Of Bedpans and Blackboards: Teaching Writing in the Educational Management Organization

Kelli L. Custer

> But worth can be assured only by a profession in which we are not servile tools, but in which we act independently in our own sphere. It can be assured only by a profession that does not demand reprehensible acts, even if reprehensible only in outward appearance, a profession which the best can follow with noble pride. A profession which assures this in the greatest degree is not always the highest, but is always the most to be preferred. . . . One who chooses a profession he values highly will shudder at the idea of being unworthy of it; he will act nobly if only because his position in society is a noble one.
>
> –Karl Marx, "Reflections of a Young Man on The Choice of a Profession"

In his article "The Informal and Informational," Mark Bousquet observes that several writers (Noble; Martin; Rhoades) have drawn a comparison between the current management situation in higher education and the structure of the Health Maintenance Organization (HMO).[1] In the HMO structure, the criteria by which the quality of care is determined originate with upper-level management rather than with the actual caregivers. Similarly, in the "EMO," the quality of the education we are providing—or are being provided—is judged to be efficient based on quality indicators which focus on accountability, not actual learning. Bousquet notes several points of comparison between the two systems' structures, but of particular interest to me is his explanation of the increasing "marketization," through the "commodification of activities and relationships" and "the unapologetic delivery of degraded service or even denial of service to the vast majority of the work-

ing class." When we compare working conditions in the fields of healthcare and composition, we see that compositionists have been placed in the role of the registered nurse.[2] On the surface, this seems logical. The fields of nursing and composition share similar histories. In their struggle to maintain professional standards within systems that are more concerned with profits than patients, nurses have negotiated challenges of professionalization similar to those of compositionists. Both roles continue to be perceived through and defined by economic forces rather than by the actual work performed.

I suspect my experience has been like that of many professionals in the composition field: the courses we teach are increasingly framed as service courses in which we are expected to produce fully developed writers in approximately 15 weeks. Our situation resembles in important ways that of the HMO where patients are quickly admitted and discharged as insurance-permitted length-of-stay is steadily decreased. In composition, we are expected to discharge our students at the end of their stay, healed of all grammatical woes. Likewise, in committee meetings, class discussions, or informal gripe-sessions with colleagues, we've probably encountered concerns that our universities are increasingly following management models derived from the health professions, and specifically the managed care organization.

Unfortunately, dissatisfaction with the conditions in which we teach composition is not new, nor even recent. In January, 1912, the National Council of Teachers of English premiered its new publication, *The English Journal*. In the lead article of that first volume, Edwin M. Hopkins asks, "Can good composition teaching be done under the present conditions?" His first paragraph, only one word in length, gives a direct answer: "No." Hopkins summarizes the problem of working conditions almost a century ago:

> Not very many years ago, when effort was made to apply the principle that pupils should learn to write by writing, English composition, previously known as rhetoric, became ostensibly a laboratory subject, but without any material addition to the personnel of its teaching force; there was merely a gratuitous increase in the labor of teachers who were already doing full duty. (2)

Over 90 years later, we are still coming to the same answer: good composition teaching is difficult or even, as Hopkins states, impossible under the current working conditions.

While on the surface it would seem that what is most desirable is to change the system, Bousquet observes that the system is entrenched. Therefore, "any 'changes' that may be wrought in the future will be wrought within the frame of 'recognizing' the inevitability of the corporate university" ("Composition as Management"). If this is true, then what we must ask is how can we conceive of our role and our work within this system? One possibility is to compare the role of the compositionist in the EMO to

that of the nurse in the HMO. Both composition teachers and nurses share common themes in their histories, including struggles with feminization of their workforces; problems arising from newly defined "quality indicators"; increased use of under-trained workers; and the struggles of professionalization. These comparisons suggest vital similarities between the field of composition and the profession of nursing. Ultimately, however, I want to argue in this piece that our role within the EMO might better be understood through comparison to the role of another important figure in the HMO, the general internist physician.

To develop this thesis, first I will define the key terms of nurse and general practitioner for the purposes of this discussion, followed by a brief survey of the origins and recent histories of the HMO and the EMO in our country. Next, I will explore four common themes which the fields of composition and nursing share. From there, I will look at the key role definitions play—those concerning "good health" and "good writing"—in determining how the work of nurses and of compositionists is understood. These insights then will lead me to advocate looking carefully at how we define ourselves as a field, with attention to benefits and consequences which may arise from choosing the label *rhetorician* over that of *compositionist*. Finally, I will consider important parallels between our work in writing instruction and that of the general internist physician in the HMO. Such similarities—even more than those we share with nurses—can provide insights about how best to position ourselves professionally in relation to our English department colleagues and within the emerging structure of the EMO.

Defining the Nurse and the General Practitioner

Before elaborating my thesis, let me define *registered nurse* and general practitioner physician or *general internist*. A registered nurse, or RN, has completed three to four years of schooling and passed a state licensing exam. According to the American Nurses Association, the registered nurse delivers care to patients through a five-step process: "collecting and analyzing physical, psychological and sociocultural data about a patient; making a judgment on the cause, condition and path of the illness; creating a care plan which sets specific treatment goals; supervising or carrying out the actual treatment plan; [and] continuous assessment of the plan." With the shift toward managed health care, the work of the registered nurse gradually was assigned to lesser-trained (and therefore lesser-paid) personnel, such as nurse's aides and LPNs (licensed practical nurses). With this shift, both the salary and job descriptions of registered nurses changed significantly; for many registered nurses, contact with the patient was replaced by more extensive paperwork. This change is often cited as one factor in an increasing shortage of registered nurses (Goodin).

The other key figure in the comparison I'll develop is that of the general internist. This type of physician was known earlier as a

General Practitioner (GP). The development of managed healthcare made the primary care provider essential. With increasing reliance on the primary care provider, GP positions have frequently split into three separate areas of specialty: 1) the *general pediatrician*, who specializes in treating children; 2) the *family physician*, who specializes in general treatment of patients of all ages; and 3) the *general internist*, who is, as the American College of Physicians asserts, a "doctor for adults." General internists complete three years of training beyond medical school in their specialty of the prevention, diagnosis, and management of diseases that affect adults (Moore and Showstack 246). Most managed care systems hope that, ideally, a general internist is viewed as "an expert in adult health who treats the whole person, takes a preventive approach, listens, and treats the patient with respect" (Arneson and McDonald 5). As I will show later in the paper, this increased demand is important in terms of the composition field as well.

