Not Just Doctors: Woman-Dominated Health Work as a Site for Rhetorical Research and Professional Change

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Abstract: Feminist rhetoricians have long been interested in women and health work, but we have consistently focused on higher-status professional discourses in health care, especially the experiences of physicians. Drawing on interviews with three women of color working in tele-observation, this article models an approach for rhetorically attending to undervalued health work where women are in the majority. Tele-observers virtually monitor high-need hospital patients via video cameras in the patient's room, typically observing 6-8 patients at a time and communicating with them using a microphone. My findings discuss the tele-observers' training and preparation, their verbal communication on the job, and their physical experience of the virtual intensive care unit. I argue that to position women of color in all echelons of health care as changemakers would require transforming public attitudes towards training, prioritizing interprofessional communication, and decentering recruitment into high prestige professions in health fields. Feminist rhetoricians can lead the way in expanding our thinking about workplace representation from an emphasis on recruiting new women into high-paying health roles towards valuing and seeking professional opportunities for women who are already engaged in a range of health work.

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Tags: Rhetoric of Health and Medicine; Technology; Health Professions; Workplace Communication; Embodiment

The Black maternal health crisis has been in the public eye lately, particularly with high profile cases like the death of Olympic sprinter Torie Bowie and Serena Williams' life-threatening delivery complications (Cash). In the United States, Black women are three times more likely to die after giving birth than non-Hispanic white women (Hoyert), while making up less than three percent of physicians (Bajaj, Tu, and Stanford). These two facts are often articulated together as part of a narrative about the need to recruit Black women into medicine. Yet, as someone who recently gave birth in Milwaukee, I was struck by the number of Black women involved in my pre- and post-natal care—as medical assistants and technicians drawing blood, taking vital signs, and generally providing much of the data for my care. What about those women? As I further considered this experience while developing this article, I wondered: How might attention to women of color in all echelons of health work change how we enact equity both in terms of professional recruitment and patient care?

Feminist rhetoricians have long been interested in women and health work, but—just as our attention has historically been skewed toward North American white women—we have consistently focused on higher-status professional discourses in health care, especially the experiences of physicians (Kondrlik; Skinner; Theriot; Wells). One can see the logic behind such an approach—drawing on research on the pay gap (Fine 57) and the "leaky pipeline" for women moving into leadership roles (De Welde, Laursen, and Thiry 1), researchers focus on understanding rhetorical and social barriers to accessing high-paying roles. Biases towards professional roles that require four-year college degrees or more are also ingrained. Most researchers work in traditional academic spaces and, as a result, carry with them assumptions about what counts as desirable work (Rose xxxix).

In contrast, this article models an approach for rhetorically attending to existing undervalued health work where women are in the majority, such as Certified Nursing Assistants ("National Nursing Assistant Survey"). In doing so, I argue that women of color in all echelons of healthcare could contribute to reducing racial and cultural disparities in care. I draw on my findings from interviews and observations of seven tele-observers in a Virtual Intensive Care Unit in the Midwest. Tele-observers virtually monitor high-need hospital patients via video cameras in the patient's room, typically observing six to eight patients at a time and communicating with them via microphone. Six of the tele-observers in my study were women, three of them were Black or biracial, and together they represented a wide range of ages (20-60) and professional backgrounds. These included stints working as an airline customer service representative, special education teacher, small business owner, nurse, EEG monitor for stroke patients, lab technician, etc.

After reviewing existing feminist rhetorical scholarship on women in health care and introducing my field site, this article analyzes the material rhetorics of tele-observers and the material conditions that best support their ongoing employment. My findings discuss the tele-observers' training and preparation for their role in the VICU (Virtual Intensive Care Unit), their verbal communication on the job, and their physical experience of the tele-observer role. Drawing on these findings, I argue that to position women of color in all echelons of health care as changemakers would require transforming public attitudes towards training, prioritizing interprofessional communication, and decentering recruitment into high prestige professions in the health fields. Feminist rhetoricians can lead the way in expanding our thinking about workplace representation from an emphasis on recruiting new women into high-paying health roles towards valuing and looking for professional opportunities for women who are already engaged in a range of health work. Such opportunities might include but should not be limited to employment as doctors.

