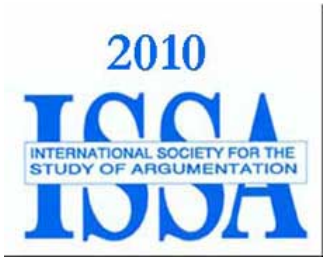
ISSA Proceedings 2010 – Widening Applications Of Phronesis In The Clinic And Beyond



1. Introduction: The Rapprochement of Medicine and Argumentation

A fortuitous rapprochement of the epistemological foundations of medicine and the kinds of communication and argumentation involved in its dissemination to patients is currently underway (Jenicek, 2009; Jenicek and Hitchcock, 2005). However, this rapprochement **[i]** has focused primarily on mapping the various attributes of argumentation in the clinical setting under the rubric of "clinical judgment" as a practice of physicians (Feinstein, 1967; Montgomery, 2006). It has not added much by way of detailing the aspects of patient argumentation and decision-making both with physicians and in contexts beyond the clinical setting. Utilizing Joseph Wenzel's (2006) tripartite understanding of argumentation, I argue that current theories of medical argumentation focus on the development of an adequate "procedure" (p. 16) for determining sound clinical judgments or "products" (p. 16). Despite a recognition of the relationship between medicine and rhetoric (Leach, 2009; Lyne, 2001; J. Poulakos, 1987; Segal, 2005), medical practitioners and argumentation theorists have largely ignored the "process" (Wenzel, 2006, p. 15) of medical argumentation, its rhetorical or sausive dimension, especially in terms of patient reasoning, argumentative practice, and therapeutic performance. This is a problem, especially given such central bioethical constructs as respect for autonomy and informed consent, both of which require a reasoning, arguing, and active patient (Beauchamp and Childress, 2009; Faden and Beauchamp, 1986).

What's more, given the current rise in chronic conditions as well as their attendant modes of treatment, a conception of patient activation enhanced by communication skills and appropriate therapeutic habits of self-care seems both relevant and essential to modern medical practice. Understanding patients as mutual agents in their own health network is a central aspect of the Chronic Care Model (CCM) that has for some time been seen as the best model for delivering health care to chronic patients (Wagner, 1998) as opposed to the acute model

that often seems to fail them (Kleinman, 1988; Morris, 1998). All of this points to the idea that patient skills and long-term habit formation, topics central to early debates about diabetes management (Feudtner, 2003; 2005), have not received enough attention in contemporary medical practice. Given that patients have a specific experiential relationship to their bodily states (both in times of health and when faced with disease) and that their treatment often involves more than simply following the advice of their physician, health practitioners are in need of a concept of patients as caregivers that accounts for their involvement in the clinical encounter as both decision-makers and rhetors. Such activities fall under the category of "lifestyle management" (Zylinska, 2009) through which patients seek to address their chronic disease conditions through the cultivation of skills, habits, and communicative acumen.

In this context, I argue that health practitioners are in need of an open conversation about the rhetorical or process-based elements of patient self-care. These elements include doctor-patient communication, patient self-criticism and analysis, the patient's belief in the possibility for change, and the communication and material enactment of therapeutic options by patients in consultation with the network of health care professionals tasked with their care (McTigue et al, 2009). In this regard, I am augmenting work already done by Sara Rubinelli, Peter J. Schulz, and Kent Nakamoto (2009) to define the role of the patient as something distinct from that of the health professional (p. 308) and involving some level of self-awareness (p. 310). Throughout the rest of the paper, I agree with them that the capacities of the patient to engage in her own care "must be re-grounded in the individual's existential experience" (2009, p. 308) rather than in the expertise of the physician.

What mode of rhetorical activity and its associated theories of knowledge and action are essential elements in describing the patient as caregiver for and of the self? Far from developing a separate notion of the "rhetorical" for the patient in the clinical setting, I instead want to argue in favor of a fusion of rhetorical activity and medical practice, thereby filling out the rapprochement between medicine and argumentation theory mentioned above. For contemporary bioethics and medical practice, the term that seems to get at this relationship is *phronesis* (often translated as practical wisdom). *Phronesis* has played a central role in contemporary debates about the nature of medicine because it is a form of knowledge that involves ethics, daily habits, lived experience, and deliberation, all