Historical Background of EMOs and HMOs

The acronym "HMO" originally meant "health maintenance organization" and appeared in 1970 when Nixon advisor Paul Ellwood coined the term to describe the type of health care pioneered in the 1930s by Henry Kaiser.[3] Initially, Kaiser, a large-scale industrial magnate, worked with physicians to establish a way to keep his employees healthy by providing facilities and prepaid physicians. Eventually the Kaiser Foundation Health Plan was also open to the public. By the time the term HMO was established, the Kaiser plan served over three million members in six different types of regional plans (Dranove 38), and prepaid group practices were considered the new hope in containing costs and increasing the efficiency of healthcare. The original intent of HMOs was to *maintain* health. Since serious illness and hospitalization were so expensive, Henry Kaiser's first managed-care program sought to provide workers with a low-cost way to receive regular check-ups, thus catching problems before they were serious. But unfortunately, in its current form, "managed care has so far served as a different way to pay for medical care, not a better way to provide it" (Felton 9).

Now, HMOs have become well established, although not always well respected. Managed care's concern for profits over patients has become a standard reference, even a running joke, in popular culture. In response to the summer 2002 film *John Q*, in which Denzel Washington stars as a father taking a hospital hostage in order to force his insurance company to pay for his son's heart transplant, the American Association of Health Plans hired the well-known Hollywood talent agent William Morris to help enhance the public image of HMOs, blaming "overzealous lawyers and too many government regulations" for the problems with American healthcare (Edwards). Supporters still proclaim the cost efficiency of managed care, in spite of continually rising costs to patients, particularly to those on Medicare, and lack of investor confidence in HMO stocks.

Meanwhile, in the mid-1990s, Wall Street analysts and investment bankers coined the term "Education Management Organizations" (EMOs) to describe companies such as Education Alternatives, Inc., a privately-funded, for-profit company managing several public school districts, and the Apollo Group, known best for its University of Phoenix franchise. Investments in the company were so high that John Sperling, the University's founder, boasted, "We don't need an endowment. We have Wall Street" (Garber 57). Although few universities state it as bluntly as this, higher education as a profit-driven venture has clearly extended beyond the virtual universities and through the ivied walls of the brick-and-mortar institutions as well. As Bousquet notes, the social response to the EMO is very different than to the HMO, with apparently high rates of student satisfaction and a general belief that the changes can be attributed to the rise of technology ("Informal and Informational").[4]

The Feminization of Nursing and Composition

Turning our attention to the common themes which exist between the fields of nursing and composition, the first parallel concerns gender inequality. Nursing has long been considered a woman's field, and in the past, was one of the few accepted, encouraged, and even "natural" roles for women. In the preface of her 1860 work *Notes on Nursing*, Florence Nightingale asserts that "every woman is a nurse." This idea is simply a given; Nightingale's aim is to help women go beyond that natural role. She explains in her collected notes, "I do not pretend to teach [every woman] how; I ask her to teach herself, and for this purpose I venture to give her some hints." Soon after Nightingale's notes were published, the first training school for nurses opened in 1861 "to all women in Philadelphia who wished greater proficiency in their domestic responsibilities" (in Lynaugh 11). As economies rapidly industrialized in the late 19th century, the subsequent rise in the number of hospitals and changes in home life increased the need for nurses. Contrary to the years before, when health care happened in the home, by 1910, most communities in the United States had at least one hospital, and about 7,000 hospitals were in operation in 1920 (Lynaugh 13).

With physicians and nurses working together in hospitals, an even stronger hierarchy was established. As one author explains, in the period following post WWII, nurses gained responsibility and status, "but [that status] always stayed one step removed from physicians' status. Bad nursing was always a convenient scapegoat for bad outcomes and could be blamed for 'thwarting' the best efforts of the physician" (Shew, in Howell 95). Even as it has moved outside the home, nursing has remained a predominantly female profession. U.S. Census Bureau statistics estimate that 96% of registered nurses working in 2000 were female (Lynaugh 21). Hidden behind the "natural role" of women as nurses are the economic realities of the profession: historically and currently, women

receive lower salaries and reduced benefits than do men, and therefore also are considered the "natural choice" for such exploitation.

Historically, composition has also been viewed as a feminized field, the "women's work" of the English department. Theresa Enos describes the situation at a public university where she taught as both "feminized" and "exploitive," explaining that "90-95% of the nontenure-track and part-time faculty teaching 95% of the composition courses were women," but that "they earned about two-thirds of what a beginning assistant professor in a tenure-track position earned, taught three courses a year more, and unquestionably worked twice as hard" (61). Other researchers have provided additional evidence. Susan Miller explains that a hierarchy has been established in English studies. In this hierarchy, literature is the real work and composition is the lesser choice; composition is "'worthy' but not 'theoretically' based, culturally privileged, work" (122). This perception is increasingly reinforced by the economic forces and the emerging business culture of higher education. Required courses such as first-year composition are "cash cows," a herd which can be further milked if the salaries remain low and the workers remain at a part-time, non-benefited status. Miller argues that this work is ideologically coded as women's work, "blurred in a matrix of functions that we can understand through the instructive example of Freud's description of the 'feminine,' which was formed at about the same time that composition courses and their teaching first achieved presence in the new university" (136). Following Freud's use of the roles of mother and nursemaid to represent women, Miller explains the composition teacher is perceived to fulfill "symbolic as well as actual functions":

> The nurse who cares for her young charge toward "adult" uses of language that will not "count" because they are, for now, engaged in only with hired help; the "mother" (tongue) that is an ideal/idol and can humiliate, regulate, and suppress the child's desires; and finally the disciplinarian, now not a father figure but a sadomasochistic Barbarella version of either maid or mother. (137)

With composition set up both as a gate-keeping requirement and a one-dose method of curing all writing ills, these roles are increasingly prominent. Each role also parallels those of the registered nurse. Although the nurse interacts with a hospital patient more regularly than does the typical doctor in his (and it still usually is a "his") brief rounds, her perception of the patient's condition is seldom thought to count as authoritative. Nonetheless, the nurse is the one who must carry out the orders, at times employing literal restraints to ensure compliance and often inflicting physical pain. This continued view of both composition and nursing as feminized allows management structures to maintain the positions' low salaries and low status. As Theresa Enos explains, "When a field

has been feminized and when a disproportionate number of its workers are female, that field is devalued and is subject to both disciplinary and gender bias" (43). The work of both nursing and composition, then, has been feminized, and (often) therefore exploited.

