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Narratives of Dispossession: Reading Antecedents of Public Health Rhetoric in Reconstruction

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While existing scholarship attributes the development of public health communication to the acceptance of germ theory and sanitary reforms in the early 20th century, this article argues that a turn to late–Civil War and Reconstruction (1863–1877) movements for health reform reveals the central role of dispossession in spurring public health ideologies. I use rhetorical analysis of primary materials from the Reconstruction era to highlight two major narratives emerging from the social movement for public health: One of sanitation, and another of interdependence. This dialectic grounds the contradictory and multiple rhetorical performances that have historically characterized the public health system, dating back to the social sanitation discourse of rapidly institutionalizing medical colleges and the rhetoric (and practice) of mutual aid among freedpeople. The article concludes by moving from rhetorical analysis to practical implications for health researchers and practitioners confronting the inexorable biopolitical roots of public health while addressing the pressing public health challenges of forced displacement worldwide.

Keywords: health communication, rhetorical analysis, public health, Reconstruction era, displaced populations

Public health communication is traditionally said to have emerged in its modern or "progressive" form in the late 19th and early 20th centuries (Schneider & Lilienfeld, 2008). This narrative within communication studies dates the arrival of modern public health communication to the widespread acceptance of germ theory and the accompanying sanitary reform movement (Salmon & Poorisat, 2020). While public health as a Western field existed long before these events, historians position the early 20th century as distinctive for its turn to widespread education and behavioral change as goals of public health to be accomplished through the use of mass communication campaigns (Kreps & Maibach, 2008). Despite the prevalence of this narrative, antecedents to modern public health rhetoric in the discourse of the Reconstruction era have not been widely examined. Considering the increased academic recognition within the last decade of the need for intersectional and critical race approaches to public health (Ford & Airhihenbuwa, 2010; Viruell-Fuentes, Miranda, & Abdulrahim, 2012), examining the racialized politics of

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Reconstruction from which modern public health emerged is pertinent. To reform and transform our public health principles and praxis, we must continue to gain a deeper understanding of their origins.

Turning to the Reconstruction era is not a significant chronological departure from the timeline already proposed by public health and communication scholars. Rather, it is a shift in emphasis from industrialization and urbanization to biopolitics of race and dispossession as primary contributors to the 19th century's "great sanitary awakening" (Winslow, 1923, p. 12). I argue that the burgeoning public health movement during the late Civil War and Reconstruction years was defined by a dialectic between two public health narratives, one of sanitation and another of interdependence. Recognizing this tension as fundamental to modern public health can move practitioners and theorists toward a critical and pragmatic approach to public health that is reflexive about its own reiterative role in holding the tension between social sanitation and social interdependence. Furthermore, the importance of the "contraband" or "freedman" as a trope in the public health discourse of this period illuminates one of public health communication's originating purposes: Determining and negotiating the boundaries between "displaced" or "dispossessed" groups and the wider body of citizens. Throughout this article, I use these two terms interchangeably to refer, broadly, to groups of people who have been structurally and/or culturally abandoned in their preestablished relationship with nation-state, community, or other governing bodies. Centering questions of dispossession within public health and health communication studies can allow us to confront the biopolitical roots that inexorably haunt our work and prompt the design of ethical research on the health of displaced and otherwise "othered" populations today.

This rhetorical analysis of Reconstruction-era public health communication thus joins other recent responses (Agnew, 2020) to the escalating need identified by Malkowski and Melonçon (2019) for the study of "persuasive dimensions and capabilities of communication practices related to public health" and policy (p. iv). In the following sections, I analyze the major Reconstruction-era campaign(s) for public health as a set of social movement rhetorics. Social movement analysis, in this case with emphasis on narrative elements and vernacular rhetoric, offers two advantages for understanding the rhetorical foundations of modern public health and their ambivalence. First, social movement criticism directs analysis toward the ways in which practical interventions such as those made in late-19th- and early-20th-century public health science are supported into materiality by the "management of symbolic resources," that is, by rhetorical maneuvering (Morris & Brown, 2006, p. 1). Second, this approach allows for parsing of polyvocality, "vernacular" rhetorics, and power differentials between sympathizers within movements, an important dimension of public health debates among White and Black Americans of Reconstruction (Ono & Sloop, 1995; Zaeske, 2002). Following prior rhetorical scholarship on social movements (Darsey, 1991; Enck-Wanzer, 2006; Griffin, 1952; McGee, 1980), I consider how those organizing for modern public health used rhetorical strategies, hailed new publics, and invoked persuasive appeals in their communication. Strategies of relevance include the use of narrative elements (Pezzullo, 2001), such as the character of the "contraband," and the appeal to morality via an elision between physical health and spiritual health.

I begin by providing a brief historical overview of public health trends within both institutionalized and lay medicine of this period. I then analyze sanitary commission reports, articles from African American newspapers, and correspondence between freedpeople and the Freedmen's Bureau in this period to illustrate the major rhetorics at play (and in dialectic) in this period of public health discourse: Sanitation and

interdependence. I close by reflecting on the practical applications of this theoretical shift, particularly for health researchers and practitioners facing an ever-escalating crisis of forced displacement across the globe.

Charting the Rise of Modern Public Health in Reconstruction

The White Institutionalization of Medicine

The importance of the mid to late 19th century for public health innovations is, as described above, well documented. One major representation of contemporary health-care changes in America came in the widespread founding of teaching hospitals and degree-granting medical institutions. While allopathic or "chemical" medicine was dominant among the new medical schools, it was not the only approach—reformed, homeopathic, botanicomedical, and eclectic teaching hospitals also existed in the pre-Civil War period (Slawson, 2012).

The new clinics, infirmaries, and teaching hospitals developed during these years were entangled from the start with the exploitation of enslaved persons for medical research. White slaveholders and medical researchers often brought enslaved patients "to dissecting tables, operating amphitheaters, classroom or bedside demonstrations, and experimental facilities" (Savitt, 2007, p. 91). In some cases, this came about when enslaved persons found themselves in need of medical care and were sent by slaveholders to the discounted or free services offered by teaching hospitals in exchange for the patient becoming a subject for physicians in training. One notable example of this practice is the exploitation of enslaved Black women's bodies by early gynecological researchers such as James Marion Sims, often without the use of anesthesia or other more popular pain mitigation techniques of the era (Cooper Owens, 2017). In other instances, and particularly in the case of experimental autopsies, Black bodies were simply taken and used without any charade of mutual benefit (Savitt, 2007).

