the presence of a physician in a medical office setting contributing to what Tom refers to as white coat syndrome.

When I asked Tom in what ways does walking and talking to a doctor differ from a traditional office visit, he said:

It is a lot different. I think again the informality is really important. You're able to…you don't feel like…first of all you don't feel like you're being charted…everything you say. But the walk doctors sincerely listen, and they give you ideas and they…you know they do more than just, the regular doctor just tells you that you need to change things…but not what type of change. They give a lot more insight. I guess they listen more and spend a lot more time. I read an article one time as I was doing a business presentation that said the average doctor stops listening to you 18 seconds after you start talking. I'll find it and I'll bring it, if I can find it. I'll bring it to you. I thought it was so funny because you know what…18 seconds may be too long for my primary care doctor. I think she stops much quicker. Really, I mean she's on the medical board she's a great doctor. She's very brilliant, but I don't think she looks at my chart until I first walk in…right before I walk in, and then she's looking at the chart the whole time I'm talking. I'll never forget one time she goes, ‘I don't want to hear that right now.’ But you just asked me a question and I responded to you. I felt so insulted. Then I was even more insulted when I lost all this weight, and she's been yelling at me
for years to lose all this weight. Then the one day I came in, I lost all this weight, she noticed on the chart and didn't say anything to me.

I replied that I could not believe his primary care physician did not say anything to him about losing weight. Tom and I sat together for a while and talked about what makes a good listener. We both agreed that a good listener is someone who is willing to take the time to listen to your questions and offer suggestions that are unique to your circumstances. In this way, a good listener offers both an embodied presence and practical suggestions in response to your questions. For instance, Tom shared with me that he had asked his primary care physician what to do to lose weight? And her response was simply exercise. Tom said, “That’s all she’d say, exercise. But what do I need to do? That’s the difference. Dr. Brooke walks with you but also brings people in to illustrate exercises and stretches.”

I also asked several of the walkers about whether or not they believed the location of the walk influenced the type of encounters they had with healthcare providers. William responded:

In private, I always feel there is a time restraint. Very seldom will a doc sit back in his chair and just talk. Usually they are standing up and ready to go out the door with the diagnosis or what they think is wrong. They are being paid by Medicare, and if you ever see the difference between what they are getting paid and what they are being charged, it is sometimes 50% difference.

William and I talked some more about privacy issues and whether he felt his information was confidential at the walk. William explained to me that when he visits the doctor’s
office they make him sign a piece of paper. “And that’s your privacy,” he said. He added, “It doesn’t really bother me either way.” What I find intriguing about the JW program is the transitional space that is created between private, public, and technical spheres. As I mentioned earlier, participants create spaces at the program to ask more personal questions and other participants will respect that space. Yet there are times when all participants join in discussions creating a type of transitional space where social interactions take place about a topic from diverse perspectives.

On more than one occasion, participants would comment that the location is important because of the social interaction. Sanjay, for instance, replied:

If it is a health concern or question asked in public, I definitely see some benefits because the doctor will give his input. But there may be others in the crowd that has gone through that, right? So they will say this is what worked for me. It happens all the time. You may have seen it also. Somebody would say, ‘Oh yea I had that problem also and this is what I did and it worked for me.’ So it broadens the perspective.

These transitional sites of change are unique to the spatial and temporal dimensions that spark meaning for JW participants. Massey (1994) suggested, “one way of thinking about place is as particular moments in such intersecting social relations, nets of which have over time been constructed, laid down, interacted with one another, decayed and renewed” (p. 120). The JW program is a context-rich environment that has evolved over time to include nets that overlap, detach, and intertwine. It is these unique social relations
informed by spatial and temporal dimensions that create dialogical health communication where new vocabularies about walk participants’ healthcare practices become possible.

**Becoming Empowered through Dialogical Exchanges**

On the morning of September 24, 2011, the weather was remarkably perfect. It was neither too cold nor too hot for walkers enjoying an outside stroll. I shadowed Dr. Brooke who walked with a participant named Jacob on this morning. Jacob shared with us his past heart issues and health experiences. Jacob initiated the conversation by telling us about a contest he recently entered where he lost over 31 pounds during a nine-week period. Jacob said he won second prize, weighing in from 236 to 196 pounds by the end of the period and added, “This all started three years ago when I was diagnosed with heart disease.” Jacob shared that his heart was abnormally large which ran in his family. The middle part of Jacob’s heart wall cavity was 18mm large and he had to undergo surgery to shave it down. At that time Jacob’s cholesterol was 193 and now down to 180. Jacob said he also stopped smoking in 1993. When I asked Jacob to share with me a memorable moment between himself and a physician at the walk, Jacob replied, “They always told me that I had been doing a great job, and it was motivation for me to keep moving. I ended up doing 3 trails and close to seven miles in about two hours and was pretty elated to see how far a had gone for that day.”

Jacob often referred to himself as a “loner.” But as time passed, I observed Jacob becoming more active with other members of the walk program. This was not at all uncommon with new members of the walk program who were undergoing cardiac rehabilitation. These individuals would constantly count steps, heart rate and often walk
at a faster pace than others. Another walker named Perry shared with me his story about his first time at the walk program. Perry said, “I was surprised with how many people were there. I would walk faster than them, probably not polite but I didn’t know better.” In January of 2007, Perry had three stents placed in his heart. In November that following year, he had another operation for the placement of two more stents. Perry said, “This was the motivation for me to continue walking.” But when I asked Perry what continued to motivate him to show up at the walks, he said, “On Saturday mornings, I am there no problem. But if I was by myself, I would talk myself out of it. At the walk, there is a doctor and people there. I guess I am not self-motivated enough.” Perry and I talked about his cardiac rehabilitation and his routine that involved walking on the treadmill. Like Perry, several participants mentioned having much more fun walking with people in a park than on a treadmill in a health club. I quote several participants who described walking on a treadmill as “boring.”

Personal responsibility conceptually is about making healthy choices that a person will benefit from and be accountable to in the present and future. No matter if the health choice is positively changing a health behavior (e.g. Jacob increasing exercise) or avoiding a negative behavior (e.g. Jacob quitting smoking), personal responsibility is inherently dialectical. Personal responsibility is dialectical because as Lupton (1995) discussed once we socially construct what a normal healthy behavior is, the individual is responsible to comply with that specific behavioral modification. Yet in order for us to become and continually feel empowered about the health decisions and actions we make and do, social interactions that prompt dialogical exchanges permit us to re-evaluate these
health choices and actions with others. Thus, a health promotional campaign that strives for personal responsibility as both a goal and strategy must include a component that offers ongoing relational support that fosters alternative understandings surrounding our healthcare practices. Like Perry, Jacob and many other walk participants have said, it is not personal responsibility (e.g. the increasing of physical activity) that motivates them to show up to the walk. It is the people. Making connections with others is what obligates us to become empowered about our healthcare decisions and practices. Dr. Brooke summed it up quite nicely when he said, “People need ownership, yet unity is strength.”

*Something about Place*

When I sat down and asked participants about how walking and talking with a doctor on a regular basis differs from traditional office visits, participants appeared eager to respond. Several participants commented that their interactions with a walk doctor did contribute to a monetary worth, that is, when considering how much it costs to schedule a yearly checkup or consult your primary care physician about a health concern. Other participants said it is nice not to have any gatekeepers and that you can readily access the walk doctor’s expertise. Another participant explained that if you have results from a medical examination, walk doctors are able to elaborate upon the information and provide their opinions to you. When I asked Matt this question, he expanded upon participants’ answers by explaining:

You have a much longer opportunity. If you want to walk for an hour and have a long dialogue you could. It is much more casual. If you are talking about something that has broad public concern you might get a lot of people into the
dialogue about it. I see a couple of values, one is I'm learning more and I'm getting exposed to a lot more medical topics that I wouldn't get exposed to. Some of the doctors come and talk about the latest medical news and if it's something that can help me or others to go talk to their doctors about it. And I've had people come out and say they went to their doctor on a specific issue and it's helped them.

