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Amplifying Rhetorics of Reproductive Justice within Rhetorics of Health and Medicine

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This dialogue works to situate Rhetorics of Reproductive Justice (RRJ) within Rhetorics of Health and Medicine (RHM) to explore how these two areas might enhance and inform one another. Through conversations with eight scholars who see their work as creating connections between RRJ and RHM, and through a series of reflective, interstitial comments, this dialogue examines current and future possibilities for work that bridges RRJ and RHM, and critically links RHM scholarship to social injustices reproductive bodies encounter.

KEYWORDS: rhetorics of reproductive justice, rhetorics of health and medicine, amplification, social justice

Introduction

The COVID-19 global pandemic, coupled with radical policies under the former Trump administration, have endangered the reproductive health and rights of millions of individuals across the U.S. At particular risk are LGBTQIA+ communities, communities of color, indigenous communities, and other historically marginalized groups who experience health disparities and intersectional inequalities at rates dramatically higher than their white counterparts. While the Biden administration promises to ease the hostile, ultra-conservative reproductive policies of the Trump era, many individuals and communities across the country continue to face significant challenges—among them abortion and contraception access, Medicaid coverage (which offers millions of low-income individuals family planning services), and access to quality maternal healthcare (Guttmacher Institute, 2020).

The policies outlined above are just a few examples of attacks on reproductive justice—or "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" (SisterSong, n.p.). The term "reproductive justice" was coined by a group of Black women in 1994 after a conference in Chicago was held to outline a Clinton Administration proposal for healthcare reform. The dearth of Black women in attendance and lack of Black perspectives in the proposed policies brought the Black women in attendance together; they then formed the "Women of African Descent for Reproductive Justice." We build on the work of these Black women to define *rhetorics of reproductive justice* (RRJ) as the study of how discursive activities mediate individuals, groups, and communities as they work to address the "intersecting oppressions" and "power systems" (SisterSong) that influence reproductive bodies and related healthcare policies. We see RRJ as a concept that can be deployed by rhetorical scholars as a theoretical framework, as a guiding methodology, and/or as a form of social activism.

Because the work of reproductive justice (RJ) scholars, activists, and allies is so urgently needed, this is an opportune time to call for rhetoricians of health and medicine to more thoroughly cultivate, sponsor, and enact RRJ work. Although, as this dialogue illustrates, there are many scholar-activists already doing work at the edges of rhetorics of health and medicine (RHM), the field has yet to make critical space for this work. We hope this dialogue begins the process of "forging a space" (Mckoy, 2019) and shifting our thinking more toward subfields like RRJ that have an

explicit and intentional focus on social justice, activism, and community engagement. As the *Rhetoric of Health & Medicine* journal editors' 2020 "Response to Racial Injustice" rightly points out, RHM must more deeply "commit to do more and better in cultivating, sponsoring, publishing, and promoting scholarship that addresses racism and interlocking systems of oppression as public health (and/or other health or medical) issues." We see RRJ as a vital way in which RHM scholars can, indeed, take up this call and bring the work of social justice more meaningfully into RHM.

Thus, the goal of this dialogue is to begin the process of "forging a space" within RHM by offering readers a curated conversation among eight scholars who see their work as amplifying rhetorics of reproductive justice within RHM contexts and as creating critical space in the field for such work. As these scholars and their work illustrate, RRJ can benefit from RHM's explicit focus on health, healing, illness, and wellbeing—particularly as it applies to how reproductive bodies are mediated in socio- and biomedical contexts. In turn, RHM can benefit from RRJ's emphasis on social justice, community outreach, and engaged activism—particularly as it applies to Black, Indigenous, People of Color (BIPOC) communities. In short, we see enormous value in putting together these distinct, yet complementary, areas of inquiry in one disciplinary "room" so that we might see what kinds of rhetorical knowledge-makings emerge.

A Brief Review: Where the Field is Now

While the subfield of RHM has increased its calls for social justice and engaged activism (Scott et al., 2020; Novotny, De Hertogh & Frost, 2020; White-Farnham, Finer, Molloy (Eds.), 2020), there remains much work to be done, particularly in light of the Black-led social justice movement in the broader field of TPC. Recent workshops like "Black Technical and Professional Communication" hosted by Virginia Tech's English Department, for instance, serve as models for more inclusive dialogues and spaces in related subfields like RHM. For us, RRJ is a praxis that can help make RHM better aligned with social justice work, particularly regarding the reproductive experiences of BIPOC. As RHM scholar Kimberly Harper put it as we were developing this dialogue with her, we must all strive to "broaden the conversation about race and the importance of 'seeing color.'" We see RHM as a dynamic and rich field and as an ideal location for fostering such conversations and intersectional work.

To date, much of the overlap between RRJ and RHM scholarship has happened loosely, if not serendipitously. Marika Seigel's (2013) groundbreaking book, *The Rhetoric of Pregnancy*, was one of the first books in technical communication to analyze concerns of interest to RHM scholars engaged in reproductive justice work. More recent work in the field has started to connect these areas of scholarly inquiry more explicitly. In *Writing Childbirth: Women's Rhetorical Agency in Labor and Online*, Kimberly Hensley Owens (2015) explained that her book "contributes to understandings of feminist rhetorical agency" and to "everyday rhetorics of health and medicine." And Erin Frost and Angela Haas's (2017) article "Seeing and Knowing the Womb" applied a technofeminist methodology to reveal the sociopolitical implications embedded within the fetal ultrasound; in doing so, they call for critical rhetorical interventions in seemingly common reproductive healthcare practices.