Both practices can be understood as historically specific articulations of a wider well-documented phenomenon in the history of American race relations: The attempt of White communities to sanitize the social body by pushing obligations perceived as ethically or physically "dirty" onto racialized others. The antebellum South's body politic demanded "persistent, vigilant cleansing of any biological degeneration that was feared to weaken culture" (Stormer, 2002, p. 46). In a concrete sense, this meant that the practice of a procedure like autopsy, widely abhorred at the time as unnatural, was pushed onto the Black community to avoid tainting White society by degrading its corpses (Savitt, 2007). The logic of racial purity and social sanitization at work in this moment gestures toward the eugenics movement that would pick up steam among American intellectuals in 1883 (English, 2016).

These rhetorics were intersected by the arrival of the Civil War and an unprecedented impetus for the rapid development of nascent organized medicine in the United States (Schultz, 1992). Homeopathic schools of medicine jostled with the new arrival of medically trained surgeons and clinicians; many men who were hired as assistant or contract surgeons for the military in the first two years of the Civil War had little to no formal medical education (Schultz, 1992). Infighting over how to handle the sick, wounded, or dead reflected tensions between "prevailing cultural attitudes and conceptions" about who could practice medicine and how it should be practiced (Nystrom, 2011, p. 170).

Ultimately, the new allopathic school of medicine, administered in a hospital, usually by men, was positioned at the top of the hierarchy over homeopathic, home-centered care accessible piecemeal to both women and enslaved persons (Humphreys, 2013). The U.S. Sanitary Commission was one powerful conduit for the popularization of allopathic measures, which would later become hallmarks of public health, including the importance of hygiene and disease prevention for the miniature urban environment of the war camp (Humphreys, 2013). While the "mass communication" of these ideas was not typically assumed until the 1890s or 1900s, proto-campaigns were dispatched from the front lines during wartime in the form of Union hospital newspapers (Spar, 2017), popular Northern newspapers, and Union Army reports.

After the war, public health policy, which had previously been at a national impasse, vaulted to a place of priority on the agendas of the newly formed boards of health and other governmental organizations (Humphreys, 2013). The ideas forwarded by Lemuel Shattuck (2008) in his 1850 *Report of the Massachusetts Sanitary Commission*—which included the supervision of water and waste, increased education of doctors in preventative medicine, and disease-specific studies—were used to justify new bodies like the Massachusetts State Board of Health in the late 1860s (Institute of Medicine (US) Committee for the Study of the Future of Public Health, 1988). In the Southern postwar context, the systems of segregated insurance and infirmaries that had previously covered medical care for the enslaved were not available as a resource to the free Black community. The Freedmen's Bureau endeavored to fill the resulting gap in clinical care, but their efforts were dampened by internal disorganization (Savitt, 2007). The chaos of trying to coordinate accessible medical care with a new population of free persons was wrapped up with internal tension among White Southerners between their paternalistic claim to control former slaves and their commitment to social sanitation. It is not hard to find the racist overtones in the ways that physicians, local and Unionist alike, blamed the difficulties of the bureau on the Black population. One example, interpreted by Savitt (2007) from a letter of Dr. Richard Arnold in 1866, Savannah, demonstrates this internal conflict surrounding the independence of the Black body:

> "The mortality (from cholera) is certainly great among the Blacks, but I am satisfied that (that) belongs to their new status of being 'nobody's n---- but their own.'" His cook, Arnold continued, had assumed that philosophy prior to her sudden attack of cholera, and now Arnold took great pleasure in repeating how Mrs. Arnold had "boldly nursed her as if she had been her slave, instead of being 'nobody's n---- but her own.'" (p. 124)

Arnold's anger reveals a prevailing distrust among White doctors at the bureau toward the independent Black subject. High mortality rates, it was suggested, were the natural outcome of a Black body moving from being an object of property to an independent subject. The audacity to live freely as a Black man or woman was positioned as a predisposition toward infection, a susceptibility to disease.

The high mortality rate noted by Arnold among Black Southerners combined with the overt racism of both Northern and Southern governments contributed to neither the bureau nor local governments accepting responsibility for the community. The bureau—aware of its temporary residence in the South and its lack of resources—pushed for the local government to take increasing responsibility for its formerly enslaved population. The local government continued to contain and segregate the problem of Black bodies by sending all freedpeople to Bureau hospitals rather than their own (Savitt, 2007). The rhetoric of the new

public health movement also facilitated social sanitation via racial segregation among medical providers themselves. Graduates of the medical colleges founded in the first half of the century boasting standardized accreditation and a clinical philosophy rooted in rational modernity were favored by the postwar establishment (Long, 2012). Black physicians who had practiced medicine for their communities while enslaved were rejected as backward and superstitious in the face of the new allopathic medicine and abandoned by the Freedmen's Bureau, which they turned to for assistance in securing payment for their services (Long, 2012). As explored below, Black-run mutual aid associations generally fared better during this era than individual Black doctors pursuing allopathic credentials.

Freedpeople's Mutual Aid

The tensions that unfolded between the two, largely White sects of mid-century medicine—the new allopathic school and the traditional homeopathic school—intersected post-Emancipation with the new publicness of formerly enslaved communities' health-care practices. Home remedies and what Sharla Fett (2002) has termed "relational" medicine (tools used especially by enslaved women to maintain health while resisting enslavers' or experimental facilities' claims to their bodies) were denigrated by institutionalized medicine during the many public health crises accompanying Reconstruction. As a swell of displaced and literally dispossessed former slaves began forging freedom, they were systematically precluded as patients and delegitimized as providers by a health-care system that was already raced, classed, and gendered against them.

Despite their abjection from institutionalized medicine post war, freedpeople found creative, complex, and effective ways to fight for their communities' health. Formerly enslaved persons' approaches to medicine were varied and sometimes existed in tension with the medical values of Black Northerners, who were free before Emancipation. The experiences of the formerly enslaved thus cannot be distilled into a monolithic depiction of "Black" public health. Rather, the specific "medical public" of displaced ex-slaves during Reconstruction was characterized, like that of all publics, by "complex sets of interacting rhetorical performances that bridge[d] public, private, institutional, and technical concerns" (Keränen, 2014, p. 104). Said another way, public health rhetoric among formerly enslaved communities during Reconstruction was varied, especially in choices about how to relate to the White institutional establishment.