The Prestige Problem

While this article calls for a shift in how feminist rhetoricians conceive of and research women's participation in healthcare, I recognize that recent feminist rhetorical scholarship on women and work is already beginning to attend to working-class women. For example, in *Women at Work* (2019), editors Jessica Enoch and David Gold describe a nearly even split between chapters focused on working-class and professional-class women (6). Similarly, Lisa Blankenship's work on rhetorical empathy includes discussion of domestic worker Joyce Fernandes's social media campaign #Euempregadadomestica (I, Housemaid). This expanding view of what constitutes work and what work is worth studying is in line with my call in this article to consider women across the spectrum of health care employment.

Indeed, much of the historical research on women's rhetoric in health care takes female physicians as its primary focus. Carolyn Skinner, Susan Wells, and Nancy Theriot all examine rhetorical practices of women physicians in the mid-to-late 1800's. Meanwhile, Patricia Fancher, Gesa Kirsch, and Alison Williams also describe how the *Woman's Medical Journal* (1893) provided social networking for women in the profession and challenged sexist institutions, but rarely included Black female physicians as authors or readers ("Feminist Practices").

Undoubtedly, this historical rhetorical research is restricted by access to women's writing, as women in high prestige fields were more widely published. Still, the field's bias towards higher status health work carries through to scholarship on contemporary women in rhetoric and professional writing. Examples include Kristin Kondrlik's examination of women doctors' professional ethos in #Likealadydoc and my own research on rhetorical positioning of physician Dr. Carla Pugh ("MacGyver"). Meanwhile, Heather Falconer's case study of a Black woman pre-med student speaks to some of the challenges of recruitment and persistence for women of color in medicine (10). An important exception is Rachel Bloom-Pojar's and Maria Barker's research on *promotores de salud*, lay workers who provide reproductive health education for local Latino/a communities. The authors show how "promotores help connect immigrant communities with social services, and they make health information culturally relevant and linguistically accessible" (85). Their research demonstrates the vital rhetorical knowledge that can be gained by considering women in health care outside of formalized professional tracks.

Field Context

This research took place in a Virtual Intensive Care Unit (VICU) housed within a research hospital's health center in Menomonee Falls, WI. The VICU is a large, open room with approximately six nurse stations spread across the right side and a set of about eight tele-observation stations next to one another on the left side. The VICU nurses monitor high-risk hospital patients' medical charts and provide supervision and advice to floor nurses. They will also cover

for tele-ops [observers] if they need a break and can answer tele-ops' questions about patient context because of their medical chart access and co-location in the VICU.

Each tele-observer has a set of double computer screens and headphones at their adjustable desk; on their screens, they remotely observe six to eight patients at several different hospital sites and with different levels of need. Their job is to make sure that patients are not violating protocol by getting out of bed or otherwise disturbing their IV lines, oxygen tubes, or other interventions. To accomplish this, tele-observers are responsible for issuing a "redirect" when a patient breaks protocol, either by speaking verbally into a microphone connected to the room or pushing a button that issues an automated verbal command. If a patient does not respond to their redirect, the tele-observer may call a nurse or sound an alarm, depending on the situation's severity. Tele-observers also have a set of paper documents where they keep track of how often patients break protocol and their interventions.

During the summer of 2021, I spent twenty hours observing operations in the VICU, staggering my observations so that I could see different staff members at different times of the day and night. Initially, I planned to focus on the virtual nursing care team, specifically their use of a patient deterioration algorithm, a system which alerts providers when patient status is likely to decline based on a set of data points. However, I became increasingly interested in tele-observation, a position that did not require any formal education, though certification as a Nursing Assistant (CNA) or prior experience was recommended. Thus, I followed up with the clinic coordinator in summer 2022 to conduct virtual interviews with seven of the tele-observers in the VICU. This research was approved by my institution's IRB; in line with that approval, I keep the hospital network anonymous and use pseudonyms for my interviewees.

For the purposes of this article, I focus on my interviews with three women who self-identified as Black or biracial, since recruitment efforts often prioritize individuals with similar intersectional identities (Bajaj, Tu, and Stanford). However, when relevant I also draw on insights from my other interview participants, as well as observations gleaned from the twenty hours I spent observing the VICU. Below, I provide some context on the three women who will be the focus of this article.

