‘Should I Have Done More?’: Proxy Agency, Gathered Ethos, and Volunteer Responsibility in the Rhetoric of Health Resettlement for Refugees

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ABSTRACT

After relocation to the United States, refugees are often assisted by community volunteers in the process of resettlement, which frequently includes navigating the financial and social aspects of life in the US. However, the medical and health aspects of resettlement, and particularly how volunteers are involved in those aspects, have gone unexplored, leading to tensions within volunteer-led resettlement groups as they attempt to negotiate the limits of volunteer involvement. To investigate how volunteers understand a process of health resettlement, their role(s) within the process, and how they rhetorically position their relationship with resettling clients, this study uses interview data from a local, volunteer-run community resettlement organization to provide a rhetorical examination of health resettlement. An analysis finds that in both contrast and response to a rhetoric of self-sufficiency established by state and federal policy, resettlement volunteers understand health resettlement through a rhetoric of responsibility. This rhetorical framework constitutes volunteers’ role as proxy agents in the process of health resettlement. Additionally, volunteers use a gathered ethos approach within this framework, drawing from community networks in order to facilitate persuasion of resettling clients toward desired health outcomes. Ultimately, recommendations are made for community sponsorship and volunteer approaches to health resettlement for refugees in the United States.

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GENERAL AUDIENCE ABSTRACT

After relocation to the United States, refugees are often assisted by community volunteers in the process of resettlement, which frequently includes navigating the financial and social aspects of life in the US. However, the medical and health aspects of refugee resettlement, and particularly how volunteers are involved in those aspects, have gone unexplored. This study uses interviews with resettlement volunteers to understand how volunteers perceive their role within the health resettlement process, how they position themselves in relation to resettling refugees, and how they expect refugees to navigate health communication scenarios. It finds that volunteers feel a tension between a rhetoric of self-sufficiency that is established by policy and a rhetoric of responsibility that is established by humanitarian narratives. This tension motivates volunteers to act as communication intermediaries, performing health communication tasks on behalf of refugee clients while also attempting to persuade clients toward particular healthcare decisions. Recommendations are made for community sponsorship and volunteer approaches to health resettlement for refugees in the United States.

Dedication

For Bianca, who is just starting her intellectual journey,

and for Linda Oshinsky, who helped start me on mine.

Acknowledgements

I am forever grateful to my committee, made up of five of the most brilliant people I know. Three of these people have served as my dissertation director at various times: First, Dr. Bernice Hausman, who has an unparalleled ability to zero in on exactly the most interesting thing I'm trying to say, which was instrumental during the beginning stages of my project; second, Dr. Kelly Pender, who is a tremendous reader and whose regular question of "But what are the implications for *rhetoric?*" kept this project grounded even as I was trying to situate it between multiple fields; and lastly, Dr. Katrina Powell, who pushed me over the finish line during a global pandemic (and subsequent IRB shutdown) with her unfailing support, encouragement, and ability to wrangle the interdisciplinary nature of this project. Her mentorship has been a constant throughout my PhD experience and I'm very fortunate to have benefitted from researching, writing, traveling, and presenting alongside her for five years. Many people over those years have told me how lucky I am to be working with her, and I wholeheartedly agree.

I was also incredibly fortunate to have Dr. Rebecca Hester on my committee, whose perspective as an STS scholar pushed me to new insight and to make clear connections in my arguments, and who is one of the most supportive people I could've ever hoped to have in my corner as a graduate student. Finally, I'm not sure I would've made it through this dissertation without Dr. Carolyn Commer, whose mentorship and persistent encouragement were bright spots when this process was darkest. My wish for every graduate student is to have a Carolyn on their thesis committee.

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Writing a dissertation while raising a small child is one of the hardest things I've ever done--even before the pandemic, but more so once it started. I am deeply grateful to Ashley, Molly, Jennica, Katherine, Jordan, Brooke, Daniel, Kayla, Amy, and Betsy for their caretaking work and love for my daughter. I'm especially thankful to my parents, Bart and Carolyn—arguably the world's best grandparents—for their willingness to babysit for weeks at a time and for their support during this project.

My closest friends, my fishters, were a bedrock of emotional support through every paragraph, page, and chapter.

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Chapter 1

"Doing More": Volunteer Dilemmas and Rhetorical Approaches in Refugee Resettlement

> *"The thing that spurred it was that we kept seeing pictures of horrible things happening in Syria, and of babies washed up on the beach…. And finally we just said, 'We can't just be sad about [the refugee crisis] anymore, and say 'Oh gosh, I wish there were something we could do.' So [we] sat down and said... 'Ok, what about the crazy idea of bringing a family to Blacksburg? And how in the world do you do that?'" - Rebecca, personal interview, April 2017*

In July 2016, a group of Blacksburg, VA residents met in the multipurpose room of the local public library to discuss the possibility of sponsoring a refugee family in town. The meeting had been initiated by four town residents who were interested in how they could help in the wake of the Syrian refugee crisis. They, like others in the crowd at the library that day, were motivated to humanitarian aid by the viral photo of the body of 3-year-old Alan Kurdi, a Syrian Muslim who drowned along with his mother and brother in the Mediterranean Sea in the attempt to reach Kos, Greece. The photo of Kurdi's body on the shore of the Turkish beach had circulated in the US against a backdrop of divisive, anti-immigration politics. While the photo was going viral in late 2015, Donald Trump had become the frontrunner for the Republican presidential nomination, calling for a national database of Muslims, expanded mosque surveillance, and a ban on Muslim immigration to the US (Haberman, 2015; Johnson, 2015). The meeting in the Blacksburg library convened only weeks after Trump officially received the nomination. And despite being advertised only by word of mouth, the meeting was standing room only, demonstrating the town's interest in helping to sponsor one or more refugee families in Blacksburg. As one meeting organizer put it, "I mean, people just started showing up. And all these emails—we still get them—'I can help, I wanna help.'"

This public-interest meeting was the start of what would become the Blacksburg Refugee Partnership (BRP), a grassroots community organization founded with the long-term goal of "offer[ing] a holistic approach to the process of resettlement" (Blacksburg Refugee Partnership, n.d.), and the immediate goal of providing financial and material support for a Syrian family to relocate to Blacksburg. The vision for the organization's members was that they would be able to provide volunteer support for a refugee family during the initial months after relocation to Blacksburg, as well as raising enough monetary donations to pay for the family's rent and other expenses. Generally, however, volunteers admit now—five years later—that they had no idea what to expect as they looked forward to the resettlement process. After gathering enough volunteers to support the initial goals and forming a small Board of Directors, the Board reached out to the local resettlement agency to express an interest in sponsoring a refugee family, particularly one from Syria.

The BRP did not have to wait long. In October 2016, only three months after the interest meeting in the library multipurpose room, the resettlement agency reached out to the BRP organizers to talk about a recently arrived Syrian family whom the agency staff felt needed more support than they could provide. The family had been in the United States for a few months already, but were now facing eviction from their apartment and were struggling to communicate both with the property management and with resettlement agency staff. The agency staff told BRP leadership that they had spoken with the parents of the family about relocating, and that the family would be interested in talking to BRP representatives about moving to Blacksburg. “Would you be interested in sponsoring them?” agency staff asked. The answer from the BRP was an immediate “yes.” Yet amongst themselves, volunteers were asking: How would they do this?

That question was the foundation for BRP volunteers as they began the process of community-sponsored resettlement. This dissertation explores community-sponsored resettlement as a *rhetorical* process, specifically related to health and how volunteers approach the experience of helping someone else navigate the United States healthcare system. While the focus in refugee studies scholarship is often on if or how volunteers help in resettlement, I will focus on the rhetorical implications of their help as it pertains to health and medicine in particular—what is revealed about health resettlement, and how volunteers discursively position themselves to make it happen.

As the following chapters will discuss, the initial question that volunteers posed facing the resettlement process—“How [will we] do this?”—morphed as the process began. Volunteers soon grappled with rhetorical issues they had not expected, such as how to communicate medical risk, where and when to try and persuade someone toward (or away from) an action, and how to navigate the tensions involved—both organizationally and interpersonally—in moments of disagreement about those actions and risks. Issues of rhetorical agency, expertise and ethos, and relationality emerge in these moments, as well as understandings of humanitarian ethics. And, as I will argue, exploring this complicated health resettlement situation from a rhetorical standpoint furthers a conversation in rhetoric of health and medicine (RHM) that is still emerging; namely, understanding the role of the nonpatient, nonprovider "third" in health discourses that are traditionally considered to happen between patients and providers. This is an important conversation to continue and expand, as RHM scholars have begun to theorize such discourses as more ecological (Gonzales and Bloom-Pojar, 2018; Walkup and Cannon, 2018; Jensen, 2015; Hausman et al., 2014) and not limited to patient/provider interaction. This study focuses on the human interlocutors that are responding both to dominant cultural narratives about health as well as to narratives about refugees and humanitarian aid. Focusing on the human actors in these health resettlement situations emphasizes the questions of interpersonal responsibility that emerge at the forefront of community-sponsored resettlement. Thus, the purpose of this project is not only to understand how volunteers discursively position themselves and act as interlocutors, but also to speak to the conversations in rhetorical studies around agential performance. This study begins to draw out a rhetoric of responsibility that speaks both to refugee studies and to rhetorical studies, and provides a venue to place both fields in conversation.

To discuss the rhetorical positioning of volunteers, in this introduction I first highlight refugee resettlement in the US, and provide an overview of the federal, state, and local approaches to resettlement. I begin here because understanding the current state of refugee resettlement, and how volunteers are factored into the process, is foundational to recognizing the significance of any rhetorical moves or positions volunteers make. I then move into the concept of *health* resettlement, as medicine and health fields are historically concerned with similar types of ethical questions as refugee studies; additionally, health is a site of resettlement that heretofore has gone unexamined. Finally, I tie the issue back to rhetorical studies, which is uniquely poised to examine the interpersonal dynamics and relationships of resettlement.

Refugee Resettlement and Community Sponsorship in the United States

Though this study takes a rhetorical approach to health resettlement, the problem that approach seeks to address is situated in refugee studies, and more applicably, the work of refugee resettlement in the United States. When the BRP volunteers agreed to sponsor that first Syrian family in Blacksburg, what they were undertaking was a process of community sponsorship, a resettlement model in which refugees chosen for resettlement are paired with community groups of volunteers who provide money, time, resources, and cultural orientation for a set time after a refugee's initial relocation. Community sponsorship is a recognized resettlement model in other countries (including Canada, Australia, and the UK), yet the United States has yet to adopt a widespread community sponsorship model, despite increasing support (La Corte and Keppley, 2020; Talla, 2016). Instead, the United States Refugee Assistance Program (USRAP) relies on a sponsorship model in which the US Department of State selects and relocates refugees to the US, then nine volunteer resettlement agencies known as VOLAGs (e.g. Catholic Charities, Jewish Family Services, International Rescue Committee) receive funding from the government to provide reception and placement services. While many of these VOLAGs rely on volunteer support to provide services such as transportation and language tutoring, most do not rely on community groups for more involved resettlement processes like enrolling people in healthcare, securing employment and housing, or registering children for school. Thus, without a clear guide as to *how* community sponsored resettlement should happen, the BRP had little idea of what to expect.

This dissertation focuses on a part of this community sponsorship process, and examines the Blacksburg Refugee Partnership as a case study. As I will discuss further in Chapter 3, selecting the BRP as an investigative site was motivated by my own participation with the group.

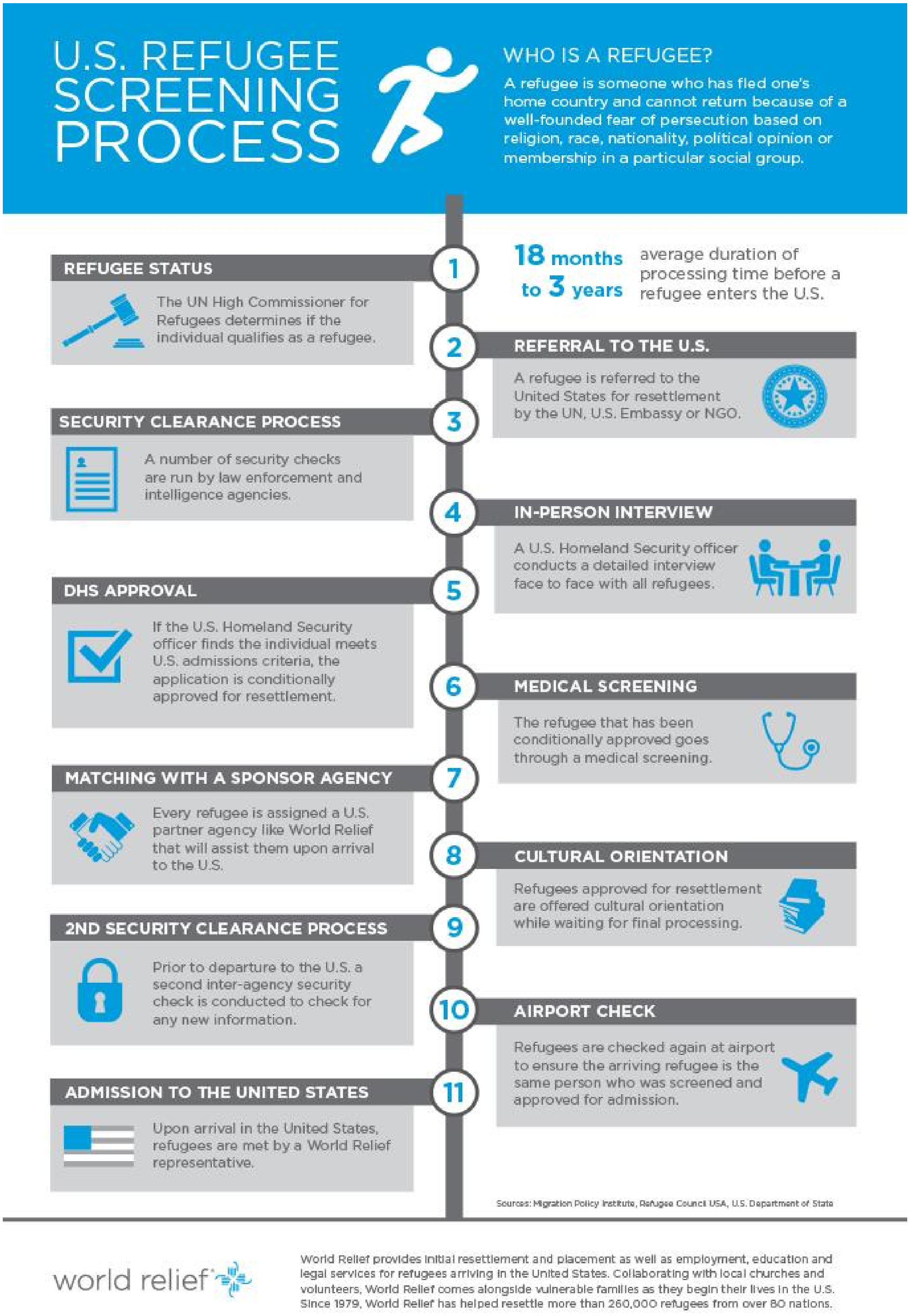
However, even if I had not already been involved with the organization, selecting the BRP as a case study would still make sense for a study concerned with rhetoric and community resettlement. The BRP is a grassroots site of everyday rhetorical, communal work, and there is an interest from rhetorical studies scholars in such organizations; Jeff Grabill, for instance, long-interested in community-based groups, has argued that groups forming around common issues or ideas—like refugee resettlement—reveal a "mundane" kind of rhetoric that demonstrates a networked, collaborative process (2013, p. 195). The BRP as a community sponsorship group is organized around "share[d] matters of concern about which [volunteers] do not agree" (Grabill, p. 199). Understanding how volunteers navigate these disagreements even as they move toward common goals in a shared matter of concern can illuminate productive paths forward in a community sponsorship model.

The local processes of resettlement, including community sponsorship, occur within a context of global and national approaches to displacement. At the end of 2019, there were 79.5 million displaced people around the world—approximately 1% of the global population. Of that number, 26 million are classified as refugees by the United Nations High Commissioner for Refugees (UNHCR) and the United Nations Relief and Works Agency (UNRWA); per these organizations, refugees are understood as persons who have had to flee their country because of persecution, war, or violence (UNHCR, 2021a). In the face of these displacement numbers (which are increasing annually), the United Nations (UN) has established three "durable solutions" for persons classified as refugees: local integration, where refugees become established in a country to which they traveled on their own (e.g., Syrian refugees who crossed the border into Turkey); repatriation, where refugees are able to voluntarily and safely return to their country of origin (e.g. Burundi refugees returning home after years of exile in Rwanda);

and resettlement, where refugees are selected for relocation to a safe third country (e.g., an Afghan refugee flees to Pakistan, applies for resettlement, and is selected for relocation to Canada). To access support—particularly with resettlement—a displaced person must register as a refugee with the UNHCR, which then pursues “the best possible durable solution” (U.S. Department of State, 2021a, “The US Refugee Admissions Program” section) for that individual based on their needs or situation. While voluntary repatriation has historically been the preferred durable solution (Warner, 1994; for more on how this priority has been contested; see Khan, 2020), extended conflict in many countries makes repatriation uncommon. In 2020, only about 251,000 refugees returned to their country of origin. The majority of refugees become locally integrated, with or without UNHCR support, in the country to which they initially fled.