essential elements of achieving and maintaining health (especially in the context of chronic disease). In discussions of this term in the context of medical practice, the primary focus tends to be on the physician as knowledge-accumulator or clinician and knowledge-producer or researcher (Beresford, 1996; Davis, 1997; Jonsen and Toulmin, 1989; Tyreman, 2000; Waring, 2000; Widdershoven-Heerding, 1987) with only a few authors acknowledging the role of the patient (Rubinelli, Schulz, and Nakamoto, 2009). The physician is viewed as the primary member of the doctor-patient dyad when it comes to medical knowledge and its application to particular cases. Therefore, adequate medical training, whether *phronetic* or not, is seen as the primary means through which to make medicine both more effective and more ethical in practice (Dowie, 2000; Kinghorn, 2010; Rees, 2005). The patient plays a supporting role, left to either accept or decline the description (diagnosis) of her situation and select from various options for treatment. In such a model of medical argumentation, rhetoric is rendered as a strategic tool, a means through which to produce arguments that might convince the patient to take action as opposed to enhancing the patient's capacity for self-activation and self-care.

Of course, there are risks associated with critically interrogating the role of the patient in her own care and viewing the patient as equal partner in the rhetorical domain of the clinical encounter. The more we interrogate the rational basis of patient decision-making, the more we potentially bolster arguments against the widening scope of patient autonomy in contemporary bioethics research (D.H. Smith, 1996). However, given current trends in disease etiology and epidemiology, the gap in contemporary medicine in terms of implementing medical practices that allow the patient to act as a co-creator of her own health must be addressed. I believe that *phronesis* can contribute to filling this gap. I side with the defenders of *phronesis* as one part of medical practice but see their lack of concern for patient *phronesis* as an invitation for theoretical and practical innovation. In the next few sections, I engage in a kind of "casuistic stretching" (Burke, 1984, pp. 229-232) of the concepts of *phronesis* and the patient in order to articulate a mode of medical praxis specific to the patient and helpful in contemporary efforts to address chronic disease.

2. Defining Phronesis *as Rhetorical Action*

In this section, I endeavor to uncover the relationship between *phronesis*, rhetorical action, and the material performance of the healthy life as constitutive

elements in the overall *good life* for patients. I do this because one of my goals is to more adequately describe the rhetorical encounter between patient and physician as well as define the discrete communicative, suasive, epistemic, and ontologic parameters for both. Put another way, thinking of *phronesis* rhetorically allows for the theorization of patient performance of good communication about her health, of health activities as such, and of habit formation through self-reflective modes of deliberation. Of course, the topic of phronesis has been discussed in a variety of fields, most notably in rhetorical studies where a vast array of different perspectives can be found (Aune, 2008; Farrell, 1993; Hariman, 2003; Self, 1979; D.L. Smith, 2003; Zickmund, 2007). However, despite this extensive work, the direct connection between medicine and rhetoric at the site of *phronesis* and in terms of patient decision-making and self-care has not been adequately articulated. However, a conception of patient *phronesis* with which I largely agree has found space in discussions of patient pedagogy. Rubinelli, Schulz, and Nakamoto (2009) argue in favor of a model of patient *phronesis* that is not a "pale shadow of the professional's expertise" but rather one that "allow[s] the patient to be a patient; interacting with health professionals effectively (asking the right questions) so as to enhance their health and, in a real sense, taking ownership of it" (p. 310). The rest of this section details a conception of *phronesis* largely in agreement with Rubinelli, Schulz, and Nakamoto (2009), in order to set up what I view as the theoretical contribution of this paper – patient *phronesis* as a form of rhetorical interaction and habit formation necessary for the production of health, especially in terms of chronic disease.

According to the classical Greek tradition, there are at least three forms of knowledge: *episteme* or scientific knowledge, *techne* or craft knowledge concerned with the production of things, and *phronesis* or practical wisdom concerned with decision-making in the realm of contingency (Jonsen and Toulmin, 1989; Nussbaum, 2001). It is Aristotle who gives us the most robust conception of *phronesis* or practical wisdom fitted for everyday experience. Following Martha Nussbaum's (2001, p. 120) articulation of Aristotle, I argue that *phronesis* is an "anthropocentric" conception of knowledge based on the notion that individuals can and do have access only to those things that can be perceived by human beings, a revival of the Protagorean teaching that "of all things the measure is man" (*Protagoras*, trans. 2001, Fragment 13). Living as a human means seeing as a human, acting as a human, and accessing knowledge of the world as a human. Nussbaum (2001), speaking about the important distinction between *phronesis*