The majority of the participants that I talked to perceive the JW program as different from a traditional office visit, and they thoroughly enjoy this difference. I also asked William and Jane what value they gained from the walk as opposed to a traditional office visit. William responded, “I like the informal rather than the formal. When I go to my back specialist, ophthalmologist, or the skin doctor, he/she wants to get in and out as soon as possible…” Jane barged in, “I sense their mind is on the clock. Whereas at JW they’re mind is loose, it is free…” “They got another patient to see in the next room. Sometimes they’re talking to you as they’re walking out the door,” William continued. “…and you don’t want to hold them up, if you have more questions. Whereas at the walk, there’s no time limit you can just rattle on and they listen,” Jane said.

Many participants of the walk program recognize that the event is not a substitute for a traditional office visit. However it was the physicians I interviewed who placed emphasis upon this point. So when I asked Dr. Brooke what differences he perceived between the walk and a traditional office visit, he provided a list:

Physical exam is the big one.

A list of medicines.
No patients vital signs in front of me.
No test results.
Very superficial relative to an office visit.

Dr. Brooke continued to explain:

But sometimes it is enough in a lot of circumstances. Half the time I can answer something and sometimes I can’t. I can say Kim that’s important you need to call your doc on Monday, or I could say no you don’t need to call right away, it’s good. So that’s just as important as not knowing the answer. I could have…I almost passed out yesterday and my right side feels droopy but now it’s all better. Do I need to do anything? Yeah TIA [Transient Ischaemic Attack or mini-stroke] first sign of stroke. You’ve got to follow up on it.

Place does contribute to creating and shaping communication that occurs between walk participants and doctors. However, walk doctors still conform to their role as a healthcare provider who swore by an oath to practice responsible medicine. According to Merriam-Webster, Medline Plus (n.d.) dictionary, the Hippocratic Oath is “an oath that embodies a code of medical ethics and is usually taken by those about to begin medical practice.” The walk doctors do embody these traits not only for their own patients but also within the community that they live and serve.

Conclusion

This chapter attends to the ways power dynamics are created within JW health organizing practices. I argue that power is reproduced in both positive and negative terms and that we often take the positive constructions for granted. Further, I contend that
power and communication ought to be understood through both discursive and embodied social constructs. This chapter also emphasizes how spatial and temporal dimensions of the JW program inform our social practices, especially when these practices do not conform to what we would normally expect. In addition, a public sphere forms from within the JW program that amalgamates private, public, and technical spheres together. These multiple perspectives help guide our inquiries and answers to our health concerns yet these meanings are not definitive (e.g. institutions’ use of naming and defining spatial and temporal locations in order to suppress autonomy).

In the section addressing communication, power, and health, I provided background information about traditional patient-provider models to illustrate how historical-cultural contexts shape our conceptions of power within these relationships. However, I offered two typologies provided by Guttman (2000) to convey how participant-provider relationships change within a health promotional campaign context. I argue that the personal responsibility typology cannot escape traditional patient-provider relationships and that these relationships are built upon a social contract that is inherently dialectical. Even so, in order for participants to become empowered, the campaign must promote a community involvement outlet where participants themselves are invested in the program. Community involvement fosters dialogical communication where healthcare providers and participants listen to each other, disagree over definitions, and redefine their own meanings concerning health, wellness, and illness.
Practical Implications

I advance some practical implications for the ways we can become more sensitive to how power dynamics inform meanings in integrative health organizing practices. JW provides an alternative context not only to our conceptions of traditional patient-provider care models but also to typical health promotional campaign models as JW doctors create ongoing relationships with members of the community in which they serve. The specific themes developed about power in this chapter include: narrowing the healthcare divide; our dialogical imaginations—stories that glide; the spoken body—becoming embodied; the voice of the lifeworld; white coat syndrome; becoming empowered through dialogical exchanges; and something about place.

Narrowing the Healthcare Divide. This journey has taught me that because we often are a part of the reproduction of power, we must take notice of moments when power is (re)negotiated. Regarding those persons we often relinquish power to (e.g. physicians), we should be reflexive about why and how this occurs—just as Dr. Brooke did when he shared his story to us at the walk. We should also attend to times when the physician becomes the patient. Meanings that arise from this process include: (a) the social construction of health through multiple interpretations of what is occurring; (b) what our bodies might be telling us through our reflection on physical anomalies; and (c) imagining through our dialogical interactions what possibly could be happening. In this way a space is created in which we empathize with one another by recognizing that we all have been or will someday be the patient or “one who suffers.”
Our Dialogical Imaginations: Stories that Glide. Following Dr. Brooke’s personal health story, I described how a walk participant came up to us to share his own personal experience with ear problems. Stories have a way of gliding across the terrain of biomedical jargon and allowing us to connect to each other over experiences we may have in common. In order to inspire stories that glide, I suggest that (a) physicians ought to share more of their personal reflections with participants, and (b) walk doctors who stroll in the opposite direction of walkers may have more opportunities to create moments to connect with participants.

The Spoken Body: Becoming Embodied. We are constantly constructing health meanings about our bodies. Yet we seldom take the time to reflect on how this process can be meaningful in a health context. We need to continue to learn how to listen to the body in ways we may not have always been accustomed to doing. Becoming embodied is about listening to the body in ways that warrant a response to care for another. Take, for instance, when a participant is looking around for somebody to talk and walk with because that morning they showed up alone. Participants may also use their bodies to vie for the physician’s attention that morning because they have questions in need of answers.

The Voice of the Lifeworld. The JW program is successful in attending to the voice of the lifeworld. This is in part due to the structure of the program that provides access to a physician on a weekly basis. This access allows participants to form ongoing relationships with doctors that foster dialogue. In turn, this dialogue permits an increase
in personal conversations that shape the social contract serving to meet the healthcare needs significant to the individual’s life history.

White Coat Syndrome. Several participants have mentioned how intimidating it is to visit their primary care physician. Consequently, they may not feel comfortable asking a question that may be important for their healthcare. Yet as we have learned, just asking a question may be pointless if the physician does not listen and/or provide guidance. The JW program provides a space where private, public, and technical spheres integrate thus making it possible for physicians (a) to attend to participants by being present to participants’ concerns and/or appreciations, and (b) to be answerable by providing practical advice and suggestions to participants’ concerns and/or appreciations.

Becoming Empowered through Dialogical Exchanges. If health promotional campaigns desire to increase personal responsibility, there must be a component that enables participants to get involved. When I sat down and talked with Jacob, we discussed the possibility of creating volunteers who would welcome newcomers to the walk program. These individuals would also walk with them if they did not already have a walking partner. The JW program has since created walk ambassadors who volunteer to greet new walk attendees. Because as we have learned, at the end of the day it is not the number of steps participants take that keeps them coming back to the walk but the people they meet.