Resettlement to a third country is the rarest option of the durable solutions; out of the 26 million refugees globally, fewer than 1% are selected for resettlement, usually after years of vetting in the form of interviews, background checks, and health screenings (see Fig 1. for the details of this process in the United States). In 2020, only 34,400 refugees were resettled globally (UNHCR, 2021b, “Welcome to UNHCR” section). Resettlement involves a lengthy selection and vetting process before state-sponsored relocation to another country that has agreed to accept them. The solution of resettlement is officially defined by the UNHCR as “the selection and transfer of refugees from a State in which they have sought protection to a third State that has agreed to admit them—as refugees—with permanent residence status” (UNHCR, 2021c, “What is refugee resettlement?” section). On paper, resettlement is the physical act of relocation to a third country that has agreed to certain conditions of aid.

Fig. 1: US Refugee Screening Process (World Relief, 2015)



U.S. REFUGEE SCREENING PROCESS

WHO IS A REFUGEE?

A refugee is someone who has fled one's home country and cannot return because of a well-founded fear of persecution based on religion, race, nationality, political opinion or membership in a particular social group.

18 months to 3 years average duration of processing time before a refugee enters the U.S.

1 **REFUGEE STATUS**
The UN High Commissioner for Refugees determines if the individual qualifies as a refugee.

2 **REFERRAL TO THE U.S.**
A refugee is referred to the United States for resettlement by the UN, U.S. Embassy or NGO.

3 **SECURITY CLEARANCE PROCESS**
A number of security checks are run by law enforcement and intelligence agencies.

4 **IN-PERSON INTERVIEW**
A U.S. Homeland Security officer conducts a detailed interview face to face with all refugees.

5 **DHS APPROVAL**
If the U.S. Homeland Security officer finds the individual meets U.S. admissions criteria, the application is conditionally approved for resettlement.

6 **MEDICAL SCREENING**
The refugee that has been conditionally approved goes through a medical screening.

7 **MATCHING WITH A SPONSOR AGENCY**
Every refugee is assigned a U.S. partner agency like World Relief that will assist them upon arrival to the U.S.

8 **CULTURAL ORIENTATION**
Refugees approved for resettlement are offered cultural orientation while waiting for final processing.

9 **2ND SECURITY CLEARANCE PROCESS**
Prior to departure to the U.S. a second inter-agency security check is conducted to check for any new information.

10 **AIRPORT CHECK**
Refugees are checked again at airport to ensure the arriving refugee is the same person who was screened and approved for admission.

11 **ADMISSION TO THE UNITED STATES**
Upon arrival in the United States, refugees are met by a World Relief representative.

Sources: Migration Policy Institute, Refugee Council USA, U.S. Department of State

world relief

World Relief provides initial resettlement and placement as well as employment, education and legal services for refugees arriving in the United States. Collaborating with local churches and volunteers, World Relief comes alongside vulnerable families as they begin their lives in the U.S. Since 1979, World Relief has helped resettle more than 260,000 refugees from over 80 nations.

Since the passage of the Refugee Act of 1980, when the US approach to state-sponsored resettlement was formally codified (Zucker, 1983), the United States has accepted about 3 million total refugees for resettlement (U.S. Department of State, 2021b). As shown in Figure 1, after the UNHCR refers a refugee case to the United States for resettlement, the US Customs and Immigration Services (USCIS), under the Department of Homeland Security, conducts the relevant screenings and makes the final determination on admission. Resettlement for refugees who are accepted by the US is overseen by the State Department, but Reception and Placement (R&P) services are provided and managed by the nine VOLAGs who have a cooperative agreement with the State Department to provide such services out of their local affiliate offices. Representatives from the nine VOLAGs meet frequently to assess biographical data for incoming refugees, and together they determine the most suitable location for placement, based on factors like the location of relatives, employment opportunities, and/or cost of living (U.S. Department of State, 2021c). Local VOLAG staff are responsible for meeting relocated refugees at the airport and taking them to their new homes, which have been secured and furnished before a refugee's arrival. Initial R&P support, including case management by VOLAG staff, is only provided for the first 30 to 90 days, during which time staff provide help with housing, finding employment, connecting with doctors, and other support. In southwest Virginia, the local VOLAG is Commonwealth Catholic Charities.

A key difference between the solutions of local integration and resettlement is that, while local integration happens wherever a refugee has initially fled, resettlement involves extensive deliberation and choice on the part of the state. By choosing to accept a resettlement referral from the UNHCR, there is a recognition of need—and an agreement that a country can address that need. Carefully picking and choosing refugees for resettlement allows the state to sidestep a broader global responsibility regarding the refugee crisis (Labman, 2007), yet the selective criteria also imply that resettlement is something beyond mere physical relocation; rather, it is a commitment by the United States. In the US, resettlement comes with a promise of citizenship: If certain requirements are met, after five years of living in the US, the former refugee may apply.

Along with citizenship, host countries commit to "facilitate integration" for incoming refugees (UNHCR, 2021d, "What is resettlement?" section). "Integration" has been theorized and measured in different ways (Ager and Strang, 2004; Strang and Ager, 2010), often involving activities such as cultural orientations or language services. However, the time period for services provided by VOLAGs is short: Generally, they are only able to provide material support (e.g. a caseworker, help with making medical appointments) for 30-90 days after a refugee's relocation to the United States. Because of this short timeframe, the integration priorities for VOLAG agency staff are often centered on securing housing and employment, leaving many refugees to navigate the other social, cultural, and technical aspects of life in the United States without institutional support.

The Blacksburg Refugee Partnership: A Community Sponsorship Model

This gap in services is, potentially, where community resettlement groups intervene; for instance, the BRP has a robust group of volunteers and financial donations that can be deployed to extend the provision of services both beyond the 90 days and into more targeted arenas such as education, language training, and health. And, since the sponsorship of the BRP's first family in fall of 2016, those expanded services have been a priority of the organization. Currently, the BRP sponsors five families, four of whom came in early 2017, in some cases arriving only days before the travel ban from Muslim-majority countries instituted by the Trump administration.

While VOLAGs often have their own affiliated volunteers, the BRP operates as a standalone volunteer community group, with its own policies, procedures, and organizational structure. And although the BRP has a volunteer list numbering in the hundreds, the number of volunteers actively providing services on a daily or weekly basis—particularly during the COVID pandemic, where services have largely been provided remotely—is only a core group of about 30-40 people. A key element of the BRP model is family-level sponsorship teams, which ideally include a small group of volunteers who each focus on a certain relevant area. A family team might have a medical coordinator, an education coordinator, a recreation coordinator, a finance coordinator, one or two translators, and an overall family liaison to coordinate efforts between the entire family team. There is a Board of Directors and a Finance Committee for the BRP, which together must approve the major organizational decisions (see Appendix B for more information). However, each family-level volunteer team largely operates under its own discretion on a day-to-day basis, generally led by one or two liaisons who coordinate efforts of the volunteer team. Not every family team may need the same kinds of volunteers, and in some instances the liaison acts as a translator as well, or a tutor is also a babysitter, or other combinations of roles.

Fig 2. An example of BRP organizational structure

Figure 2 shows a sample of this flexible organization structure. Instead of a rigid hierarchy, each "bubble" might move closer to, or farther away from, the liaison and other family-level volunteers depending on needs at the time. The Finance Committee, the Board of Directors, and the Organizing Committee frequently overlap, with many members of one also sitting on another, causing meeting agendas to slip easily from a Board topic to a Finance topic. Similarly, the dotted lines are an example of how volunteers occupying different roles on a family team level may be on the Board of Directors, or the Finance Committee. Five years after the first BRP-sponsored family was resettled in Blacksburg, this flexible structure is even more apparent. Most of the family teams look a bit different: some still have dedicated medical coordinators, while others feel like they no longer need a medical coordinator; some have the same volunteers with which they started, while others have had turnover in every position; some rely only on the liaison for regular contact. Overall, what has remained consistent is the presence of at least one liaison for each family team, who remains in frequent contact with the BRP-sponsored family to address ongoing needs and concerns.

Considering this years-long and ongoing example of volunteer involvement, this dissertation focuses on the rhetorical process of community-sponsored resettlement through the example of the Blacksburg Refugee Partnership. The exigence for the project is twofold: First, there is a need for research that focuses on community sponsorship, and second, the role of the resettlement volunteer must be better understood. Both of these exigencies are complemented by a rhetorical approach, which has the potential to reveal and complicate volunteer/refugee identities and relationships through analyzing volunteer discourses. Understanding these rhetorics of resettlement gives a more complete picture of what community sponsorship does and can look like to resettlement agencies.

Research that focuses on community resettlement, particularly in the United States, is lacking; as I heard from one VOLAG representative, resettlement agency staff are missing the research that demonstrates how the model can and does work on a local level, which leaves staff unsure of how to implement programs. The need is particularly pressing in 2021. Because about one third of VOLAG resettlement offices across the country were closed under the Trump administration, increasing the refugee resettlement cap from 15,000 (as it was when now-President Biden took office) to the anticipated 62,500 by the end of fiscal year 2021 has become a scramble of figuring out how to increase resettlement capacity. Community sponsorship, or co-sponsoring with a resettlement agency, is a potential solution that sidesteps the need for a dramatic increase in agency staff or offices before resettlement numbers can increase. Research into an existing sponsorship group can provide crucial and persuasive insights as VOLAG leadership make decisions on how to proceed.

A second, related exigence is that the role of the resettlement volunteer has gone understudied, particularly as it relates to the concept of "resettlement" and resettlement objectives. Although a BRP volunteer handbook exists—and even filled with position descriptions that people in those positions wrote (see Appendix B)—the operational structure is left intentionally flexible to give family teams flexibility in approaching the unique circumstances of each resettling family. Yet the lack of a clear understanding around the volunteer role has contributed to concern among BRP leadership about what has been termed "the exit strategy": how to know when a family has, in fact, been resettled. Because each of the currently sponsored families have been receiving various forms of assistance from volunteers for years, BRP leadership has increasingly pushed for volunteers to be less involved in the day-to-day activities of the families, even terming 2019 "the year of stepping back" in organizational meetings. Yet despite this goal, BRP leadership was met with resistance from volunteers who felt that their involvement was still needed.

The "exit strategy" and the problem of extricating volunteers is something I have experienced firsthand as a BRP volunteer. When I joined the organization in late 2016, I informed organization leaders of my professional background in health communication, and in March 2017 they asked if I would volunteer as a medical coordinator for three of the incoming sponsored families. I agreed, and I found myself elbow-deep in the work of seven other people's medical care: scheduling appointments, talking to doctors, picking up medications, calling insurance, following up with specialists, and generally being on-call for medical emergencies where BRP clients may require help navigating the US healthcare system. After three years of performing this role, I took over a more managerial position within BRP and became the lead medical coordinator, responsible for providing guidance and oversight to the medical coordinators on each family team, but less involved in the day-to-day health activities in the way I once was. This is the role I currently occupy with the BRP (see Chapter 3 for more detail).

To investigate both the rhetoric of resettlement and the role of the volunteer, this study examines health as a discrete site of resettlement. This logically follows my own experience as a volunteer medical coordinator, but also has the potential to speak to issues of volunteer resettlement roles more broadly. Because (as I will explore in later chapters) volunteers are often heavily invested in health, health performance, and health decisions as having very high stakes ("life-or-death," as one volunteer described), medical coordination is where volunteers are particularly reluctant to find the "exit strategy" for fear of poor health outcomes.

Theorizing Health Resettlement for Refugees

Despite volunteers' concern about health now, medical care began as one of the least-considered aspects of resettlement when the BRP first decided to sponsor a family. While preparing for families to arrive, arrangements were made for potential employment, housing, and education—yet it was not until a few weeks before the family arrived that an insightful volunteer asked, "Shouldn't we have someone coordinating medical care?" According to volunteers who tell the story now, no one was quite prepared for how important that question would become. In the two and a half years since BRP's founding, medical coordination—an afterthought then—has become a primary focus of the organization. As the current lead medical coordinator, I facilitate monthly meetings with the healthcare team, made up of volunteers who assist each family with healthcare needs. Our meetings generally boil down to the problem of resettlement itself, with volunteers unsure of when to step in, back off, and/or call medical professionals about a situation. No one is quite clear on what resettlement *is*, which makes it difficult to gauge when resettlement has been achieved—and when volunteers' involvement in the process can or should end. Additionally, resettlement is discussed as an overall state of being, and not as a process that is broken down into categorical parts (e.g. specific to health and medicine), which leaves volunteers thinking of health *in service to* resettlement, rather than *health resettlement* as a discrete process and set of goals[1]. Yet it is clear from conversations about what volunteers expect regarding health and medicine that health resettlement *is* treated as a process in its own right, albeit one that has gone unexplored—and unexpected in the same way BRP volunteers initially overlooked the need for medical coordination. Thus, this study examines that process of health resettlement, including what outcomes volunteers look for in health resettlement and how they rhetorically position themselves (and refugee clients) within it, generating insights into both humanitarian aid and rhetorics of health and medicine.

Even outside of volunteer involvement, health is a relatively unexplored area of resettlement. In the United States, short-term "resettlement services," like healthcare, are managed through the Office of Refugee Resettlement (ORR). The services offered by the ORR are specifically outlined, but "resettlement" is left undefined. The lack of specification allows the term to be, as Ives (2007) argues, "conceptualized at the federal level as economic self-sufficiency" (54): the mark of successful resettlement is the ability to hold a job and provide for yourself financially independent of government assistance. Dykstra-DeVette (2018) finds in her analysis of VOLAG materials that that similar language of "financial independence" is what marks successful resettlement for caseworkers (185). In both the federal and the nonprofit spheres, resettlement is nearly inextricable in most discourses from self-sufficiency or self-

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[1] I use "health resettlement" here, though "medical resettlement" would be a more precise term for capturing the specific process of engagement with the US healthcare system on which I mainly focus in this study. However, "medical resettlement" is an already existing term referring to a UNHCR process of resettling a refugee specifically because of a needed medical intervention. Thus, I use "health resettlement" as a close substitute.

reliance, terms which largely go undefined but are almost always presented in an economic context (i.e., being self-sufficient means one is not reliant on public assistance).

Measured only by economic self-sufficiency, resettlement success explains little about *what resettlement looks like medically.* This lack of attention to medical resettlement is a rhetorical issue. Largely missing in the government, global NGO, and VOLAG conversations around resettlement are the complicated medical procedures, policies, discourses, and forms refugees must navigate during the process of resettlement, beginning before they are even brought to the United States. Instead, the goal of medical access and care remains tied to economic self-sufficiency; namely, being in good enough health to make enough money to pay the bills. The analyses in this dissertation illustrate how a rhetorical understanding of health resettlement provides an intervention away from focusing only on economic self-sufficiency. This intervention is especially relevant to federal and state policy. While current refugee resettlement policy is largely focused on the economic aspects of resettlement (such as having a job), the medical and health aspects of resettlement, and particularly how volunteers are involved in those aspects, has gone unexplored. Meanwhile, refugees resettled in the United States are more likely than other immigrant groups to have chronic health conditions (Yun et al., 2012), have lower rates of preventative care utilization compared to the general population (Morrison et al., 2012), and experience barriers to healthcare-related transportation and translation (Mitschke et al., 2011), data which point to a need for increased attention on health resettlement. The research questions outlined in this dissertation directly address these issues.

BRP volunteers can attest that the process of health resettlement is real and complicated, tied to economic outcomes such as employment and bank accounts but also extending beyond those metrics. Yet unlike an economic resettlement that can be marked by concrete outcomes such as employment, health resettlement is a much more nebulous concept. What health status should be achieved before volunteer help is no longer needed? Because there is no formal or organizational guidance about when health resettlement is achieved, groups assisting refugees, like BRP volunteers, are left to navigate and guide the process based on *their own perceptions of when someone can be considered "health settled."* This ambiguity leads to tension between the BRP leadership, family team volunteers, and often refugees themselves as volunteers attempt to negotiate and define the limits of their involvement.

The problems for refugee studies are 1) that it currently lacks a robust understanding of the process of health resettlement, specifically; and 2) while the role of volunteers has been explored, it has yet to be explored as a critical site of inquiry driving and shaping resettlement. Current discussions about responsibility toward refugee populations often focus on state-level responsibility (Goodwin-Gill, 2014; Skordas, 2016; UNHCR, 2017), and yet at the same time community members are the ones most directly responding to refugee needs. Thus, there is a need to understand interpersonal responsibility in refugee resettlement, along with the implications for how resettlement is enacted through that responsibility, that has not yet been addressed in either refugee studies or rhetorical studies. As my research participants shared their experiences during my data collection interviews for this project, it became clear that "responsibility" was a rhetoric that revealed how volunteers saw their own positioning in the process of health resettlement, as well as the positioning of refugee clients. In the following section, I explain how focusing on agency, ethos, and responsibility can provide insights into health resettlement.

A Rhetorical Examination of Health Resettlement

To address the rhetorical implications of health resettlement, this dissertation examines "misunderstanding and its remedies" (Richards, 1965, p. 3) within the case study of the BRP. As the previous discussion shows, a variety of stakeholders, each with their own different understandings of what it means to be "resettled" and the responsibilities involved in making resettlement happen, are at work when assisting refugees with their healthcare. This case study focuses on the "rhetoric" of resettlement in two ways. First, I use rhetorical analysis to describe the rhetorical situations (i.e., the context and circumstances out of which discourses emerge) that resettlement volunteers navigate in the process of aiding resettling refugees, particularly in medicine. Situations such as communicating medical risk or determining how and when to intervene in medical decision making, as well as the expectations of how refugees must navigate these situations, fall under this category. Second, a rhetorical analysis identifies the discourses and narratives about refugees that affect perceptions of successful resettlement; for example, a rhetoric of self-sufficiency identified by text describing the goals of resettlement, or a rhetoric of responsibility identified by the language volunteers use to describe their experiences. Within this category is also language used to describe what refugees *are* or *are not* (e.g. not able to successfully navigate the discourse community of American medicine, not self-sufficient, lacking or having particular healthcare knowledges). Overall, this study focuses on the narratives of BRP volunteers who assist in the process of health resettlement, and on how those narratives contrast with the policy-level understanding of what resettlement is and should do. Volunteer narratives are important for a better understanding of the process and outcomes of a community sponsorship resettlement model, but also for revealing the attitudes, values, and relationships that drive health resettlement. Additionally, these narratives serve to complicate the volunteer role, which is often taken for granted under a humanitarian approach.