and *episteme* in Aristotle, writes that "truth *in* appearances, is all we have to deal with; anything that purports to be more is actually less, or nothing" (p. 291). While Aristotle does speak of craft knowledge (*techne*) and knowledge that goes above and beyond the world of contingency (*episteme*) throughout his work, he utilizes substantial space in his treatises on rhetoric, ethics, and politics to deal with *phronesis* or that particular brand of human understanding that is based on navigating the appearances and contingencies of daily life. Many scholars have noted the Aristotelian concern with appearances or *phainomena* and their relationship to the conception of *phronesis* that he defends (see, e.g. Farrell, 1993; Nussbuam, 2001). While such a form of knowledge is principled in the sense that it often involves a kind of application of generally accepted frames and guiding concepts (Jonsen and Toulmin, 1989, p. 307), it is fundamentally about deliberative excellence, about the capacity for argument and rhetorical skill in deliberating about decisions that must be made, "in a concrete situation pervaded by uncertainty" (Davis, 1997, p. 186). As Aristotle points out in his *Nicomachean Ethics*, "the prudent man in general will be the man who is good at deliberating in general" (trans. 2003, VI. v. 2), and "things whose fundamental principles are variable are not capable of demonstration, because everything about them is variable" (VI. v. 3). In other words, *phronesis* deals with the general good for individuals in their context as human beings (i.e., contingency). This is a category of knowledge that does not admit of absolute certainty (as in the case of *episteme*). Most important, following Nussbaum's (2001) understanding of Aristotle's vision of *phronesis*, is its connection to *eudaimonia* or human flourishing (for her translation of the term, see p. 6). *Phronesis*, on this view, is fundamentally about excellent deliberation, decision-making, and action in moments of contingency in pursuit of *the good life*.

Given its concern with deliberative excellence and the world of phenomena, it should come as no surprise that many scholars (Farrell, 1993; Nussbaum, 2001) see connections between *phronesis*, deliberative excellence, and the art of rhetoric. Writing about this connection, Lois Self (1979) notes that "there are important theoretical and practical relationships between rhetoric and *phronesis* and it is the man of practical wisdom who has both the capacity and incentive to be an ideal practitioner of the Aristotelian art of rhetoric" (p. 143). Below, I show that the architecture of both the art of rhetoric and the application of wisdom in moments of contingency (*phronesis*) are fundamentally related. To do so, I draw on Trevor Melia's (1992) tripartite definition of rhetoric that involves ontological

("world view"), analytical, and productive elements (p. 100). What I offer is a description of a rhetorically inflected conception of *phronesis* that is best fitted to a discussion of medical decision-making and care from a patient perspective. I do this in order to show that at least one crucial element of treating patients in the clinical setting, whether dealing with a chronic or acute condition, is the ability of the patient to engage in suasive communication, excellent deliberation (both self-other and self-reflective), and the formation of adequate habits for the production and maintenance of health. Of course, many others have articulated the connection between *phronesis* and rhetoric. My hope is to offer a rendering of the concept that is best fitted to patient care of the self.

Phronesis is an ontological state. Rhetoric has an ontological scenery or "world view" that roots human existence within the realm of contingency (Melia, 1992, p. 100). It involves an ontology concerning "things which seem to admit of issuing in two ways" (Aristotle, *Rhetoric*, trans. 2000, I. ii. 13). It therefore demands a certain character in the form of the rhetorician who accepts her existence as contingent upon an ever-changing world. Likewise, *phronesis* involves a certain character or disposition (*hexis*) that allows the individual to make informed choices and act upon them (Nussbaum, 2001, p. 324). As Aristotle points out in the *Nicomachean Ethics*, knowledge of deliberation as well as its excellent manifestation in action are essential for the *phronimos* (or that individual that is wise). Therefore, *phronesis* involves the adoption of a view of the world from a human perspective in moments that admit of being otherwise. For these reasons, *phronesis* involves ontology in two senses: (1) the *phronimos* exists in a state of being in contingency (a point that it shares with rhetoric) and, (2) the *phronimos* exhibits a disposition or character that is constantly being revised due to new experiential inputs (involving knowledge of *the good life* as well as excellent deliberative skill).