Some freedmen worked to achieve legibility—or at least adjacency—to the White institution of medicine and public health. This was attempted by some freedmen (women, at this point, were overwhelmingly denied the ability to practice as physicians) by applying to White Southern medical schools or obtaining essential professional resources like blank death certificates from White doctors to run their own practice (Long, 2012). These efforts at entry into the allopathic medical establishment were varied in their success. As Savitt (2007) has documented, the first Black medical colleges were funded (though none with state assistance) during Reconstruction, including long-standing successful institutions like Howard and Meharry. Many others among these institutions, though, closed by the early 20th century due to a lack of financial support from the White medical institution (Savitt, 2007).

Black-run mutual aid associations and benevolent societies took another approach, working alternately in tension and collaboration with largely White public health institutions like the Freedmen's

Bureau. Public health projects of these organizations included organizing to combat smallpox, cholera, and yellow fever, as well as tending to indigent community members in Southern cities (Long, 2012). These societies were actively developing a mutual aid model of public health that boasted a level of "organization, financial resources, and practical effectiveness" that contrasted sharply with the chaos of contemporaneous Freedmen's Bureau–led initiatives (Long, 2012, p. 90). Bureau-led projects like the 1866 public health tax levied on African Americans in Tennessee and Kentucky routinely failed, while the charging of dues by mutual aid societies successfully helped fund medical and funeral expenses for Black urban communities (Long, 2012). Mutual aid societies also positioned themselves as mediators and advocates between the realms of the Black Southern medical public and the White institutions:

> In their dealings with illness, African American associations bridged the two realms of public and private. In the public realm they worked primarily with allopathic and largely white medical community. Hiring doctors and contracting with druggists, representatives from the societies were able to negotiate better feeds and rates and better care than individuals without the financial weight of an association behind them. (Long, 2012, p. 99)

Mutual aid efforts such as these circulated what Ono and Sloop (1995) have called a "vernacular rhetoric" of public health. Vernacular rhetorics are those used by ordinary people to communicate around, outside, and against hegemony within their own communities. These rhetorics matter for critical communication studies because they demonstrate the grounded and localized strategies already in use for resisting hegemony; in the instance of post-Emancipation mutual aid societies, they show an alternate rhetoric of public health that emerged from Black lived experience in the South and supported the wellness of communities heavily disadvantaged by White institutions. As I show in the following sections, this alternate public health rhetoric is also not reducible to an act of resistance alone. Rather, it presents its own terms and articulates practices of innovation beyond the discourse of resistance that is "deeply resonant with black culture and history, but [not] sufficient for describing the totality of black humanity" and scientific creativity (Quashie, 2012, p. 26). One example of such a vernacular public health rhetoric comes from *A Book of Medical Discourse in Two Parts* by Rebecca Davis Lee Crumpler (1883), which will be analyzed below.

The negotiations between and within these approaches to public health in the Reconstruction era—those produced in modern teaching hospitals, the Freedmen's Bureau, newly instated statewide and citywide Boards of Health, Black-led mutual aid associations, and homeopathic networks of care—determined who would constitute the "public" of the emerging American public health system, among other theoretical issues. In the following section, I explore some of the rhetorical tools employed within these different approaches and argue that most can be mapped onto a dialectic between sanitation and interdependence models of public health.

Rhetorics of Sanitation and Interdependence

Sanitation as a Moral Imperative

Lemeul Shattuck's (1850/2008) *Report of the Massachusetts Sanitary Commission* may have been published before the Civil War and Reconstruction eras, but its proposals would play a major role in

encouraging material and cultural support for the creation of Boards of Health in the 1860s, as described above (Institute of Medicine (US) Committee for the Study of the Future of Public Health, 1988). Shattuck's report (1850/2008) also demonstrates how appeals to sanitary measures as a moral responsibility were levied in support of the public health movement. It repeatedly describes the implementation of his suggested measures as a choice of societal good over evil; "crowded lodging-houses and cell-dwellings" as well as imbibing alcohol, he writes, raise "sanitary evils" that must be mitigated (Shattuck, 1850/2008, p. 231). Addressing these sanitary evils was a moral imperative to slow down not just the spread of illness but also the spread of societal decay. He poses rhetorical questions to his readers about the societal threat of overcrowded and impoverished dwellings: "Can moral principle be inculcated in such an atmosphere, and surrounded by such influences? Must not degradation, vice, crime, be their natural, inevitable tendency?" (Shattuck, 1850/2008, p. 281).

For Shattuck (1850/2008), if sanitary reform was a moral imperative, it was also an individual moral responsibility. He critiqued his fellow reformers for neglecting the role of individuals who made up the "public" of public health. This was less an appeal to the "everyman" directly, considering the bureaucratic audience of the report, and more an appeal to legislators' idea of an atomized public with individuals who could be held accountable. "Every person," Shattuck (1850/2008) argued, "in every situation can do something to promote this reform; and every such effort wisely directed, will increase the amount of his own, individual enjoyment, and add to the aggregate enjoyment of the people of the whole Commonwealth" (p. 277). Such appeals to individual responsibility in the public health movement were echoed by many religion-based aid and sanitation commissions who heralded the "earnest, devoted, and Christian laborers" who supported public health by volunteering their time to supporting soldiers, veterans, and freedpeople (The Western Sanitary Commission, 1864, p. 122).

On the other side of appeals to the ideal of personal responsibility was the abjection of those deemed irresponsible or unsanitary—the contagious. William Budd (1873/2008) gestured toward the way that the individualized "public" of sanitary reform's public health narrative required not just upstanding characters but also the transgressive "infected" (or infecting) man. This enemy of public health was, according to Shattuck (1850/2008), any man "who causes a nuisance" that prevented "any other person from enjoyment of life and health" (p. 234). This character was often cast in public health texts of the era as the freedman, the immigrant, and/or the uncertified and false physician. A salient example recurrent in Union newspapers of the late war years was the "contraband," the escaped ex-slave facing poor toilet facilities, wounds prone to infection due to the lack of antiseptics, and disease outbreaks in Union camps. As Long (2012) has argued, the figure of the contraband introduced the Northern reading public to the messiness of Emancipation understood as a public health crisis.