Rhetoric of health and medicine (RHM) scholars have investigated similar discourses of medicine, focusing on patient narratives, agency, expertise, technical communication, and other discursive interactions that are meant to persuade, establish credibility, or reinforce health values, among other objectives. The consequences of these discourses often mirror the same outcomes that concern resettlement volunteers: worse health access, misunderstandings between patients and doctors, misdiagnosis, or lack of patient agency. In Chapter 2 of this dissertation, I will provide a more in-depth overview of this parallel. Generally speaking, rhetorical studies, and particularly those focused on rhetorics of health and medicine, have been concerned with similar issues of decision making, intervention, and relationships. My purpose with this study is to offer a rhetorical examination of the involvement of volunteer medical coordinators in the process of health resettlement, especially in understanding how volunteers position the goals of the process, and persuade resettling refugees toward those goals with a particular relationship. Investigating how volunteers perceive and navigate health resettlement provides insights into their expectations for the discourse community of American medicine—specifically, the genres and rhetorical situations that resettling refugees are expected to navigate under and with volunteer supervision.

This investigation is also a compelling addition to the body of RHM literature, which has focused on the relationship between medical authorities and the public (e.g. public health messaging, clinical interactions), but has only occasionally interrogated medical situations that involve a third party (such as Rachel Bloom-Pojar's 2018 study of medical translators). Exploring what happens when volunteers are involved in health resettlement—neither patient nor doctor—has implications for how we understand the role not only of volunteers, but of others who occupy this third space in medical interaction, such as family members and caretakers. Rhetorical studies of medicine have illuminated patient agency (and how it often conflicts with physician expertise), and extending this investigation to health-related interactions between two non-expert interlocutors has the potential to reveal different understandings of agency, expertise, and intervention within health discourses. How volunteers decide to intervene in health resettlement is, as later chapters will argue, based on risk assessment, which affects how they expect agency to be performed and what they do when it is not. Risk, then, is where we see the tension between ethos and agency, responsibility and self-sufficiency; by accepting their role as volunteers, community members step into a role that must navigate these competing issues, values, and tensions with little oversight or guidance.

Through a rhetorical examination of health resettlement for refugees, particularly regarding agency and relationality, this dissertation will also lay the foundation for a conception of health citizenship that speaks to both refugee studies and RHM. Because resettlement is, in many respects, the work of a community, how volunteers understand and enroll resettling refugees into health becomes relevant for the years-long journey towards political citizenship that is undertaken by, and expected from, refugees. As Ong (1996) notes, “It is precisely in liberal democracies like the United States that the governmentality of state agencies is often discontinuous, even fragmentary, and the work of instilling *proper* normative behavior and identity in newcomers must also be taken up by...civil society” (738, emphasis added). A critical examination of how volunteers understand “normative behavior and identity” in health influences how health resettlement will happen. And because citizenship “is in many respects a discursive phenomenon” (Spoel et al., 2014, p. 134), exploring which “discursive phenomen[a]” volunteers associate with health resettlement (and, by extension, citizenship) adds to a disciplinary understanding of how health citizenship is a rhetorical practice. Focusing on volunteers shows that health resettlement is not only about the individual performances of health practices (including navigating the technical discourse of health) but also about the rhetorical interactions of health—that is, curating networks of expertise, trust, values, and access—that mark someone as gaining citizenship not in the legal sense, but in the sense of having the correct rhetorical skill set.

Overall Research Questions and Chapter Summaries

With the understanding of the complexities of health resettlement and citizenship as discursive processes, this dissertation addresses the following research questions:

1. How do BRP volunteers understand the process of health resettlement? How does this understanding compare to the federally defined resettlement process?
2. What discursive roles and responsibilities do volunteers adopt within the process? What impact, if any, does this positioning have on community sponsorship?
3. How do volunteers leverage their role and relationship with resettling refugees in order to ensure certain outcomes in the health resettlement process?

The following chapters of this dissertation address these questions, framed within rhetorics of health and medicine. In Chapter 2, "Medical Authority, Volunteerism, and Rhetorics of Resettlement," I provide a review of the relevant literature between both rhetorical and critical refugee studies. This chapter includes discussions of how rhetoricians and other scholars have theorized refugee resettlement, particularly around the concept of self-sufficiency, and how moving toward a community resettlement model introduces new rhetorical understandings of resettlement. The literature review also provides an overview of studies of volunteerism in refugee resettlement, and introduces theories of responsibility from refugee studies, medicine, and rhetoric. Chapter 3, “The Blacksburg Refugee Partnership as Community-Based Case Study,” introduces the Blacksburg Refugee Partnership organization more thoroughly as a case study for this project, and details my ethnography-informed approach as both a participant and an observer. I also provide a rationale for choosing an ethnographic approach to the case study, and explain how using semi-structured interviews with BRP volunteers addressed the research questions of this study.

In Chapter 4, “Intervening for the Other: Rhetorics of Hospitality and Agency in Health Resettlement,” the first of my two data analysis chapters, I analyze existing resettlement policy at the federal and state levels to further tease out a resettlement rhetoric of self-sufficiency. I argue that while these policies rely on a rhetoric of self-sufficiency, looking to community sponsorship makes space for a rhetoric of responsibility that constitutes resettlement as an interaction between volunteers and refugees. I contrast policy’s rhetoric of self-sufficiency with volunteers’ perception of their role in health resettlement, which I find is motivated by a rhetoric of responsibility that pushes them to adopt a role as proxy agents in order to avoid what they perceive to be the “life-or-death” health consequences for resettling refugees. Thus, health resettlement is marked by knowing the right ways and times to engage in the rhetorical situations of medicine, a knowledge of which also demonstrates volunteers’ success in their role as proxy agents. By positioning themselves in a responsible relationality with refugee against the policy-driven call to self-sufficiency, volunteers become the embodiment of these conflicting resettlement goals.

In Chapter 5, “Relationships and Authority: Creating and Gathering Ethos in Medical Decision Making,” the second data analysis chapter, I argue that a rhetoric of responsibility constitutes the relationships and identities that volunteers adopt to establish a persuasive ethos in reaching health resettlement goals. I analyze volunteers’ narratives about health resettlement to show how they develop a certain relationship with sponsored refugees; I then explore how volunteers lack a guiding framework for understanding their relationship with resettling refugees, and, lacking that framework, adopt one that is informed by familial relationships like parenting children. This framework demonstrates the ethical responsibilities adopted by volunteers as they attempt to persuade refugee clients away from risky health decisions, and speaks to the relationality of refugee resettlement that has lacked investigation. The framework also provides a way for volunteers to leverage expertise in a way that is familiar, while lacking the same familial authority (and agential capacity) that a parent-child relationship would typically have in a medical scenario. Thus, volunteers must persuade refugees toward certain actions, *gathering* a team of various experts to supplement their own ethos as volunteers. I find that gathering ethos in this way allows volunteers to keep their familial-styled ethos while also appealing to medical authority.

Finally, in Chapter 6, “Conclusion: A Way Forward for RHM, Refugee Studies, and Refugee Resettlement,” I propose that this research has implications for a rhetorical understanding of clinical situations beyond patient-physician interaction, as well as offering practical recommendations for resettlement groups tasked with training medical volunteers. I also offer implications for refugee studies and urge the field to more thoroughly attend to issues of volunteer interaction in resettlement. Additionally, I propose that this study may lead to new understandings of health citizenship and how the discursive performances of health are tied to the political journey toward citizenship for refugees.

Ultimately, my objective with this dissertation is to provide useful insights not only into a new site of rhetorical-medical interaction, but into the perspectives of volunteers engaged in the work of community sponsorship. With these insights, my goal is that community sponsorship practice might be better understood and improved. Instead of seeing volunteers only as well-meaning neighbors, I hope to establish that volunteers bring their own rhetorical and cultural expertise that directs and shapes the process of health resettlement; and, further, that this direction is not accounted for in our current resettlement policy and conceptions of how resettlement programs can operate ethically, equitably, and productively.

Chapter 2

Medical Authority, Volunteerism, and Rhetorics of Resettlement

During the process of health resettlement, volunteers lack a clear understanding of their roles, responsibilities, and relationships, which leaves them to personally grapple with the ethical choices of when to engage, what to say to prevent health risks, and how to recognize and prioritize someone else's agency in medical decision making. To situate this problem in the scholarship of both rhetorics of health and medicine and refugee studies, I will first provide an overview of how refugee resettlement has been approached rhetorically, both in understanding refugee identity and in interaction between refugees, the state, and the resettlement agency staff. I then explore how rhetoric of health and medicine (RHM) scholars have discussed the power balances in health interactions, specifically focusing on provider/patient interaction, in order to extend this conversation to the role volunteers play in the health resettlement process. Following this exploration of RHM scholarship, I review how medicine has conceptualized the ethical tension between patient autonomy and provider intervention as a framework for understanding the role that volunteers begin to adopt; this is followed by an overview of the significance of the volunteer role in refugee resettlement more broadly, as studied by refugee studies scholars. Finally, I provide context for how "self-sufficiency" has been conceptualized in refugee resettlement—particularly how it shifted the burden of resettlement from a state-level responsibility to a personal one—and discuss how rhetoric scholars have theorized responsibility in a way that captures the interpersonal interaction between refugee and volunteer.

Rhetorics of Resettlement: Reviewing the Literature

For health resettlement, research into volunteer training and communication with refugees addresses a common understanding of what it means to "resettle" into the medical system, as well as how volunteers should be a considered element of health communication and access. Volunteers must engage in persuasive processes in meetings as group values are negotiated, as well as with the clients they are assisting in resettlement. If resettlement is to be a certain kind of performance, it follows that that process must be explained, discussed, and persuaded toward. Understanding health resettlement as a fundamentally rhetorical process acknowledges the significance of the role volunteers play and focuses attention on different rhetorics that establish themselves in resettlement discourse.

To understand how a rhetorical approach to medical resettlement—or resettlement generally—is relevant, it is necessary to recognize how scholars have studied the general discursive elements of the resettlement process. Though most of these scholars do not discuss the implications of a rhetoric of self-sufficiency on the *process* of resettlement, some have argued that a rhetoric of self-sufficiency introduces a tension in the construction and perception of refugees. Camps (2016), for instance, analyzes policy about refugee language training that places the burden of economic independence on refugees while keeping agency and control of offered services in the hands of the state, making refugees simultaneously responsible and powerless. Dykstra-DeVette (2018) argues that the "empowerment rhetoric" used by VOLAGs is intended to "combat constructions of refugees as burdens on their host society" (184) but fails to challenge the assumption that economic independence should be the ultimate goal of resettlement. Similarly, Easton-Calabria and Omata (2018) critique the term "self-reliance" in resettlement discourse, noting that it is routinely and unnecessarily juxtaposed against “dependency” in a way that ignores cultural and political contexts. Tyeklar (2016) argues that the rhetoric of self-sufficiency used by VOLAGs leaves “self-sufficiency” as a nebulous term and does not recognize the many other skills and knowledges necessary to navigate life in the United States. Together these scholars build a rhetoric of self-sufficiency in resettlement that a focus on medicine can contribute to and expand upon, specifically building on Tyeklar’s observation that economic self-sufficiency does not adequately address other aspects of resettlement.

Outside of a definition of economic self-sufficiency, resettlement can be explored in terms of language (generally related to English proficiency) and cultural brokering. From her interviews with Bosnian refugees, Ives (2007) finds, unsurprisingly, that language often acts as a barrier to social integration; she argues that refugee voices need to be an integral part of policy development concerning language expectations for refugee resettlement. Ives also notes that resettlement policy pushes for a one-way street of assimilation instead of the two-way street of integration (in which both cultures make room for connection) that it claims (61). Steimel’s (2017) findings regarding resettlement-as-assimilation are similar. Steimel examines the relationships between resettled populations and volunteer resettlement organizations in order to understand how expertise and epistemologies emerge during the resettlement process. From her interviews with refugees, Steimel finds that refugees arrive with “little in terms of either material belongings or knowledge of life in the United States. As such, the refugees described entering with a real need for practical information (e.g., information about how to perform daily life in the US) to be shared with them” (6). At the same time, the theoretical understanding of resettlement issues offered by agency workers was less valued by participants than the lived experience of resettlement offered by other refugees, yet participants also noted their reliance on (and frustration with) agency workers as “cultural brokers” to solve problems outside their knowledge set. Most interesting for the literature on resettlement issues is Steimel's analysis that this knowledge transmission from agency worker to refugee is often framed as the goal of resettlement: assimilation in which contact with US culture is high and maintenance of the previous culture is low (10-11).

The values undergirding resettlement manifest in myriad arenas within a volunteer nonprofit; one could propose a study about how volunteers insert themselves in finances or English-language learning to answer the same question. For instance, Dykstra-DeVette and Canary (2019) explore the concept of "empowerment" for refugees as it is written and enacted by a local resettlement agency, noting the tensions inherent in institutional understandings of what empowerment (and through empowerment, resettlement) looks like. Concerns over what resettlement *is* run alongside a discursive struggle over refugee identity through the displacement and resettlement process; multiple studies have focused on the how the narratives around forced displacement influence the reception of those displaced (Powell, 2012; Lee and Nerghes, 2018; Lionberger, 2017; Loring, 2016; Gomez, 2018; KhosraviNik, 2009, Dykstra-DeVette, 2016) as well as on how refugees themselves have worked to reclaim or reorient the narrative through the use of technology and digital space (Chouliaraki, 2017; Georgiou, 2018; Nikunen, 2018; Risam, 2018).

Authority and Discourse in Health and Medicine

From this research, it becomes clear that resettlement is inextricable from discourse and the ways in which information is 1) framed and 2) communicated. Recognizing resettlement as a discursive process opens room for more investigation, and I propose health resettlement in particular as a site for this inquiry because the concept of having to be "resettled" into a medical system has gone undertheorized. Resettlement policy—and consequently most resettlement data—overwhelmingly focuses on economic self-sufficiency and language skills, yet those involved in resettlement recognize medicine and healthcare concerns as a significant use of time, money, and volunteer attention. While health concerns are often considered an impediment to resettlement (Dowling, Enticott, and Russell, 2017), rarely is healthcare conceptualized as a discrete area of resettlement. Arguably research into the medical needs of refugees has already focused on what might be called health resettlement, if defined as the best means of achieving integration into the healthcare system. However, little research has focused on the discourses of health resettlement, or on health resettlement as a *rhetorical* process—a process of persuasion toward particular outcomes—in the way that RHM scholars frequently approach medical interactions. To understand, then, the discourses that shape the process of resettlement into the US healthcare system, I turn to the RHM scholars who have specifically focused on institutional structures as they are discursively navigated by patients, with the purpose of demonstrating how the institutional rhetorics of resettlement as they pertain to medicine bleed into everyday discourses and performances.

Within the process of resettlement generally, refugees must navigate situations of power and authority that constrain movements across borders, actions within countries, and available resources as residents. An understudied manifestation of these power negotiations is resettlement into the US healthcare system, where a specific subsection of US culture must be interacted with. Though I will argue in this dissertation that refugees resettling in the United States face a unique process of health resettlement that is not fully comparable to what established residents experience in the healthcare system, I will first outline the approaches taken by scholars of medical rhetoric regarding positions of institutional authority in healthcare practice. These approaches are a foundation for establishing how the importance of rhetorical investigation into medicine parallels why we also need a rhetorical investigation into health resettlement, a process that is also designed to rely on particular constructions of access and authority.

For decades, scholars have argued that studying the rhetorics of health and medicine (RHM) is a way to understand the “exigencies, functions, and impacts of health-related discourse” (Scott, Segal, and Keranen, 2013, p. 1) and the lived experience of medicine (Meloncon and Frost, 2015, p. 10) in the face of “the often strict and authoritarian structures of Western biomedicine” (Graham, 2009, p. 378). Some RHM scholars have focused on how health-related discourses intersect with medical authority in public health (Lawrence, Hausman, and Dannenberg, 2014) and in clinical settings (Stone, 1997). Because RHM is concerned mainly with the institutional discourses of medicine, studies of authority generally focus on the interaction between the patient and the medical service provider (e.g. a clinician, a nurse, a public health official, etc.). In some of RHM’s foundational texts, Segal (1994, 2005) argues that the physician/patient relationship is an inherently asymmetrical one, as the physician is understood to have superior knowledge of health matters and a qualification to give medical advice (though the patient certainly has a knowledge of their body). Segal presents this asymmetry as both inevitable and, if paternalism can be avoided, ultimately beneficial to the patient because the physician’s medical knowledge ideally improves the patient’s life.

In my project, I do not necessarily seek to question the “inevitably” of such asymmetry—instead, I recognize this as a parallel with resettlement infrastructure and the provider/refugee dynamic, and as well as with the positioning of community resettlement volunteers in the resettlement process. However, resettlement volunteers who interface with healthcare needs for refugees often do not have medical expertise, unlike the physician/patient dynamic that Segal and most RHM scholars describe. What I seek to explore is if—and, if so, how and to what effect—the expectations of volunteers and volunteer groups rhetorically figures them as authorities in the health resettlement process. Like the medical expertise of the physician is supposed to lead the patient to better health, the resettlement volunteer is supposed to lead the resettled person to better integration (as understood by policy to mean self-sufficiency, as I will explore further in Chapter 4).