Something about Place. The walk is not designed to substitute for an annual medical office visit. However, there is something about place that renegotiates our conceptions of power within the participant-provider relationship. Several factors
contribute to this renegotiation of power including: (a) an increase in the direct access of care, (b) a monetary value provided for participants by the walks, and (c) an increase in time to foster relationships. When I asked William about what this relationship means to him, he explained to me:

You talk about other things. I ask him about his kids and what they’re doing and he asks about mine. We just talk about what he’s been doing and how he’s been feeling. Some problems he’s been having. It’s more of a friendly atmosphere, like talking to a friend, and I look upon him [Dr. Brooke] as a friend.
CHAPTER 8: DISCUSSION

In this discussion chapter I first summarize briefly the main contributions of each preceding chapter. Next, I describe how a feminist approach to phenomenology and pragmatism helps us to understand being, doing, and becoming in the JW context. Third, I briefly outline some future directions for research. Then, I describe the significant contributions this project offers to theory, methods, and practical activity. Finally, I share my final thoughts and reflections about my journey.

My dissertation project examined how healthcare professionals and community members gathered together to engage in exercise and create meanings about their health in a program called Just Walk/Walk with a Doc. JW, founded in 2005, is an integrative healthcare organization joining healthcare professionals (e.g. nurses, doctors, medical students, healthcare specialists) with community members on a weekly basis to walk and talk about health issues. Throughout this project, I have suggested there is a vital need to understand how individuals make sense of their health outside of institutional contexts. Thus, examining communication occurring among participants of the JW program helps us understand why these integrative health programs are meaningful.

To situate my observations and interpretations concerning meaningful health interactions, in chapter 2 I drew from a meta-theoretical framework that combines phenomenology and pragmatism. In doing so, I argued phenomenology attends to being (e.g. embodied presence) whereas pragmatism attends to doing (e.g. practical experiences) in a healthcare context. Further, I suggested that a feminist epistemological approach to phenomenological and pragmatic thought offers an additional perspective for
examining how social structures enable and constrain our understandings of who we are and what we can do in order to become the healthy person we desire.

In chapter 3, I provided a review of literature establishing how and why an emphasis upon embodiment in health promotional campaigns contributes both to the process and outcomes of health activities. I urged health advocates and scholars to attend both to verbal and nonverbal communication messages sent in a health program that promotes healthy lifestyle behaviors. In doing so, I suggested that embodied cues can offer insight into persuasive elements of a health promotional campaign and specify how health programs become meaningful to participants.

In an effort to follow my own recommendations, my methodological approach to understanding descriptions of JW interactions emphasizes embodied meanings that complement the spoken word. In chapter 4, I described how my methodological orientation attends to: a) my own reflexive accounts of embodiment; b) the ways I make sense of stories; and c) my own and others’ pragmatic use of discourse and embodied meanings. I discussed how my methodological practices of ethnography and narrative interviewing align with my methodological orientation. I described the struggles I encountered upon entering the field for the first time, becoming a co-participant of the JW program, and writing as a method of making sense of these events both in the present and in the past.

In chapter 5, I examined the ways that lived and told health narratives offer us insight into meaningful storytelling in the JW program. I suggested that attending to the frame of reference in which a story is communicated illuminates deeply rooted health
values. My ethnographic descriptions provided a reconstruction of storied accounts where health values emerged in the JW program. My observations and interpretations affirmed the ways we embody our roles and relationships in relation to our health (e.g. the social component made possible in an integrative healthcare context) and influenced dialogical interactions at the JW program. Moreover, I claimed that our search for meaning during these interactions rendered health meanings that are sometimes inconclusive, inconsistent, and indeterminate. In this way storytelling accounted for how various health values emerging among self, other, and society are created and embraced in this program. Finally, I expressed that the JW program’s willingness to embrace diverse health meanings has the potential to narrow the healthcare divide or close the knowledge gap between healthcare provider and participant.

To further explore diverse health values in the JW program, in chapter 6 I discussed the role of cultural background in shaping our health perspectives. In doing so, I broadened my definition of culture to include gender, race, ethnicity, sexual orientation, able-bodiness, and class. I suggested that we embody and share our unique life histories, which inform us about the health beliefs we perceive as valuable. These underlying values shape the decisions we make about our health as well as the actions we take to maintain our health. Further, I offered ethnographic descriptions of interactions taking place at the JW program where individuals and collectives created a space for both differences and similarities. Diverse and unique health values were respected. I argued that the JW program is transformative because our personal experiences inform potentially public and political spheres regarding our healthcare practices.
In chapter 7, I expanded upon transformative change in the JW program by examining how power is reproduced, disrupted, and/or redefined within the healthcare provider-participant relationship. Power is reproduced when we socially construct what it means to be healthy and live a healthy life. Yet these constructions have both positive and negative implications. Positive implications most often occur when power is disrupted by the use of spatial and temporal dimensions not entirely constrained by institutionalized ideologies. And when this disruption occurs, the result is a countervailing energy leading us to redefine alternative possibilities for describing relationships between healthcare providers and participants. Throughout this chapter I insisted that health promotional campaigns that offer a space for fostering both individual empowerment and community dialogue are most effective. Without devoting our attention to individual perspectives and celebrating a diversity of health values, dialogue would be nearly impossible.

A Feminist Approach to Phenomenology and Pragmatism in Relation to JW

To explore the connection between my meta-theoretical framework and the JW program, I will review my description of being, doing, and becoming. Then I will synthesize ideas from each interpretation chapter to draw upon and connect the meta-theoretical framework to the JW program. My reasons for the development of this section are twofold. Foremost, I desired to demonstrate these theories’ unique insights for scholars attending to and comprehending health meanings. Secondly, I believe these sensibilities offer us knowledge about how certain practices taking place in the JW program can be embraced in other healthcare movements.
In chapter 2, I outlined a theoretical approach that drew upon phenomenology, pragmatism, and feminism. In doing so, I suggested that being involves the deeply-seated health values we attribute to our embodied experiences. I engaged with the work of Merleau-Ponty (1945/1962), who insisted that being is a process of esse that occurs prior to language and it should be appreciated. For instance, a simple smile can alter another person’s mood. Further, Merleau-Ponty (1945/1962) wrote, “the body is a power of natural expression” (p. 211). Accordingly, our bodies do communicate to one another, as when our bodies reveal that we are attentive or in need. When we walk with another person at the JW program, we have the option either to be present with our walking buddy or simply to focus on obtaining our walking goal. Listening is what accomplishes presence with another without violating another’s being or trust (Levinas, 1974/1998).

Yet as Seigfried (1996) suggested, we also are able to listen for an anticipated response that may potentially facilitate future actions (e.g. when someone’s silence warrants a response to a question that is contextually-based). Thus, our responsibility to attend to another’s needs extend beyond our embodied presence. For example, if someone desires affirmation or a response to a health question relevant to what they value. James (1967) insisted we have a moral and ethical obligation that we must account for when another is sharing meaning. Thus, doing is our embodiment of health values during the unfolding of practical experiences. In this way, our perceptions and practices inform one another. In other words, what we value about our health will influence our health behaviors.
Even so, a feminist approach to pragmatism and phenomenology advances two questions for us to consider: 1) Is everyone’s experience the same? and 2) Are some values at times prioritized over others? A feminist approach would suggest that not everyone’s experience is precisely the same nor is everyone’s experience significantly different. Secondly, a feminist approach would insist that the health values we attribute to our experiences are not free from social conventions. Thus, becoming is the reflexive dimension rendered from the interplay of being and doing that may alert us to a different way of seeing ourselves and possibly result in a different course of action. Becoming, in this way, can either be transformative or constraining. In relation to the JW program, becoming is transformative change.

Having revisited being, doing, and becoming, I turn to each interpretation chapter to illuminate the development of these ideas. I first readdress some main contributions of each chapter. Then, I focus upon the link between being (e.g. embodied presence), doing (e.g. practical experiences), and becoming (e.g. reflexivity) in relation to the JW program. In doing so, I hope to convey how the JW program offers an alternative way for thinking about our health and living out these meanings that differ from traditional healthcare campaigns.