Role of Quality Indicators in HMOs and EMOs

A second parallel between the fields involves the role of quality indicators. For economic gain, HMOs and EMOs tend to abuse the indicators that are used to judge the work of nurses and composition teachers. In nursing, traditional indicators of good patient care have been mortality, morbidity, and length of stay (Conger 706), the latter of which has been increasingly shortened to maximize the potential for an increased number of paying patients to be cycled through the system. Although they have been considered means of measuring cost effectiveness, these indicators are not always applicable when considering the work of nurses. The mortality rate, as Conger points out, often "is more closely related to the patient's age, severity of illness, and extent of comorbidities than to specific nursing interventions." Morbidity—the incidence of disease—is only sometimes related to nursing care, particularly in following general safety and hygiene practices ("universal precautions"), but many other variants beyond the nurses' control are also involved. The length of the patient's stay is something over which nurses likewise have little power. Therefore, Conger suggests that new indicators of quality care be devised. She suggests using "nurse-sensitive quality indicators," including aspects of morbidity related to universal precautions (maintenance and care of IV, catheter, and surgical dressing sites); issues of risk management (keeping patients from falling, avoiding medication errors, and watching for bed sores); issues of patient quality of life (self-care activities and management of symptoms) and psychosocial status; and support to patient families (707).

These descriptions of a need to change the indicators of HMO quality are compellingly familiar to the concerns we have all read, heard, or expressed about EMO quality indicators. The standardized test doesn't account for variations inherent in students, but it is still often used to assess the performance of instructors. Most state school systems in the last several years have been forced to cut the number of total credits from their curricula because a student's "length of stay" has been used as an indicator of quality – "quality" again being used as a euphemism for "cost effectiveness," translated more clearly as "higher profit margins." Not only are the indicators not "instructor sensitive," but they are not even "education sensitive." In a hospital setting, the goal is ostensibly for the patient to return to health more quickly; therefore, a quicker exit from the hospital might be considered desirable. For students, however, the formula is not to *return to* a state of being from which they came; rather, it is to *attain* a particular state. Whether a student graduates in four years does not have much relevance in rating the quality of a teacher, but more importantly, this time limit does not

guarantee the quality of the *education*; rather, it indicates the highest level of turnover rate so that more student dollars can be pushed through the system without the higher cost of employing more personnel to "service" these students.

"Unlicensed Assistive Personnel"

A third parallel between the two fields of nursing and composition can be observed in disputes over the accreditation of practitioners. In the case of nursing, this dispute centers on the role of "unlicensed assistive personnel" (UAPs). The level of training required for these aides varies; programs advertising their courses on the Internet average 90-100 hours of class and practical training of about 6-9 weeks. Ostensibly, the aides are available to do the "scut work" of nursing—changing linens, giving baths, taking temperatures and other vital signs—while the nurses can complete the paperwork and charting necessary to track the progress of the patient. As accountability levels have increased, so has paperwork.

Many nurses worry, however, that aides are used too frequently and inappropriately. The direct time spent with the patient that is being assigned to aides is often when nurses are most able to assess the patient's condition. The American Nurses Association issued a policy statement reflecting this concern, claiming that "in virtually all health care settings, UAPs are inappropriately performing functions which are within the legal practice of nursing. This is a violation of the state nursing practice act and is a threat to public safety." Because the registered nurse is responsible for delegating the work, The Association emphasizes the need to decide when that delegation is both safe and appropriate and declares, "Any nursing intervention that requires independent, specialized, nursing knowledge, skill or judgment can not be delegated."

This position of the American Nurses Association is certainly in part a call to preserve a higher quality of care for patients. Moreover, they are fighting to preserve the status of the work they do. Once UAPs are used to cover some of the duties previously performed by nurses, then management is able to justify paying nurses less because the new work they have been assigned—often administrative in nature—can be deemed as less valuable.

The situation in composition has often been to treat every writing teacher as a "UAP," although in fact many are well trained. Theresa Enos explains that the heavier teaching loads (and indeed, the lower salaries) which are typical to composition faculty are justified because research and committee work are often not required. Such views not only reinforce the notion of "simply teaching" as at the bottom level of value in the institution; it also assumes that composition teachers, particularly those with a less-specialized background, would not be interested and/or effective in work outside the classroom. Therefore, on the one hand, as with nursing, the composition classroom is often staffed by "UAPs" whose low salaries are justified by their lack of training. But even when composition teachers do have specific training in composition or rhet-

oric, the extra duties that are added—as with nursing—are in the form of paperwork and administration, such as directing writing programs and writing centers. As in my experience, sometimes these are duties assigned with little or no compensation, seldom with any formal recognition, and, as Enos explains "often not counted in tenure decisions; or if it is counted, such work usually falls under service" (95).

Ironically, then, even as I return to school in order to advance, I likely will be "advancing" into administrative work and moving beyond the real work of my profession—teaching—which is the reason I entered the field in the first place. Bruce Horner addresses this problematic issue of advancing in a field through distancing oneself from its material labor. In his "materialist critique," Horner asserts that composition's move toward professionalization has often involved this same shift, "legitimate work" now defined "as the acquisition, production, and distribution of print-codified knowledge about writing: the production and reception of (scholarly) texts." He continues, "In this discourse, the "work" associated with such activities as teaching is deemed "labor," the implementation of the work of professional knowledge, and thus susceptible to proletarianization. . . . For in academic professional discourse, knowledge is recognized only as it appears in commodified textual form as explicitly theorized" (173). Clearly, our striving toward professionalization may have moved us deeper into the text and further from the classroom.