Thus my study seeks to build on how RHM scholars have explored both rhetorical figurations of authority and on how patients have navigated these figurations. In one example, Arduser (2017) confirms that this understanding of authority manifests in how providers talk about their patients. Yet Arduser also reveals how patients use rhetorical strategies to imitate medical authority and overcome this asymmetry. Also recognizing the asymmetrical relationship into which patients are placed, Koerber (2006, 2013) highlights the disciplinary rhetorics embedded in healthcare interactions that patients must navigate. In her work on breastfeeding practices, she reveals how breastfeeding women are at the epicenter of contradicting medical advice and practice, and how they adopt positions that use another form of authority (e.g., a La Leche League leader) to disrupt or resist another (e.g., a hospital nurse).

As these RHM scholars have noted, not only is medical authority tied up in particular disciplinary rhetorics, but patients adopt—or seek to adopt—their own authoritative positions within those rhetorics. What these studies do not address, and what I seek to add, is how an understanding of a discourse of authority in a fundamentally asymmetrical situation—in this case, medical resettlement for refugees—manifests among those without formalized medical expertise, like resettlement workers and community volunteers. In other words, how can RHM think about medical authority and agency within a relationship that does not center a medical expert?

One recent example of scholarship in this area is Bloom-Pojar (2018), who focuses on the effect of having a translator as an addition to the traditional patient-provider relationship. She argues that this awareness of other actors in the medical communication process demonstrates a collective rhetorical action, but also highlights how medical communication is always a process of translanguaging that requires multiple actors to struggle together toward a common goal. Though I anticipate based on my own experiences that the volunteers involved in medical resettlement will each describe their goals for the process differently, Bloom-Pojar's recognition of how translators change the medical interaction provides a foundation for recognizing how resettlement volunteers involved in others' medical care might also be involved in a translanguaging process, especially as they occupy a position of expertise.

Volunteer Responsibility and Constitutive Rhetoric in Health Resettlement

Though the identity of the volunteer has gone less explored, the identity of the displaced—and particularly how that identity is constructed—has been thoroughly explored. Constructions of the refugee as occupying a position of helplessness (Rajaram, 2002) become a constitutive rhetoric (White, 1985) that shapes identity; the positioning of refugees in humanitarian discourse, combined with a failure of state-level humanitarian aid (Hyndman, 2000), leaves volunteers to take up the constitutive call to humanitarianism. By agreeing to volunteer, volunteers have already been persuaded toward the beginnings of an identity by the dominant discourses of *refugee* identity. In other words, volunteer roles are shaped by what it is understood that refugees are (or rather, are not). Thus, even as Steimel (2016) calls for volunteer-refugee relationships to be shaped dialogically on the ground instead of from the organizational top down, any new figuration of this relationship is already fighting against the dominant rhetoric around volunteer identity. Further, the identity into which volunteers have already been constituted carries a weighty ethical call: to *help*. The constitutive rhetoric becomes one of responsibility that compels volunteers to act.

There is no shortage of theories of responsibility in refugee resettlement; for decades, scholars and theorists have argued about the responsibility of the state toward the refugee (Arendt, 1951; Derrida and Dufourmantelle, 2000; Agamben, 1998). Other scholars have noted the failure of the state to provide humanitarian aid for refugees, increasingly as neoliberalism and self-sufficiency have taken hold across Europe, Canada, and the US (Hyndman, 2000). In the wake of this shift, the dominant rhetoric of resettlement policy and practice in the United States constructs refugees as temporarily dependent on the state, with an ultimate goal of economic self-sufficiency (a concept I will explore further in Chapter 4) that would make them independent. While refugees upon admittance to the US are no longer stateless to the extent of exclusion from the jurido-political space (as described by Giorgio Agamben)—after all, the years-long process of selection and vetting for refugees is in itself a type of enrollment into a legal and political identity—refugees are not welcomed onto US soil as citizens. And, as policy calls them to a rhetoric of self-sufficiency as they work toward gaining citizenship, the ambiguous process of "resettlement" becomes defined by the move from exclusion (not self-sufficient) to inclusion (self-sufficient).

If the dominant resettlement rhetoric is one of self-sufficiency, as has been previously argued (Steimel, 2017; Dykstra-DeVette, 2018), where does that rhetoric leave volunteers who feel responsible to assist? The rhetoric of self-sufficiency which emerges in institutional practice conflicts with the rhetoric of responsibility that volunteers use to construct their identities. Because this dissertation work is positioned both in the rhetoric of health and medicine and in refugee studies, I have sought to engage with a theoretical concern that has spanned both refugee studies and medicine, namely a responsibility toward an Other, whether abstractly or in practice. Discussions of responsibility are ever-present in refugee studies, particularly regarding the responsibilities of international organizations and governments in responding to a growing refugee crisis. For my purposes in this study, I build on the theorization of responsibility on an interpersonal level across these spheres, both by a Levinasian ethic that engages refugee studies and a traditional bioethical framework that has informed medical practice for decades.

Ethics of Care: Frameworks of Responsibility in Medicine

The asymmetry that permeates the integration process, especially when volunteers are involved as a third party in medical interaction, invites a discussion about not only rhetoric but rhetorical *ethics*—not just recognizing that volunteers are part of the discursive process of resettlement, but the position they adopt as interlocutors within that asymmetry. Exploring an ethical position in *health* resettlement is especially important. If volunteer or nonprofit groups assist in managing care past the three months resettlement agencies offer, their participation may introduce relative strangers handling sensitive medical information as Medicaid enrollment is managed, and as chronic conditions move into the forefront. This model of care—one in which a patient is put in a position to rely on English-speaking volunteers to speak to physicians, schedule medical appointments, and manage health insurance—introduces complex questions concerning patient autonomy and agency, and raises concerns about the adequacy of ethical approaches to the medical system as a one-on-one, patient-physician interaction.

As I will discuss in Chapters 4 and 5, volunteers construct their role as one which is responsible for ensuring that “good health” happens for resettling refugees. The issue of responsibility—in particular, an ethical responsibility to or for someone else—has been explored both in medical ethics and, to a lesser extent, in rhetorical studies. Medical ethics scholars debate a range of issues, and many of these discussions are informed by what Beauchamp and Childress put forward in their 1977 foundational text as the now-common principlism framework; in this framework, each ethical decision can be weighed using four key principles:

- Autonomy: to ensure the capacity for independent, rational choice (e.g., seeking informed consent before a patient enters a clinical trial)
- Beneficence: to do what is in the best interest of the patient
- Nonmaleficence: to avoid actively harming the patient (often invoked in discussions over physician-assisted suicide)
- Justice: to emphasize fairness and equality

A consideration of these principles, they argue, can assist physicians in making difficult ethical decisions in sites of concern, such as developments in medical treatments and technologies, clinical testing, and end-of-life care. Generally, principlism is intended to come to the forefront in difficult ethical decisions (e.g., clinical testing, end-of-life concerns, pregnancy and neonatal care, navigating new medical technologies) with each principle weighed against the others to help physicians, researchers, other medical professionals, and patients determine an appropriate course of action. Principlism remains a leading paradigm in Western bioethics, though many scholars have attempted to complicate its approach, especially as bioethics as a field broadens globally.

Though Beauchamp and Childress have stressed that no principle should receive *a priori* precedence, autonomy generally remains paramount. This elevation of autonomy is understandable, considering many of medicine's most egregious historical missteps were situations in which medical practitioners acted on people's bodies without permission or even knowledge; recognizing autonomy means to ensure that patients are subjects, not objects, in the medical process. Nevertheless, a common tension arises between autonomy and beneficence, as the autonomous choice made by the patient may not be what the medical expert believes to be in the best interest of the patient, potentially working against an outcome the expert feels responsible to reach. This tension necessitates further inquiry into what makes patients "autonomous" when they make a decision: Are they acting rationally? Does their choice align with their long-term values? Are they competent? And, if the patient fails to meet the standard of what the physician believes is autonomy, what level of intervention on the part of the physician or medical establishment is acceptable? If a patient is not acting "rationally" (an important element of autonomy in traditional principlism), is it ethically necessary for the physician to override a patient's choice for the good of the patient, or to make sure no harm comes to them? These questions depend on an individualistic approach to autonomy, one in which an agent is determined to have acted independently and free of outside coercive influence. Autonomy is perceived to be an individual mental process. An individualistic configuration of autonomy, proponents argue, is a safeguard against paternalistic medical and social influences, and necessitates that physicians give patients all relevant information so that patients are able to make an informed decision.

While generally recognizing the importance of principlism, feminist bioethicists have sought to complicate the way the principle of autonomy is conceptualized in the field. Feminist bioethicists including Mackenzie and Stoljar (2000), Sherwin (2012), Jennings (2016), and Holmes and Murray (2016) push back against the idea of autonomy as something individualistic and rationalistic that requires a physician to determine if its conditions have been met. While Mackenzie and Stoljar emphasize that autonomy is a useful concept in that it is crucial to understanding oppression and subjugation, they argue alongside other feminist authors in their collection that the traditional notion of individualistic autonomy upholds inherently masculinist ideals of selfhood and agency in how it expects patients to engage with medicine in an independent, isolated way, threatening the freedom of those who may engage with medicine in ways that are more *inter*dependent and social. Feminist bioethicists advocate instead for *relational* autonomy—the understanding that people are socially embedded and identities are formed within the context of social relationships, and that choices are made within these contexts. No patient can be the individualistic, rational agent, they argue, because agents are created only via their relationship with others. Further, relational autonomy accounts for memory, imagination, and emotion, which are neglected in the traditional notion of autonomy.

Rogers, Mackenzie, and Dodds (2012) call for bioethics to address vulnerability more specifically, claiming that the lack of proper theory around vulnerability often leads to paternalistic interventions that further marginalize vulnerable groups—interventions that causes what Rogers, Mackenzie, and Dodds term “pathogenic vulnerability” (25). They identify a relational approach as being the closest proposed solution to this problem, as this approach “is committed to the view that the obligations arising from vulnerability extend beyond protection from harm to the provision of the social support necessary to promote the autonomy of persons who are more than ordinarily vulnerable” (24). Rogers, Mackenzie, and Dodds promote relationality while keeping principlistic language, advocating that “protection from harm” (i.e., nonmaleficence) is best achieved through beneficence in the form of social support that *promotes* autonomy. Instead of beneficence and autonomy being in conflict, the authors argue that beneficence in the larger context works alongside patient autonomy.

The positions of vulnerability that patients are often configured into, as well as the feelings of responsibility that can lead to paternalistic intervention, are important to understand when beginning an analysis that includes the third-party volunteer. As I will show in my analysis, volunteers adopt a particular kind of ethos in medical resettlement, and position themselves at a similar crossroads between recognizing the autonomy of a resettling person and constructing a responsibility for not allowing poor health outcomes to happen. The trend in bioethics toward a more relational approach to autonomy seems to align with the community model of resettlement that encourages volunteers to become involved in healthcare mentorship for refugees; after all, an individualistic approach to autonomy, principlism, and medical ethics contradicts how refugee populations necessarily interact with Western medicine during the process of resettlement. Tham and Letendre (2014) argue that a relational approach leads to and supports a cross-cultural ethic of medicine, instead of the individualistic notion of autonomy and principlism that some scholars have criticized as forcing Western ideals into a global bioethics (Chattopadhyay and De Vries, 2008; Widdows, 2011; Po-Wah, 2002; Myser, 2003). Outside of bioethics, relationality has been espoused by feminist ethics since the 1980s. Scholars like Gilligan (1982), Noddings (1984), and Tronto (2005) argue for an ethic of care that is grounded in relationships and responsibility, as opposed to the rights-based ethics popular in Western philosophy (such as bioethical principlism). Instead of a generalizable principlism, an ethic of care is situational and contextual, motivated by the idea of *caring for* someone outside of oneself.

Health Access and Medical Needs for Resettling Refugees

Health is a significant factor in both pre- and post-migration, making health resettlement an important topic of study. Mental health and physical health are often considered impediments to an economic-focused integration and/or the process of resettlement, such as getting a job—in Ager and Strang's (2004) terms, this would be considered a "means" to integration—but few studies have focused on health as a "measure" of integration. In other words, understanding the process of integration specifically as it pertains to the United States healthcare system is a critical perspective not fully addressed in refugee studies. Discussions within refugee studies about when one is "integrated" are ongoing, but measurable outcomes for health integration are not included in those discussions.

For refugees, public health scholars have argued for an awareness by the medical community of the unique health needs that refugees are resettled with (Thiel de Bocanegra et al., 2018; Yun et al., 2012; Straiton, Reneflot and Diaz, 2017; Reed and Barbosa, 2017), and how practitioners might better address these health needs (Pace et al., 2015; Brady et al., 2018; Duckles, Barden-Maja, and Caplow, 2018). Some have specifically researched the difficulties refugees have in accessing care in the United States, and have found, predictably, that language barriers are a significant impediment alongside cultural differences in medical understanding (Mitschke, 2011; Morris et al., 2009; Mirza et al., 2014; Floyd and Sakellariou, 2017; Brisset et al., 2014). Logistical concerns are also barriers; Morillo (2019) finds that after the initial health screening, accessing medical care becomes more difficult for refugees due to language barriers, but also a lack of transportation and misunderstanding of the complicated US healthcare system (also Taylor et al., 2014). Because of these access problems, Carrico et al. (2017) find that newly resettling refugees are more likely to have fragmented and episodic care via emergency departments instead of long-term and stable healthcare.

As mentioned earlier, the US resettlement system operates on a resettlement model that relies on local VOLAG offices for service provision. Ostensibly this model of resettlement would provide community support necessary to relieve the burden of many barriers to health faced by resettling refugees. Across the United States, voluntary agencies with cooperative agreements with the Department of State take the lead on resettlement services. And adjacent to these agencies are the community-level, all-volunteer organizations (often churches or similar) that agree to "sponsor" families that have been placed in their area. However, there is no official data on how many of these volunteer organizations exist. In the state of Virginia, such organizations have made the news in Blacksburg, Roanoke, Harrisonburg, Charlottesville, Northern Virginia, Richmond, and Hampton Roads, mirroring the largest VA resettlement areas according to State Department data. Like the BRP, these groups aim to provide services to supplement or extend services that VOLAGs provide. Services provided by VOLAGs include cultural orientation, as well as rides to initial doctors' appointments and assistance with reading mail (often crucial for Medicaid access, particularly for refugees who have no written literacy). However, VOLAG services do not extend to providing transportation to medical appointments past the initial follow-up appointment, nor do they provide assistance with interpreting or implementing instructions from medical practitioners. Transportation and translation, among other logistical issues, remain significant barriers to refugee healthcare; in some places and cases, volunteer-run sponsorship groups step into these gaps.

Volunteers' Impact in and on Resettlement

To understand the potential impact of resettlement volunteers, it is important to note that the US resettlement program relies on VOLAGs to provide most of the resources (with government subsidy) during the process. In turn, the VOLAGs—generally lacking staff and resources—often rely heavily on community churches and volunteers to supplement support (Kenny and Lockwood-Kenny, 2011). Volunteer support depends on the resettlement area, but in Kenny and Lockwood-Kenny's (2011) ethnographic study, as well as in my study in Blacksburg, volunteers provide the only available assistance with tasks like enrolling in government programs, making and keeping medical appointments, and navigating the banking system.

Because of the central role volunteers play in the national model of resettlement (Eby et al., 2011), it is necessary to consider in what ways volunteers affect integration. Eby et al. (2011) argue that faith-based volunteer communities increase integration prospects for refugees by providing access to long-standing community presence and local networks, factors which have been noted as especially important in integration (Ager and Strang, 2004; 2010). However, McKinnon (2009) argues that the way volunteer organizations recruit volunteers positions refugees as passive subjects that need help and education, thereby furthering an ideology of assimilation that erases refugee experience and agency. This is reflected in qualitative studies that examine interview data from resettlement volunteers; volunteers describe their relationship to resettling refugees as a parent and a child (Sawtell et al., 2010), worry about encouraging dependency (Thomson, 2014), and perceived refugees as being needy (McAllum, 2017). Erickson's (2012) study suggests that even resettlement volunteers who are senior citizens—those who, Erickson hypothesizes, should be sympathetic to a model of citizenship that goes beyond neoliberal ideas of self-sufficiency because they themselves are outside that paradigm—

reproduce a framework wherein they need to "teach" refugees how to work hard and be self-sufficient.

These studies include research on how volunteers are recruited and how they approach resettlement. What such research invites is further investigation into how volunteers are trained—that is, organizational discussion around values and outcomes—and how they communicate information to the refugees they are assigned to "teach" in the service of these outcomes, especially amid the circulation of "self-sufficiency" as a prevailing rhetoric. If volunteers are a crucial element in the resettlement process, they are crucial both because of the social and resources networks they link to *and* because, due to more personal attention, they are often the people most immediately influential on those being resettled. Evidence and personal experience point to the work of volunteers as something that improves the resettlement process. What research has yet to explore is how a fundamental cultural understanding of resettlement is *shaped* by the resettlement rhetoric brought by volunteers to the resettlement table. What this study aims to address is how moments of difficulty in medical resettlement reveal these rhetorics and the ethical issues that emerge when volunteerism is left unexamined as a load-bearing wall of resettlement infrastructure.