Narrative

In chapter five, I discussed how storytelling in the JW program becomes meaningful to participants and healthcare providers. More specifically, I described that stories are both lived and told. Thus, I suggested embodied meanings communicate stories that tell us when someone is in pain, happy, sad, or even paying attention. I also
suggested that the exchange of information occurring during storytelling communicates
to us what someone values about her or his health (e.g. serving as a witness). Thus,
storytelling becomes meaningful because the act itself obliges us to take another person
seriously as we are both bodily present and responsive to what another values as
important about her or his health. I have observed participants both being present and
serving as witnesses through sharing and exchanging their storied accounts of health
conditions, vulnerabilities, and palliative information at the JW program.

Accordingly, in chapter five I shared the story of Tom and Jerry’s exchange of
health information. In recalling these events, Tom shared with Jerry that he was recently
diagnosed with diabetes type II. Upon hearing this information, Jerry shared with Tom
his own story about his diagnosis with diabetes type II. Jerry responded to Tom by
advising him to seek out a nutritionist, visit the doctor on a regular basis, and to always
carry a meter in his vehicle. Jerry, who has been through the experience, felt obligated to
act as a witness and provide Tom with information and resources. And when I walked
with Tom and Jerry, I learned how each of them reconciles their own sense of essence in
relation to their diabetes diagnosis. They explained that diabetes is a diagnosis that they
will continue to live with for the rest of their lives. Both Jerry and Tom have accepted
this diagnosis as a part of themselves. Even so, they shared with me that this acceptance
and identification of the condition liberates them to focus on maintaining other aspects of
their health (e.g. heart health, weight loss, and decreasing the number of medications they
take).
Storied accounts do offer us more richly grounded glimpses for understanding the embodied values we associate with our health experiences. For instance, Jerry shared that he values the walk because he sees other people like himself, not “people in their 20s with hard bodies.” When I asked Tom what he values, he suggested that society commoditizes fitness these days and that “just walking” is free and a social event. Both Jerry and Tom also discussed the value they place upon their friendships created and fostered in the JW program. The concept of being involves a co-presence with one another that mutually constitutes self and other as answerable and obligated to attend to embodied values (e.g. listening to embodied clues) and meaning (e.g. Tom and Jerry providing affirmation of each other).

Yet we also embody these values by practicing healthcare choices that are lived through our storytelling with one another. This can be as simple as “Just Walking” at one of the JW events. Or, it also can be a display of support, for instance, when Jerry’s friends including Tom showed up at a 5K relay that Jerry participated in when no one, including his immediate family and friends, did. Buber (1958) believed that I and Thou are interrelated through mutual action and responsiveness, so that our actions must consistently support and affirm our talking. At other times, these actions may mean asking one another where they have been if they did not show up to a JW walk event that past Saturday. For this set of friends, asking these questions is not a violation of privacy. Rather, it is a response to another conveying that they care and take each other seriously, and that they hold each other accountable. In this way, doing is both an embodied
presence and response that requires each person to act in ways that are supportive of their healthcare decisions and practices.

When our previously avowed values about who we are collide with new practices we actually are performing, over time we may become aware that we see ourselves and experience our surroundings differently. This altered perception may be as minute as taking fewer heavy breaths when we walk or feeling less pressure upon our joints that used to cause us pain. Or it may be as monumental as when Tom and Jerry both decreased the number of medications they were prescribed over the past year. Even so, sometimes we are unable to accept or understand such changes even though we do see ourselves differently. Consider the many stories we hear of those persons who have lost weight but in a year put double the weight back on. At other times when we are increasing our physical activity to maintain our weight loss, we may never come to see ourselves differently if we convince ourselves that there is nothing to see. The challenge is to accept these changes, revise our perceptions of ourselves and our practices, and fully embrace who and what we are becoming. Thus, what was once unimaginable for us may now be imaginable, especially if these self-perceptions are accomplished with and supported by other persons sharing these practices. For example, Tom joined a walking team that registered for Relay Around Columbus. This team was composed of 6 members who walked a total of 70 miles. Tom shared with me that he began training because the organization rates how fast they walk. He said:

I practiced like crazy every day, 10 miles, 6 miles a day walking, trying to get ready for this. My rate, when I checked it the week before, my rate was still only
3 and a half miles per hour and I was like, “Oh my gosh, I am barely making the number, the minimum threshold that you can be.” You know if you're 2 and a half miles per hour, you can be cut from the race. So, I was worried about…3 and a half miles per hour is the minimum rate they want you walking. And so I walked faster thinking I'm not going to keep up, and here I was at 4 miles an hour. I had practiced all this time thinking I'm barely making this cut. So, when I do this course I'm walking at 4 miles an hour. I've never walked 4 miles an hour in my life…on both legs…I did. I couldn't believe it you know. And so I was like wow. I better set my pace chart to 4 miles an hour now but I didn't know that so it was interesting.

In this way, becoming involves a reflexive account where someone learns about him or herself in reflecting over time, grasping how the interplay between both being and doing makes possible what was once impossible. Tom’s story also strongly reflects that his altered perceptions and practices are motivated and achieved by the opportunity to walk with and be answerable to other persons.

The ways in which storytelling edifies the self and others while also guiding us in understanding why we do what we do demonstrates how processes and outcomes are interrelated during health campaigns. Stories are meaningful to us because embedded within them are what we value (e.g. personal, health related, or otherwise). When we exchange stories, others witness our being just as we witness theirs. Meanwhile, living out our stories provides us with a purpose, whether this is walking the 7 mile trail or the 1 mile trail around the park. We also engage in doing such activities with others by asking,
answering, or sharing information and resources about health. Our desire to become a
healthy person (which is a unique process for each individual) is continually nurtured
through our participation with others in the JW program who also desire to become
healthy persons, and - together - we eventually make it happen.

Culture

In chapter 6, I explored how our cultural backgrounds shape what we believe is
valuable concerning our health. In doing so, I suggested that health values stem from
personal experiences and these values are shared. Yet I also argued that the cultural
meanings informing our health identities and practices can be similar to and different
from our own. Our respect for differences influences how we understand our own and
others’ health perceptions and practices. Even so, what we value is also informed by our
cultural upbringing, training, and education. These social structures may indeed prioritize
some values over others. Take, for instance, a person who feels afraid to speak to a
physician because he/she believes in alternative medicine over traditional medicine. Even
so, I argue that our sensitivities to these health differences liberate another to become the
person they so desire.

What we value when it comes to our health potentially differs for everyone. But
because we each are unique individuals with different experiences and backgrounds, we
likely will not understand all of our differences. Even so, we can try to live a life that
remains open to the exchange of diverse experiences. In referring back to some of the
accounts described within chapter 6, one tension concerning our health arising from
diverse backgrounds involved the interplay between natural and cultural processes. What
is considered “natural” often is understood in terms of a phenomenon occurring in nature regardless of what we humans do. In contrast, cultural processes are viewed as shaped by some type of human intervention that guides us in dealing with the world around us. Aging, for example, is both a natural and cultural phenomenon. The aging process is natural because from the minute we are born, we also are dying. Aging is also a cultural phenomenon when we consider how we regard the process and from whose point of view. But in this context consider meanings surrounding the benefits of exercise and how diverse points of view process this phenomenon differently. Cultural conventions such as medicalization persuade us to believe that exercise is considered a beneficial for becoming a healthy person. In Western culture physicians use scientific evidence to support this claim. However, according to fellow walkers Cuihua and Dagui, from an Eastern perspective exercise is viewed as a natural process because this behavior is learned growing up. So, what happens when these two perspectives collide?