More recent work has further solidified connections between RRJ and RHM. For example, Bethany Johnson, Margaret Quinlan, and Nathan Pope's (2020) recent article published in this journal examines how self-disclosures of in vitro fertilization treatment via social media platforms help patients find social support outside of traditional healthcare settings. Sharon Yam's (2020) article on visualizing birth stories likewise called upon rhetorical scholars to adopt a reproductive justice framework to better understand the sociocultural forces impacting reproductive lives. We have also seen our own work become more openly situated in both areas of inquiry. In our most recent collaborative book chapter entitled "Rhetorics of self-disclosure: A Feminist framework for understanding infertility activism" (Novotny & De Hertogh, 2020), we drew from concepts in feminist rhetorical studies, rhetorics of health and medicine, and reproductive justice to argue that self-disclosure is a critical component of infertility activism.

What these examples illustrate is that reproductive justice is a critical area of inquiry within RHM and one that needs more support as the field forwards its commitment to diversity and inclusion. As both a social justice practice and as a rhetorical framework, reproductive justice advocates argue that safe and sustainable access to reproductive health is determined not just through healthcare systems, but are often also determined by the very communities in which we live. By drawing upon this reproductive justice framework, we shift prior RHM conversations about reproductive health towards a more inclusive framework that sees the reproductive body as always already navigating, negotiating, and fighting the socioeconomic,

racial, and homophobic barriers limiting care. We, therefore, see this dialogue as an important step in beginning the process of examining current and future possibilities for work that not only bridges RRJ and RHM, but also embraces the commitment to intervene in interlocking systems of oppression.

Amplifying RRJ within RHM

A major thread running throughout this dialogue is *amplification*. We use the word "amplify" to describe ways dialogue contributors see their scholarship as amplifying marginalized reproductive health experiences within rhetorics of health and medicine. In using this term, we draw from Temptaous Mckoy's (2019) concept of "amplification rhetorics," or the process of "forging a space" for marginalized voices, contributions, and lived experiences within a broader scholarly field. Although Mckoy's notion of amplification rhetorics focuses specifically on Black voices and experiences, this concept helps us describe the kinds of activist, social-justice-oriented work all of the contributors bring to this dialogue. Moreover, because the reproductive justice movement was founded by Black women, we see amplification rhetorics as an appropriate framework for thinking about how RRJ can be further enhanced and developed within RHM.

This said, it would be negligent of us to not discuss amplification as a complex practice. At its core, amplification is messy and requires care in its application. As a practice rooted in womanist theory, McKoy explained that amplification is not just validating a marginalized experience, but is also making space to hold others accountable to knowing a lived experience, even if the listener who is told about that experience does not self-identify with it (2019, p. 45). Amplification requires that we, as listeners, reflectively ask what our role is in knowing that lived experience.

McKoy's discussion of amplification leads us to understand it as both a micro and macro practice. We suggest that micro amplifications happen in the moment of learning a new truth, a new lived experience previously misunderstood, misrepresented, or silenced. Macro amplification, for us, demands accountability on a collective scale —not just passive acknowledgement recognizing that truth. In contrast, we define micro amplification as an act signifying accountability yet often occurring only on an individual scale. In the dialogue below, we demonstrate amplification on a micro and

macro level. Micro, in that many of the contributors speak to how they—through their research practices—amplify marginalized experiences pertaining to reproductive health. Macro, in that assembled, we find exigence in the need for us as RHM researchers to attend collectively, as a field, to the inequities our micro research reveals.

In order to best amplify a range of RRJ voices and experiences within RHM, this dialogue features the work of eight scholars, each of whom offers a multidimensional perspective and a unique lens through which to see how RRJ scholarship and activism can forge social justice spaces centered around reproductive health within RHM. They also represent a range of backgrounds and interests and are at various stages of their careers and within RRJ/RHM projects. As we as the lead authors discussed the voices we wanted this dialogue to include, we made careful choices about inviting scholar-activists who find themselves working at intersections between RRJ and RHM and who represent diversity and inclusivity, both in terms of their own lived experiences and in their areas of scholarly inquiry. Because the two of us position ourselves as white, cisgender women—and because the reproductive justice movement was forged by women of color—we were committed to crafting a dialogue that represents and honors diverse voices and experiences.

Thus, this dialogue features the work of the following scholar-activists, each of whom sees their work as creating critical space for rhetorics of reproductive justice within an RHM context.

- Lora Arduser and Mark Hannah
- Kimberly Harper
- Sheri Rysdam
- Barbi Smyser-Fauble
- Melissa Stone and Stacey Pigg
- Shui-yin Sharon Yam

Each of these contributors forge a space within RRJ and RHM in unique and influential ways. Lora Arduser and Mark Hannah, for instance, examine relationships between endocrinologists and transgender patients, while Kimberly Harper researches Black maternal health in community spaces. Sheri Rysdam looks at the rhetorical work of doulas in childbirth settings, and Barbi Smyser-Fauble researches how digital spaces shape public perceptions of reproductive technologies. Melissa Stone and Stacey Pigg

offer a portrait of what effective mentorship in RRJ/RHM spaces looks like, while Shui-yin Sharon Yam investigates the implications of gender inclusive language use within the reproductive justice and rights movements.