Professionalization

This concern leads to a fourth parallel between the fields of composition and nursing: the ways in which each has struggled with issues of professionalization. Richard Ohmann explains the steps a field takes toward professionalization. First, the profession "ground[s] its practice in a body of knowledge." That knowledge is then "develop[ed] and guard[ed] . . . within a universally recognized institution as a university." Access to the knowledge, "lore and skills" is limited "requiring aspirants to pass through graduate or professional programs." Finally, this certification is controlled and granted only to those who meet agreed levels as established by employers and other institutions, such as state licensing boards (227).

Ohmann's definition can be clearly traced in both fields. Beginning with nursing, its history shows the shift from "every woman is a nurse" to required study and formal licensure. Originally, most nursing training was completed on the job as nurses worked in hospitals. Gradually, the body of knowledge that makes up the substance of the nursing field has come to be more guarded. Although requirements vary from state to state, all nurses in the United States and District of Columbia must graduate from an accredited program with either an associate degree or a bachelor's degree in nursing and then pass the national licensing exam. Periodic renewal of the license is also required in all states, usual-

ly involving continuing education units. Although either degree is sufficient, prospective nurses are advised to "carefully weigh the pros and cons of enrolling in a B.S.N. [bachelor of science in nursing] program because, if they do so, their advancement opportunities usually are broader" ("Registered Nurse"). As part of the move toward professionalization, a higher level of specialization allows a higher level of advancement. For nurses, these "advancement opportunities" include administrative positions and entrance into graduate programs, which may involve "research, consulting, teaching, or a clinical specialization." By establishing a body of knowledge and limiting the access to that knowledge to those with training, and then by taking a stand on the issue of UAPs and enforcing those measures, the American Nurses Association furthered the status of its profession.

Professionalization has also been hotly debated in composition. Robert Connors traces the field's historical struggle to become a recognized discipline, calling the 1990s "the 'Era of Disciplinarity' in the field of composition studies" (4). We have established a body of knowledge, and as Connors points out, we have seen a marked increase in the number of institutions granting PhDs in Composition/Rhetoric, an estimated 80 nation-wide (17). We have also seen policy statements issued similar to those from the American Nursing Association, such as the Wyoming Resolution, passed in 1987 by the Conference on College Composition and Communication and formally titled its "Statement of Principles and Standards for the Postsecondary Teaching of Writing."

The Wyoming Resolution has been considered an important step in addressing labor issues within the field of composition. Almost immediately following it, though, came the question of whether such moves toward professionalism would actually improve our working conditions. In a 1991 reaction to the resolution, William S. Robinson states, "I do not question that the CCCC 'Statement of Principles and Standards' responds to real needs and real injustices, both of which exist in God's plenty. But in addition to the injustices wrought upon many of us, injustices are wrought upon the students in composition classes taught by teachers who do not know their business" (348). This is not to say that every adjunct, graduate student, lecturer or non-tenured faculty member teaching composition "does not know their business." Too often, though, the assumption with any skill is that if we have it, we can teach it, or more to the point in composition: if we have a textbook, we can teach it.[5]

Definitions of "Health"

In terms of the history and struggles of the two fields, then, nursing and composition share important similarities. At this point we need to shift away from understanding our working conditions in the EMO and turn to understanding our work itself. The changing structure of both the healthcare and educational systems causes the meanings of key terms also to change, even ones which seem fixed.

For example, one doctor writing about the subject explains that "doctors are now defined as 'providers'; the 'care' in 'health care' is now defined as 'management'; and 'patients' are 'consumers'" (Feinstein 202). It is important that we begin to ask questions regarding some of the fundamental terms of our fields: What is good health? What do nurses do to help patients return to—or attain—this? And on the side of the EMO, what is good education, or good writing? What do instructors do to help students attain either of these? And most importantly, how does a profit-driven environment influence these definitions?

For both fields, a simple definition of opposites is not enough; good health is more than just the absence of illness, just as good writing is more than just the absence of grammatical errors. First, let me turn to some evolving definitions of health. Patricia Benner and Judith Wrubel consider several definitions of health in their work *The Primacy of Caring: From Novice to Expert*. This source is of particular interest here as it seeks to balance a discussion of nursing theory and practice. As the authors explain in their preface, "This book shares the phenomenological and feminist goal of making visible the hidden, significant work of nursing as a caring practice. Phenomenology and feminism have influenced the work, but expert nursing practice illuminates all the theoretical points" (Benner and Wrubel xi). The authors consider five different definitions of health: as 1) an "ideal state"; 2) "the ability to fulfill social roles"; 3) "a commodity"; 4) "human potential"; and 5) "a sense of coherence" (151-9).

The first definition—health as an ideal state—is taken from the definition stated in the World Health Organization's 1949 constitution: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity" (Benner and Wrubel 151). Benner and Wrubel argue that this definition "sets up a decontextualized standard that ignores personal and social resources, constraints, and possibility . . . [and] ignores temporality and the limits of formalism," and therefore is not a beneficial definition.

The second definition of health that Benner and Wrubel consider is a sociological view, positing that health is "the state of optimum capacity of an individual for the effective role and tasks for which he has been socialized" (Parsons in Benner and Wrubel 151). In this conception, then, health could mean, for example, that the manual laborer has sufficient strength and stamina to perform heavy labor, but that the office worker need only possess the manual dexterity required for typing and filing. The difficulty with this definition is that it again is based on an ideal, not taking into account "degrees of health" and assuming that the assigned social roles are themselves healthy. Such concern with this definition is particularly familiar to those studying composition and the debates over whether students should be taught to write for the academy or for the "real world." This sociological view of health "ignores the person's sense of fulfillment and well-being" (151), and therefore is also a less desirable definition.