Prioritization of Self-Sufficiency in Refugee Resettlement

The important presence of volunteers in the process of refugee resettlement invites a question of how volunteers help, and how much. Though scholars have noted that integration is a two-way process, wherein refugees are expected to adapt to a new culture while their new community also shifts to accommodate its newcomers (Ager and Strang, 2004, 2010; Valtonen, 2004; Castles et al., 2002), the expectation of integration still places a disproportionate burden on refugees themselves. This is evident in the US resettlement policy that prioritizes economic self-sufficiency above other measures, following a decades-long global trend toward individual responsibility in refugee resettlement (Easton-Calabria and Omata, 2018). Following policy's lead, research on integration often focuses on markers of economic self-sufficiency, like rates of business ownership or economic boost to communities (Bernstein and DuBois, 2018). However, many scholars have noted that giving priority to economic self-sufficiency as a measure of integration overlooks other measures of well-being as noted in the UNHCR goals for refugee resettlement (Dubus, 2018; Wachter et al., 2016; Ives, 2007; Curry, Smedley, and Lenette, 2018; Lee et al., 2015). Additionally, the focus on individualistic self-sufficiency becomes an excuse for governments to ignore a lack of infrastructure and resources that would make it easier for refugees to support themselves in a sustainable way (Easton-Calabria and Omata, 2018; Harris, 2016; Browne et al., 2016). Instead, the self-sufficiency focus has allowed for a reduction in resettlement resources that strains communities and contributes to public perception of refugees as a deficit (Brown and Scribner, 2014). Acknowledging this push toward self-sufficiency, Finney (2018) argues for a redefining of "self-sufficiency" itself as a process of interdependency that considers psychological and social aspects, not only economic. Other scholars have pushed for a greater recognition of refugees' own culturally defined priorities and concerns during integration (Colic-Peisker and Tilbury, 2003; Curry et al., 2018), as the resettlement process is shaped by the aspirations and intentions of newcomers themselves (Strang and Ager, 2010), and the recognition of the pre- and post-migration factors that affect the resettlement process (Wachter et al., 2016; Kenny and Lockwood, 2011; Kyriakides et al., 2018).

In the United States, the push for self-sufficiency as a goal is potentially the most valuable distinction between voluntary migrant *integration* and forced migrant (e.g., refugee) *resettlement,* even as scholars of forced migration have debated the consequences of treated these groups separately (Bakewell, 2008; Cole, 2017; Kyriakies et al., 2018). Voluntary migrants to the US must demonstrate before being cleared for migration that they have the financial resources to support themselves. In contrast, refugees are accepted with no such requirement. Thus, as Kyriakies et al. (2018) argue, "resettlement success" for refugees is "measurable by objective indicators of self-sufficiency—regular employment, stable housing, local relationships, cultural mores, as well as mental and physical health" (17) in a way that is tied to *autonomous personhood.* While voluntary migrants come to the US already as autonomous persons with agency, refugees are understood to be the subjects of rescue who must be supported until they achieve self-sufficiency.

The understanding that refugees are expected to achieve not only cultural integration markers but also *self-sufficiency* markers in order to be resettled is what motivates this study. Not only is resettlement broadly driven by a rhetoric of self-sufficiency, but one can reasonably assume that similar markers bleed into the various facets of the resettlement process, including healthcare.

Rhetorical Ethics, Responsibility, and the Other: Shifting Resettlement Priorities

Even as they remain dependent on social groups and relationships to access care, resettling groups are inserted into a medical (and legal-medical) culture that still prioritizes individualistic behavior and decision making. The tension between provider responsibility and patient autonomy demonstrates how responsibility—and what providers do in the face of that responsibility—is already a crucial conversation that needs to be extended to health-resettlement volunteers as well. And since volunteers cannot act with the same institutional authority as a medical professional, the conversation around responsibility and autonomy centers around discursive intervention, inviting questions of the ethical approach volunteers adopt in that role. Though rhetoricians have discussed a feminist care ethic in terms of methodological approach (Kirsch, 1999; Powell and Takayoshi, 2003; Barton, 2008), less work has focused on how an ethic of care manifests in community-based rhetoric, or rhetorical interaction generally. When considering refugee resettlement, and volunteer involvement in that resettlement, any rhetorical analysis will inherently deal with the feelings that motivate volunteers to do this work. For the BRP, those feelings originated—as I quoted from two BRP volunteers in Chapter 1—from the conviction that there were people in Syria who needed help.

Refugee studies as a field often uses the work of Giorgio Agamben or Hannah Arendt, among others, to talk about ethical responsibility toward displaced populations at the level of the state. However, for this particular project, I am interested in how responsibility toward refugees has been theorized at the interpersonal level—how ethics manifest in interaction. Among theorists writing about these interpersonal ethics, the work of Emmanuel Levinas speaks to both statelessness and the process of seeking refuge *and also* to the idea of a discursive ethic that is triggered when one is approached by a vulnerable Other. The seminal philosophy of Levinas predates feminist care theorists, yet some have argued that Levinas's philosophy of ethics in interaction, and particularly the self's inherent obligation toward an Other, offers a similar care ethic that aligns with later theories of care and responsibility (Taylor, 2005; Kong, 2008; Diedrich et al., 2006). Out of all the theories of responsibility and care ethics, Levinas is the most useful for this particular project because of how he theorizes individual responsibility. Thus, in this section, I will provide a deeper interpretation of how Levinas has been used and understood in our field in order to provide a foundation for the deep-seated feelings of discursive responsibility felt by volunteers.

Theorizing the particular obligation that a self has toward an Other, Diane Davis (2010) argues that the communicative obligation Levinas describes in his work is, in fact, rhetorical; this "rhetorical imperative" is one that insists on acknowledgement and response when greeted by an Other. In this way, the self gives up its egoism and instead allows itself to be acted upon in a rhetorical exchange. In *Totality and Infinity* (1969), Levinas explores the idea of the self ("the same") and the Other. The distance between these two entities, he says, is unbridgeable—in contrast to theorists like Hegel who incorporate the other into the self, Levinas puts forth that the other can never be subsumed into an objectivity or into the self, and that it always and necessarily remains distinct. This distinctness poses a challenge to cohabitation: how can the other be understood? Can it ever be understood? Levinas redirects the focus from understanding to what he describes as the ethics of obligatory response—the preoriginary responsibility of the Self to acknowledge the presence of the other. "The *relation* between the same and the other—upon which we seem to impose such extraordinary conditions—is language," Levinas says (*TI* 49). These "extraordinary conditions" call for an abandonment of ego—a "non-allergic reaction to alterity," in which the other is offered consideration instead of the "murder" that Levinas says is inherent in reducing the other to the same.

Diane Davis takes this imperative to respond to the other and calls it rhetorical. In her book, *Inessential Solidarity,* Davis argues for this rhetorical engagement and the ways in which it manifests, from hermeneutics to personal agency to judgment. Before one can understand the elements of how the self and the other enter into a judgment with one another, one must understand Levinas's concept of the face. The face, according to Levinas, is "[t]he way in which the other presents himself, exceeding *the idea of the other in me*" (*TI* 53; emphasis in original). This presentation or state of being "exceeded" is not something the other *chooses* to do; it is an integral part of the preoriginary exchange. Levinas explains that this exchange—this overwhelming of the self, the "infinite in the finite, the more in the less"—leads to a desire ("Desire") for infinity in the form of transcendence, and that this Desire is what puts an end to the selfish dominion of ego because it is a Desire that *seeks* the infinite, seeks the consuming exchange with the other instead of its own dominance. Says Levinas, "[This Desire] is positively produced as the possession of a world I can bestow as a gift on the other—that is, as a presence before a face…incapable of approaching the other with empty hands" (*TI* 52). The imperative is to receive willingly and give freely. Though Levinas has a disdainful attitude toward rhetoric in his work, Davis argues that the communicative obligation he describes—the preoriginary exchange—is, in fact, rhetorical; this rhetorical imperative is one that insists on acknowledgement and response when greeted by an other. In this way, the self gives up its egoism and instead allows itself to be acted upon when approached by a face.

His naming of the concept is deliberately ambiguous: the self faces a *face*, and uses *hands*, and is *naked*, all intrinsic to the experience of human embodiment. Levinas presumably intends for us to grapple with how much of this terminology is literal and how much is theoretical. Davis, in making the Levinasian imperative rhetorical, leans more toward the idea of the face-as-embodiment, the exchange-as-embodied; she devotes a chapter in *Inessential Solidarity* to figuration of the face, and exploring if a physical face is representative of one's essence. "I could take a train trip or go people watching at the local mall," she says, "without ever encountering a face; once I do, however, the entertainment is over, trumped by an irremissible obligation" (58). There is an implicit acknowledgement of this physical side of

Levinas's concept of the face, one where the body of a human being exchanges language with another body of a human being, that Davis brings to the forefront over the course of her argument for a rhetorical imperative:

> The saying of the face comes through as a rhetorical imperative, an obligation to respond that holds the 'I' and the other in an extreme proximity, in a nearness so excruciatingly close that s/he touches me, affects me, overwhelming my powers of comprehension but without absorbing me. In the face of the Other, my power ceases. I lose my capacity to grasp, to comprehend, to know (56-57).

In *Totality and Infinity*, Levinas explains that part of the self's ethical obligation to the other is hospitality—an infinite welcome—which is offered through language and essential to the "metaphysical event of transcendence" (*TI* 254). In this passage, he uses the French word *hôte* to describe the self-as-subject; in Derrida's gloss of the text, he points out that *hôte* has a double meaning of both "host" as well as "guest." Therefore, Derrida explains, when the subject engages with an other in the moment of ethical obligation, he acts in both roles simultaneously. In the instant the other approaches the subject, the "guest becomes the host's host. The guest (*hôte*) becomes the host (*hôte*) of the host (*hôte)*. These substitutions make everyone into everyone else's hostage. Such are the laws of hospitality" (*OH* 125). Because the infinite obligation makes the subject beholden to the other, the subject becomes "hostage" to that other. To Davis, the host being taken hostage means that his sovereignty is lost—he is no longer master of the dwelling that should be his, and is therefore no longer capable of extending hospitality to any others. There is "no hospitality without a home to offer," she says, "but on the other hand, 'pure' or infinite hospitality, if there is such a thing, would be what frustrates or circumvents all sovereignty" (132-3). In other words, hospitality requires a host, but the obligation of hospitality makes the host *hostage* to its guest—a conundrum.

However, in *Otherwise Than Being*, the original text upon which Derrida builds his host/hostage thought, Levinas says that

> [i]t is in the passivity of obsession, or incarnated passivity, that an identity individuates itself as unique, without recourse to any system of references, in the impossibility of evading the assignation of the other without blame. The re-presentation of self grasps it already in its trace. The absolution of the one is neither an evasion, nor an abstraction; it is a concreteness…. For under accusation by everyone, the responsibility for everyone goes to the point of substitution. A subject is hostage. (112)

Levinas does not say that the host is hostage to the other; rather, a subject is hostage to the *responsibility that comes out of self.* The self, having the preoriginary obligation to respond, "grasps it already in its trace"—the antecedent for "it" is left intentionally ambiguous, but the sentence reads as something reflexive, as the self grasping itself. It is not clear that the self is instead being grasped by the other, but rather seems that the "passivity" of the self is what becomes the hold. Later in the same section, Levinas further explains that "[t]his exigency with regard to oneself…is produced in the form of an accusation preceding the fault, borne against oneself despite one's innocence…and puts the being in itself in deficit, making it susceptible of being treated as a negative quantity" (113). Levinas recognizes the self's need to accuse—to assign blame—for the discomfort of being hostage, and although the obligation of the self is beyond and outside of choice, there is still the inclination for the self to take blame.

Because this dissertation work is positioned both in the rhetoric of health and medicine (or RHM) and in refugee studies, I have sought to engage with a theoretical concern that has spanned both refugee studies and medicine, namely a responsibility toward an Other, whether abstractly or in practice. Levinas's theorization of responsibility of *preoriginary*—that is, preceding choice or even awareness—suggests a relationship that is more abstract than one into which volunteers willingly enter. However, Levinas is useful for this project in moving toward an idea of a volunteer role, and volunteer/refugee relationship, that is suggested by the deficit narratives of displacement and refugee identity. These narratives exist even before particular refugees are resettled in Blacksburg among particular volunteers, which is reflected in how volunteers describe their role in resettled and feeling "hostage" to the situation in a way they did not choose. Most discussions of responsibility regarding refugee resettlement center on state-level responsibility toward displaced populations. By including Levinas's idea of responsibility, my goal is to focus specifically on the acutely interpersonal—on resettlement as enacted within these relationships.

Theorizing these relationships as existing outside of strictly what volunteers choose, and even as relationships that hold them "hostage" as international actors fail to intercede appropriately in refugee resettlement, also shapes the boundaries of volunteer ethos and positionality. Levinas suggests a responsibility that exists in tension and in close contact, which is useful for theorizing how volunteers are able to position themselves within resettlement, as well as what kind of ethos can be developed and leveraged. These conceptions of volunteer ethos and responsibility have yet to be addressed in larger discussions about refugee resettlement.

For my purposes in this study, I build on the theorization of responsibility on an interpersonal level across these spheres, both by a Levinasian ethic that engages refugee studies and a traditional bioethical framework that has informed medical practice for decades. Both Levinasian and bioethical theories of responsibility have been taken up in rhetorical studies, with scholars arguing that rhetoric is not only concerned with a responsibility of a rhetor, which is a discussion that traces back to classical rhetoricians, but also of the boundaries, tension, limitations of that responsibility. Issues of responsibility and boundaries motivate the problem of volunteer-driven health resettlement, and thus I examine how volunteers rhetorically position and act on a sense of responsibility toward resettling refugees, particularly regarding health.

Whether deliberate or compelled, the responsibility as a frame to understand health resettlement warrants further theorization and understanding, especially when the volunteer role has largely remained uncriticized despite its tendency to breed paternalism. In the following analysis chapters, I will demonstrate how volunteers' rhetoric of responsibility challenges the established rhetoric of self-sufficiency, and creates a rhetorical positioning that both reflects a feeling of care and reveals an anxiety for self-sufficiency. Yet at the same time, the discussions in the following chapters reveal that volunteers' rhetoric of responsibility can exacerbate the conflict over which risks to mitigate, when, and how. In the discussions of each chapter, I examine these conflicts in relation to BRP's stated goals, overall expectations of refugee resettlement, and individual volunteer conceptions of responsibility, care, and medical knowledge and decision-making.

Chapter 3

The Blacksburg Refugee Partnership as Community-Based Case Study

As discussed in Chapter 2, the existing scholarship about volunteers and responsibility suggests a need for deeper investigation into volunteer roles and conceptions of health resettlement. The research questions posed in the introductory chapter include: How do volunteers understand a process of health resettlement? What discursive roles and/or responsibilities do volunteers adopt within the process of health resettlement, and what impact does this positioning have on community sponsorship? And, finally, how do volunteers leverage these roles and relationships to reach certain outcomes of health resettlement? I ask these questions in order to explore the intersection of rhetoric and resettlement that has previously been unstudied, particularly as other facets of resettlement rhetoric have been analyzed at the federal and VOLAG levels. Focusing on volunteers and how they situate themselves through discourse potentially reveals a way of understanding the rhetoric of resettlement, and how it constitutes the health resettlement process, that is different than institutional-level framing.

To explore these questions, this study takes a qualitative approach to understand the experiences and perceptions of volunteers as they engage in health resettlement practices. For this study, I analyze which meanings volunteers bring to health resettlement, describing participants' experiences in "their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them" (Denzin and Lincoln, 2000, p. 3). More specifically, I have taken a case study methodological approach. A case study "is an investigation and analysis of a single or collective case, intended to capture the complexity of the object of study" (Stake, 1995 qtd. in Hyett, Kenny, and Dickson-Smith, 2014, p. 2). This approach “allows the researcher to explore individuals or organizations…, relationships, communities, or programs” (Baxter and Jack, 2008), while providing an opportunity for participants to tell their stories and describe their views of reality (Baxter and Jack, 2008; Crabtree and Miller, 1999).

A case study approach is useful for answering questions about behavior, while also wanting to provide boundaried contextual information around a phenomenon (Yin, 2003; Miles and Huberman, 1994; Merriam, 2009). Giving participants space for their stories provides a better understanding for participants’ actions within these contexts (Lather, 1992; Robottom and Hart, 1993). As Baxter and Jack (2008) explain, it is important for researchers to know the context behind the actions because “[it is] in these settings that the decision-making skills [are] developed and utilized. It would [be] impossible for [the] author to have a true picture of [participant] decision making without considering the context within which it occurred” (545).

Thus, in my study, I have focused on the behavior and discourses of volunteers within a particular context of refugee health resettlement in the United States, and particularly in a community sponsorship model. Along with a focus on health, the BRP organization provides the necessary “bounded context” (Miles and Huberman, 1994) for this study. Within this boundary, a case study approach allows for a variety of qualitative methods (Hyett, Kenny, and Dickson-Smith, 2014) including observation, interviews, focus groups, and surveys, among other collection methods. Considering the privacy concerns of BRP clients, I have not included detailed observation beyond my own experiences. However, because my insider position as a fellow volunteer has informed my interview questions, my interview data are informed by this insider knowledge. Additionally, I provide extensive context into refugee resettlement and policy in the United States to outline the backdrop against which the BRP case study, and the volunteers' approach to health resettlement, are occurring. Even though the goal of a case study is to understand a bounded phenomenon and not necessarily to produce generalizable results (Thomas, 2011), my aim with analyzing the BRP as a case study is to produce the beginning of a model that can be applied to—or studied within—other community sponsorship groups.