During the summer of 2020, we invited these contributors to reflect on and share how they see their scholarship forging and amplifying RRJ within RHM. Returning to those conversations, we noticed five main themes grounding how each contributor approaches their work to amplify the aims of reproductive justice:

- Our bodies orient us to reproductive justice work
- Why reproductive justice work matters to RHM
- Rhetorical methods and methodologies can amplify reproductive justice
- Sustaining an RRJ + RHM space
- Future sites for furthering RRJ + RHM

In what follows, we model the micro and macro goals of amplification by walking readers through various moments when contributors have had to grapple with decisions about their work, expertise, and embodied positionalities in order to amplify reproductive justice goals. At the end of thematic sections, we underscore and synthesize key points and insights contributors have in common to illustrate how we as a field might adopt specific practices to support the amplification of RRJ within RHM. Like Laura Gonzales and Rachel Bloom-Pojar in their *RHM* dialogue, "A Dialogue with Medical Interpreters About Rhetoric, Culture, and Language," we see these crisscrossing observations as a co-construction of knowledge—as a weaving together the various narratives, practices, and moments of amplification happening across these conversations as well as the scholarly and activist spaces our contributors inhabit.

A Dialogue Among RRJ & RHM Scholars

Theme 1: Our bodies orient us to reproductive justice work.

Amplification of RRJ with RHM can start by becoming aware of how our bodies orient us to the various embodied knowledges, lived experiences, and relationships we have with reproductive justice. Critical awareness of these orientations can serve as "in-roads" to amplifying a space between RRJ and RHM.

Lora and Mark: We first collaborated on an article for a special issue of *Technical Communication Quarterly*. The article is "Mapping the Terrain: Examining the Conditions for Alignment Between the Rhetoric of Health and Medicine and the Medical Humanities" (2018). We are now working on a project that examines what we are calling "practitioner nuance," using the work endocrinologists do with transgender patients as a case study.

In general, healthcare treatment of transgender people requires a multidisciplinary approach in which endocrinologists play a crucial role (see T'Sjoen et al., 2019). More specifically, endocrinologists, who work with issues regarding the body's hormones, need an ability to communicate across medical sub-expertise areas (like obstetrics, gynecology, internal medicine, and pediatrics), and we call this communicative capacity "practitioner nuance," or the ability to translate transgender-related fertility issues across these various specialty areas. To better understand the role of such specialized expertise in communicating fertility rights language for transgender individuals, we designed an interview study with endocrinologists that will be coupled with textual analyses of professional and public documents regarding transgender reproductive health. This analysis will offer a much-needed perspective not only on the status of reproductive justice for transgender individuals, but also on the type of medical training needed for positioning practitioners to respond competently to transgender reproductive issues they encounter in their work. The rhetorical work of translating and applying such expertise through careful patient engagement intersects with RHM interests in patient centered care, in particular in valuing patient's embodied expertise.

The two of us bring different, yet complementary sensibilities to our collaborations. Lora's research is situated in the rhetoric of health and medicine. Mark's research is situated at the intersections of technical and professional communication, law, and expertise studies. At the same time, both of us are interested in questions of empowerment, social justice, agency, and expertise.

For Lora (who has spent years as a scholar in RHM) and Mark (a former attorney and now scholar examining the intersections of law and rhetroic), their professional experiences orient them uniquely to their work with transgender

individuals. As they remark, they are able to meet the aims of their project—which are rooted in the intersections of health, the law, and expertise—because of their backgrounds and knowledges that they collectively bring to the project. Their professional experiences offer deeper insight into embodied knowledge can be surfaced in fertility clinic.

Kimberly: Right now, I am working to create a Black maternal health center in Greensboro, NC. It is tentatively named the Sankofa Birth Network (SBN). I am the founder. I envision SBN as a place where women can receive reproductive health and maternal health services, such as breast cancer screenings, mammograms, and prenatal and postpartum support in the form of parenting classes, wellness classes, lactation classes, and a host of other things.

I arrived at this topic because of a birth trauma that I experienced with my first child. It is my personal belief that I could have died due to the amount of blood loss I experienced after giving birth. In addition to my birth trauma, when I was in need of postpartum care for my depression, there were no resources available to me. I lived in a small, southern town.

As I continue to raise my children, I'm heavily interested in ways to rectify the judicial system in this country. I have a son who will become a Black man in America. If we do not find a way to hold police accountable for the violence they perpetuate in Black communities and other communities of color, I do not know what this world will be like for my 5-year-old in 20 years. As I type this, I am infuriated and angered by the death of another unarmed Black man at the hands of vile police officers. I am incensed at the racial profiling that Black citizens encounter by white, citizen police, and I'm at times defeated because I don't know what to do to help the country I call home. So my interest is personal.

Barbi: I am currently working on a project that examines how digital spaces (like Twitter) work to inform and shape public perceptions about the use of reproductive technologies. Specifically, I am examining how social media debates can position "three-person IVF" (a reproductive technology that uses a form of gene manipulation) as being a technological advancement that is both

progressive and discriminatory—depending upon the viewpoint and positionality of the individual(s) discussing or commenting on them. In my research, I examine how this technology can be identified as "progressive" for furthering the principles of reproductive justice by creating more "paths" to parenthood for more individuals. However, this same technology can also be identified as "discriminatory"—particularly for those who identify as disabled—because it can cause people to question "what lives are worth living."

As someone who has worked in the medical industry (as a pharmaceutical sales representative for eight years), I have always been interested in how discourses of medicine (procedures, studies, technologies, pharmaceuticals, etc.) shape public perceptions about identities—how an individual's identity can be disregarded or dismissed based upon a medical diagnosis, involvement in a study, throughout the course of a treatment, or because of an assumed expert/non-expert status about medical knowledge of a body.