As a solution, Shattuck (1850/2008) suggested the creation of a "Sanitary Police" in the form of local health boards, one of whose functions would be the policing of migrants and displaced persons: "That emigration, especially of paupers, invalids, and criminals, should, by all proper means, be discouraged; that misrepresentation and falsehood, to induce embark in passenger-ships, should be discountenanced and counteracted" (p. 236).

The usage of "passenger-ships" here suggests that Shattuck (1850/2008) was referring to emigrants from outside the United States, but it is worth considering the resonance his claims would have had in a post-Emancipation Union for displaced persons more generally, including freedmen.

Charitable organizations like the Western Sanitary Commission departed from Shattuck's (1850/2008) call for policing in the later years of the war and early Reconstruction years. Instead, they used appeals to "amelioration" and "look[ing] after" to encourage a paternalistic practice of health care toward freedpeople struggling with unsanitary conditions in Union camps (The Western Sanitary Commission, 1864, pp. 112, 113). While compassion was encouraged in the commission's vision of public health, the "public" of freedpeople hailed remained at a socially sanitary distance:

> There are multitudes of these poor refugees, numbered by thousands, who have come to us from rebel persecution and outrage, or have been driven, by the ravages of war, and the destitution of food and clothing, to seek a refuge within our lines. (The Western Sanitary Commission, 1864, p. 128)

This rhetorical abjection of freedpeople was not so much an effect of the sanitary reform movement as a necessary component of its flourishing and the development of a visceral public that would motivate public health rhetoric for years to come (Johnson, 2016). The development of the system of public health as envisioned by a largely White, institutionalized medical establishment required the dispossession of former slaves as a sanitary threat both on the basis of their Blackness and being displaced persons. Rather than approaching the health problems of Black freed communities "as an afflicted organ of the body politic, the afflicted were themselves treated as the disease" (Long, 2012, p. 51). By identifying an unsanitary and abjected subject, the sanitary reform movement could consolidate those "earnest, devoted" followers of public health regulations in a coalition against a common problem.

Mutuality and Interdependence

Rebecca Davis Lee Crumpler, born free in 1831, worked as a nurse in Charlestown, Massachusetts, until "the doctors under whom she served recommended that she study medicine" (Paban Mishra, 2019, p. 215).[2] When she graduated from the New England Female Medical College in 1864, she became the first Black woman in the United States to obtain an MD. This accomplishment is made particularly stark considering the very limited access of both White women and Black men to medical degrees at the time, even in the North; even recent comprehensive accounts of the era have stated that no American medical college had knowingly graduated a Black doctor of any gender before 1866 (Long, 2012). Crumpler went on to work as a physician with the Freedmen's Bureau of Virginia in the first year of Reconstruction. Crumpler's (1883) later combination of homeopathy and allopathic

[2] Interestingly, Crumpler's transition from nurse to physician is one of the least documented periods of her life. It is uncertain how she was able to obtain admission to the New England Female Medical College in 1860, when medical colleges were only beginning to open their doors to White women. Further analysis might include an investigation of archival materials surrounding the New England Female Medical College to get a sense of the institutional structure that gave Crumpler this window to obtaining a medical degree.

public health discourse in *A Book of Medical Discourses in Two Parts*, a layperson's health handbook, is an example of another narrative used within the Reconstruction-era public health movement—that of community medicine and interdependence.

A Book of Medical Discourses (Crumpler, 1883) was written to "mothers, nurses, and all who may desire to mitigate the affliction of the human race" on issues including marriage and childbirth, postpartum recovery, creating a supportive environment for a child, the responsibility of parenthood, women's education, and the heavy physical toil facing working men and women in the Black community (p. iii). Crumpler's (1883) writing on these topics and to this audience in and of itself is inherently political in the face of gender norms: "If women are permitted to read and reflect for themselves, it is hardly possible that they will say it is uninteresting to them, or that it should only be read by men" (p. 4), she writes in her introduction, conjuring an audience of both White and Black women, for whom literacy would have been a particular political act in the aftermath of plantation literacy policing.

Crumpler's (1883) prioritization of a female audience also gave a nod to the former centrality of bondswomen who "grew herbs, made medicines, cared for the sick, prepared the dead for burial, and attended births in black and white households" pre-Emancipation (Fett, 2002, p. 5). While White women retained recourse to their authority as maternal and domestic figures of healing in the new allopathic era, Black women were denied assigning this legitimacy to their historical expertise and experience as healers (Fett, 2002). Crumpler's (1883) invocation of the audience restores legitimacy to the consideration of Black female medical practitioners like herself. This desire to rhetorically expand the "public"—and importantly, the public-as-practitioners—of public health messaging is also visible in the language of the Western Sanitary Commission (1864), which features the contributions of female nurses in wartime in seven of the 11 chapters describing their organization's history.

Crumpler (1883) also turns explicitly to racial justice in her monograph, appealing (like Shattuck, 1850/2008) to moral uprightness and a healthy society as intertwined goals:

> Does any one believe that the majority of the little children who witness the farce of "Punch and Judy" every summer, gain a moral, or feel that it is wrong to imitate beating a wife, killing a baby, or hanging a Black man? The popular adage, "No n-----, no fun," is why such schools are tolerated on our Public Parks. Are they not a curse to our land? May not such shameful scenes prove to be the primary lessons in pugilism, murder, and suicide? (p. 118)

Unlike Shattuck's (1850/2008) "sanitary police" suggestion, one of Crumpler's (1883) proposed antidotes to the spectacle of racist violence as a public health issue picks up on the rhetoric of mutuality at play among benevolent societies: Self-care in the Black community.[3] "The laboring men of my race," she writes, "take much better care of the horses intrusted [spelling in original] to their care than they do of their own health" (Crumpler, 1883, p. 116). Likewise, Crumpler (1883) recognizes many Black women as stuck

[3] The rise of self-care as a conceptual component of public health is further explored in the context of White Union soldiers' mental health by Kathryn Shively Meier (2013).

in conditions damaging to their health by the "heavy disadvantages" of often having to provide domestic labor to White families (p. 115). Enabling the Black population in America to live longer and healthier lives, she argues, is a way of giving "honor to that noble race with which we are identified, in point of strength and longevity" (Crumpler, 1883, p. 117). The public health problem, in other words, constituted the conditions not only inhospitable to but also biased against Black self-care. Moreover, pursuing Black health and self-care was positioned as a "noble" pursuit, capable of exerting what a November 1862 article in the *Christian Recorder* would call a "moral influence" on the newly reunited nation:

> The fact is, we need a colored hospital, and the next question is, can we have it. I answer, we can if we will try. Let the generous hearts of the great North unite on the subject and Baltimore and Washington do the same, and in a short time we will have a house fitted out, properly officered with intelligent men of our race, with every thing necessary for the sick and afflicted. One cent per week from our people would support as fine a hospital as could be desired. And I believe that many would be willing to give from one to five dollars per month for the sustenance of an institution of that kind. Besides, many of our white friends would greatly aid in the project, and the moral influence which would grow out of it would tell with thrilling effect upon our opposers and calumniators. It would, furthermore, turn the attention of our people to the great subject of their own responsibility, on to the help-yourself doctrine, which must ultimately triumph, if we ever triumph. (Turner, 1862, para. 9)

This narrative of public health praxis as empowering individuals through care of the self shares commonalities with Shattuck's (1850/2008) emphasis on individual moral responsibility to health. Unlike sanitary reformists' narrations of public health as a project taken up as each citizen's individual obligation, narrations of public health as a mutual project centered on stories of collective action. One example can be seen in Rev. Elisha Weaver's (1862) recounting in the *Christian Recorder* of a story from the Washington contraband camp. Spouses Rachel and Sandy were separated in the camp when Sandy was placed in jail based on fugitive slave laws. Shortly thereafter, Rachel was also captured and lodged in the same jail, leaving their three children alone. Weaver (1862) recounts how Rachel's friend was able to mobilize the legitimacy and power of the Union Army to secure her release:

> A friend to Rachel, who knew of her fate and knew that her babes were crying for her while she was weeping for them, laid her case before Colonel Doster, the Provost Marshal, who found that both Rachel and her husband were "snatched up" while under "military protection," and proceeded, on the ground of *military necessity*, with a posse to the jail in Washington, and first demanded the person of Rachel, then of her husband. . . . It was an interesting fact, that Rachel in pursuit of her husband, got into jail, and by that means got her husband out of jail, and has enlisted hundreds into a sympathy with her love of freedom. (para. 2)

Like the mutual aid societies, Crumpler and other rhetors of community-based public health empowered Black subjects to address, prevent, and treat their own ill health rather than sending Black patients into White institutions premised on their abjection. Crumpler (1883) is clear about her particular

passion for "the possibilities for prevention" above treatment (p. 4). This is the two-part rhetorical advocacy of Crumpler and her fellow public health advocates' public health writing: She (Crumpler, 1883) calls explicitly for improved self-care among a community never intended to survive or flourish beyond the labor it produced, and in addressing her medical advice specifically to those communities excluded from such knowledge, she actively works to hand Black men and women the tools by which to stay healthy together—and in doing so—stay free.

Implications for Researchers and Providers

As Malkowski and Melonçon (2019) write, rhetorical analyses like the one above are not merely theoretical thought experiments but essential equipment for researchers and practitioners in developing "a more holistic understanding of public health's complexities and the ways that attentive language can help influence those realities" (p. xi). Turning to the antecedents of modern public health communication in the Reconstruction era offers new insight into the narratives, appeals, and logics that have been foundational to the field and where professionals might intervene today to reshape it. A few key implications of this rhetorical history are outlined below.

Centering Cross-Cultural Health Communication

Intercultural and cross-cultural studies of communication provide analysis of "intrapersonal processes in intercultural communication, intercultural communication competence, adaptation to a new culture, cultural identity in intercultural contexts, and power inequality in intercultural relations" (Kim, 2001, p. 139). The importance of such cross-cultural projects in health communication is well-documented, particularly in the effort to dismantle systemic barriers and increase health equity (Zegers & Auron, 2022). Centering Reconstruction in the narrative of public health communication underlines the importance of such theoretical approaches by clarifying that public health communication has always been cross-cultural. More pointedly, public health communication in America has always been about negotiating between medico-cultural publics, especially who is included, excluded, or abjected from the "public" of health. The preceding rhetorical analysis demonstrates that public health communication has never been a unidirectional broadcast to the masses but rather a ground of debate and difference among narratives of health within distinct communities. This rhetorical history also reveals the centrality of Black publics—and, specifically, formerly enslaved peoples as a literally displaced and dispossessed Black public post-Emancipation—to these debates. Reclaiming this history of public health within communication studies thus calls for increased studies of displaced people's material and discursive role in the structuring of public health messaging. It also requires a definition of "displaced" and "cross-cultural" communication that is less tied to national borders and reinforcing differences and more attentive to the complex dynamics of internal dispossession. Public health communication studies would benefit from centering these concepts not simply as subfields but also as structuring lines of inquiry for the discipline at large. The *International Journal of Communication* is particularly well-suited to model this shift, having recently highlighted the importance of cross-cultural approaches to our contemporary digital and political climate (Odağ, Schneider, Buhin, & Kim, 2023) and developed a record for featuring cross-cultural health communication studies (Ng, Chan, Balwicki, Huxley, & Chiu, 2019; Oktavianus & Lin, 2022; Wu et al., 2022).

Redistributing Experimental Risk

The Reconstruction narrative reinforces the evidence from critical health studies scholars that innovation in medicine and public health is structured around the exploitation of marginalized and displaced peoples. Teaching the history of public health in America beginning with figures such as Betsey, Lucy, and Anarcha (three enslaved women who were the subjects of the "Father of Gynecology," Dr. J Marion Sims; see Cooper Owens, 2017) can provide the next generation of public health clinicians, policy makers, and researchers with a more accurate foundation in the uneven distribution of health risk that has been the basis for progress. Approaching public health communication with this awareness also has implications for health messaging today. It can provoke instructive conversation on complex issues such as how to include marginalized communities in research without leaving them "researched to death" (Goodman et al., 2018), and how risk can be equitably distributed in clinical research. It can also prompt creative and critical analysis of how medical exploitation occurs not only as explicitly as direct experimentation on enslaved people but also implicitly and indirectly today; one salient example is the inequitable absorption of risk seen in the disproportionate effects of pre-vaccine COVID-19 among non-White populations and essential workers (National Center for Health Statistics, n.d.).