A third definition of health, that of a commodity, is considered a

"medicalized view of health" in which "the self and the body are understood as raw material to be shaped and controlled in accordance with principles of science and technology" (Benner and Wrubel 151-2). The authors point out that Foucault analyzed this shift of health as a correction of deficits in *The Birth of the Clinic*. As Foucault further explains in "The Politics of Health in the Eighteenth Century," the change in this time period "correlate[s] … with the emergence at a multitude of sites in the social body of health and disease as problems requiring some form or other of collective control measures" (167-8). This observation suggests an interesting connection with the commodification of higher education and the "collective control measures" imposed by outside investors and non-educator governing bodies. Benner and Wrubel argue that the commodity view of health "promises 'instant' cures without personal effort" (153), which then promotes a disconnect between the means and the ends of attaining a level of health.

Considering "health as a human potential"—Benner and Wrubel's fourth definition—places health as a state people are pursuing but not necessarily perfectly maintaining. Health, then, becomes a process, occasionally incorporating only functional levels of performance, but with the possibility of including mental and spiritual health as well as physical wellness. In this definition, health is something toward which someone can strive, but never really attains, and this process is generally an individual quest. Benner and Wrubel the health as a human potential "is a personal quality that the person has, and as with all possessions (in our culture), it is the person's responsibility to use it." In this view, the health care provider is responsible for eliciting the potential from the person, rather than potentiating a situation that would solicit the person to be healthy or helping the person to develop or reintegrate healthful understandings of the self or the situation" (157). This definition of health emphasizes the importance of the individual realizing the possible health benefits to be found in collaboration or in a community, particularly as facilitated by the healthcare worker.

Benner and Wrubel's fifth definition of health, that of a sense of coherence, is based on the work of Aaron Antonovsky, a leading figure in the field of medical sociology (Frankenhoff). Antonovsky's view of health "emphasizes a sense of coherence that comes from belonging to a sociocultural group in which meanings are integrated and lived out as one's own concerns" (Benner and Wrubel 159). By incorporating "being as well as becoming," this phenomenological definition is "based on an integrated view of mind/body/spirit" (162). Such a definition of health seems to me the broadest, and even the "healthiest" one. "Health" here relies on a sense of balance between the physical, emotional, and mental aspects of the self and one's environment. From this perspective, then, what might first appear as the common cold arriving at the inconvenient time of semester's end may actually indicate an imbalance between the individual's mental and emotional needs and the capacity of the environment to support them. The third def-

inition—health as a commodity—is the very idea we are hoping to avoid in both the HMO and the EMO. These last two definitions of health—health as a continuously pursued potential and health as a sense of coherence within the individual—are of particular interest to me when paralleled with definitions of writing.

Definitions of "Writing"

As in the case of good health and the healthcare profession, compositionists have grappled for some time with conflicting definitions of good writing. James Moffett, whose thinking has widely influenced subsequent theorists on the teaching of writing, offers a taxonomy distinguishing between commonly held views of what it means to write. Moffett distinguishes four levels, beginning with what he calls a materialist definition: *writing as handwriting and drawing*. This definition applies most readily to the work of young children who must learn to record the graphic symbols of a written language in the first years of schooling or before (276). Moffett's next level of writing, *transcription*, involves learning to capture in script the sounds and meanings of spoken language as well as the scribal copying of language from the texts of others (276). Moffett argues that, for the most part, these early levels provide the dominant rationales for the teaching of writing at the elementary stages of American education, and often beyond.

Moffett's third level emphasizes attention to formal considerations at and beyond the sentence level, such as conventions of usage and standard patterns of organization, what he defines as a *craft* view of writing (278). From this perspective, good writing means following commonly taught rules for using accepted types of discourse (such as the so-called modes of description, narration, exposition, and argument) and language structures (such as subordination, parallelism, and topic sentences). In American education, this level of Moffett's taxonomy coincides with what has been described as *current-traditional rhetoric* (Young 31), a teaching practice which has dominated much of high school and college level composition pedagogy since the late nineteenth-century. Given such a long history, it's not surprising that Moffett believes the craft view, alone or in tandem with the previous levels of his taxonomy, represents the most widely accepted view of good writing in our culture today.

Moffett addresses in his final level in the taxonomy the kind of shift we must take to move beyond this view of teaching: recognition of writing as a form of authorship. Moffett asserts that in our best practice as teachers of composition, we need to "conceive of writing . . . as full-fledged authoring, by which I mean authentic expression of an individual's own ideas, original in the sense that he has synthesized them for himself." In this view, Moffett contends that "behind the basic meaning of 'author' . . . lies the assumption that a writer has something unique enough to add to the communal store of knowledge" (278). As we continue in this discussion of writing instruction within the EMO structure, I feel it is essential to

use the definition of "writing as authorship" as the central definition of good writing.

In defining good writing, I believe—as does Moffett—that we also need to move beyond the current-traditional model. Moffett argues, "Currently, most schools teach something else and call it writing." This practice continues because "nearly all the stakeholders in the teaching of writing have reasons for wanting to interpret it as 'mechanics,'" specifically, he claims, because "everyone senses, quite rightly, that real authoring would require radical changes in student role . . . and the whole atmosphere of schooling" (279). Stated bluntly: such a radical change would simply cost institutions more money. Today, as Sharon Crowley has recently noted, the current-traditional approach to teaching writing runs rampant in the majority of composition textbooks, and such an approach makes for a cheap way to "teach" composition—with a craft-based, current-traditional textbook emphasizing transcription skills, and even perhaps penmanship, in hand, practically anyone can "teach" writing, and for a low salary.

Comparing these taxonomies for defining good health and good writing suggests in part how we might address the changing professional environments of the HMO and the EMO. Returning to Benner and Wrubel's final two definitions of health—health as potential and as coherence—we can draw parallels to ideals of good writing. Moffett claims that in an effort to move toward writing as authorship, "The most fundamental way to improve compositional 'decisions' about word choice, phrasing, sentence structure, and overall organization is to clarify, enrich, and harmonize the thinking that predetermines the student's initial choices of these" (279). Such a view would seem to follow Benner and Wrubel's sense of health as a balance one is able to find within the support of a community. I equate this view of health with the way in which I try to teach composition, providing opportunities for student writers to work collaboratively with each other in order to gain awareness of the key components in effective writing: the rhetorical triangle of audience, purpose, and style (Booth 27).