Then, when I experienced my own medical journey with infertility (as well as other journeys with family members impacted by other diagnoses), I learned firsthand how embodied knowledge and my own narratives were often dismissed as being "emotional" or unrealistic. Thus, I saw how even when someone had a background and knowledge about the ins and outs of medical discourse (interpreting data and clinical trial information), I still struggled to be a valued member of the medical team. This experience was fascinating and infuriating as I was the one experiencing this journey—my body was the one undergoing a variety of treatments and procedures. Thus, fighting for a position as a valued member with important input for the discussion was challenging, but it also taught me valuable lessons. From these different life experiences, I was drawn to research that focused on how people are informed about a medical diagnosis (where and how they get information), how they talk about it (are they redefining access, reclaiming space for valuing embodied knowledge, progressing reproductive justice, or reinforcing stereotypical and excluding practices), and which stories (narratives) are the ones that are expected and which ones are being silenced or erased from the conversation (devalued or disregarded).

Reflecting on this conversation, we learn how "embodied knowledges" amplify connections between RRJ and RHM. For instance, both Barbi and Kimberly share how their lived experiences motivated them to pursue RRJ and RHM work. What strikes us in these examples are how embodied knowledge and lived experience expand the purview of bodies in health and medicine, reorienting our focus towards moments when the body is marginalized. By joining RRJ and RHM, we see more explicit attention to (and as we see it a call to intervene in how) bodies that are often underserved, misunderstood, and at times, dismissed all-together by healthcare providers.

Sheri: Currently, I am working to amplify a volunteer doula program that I was a part of for six years, both as a volunteer doula and as a coordinator for the volunteer doula program. My goal is for the program to be better understood and for its positive aspects to be implemented in other institutions and communities.

I am trained as a rhetorician and as a doula, so combining these two areas of expertise seems natural. When it comes to rhetorical justice and/in rhetorics of health and medicine, I always write about doula work and/or the childbirth setting. I am also interested in this area because I am a new mother who has been navigating healthcare's birthing spaces firsthand.

Sharon: I am currently working on a project with Natalie Fixmer-Oraiz that examines gender inclusive language use within the reproductive justice and rights movements. This project is a response to the high rates of birth trauma and prevalence of medical and social discrimination against non-normative birthing people as well as the racial disparities in maternal mortality and morbidity in the U.S.

The completion of my book *Inconvenient Strangers* coincided with a time when my partner and I were having intense discussions on whether we wanted biological children. Because we both felt so ambivalent about that, my researcher training kicked in, and I started gathering different kinds of information on pregnancy and birth: from podcasts like *The Longest Shortest Time and Birth Monopoly*, to compiled peer-reviewed research on Evidence Based Birth and the Guttmacher Institute. In this process, I realized that my hesitance to have children stems from a deep fear of birth, and dominant ideologies and expectations about mothers

and motherhood that are often pronatalist and reinforce biological essentialism.

In sum, I did not arrive at my current research agenda through professional conversations in rhetorical studies. Instead, my research on doulas, advocacy, and RJ is a confluence of the feminist adage "the personal is political," and the argument Laura Briggs made in her latest book, *How All Politics Become Reproductive Politics*. While this project stemmed from my seemingly personal anxieties and fear about birth, it in fact has always been connected to political issues and systems of power—such as gender, race, and immigration—that I have been passionate about.

Sheri and Sharon's work illustrate how personal, lived experiences often inform the kinds of amplification and advocacy work RRJ/RHM scholars find themselves doing. In Sheri's case, her experiences as a new mother navigating hospital birthing spaces informs her work as both a doula and a researcher. Sharon finds that she and her partner's ambivalence about parenthood shapes the kinds of RRJ/RHM research she pursues and the areas of inquiry she hopes her work amplifies. The two of us are struck at how our relationality to RRJ/RHM work influences how research projects develop; something that may be important as we develop our projects and in how we mentor emerging scholars interested in this work.

Stacey & Melissa: We are working together through a messy project of creating a knowledge foundation in an emerging subfield of an emerging field. I (Stacey) am the "advisor" in this process and Melissa is the "graduate student," but as both experience and research show, advising a project and mentoring are not the same activity. I (Melissa) am currently working on my doctoral dissertation and Stacey is chairing my committee. My dissertation project frames menstrual healthcare as a feminist rhetorical issue. While much work has been done with reproductive healthcare in the area of feminist rhetorics of health and medicine, it seems to me that the topic of menstrual healthcare needs to be taken up more directly.

Coming up with the approaches, methodologies, and methods for this project has been a difficult task for Stacey and I because there is such a lack of scholarship in rhetorical studies of health and medicine that deals with menstruation directly. We, thus, realized that my dissertation was well-positioned to create

a foundation from which to study menstruation from a feminist rhetorical perspective. Coming to this conclusion about my dissertation really has been a joint effort on mine and Stacey's part, which I believe is indicative of a professional feminist mentoring relationship. As Stacey mentioned earlier, advising and mentoring are not at all the same. For me, advising an academic project is more about directing someone in what they should or should not do, while mentoring an academic project is more about guiding someone, understanding their personal goals and motives, and being willing to learn from the mentee in addition to imparting expert knowledge on the mentee. In our case, we are working in the realm of mentoring rather than advising.