Deconstructing Sanitation

The importance of sanitation to advancements in public health and quality of life cannot easily be overstated. This makes the study of rhetorical and ideological dimensions of sanitation all the more important within public health communication studies. We must ask how public health messaging that encourages clinical sanitation strategies and community health can be crafted while dismantling the rhetorics of social sanitation that have historically accompanied such initiatives. Following Malkowski and Melonçon (2019), more critical rhetorical studies on public health and greater interdisciplinary integration of such analyses in the training of public health professionals are needed (Johnson, 2016; Winderman, Mejia, & Rogers, 2019). Beyond rhetorical analysis, qualitative and quantitative research is also essential for understanding how social sanitation continues to structure public health outcomes and how we might challenge its discursive hold (Campeau, 2019). It is worth restating here that cross-cultural communication around sanitation, or other themes of public health rhetoric, cannot be distilled into the study of dueling "good" or "bad" monoliths. Crumpler's (1883) work, analyzed above, illustrates the discursive complexity at play within even one public health text; while her work invokes what I interpret as a mutuality-based public health of the dispossessed, it also bears distinct traces of the eugenic utopianism that had not yet been revealed for its full abusive and genocidal iterations at her time of writing (Lake, 2018).

Studying Knowledge Regime Shifts and Rhetorical Displacement

A Reconstruction-anchored history of public health communication demonstrates that periods of paradigm shifts in medical culture historically coincide with new disavowals of vernacular knowledges. This can lead to further rhetorical displacement of the materially displaced within health and medicine; for instance, formerly enslaved persons were first displaced from their land and residence, then faced the rhetorical displacement of their medical expertise within an institutionalizing system of public health that disavowed homeopathy. Once the complexities of practices, counter-hegemonic negotiations, and health expertise among

dispossessed and otherwise marginalized groups are documented through cross-cultural projects, the next step is creating institutional guardrails to ensure that those knowledges are not erased under the progress narrative of dominant medical culture. "Normal science" resists the assimilation of what it deems novelties or anomalies; without intentional action, public health progress will continue to be accompanied by the delegitimization of displaced and marginalized expertise in favor of the dominant paradigm (Kuhn, 1970). As described below, this comes at the loss of valuable knowledge for the improvement of public health praxis for all.

Investing in Community-Led Projects

The success of Reconstruction-era Black mutual aid associations and benevolent societies supports contemporary research showing that community-led health initiatives are more effective than top-down projects led by researchers or government bodies (Cook, 2008; McFarlane, Occa, Peng, Awonuga, & Morgan, 2022). This rhetorical history of public health communication can thus serve as another piece of supporting evidence in advocating for the investment of material resources—including grant funding, university time, researcher energy, and journal space—into community-based participatory research (CBPR). Unlike less rigorous forms of community-engaged research, CBPR requires the systematic sharing of leadership, decision making, resources, data, and credit between researchers and community partners (Giachello, 2007). Beyond simply accessing community knowledge and experience, CBPR also prioritizes community partners' expertise and priorities on equal footing with that of the researcher, enabling "collective, reflective and systematic inquiry . . . with the goals of educating, improving practice or bringing about social change" (Tremblay, Martin, McComber, McGregor, & Macaulay, 2018, p. 487). While CBPR does not erase the risk of exploitation at play when researchers enter the community, it does provide a rigorous interdisciplinary structure to the ethical centering of community knowledge in research. Investing in community-based public health initiatives and research is essential when strict timelines and the demand for ever-increasing research productivity in the neoliberal academy often undermine community research timelines conducted "at the speed of trust" (maree brown, 2017, p. 42; Peterson & Gubrium, 2011).

Black Feminist Health Science Studies and Public Health

One strand of health studies already continuing the Black mutual care legacy of Reconstruction is Black feminist health science studies (BFHSS). Defined by Bailey and Peoples (2017) as "a critical intervention into a number of intersecting arenas of scholarship and activism, including feminist health studies, contemporary medical curriculum reform conversations, disability studies, environmental justice, and feminist technoscience studies" (p. 2), BFHSS contextualizes biomedical messages in their social and ideological contexts. It is based on five principles: (1) the centering of Black women's expertise, (2) interdisciplinarity, (3) subverting the high-tech/low-tech divide, (4) recognizing the power of media representations of health, and (5) incorporating justice as a research goal (Bailey & Peoples, 2017). Notable examples include Ruha Benjamin's (2019) monograph on algorithmic racism, the "The New Jim Code," and Sami Schalk's (2022) research on Black disability politics. Teaching and citing works like these within public health studies and policy does not just represent an act of resistance to institutionalized racism in medicine or a restoration of erased histories, it also represents a turn to an alternative imagination of public health, one rooted in a history of mutual aid and poised to guide our reimagining of what public health communication can become for all communities.

Conclusion: Public Health, Displaced

Reimagining public health communication strategies and rhetoric is essential in the ongoing afterlives of COVID-19, which have highlighted preexisting areas of inadequacy and made clear the stakes of leaving them unaddressed in the future. Two interlocking crises that make this need particularly pressing are the rise in international refugees, with the largest ever increase in forcible displacement occurring in 2022 (United Nations High Commissioner for Refugees, 2023), and the climate crisis, which promises to both provoke further displacement and produce new environmental health complications for migrants. The increase of displaced persons created by these crises in the years to come will place pressure on national health-care systems globally, and as this rhetorical history has shown, public health messaging evolves in a co-constitutive relationship with the displacement of marginalized peoples. Researchers and practitioners are facing an opportunity to perpetuate discourses of sanitation and practices of abjection or to contribute to the development of a reimagined public health that recognizes our mutual entanglement.

This rhetorical history of American public health is not intended to replace the sanitary reform and germ theory narrative as "the" story of public health communication. Rather, it demonstrates the value of multiplicity, of complicating the application of any one story or date to the original hailing of public health's "public." Public health as a movement is not a unidirectional broadcast of campaigns to the masses—it is a chorus of rhetorical performances whose primary directive is negotiating who the public is, who is abjected from it, and who might one day be let in. I have provided a broad rhetorical history of public health communication's American origins as seen through the performances of institutionalized allopathic medicine, formerly enslaved healers, government bodies, mutual aid organizations, Black medical colleges, and other stakeholders in Reconstruction-era debates about health and medicine. I have also argued that such a rhetorical analysis of public health communication is valuable for researchers, clinicians, and policy makers. Some of the practical actions supported by this rhetorical analysis include (1) broadening cross-cultural methodologies in health communication, (2) redistributing the risks of medical progress equitably, (3) deconstructing reliance on a rhetoric of sanitation, (4) studying the displacement of knowledges during medical revolutions, (5) investing in community-led public health projects and communication, and (6) centering BFHSS. Each can serve as a step toward reimagining a more equitable, just, and effective practice of health communication for a plurality of medical publics.