What we perceive and value as healthy involves what we have learned as cultural beings, which in turn informs our perceptions of health practices. Throughout my field experiences, I have learned how to appreciate these enculturated differences of opinion while recognizing that I will never fully grasp the beliefs of each perspective. For instance, the participating physicians have undergone years of training and residency in Western medical practices that come to inform who they are and how they practice medicine. On the other hand, Cuihua and Dagui grew up in a culture where regular physical activity unreflectively becomes a significant part of their everyday lives. Thus,
our perceptions about who we are (e.g. being) and what we do (e.g. doing) are informed by the enabling and constraining parameters of cultural-social conditions (e.g. becoming).

When Eastern and Western understandings of health clash, differences become much more noticeable. For example, Dr. Brooke and Cuihua and Dagui have different beliefs about prescription drug use. Dr. Brooke often advocates the ABC’s when preventing cardiovascular disease and stroke. This approach includes regularly taking aspirin, checking blood pressure and cholesterol, and smoking cessation. In contrast, Cuihua and Dagui find it odd that so many Americans take aspirin on a daily basis. When I asked Dagui whether he has ever taken aspirin, he responded, “I only had to take aspirin 3 times in my life. That’s it.” From my own personal experience, I am unable to recall how many aspirin I have taken because the number exceeds what I am capable of remembering. In this sense, we embody values that in turn inform what we do when we make decisions about our health and ultimately act upon what we consider to be important.

By reflecting upon how we embody what we value and what we do, we may come to recognize that others perceive us differently than we see ourselves. Interestingly, both natural and scientifically informed cultural perspectives ultimately conclude that exercise is the best medicine. Yet how we arrive at these conclusions differs according to our unique experiences and diverse backgrounds. It so happens that in this case there is a commonality that unites our differences - exercise is beneficial. But at the same time, if we remain open to understanding our differences, the reasons why each believe exercise is beneficial may change how we interact with persons who have underlying values that
differ from our own. In this way, we become more sensible to each other’s standpoints as we discern what it means to be healthy and live a healthy life.

Acknowledging differences addresses persons’ experiences and outlooks that we may never fully grasp. Even so, it is vital to recognize that these diverse experiences are important for understanding health communication. Whether exercise is supported as a natural or scientific phenomenon that is beneficial to our health, we often take for granted the socio-cultural aspects underlying the values we deem important. If we argue that exercise is a natural process, we take for granted the social components that contribute to the human motivation and coordination of activities in a program like JW. On the other hand, if we regard exercise as preventive medicine (e.g. 150 min/wk.), we also neglect the social component involved in practicing this health behavior. In an effort not to foreclose any meanings, health communication campaigns ought to understand the values embedded within both perspectives. In this way, we do not take for granted values that differ from our own, even if we both practice the same health behavior.

Power

In chapter 7, I explored power as it is reproduced, disrupted, and/or redefined within the participant-physician relationship in the JW program. More specifically, I suggested that positive power is taken for granted. For instance, we may unwillingly relinquish power to physicians when inside of doctors’ offices because we are afraid to speak up about our health concerns (e.g. the white coat syndrome). Unique to the JW program is the informal setting where participants seldom feel the need to be anxious when speaking to a walk leader. Further, the structure of the walk offers a space where
listening and being present for another is fostered. In contrast, a traditional office visit lasts about 15 minutes. Even so, when we are listening responsibly and responsively to others, we are attending to another person in that present moment (e.g. being) while also anticipating another’s needs (e.g. doing).

In chapter seven, I shared the conversation Tom had with his primary care physician. During this account, Tom said, “…the average doctor stops listening to you 18 seconds after you start talking…I thought it was so funny because you know what…18 seconds may be too long for my primary care doctor.” As Tom and I continued to talk, I began to feel his frustration and was more able to comprehend his reasons for why the walk was such an important part of his life. His primary care physician kept telling Tom to lose weight. However, Tom’s primary care physician was merely telling Tom what to do rather than “showing” or offering possible suggestions for how to become successful. What Tom cherishes about the walk goes beyond listening because doctors walk and talk with participants of the program. This shared activity fosters an ongoing relationship that affords a space for listening while also showing participants how to embody their own health values unique to their own circumstances.

Listening, I found, is first and foremost an active response to another’s embodied presence - which includes silence and our undivided attention. In chapter five, I shared the story about Tom walking with his son and how the embodied presence of being there with one another created a moment of bonding. Later on, during my interview with Tom, he shared:
I know that Doc Brooke one time had his…his father came walking with him one
time, and his father brought his hiking stick with all his experiences of what he
did. And Doc talked about how he…that's something he thought about his father,
and I could think about how my dad raised me in scouting and taught me things
too. I'm always proud of my dad. I guess that's one thing thinking back, I thought
it was really neat that he had called out his dad in front of everybody else…that
was really nice.

The physician and participant relationship in the JW program, for example, affords a
space for each party to learn about the other. In this setting, physicians are attentive to
your own personal values as you become attentive to theirs. Thus, who we are (e.g.
being) contributes to health values important to our experiences and to fostering
relationships with others in our lives.

Even so, the ways in which we embody these lived experiences are contingent
upon what we believe is valuable. Take for example Tom and his son’s walk. Tom
appreciated this experience as time spent with his son as well as contributing to bettering
his health. However, his son usually walks while listening to music. For Tom this act of
walking held great significance for building a bond between father and son. His son,
however, may not realize this significance until later when reflecting back upon his life.
This is an example of Hamington’s (2002) embodied imagination where we hold onto
embodied memories only to recognize later in life their relevant importance.

What we do also relates to what we value as important. This is what Seigfried
outcome” (p. 166). Walking, for Tom, whether it is with his son, friends, or a physician is about the act of doing the activity with others, and this is what Tom values. Yet, participants in the JW program also anticipate a response to their health questions, concerns, and/or appreciations. For example, Tom appreciated the ways Dr. Brooke provided resources for exercising and stretching. In comparison to a traditional office visit, Dr. Brooke used his power in a productive way by showing and telling what it means to be healthy and live a healthy life. Tom was better able to envision himself acting upon these health practices and activities, thus making possible what he could not imagine prior to this interaction. Becoming healthy was more than just telling, it involved showing Tom what was possible in order for him to imagine and lead a different life.

Listening while also anticipating a response is about restraining our own beliefs and attending to what others value while also being able to respond to the needs of others. Health promotional campaigns ought to encourage this type of listening as both an act and response. One way to achieve this kind of listening involves simply asking: What do you find most meaningful at the present time, and why is [what you find meaningful] important to you? By asking and attending to this question so openly addressed to another person, we are better able to attend to each other in the present moment. Meanwhile we also are accountable to learning about and responding to needs that reflect another person’s unique set of circumstances.

Limitations

This dissertation provides ethnographic descriptions of interactions that occurred among members and organizers of the JW program. Even though I participated in this
program for almost two years, there are limitations to this inquiry due to my methodological approach, study design, and practical requirements of the research. First, the embodied activities of ethnography are time-consuming and take place across a variety of physically dispersed locations. Dedicating myself to witnessing and participating in actual JW events required me to make choices about the materials I would focus upon in performing my analyses. Thus, in this study I did not analyze my extensive archive of mediated messages associated with the program. This decision in turn limited my ability to analyze intertextuality (e.g. website, emails, and videos) within the organization in relation to interactions that occurred at the JW events. Second, for similar reasons I was unable to commit additional time to an array of extracurricular activities organized by the JW program (e.g. Relay Around Columbus and attendance at local sporting events). As a result, I was unable to witness the development of friendships and social relationships outside of the structure of the walk despite their readily apparent significance during the walks themselves. Finally, I did experience difficulty rendering the panoply of “extra” discursive practices of JW participants in words. On many occasions words could not do justice to the depth and range of embodied experiences and emotions that I felt during my times spent in the company of persons associated with the JW program.