The intersection of this topic with the rhetorics of health and medicine came later in my (Melissa's) life when I began a graduate degree in English. Pursuing a PhD and working with Stacey both in coursework and on other academic projects has helped to make the intersection of menstrual healthcare and rhetorics of health and medicine flourish even more.

Stacey and Melissa's conversation emphasizes mentoring and relationship-building as key elements to amplifying work that bridges RRJ/RHM scholarship. As scholars interested in mentoring future RRJ/RHM work, we are drawn to the "behind the scenes" mentoring moments shared by Stacey and Melissa. In particular, their dialogue reveals how complicated and messy it can be to develop "a knowledge foundation in an emerging subfield of an emerging field." This point makes us wonder how others both develop projects and situate reproductive justice work in RHM?

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Theme 2: Why reproductive justice work matters to RHM.

RHM as a field can amplify and aid macro-advocacy efforts supportive of reproductive justice.

Kimberly: Black women still have a higher chance [than white women] of dying from childbirth. So, looking at that from a rhetorical perspective, I started asking myself, "What can I do to help

empower other Black women?" And that's where, for me, the conversation of rhetoric and the rhetoric of health and medicine comes in. Because Black communities have traditionally had a very negative relationship with the medical establishment. Look at the Tuskegee experiment, for example.

Ultimately, I feel like what we do for Black women can serve all women. While it's Black maternal health, it is really maternal health because when you change the baseline for Black women and women of color, *all* women benefit.

Lora: Serving all women is an important point. In our project, we are still in the process of interviewing the endocrinologist. But I do think that implicit bias is going to be something that we come up against and encounter, particularly with the type of language that clinicians use.

Mark: Yes, just to add to Lora's point. I was really drawn to Kimberly's statement about "serve all women." How does that phrasing resonate in the public, within the endocrinologist community, or even within the transgender community? This idea of who's being served.

Lora: And I think that the amplification idea is really interesting for me, because I see our project as being much more firmly grounded in RHM than in reproductive justice, but I think in what we're doing, we're amplifying the goals of reproductive justice by focusing on the transgender population.

Stacey: Something that Lora said resonated with me. In thinking about Melissa's project, it's been easier to situate what Melissa is doing through an RHM lens than a reproductive justice one. Not that that's not there, but I think that there's been a tension in trying to think about how to position the project and deciding exactly where and when the kind of advocacy moment, and amplification moment happens in the project. So that is something interesting to think about . . . where and when the moments of emphasizing the reproductive justice lens evolve in the creation of a project and a career, and a knowledge foundation in the long term.

Something that stood out about this conversation is not only how these scholars situate their scholarship within RHM, but how they can also see that work as "amplifying the goals of reproductive justice." It was interesting for us to observe Kimberly, Lora, Mark, and Stacey form connections (however tentative and incipient) between these areas and to also frame those connections in terms of amplification, service, and the creation of a "knowledge foundation" for other scholars in the field. Seeing these connections emerge is an important consideration for RHM scholars who likewise see the rhizomatic nature of their scholarship and activism within an RRJ/RHM framework.

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Theme 3: Rhetorical methods and methodologies can amplify reproductive justice.

Rhetorical methods and methodologies can support the amplification (and often advocacy) of reproductive justice. For instance, embracing reproductive justice in rhetorical studies asks the field to critically engage with how rhetorical scholarship can respond to contemporary crises (such as the forced sterilization of women of color reported by the ACLU) to broader discussions related to the role of ethos and expertise in reproductive justice work. Contributors grappled with the extent to which our disciplinary training can amplify the goals of reproductive justice.

Sharon: As I was reading some of the reflections offered by Melissa and Stacey prior to this conversation, I also was thinking about these questions. Specifically, does scholarship that mobilize an RJ framework, as a theoretical or analytical framework, necessarily have to also prescribe a qualitative ethnographic research method? I don't have a concrete answer to that, but I can think of one example drawing from my own work.

I recently wrote an article for a transnational feminism journal. In the article, I applied the RJ framework to understand how Hong Kong activists, protestors, and people in their everyday life have been dealing with the tear gas and the use of tear gas as a public health crisis. I ended up organizing the article by pillars in order to make the argument that RJ as a framework can be used to analyze transnational activism and social movement. So in this particular case, I did not do any community-engaged work, nor

did I do ethnographic studies, but nevertheless, I would consider that to be an example of RJ scholarship. And so I guess that it will be a counter-example to thinking about RJ from a strict ethnographic method.

Barbi: I think what Sharon offers is a really interesting point because I do think there's this focus on experiential knowledge [in RJ], that it always has to be grounded in qualitative approaches to things. So it's also interesting to think about when you're looking at something that's more quantitative or like a textual analysis. Where you're looking at, not necessarily, individual experiences, but how text or different parts of language, or the quantification, the terms, and definitions are actually prescribing certain approaches to medicine, or to other aspects. These quantitative elements are items that are such a large part of medical discourse, and while reproductive justice discussions work hard to emphasize the value of experiential knowledge (qualitative data), individuals should not avoid quantitative elements.

Identifying how many times someone is referenced as a person, or as a human being versus as a means to get data, for example, is an interesting way to engage with quantitative data. Doing this type of research is not necessarily something where you're accounting for a human experience, but you're looking at how language is defining how individuals are identified. So, this research is using quantifiable data to illustrate how technical documents can work to dehumanize individuals, which can impact the value of their stories (their narratives) and their value as "partners" in medical care. So, I mean I do think that there is a sort of . . . it's an expectation (the need to focus on qualitative and not quantitative data) that doesn't necessarily have to work that way. But it's an interesting dynamic.