References

Agnew, L. (2020). Managing visibility: Emotion, mascots, and the birth of US cancer rhetorics. *Rhetoric Society Quarterly, 50*(3), 194–202. doi:10.1080/02773945.2020.1752130

Bailey, M., & Peoples, W. (2017). Articulating Black feminist health science studies. *Catalyst: Feminism, Theory, Technoscience, 3*(2), Article 2. doi:10.28968/cftt.v3i2.28844

Benjamin, R. (2019). *Race after technology: Abolitionist tools for the new Jim Code*. Hoboken, NJ: Wiley.

Budd, W. (2008). Typhoid fever—Its nature, mode of spreading, and prevention. In D. Schneider & D. E. Lilienfeld (Eds.), *Public health: The development of a discipline from the age of Hippocrates to the progressive era* (Vol. 1, pp. 394–509). New Brunswick, NJ: Rutgers University Press. (Original work published 1873)

Campeau, K. L. (2019). Vaccine barriers, vaccine refusals: Situated vaccine decision-making in the wake of the 2017 Minnesota measles outbreak. *Rhetoric of Health & Medicine, 2*(2), Article 2. doi:10.5744/rhm.2019.1007

Cook, W. K. (2008). Integrating research and action: A systematic review of community-based participatory research to address health disparities in environmental and occupational health in the USA. *Journal of Epidemiology and Community Health, 62*(8), 668–676. doi:10.1136/jech.2007.067645

Cooper Owens, D. (2017). *Medical bondage: Race, gender, and the origins of American gynecology*. Athens: University of Georgia Press.

Crumpler, R. D. L. (1883). *A book of medical discourses in two parts*. Boston, MA: Ashman, Keating, & Co.

Darsey, J. (1991). From "gay is good" to the scourge of AIDS: The evolution of gay liberation rhetoric, 1977–1990. *Communication Studies, 42*(1), 43–66. doi:10.1080/10510979109368320

Enck-Wanzer, D. (2006). Trashing the system: Social movement, intersectional rhetoric, and collective agency in the Young Lords Organization's garbage offensive. *Quarterly Journal of Speech, 92*(2), 174–201. doi:10.1080/00335630600816920

English, D. K. (2016). Eugenics. *Oxford Bibliography in African American Studies*. Retrieved from https://www.oxfordbibliographies.com/view/document/obo-9780190280024/obo-9780190280024-0029.xml

Fett, S. M. (2002). *Working cures: Healing, health, and power on Southern slave plantations*. Chapel Hill: University of North Carolina Press.

Ford, C. L., & Airhihenbuwa, C. O. (2010). The public health critical race methodology: Praxis for antiracism research. *Social Science & Medicine, 71*(8), 1390–1398. doi:10.1016/j.socscimed.2010.07.030

Giachello, A. (2007). *Making community partnerships work: A toolkit* (D. Ashton, P. Kyler, E. Rodriguez, R. Shanker, & A. Umemoto, Eds.). March of Dimes Foundation. Retrieved from https://aapcho.org/wp/wp-content/uploads/2012/02/Giachello-MakingCommunityPartnershipsWorkToolkit.pdf

Goodman, A., Morgan, R., Kuehlke, R., Kastor, S., Fleming, K., Boyd, J., & Western Aboriginal Harm Reduction Society. (2018). "We've been researched to death": Exploring the research experiences of urban indigenous peoples in Vancouver, Canada. *International Indigenous Policy Journal, 9*(2). doi:10.18584/iipj.2018.9.2.3

Griffin, L. M. (1952). The rhetoric of historical movements. *Quarterly Journal of Speech, 38*(2), 184–188. doi:10.1080/00335635209381762

Humphreys, M. (2013). *Marrow of tragedy: The health crisis of the American civil war*. Baltimore, MD: Johns Hopkins University Press.

Institute of Medicine (US) Committee for the Study of the Future of Public Health. (1988). *The future of public health*. National Academies Press. Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK218218/

Johnson, J. (2016). "A man's mouth is his castle": The midcentury fluoridation controversy and the visceral public. *Quarterly Journal of Speech, 102*(1), 1–20. doi:10.1080/00335630.2015.1135506

Keränen, L. (2014). Public engagements with health and medicine. *The Journal of Medical Humanities, 35*(2), 103–109. doi:10.1007/s10912-014-9275-7

Kim, Y. Y. (2001). Mapping the domain of intercultural communication: An overview. *Annals of the International Communication Association, 24*(1), 139–156. doi:10.1080/23808985.2001.11678984

Kreps, G. L., & Maibach, E. W. (2008). Transdisciplinary science: The nexus between communication and public health. *Journal of Communication, 58*(4), 732–748. doi:10.1111/j.1460-2466.2008.00411.x

Kuhn, T. (1970). *The structure of scientific revolutions* (2nd ed.). Chicago, IL: University of Chicago Press.

Lake, C. (2018). Eugenics in late 19th-century feminist utopias. *The American Journal of Economics and Sociology, 77*(5), 1277–1312. doi:10.1111/ajes.12251

Long, G. (2012). *Doctoring freedom: The politics of African American medical care in slavery and emancipation*. Chapel Hill: University of North Carolina Press.

Malkowski, J., & Melonçon, L. (2019). The rhetoric of public health for RHM scholarship and beyond. *Rhetoric of Health & Medicine, 2*(2), Article 2. doi:10.5744/rhm.2019.1010

maree brown, a. (2017). *Emergent strategy: Shaping change, changing worlds*. Chico, CA: AK Press.

McFarlane, S. J., Occa, A., Peng, W., Awonuga, O., & Morgan, S. E. (2022). Community-based participatory research (CBPR) to enhance participation of racial/ethnic minorities in clinical trials: A 10-year systematic review. *Health Communication, 37*(9), 1075–1092. doi:10.1080/10410236.2021.1943978

McGee, M. C. (1980). "Social movement": Phenomenon or meaning? *Central States Speech Journal, 31*(4), 233–244. doi:10.1080/10510978009368063

Meier, K. S. (2013). *Nature's civil war: Common soldiers and the environment in 1862*. Chapel Hill: University of North Carolina Press.

Morris, C. E., & Brown, S. H. (2006). *Readings on the rhetoric of social protest* (2nd ed.). State College, PA: Strata Publishing.