Ava is a Black woman in her twenties who was pursuing a bachelor's degree in Biology at the time of this study, with the goal of becoming a Genetic Health Counselor. She received her CNA certification during college and had been working as a CNA in a clinic on her campus that served both resident nuns as well as high-need locals. The VICU position was her first virtual job, and she had been working there for one year part-time when we spoke. Ava and I met over Zoom and were able to interact through both video and audio during the interview.

Becca is a biracial (Black and white) woman in her thirties who had a wide range of previous experience in healthcare as a Certified Nursing Assistant (CAN) and a health aide, as well as in childcare and family care. She had been working in the VICU for four and a half years, alternating between full- and part-time work. At the time of the interview, she was working part time in the VICU and as a medical aide while studying for a degree in social work. She had a young child who she carried with her around her house for most of the interview, and we paused occasionally so she could attend to the child.

Finally, Darilyn is a Black woman in her forties who had been working in the VICU for two months when we spoke. She had held a wide range of prior health care positions, including as a phlebotomist, a triage coordinator, and as a CNA. She was working part time at the time of the interview. We spoke over the phone rather than over video, so I had less access to her expressions and movement while speaking.

Interview and Observation Findings

Drawing on my interviews and observations in the VICU, this section analyzes the material rhetorics of tele-observers' work and workplace. I discuss tele-observers' preparation for the job, verbal and written communication practices on the job, and embodied experience of the VICU. These findings provide grounding for the subsequent discussion section, where I attend to how under-valued health workers' material rhetorics can help feminist rhetoricians transform our thinking about enacting equity in professional recruitment and patient care.

Training and Preparation for Tele-Work

In the white-collar roles that are often the focus of gender and health work scholarship, training is long-term and sequentially organized, with workers deciding early in their educational lives their field of work and then investing years into acquiring appropriate credentials. In contrast, training and degree requirements for the tele-observer role were minimal. During their first two weeks of work, participants received training and mentorship during their regularly scheduled hours, focused primarily on learning the technical systems for the job. All three women in this study had CNA certificates, but several interviewees did not. Tele-workers instead relied on years of related and adjacent experience in health care, customer service, education, and more to inform their practices on the job.

When asked about training for the position, most participants described a focus on the technology they would be using, including the video monitoring system and the auditory system that allowed them to use a microphone to speak into the patient's room. Participants also noted that understanding medical terminology and hospital operations were necessary for their day-to-day practices, but that they either came in with that knowledge or learned it on the job. Prior

knowledge that supported the tele-op role, then, came primarily from participants' previous experiences, both learning in formal educational programs and prior employment.

Ava and Becca were currently enrolled in degree programs, and Becca reflected that her social work courses supported her ability to contextualize patient experiences, saying:

> Somewhat understanding why people do the things that [they] do, commit, or try to commit suicide. Or the reasons why. It's just so many different forms of mental health out there [...] So I'm kind of seeing how people act it out in the emergency rooms or in the different hospitals.

Here, Becca draws a connection between what she is learning about different mental health diagnoses in her classes and their enactment by patients on the screen. Seeing her patients "act out" the different diagnoses helps her to contextualize the experiences of her patients. Similarly, Ava's CNA coursework contributed to her empathy for the patients she was observing. She explained: "If you first walk into a room and patient's arguing, they're cranky, you're just like 'oh this person's mean,' but then you don't think about, 'hey they're in a lot of pain, they're under a lot of stress, they might be trying to figure out how they're going to pay for this treatment.'" While Becca described learning to contextualize mental illness, Ava's lessons were more holistic, focused not just on how a patient's diagnosis might influence behavior, but also on their external lives and experiences.