Phronesis is a method of analysis. In his *Rhetoric*, Aristotle defines the art as fundamentally analytical: "its function is not so much to persuade, as to find out in each case the existing means of persuasion" (I. i. 14). Here, rhetoric is viewed as a method for sizing up a situation and/or audience (Bitzer, 1968). In a very similar sense, *phronesis* deals with internal deliberation and considered action as well as the application of experiences to individual cases. One can see a clear connection here between Aristotle's definition of rhetoric and his conception of ethical and medical deliberation in his *Nichomachean Ethics*. In the case of

rhetoric, one is looking for the elements of persuasion. In the case of *phronesis* and for that matter the art of medicine, one is looking for the elements of right action in response to the particular case, both in terms of human biology and ethics. In my rhetorically inflected version of *phronesis*, supported by Aristotle's own conception of *phronesis* (as involving the skills of deliberation), this form of knowledge is about finding the right course of action in a particular case through self-persuasion and the persuasion of others. This requires the capacity to correctly size up a situation and compare it to other situations experienced in the past. As Joseph Dunne points out, "each new act [of the *phronimos*] arises within the terrestrial magnetism of our past acts which lie sedimented in our habits" (p. 111).

Phronesis is a mode of production and performance. Among other things, rhetoric involves the creation of suasive discourse for a specific audience. Phronesis is also about performance, but in this case we might think of it as the performance of good character and excellent deliberation (Hariman, 1991; Nussbaum, 2001; Self, 1979; Schwarze, 1999). To display *phronesis*, one must have both the right disposition as well as the ability to act based on that disposition (Aristotle, *Nicomachean Ethics*, VI. v. 6). It is in the work of one of Aristotle's contemporaries, Isocrates, that we find the most compelling defense of *phronesis* as a mode of action and a means to build *ethos* (credibility) for the rhetor. Iscorates engages in just this kind of activity by writing speeches in which he, according to Stephen Schwarze (1999), performs *phronesis* for his audience. This understanding of Isocrates' work as engaged in developing a theory of *phronetic* performance has been noted by several prominent rhetorical theorists (see, e.g. Depew, 2004; Haskins, 2004; T. Poulakos, 1997). Whether we attribute the possibility of *phronetic* performance to Aristotelian theory or Isocratic speech writing, the point remains the same. *Phronesis* is a rhetorical and embodied performance of *the good life*.

3. Phronesis*, Health, and the Art of Medicine: The Detractors*

The rapprochement of argumentation and medicine referenced earlier has been made possible, at least in part, due to the cooperative work of Milos Jenicek and David L. Hitchcock (2005) who have written a wonderful text on clinical argumentation. However, when it comes to considering the role that *phronesis* might play in clinical practice, they are skeptical. They define *phronesis* as "the process of knowing and doing, experiencing and acting, undertaken by a

physician on behalf of a particular patient in a specific clinical situation and setting" (Jenicek and Hitchcock, 2005, p. 273). This seems very close to the conception of *phronesis* adumbrated in the previous section. It includes the necessity of experience, the changing parameters of practice based on different individual needs, and the importance of both theory and practice in the effective application of medical knowledge to the everyday happenings of the clinic. They argue that "like the basic sciences (*episteme*) learned theoretically and the medical art (*techne*) acquired by clinical training, *phronesis* is learned through both theory and practice, and this book aspires to contribute to it" (p. 254). So far, so good; however, they end up rejecting *phronesis* as a central term for the practice of physicians: "Medical examination, diagnosis, prognosis, and treatment are not forms of praxis guided by practical wisdom about the patient's ultimate good. They are exercises of a *techne* or art, whose goodness lies ultimately in the product (the patient's health, comfort, etc.) rather than in the performance" (p. 203). In these few lines, Jenicek and Hitchcock put forward the primary arguments against an application of *phronesis* to clinical practice and for that matter, any health-related activity undertaken by physicians or their patients.