National Center for Health Statistics. (n.d.). *Distribution of COVID-19 deaths and populations, by jurisdiction, age, and race and Hispanic origin* [Data set]. Retrieved from https://data.cdc.gov/NCHS/Distribution-of-COVID-19-Deaths-and-Populations-by/jwta-jxbg

Ng, Y. L., Chan, K., Balwicki, Ł., Huxley, P., & Chiu, M. Y. L. (2019). The digital divide, social inclusion, and health among persons with mental illness in Poland. *International Journal of Communication, 13*, 1652–1672.

Nystrom, K. C. (2011). Postmortem examinations and the embodiment of inequality in 19th century United States. *International Journal of Paleopathology, 1*(3), 164–172. doi:10.1016/j.ijpp.2012.02.003

Odağ, Ö., Schneider, F. M., Buhin, L., & Kim, J. (2023). Media use and political engagement: Cross-cultural approaches—Introduction. *International Journal of Communication, 17*, 1390–1401.

Oktavianus, J., & Lin, W. Y. (2022). Community storytelling networks and empowerment of migrant domestic workers: A communication infrastructure approach. *International Journal of Communication, 16*, 5162–5183.

Ono, K. A., & Sloop, J. M. (1995). The critique of vernacular discourse. *Communication Monographs, 62*(1), 19–46. doi:10.1080/03637759509376346

Paban Mishra, P. (2019). Crumpler, Rebecca (1831–1895). In R. Welch & P. A. Lamphier (Eds.), *Technical innovation in American history: An encyclopedia of science and technology* (Vol. 1, pp. 214–215). New York, NY: Bloomsbury.

Peterson, J. C., & Gubrium, A. (2011). Old wine in new bottles? The positioning of participation in 17 NIH-funded CBPR projects. *Health Communication, 26*(8), 724–734. doi:10.1080/10410236.2011.566828

Pezzullo, P. C. (2001). Performing critical interruptions: Stories, rhetorical invention, and the environmental justice movement. *Western Journal of Communication, 65*(1), 1–25. doi:10.1080/10570310109374689

Quashie, K. (2012). *The sovereignty of quiet: Beyond resistance in Black culture*. New Brunswick, NJ: Rutgers University Press.

Salmon, C. T., & Poorisat, T. (2020). The rise and development of public health communication. *Health Communication, 35*(13), 1666–1677. doi:10.1080/10410236.2019.1654180

Savitt, T. L. (2007). *Race and medicine in nineteenth- and early-twentieth-century America*. Kent, OH: Kent State University Press.

Schalk, S. (2022). *Black disability politics*. Durham, NC: Duke University Press.

Schneider, D., & Lilienfeld, D. E. (Eds.). (2008). *Public health: The development of a discipline from the age of Hippocrates to the progressive era* (Vol. 1). New Brunswick, NJ: Rutgers University Press.

Schultz, J. E. (1992). The inhospitable hospital: Gender and professionalism in civil war medicine. *Signs: Journal of Women in Culture and Society, 17*(2), 363–392. doi:10.1086/494734

Shattuck, L. (2008). Report of the Sanitary Commission of Massachusetts 1850. In D. Schneider & D. E. Lilienfeld (Eds.), *Public health: The development of a discipline from the age of Hippocrates to the progressive era* (Vol. 1, pp. 206–281). New Brunswick, NJ: Rutgers University Press. (Original work published 1850)

Slawson, R. G. (2012). Medical training in the United States prior to the civil war. *Journal of Evidence-Based Integrative Medicine, 17*(1), 11–27. doi:10.1177/2156587211427404

Spar, I. (2017). *Civil war hospital newspapers: Histories and excerpts of nine union publications*. Jefferson, NC: McFarland.

Stormer, N. (2002). *Articulating life's memory: US medical rhetoric about abortion in the nineteenth century*. Lanham, MD: Lexington Books.

Tremblay, M. C., Martin, D. H., McComber, A. M., McGregor, A., & Macaulay, A. C. (2018). Understanding community-based participatory research through a social movement framework: A case study of the Kahnawake Schools Diabetes Prevention Project. *BMC Public Health, 18*(1), 487–504. doi:10.1186/s12889-018-5412-y

Turner, H. M. (1862, November 1). The condition of the contrabands in Washington. *The Christian Recorder*. Accessible Archives. Retrieved January 15, 2024 from http://www.accessible.com.turing.library.northwestern.edu/accessible/print

United Nations High Commissioner for Refugees. (2023). *Global trends: Forced displacement in 2022*. Retrieved from https://www.unhcr.org/global-trends-report-2022

Viruell-Fuentes, E. A., Miranda, P. Y., & Abdulrahim, S. (2012). More than culture: Structural racism, intersectionality theory, and immigrant health. *Social Science & Medicine, 75*(12), 2099–2106. doi:10.1016/j.socscimed.2011.12.037

Weaver, E. (1862, December 6). Harewood Hospital, near Washington, D.C., Nov. 26th, 1862. *The Christian Recorder*. Accessible Archives. Retrieved January 15, 2024 from http://www.accessible.com.turing.library.northwestern.edu/accessible/print

The Western Sanitary Commission. (1864). *The western sanitary commission: A sketch*. Sabin Americana. Retrieved from https://www.gale.com/c/sabin-americana-history-of-the-americas-1500-1926

Winderman, E., Mejia, R., & Rogers, B. (2019). "All smell is disease": Miasma, sensory rhetoric, and the sanitary-bacteriologic of visceral public health. *Rhetoric of Health & Medicine, 2*(2), Article 2. doi:10.5744/rhm.2019.1006

Winslow, C. E. A. (1923). *The evolution and significance of the modern public health campaign*. New Haven, CT: Yale University Press.

Wu, J., Hsiao, H., Chen, L., Weng, C. Y., Chang, P. S., & Chu, S. Y. (2022). A multiple-stakeholder perspective of patient-provider communication among families with rare diseases in Taiwan through a cross-cultural lens. *International Journal of Communication, 17*, 192–213.

Zaeske, S. (2002). Signatures of citizenship: The rhetoric of women's antislavery petitions. *Quarterly Journal of Speech, 88*(2), 147–168.

Zegers, C., & Auron, M. (2022). Addressing the challenges of cross-cultural communication. *Medical Clinics of North America, 106*(4), 577–588. doi:10.1016/j.mcna.2022.02.006