To counteract the view of the writer as solitary genius, forwarded by the literary tradition of Romanticism, collaborative pedagogy seeks to advance the importance and strength of a community of writers. Interest in collaborative pedagogy can be traced to the scholarship of Kenneth A. Bruffee. Because individualistic teaching methods proved unsuccessful with new populations of nontraditional university student writers, Bruffee helped develop in the 1970s and 1980s a new approach based around three principles of collaborative work: 1) "thought is internalized conversation"; 2) "writing of all kinds is internalized social talk made public and social again . . . internalized conversation re-externalized"; and 3) "to learn is to work collaboratively to establish and maintain knowledge among a community of knowledgeable peers" (639-646). Such principles of collaborative pedagogy in part echo the notion of health as a balanced potential, realized through the facilitation of the healthcare professional. Within the new management

environment, however, the problem is that maintaining a commitment to these ways of defining both health and writing requires significant expenditures of effort and energy which, in the HMO/EMO system, remain unrewarded by significant expenditures of salary and respect.

Compositionists vs. Rhetoricians

Reconceiving how we define the material conditions of our work also allows us to redefine our roles within the managed education system. Maureen Daly Goggin explains, "What disciplinary practitioners choose to call a field has enormous implications for its future situation within the academy. Definition is a political act. The different names used to signify our disciplinary enterprise reveal a substantive conflict over how we define ourselves and our work" (29). Looking at today's post-secondary literacy instruction, Goggin explains an ongoing struggle between what she terms "compositionists" and "rhetoricians." "From the perspective of the "compositionist," teaching writing is perceived to be "a subfield of English studies," with the work of first-year composition as "a site of both knowledge production and dissemination." From the perspective offered by the term "rhetorician," however, the discipline is defined "in broader terms with composition as one component, a pedagogical component, of the field" (Goggin 29). She argues that we need to move away from the title of compositionist and toward rhetorician because "to continue to equate our identity and our work solely with first-year composition as it is presently configured keeps us restricted and unfulfilled." She continues, "By contrast, under the rhetoricians' concept, it is possible to imagine a rhetorical discipline and a set of courses in a broad range of literate practices" (44). Theresa Enos further explains the difference implications of the two terms: "rhetoric is the theory that drives practice, that is, an intellectual distinction, not a programmatic one" (78). In terms of the analogy I have presented so here, the designation "rhetorician" can be understood as the "general internist" of the EMO, with the term "compositionist" more closely related to "nurse." This change in role definitions reflects a more accurate and desirable set of hierarchies. In the medical system, the nurse is considered inherently the subordinate of the physician, largely based on their differing levels of training and expertise. Reconceiving our role in comp/rhet toward the general internist allows us to place ourselves as an integral part of the functioning of the managed education system.

On the medical side of the analogy, a general internist is "a comprehensive provider for the health needs of adults" (Sox, et al 618). Most important to this analogy is that internists have an equal amount of training compared to their counterparts in other specialties; indeed, internal medicine is considered a specialty in itself. Although some of the internist's functions are similar to those of other physicians, other functions are distinctive to the general internist, such as acting as the patients' primary and continuing

contact for consultations and diagnoses. Changes involving managed care systems have resulted in an increased demand for all primary care physicians and a decreased demand for specialists (such as cardiologists, oncologists, gastroenterologists, etc.) (Rivo and Satcher; Seifer, Troupin, and Rubenfeld). As many of us have experienced, one of the most prevalent managed care strategies is to use the primary care physician as the gatekeeper to the specialist. Rather than patients being allowed to go directly to the specialist for their particular condition, the patient must first see the primary care physician for a referral. This procedure requires that the internist have both a significant depth and breadth of knowledge to diagnosis, assess, and treat or refer patients who have a considerable variety of health needs. Because of this, the American College of Physicians Taskforce seeks to emphasize the model of "general internist as the local expert on a special topic" (621) rather than be perceived solely as a gatekeeper.

In the academy, the assumption often is that if the work is not specialized, it isn't of value. By continuing to perceive ourselves as nurses, we place ourselves in the undervalued tier. If we reconceive our role as rhetoricians, functioning as general internists, we can provide an integral first point of contact with students. More importantly, if we expand the sense of our role in the EMO, we also become a continuing force throughout the system. As with internists, teachers of writing often need to have a depth of knowledge in our own specialization as well as a breadth of knowledge in all fields. Conceiving ourselves as specialists also places us on more even ground with our literature colleagues. Traditional wisdom holds what Robert Scholes asserts: "Teachers of literature became the priests and theologians of English, while teachers of composition were the nuns, barred from the priesthood, doing the shitwork of the field" (36). Too often, writing has been conceived of as something anyone with a textbook can teach. Changing our identity to be that of a general internist—"a local expert on a special topic"—can help us to challenge that historical hierarchy. As has been recommended in medicine—that general internists receive more training—positioning ourselves as experts requires continuing our study of literacy both in theory and practice. John Gerber calls such a change "commonsense," claiming that "both the MA and PhD candidate should be encouraged to make writing, the theories of writing, and the theories of teaching writing an area of specialization" (64). Teaching composition is an important responsibility for faculty in English departments. We can model that new role of general internists of EMO by ensuring we can provide appropriate care for the students in our classroom at the same time that we use our expertise to shape informed policies toward issues of literacy and language learning.

Reconceiving Our Role in the EMO

Accomplishing such an identity shift takes work beyond simply requiring more training. One important step is changing public perception. The American College of Physicians (ACP) asserts that for

patients to make an informed decision when choosing a primary care physician, they must be aware of an internist's skills. Through a national survey, the ACP discovered that in fact the "public is generally unaware of what an internist is or does" (Arneson and McDonald 5). In response, the ACP began a marketing campaign, part of which included adding "Doctor for Adults" in their educational publications about internists. A follow-up survey after nine months of the campaign showed a clear increase in understanding about the skills and abilities of the general internist. This education, coupled with the public relations efforts mentioned earlier by some of the large-scale HMOs such as Kaiser-Permanente, gives patients the background knowledge necessary to make informed decisions.