In fact, there are three primary reasons often given to reject the application of *phronesis* to medicine in general: (1) *phronesis* deals only with the good for the overall human being (as discussed in the previous section) and not the various products of life (health is understood here as a product), (2) the fact that Aristotle, Hippocrates, Plato, and many other Greeks refer to medicine as a *techne* rather than *phronesis* (on this, see Nussbaum, 2001, p. 95-96), and (3) the fact that *phronesis* is meant to gain meaning in its mere performance (as opposed to in the products that it might produce for the individual). The rest of this section responds to these criticisms, taking on debunkers of "medicine as *phronesis*" through an application of my rhetorically inflected conception of *phronesis* developed in the previous section. While I am not the first to engage in a defense of *phronesis* in the context of medical practice (see e.g. Beresford, 1996; Davis, 1997; Pellegrino and Thomasma, 1993; Tyreman, 2000), I hope to join cutting edge work that envisions the patient as engaged in the artful application of medical advice mixed with her own experiential knowledge about health (and in particular, *her health*), something best described through the lens of *phronesis* (Rubinelli, Schulz, and Nakamoto, 2009).

Jenicek and Hitcock's (2005) criticism of *phronesis* as being about the overall

good of humans as opposed to their health is echoed by Duff Waring (2000) who offers two primary claims: (1) that medicine is best described as *techne* or craft knowledge (p. 144), and (2) that the contemporary revival of medical *phronesis*, primarily due to the research of Albert R. Jonsen and Stephen Toulmin (1989) would relegate medical knowledge and bioethics to the purview of elite *phronimoi* (mainly physicians) who would control the definition, appropriate practice, and ethical application of medicine (p. 148-9). I will take on both the descriptive and normative arguments being made here in my development of medicine as a *phronetic* art, particularly for patients. As I will show, the criticisms of physician *phronesis* cut against the conception of patient *phronesis* that I defend. For this reason, I answer these criticisms in order to complete the theoretical work of this paper.

The Descriptive Claim: Techne vs. Phronesis. Waring (2000) relies on the claim that Aristotle's conception of *phronesis* describes the attributes of the good person (*phronimos*) as opposed to the good physician (p. 142). He is correct on this point. Even a basic reading of the *Nicomachean Ethics* reveals that, for Aristotle, medical practice and the physician may in some ways be analogous with ethics and the disposition and actions of the *phronimos*, but they are not isomorphic with them. Aristotle does not intend to argue that medicine is of necessity directly related to the activities of the *phronimos* (Dunne, 1985; Jaeger, 1957; Seidler, 1978). However, Aristotle was not concerned with medical ethics, with the current expansion of "lifestyle management" for the treatment of chronic disease, or with the autonomous decision-making of patients. As F. Daniel Davis (1997) points out, "*phronesis* is critical to the appropriate exercise of medicine's moral virtues in the concrete circumstances of the clinical encounter with a particular patient" (187). In other words, the contemporary notion of medicine always already includes ethical action within the choices made by particular physicians and for particular patients.

It seems that Waring, and those who agree with him, are caught in a kind of double anachronism. First, they seem to believe that the vision of *phronesis* developed by an ancient Greek mind for a specific cultural context can and should be translated directly into our contemporary world (for a critique of this form of anachronism, see MacIntyre, 2003). Second, they seem to acknowledge an analogy between medicine and ethics but then utilize the version of medicine popular in Aristotle's time (and written into his text) in order to prove that

contemporary medicine must also remain a merely paternalistic *techne*, one done by physicians and enacted through the appropriate knowledge of the craft. New trends in medicine indicate the extent to which we must have a wider conception of medicine that goes beyond "general biological theories" (Jonsen and Toulmin, 1989, p. 285) and deals with the ethics as well as the science of the clinical encounter.

Furthermore, Waring and others have argued that medicine, because it deals with the external good of health, must be seen as a form of craft knowledge (*techne*). I argue, following Davis (1997) that medicine should not and cannot be fully described as a practice by the term *techne* (p. 191). In staking out his claim, Waring relies on Joseph Dunne's (1985) definition of *techne* in terms of external goods (products) as opposed to character, disposition, and good living or the internal goods associated with *phronesis* (p. 107). However, as Dunne points out, the ethical agent (*phronimos*), "can never possess himself in the way that the craftsman possesses the form of his product; rather than his having any definite 'what' as blueprint for his actions or his life, he becomes and discovers 'who' he is through these actions" (p. 108). I believe that in order to adequately address the problems that physicians and patients face, especially when considering chronic care and "lifestyle management," we need a concept closer to experience and habits of action than to procedure and learned process for the purpose of production. Dunne's argument (as rendered by Waring) is unravelled when rearticulated in terms of my rhetorically inflected notion of *phronesis* as experiential knowledge performed in daily activities. When dealing with long-term conditions that must be treated based on the needs of the individual and that involve patients engaging in their own care with associated changes in lifestyle, we need a concept that can deal with bringing into action those things learned not in the classroom or even with the physician but through experientially acting them out. Therefore, while Dunne defines medical practice as a *techne*, his definition of *phronesis* seems to better describe the medical context of chronic patients (and perhaps even their physicians).