Stacey: Yes, let me backup to explain where our thinking about the link between qualitative work and RRJ emerged. In relationship to Melissa's project, I found myself wondering: is it even possible to do rhetorical reproductive justice work without an ethnographic qualitative orientation that uses participatory action research or other means that lead to direct community benefits?

Participatory action research seemed most likely to ensure that research would be shaped by, and eventually benefit, communities outside academia, rather than circulating only within academic circles.

However, this is a problem for Melissa's project because she is enrolled in a graduate program that funds 4 years. If you haven't experienced this timeline as a student or advisor, it's brutal. Students generally finish comprehensive exams at the end of year 3 and then have one year for dissertation research and writing. It's doable, but alters what research and writing are possible and creates significant challenges to participatory research. One is the significant amount of time that Melissa needs to spend theory-building. The second is her lack of an already established connection to a community group or activist organization where mutual trust was already established. Both of these issues are related to lack of time and resources. Most of Melissa's desires for direct community-based research have been put on to her "after graduation" list, which poses issues for working in this field.

Melissa: With Stacey's mentorship, we decided that my dissertation would be focused on building a theoretical project with the hopes of using that to amplify voices and create a more inclusive community in which to study and address menstruation. I want my project to focus more on critically engaged ways of DIY making. Due to the funding and time constraints involved with pursing a PhD, this isn't something I am able to do right now, but in the future I hope to create some sort of feminist critical making community (whether that's through workshops, teaching, interactive conference presentations, DIY videos, etc.). I want my future work to have goals and motives for intervening in negative legacies about menstruation and menstrual health.

What Sharon, Barbi, Stacey, and Melissa's comments illustrate is that there is an underlying assumption that reproductive justice work must use qualitative, ethnographic (or even community-based) methods to be considered activist work. These four scholars push against that assumption and make convincing arguments for how more theoretical, rhetorical work contributes to amplification and

knowledge-making just as equally as qualitative research. We think these points are significant to RHM scholars who want to pursue RRJ projects that do not use qualitative or community-engaged methods.

Mark: Something that I've been thinking about in the context of our conversation is the nature of RJ as being community-centric. And for Lora and I, we're really interested in this idea of expertise, how expertise is deferred to a client or a patient within a community. And reading everybody's comments in the Google doc, there was some attention to or description of expertise. Like being heard or not being heard as someone with expertise dealing with medical issues. In the context of rhetoric studies, there seems to be an implicit assumption that we are to defer our expertise to non-experts like patients, or to our stakeholders or partners. How do we make that deferral more explicit in the context of RJ work, like in our methodological choices? How do we articulate it, or verbalize it, and move it from the implicit to the explicit?

Lora: That was actually a question that I had for you, Sheri, because of your own position in terms of your project. You have various types of expertise, and you bring expertise from all of these areas. And I wonder how you kind of negotiated that. You're a doula, you're a mother, so I'm wondering, how does it inform your research, and how does it challenge your project? Being an expert in all these different areas.

Sheri: Well, it's evolved over the years because my experiences have changed. When I first started doula work, I didn't see it as part of my rhetorical work. However, after the first training, I began to see how rhetoric is happening and often really intensely happening. Yet, it's not being named. Now, though, over the course of time and experience, I have a really strong ethos attached to my work as a doula. That is a huge benefit, I think. For instance, as a doula, I use rhetorical ethos to build my expertise both in the hospital room or the birthing place and in my scholarship. My ethos allows me to be more effective at amplifying injustices that I have experienced by writing about them, and sharing those and talking about how,

for example, I recently wrote about how we can use rhetorical strategies to help improve consent in the childbirth setting. And that's directly related to my experience and being able to share stories about what I see and what has happened.

Lora and Mark's questions concerning how expertise amplifies RRJ and RHM work are particularly poignant, especially given Sheri's response to Lora's question. For Sheri, expertise is something that is gained through time and experience. Additionally, Sheri's use of rhetorical ethos "to build . . . expertise both in the hospital room or the birthing place and in . . . scholarship" aids her in situating herself as an expert—a rhetorical move that allows her "to be more effective at amplifying injustices." For us, we see expertise and ethos as interwoven rhetorical gestures that, when deployed in reproductive health settings, can amplify moments of reproductive justice.

Lora: I think Sheri's ability to draw on her own experiences to amplify injustices in reproductive health spaces and scholarship is important and a thread that unites many other scholars represented in this dialogue. However, I do feel like Mark and I are kind of outliers because we don't have the same sort of experience that I think a lot of folks have either being a doula or working with the different centers. Neither of us are endocrinologists, so we're outliers that way. Instead, I've been thinking about this work as amplification in that Mark and I occupy more ally positions. Specifically, if we contextualize our project as an ethnographic research project, I guess rather than being participant-observers, we would be acting from an observer stance.

Such a stance has allowed us to think a bit more about *vulnerability*. Transgender people are particularly vulnerable in seeking medical care, a vulnerability that carries over from daily life and a factor that doctors must account for in their delivery of care. We surmise that doctors with uncertain expertise have a modicum of vulnerability or operate from a position of vulnerability too. Theirs is not an equivalent form, type, or scale of vulnerability, but there is a vulnerability associated w/ operating outside one's expertise area. There is a hesitancy, caution, or risk-taking that characterizes decision-making that stems from uncertainty. Ultimately, the

doctor-patient relationship based on a bilateral or a shared experience of vulnerability refigures the doctor-patient relationship that has been examined extensively in RHM and Medical Humanities research.