Foundation and Structure of the Blacksburg Refugee Partnership

As a site of inquiry, I look to the Blacksburg Refugee Partnership (BRP), a local community resettlement organization, as a case study of health resettlement for refugees. As mentioned in Chapter 1, the BRP was founded in the summer of 2016 with a town-hall style meeting held in the local library, organized by four residents and so well attended that it was standing room only. According to the organizers, the meeting was prompted by seeing the viral photo of Alan Kurdi, a three-year-old Syrian boy who drowned in 2015 while attempting to cross the Mediterranean Sea from Turkey to Greece. The photo of Kurdi lying prone on a Turkish beach sparked international outrage as the boy became "an instant global icon of the Syrian refugee crisis" (Adler-Nelson, Anderson, and Hansen, 2020, p. 75), and a symbol of how refugees were being failed—that is, left to die trying to reach asylum—by unsympathetic governments. Thus, the BRP organizers were moved by moral responsibility to act. Shortly after their initial meeting, a core group of volunteers started meeting with the intention of sponsoring a Syrian refugee family for relocation to Blacksburg.

Blacksburg is a town in southwest Virginia, situated between the Blue Ridge and Allegheny mountains about 40 miles west of Roanoke. With about 44,000 permanent residents, the economic and social life of the town largely centers around the presence of Virginia Tech, a public R1 university with about 37,000 students and a large international population. Though

Blacksburg is a relatively significant distance from the Catholic Charities resettlement office in Roanoke—the office through which all the resettled refugee families in Blacksburg were initially resettled—the town was considered potentially beneficial for sponsorship because of the availability of Arabic and Farsi translators and job opportunities through the university. As I will later explain further, focusing on resettlement in this location through the case study of the BRP and its volunteers is informed by my insider access to and knowledge of the organization.

In an interview with the four BRP founders, when I asked if there was any pushback to the formation of the Partnership, one told me that a similar group in a nearby town had attempted to settle a refugee family there, but was met with opposition from certain community factions. Even though all four organizers told me they did not think about whether there would be opposition before bringing refugee families to Blacksburg, there is still the explicit acknowledgement of an unknown element that could manifest just as it did in a town 30 minutes away. Instead, the group was initially formed by word-of-mouth, where information spread from one trusted person to the next. A simple Google search for "Blacksburg Refugee Partnership" is telling: although the group began in July 2016, there are no news articles about its formation until January 30th, 2017, three days after then-President Trump's issuance of the executive order banning migration from Muslim-majority countries. From then until mid-February of that year, six articles were written about the Partnership and the Syrian family stranded in Jordan by the order who was due to come to (and eventually did arrive in) Blacksburg.

After communicating with the nearby voluntary resettlement agency (VOLAG) responsible for managing resettlement in the area, the BRP agreed to sponsor a Syrian family who had initially been resettled in a nearby city and was struggling financially. This family became the first of six who were eventually sponsored by the BRP: a Syrian family of seven, moved to Blacksburg in October 2016 after first being placed in another city; another Syrian family of seven, resettled directly in Blacksburg in February 2017; an Afghan family of seven, also resettled directly in Blacksburg; and three single-mother Afghan families of two to three each, moved to Blacksburg together in March 2017 after forming a friendship in their first resettlement site. Both the second Syrian family and the larger Afghan family narrowly made it into the United States because of the (then newly inaugurated) Trump administration's travel ban on Muslim-majority countries, catching flights during a brief window when a federal judge had put a stay on the executive order. One of the Afghan families later relocated to another city, so at the time I began my case study, the BRP was sponsoring five families in Blacksburg.

From the beginning, the BRP has had a flexible organizational structure. As discussed in the introduction, the key structural units are volunteer teams working with each individual refugee-background family; within these volunteer teams, there is generally a dedicated volunteer for health, another for education, another for translation, another for financial management, and so on (see Fig. 2 in Chapter 1). As of 2021, most family teams had been winnowed down to a smaller group of volunteers as BRP retention waned (potentially due to the COVID-19 pandemic). These volunteers work together under the umbrella of the family liaison, a volunteer responsible for managing many of the day-to-day resettlement concerns and interfacing most frequently with the family. Outside of the core family groups, other BRP volunteers work on an as-needed basis for tasks like providing transportation or childcare. Even though the BRP has a Board of Directors through which major financial contributions (like paying a family's rent) must be approved, most Board members are themselves volunteers on family teams. This overlap can make it difficult to know who is "in charge" when problems arise. In some cases, issues are brought to the entire Board; in other cases, often including situations that must be resolved quickly, two or three founding Board members may make the decision. At the same time, a less rigid organizational structure means that liaisons and family teams operate largely independently, often leading to different family teams approaching similar issues in different ways.

A Critical Incident Approach to Resettlement Practice

What makes the BRP useful as a case study is not just that it is an example of a community group filling the gap left by a short, policy-driven resettlement timeline, but also that the different ways volunteers approach problems often lead to conflict within the organization that reveal the tensions between different resettlement rhetorics. The same flexibility that allows volunteers to act in the way they believe is best also means there is little "official" guidance on what to do in more difficult scenarios, especially in relation to refugee health, privacy, and navigating the US healthcare system. The issues faced by the BRP, though they may be unique to local infrastructure and resources, are nonetheless indicative of larger issues around refugee resettlement—and health resettlement—in the United States. Because community resettlement groups are regularly in sponsorship positions, volunteers must determine the boundaries and ethics of their roles and responsibilities. To explore these moments of conflict, I take a critical incident approach to this study. As a method of inquiry, a critical incident approach considers how "narratives that elaborate on stakeholders' reasoning, social positioning, and life contexts generate new information and propel discussion that can move people beyond personal expression to public problem solving" (Flower, Higgins, and Long, 2000, p. 21). Interviews with volunteers produce narratives that are "focused around the causes of and responses to problems"

(21) in ways that reveal values, priorities, and social positioning as volunteers move within a process of refugee resettlement.

Shifting to a critical incident approach moves refugee resettlement, which is often discussed and problem-solved on a state or national level, into a space of interpersonal and community relationships. According to Flower, Higgins, and Long, "[i]n listening for critical incidents we are attempting to hear where the private, localized knowledge of an individual or group might be reflective or indicative of a more public issue of shared concern” (74). The questions that motivate conversations about refugee resettlement more broadly—How do refugees impact the economy? How many refugees receive government benefits? How should we vet refugees? Should we bring refugees to the US, and if so, how many?—are not the conversations motivating a volunteer resettlement group in a mid-sized university town. Because refugee resettlement becomes an acutely local situation, with state and federal governments relying on community-level resettlement agencies and citizen-volunteers to shepherd newcomers through the process, it becomes vital to understand the “critical incidents” that emerge at the local level. Focusing on health resettlement first as a performance of situations within a local context brings an awareness that resettlement *is* local. As the analyses in this dissertation illustrate, though federal and state-level policy acts as constraints on these rhetorical situations, it is often things like technology use, communication strategies, volunteer values and priorities, and organizational structure that steer what resettlement is and becomes.

Similarly, though vital conversations are happening on broader levels about refugee health, including common health concerns, Medicaid and provider access, and mental health needs, a critical incident approach focuses on the situation as it exists at a local level, informed by the situatedness of the stakeholders in how they express problems and explore solutions. The work of Flower, Higgins, and Long in critical incident approaches dovetails with a concern about building community and solving community problems through research (Grabill, 2012). For the BRP in particular, a critical incident approach is relevant because it focuses on *deliberative practice*—talking through scenarios—instead of trying to codify "the rules" in a policy, which may not capture the variety of situations in which volunteers might find themselves.

Research Positionality and Insider Status

As mentioned earlier, I have four years of volunteer experience with BRP, which significantly influenced my research design and focus on critical incident approach. My deep involvement with the organization also warrants a critical reflexive approach to my positionality as a researcher and my interpretation of the data. Thinking reflexively about how my own positionality—that is, my "influence on and in the research process"—is an important part of qualitative research (Savin-Baden and Major, 2013, p. 3). The positionality of a researcher can influence not only how they choose to approach the project, but also how they analyze the outcomes of that research (Foote and Bartell, 2011). Thus, "[s]elf-reflection and a reflexive approach are both a necessary prerequisite and an ongoing process for the researcher to be able to identify, construct, critique, and articulate their positionality" (Holmes, 2020, p. 2). Because I am both a researcher and a participant, elucidating my positionality is especially important to demonstrate my awareness of how these roles interact.

One important aspect of my positionality with this research is my "insider" position. The insider/outsider positioning of a researcher is a helpful framework for understanding whether a researcher shares important elements of identity with their research participants (Hammersley, 1993; Weiner-Levy et al., 2012; Sanghera and Bjokert, 2008) and what implications this might have on study design and analysis. Although some of the BRP medical volunteers do not share my ethnicity, cultural background, age, or other identity markers, we share the cultural context of being resettlement volunteers. Thus, for this study, it is helpful to consider my position to be one of an insider and as having a shared context and experience with my research participants.

My insider status with my research participants allowed me a particular kind of access, since I was regarded as being in a similar position as the volunteers I was interviewing. Not only had I spent years attending meetings and having discussions with volunteers about the subject about which I was now interviewing them, but I had also "done the work" of volunteering and providing assistance in helping resettling families access medical care. Thus, the questions I was asking volunteers were based on years of conversations with other volunteers, BRP leadership, and resettling families, as well as from my personal experience as a volunteer in medical situations. This possession of *a priori* knowledge marks me as an insider in qualitative research (Sanghera & Bjokert, 2008). However, this same positioning also means that research participants may assume we have the same opinions or level of knowledge about health resettlement situations (Holmes, 2020). This assumption became apparent during my interviews, where interviewees would make references to situations with which they thought I was already familiar; almost every interview recording has asides of me expressing surprise about something a volunteer brought up as if I were already familiar with it. Because of these potential assumptions, volunteers may have neglected to provide more detail or examples in the way they would have if interviews had been conducted by a researcher unaffiliated with the BRP. At the same time, an outside researcher would not have the background or context that would ground the interview questions in the same way. An awareness of this positioning was important during the interview process and remained critical during the data analysis.

Perhaps the most immediate consequence of my insider positioning as a researcher and interviewer is that some participants may be reluctant to express genuine answers about their experiences with resettlement because 1) I am on the BRP Board of Directors, with whom some volunteers have had previous conflicts; and 2) even before I was on the Board of Directors, I was vocal about my disagreement with other volunteers during medical team meetings when I believed them to be taking an overbearing approach to health resettlement. Two of my research participants directly referenced our previous conflicts about approaches to health resettlement. Despite these prior conflicts, I feel I have friendly relationships with the volunteers included in this study, though I understand that to be my perception. That said, it is possible that our friendly relationships contributed to their agreeing to be interviewed. It might also be true that medical volunteers who self-excluded from this study did so because of prior disagreements with me or the Board. I also kept in mind that medical volunteers who did agree to be interviewed may be less willing to talk about interpersonal conflict within the organization because of our continued contact in the future (Holmes, 2020). Thus, though I did ask volunteers indirectly about their relationship with BRP leadership and other volunteers by asking who they turn to if/when they need help, I have tried to focus my analysis more on their approach to health resettlement problems and not specifically on organizational conflict. Finally, as these examples suggest, I recognized both the enabling and limiting aspects of my insider status and engaged in an ongoing process of reflexivity during data collection and analysis.

Ethical Responsibility in Refugee Research

As I analyzed issues of conflict and concern during data analysis, I adopted a methodology that incorporates the theories of responsibility that I explore in the study; namely, a feminist approach that prioritizes care for and reciprocity with research participants. Feminist rhetoricians have turned attention toward the more mundane and "everyday" rhetorical practices typically embodied by women and overlooked in scholarship (Kirsch and Royster, 2012; Powell, 2009; Duthely, 2017), highlighting the importance and effects of these rhetorical spaces. A feminist approach also reflects my position both as participant and observer; following the guidance of Selfe and Hawisher (2012), I have sought to "forge relationships over time…around conditions of mutual interest" (p. 37) and not shy away from the collaborative meaning-making that comes from a more conversational interview style. This conversational style, where at times I will offer advice about how I dealt with a situation as a volunteer or offer a success story of my own, is part of the commitment to reciprocal research also championed by feminist scholars (Powell and Takayoshi, 2003; Cushman, 1996; Royster and Kirsch, 2012). Through this collaborative meaning-making, my goal is to work with BRP volunteers in a way that is "not necessarily…the 'exchange' that more traditional definitions of reciprocity seem to nudge at, but more-so as a collective and gradual move with the communities we engage in a forward and socially-just direction" (Haywood, 2019). As part of this direction, I strive to represent my research participants fairly in my analysis while also understanding volunteers as being in a position of power relative to resettling refugees, and recognizing that a socially just direction requires a critical analysis of how resettlement is enacted by volunteers.

Refugee studies research can be ethically fraught, particularly in how researchers interact with potentially vulnerable refugee populations (Jacobsen and Landau, 2003; Bloch, 1999; Rodgers, 2004; Ellis et al., 2007; Guerin and Guerin, 2007; Voutira and Doná, 2007; Block et al., 2013; McMichael et al., 2015; Obijiofor et al., 2016) and because of the "misrepresentations of refugees that circulate in the public sphere" (Allotey and Reidpath, 2019, p. 2). Given this concern, the Refugee Studies Centre at Oxford has developed a set of ethical guidelines that propose “good practice” for refugee-related research (2007). They note that because forced migration research is contextual and complex, there is not a prescriptive code that fully captures all situations of vulnerability and ethical considerations. Rather than focus on ethical principles, the guidelines focus on establishing *relationships* between participants and researchers.

These relationships are emphasized not just between researchers and refugee-background participants, but also other stakeholders in the resettlement process (e.g., resettlement volunteers). This contextual ethical approach aligns with the approach I take in this study, where I specifically focus on relationships between resettlement stakeholders, including myself as a volunteer. Even though this study did not engage with refugee-background participants directly, I still have still taken the same ethical considerations into my research with participants, particularly since my relationships with BRP volunteers will continue to be ongoing after the study’s completion. Overall, the ethical purpose of this study is to “design and conduct research projects that aim to bring about reciprocal benefits for refugee participants and/or communities” (Mackenzie, McDowell, and Pittaway, 2007, p. 299). Understanding volunteers’ roles and rhetorical approaches to health resettlement is one aspect toward improving resettlement practice.

In this vein, Voutira and Dona (2007) have identified key methodological features that are intrinsic to refugee studies: multi- and interdisciplinarity, bottom-up approaches to research, and a relationship between advocacy and scholarship. Speaking about the discipline, they note that

> [a] defining feature of refugee studies during its consolidation period was the adoption of a refugee-centered, bottom-up approach that saw refugees as actors and agents. To speak

> of [a methodological] approach is not to refer to a particular set of tools or methods like fieldwork, survey or experiments. It is rather to define the focus and perspective taken. (166)

As Voutira and Dona explain, it is the perspective of the approach that especially designates the research as contributing to refugee studies. In the case of this study, although I am interviewing resettlement volunteers and not refugee-background participants, the methodological approach has still centered "refugees as actors and agents." I use the same centering in my interviews with volunteers, where assumptions about refugee agency operate within my interview questions. Thus, despite being about volunteer perceptions and narratives, the study remains focused on implications for refugees as actors in health resettlement, with the eventual goal of speaking back to government and VOLAG authorities. The approach in this study focuses on individual experiences of volunteers as participating in resettlement on the ground while also being influenced by the dominant policy narratives that push for self-sufficiency.

This bottom-up approach, combined with Voutira and Dona's third methodological feature of advocacy and scholarship, pairs with what Middleton et al. (2011) term *rhetorical* field methods. These methods, they argue, "embrac[e] the critical spirit….and desire to identify possible emancipatory alternatives" that are the signature of critical rhetoric (McKerrow, 1989). Rhetorical field methods focus on the underrepresented voices not typically included in analysis, challenging whose voices are "worth" studying and which rhetorical actions are considered "worthy of scrutiny" (Ono & Sloop, 1995). Overall, rhetorical field methods focus on "live" elements of rhetoric that are not captured by textual representation (Middleton et al., 2011, p. 389). Given the constraints of the project, this study centers the voices of volunteers and not refugee-background clients, so a rhetorical field method approach that centers typically excluded voices is the long-term goal of this project rather than an immediate outcome. As mentioned, exploring volunteer understandings of health resettlement is a necessary step toward incorporating the lived experiences of resettling refugees themselves. Talking to volunteers reveals elements of the critical spirit—of examining power relations in health resettlement and the way rhetorics deployed by volunteers shape the resettlement process.

Recruiting BRP Volunteers as Research Participants

To understand volunteer perspectives specifically on health resettlement, I recruited study participants from among the BRP volunteers who are involved in health coordination. Recruitment involved sending an email to all current medical coordinators and liaisons, as well as two volunteer translators who I knew had also been involved in medical translation, with a total recipient list of nine people. My recruitment email explained that I was interested in hearing volunteers' perspectives on how they have communicated and coordinated medical care outside of the doctor's office, with the hope of informing resettlement practices in the future. The email also asked recipients to forward my request on to other volunteers from their respective family teams, current or former, who they felt also had significant experience with health coordination. From this pool, eight active volunteers agreed to be interviewed.

After I sent out a request for study participants, a fellow medical coordinator replied to the email list (which I had deliberately left non-blind-copied so that volunteers could verify if I had missed anyone relevant, and forward accordingly) expressing a concern that participating in this study would violate the confidentiality agreements they had committed to regarding sharing medical information about the families. I shared the interview protocol with the group so they could see that the questions I would be asking did not focus on the particulars of anyone's health, but rather on their navigation of the healthcare system. I reassured interviewees that pseudonyms would be used, but that as they answered questions, any specific anecdotes about medical conditions could be kept as general as possible. Additionally, I reminded all participants before the beginning of our interviews to only reveal information as sensitive as they would feel comfortable sharing during our medical team meetings, reminding them that BRP-sponsored families have agreed to the limited sharing of medical information in situations where volunteers need advice or assistance from other volunteers.