Directions for Future Research

With any project, we are limited in the amount of time and resources that support our efforts to explore all the particular communication phenomena that interest us. My dissertation research serves as a springboard for future research. In this section I describe
three potential new areas of study: a) decentered organizational structure, b) mediated communication, and c) caregiver support dynamics. I also argue for the importance of completing such work.

A future study investigating the decentralization of power would yield interesting findings concerning health organizing in localized communities. This dissertation project attempted to describe the structure of the walks that I participated in and observed. These two walks included the one led by the founder that takes place at Highbanks Park and the one led by an OB/GYN that takes place at Antrim Park. When I began observing the program, there were only 5-10 walks taking place. Now there are eighty walks happening all over the nation and the world. What usually occurs when a physician requests to join the JW program and lead a walk is that JW mails this new partner a start-up kit. Inside the start-up kit the new partner will find a how-to-guide, a fact sheet about the benefits of walking, a CD disk that provides JW document templates for their own personal use, and a car magnet. After the partner has received this information, the walk is then promoted, led, and organized at the discretion of the new partner. This process decentralizes power where the local physician has complete control over the selection of communication methods and topics for the health talks. Yet, health needs vary depending upon the population of local communities. This future study would investigate communication networks between the daily operations within the JW office and the new partners in charge of leading a walk. A study that follows communication materials from the founding organization to the local community has the potential to explore the effectiveness of JW information for start-up programs.
In addition, a comparative study is needed to explore the communication within and between different walking programs. The conceptual framework I advance in this project highlighting being, doing, and becoming ought to be explored through participating in and observing other walks. By doing so, I could examine whether the health processes in other walks embrace embodied presence, practical experiences, and reflexivity in relation to transformative change. This research could contribute to a better understanding of whether transferability of the JW program to another site location is effective.

To consider another issue for future research, my dissertation work did not explore the mediated messages that are sent from the leader of the walk. Each Friday Dr. Brooke sends out an email that typically includes a short fiction story and a reminder about the walk. A future project should examine how individuals use these messages and how they react to the humor employed in these short fiction stories. From my conversations with walk participants, some walkers’ turned away from the walk because of the use of humor. One participant explained to me that these people perceive physicians in a highly authoritative role and did not want to accept anything less. Yet participants who attend the walk on a regular basis find the humor more humane. The emails also served as a scaffold for dialogue during the walks. A discourse analysis of the reminder emails would possibly offer some interesting findings about the combination of medicalization and humor. By pursing such a study, scholars could explore the effectiveness of humor in health promotional campaigns.
Finally, I did not examine the roles of significant others in the lives of participants who attend the walk on a regular basis. Some partners both participated in the walk while others did not. When I interviewed some of the participants, they did begin to share with me their frustrations with their significant others who did not support their efforts. However, there were other partners who just physically could not walk in the park because of the environment. A future study should investigate how participants’ primary relationships, such as with partners, children and other kin influence walk participants’ motivations and goals to continue increasing physical activity and involvement in the JW program. By doing so, researchers may learn how significant others outside of a health promotional campaign network influence their health decisions and behavioral changes.

**Significant Contributions**

Some of us, including myself, are lucky to be born into a family with people who are experts in the medical field. Yet for so many others this often is not the case. JW is a program that fulfills a need in our society where relationships between healthcare providers and individuals with health concerns are encouraged and fostered. At times when we have no one else to turn to for medical advice, information, and/or just to talk, there is always someone there at the walk that will listen and respond to our health concerns - whether this person is a doctor, healthcare specialist, friend, or new acquaintance. This project contributes, theoretically, methodologically, and pragmatically to the ways we exchange and act upon health information in an integrative health organizing program, JW. Theoretically, I argue that by combining principles of phenomenology and pragmatism guided by a feminist epistemological lens, we are better
prepared to attend to health meanings communicated through and from the body.

Expanding upon how we attend to embodied cues, I advocate for a methodological orientation that emphasizes a) reflexive embodied ethnography, b) narrative ethnographic reconstructions/reflections, and c) discourse-in-use and “extra” discursive practices (e.g. language and embodied health meanings). Finally, I offer pragmatic implications at the close of each interpretation chapter in order for health practitioners to gain insight into how meaningful interactions were created in the JW program.

Theoretically, I advocate that by listening to each other’s spoken words and embodied meanings, we are better able to understand the values that we attribute to our health experiences or being. During this process of attending to each other, we are actively responding or doing practices that involve caring, sharing, and walking. We walk side by side with each other, serving as a living witness both to each other and to ourselves. In doing so, we become the person we had envisioned initially or that emerged through our walking and talking activities, which leads us to new possibilities we may never have imagined otherwise. According to Tracy (2010), theoretical significance, “offer[s] new and unique understandings that emerge from the data analysis--conceptualizations that help explain social life in unique ways and may be transferred to other contexts” (p. 846). This project theoretically contributes to an alternative way of understanding phenomenological and pragmatic approaches with a feminist epistemological framework to make sense of health meanings in an integrative health program. Even so, I also suggest that these concepts be considered and further explored in the future when we examine health campaign programs.
I favor a methodological orientation that addresses: a) reflexive embodied ethnography, b) narrative ethnographic reconstructions/reflections, and c) discourse-in-use and “extra” discursive practices (e.g. language and embodied meanings). Accordingly, I offer a crystallized methodological framework that takes into consideration diverse perspectives in examining a particular communication phenomenon. First, I argued that reflexive embodied ethnography involves: a) a reflexive dimension where our experiences continue to alter how we perceive the world that surrounds us; b) an attention to embodied meanings that offers us unique ways for understanding health meanings; and c) an approach that is ethnographic while also reconstructive. My methodological orientation thus includes information about how I came to understand the process of story making and telling as well as the pragmatic outcomes that emerge from this process. For example, when a participant shares a story about a health experience, another listener may act upon the advice and teachings emerging from the story. Thus, my attention to storied interactions informs both process and effectiveness of health campaigns. In this way my methodological approach offers what Tracy (2010) refers to as “methodologically significant approaches [that] not only may lead to theoretical insights and practical usefulness but also contribute to future researcher’s practice of methodological craft skills” (p. 846). My methodological techniques permitted me to attend to health values as they are: a) both embodied and spoken, b) created by myself and others, and c) informative of both the process and outcome of the walk program.
Finally, I intended to provide feedback not only to organizers of the JW program but also for health practitioners who feel inspired to design, implement, and evaluate a campaign that amalgamates individual health values and communal support. According to Tracy (2010), “Practically significant research asks whether the knowledge is useful. Does it help to shed light on or helpfully frame a contemporary problem? Does it empower participants to see the world in another way? Does it provide a story that may liberate individuals from injustice?” (p. 846, original emphasis). Near the end of each interpretation chapter, I provide information concerning what worked well, what did not work as well, and what alternative options are possible that the organization has yet to consider. In this way, my hope has always been that we can learn best from one another and that others can also learn from our own misgivings, mistakes, and meaningful achievements. Hopefully, such learning will make more graspable what was once impossible to understand about the way we make sense of health.

Final Reflections

“A face is a trace of itself, given over to my responsibility, but to which I am wanting and faulty” (Levinas, 1974/1998, p. 91).