On the other hand, several participants offered specific examples of the ways their physical experiences with patients in healthcare contexts gave them the embodied rhetorical knowledge to intervene with patients on their screens. Becca, who was also working as a medical aid, explained that her direct patient experience gave her interventions urgency: "If the patient's sitting in the poop, you know, kind of understand not what the feeling is but what you should do in a better way pretty much […] I can be quick when I need to." Becca's embodied encounters with patients in a hospital context, then, prompt her to intervene quickly. In a similar way, Darilyn described a situation where the patient had what looked like yellow cream all over their protective mitts. Even though she could not see the color clearly on the screen, she reached out to the nurse, noting that the location of the fluid on the back, shoulders, and mitts cued her into something being wrong. It turned out that the liquid was blood, and Darilyn credited her prior work as a CNA with helping heighten her awareness of the problem, even though the screen distorted the situation.

Overall, participants drew flexibly on their prior education and experience to inform both their physical and emotional rhetoric with patients in the VICU. Prior embodied experiences were far more influential to their practice than formal credentialing or on-the-job training. As I discuss later, this points to a need for feminist rhetoricians to attend to health professionals outside of four-year credentialed positions, since formalized education creates both financial and logistical barri-

ers that limit who we consider to be workers and what we consider to be work.

Communication on the Job

To enact change in a workplace, especially in terms of patient advocacy, individuals need to communicate effectively about a patient's status to an entire healthcare team. One of the biggest challenges in medical contexts is that data-driven evidence and claims are often much more highly valued than claims based on embodied or intuitive knowledge (Campbell & Angeli 356). For tele-observers, knowledge of patient needs was often born of careful observations of patient behavior over a period of many hours. In fact, they were restricted from access to data: the tele-observers were not authorized to view patient charts. Thus, when they sensed something was wrong and needed to communicate that to a nurse, it could be difficult to persuade their team.

The tele-observers were encouraged by both their site manager and one another to "trust their gut," and yet, that did not ease the process of persuading a healthcare team to intervene with a patient. Another interviewee, Ginny, a white woman in her fifties who had worked in the VICU for two years, explained: "I think as human beings we communicate on so many levels that we're not even aware of. So it could just be the facial expression on someone that you've been watching that because you've been watching them for eight hours you notice a change and then you'll click on that room." These small changes often show up before the data-oriented tracking—before the telemetry machines know that a patient is crashing, for example. They are also more difficult to articulate to a nursing team.

In general, the tele-observers had to navigate several communication challenges when interacting with their patients and the floor nursing staff. With patients, tele-observers recognized that they were a disembodied voice in the room issuing directives and that, depending on the patient, they could expect a range of reactions. Some participants described using the patient's name in an initial redirect, modeling language for me like, "John Doe, could you please sit down?" (Ava). Ava explained that using their names helped patients to know that the instruction was directed at them, especially for disoriented patients. Other observers seemed more comfortable relying on automated redirects, however, rather than speaking personally to the patient. Darilyn, for example, said that she primarily used the automated messages and would only use her own voice if there was not an appropriate automated message. She felt that patients responded better to the recording.

Meanwhile, when it came to communicating with nurses on the floor, tele-observers navigated a precarious balance between reaching out to nurses for updates when necessary but also not bothering a harried team who often seemed inconvenienced by the tele-observers. The nurses were on twelve-hour shifts, while tele-ops were on eight-hour shifts, meaning that nurses'

hand-offs to the tele-ops—when they provide an overview of the patient's status and needs—did not align with the hand-offs they give to incoming nurses on the floor. In addition, tele-ops had the authority to remove cameras from a patient's room after a period of inactivity, but nurses often wanted to keep the camera in the room for an added layer of security. Becca explained that tele-ops have a script available to them for when they need to notify nurses that a camera is being removed. This script frames the removal as a directive rather than a request, helping to combat the challenging power differentials of the conversation:

> Your patient has had very little interventions in the last twenty-four hours so we're going to pull the camera. And most times they'll say, 'well we have a doctor's order' or 'we had interventions' but they're not on our sheet, so we just have our [VICU] nurses take a look at that and we'll give them a call back.

In Becca's explanation, we can see how relying on nurses' updates about patient interventions creates gaps in tele-ops' knowledge. Thus, the tele-ops leverage personal relationships with nurses in the VICU to help navigate a difficult conversation with nurses on the floor, gaining legitimacy through this relational support.