Throughout this dissertation, I have used pseudonyms for both volunteers and for refugee-background individuals about whom volunteers referred. Additionally, I have modified or anonymized details as necessary to minimize the risk of identification, especially considering the sensitive nature of medical information being discussed. Mackenzie, McDowell, and Pittaway (2007) have noted the danger of publishing identifying information about refugees, who are often fleeing politically (and interpersonally) dangerous circumstances. Thus, all information in this study has been anonymized so that resettled families would not be able to be identified even though the actual name of the town is being used. Though researchers have suggested that non-anonymization is a way for refugees to reclaim agency in narratives (Svalastog and Eriksson, 2010; Wiles et al., 2012), because this study focuses on volunteers and how volunteers talk *about* refugee healthcare access (as opposed to having narratives from refugees themselves), names and identifying information have been anonymized to protect client privacy.

Explaining my ethical approach to potential participants up front, all interviewees had advance access to my guiding interview questions. However, the interviews remained semi-structured, loosely following an interview protocol while also “[p]ermitting the respondent to talk about what the respondent wants to talk about, so long as it is anywhere near the topic of the study" (Weiss, 1995, p. 49). Though some interviewees admitted to not looking over the questions beforehand, others came to our interview with detailed notes about how to respond to each protocol question. Many anticipated follow-up questions in their responses to my first questions, such as when I would ask "Can you describe your role within BRP?" For instance, one interviewee answered that question by talking at length about medical resettlement and common problems they encountered, specifically mentioning the questions later on my list when she did so. This anticipation was not a problem, but in my subsequent coding and analysis I have kept in mind that certain ideas, terminologies, or thought processes may have not been organic to the interview itself (e.g., it is less noteworthy that a volunteer might use the phrase "medical resettlement" before I had introduced the concept in our conversation).

Data Collection and Analysis

In-depth, semi-structured interviews were chosen as the primary data collection method in order to focus on participants' lived experiences as volunteers implicated in a process of health resettlement (Lindlof and Taylor, 2011). Within the inner- and outer-facing texts of the BRP, there are not lengthy, persuasive arguments being made; there are not newspaper editorials being written to argue for its existence; there are not official memos or research notes being taken. And yet there is an abundant amount of intra-group rhetorical work happening in the form of weekly (now semi-weekly) organizing meetings, emails sent to the mailing list regarding new website text, and carefully targeted advertising about Partnership events. Unlike other studies focused on public deliberation around matters of health concern, BRP meetings are closed to the public due to ongoing anti-immigrant sentiment in the region and out of concern for the safety for resettled families; thus, I have not included observations of these meetings in this study.

Instead, qualitative interviews were used to understand the phenomenological experiences of volunteers in the process of resettlement. Analyzing interviews as representations of volunteer values, anxieties, actions was used to get at how they act in moments of concern and also what they experience as their personal responsibility and rhetorical agency in health resettlement.

Five interviews were conducted in a sound booth in the Virginia Tech library, with two conducted in a local restaurant per the interviewees' requests, and another conducted by phone because of geographic constraints. All were conducted in English and took place during February and March 2020. Interviews ranged from 30 minutes to 2.5 hours and were recorded using the Otter.ai app. All interviewed volunteers are female, reflecting the majority demographic of BRP membership. Four are originally from the United States, one is from Egypt, one is from India, and two are from Iran, though all have lived in the US for a number of years. All but one has been with the BRP since the initial arrival of the five sponsored families in 2016 and 2017. One is a retired veterinarian, but none of the other interviewees have any formal medical training.

To elicit narratives about their goals for health resettlement and the moments when these goals were challenged, I asked questions such as "What do you think it looks like for a refugee to be resettled successfully?" and "What is a typical problem that you encounter in coordinating medical care?" (See Appendix A for the interview protocol). Following data collection, three of the interviews were auto-transcribed by the Otter.ai app and manually revised as necessary. The remaining five were professionally transcribed. After gathering the corpus of transcripts, I began the initial coding process. I was guided by what I wanted to learn from these interviews based on my own ethnographic and situated experience as a volunteer, as well as close readings of the 2018 Virginia State Resettlement Plan, the Federal Code regulating refugee resettlement in the US, and BRP organizational documents. These interviews were an opportunity to gain insight from BRP volunteers that may align or diverge with my own volunteer experience. Aligning my research questions, my aim during the coding process was to discover how volunteers understand their role, both in relationship to refugee-background individuals and in relationship to BRP itself, and how this role impacts the way they understand refugee health or interaction with medicine. As I will discuss further in Chapter 4 and 5, these interviews—particularly the interview questions focused on conflict and fraught decision making—were instrumental in understanding how volunteers conceptualize and enact agency and ethos within the health resettlement process, as much of their description of conflict revolved around expected actions and their own persuasive impact.

During my interview-gathering period, I wrote analytic memos both immediately after each interview and as I listened to the recording afterward. The emergent categories in these memos became the basis for a provisional coding scheme (Creswell, 2007) that I used for a first pass through the interview transcripts. The first round of coding was done by hand on transcript printouts as I began expanding and refining my provisional codes. During this first round, I employed a combination of coding approaches: values coding (Saldana, 2009) and process coding (Corbin and Strauss, 2008). A values coding approach "reflect[s] a participant's values, attitudes, and beliefs, representing his or her perspectives or worldview" (Saldana, 2009), fitting appropriately with the question of how and what volunteers prioritize and seek after in the process of health resettlement. In addition, and aligning with a critical incident approach, process coding searches for "ongoing action/interaction/emotion taken in response to situations, or problems, often with the purpose of reaching a goal or handling a problem" (Corbin and Strauss, 2008, p. 96-7). Combined, these coding methods examine both volunteer values and the actions they take in the wake of those values. At this stage of the coding process, I also left my own process open-ended enough to include codes that may not fall into either of these two categories. Following my first round of coding, I had 12 codes that emerged around problem-solving strategies, team relationships, and volunteer goals for resettlement: choice, goals, family relationships, communication, bureaucracy, organization, conflict, ignorance, solutions, emotional investment, volunteer challenges, previous skills/knowledge. The second and third rounds of coding were done in MaxQDA. In these rounds I employed a focused coding approach (Charmaz, 2006) to eventually categorize my 12 first-round codes into 5 overarching coding themes: goals, relationships, logistics, problems, and roles. Segments were not limited to one code or theme at any stage of coding.

The following chart includes the major themes and how the first-round codes fit within them, including examples of coded segments.

Table 1: Sample Coding Schema

THEME: GOALS		
Code:	How segment fits the theme:	Segment:
V	A description of general values that volunteers aspire to	“I would like for them to feel a sense of belonging to the community. A faith in the fact that they are safe, that they have opportunity, a decrease in fearfulness And on top of that I want them to feel like they can make, can and will make their own decisions as to the things that affect their lives and the lives of their children.”
G	A description of a specific end result for resettlement that volunteers prioritize	“Somebody has to kind of, you know, wean down the specialists until she's getting good medical care. And that it all makes one coherent, sensible picture. And that hasn't happened for [her] yet. I think that's a goal that's very necessary—that she's not seeing too many doctors who are

		not really useful for her.”
THEME: RELATIONSHIPS		
Code:	How segment fits the theme:	Segment:
B	A description of how volunteers interact with each other within the BRP	“Yeah, I talk to Tim more than Stacey. I talk to Stacey, but if I talk to Tim and I think, ‘Okay we’re together on this,’ then I don’t feel it’s so important to call Stacey. But if we can’t really see it straight then I say, ‘Oh, let’s get Stacey.’ Because the three of us—it’s totally secure.”
R	A description about volunteers’ relationship with refugee clients	“I saw how you can be “friends” without being what somebody must think as a friend like you don’t have to have them overnight or even to dinner, but you were their friend and in that you let them access your network, which is what we’ve done for our families.”
O	A description about how volunteers establish relationships with people outside the BRP	“I think the only time I felt like I needed some outside help that we can’t figure out is with reaching out to [a care coordinator in the local health system], because I felt like we need that person with the medical background who can talk to them about just general…[medical] things.”
F	A description of how refugee clients interact within families	“Farid has stepped up a lot and he wants to be involved in his dad’s health because his dad has a lot of problems and isn’t always on top of taking care of himself and taking all his medicines. The last time I was at their house, like Farid has even gone to some appointments with him.”
THEME: LOGISTICS		
Code:	How segment fits the theme:	Segment:
I	A description of barriers to institutional access	“We were limited by male members of the family [who] wanted to only meet with male nursing or doctor staff. Same thing with the females, they only wanted to meet with female members, which [the community health center] is great but it’s a small facility, so that was very hard to coordinate. Also you have to reapply every year with the [health center] and show financial need, which at this point it’s very difficult because families have jobs. You have jobs and trying to get everybody in a room to do the paperwork—it’s a pain.”

P	A description of institutional procedure that has to be navigated	"[In Afghanistan] you just go to the doctor, and you wait in a very, very long line. And you see the doctor. So there is no appointment that you have made that you have to make and be there. If you don't go that day, nothing bad happens. Somebody else is there to see the doctor. The doctor never sits idle, too, if somebody doesn't show up for that meeting. I think for at least Nazmeen, it took a long time to understand this [difference]."
THEME: PROBLEMS		
Code:	How segment fits the theme:	Segment:
C	A description of something within the BRP that was challenging for volunteers	"I feel like we just try to do the best we can but there wasn't a preparation for let's say the health coordinators or the family coordinators of where these people are coming from. We didn't really have any formal way of orienting them so that they can handle and deal with helping those families achieve some kind of independence and take care of their health."
E	A description of an external problem (i.e. a problem that, in the volunteers' view, did not originate with the refugee client)	"Like there was a time when I guess [the adults] missed a single piece of mail that said that they had to go in for an appointment, and they wound up not having health insurance for maybe a year or so. And that was really stressful because it created a lot more work for me, like signing them up for financial assistance programs and figuring out how to get their prescriptions covered and stuff like that."
N	A description of an internal problem (i.e. a problem that, in the volunteers' view, originated with the refugee client)	"And he is supposed to need [the medication] certain days and hours per day, and so the report comes back that he's only used it for that many days out of the 30 days. And he's used it the minimum [amount of days], and some days he won't even do it, and I told him... you run the risk of losing [the medication]. Insurance won't pay for it if you continue to do that."
THEME: ROLES		
Code:	How segment fits the theme:	Segment:

A	A description of ideal or effective volunteer attributes	“First, [the volunteer] should have lots and lots and lots of patience, lots of patience. And be prepared for everything, from [the] ER to staying in the hospital till four o'clock in the morning, to getting a call that she's sick at work, or because of the...stress she fainted at church or ESL class. So just be prepared, always.”
T	A description of volunteer tasks	“Basically, it's coordinating everything that she needs coordinated, like from childcare to to medical appointments to food stamps and taxes and so on and so forth. Just having everything coordinated.”
H	A description of how or why the volunteer began their role with the BRP	“When I saw a notice on Facebook, a post asking for volunteers to help. And I called up the number and at the time what they needed help with was childcare. So I signed up for that after the...orientation.”
S	A description of setting boundaries around tasks volunteers will not or cannot do	“In that situation they wanted me to take her to the doctor. I couldn’t because I had to go get my own children from something. I physically couldn’t take her to the doctor at that minute.”

As is indicated in these themes, the focus is largely on how volunteers conceptualize their role and responsibility, and how they interact with others in that process. These themes are further explored and analyzed in Chapter 4, “Intervening for the Other: Rhetorics of Hospitality and Agency in Health Resettlement,” and Chapter 5, “Relationships and Authority: Creating and Gathering Ethos in Medical Decision Making.”

Limitations of the Study

This dissertation focuses on how volunteers' frame their roles and relationships in health resettlement. However, because of my commitment to amplifying refugee experiences of resettlement, my original research plan was to interview both resettlement volunteers and refugee-background individuals at two sites in Southwest Virginia, with research questions that asked about the experiences of refugees during the process of health resettlement. However, only two days after I completed my last volunteer interview in one of those sites, the Virginia Tech IRB suspended all in-person human subject research protocols because of the COVID-19 pandemic, which prevented me from completing the 25 intended interviews (15 volunteers, 10 refugee-background newcomers) across the two research sites. Because I strongly believe that changes to resettlement policies, whether in government or nonprofit organizations, should not be made without being led by the voices and expressed needs of refugee individuals and communities, I intend to resume interviews with refugee-background newcomers once the pandemic restrictions are safely lifted.

However, while these restraints limited the data set to only the voices of resettlement volunteers, it became clear in conducting the interviews that the rhetorical issues faced by volunteers as they assisted in medical resettlement warranted careful study on its own. While the scope of the project has been adjusted to reflect the pandemic-precipitated changes, I focus on the rhetorical experiences and problems experienced by volunteers during the process of assisting in medical resettlement, focusing specifically and more thoroughly on how volunteers understand and enact health resettlement. This focus potentially provides valuable insight for other resettlement organizations who might encounter similar problems. When I am able to resume interviews for future research, I will then be able to compare the experiences of these different resettlement stakeholders and identify opportunities to better inform volunteer engagement, and ask questions about how refugee clients engage with volunteers in moments of conflict. In the meantime, I have taken care in this dissertation manuscript to avoid speaking *for* refugee-background individuals in southwest VA or speculating what behaviors, policy, or approaches may be having positive or negative effects during their process of resettlement.

Though I conducted interviews with two volunteers from a resettlement group in my intended second research site, the interruption of my data collection led me to exclude these interviews due to a limited sample size, and instead focus on the seven interviews which were collected in my first research site. With the exception of one interviewee with whom I had only worked for about eight months prior to conducting our interview, I have known and worked alongside each of the interviewees since January 2017, allowing me to focus deeply on the BRP as a case study. A second research site, with a separate group of resettlement volunteers, would have served to balance my own position as a participant in my first research site. Instead, my relationship with each of the interviewees is familiar and often casual. This tone is reflected in the way I conducted interviews, often making asides to compare my experience with theirs, share anecdotes, or express my own feelings. As a participant-observer, this approach was informed by feminist research methodology (Royster and Kirsch, 2012) which makes space for interviewing to be more conversational and empathetic. Although the study size for this dissertation is small, local, and in some ways resists generalization, the benefit is a closer and deeper understanding both of local resettlement and of volunteer motivations. This focus allows for a more targeted recommendation for the BRP specifically, which makes this research with the BRP more reciprocal and beneficial for volunteers. In addition, this in-depth analysis, as discussed in Chapter 6, will provide the grounding for future comparative research.

Though I have been an active participant in the BRP for over four years at the time of this writing, and some of my interview approach is informed by ethnographic practices of observation (Kawulich, 2012), the data presented in this dissertation is *not* a result of a true ethnographic study. I received explicit consent from interviewees to present their words here, but I have not received broader consent to record or recount the often personal and private words used in BRP meetings and communications, a choice I made deliberately so as to not compromise the integrity of a space that is important in securing community resources for resettlement, talking about sensitive medical information (that we had consent from resettling families to share only with other volunteers as necessary), and for navigating fraught emotional reactions and frustrations. My concern was that knowing that these interactions were being observed for research purposes would prevent the communal problem-solving and knowledge-building that I had seen was important in resettlement work. Instead of a broad observational approach, I will present both the interviews and, sparingly, a story of my own volunteer experience in moments of conflict or difficulty.

As mentioned previously, my positionality as both a participant in BRP and a researcher certainly had an impact on the data gathered for this study. Because I already had, in most cases, a years-long relationship with the study participants, this familiarity inextricably affected the conversational tone of the interview, the information volunteers felt comfortable sharing, and my access to participants and how they were recruited. While for some participants my role in the BPR organization acted as a shortcut to talking about difficult topics that have been discussed in BRP meetings previously, two participants in their interviews directly referenced my position on the BRP Board of Directors (a position to which I was elected just before beginning interviews) as they expressed to me their conflict with the organization. This does not negate the relationship

I have fostered with these volunteers over the years, but it was clear that they saw me both as a researcher, a volunteer, *and* occupying a position with the BRP that was associated with a kind of antagonism for them as they performed their roles as volunteers. Before beginning my study, I considered if I should focus on a different resettlement site in order to have more distance as a researcher. Ultimately, however, I determined that my years of volunteer experience and relationships with fellow volunteers—and even my position as a new Board member—could potentially result in more intimate discussions about volunteers' ethical quandaries and beliefs about health resettlement, making the potential benefits of my position worth the potential costs. My decision to lean into my close relationship with research participants, as opposed to attempting to keep distance, is informed by previous community-based scholars (Cushman, 1996; Grabill, 2012; Kirsch, 1999; Mocarski et al., 2020) and provided more opportunity for reciprocal work (Powell and Takayoshi, 2003). Many of the same themes emerged from the two interviews conducted with non-BRP volunteers, but given more time before the coronavirus stay-at-home orders, I would have sought to do additional interviews with this secondary site in order to compare results and gain a clearer insight into how my position might affect the data.

Because this dissertation is framed entirely through the lens of volunteer experiences, there are moments in these interviews that are representative of a *perception* of refugees, but those perceptions must not be taken as *objective truth.* For instance, there are multiple moments of volunteers speculating about what a refugee-background person does or does not know, believe, or understand. Because my questions for volunteers were written to complement similar questions for refugee-background persons, the data set included here is missing the counterbalancing experience to round out the volunteer perspective. My request for readers of this dissertation is that neither the words of volunteers nor my analysis of them—whether reinforcing a positive image of refugees in the US or a negative one—not be taken out of context. It is especially crucial that moments of assumption, frustration, or conflict described by volunteers not be used as weapons against the refugee resettlement program or against refugees themselves. Volunteers in this study are constructing certain narratives that may be perceived as capturing refugee identity; however, identity construction of refugees from third parties is fraught and often reductive (Rajaram, 2002; McKinnon, 2009, 2011; Powell, 2012; Risam, 2018). Like other rhetorical studies scholars studying refugee resettlement (Reyes, 2020; Nur Cooley, 2020; Lyon, 2018; Randall, Powell, and Shadle, 2020) these limitations and ethical concerns inform my data collection and analysis, and in the chapters that follow, I present findings with these dilemmas for research in mind.