As I draw this final chapter to a close, I cannot help but be reminded of the ways my own part in this story has changed what I believe to be important. At first, I had no idea that the social bonds I created with others at the JW program could potentially last a lifetime. Nor was I even originally interested in studying embodiment in relation to health promotional campaigns. I simply made myself present to others while others made themselves present to me. Gradually, I began to become a part of others’ worlds as they
became a part of mine. In doing so, my primary intention was to attend to other persons in ways that did not foreclose any possibilities. Thus, being, doing, and becoming are not only concepts that I philosophize throughout this project, these are concepts that I myself lived.

Memories of embodiment can be painful. If someone that you loved is no longer here, all you have left are these memories. I was for the longest time resistant to attending to embodiment as these meanings reminded me of those loved ones who have passed from my known life. Yet, during my own search for meaning, I realized that these embodied memories live on forever. Thus, I often seek refuge in the words of Levinas, who refuses to be content with the finality of death. And this makes me responsible to other beings. I am answerable to another person as another is answerable to me, and together our memories live on into infinity. This is the reason why embodiment and being became an important contribution to this dissertation. In this way, our existence becomes meaningful as we begin to live our lives with purpose.

Along my journey, being and doing were intimately intertwined. Not only was I bearing witness to another’s presence, I was experiencing the world with another. Walking, talking, sharing, and caring - in this way - I was living what I believed. Through doing, I was recreating our stories together and being actively responsible for describing the unfolding of events that took place at the JW program. My practical experiences with others led me to recognize the connections that we foster together when we begin to build relationships. In this way, I became a part of a history that I myself recreated - which is
contingent upon descriptions that others’ expressed to me as well as my expressions to others.

As I became more aware of who I was in the midst of what I was doing I began to see myself differently. I vividly remember repeating to each new participant I walked with who I was and what I was doing. These sentiments eventually resonated with me and I began to believe in myself. That is, I took my personal convictions about health communication scholarship seriously in a place where attending to the human domain of health communication was embraced. I became the health communication scholar that I had always envisioned - passionate, compassionate, and part of a community that aspired to make a difference.
REFERENCES


Norwood, NJ: Albex.


APPENDIX A: IRB APPROVAL

The following research study has been approved by the Institutional Review Board at Ohio University for the period listed below. This review was conducted through an expedited review procedure as defined in the federal regulations as Category(ies):

Project Title: Walk with a Doc

Primary Investigator: Kimberly Renee Field-Springer

Co-Investigator(s):

Faculty Advisor: Devika Chawla

Department: COMS

Rebecca Cale, AAB, CIP
Office of Research Compliance

Approval Date: 02/04/11
Expiration Date: 02/03/12

This approval is valid until expiration date listed above. If you wish to continue beyond expiration date, you must submit a periodic review application and obtain approval prior to continuation.

Adverse events must be reported to the IRB promptly, within 5 working days of the occurrence.

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved by the IRB (as an amendment) prior to implementation.
APPENDIX B: IRB RENEWAL

The following research study has been approved by the Institutional Review Board at Ohio University for the period listed below. This review was conducted through an expedited review procedure as defined in the federal regulations as Category(ies):

Project Title: Walk with a Doc

Primary Investigator: Kimberly Renee Field-Springer

Co-Investigator(s):

Faculty Advisor: Devika Chawla

Department: COMS

Rebecca Cale, AAB, CIP
Office of Research Compliance

Approval Date: 12/28/11
Expiration Date: 12/27/12

This approval is valid until expiration date listed above. If you wish to continue beyond expiration date, you must submit a periodic review application and obtain approval prior to continuation.

Adverse events must be reported to the IRB promptly, within 5 working days of the occurrence.

The approval remains in effect provided the study is conducted exactly as described in your application for review. Any additions or modifications to the project must be approved by the IRB (as an amendment) prior to implementation.
APPENDIX C: QUESTIONS THAT GUIDE FIELD NOTETAKING

1. Need to learn how to interrogate your own assumptions.
   a. What assumptions emerged in my fieldnotes?
   b. What are the possible different interpretations?
   c. Why do these differences matter?

2. Need to learn how to understand from multiple perspectives.
   a. How might my participants understand the situation based upon their own unique experiences?
   b. What experiences inform the ways others make meaning?

3. Need to learn to understand how the context shapes histories, meanings, and subject positions.
   a. What is it about the organization that makes this space unique?
   b. What is it about the organization that makes time we spend together unique?
   c. What enables or constrains others to act in a particular way?
   d. Are gendered meanings and actions shaped by cultural conceptions or localized co-constructions?
   e. “Rich description” Describe the scene, characters, plot, theme, content, climax, etc.
      i. What do these tell you about communicative acts?
   f. Incorporate discursive and embodied interpretations in order to analyze these meanings.

4. Ethics/Reflexivity
   a. Decide how to keep participants anonymous.
   b. You are accountable for the stories that your participants share.
      i. How will you negotiate objective-subjective positionality?
   c. Be reflexive about how you as a researcher are both vulnerable and in a position of power.
      i. How will you remain accountable to your position as researcher and co-participant of the organization?
Title of Research: Walk with a Doc

Researchers: Kimberly Field-Springer

You are being asked to participate in research. For you to be able to decide whether you want to participate in this project, you should understand what the project is about, as well as the possible risks and benefits in order to make an informed decision. This process is known as informed consent. This form describes the purpose, procedures, possible benefits, and risks. It also explains how your personal information will be used and protected. Once you have read this form and your questions about the study are answered, you will be asked to indicate your agreement by proceeding to the next page of the survey. This will allow your participation in this study. You should receive a copy of this document to take with you (if you would like to keep a copy for your records, please take this page now).

Explanation of Study

Purpose of the research

This study aims to understand how participation in a Walk with a Doc could potentially create better relations between health care providers and community members. Specifically, I am interested in if dialogue occurs between providers and community members and information is shared through stories about health and healing.

Procedures to be followed

If you choose to participate in this research, you will be asked to tell your story. By nature of the project, you will be providing intimate details about yourself and how these experiences inform your relationship with healthcare providers. You must be at least 18 years old in order to participate in this study.

Duration of subject's participation

I anticipate that this interview will take about 1-2 hours in length to complete.

Risks and Discomforts

Risks or discomforts that you might experience are audio recording. At anytime, you may request not to be audio recorded. Your participation in this study is completely voluntary, and you are free to (a) refuse to answer any questions and/or (b) withdraw your participation from the study at any time during completion of the interview.
Benefits
I hope to add to the scientific understanding of patient-provider relationships, with the end goal of helping people have positive relationships. As you are a participant in Walk with a Doc, I hope that you will feel good that you have contributed to our knowledge about communication between community members and healthcare providers. Beyond this, I do not anticipate any direct benefits provided to you, personally, by this research.

Confidentiality and Records
Due to the nature of this study, you will be providing details about your experience with healthcare interactions. Data gathered from the study will be secured. Your identity will not be revealed in a publication.

Compensation
You will receive no compensation for your participation in this study.

If you have any questions regarding this study, please contact Kimberly Field-Springer, (330)524-6817, kf837209@ohio.edu.

If you have any questions regarding your rights as a research participant, please contact Jo Ellen Sherow, Director of Research Compliance, Ohio University, (740)593-0664.

I certify that I have read and understand this consent form and agree to participate as a subject in the research described. I agree that known risks to me have been explained to my satisfaction and I understand that no compensation is available from Ohio University and its employees for any injury resulting from my participation in this research. I certify that I am 18 years of age or older. My participation in this research is given voluntarily. I understand that I may discontinue participation at any time without penalty or loss of any benefits to which I may otherwise be entitled. I certify that I have been given a copy of this consent form to take with me and keep for my records. By signing below, I affirm that I understand this paragraph and agree to participate as a subject in the research described.