A similar increase of public awareness about the extent of the writing teacher/rhetorician's expertise is also important. Eileen Schell suggests that we "examine the growth of administrative positions in light of the shrinking resources available for instructional faculty and make that information widely available to multiple publics; . . . [and] find rhetorically effective ways to communicate this broad activist educational agenda to legislators, parents, and taxpayers" (*Moving a Mountain* 338). Even in publications like this one, we usually are "preaching to the choir." We meet at conferences and discuss the problem with people who already know the problem. We may not end up with our own version of the film *John Q*, wherein students and parents take a university hostage until they get a well-trained and fairly compensated instructor in the composition classroom; however, making public the problems inherent in this emerging system of higher education could also help us to more clearly define our role within the system. Such advertising may need to start on the local level but could extend to documents such as catalogs, websites, and even accreditation materials. Such action would require effort on our part, and again, this extra work likely will not be compensated.

As Schell notes in another publication, the main obstacle for achieving this "conversionist reform" is in persuading "central administrators and faculty members that devoting money to such reforms is necessary" (*Gypsy Academics* 107). Schell later argues that enacting a unionist/collectivist agenda of reform requires "academic citizenship, the idea that academic faculty are responsible for directing and changing the working conditions that both enable, define, and, if we are not careful, constrain our ability to think, teach, and write" (119). I would argue that attaining this academic citizenship requires us to conceive ourselves as worthy members of the academy.

In the field of composition, we have decried our working conditions for almost a century. Historically, we have held roles—and, out of financial convenience to institutions, been *held in* roles—similar to those of the registered nurse. As the system of higher education has moved closer to that of the managed care organization familiar to us from the field of medicine, we have not changed our role to accompany the structural shift. It is clear we are unlikely to make substantial changes to the system in which we are now work-

ing. Perhaps the only—and even most important—shift we can strive for will be changing the way we see the work itself. In doing so, we may find that, ironically, the new environment of the EMO actually provides us the opportunity to adopt an institutional role and professional identity which better fits our responsibilities, talents, and aspirations.

Notes

[1]Warm thanks to David Downing and Claude Mark Hurlbert for their patience and support, and for modeling the utmost in noble professionalism. Thanks, too, to my mother, June Custer, for lengthy discussions regarding the role of the nurse; to Amy Jo Minett, for thoughtful feedback and support; and especially to J.S. Dunn, Jr., for sharing his immense intellect with such generosity.

[2]I first thought of this comparison as I considered a role within the medical field with which I have been intimately familiar all my life. My mother has been a registered nurse since 1962, with many of those years spent in the high-pressure environment of the intensive care unit. Growing up, I watched her work long hours, come home exhausted and frustrated and near tears over the difficulties with patients, the shabby treatment by self-important "M.D.-eities," and the increasingly unfair scheduling practices by the administration. As I chose my own profession, she and I often have joked about how we have such different jobs, with only very different types of colon problems to connect the two. However, it occurred to me that our working conditions have similarities. I feel a deep commitment to being a teacher, with a passion both for the field of writing and for my students. I find teaching writing to be exciting, frightening, challenging, and frustrating. I have worked long hours, felt undervalued and snubbed by colleagues in literature who imply they work in "real" academic subjects, and I have endured endless complaints from both in and outside university systems about how "students just aren't being taught to write these days." I have also come to the difficult realization that simply completing my PhD will not change these conditions.

[3]The original intent of this structure is apparent in the chosen term, "Health Maintenance Organization." Popular use has caused the term HMO to be thought of as the only method of managed care in medicine. In our discussions of the parallels between the two systems, the more correct term and the one used in medical literature is "MCO": "Managed Care Organization." This would lead us to the "MEO," or Managed Education Organization. However, to avoid confusion and maintain the vocabulary already in use, I will continue to use the term HMO as a catch-all phrase for the various models of managed healthcare.

[4]Technology has also had a significant impact on healthcare. One author asserts that "the role of technology in defeating caring cannot be overestimated" (Cassell 112). He further explains, "The hold of advanced technology on medicine is something like the

sorcerer's broom in the fairy tale—what started off under the control of physicians has now assumed an unstoppable life of its own" (113). Clear parallels between medical informatics and the technologized university can be made, but these are beyond the scope of my paper.

[5]Certainly this is a highly cost-effective method. The instructor of record is not only underpaid, but the *real* teacher, the textbook, is usually available for student purchase at less than $75 a copy per semester. Textbooks also require no fringe benefits.

Works Cited

American Nurses Association. "Registered Nurse Utilization of Unlicensed Assistive Personnel." 1997. *Nursing World Online: Reading Room*. 10 Dec. 2002. <http://www.nursingworld.org/readroom/position/uap/uapuse.htm>.

Arneson, Janet, and Walter J. McDonald. "Can We Educate the Public About Internal Medicine?: Initial Results." *The American Journal of Medicine* 176 (7): 1-5.

Benner, Patricia, and Judith Wrubel. *The Primacy of Caring: Stress and Coping in Health and Illness*. Menlo Park, CA: Addison-Wesley, 1989.

Booth, Wayne C. "The Rhetorical Stance." *Now Don't Try to Reason With Me: Essays and Ironies for a Credulous Age*. Chicago: Chicago UP, 1970. 25-34.

Bousquet, Marc. "Composition as Management Science: Toward a University Without a WPA." *JAC* 22.3 (2003): 493-526.

_____. "The Informal and the Informational." *Workplace* 5 (1). Available from <http://www.louisville.edu/journal/workplace/issue5p1/bousquetinformal.html>.

Bruffee, Kenneth. "Collaborative Learning and the 'Conversation of Mankind.'" *College English* 47.6 (November 1984): 635-52.

Cassell, Eric J. "Forces Affecting Caring By Physicians." In *The Lost Art of Caring: A Challenge to Health Professionals, Families, Communities, and Society*. Eds. Leighton E. Cluff and Robert H. Binstock. Baltimore: Johns Hopkins UP, 2001. 104-124.

Conger, Margaret L. "Nurse Executive Practice for the New Millennium." In *The Nursing Profession: Tomorrow and Beyond*. Ed. Norma L. Chaska. Thousand Oaks, CA: Sage, 2001. 701-712.