Barbi: I think Lora's point is important because a lot of us have different or complex identities that we're bringing into the research, or different perspectives that maybe we don't see as either an advocate only, or ally only. I know for my project on "three-person IVF", I occupy unique positions. I'm someone who's gone through the infertility journey; I've done IVF. I've worked with reproductive endocrinologists. I've also been a pharmaceutical representative where I was taught to understand, present, and discuss data in clinical trials, and saw how data was presented with a variety of different positions in terms of how they not only continue to talk with patients, but also how they continue to choose medications or do what was "best" for someone else's body.

My work tries to draw from some of that experience, but I also know that I can't fully experience things from some of the positionalities that I'm trying to write about. I think we need to consider these different viewpoints and recognize the limitations of our own embodied experiential knowledge to value more knowledge. This may mean that while I'm trying to do this sort of allyship advocacy scholarship, I also need to recognize and account for the reality that I can't speak to all of these things. However, I might have a platform that affords me some agency to amplify someone else's voice and experience.

This conversation illustrates how RRJ/RHM scholars often "occupy unique positions" in the research spaces they inhabit and in terms of how they see their scholarship amplifying reproductive justice work. For Lora and Mark, their amplification work happens through allyship with the transgender endocrinology community by paying attention to the various and complex experiences of vulnerability and expertise, whereas Barbi's research embodies intersections between her lived experiences and previous professional work as a pharmaceutical representative. What this conversation illustrates is that the amplification of reproductive justice work in RHM can take many shapes and forms, ranging from

more traditional scholarly approaches to qualitative work that grows out of personal, lived experiences.

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Theme 4: Sustaining an RRJ + RHM space.

Collectively, there is consensus that for rhetorical work on reproductive justice to matter, we must make this scholarship accessible or applicable to broader publics. Reproductive justice work—at its heart—is about bodies and the communities that bodies live in. RHM, if it is to amplify RRJ, must then imagine what challenges, hesitations, and resistance scholars may encounter in wanting to do this work and develop reflective practices that can account for how our research empowers the subjects of our work: the people and the communities they live in.

Lora and Mark: As our research presented in the *TCQ* [*Technical Communication Quarterly*] article pointed out, RHM scholars are interested in moving their work beyond the confines of their scholarly fields and into spaces of practical healthcare delivery. Our work with endocrinologists is an example of a site of practical health care delivery. In terms of RJ work for transgendered individuals, our work has implications for policy (i.e. informing guidelines endocrinologists use) and medical training.

Our project also disrupts RHM research on doctor-patient relationships by exposing not only the vulnerability of patients, but also the attendant vulnerability of doctors in RJ work.

Barbi: I feel that the future implications of my current RHM/RJ project could be to consider how a reproductive technology impacts more people in multiple ways—what are the negative (excluding, further marginalizing, and discriminating) effects, as well as the progressive (advances to help support more people on their infertility journey). And, as stated before, I think that this research will continue to foster interest in RHM and RHM scholars will continue to examine how technological advances can have both positive and negative implications (like 23 and Me or IVF) and how societal norms and prejudices can be reflected in how a reproductive technology is used and who has access to the reproductive technology.

Melissa: One thing that is *very* important to my work with menstruation is attending to careful language use when referring to menstruating bodies. In my work, I choose to use the term "menstruator" to get away from the historical and pervasive use of gendered pronouns when referring to menstruators. So much of the language used to refer to those in systems of reproductive health frame experiences like menstruation, pregnancy, menopause, etc. as "women's issues." While I understand there are practical reasons for this, it also means that queer folks who have fraught relationships with the normalized idea of what it means to be a "woman" might be excluded from accessing important reproductive health knowledge and support.

Kimberly: I would like to think that my work will impact health care providers who serve Black women and women of color. I hope that my work on the ethos of Black mothers will start conversations and, in some way, inform implicit bias training for medical professionals. Within the academy, I would like to see my work broaden the conversation about race and the importance of "seeing color."

Sheri: My hope is that my work will be read and understood by healthcare professionals, students, teachers, and rhetoricians alike, so that these concepts can be enacted in childbirth settings and even forwarded to other relevant spaces. I hope that this work leads to better health outcomes and more positive birth experiences for women.

Sharon: As a community-engaged researcher, I think the future implications of this project are two-pronged. On the one hand, because this research compiles and organizes effective advocacy tactics doulas from different positionalities engage in, it validates the embodied knowledge and practices of birthworkers, while serving as a guide to doulas and doula training organizations who may want to expand their repertoire.

On the other hand, this project reminds researchers in rhetoric to be open in the co-creation of meanings, including the redefinitions of rhetorical concepts. For instance, in my case, I used

to word "advocacy" in my interview questions a lot initially, until I realized that it carried very different and sometimes highly contentious connotations for doulas, depending on where they received their training and their positionality. While doulas might refuse the label "advocate," a lot of their actions were about helping their clients express their needs, and to have those needs met by medical providers—which, as a rhetorician, I would consider performances of advocacy. My own definition of "advocacy" and what it entails have morphed beyond the way it is defined in current rhetorical scholarship as a result.

Reading these remarks, it is clear to us that all of the contributors hope their scholarship has meaning "beyond the confines of their scholarly fields" and contributes to work in healthcare settings. Still, as Sharon reminds us, there also appears to be an inherent appeal for RRJ/RHM work to contribute to reproductive advocacy and amplification.

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Theme 5: Future sites for furthering RRJ + RHM.