In general, the tele-ops were in a difficult position of having extensive patient knowledge that helped them to recognize subtle problems alongside communication challenges and workplace structures that limited their ability to act on that knowledge. In immediate interactions with patients, they could rely only on verbal communication to redirect patient action. Meanwhile, when reaching out to nurses, they were faced with power differentials born of both information differences (data vs. intuitive knowledge) and educational differences.

Embodied Experience of the VICU

While the tele-observers faced several communication challenges, they also frequently reflected on how relaxed and comfortable this job was compared to their previous roles in healthcare. Becca described the atmosphere as "laid-back," while Ava noted, "I wouldn't say it's stressful, it's a very relaxed feel. We can get up; we can stand at our desks too." Several of my participants mentioned the availability of standing desks and workout equipment when I asked about their physical experience of the job. This was interesting, in part, because while the nursing team on the other side of the room was almost always standing at their desks, I never saw a tele-observer standing during my observations.

Meanwhile, in terms of their emotional experience, participants also commented on the reduced emotional load enabled by their virtual presence. Ava, comparing her experience to working as a CNA with the nuns on her campus, noted, "I would say emotionally, my CNA job was very demanding because many of the sisters were lonely, so I was their only source of outside connec-

tion." I asked all participants whether they ever felt like they wanted to "reach through the screen" while working and received split responses. Of this sub-group, Ava and Darilyn said "no," while Becca said "yes." Ava noted that her instinct when a patient needed intervention was to try to get a nurse there quickly. However, she emphasized, "I try not to take this home with me because we're not doing so much for them emotionally." Meanwhile, Darilyn expressed some sadness about her futility, "You just wish that they wouldn't do things, you know certain things, hurt themselves. I just act as urgently as I can to help them." In contrast, in her response, Becca repeated twice that she "want[ed] to help more": "If they're going to fall, I want to kind of catch them, but the stat alarm doesn't really work because most times in two of the hospitals they can't run there fast enough."

In part due to the perceived low physical and emotional load of these jobs, many participants indicated an investment in staying in the positions long term. This was buttressed by the fact that the positions had good benefits that participants could access even if they were working part-time. Darilyn commented that she "hope[s] to stay here," while Becca, who was in school for social work, noted: "I would say I would never leave it because when I'm ready to retire I can pick and choose what I want so, as long as you stick with OPT [optional part time], you'll be good." Other participants made similar observations about their ability to stay on into older age. Knowing that retention can be a huge problem for marginalized workers, the fact that the tele-observer role was one that participants could imagine fitting into their lives for the foreseeable future is significant.

Learning from Woman-Dominated Health Work

Drawing on my conversations with Ava, Becca, and Darilyn, I argue that we can leverage the presence of women of color in all echelons of health work to help address racial and cultural disparities in care. However, this will require transforming how the public thinks about training, interprofessional communication, and recruitment in health fields. Feminist rhetoricians can contribute to these efforts through ongoing attention to and publicization of the experiences of under-valued health workers.

Implications for Training

The barrier to entry for tele-observer work was low, with a recommended CNA certification that could be waived for workers with appropriate experience. This is important because low-cost community college options for certification are often difficult to access ("Spring 2023"). In fact, one of my participants described how her career goals changed due to limited access: "I was actually going to look into becoming like a surgical tech. And then the one main class for that […] was booked up for the next two years, so I was like, 'well I'll just put that aside for now' and then I ended up getting the job with social services" (Evie). Overall, formal educational re-

quirements can create significant financial and logistical constraints for workers. Meanwhile, when public institutions cannot provide access to certification, private institutions step in. In this way, demanding formal certification for health work can both limit access and require participation in predatory for-profit institutions that target first-generation students and people of color (Cottom 186-7).

An alternative would be to find more consistent ways to value and "count" worker experience towards professionalization. As I discussed, tele-observers in my study relied heavily on communication strategies and embodied knowledge from their previous work experience, in addition to formal coursework. Other countries with more robust investment in vocational education training are far ahead in developing systems that recognize and value this workplace experience alongside formal coursework. For example, in 2018, Finland revised its vocational education programs to broaden the contexts in which students can acquire qualifications, including increased opportunities for on-the-job learning (Rintala & Nokelainen 114). Looking to similar models could help health care employers and educators in the U.S. to think expansively about how we define qualifications for different types of health work. Feminist rhetoricians can contribute by drawing attention to the complex rhetorical knowledge that individuals gain outside of formalized education and through a range of workplace experiences.