Signature_________________________________________ Date__________________

Printed Name________________________________________

Version Date: 11-14-2010
APPENDIX E: PARTICIPANT INTERVIEW PROTOCOL

Description of study for the participant: This study hopes to gain a better understanding of the relationship between health care providers and Just Walk/Walk with a Doc participants. Specifically, I am interested in how this program informs the meanings we attribute to our own healthcare and the healthcare of others in our lives.

I. Demographic Information:

Name:
Pseudonym:
Male/Female/Age/Other:
How long have you participated in this organization?
What do you do for a living?

II. Warm-up:

1. When did you first hear about Walk with a Doc? From whom? (Probe for details and instances)

2. How many Walk with a Doc events have you attended? Details: Where, what (was entailed), when, who, why (probe location and recalled fellow participants).

3. Can you take me back to your first event and describe that day for me? (Probe for details: What did you like best about your first Walk? What made you nervous or surprised you? Probe description and feeling)

4. What does an ordinary day at the Just Walk event look like? Probe: Can you lead me through an event? Have there been changes? If yes, can you describe these changes? If no, why do you think that is?

5. Please share with me a story that led to your decision to join the Just Walk program? (Probe depending on answer with story)

6. Would you please share with me a story that another participant shared with you in the past that made you re-examine your own health experiences? (Probe: a moment that transformed the way you understand your health?)

7. What personal experiences have you had with another participant of the Just Walk program that made you alter your future healthcare decisions? (Probe: was there an ah-ha moment or some goal you are now working towards attaining?)
8. In what ways do you believe your participation in the walk contributed to the health experiences of others? Why do you believe you have had an impact on them? (Probe: What advice have you offered another participant?)

9. In what ways has this program changed your views of what society tells us about being healthy? Is there anything about the Just Walk organization that shaped or informed your beliefs about good health? Probe for examples.

10. What does this program mean to you? Probe for concrete examples.

11. Can you share with me a time you asked the physician a specific question? What made this interaction meaningful to you?

12. How does the fact that you are walking with a male or female doctor affect your conversations during the walks? (Is there an awareness of similarities or difference?)

13. Can you describe a time when the gender of the physician influenced your decision to ask or not ask a specific question? Probe for example.

14. Can you describe a time when your own gender influenced your decision to ask or not ask a physician a specific question? Probe for example.

15. Can you share with me a story about a time when a physician at the Just Walk program highlighted or responded to your personal values and beliefs? Probe for specifics about personal standpoint.

16. What is your most memorable moment participating in the Just Walk program?

17. Would you share with me your favorite story about an interaction you had with a physician at the Just Walk?

18. Please describe for me a time when you felt uncomfortable sharing health information with a doctor at the walk? Have you ever felt that a doctor was uncomfortable with information you shared about your health? Please explain why you think that was the case. On the other hand, can you share a moment you felt comfortable sharing information with the physician?

19. In what ways does walking and talking with a doctor differ from a traditional office visit? What value do you feel is gained from taking these walks? Can you
describe any aspects of a regular office visit that you miss when taking the walks with the doctor? (Probe: In what ways is the walk similar to a traditional doctor’s office visit?)

20. Is there anything about the locations of the walk that you believe contribute to your healthcare encounters with the doctors? (Probe: public park versus hospital)

III. Participant’s Role [From Fieldnotes]: In this section of the interview protocol, I asked questions from conversations I have had in the past with the individual. Typically, I wrote out 3-5 questions prior to sitting down and speaking with the participant. However, some questions emerged during the interview process. I used this time to ask these questions and further probe participant’s responses.

21. Specific to the individual.

_______________________________________________________________

_______________________________________________________________.

(Probe for instances and examples)

22. From our conversations,

_______________________________________________________________

_______________________________________________________________.

(Probe for instances and examples)

23. _________________________________________________________

_______________________________________________________________.

II. Closing:

24. Is there anything I haven’t asked that you would like to share with me today?

25. Is there any question that you thought I would ask you but did not?

26. Is there anything that you would like to ask me?
APPENDIX F: PHYSICIAN INTERVIEW PROTOCOL

Description of study for the physician: This study hopes to gain a better understanding of the relationship between health care providers and Just Walk/Walk with a Doc participants. Specifically, I am interested in how this program informs the meanings we attribute to our own healthcare and the healthcare of others in our lives.

I. Demographic Information:

Name:
Pseudonym:
Male/Female/Age/Other:
What is your specialty?

II. Warm-up:
1. Can you share with me how the doc program started? (Probe for details: Why did it quit? Why did it start up again?)

2. What motivated you to start (and continue) the walk with a doc program? (Probe for details and instances)

3. How many Walk with a Doc events have you led? Details: Where, what (was entailed), when, who, why (probe location and recalled fellow participants).

4. What does an ordinary day at the Just Walk event look like through your perspective? Probe: Can you lead me through an event? Have there been changes? If yes, can you describe these changes? If no, why do you think that is?

5. Please share with me a story that led to your decision to share personal health information about yourself at the walk? (What goes into your decisions to share or not share information about yourself?)

6. Would you please share with me story about if and when a participant told you a health experience that made your alter your own healthcare choices?

7. Can you share with me how you come up with your choices to talk about certain health topics prior to the walk?

8. In your opinion, why do other docs get involved with this program?
9. In what ways do you believe your participation in the walk contributed to the health experiences of others? Why do you believe you have had an impact on them? (Probe: What advice have you offered another participant?)

10. In what ways has this program changed your views of what society tells us about being healthy? Is there anything about the Just Walk organization that shaped or informed your beliefs about good health? Probe for examples.

11. What does this program mean to you? Probe for concrete examples.

12. Can you share with me a time you provided information about a participant’s specific question? What made this interaction meaningful to you?

13. How does the fact that you are walking with a male or female participant affect your conversations during the walks? (Is there an awareness of similarities or difference?)

14. Can you share with me a story about a time when a participant at the Just Walk program highlighted or responded to your personal values and beliefs? Probe for specifics about personal standpoint.

15. What is your most memorable moment participating in the Just Walk program?

16. Would you share with me your favorite story about an interaction you had with a participant at the Just Walk?

17. Please describe for me a time when you felt uncomfortable with information a participant shared with you at the walk? Have you ever felt that a participant was uncomfortable with information she/he shared about your health? Please explain why you think that was the case. On the other hand, can you share a moment you felt comfortable with information shared with you?

18. In what ways does walking and talking with a participant differ from a traditional office visit? What value do you feel is gained from taking these walks? Can you describe any aspects of a regular office visit that is absent when taking the walks? (Probe: In what ways is the walk similar to a traditional doctor’s office visit?)

19. Is there anything about the locations of the walk that you believe contribute to your healthcare encounters with the participants? (Probe: public park versus hospital)
III. Physician’s Role [From Fieldnotes]: In this section of the interview protocol, I asked questions from conversations I have had in the past with the individual. Typically, I wrote out 3-5 questions prior to sitting down and speaking with the participant. However, some questions emerged during the interview process. I used this time to ask these questions and further probe physician’s responses.

20. Specific to the individual.

__________________________________________________________________

__________________________________________________________________

(Probe for instances and examples)

21. From our conversations,

__________________________________________________________________

__________________________________________________________________

(Probe for instances and examples)

22. ______________________________________________________________

__________________________________________________________________

II. Closing:

23. Is there anything I haven’t asked that you would like to share with me today?

24. Is there any question that you thought I would ask you but did not?

25. Is there anything that you would like to ask me?