There is rich potential in amplifying RRJ within RHM for areas like embodied or material rhetorics, interdisciplinary work, and community-engaged projects. Each of our contributors shared what they see as future implications and applications for forging new RRJ spaces within RHM scholarship. The contributors identified additional areas and sites where RHM scholarship could continue to amplify reproductive justice.

Lora and Mark: The year 2020 has proven to be a challenging year to say the least, and we've witnessed an intensification in public discussions about issues of justice, equity, rights, and the like. Attention to law's role in addressing these issues similarly has increased, which has motivated us to consider how law intersects with issues of reproductive justice. Can rhetorical investigations of these intersections provide new pathways for bridging RRJ/RHM scholarship?

Relatedly, issues of self-disclosure (which Maria and Lori Beth argue is critical for infertility activism) become increasingly precarious in RRJ and RHM dialogues in terms of defining who

"counts" as a woman. Future investigations that broaden this definition, therefore, can make these activist conversations more inclusive.

Kimberly: I take from this conversation the urgency for action surrounding topics associated with RRJ/RHM activism. It's clear we have the data, theoretical frameworks, and methodologies that support "why" this work is important, but our healthcare system and other related areas are slow to keep pace. So, for me, this conversation represents the need to empower people at the grassroots level. As such, it is imperative that we continue to push for incorporating more community-driven advocacy models that emphasize allowing patients to define and help create healthcare systems that are more equitable and empowering.

Sheri: I gave birth in a hospital setting at the end of 2019, just before the pandemic hit U.S. soil. I was able to have my chosen attendants at my birth. However, since the pandemic began, hospitals have reduced the number of visitors, and in some cases, banned visitors altogether, including birth doulas. The pandemic is causing more people to give birth alone, and sometimes the result of disaster capitalism is the permanent implementation of bad practice. As we navigate safe childbirth during a pandemic, and in its aftermath, I hope that we take the opportunity to reimagine and create new and improved birth spaces that allow people to safely give birth on their own terms.

Barbi: 2020 has presented a variety of challenges to matters of equity and social justice for some individuals, and with the most recent appointments to the U.S. Supreme Court, it appears that the challenges for reproductive justice could intensify. These challenges, along with the points made throughout the important discussions in this dialogue, reinforce the urgency and need for more action associated with reproductive justice activism. As scholars and activists for change, we should place a stronger focus on amplifying the work of those who are doing the grassroots work to make legislative and policy changes. We should also do more to amplify the work of underrepresented and marginalized positionalities and

experiences to ensure that these perspectives are valued and a driving source for positive change.

Melissa and Stacey: Even before the pandemic, mentorship for work in rhetorics of reproductive justice was complicated. We need to draw from TPC's models of feminist and networked mentoring to address the complex and multiple forms of disciplinary, theoretical, methodological, policy, embodied, cultural, and community expertise needed to create scholarship that advocates for more just reproductive health practices. To do so, we should be thinking about how to prepare new scholars to create broad networks of support, including relationships to activists and practitioners outside academia that help hold them accountable for who and what their scholarship serves. We also should not downplay the importance of mentorship for strong theory-building, which remains crucial to enacting social justice work in the rhetoric of health and medicine.

Sharon: COVID-19 has intensified the precarity people face in the medical industrial complex in the U.S. Unsurprisingly, the pandemic disproportionately affects Black and brown people. For instance, journalists have reported on the strategic use of Black and brown birthworkers to support their clients and community while hospitals limit support personnel for birthing people (Turner, 2020). This moment calls for us to further interrogate and articulate how grassroots advocates who work in the community challenge dominant rhetorical practices in health and medicine that perpetuate harm. While doing so, we must also invent and enact ethical research methodologies that hold ourselves accountable as rhetoricians of health, medicine, and reproductive politics.

Not surprisingly, nearly all of the contributors commented on the impact COVID-19 has had on amplifying inequities and racial disparities in accessing healthcare and health information. Reproductive health is not invulnerable to the effects of the pandemic. New exigencies have emerged as a result of the precarious environments we have been forced to navigate during this time, and, as a result, has left contributors asking: what is our role as researchers? This question

is not unique to RHM nor to RRJ. However, by asking this question, we may be able to reimagine not just the sites of where we "do" reproductive justice research, but how we go about this work ethically and, more importantly, how the outcomes of this research offer better care for those who are in need of help.

Conclusion

The development, writing, and revision of this dialogue has occurred nearly over a year. Yet, we are struck at the continued relevance and increasing exigency of our call to amplify RRJ within RHM. Reproductive bodies continue to be policed, stigmatized, regulated, and surveilled.

Because of these violences, the key concept we hope readers take away is that RRJ presents, as Sharon Yam pointed out above, a unique opportunity for RHM to further "invent and enact ethical research methodologies that hold ourselves accountable as rhetoricians of health, medicine, and reproductive politics."

One way to achieve such a goal is through a deeper engagement with rhetorics of reproductive justice and with the theories, methodologies, and social justice focus that this area of inquiry pioneers. We also hope this dialogue encourages those working at the fringes of RRJ/RHM to explore how their work might enrich RHM scholarship and forge within the field research practices that better cultivate, sponsor, and address "racism and interlocking systems of oppression" (Molloy, Melonçon & Scott, 2020). We conclude with a call for RHM scholars to put their scholarship into conversation with issues pertinent to reproductive justice. By doing so, RHM scholarship may better support the necessary actions needed to confront the systematic harm imposed on reproductive bodies.

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