Connors, Robert. "Composition History and Disciplinarity." *History, Reflection, and Narrative: The Professionalization of Composition 1963-1983*. Eds. Mary Rosner, Beth Boehm, and Debra Journet. Greenwich, CT: Ablex, 1998. 3-22.

Crowley, Sharon. "Around 1971: Current-Traditional Rhetoric and Process Models of Composing." In *Composition in the Twenty-First Century: Crisis and Change*. Eds. Lynn Z. Bloom, Donald A. Daiker, and Edward M. White. Carbondale, IL: Southern Illinois UP, 1996. 64-74.

Dranove, David. *The Economic Evolution of American Health Care: From Marcus Welby to Managed Care*. Princeton, NJ:

Princeton UP, 2000.
Edwards, Bob. "Profile: HMOs Become Favorite Targets on Television Shows and in Movies." *NPR Morning Edition* 16 July 2002. Transcript available online. Ebscohost Database: Newspaper Source. Persistent link: <http://search.epnet.com/direct.asp?an=6XN200207161003&db=nfh>
Feinstein, Alvan R. "Appraising the Success of Caring." In *The Lost Art of Caring: A Challenge to Health Professionals, Families, Communities, and Society*. Eds. Leighton E. Cluff and Robert H. Binstock. Baltimore: Johns Hopkins UP, 2001. 201-217.
Felton, Geraldene. "Building for the Next Century: Nursing's Bias Is Its Glory." In *The Nursing Profession: Tomorrow and Beyond*. Ed. Norma L. Chaska. Thousand Oaks, CA: Sage, 2001. 3-16.
Foucault, Michel. "The Politics of Health in the Eighteenth Century." *The Foucault Reader*. Ed. Paul Rabinow. New York: Random House, 1984.
Frankenhoff, Charles. " Antonovsky's Sense of Coherence Concept: An Instrument for Primary Prevention in Social Work." *International Social Work* 41.4 (1998) 511-523.
Garber, Michael P. "Wall Street Ph.D." *National Review* 30 Sept. 1996: 57+.
Gerber, John C. "Suggestions of a Commonsense Reform of the English Curriculum." In *The Writing Teacher's Sourcebook*. 2nd ed. Eds Gary Tate and Edward P.J. Corbett. NY: Oxford UP, 1993. 60-64.
Goggin, Maureen Daly. "The Disciplinary Instability of Composition." In *Reconceiving Writing, Rethinking Writing Instruction*. Ed. Joseph Petraglia. Mahwah, NJ: Erlebaum, 1995. 27-48.
Hopkins, Edwin M. "Can Good Composition Teaching Be Done Under Present Conditions?" *The English Journal* 1.1(1912). 1-7.
Horner, Bruce. *Terms of Work for Composition: A Materialist Critique*. Albany: SUNY, 2000.
Howell, Joel D. "A History of Caring in Medicine." In *The Lost Art of Caring: A Challenge to Health Professionals, Families, Communities, and Society*. Eds. Leighton E. Cluff and Robert H. Binstock. Baltimore: Johns Hopkins UP, 2001. 77-103.
Lynaugh, Joan. "Nursing's History: Looking Backward and Seeing Forward." *Enduring Issues in American Nursing*. Ed. Ellen D.Baer, et al. New York: Springer, 2001. 10-24.
Martin, Randy. "Education as National Pedagogy." *Chalk Lines: The Politics of Work in the Managed University*. Ed. Randy Martin. Durham: Duke UP. 1-32.
Marx, Karl. "Reflections of a Young Man on The Choice of a Profession." *Marx-Engels Collected Works, Volume 1*. June 1, 2003. <http://www.marxists.org/archive/marx/ works/1837-pre/marx/1835-ref.htm>
Miller, Susan. *Textual Carnivals: The Politics of Composition*. Carbondale, IL: Southern Illinois UP, 1991.
Moffett, James. "Integrity in the Teaching of Writing." *Phi Delta Kappan* Dec. 1979: 276-79.

Moore, Gordon, and Jonathan Showstack. "Primary Care Medicine in Crisis: Toward Reconstruction and Renewal." *Annals of Internal Medicine*. 138.3 (2003): 244-48.

Nightingale, Florence. *Notes on Nursing: What It Is, and What It Is Not*. 1859. Commemorative Edition. Philadelphia: Lippincott, 1992.

Noble, David. 2001. *Digital Diploma Mills: The Automation of Higher Education*. New York: Monthly Review Press.

Ohmann, Richard. *English in America*. New York: Oxford UP, 1996.

"Registered Nurses." Bureau of Labor Statistics. U.S. Department of Labor. Occupational Outlook Handbook, 2002-03 Edition. June 2003. <http://www.bls.gov/oco/ocos083.htm>.

Rhoades, Gary. *Managed Professionals: Unionized Faculty and Restructuring Academic Labor*. Albany, NY: SUNY, 1998.

Rivo, Marc L. and David Satcher. "Improving Access to Health Care through Physician Workforce Reform." *JAMA: Journal of the American Medical Association* 270.9(1993): 1074-1079.

Schell, Eileen. *Gypsy Academics and Mother-teachers: Gender, Contingent Labor, and Writing Instruction*. Portsmouth, NH: Boynton/Cook, 1998.

_____. "What's the Bottom Line?" *Moving a Mountain: Transforming the Role of Contingent Faculty in Composition Studies and Higher Education*. Eds. Eileen Schell and Patricia Lambert Stock. Urbana, IL: NCTE, 2001. 324-340.

Scholes, Robert. *The Rise and Fall of English*. New Haven: Yale UP, 1998.

Seifer, S., B. Troupin, and G. Rubenfeld. "Changes in Marketplace Demand for Physicians." *JAMA: Journal of the American Medical Association* 276.9 (1996): 695-699.

Sox, Harold C., et al. "The Role of the Future General Internist Defined." *Annals of Internal Medicine* 121(8): 616-622.

Young, Richard. "Paradigms and Problems: Needed Research in Rhetorical Invention." *Research on Composing: Points of Departure*. Eds. Charles R. Cooper and Lee Odell. Urbana, IL: NCTE, 1979. 29-48.


TUITION WAIVERS
PUT PEOPLE #1