Implications for Communication

I was stunned to learn that the tele-observers did not have access to patient health records and impressed by their ability to rhetorically navigate complex interprofessional relationships without that access. They relied heavily on their own documentation as well as the knowledge of the nurses in the VICU to argue for removing patient cameras. Their lack of access to the health record also compounded their disadvantages when advocating for patients. Nurses were likely to brush off their concerns in part because of educational differences. Evie captured how the differing levels of access and expertise shaped communication between tele-ops and nurses: "[The nurse] is just seeing that patient for a few minutes at a time […] where I'm monitoring that patient that whole time. So I'm the one who has, I guess not more education, not a better/higher degree, but I'm witnessing and noticing more." Tele-ops struggled with this combination of less educational standing and limited chart access, but more embodied patient knowledge. Therefore, when calling a nurse to alert them to a problematic change in patient behavior, they had to rely on intuitive claims that are often not as persuasive in medical contexts (Campbell & Angeli 356).

If we are to leverage the embodied, intuitive knowledge of a wide range of health providers—letting the perspectives of women of color become part of the conversation—we need to consider how to elevate their voices in interprofessional contexts. In the case of tele-observers, granting access to patient charts and including tele-observers' notes in the patient record—rather than isolating this information on paper documents—would go a long way. Feminist rhetoricians,

meanwhile, can value the important rhetorical work that tele-workers and individuals in similarly undervalued roles perform by attending to it in our scholarship and calling for change. In addition, more effort to incorporate interprofessional communication training for both nurses and tele-observers could help to support trust and open communication between the two groups. Tele-observers who had worked in previous health care settings noted how their knowledge of nurses' experiences helped them to collaborate effectively with this group. However, floor nurses also need to understand the tele-observers' experiences and limitations so that trust can be mutually established. Meanwhile, as I have argued elsewhere, rhetoricians of health and medicine can play an active role in contributing to such interprofessional communication training ("Rhetoric of Health" 7).

Implications for Recruitment and Retention

I want to end with the question that began this article: how might attention to women of color in all echelons of health work change how we enact equity both in terms of professional recruitment and patient care? A simple answer is that perhaps we might look to an existing workforce of Black women already engaged in patient care when we consider *who* to recruit. However, just recruiting marginalized individuals into prestige positions is not enough. A more complex answer is that we must consider how future health care positions can reflect some of the specific advantages of the tele-observer role that made it an appealing long-term option for many of my participants. Feminist rhetoricians can contribute to building an understanding of the material rhetorical experiences that facilitate ongoing professional engagement and success for women of color.

My participants could imagine themselves working in the VICU long-term because their physical and emotional distance from the hospital floor helped them to avoid burn-out. Economic historian Claudia Goldin argues for the need to "make flexible positions more abundant and more productive" (15). While clearly health care is still going to require in-person work alongside virtual roles, we might look to careers like Ava's and Becca's for a vision of the future—working part-time in person in a hospital setting and part-time virtually. Both participants noted how these dual roles helped them to feel both emotionally engaged and present with patients and to avoid exhaustion. And, indeed, their workplace experiences helped them to be better virtual providers as well.

Finally, choice has a positive effect on the workplace experiences of tele-observers. They could stand or sit; work out or not; use the voice recording or speak directly to patients. These options gave them flexibility and the ability to alter their workplace practices in response to their unique rhetorical positioning and needs. Considering what it might look like to integrate similar elements of choice into health care work should be a priority.

The shifts I am calling for here are by no means small. They call for transforming the ways we think about work and education broadly to help us to recognize the gaps in our existing frameworks. A first step might be more feminist rhetorical scholarship attending to the everyday embodied rhetorics of women in less prestigious health roles. What else can we learn from attending to the material rhetorics of under-valued women health workers? Where else are we failing to look? Who else are we forgetting to include when we study the rhetoric of women's health work? And how might listening to these groups help us to transform the ways we think about concerns like recruitment and the Black maternal health crisis in a variety of professional fields and contexts?

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