In addition, as Jonsen and Toulmin (1989) point out, philosophical concepts arise out of the particular socio-cultural milieu and social scientific understandings of the era in question (p. 293). It may be that the medicine of ancient Greece did not require or demand a conception of medical knowledge for the patient best summed up by the term *phronesis*; however, our age is certainly in need of just

such a concept. It might be possible to suggest that the health of the patient is in some ways an external product for the physician, but it is almost impossible (for me, at least) to imagine a patient being able to see her own health, the choices concerning her own health care, which are ultimately both ethical and biological, and her activities in support of her health, as somehow external to her being. Another way of putting this point is to argue that patient *phronesis* involves making ethical, goal-oriented, and experience-based decisions in actualizing a healthy life. Simply because Aristotle finds reason to differentiate between health as a product and the overall good life as constitutive of the agent does not mean that we must do the same. Instead, we might come to the understanding that health is at least one part of this constitutive drive for *a good life* (and perhaps one of the more important parts in our bio-technological age).

The Normative Claim: Medical Phronimoi as Experts. Waring's argument in opposition to Jonsen and Toulmin's revival of *phronesis* in the context of medicine and bioethics involves a normative claim concerning the problem of expertise. He rightly points out that Jonsen and Toulmin (1989) participate in extending the paternalism of previous medical traditions by imbuing only medical and ethical experts with the power to make truly *phronetic* decisions (p. 313-314). However, we need not follow Jonsen and Toulmin in this regard. Given the extensive literature in medical ethics concerning the need for informed consent as well as the increasingly prevalent belief that patients will need to work on their own habits and implement their own methods of self care to successfully deal with chronic conditions, this argument seems shortsighted and problematic. As Aristotle points out in the *Nicomachean Ethics*, "an act done through ignorance is in every case not voluntary" (III. i. 13). In cases where patients are being asked to change their own habits, to follow a regimen, to learn about what works for them, and how to most appropriately engage in their own care, a proper understanding of informed consent requires physicians to avoid the role of *phronomoi* and simply detail the life goals, habits, and kind of health that the patient should and must attain. Instead, patients should be allowed to form their own consistent set of goals and values and physicians should, to the best of their ability, approach patients as decision-makers (Brock and Buchanan, 1989), as *phronomoi*.

How is this done? I would argue that it can and should be done as a shared, mutually deliberative, and pedagogical encounter between patient and physician in which both are engaged in *phronesis*. In such a model the physician applies

knowledge of the good for patients in general to the specific case of the patient that confronts them (Davis, 1997, p. 182). The patient must then make a decision, based on her conception of *the good life* that actualizes her health (a constitutive element in their overall life) and that is based on her own experiential knowledge about how her body interacts with her world (the daily *phainomena* that define her existence). In this way, patient *phronesis* flips "the normative claim" on its head by investing individual patients with the power to make decisions about their own health, persuade their physicians about their experiential knowledge of their health, and enact their own health in their daily lives.

4. Conclusion: Patient Phronesis *Articulated*

Having answered the two main objections of the application of *phronesis* to clinical medicine and action oriented toward the production of health, I am now in a position to sketch the outlines of my conception of patient *phronesis*. I endorse the view, presented most persuasively by Davis (1997), that "the *telos* of clinical reasoning is a particular act, a right and good healing action on behalf of the individual patient – not the theoretical truth of *episteme* nor the production of an object in accord with *eidos*, as in the case with *techne*" (p. 191). This he articulates in the context of the physician; however, as I have already argued, the patient is now increasingly involved in the creation of her own health. The claim that patients are *phronomoi* may be made even more persuasively than in the case of physicians, for whom the health of the patient is an external good. In addition, as Davis (1997) points out, physicians are also engaged in the other forms of medical knowledge and activity, *episteme* and *techne* (p. 191). What really gets at the activities of patients in the clinical setting and beyond, what makes them active in their own health care, what allows them to be fully autonomous agents acting with truly informed consent, is *phronesis.* For the patient, health is not an external product, not simply something to be achieved through habit, but rather part and parcel of her conception and constitution of *a good life*. One cannot step outside one's body and act upon it. Nor can an individual divide her health from the other elements of her life. For these reasons, acts of self-reflection, internal deliberative excellence, and the performance of health activities are and must be understood through the lens of *phronesis*.

Applying the tripartite understanding of *phronesis* charted earlier, based on Melia's (1992) definition of rhetoric, we can see even more clearly how it is that patients are themselves engaged in *phronetic* activity. They must form a

particular disposition or *ontological* viewpoint that sees the world and their identity as inherently mixed up as well as potentially mutable. They must constantly adapt to changing circumstances through the application of past experience as well as the clinical knowledge (*episteme* and *techne*) shared by their physician. In this sense, they must *analyze* situations and react to them utilizing all that their perceptions, experiences, and understanding of their bodily state can give them. Finally, they must *perform* the right kinds of activities in response to the changing conditions of their life world including their bodily states, their relational networks, and their ever-changing experiential base. They must also communicate these things persuasively not only to themselves but also to others.

Especially when considering the nature of "lifestyle management" and chronic care, patients must be able to actively engage with their physicians through the use of rhetorical and communicative prowess. Some may find the notion of patients and physicians "arguing" somewhat problematic; however, my view is that through argument and persuasion, through the process of constituting shared knowledge about goals, behaviors, best practices, and overall conceptions of *the good life*, patients and physicians can help to co-create this life. In this way, patient *phronesis* is the application by the patient, always already constituted as an autonomous agent with a sense of *eudaimonia*, of clinical knowledge (in the form of advice) to the specific and yet always changing dynamics of life. This mutability of life (Nussbaum, 2001, pp. 302-305) as well as the needs and practices of patients is what recommends a rhetorically inflected conception of *phronesis*. As mentioned earlier, it is not enough to know what is the right action to attain health. Even knowing this means only knowing it for a specific person with a specific set of needs, experiences, and biological idiosyncrasies. The individual must enact her understanding of health and *a good life* in order to attain them. Patients must also be prepared to engage in argument about this vision *of the good life* and this vision must necessarily include the health of both body and mind. Interestingly enough, this vision of *phronesis* and its associated concern for *the good life* is already partly endorsed by bioethicists, albeit without the explicit use of the term: "the capacities for deliberation, choice, and action that normal humans possess make it possible for them to form, revise over time, and pursue in action a conception of their own good" (Buchanan and Brock, 1989, p. 38). For this reason, *phronesis* gets at the rhetorical aspects of medicine in the body and mind of the patient in a way that clinical judgment and physician

argumentation cannot. It also provides a framework for understanding patient experiential knowledge and habit formation in the pursuit of health and good living. This requires the health literacy and communication skills detailed in Rubinelli, Schulz, and Nakamoto (2009) as well as the ongoing empowerment of patients in the therapeutic performances they must enact on a regular basis to maintain their health.

Finally, patient *phronesis* fills out the argument-medicine merger discussed in previous sections. The role of physicians has received ample attention (although their use of persuasive communication has received slightly less attention than their use of proper argument forms and styles). The role of the patient has received less attention and certainly deserves more. Informed consent (both an ethical and legal construct) is meant to enforce the role of the patient in making decisions, but it does not explain how the patient effectively does so. Respect for autonomy enshrines the patient as the ultimate decision-maker without actually accounting for the decision-making process she must endeavor to master. Both assume rhetorical and argumentative features that are hardly ever discussed. Put another way, the rhetorical or "process" (Wenzel, 2006, p. 15) based elements of medical argumentation account for the performative activities of the physician and the patient rather than their right application of principles to cases or their adequate understanding of biology. In addition, it is these performed activities that are at the heart of contemporary efforts to deal with lifestyle changes that might impact the increasing incidence of chronic disease. This paper shows that Rubinelli, Schulz, and Nakamoto (2009) have hit on a concept that can transform not only the role of the patient but also the physician. The principles and practices of informed consent and respect for patient autonomy may need to be augmented to include a pedagogical mission for physicians in which they help patients realize and understand the need for their *phronetic* performance of health in attaining their conception of the *good life*. Finally, this paper adds to current conceptions of *phronesis* for both patients and physicians by articulating its attributes, defending it against *techne*-based accounts, and providing a rhetorical and performative foundation for understanding the patient role in the clinic and beyond.

NOTES

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