Chapter 4

Intervening for the Other: Rhetorics of Hospitality and Agency in Health Resettlement

In Chapter 1 of this dissertation, I detail the three durable solutions for refugees as established by the United Nations High Commissioner for Refugees (UNHCR): voluntary repatriation, wherein a refugee chooses to return to their home country; local integration, wherein a refugee settles permanently in a country to which they have fled for asylum; and resettlement, wherein a refugee is relocated, through the coordination of national governments and the UNHCR, from an asylum country to a third country that has agreed to offer them permanent residence (UNHCR, 2021c). Regardless of which solution is deemed most appropriate, the UNHCR is ultimately focused on moving refugees from a transient situation to a permanent one. Yet for local integration and resettlement, the understanding of what that "permanent" situation includes has been a point of discussion among academics and politicians: Other than physical relocation, what is involved in resettlement? Who is responsible for it? What does it mean to be "settled" in a place?

In this dissertation overall, I approach these questions through an understanding of *health* resettlement. Health resettlement is a term that I am introducing to change the widely accepted understanding of what resettlement is and includes. While in refugee studies health is occasionally positioned as a factor of integration (Ager and Strang, 2004; 2010), the discussion around it is generally limited either to physical and mental health outcomes, or to the healthcare barriers that stand in the way of those outcomes (e.g. lack of interpretive services)(Morris et al. 2009; Mitschke et al. 2011; Morrison et al. 2012; Sangaramoorthy and Guevara, 2017; Semere et al. 2018). There is little investigation into health as its own *process* of resettlement, especially in the ways that volunteers are mediators of that resettlement (McAllum, 2019). Thus, defining what it means for refugees to be "health resettled" guides the questions in this study overall. As the conclusion in this and the next chapter illustrate, a rhetorical approach to resettlement helps to highlight how health resettlement as a process is not merely a series of outcomes, but is also reflective of situations and discourses that frame both how refugees are perceived as Others and what it means for them to be "settled" in the United States.

In this chapter, I begin to build an understanding of resettlement, and health resettlement in particular, by first analyzing how federal and state resettlement policies present the government's expected self-sufficiency outcomes of the health resettlement process. I then compare the rhetoric of self-sufficiency at the policy level to rhetorics of responsibility through the case study of the Blacksburg Refugee Partnership (BRP), a local, community-based resettlement group as described in Chapter 3. In this case study, I analyze how resettlement is framed at the organizational level of the BRP, and how this framing mimics a rhetoric of self-sufficiency while at the same time moves toward a more contextual, situational understanding of resettlement that is informed by direct interaction.

In her theorization of what constitutes a resettlement rhetoric, Dykstra-DeVette (2018) centers the "rhetorical constructions of refugees by the state" and by "humanitarian organizations that assist refugees [i.e., VOLAGs]" (182). Similarly in this study, I approach a rhetoric of resettlement not only as BRP volunteers' rhetorical constructions of refugees—which, I will argue, falls back on the rhetoric of self-sufficiency that is present in policy—but also on the rhetorical construction of volunteers *themselves* in relation to refugees. Expanding resettlement rhetoric to include relationality between refugees and resettlement volunteers creates space for theorizing a *responsibility* as a resettlement rhetoric, and not only self-sufficiency. Thus, I analyze volunteer discourse within the BRP community to more deeply understand the rhetorical strategies they use to guide the health resettlement process within the role they have constructed for themselves and refugees. This involves an examination of the discursive actions and abilities volunteers expect from refugees to mark them as being "health settled." Finally, I examine how BRP volunteers frame resettlement through a rhetoric of hospitality, and how this both subverts a rhetoric of self-sufficiency while also inviting volunteers to intervene as proxy agents in the process. This analysis provides valuable insight for community resettlement groups, who are responsible for training the resettlement volunteers and producing materials directing volunteers in their efforts. Additionally, investigating volunteers' role in health resettlement introduces to RHM scholarship to a concept of agency that is primarily concerned with the clinical interaction, yet exists largely outside of it. While the field of rhetoric of health and medicine (RHM) is concerned with health discourses in a variety of forms, what it has yet to explore is outsider intervention into what is traditionally positioned as autonomous health management.

Because this chapter is mainly concerned with resettlement at the level of community sponsorship as explained in chapter one—that is, a model where community groups agree to take on a responsibility for providing aid for resettling refugees, and volunteers assist resettling refugees in their homes and other personal spaces—my analysis here draws from the work of Emmanuel Levinas (1974, 1969) and his theorization of being presented with "the face of the Other" (see Chapter 2 for further discussion). While it is more common in critical refugee studies to invoke scholars such as Hannah Arendt or Georgio Agamben, these scholars write primarily about the responsibilities of political states, and the effects of statelessness for refugees. In contrast, Levinas's most well-known theory centers on what he calls "the face," which is (at least at its start) a singular interaction, in which an individual self is presented with the face of an individual Other, and has an obligation to respond that precedes any agency or choice to do so. This obligation is an ethic of responsibility that is motivated by being faced with what Levinas conceptualizes as the vulnerability of "the Other," and when faced with that vulnerability, the self must necessarily be overwhelmed by it. As rhetorician Diane Davis describes, "there are no heroes in Levinas; there are only hostages with assignments" (103). How Levinas positions the relationship between "the self" and "the Other" risks being essentialized as a savior mentality, especially in the brief explanation given in this chapter. That essentializing is a problematic framework that I do not intend to validate or perpetuate. Levinas is useful here, in part, because volunteerism in refugee resettlement does trend toward saviorism, and interrogating that relationship between the volunteer and the refugee *from the perspective of the volunteer* helps reveal how it shapes and impacts health resettlement. I examine the more paternalistic aspects of the volunteer/refugee relationship in the following chapter.

As an abstract, metaphysical ethic, Levinas's theory of the face cannot be easily reduced to a normative set of rules or descriptions about behavior (Nortvedt, 2003; Nordtug, 2015). Thus, a Levinasian framework helps explain how volunteers shape their own role through the interaction with "the face," and particularly their *rhetorical* role, which becomes a crucial part of health resettlement as volunteers act as mediators between resettling refugees and medical professionals. Using this ethical framework to analyze interactions helps situate this case study in the actual process of a volunteer being confronted with an Other and determining how to respond, through which we better understand health resettlement.

Rhetorics of Resettlement in Federal and State Policy

An overview of the federal and state policies regarding resettlement is necessary to establish the landscape in which local resettlement takes place, and the understanding of "resettlement" that is established by these policies. As discussed in Chapter 1, the resettlement model used in the United States is such that:

- The federal government is responsible for initially relocating refugees via the Department of State.
- The federal government contracts directly with nonprofit voluntary agencies (VOLAGs), like Jewish Family Services or Catholic Charities, to provide 30-90 days of resettlement services with federal funding.
- Each state that participates in the resettlement program may receive grant funding from the federal government to fund additional services such as time-limited cash and medical assistance, English language training, or other programs. (Virginia Refugee Resettlement Program, 2018, pp. 1-2)

As in the case study I examine here, there are instances where a grassroots community group will volunteer to sponsor a refugee beyond the initial period of government services. However, the standard model includes three actors: the federal government, the state government, and the VOLAG. In this section, I will focus on the key policy documents that outline the role of the federal and state governments in Virginia, including the Refugee Act of 1980, the Refugee Resettlement Program overview in the Code of Federal Regulations (45 CFR Part 400), and the Virginia State Resettlement Plan for fiscal year 2018-2019. Because policy influences the construction and perception of refugees (Camps, 2016; Easton-Calabria and Omata, 2018), understanding how resettlement is framed at the policy level provides context for how community-based volunteers might also understand the process and in turn how they instruct refugees in that process.

To explore how these documents frame health resettlement, I searched specifically in these policy documents for explanations about medical goals or outcomes for resettling refugees. How these policies outline goals and/or outcomes for health resettlement reveals a particular idea not only about what is most important in the process, but about refugees themselves. This language of goals and outcomes is mirrored throughout all three key documents, with a primary focus on economic self-sufficiency:

Table 2: Policy Excerpts

Refugee Act of 1980	"The Director [of the Office of Refugee Resettlement] is authorized to allow for the provision of medical assistance under paragraph (1) to any refugee,...but only if the Director determines that...this will (i) encourage economic self-sufficiency, or (ii) avoid a significant burden on State and local governments."
45 CFR Part 400	each state resettlement plan must "[d]escribe how the State will coordinate...medical assistance with support services to ensure their successful use to encourage effective refugee resettlement and to promote employment and economic self-sufficiency as quickly as possible."
Virginia State Resettlement Plan, 2018-2019	"Virginia's primary goals for newly arriving refugees are durable economic self-sufficiency and social integration into Virginia's communities. … The Office of Newcomer Services contracts with resettlement service providers to require the development of a family Comprehensive Resettlement Plan which identifies the...medical services needed for the family to attain economic self-sufficiency."

Economic self-sufficiency is commonly understood as the mandated goal for refugee resettlement (Halpern 2008; Eby et al., 2011; Brown and Scribner, 2014; Lee et al., 2015; Biddle, 2018), and that goal manifests in the discourses of resettlement (Nawyn, 2011; Tyeklar, 2016; Steimel, 2017; Dykstra-DeVette, 2018), so it is unsurprising to see a general focus on economic self-sufficiency in these policies. What a focus on medical and health outcomes highlights, however, is how even health is tied to this particular way of representing resettlement as an economic advantage to the host country. The "medical assistance" described in both the Refugee Act of 1980 (the Refugee Act) and the Code of Federal Regulations (the Federal Regulations) refers to the Refugee Medical Assistance program, wherein a government-funded, Medicaid-style health insurance is provided for eight months to refugees who do not otherwise qualify for Medicaid. In the Act, this assistance is offered "only if…[the provision of medical assistance] will encourage economic self-sufficiency," while the Regulations echo that the state will "ensure [the provision of medical assistance]" is used "to promote...economic self-sufficiency as quickly as possible." Positioning the provision of medical assistance as contingent upon "ensuring"—or "only if"—it is used in service of economic self-sufficiency not only reduces healthcare to a matter of economic production, but also constrains how health resettlement can be discussed at the level of the state; the implied threat from the federal policy is that medical assistance must be used for the purpose of economic self-sufficiency, or federal funding for the program will no longer be offered.

Thus, it follows that the Virginia State Resettlement Plan (the State Plan) indicates that economic self-sufficiency is one of the state's primary resettlement goals, under which offered services are subsumed. The State Plan shifts from discussing the conditions for the provision of medical assistance, which concerns the availability of health insurance and care, to identifying the specific medical services "needed for the family to attain economic self-sufficiency." As part of the described Comprehensive Resettlement Plan that is developed by VOLAG caseworkers with each refugee client (or family), identifying these medical services is now at the level of community resources and networks: What are the medical needs that might stand in the way of attaining economic self-sufficiency, and which services exist to address those needs? While the

Refugee Act and the Federal Regulations present medical assistance in the abstract, the State Plan indicates that at a community level, "ensuring" that that assistance will be used appropriately is done by treating health needs as they present a barrier to the larger goal. Because the health resettlement goal in these policies is to promote a body capable of economic self-sufficiency via employment, and not on actual health-related goals, the concept of health resettlement is foundationally linked to a rhetoric of economic self-sufficiency.

Rhetorics of Resettlement in Voluntary Resettlement Organizations

Understanding a rhetoric of resettlement as it is established in federal and state policy helps contextualize what occurs on the local level of resettlement. Because all refugee resettlement in the US works officially through one of nine voluntary agencies (VOLAGs) that have cooperative agreements with the State Department, how these organizations frame the concept of resettlement is impacted by their relationship with the government and government policies (Nawyn, 2011). And since VOLAGs are the vehicle for resettlement services, they play a significant role in shaping the process of resettlement at a local level.

The same rhetoric of self-sufficiency that constructs the identity of refugees and the process of resettlement is also present within VOLAG discourse (Tykelar, 2016; Steimel, 2017; Dykstra-DeVette 2018). As in federal and state policies, "resettlement" is left nebulously defined in VOLAG discourses, yet VOLAG caseworkers indicate that "employment and financial independence indicate and constitute successful resettlement" (Dykstra-DeVette, 2018, p. 186). And because an overall focus on economic self-sufficiency comes at the expense of understanding other integration factors for life in the United States (Tyeklar, 2016), that focus reinforces the idea put forward in both the Federal Regulations and the Virginia State

Resettlement Plan that any official notion of resettlement—including any existing health component—operates primarily in service to economic self-sufficiency. What VOLAG caseworkers see as the goal of resettlement is especially important, since VOLAGs play the most crucial role in not only the conception of resettlement but in enacting the process (Mott, 2010). The material resources that VOLAGs can provide to refugees are time limited, generally only lasting for a matter of months post-arrival, which means there is not only an expectation of self-sufficiency but only a brief timeframe in which it is expected to occur.

Thus far it is fairly straightforward to trace a rhetoric of resettlement from the federal level, through state policy, and into VOLAG discourse. It is clear from these documents that economic self-sufficiency is an ideal that policy makers hold and a constitutive rhetoric in the US resettlement landscape. By examining the rhetorical construction of self-sufficiency as an ideal to be achieved, we can see that policy makers see economic self-sufficiency as a marker of what successful resettlement *should* be, and what resettling refugees should become—that is, economically self-sufficient. In turn, rhetorics of self-sufficiency are used to justify the limited material resources provided by VOLAGs. As a result, caseworkers are compelled to focus primarily on securing employment for refugees before their eligibility for caseworker assistance runs out (within 90 days). Understanding health resettlement as operating within this rhetorical frame, then, provides some insight into ways that medical decision making can be fraught for volunteers—as the ideal of self-sufficiency comes in conflict with their ideals of responsibility and healthcare decision-making. This dissertation seeks to understand and define health resettlement outside of the policy framework focused on economic self-sufficiency.

Rhetorics of Resettlement in the Blacksburg Refugee Partnership: The Year of "Letting Go"

Since a volunteer sponsorship group like the Blacksburg Refugee Partnership (BRP) operates largely outside of the policy-driven resettlement infrastructure, and also has more flexibility in the allocation of material resources like financial assistance and volunteer help, the goal of economic self-sufficiency is not as immediately pressing. The flexibility of the BRP's position does a number of things: first, it allows for a conceptualization of a different definition of resettlement that is not immediately limited by economic concerns; second, because the economic concerns are not limiting, there is space for health to be considered as its own resettlement process; and third, it means the organization and its volunteers are left to establish their own understanding of when health resettlement has been achieved. Therefore, identifying the rhetorics that are deployed by volunteers in their roles as medical coordinators helps to find the boundaries of health resettlement in a community setting—boundaries which are determined more contextually, and in response to personal interactions with "the face of the Other."

In the spring of 2019, the leadership of the Blacksburg Refugee Partnership (BRP) began a focus on what it called "the year of letting go," with the intention that by the end of the calendar year, most or all of its sponsored families would no longer need regular volunteer support. However, this plan was vocally met with frustration, and even resistance, by many volunteers in BRP's monthly organizing and Board meetings. Over the four years since the foundation of the BRP, one of the key issues faced by the volunteer team of medical coordinators—and by the organization more broadly—is a tension around what resettlement *is*. The ambiguity around the term has led to many disagreements about how to navigate medical situations, health practices, and logistical concerns, and, crucially, about when volunteer assistance becomes unnecessary. Or, in other words, when volunteers should step back or “let go.”

Framing this shift in organizational philosophy as “letting go” reveals a certain attitude toward volunteer involvement; namely, that volunteers are holding onto something that they must now choose (or be persuaded to choose) to release. It is a shift that puts nearly as much focus on volunteer action as it does on refugee needs, and it is a shift that situates ideological controversy around if and when volunteers should “let go” into the foreground. Therefore, using the BRP as a case study for health resettlement offers a more expansive understanding of the term that is not limited by economic self-sufficiency, but also reveals an ongoing tension at an organizational level about how health resettlement will be measured and shaped outside of that metric, and what space that makes for a different construction of refugee and volunteer identities. Because medical volunteers are interacting with sponsored families most closely, how these volunteers conceptualize health resettlement, and their own role within it, is separate from how the BRP organizational leadership instructs volunteers in what to prioritize.

To determine the goals of resettlement as interpreted by the BRP on an organizational level, I examine its core operating policies. Previous research has explored how organizational documents, like mission statements and policies, can act as rhetorical devices to declare particular organizational values (Morphew and Hartley, 2006; Williams, 2008; McCoy, 2019); therefore, understanding how the BRP frames these values is a necessary component before moving to focus on how volunteers themselves perceive health resettlement. Both the BRP mission statement, along with one of the core policies, reference a goal for resettlement:

> The mission of the Blacksburg Refugee Partnership (BRP) is to resettle refugee families in the Blacksburg region and assist them until they are able to meet their own needs and participate in the community independently.
>
> Our activities in partnership with the refugee families always consider the ultimate goal of the families living independent of our support. (Appendix B, p. 160)

What is centered in these BRP policies is an idea of participating in the community and living "independently." In other contexts, "independent" might be used synonymously with "self-sufficiency," yet the way it is positioned in context here turns the goal of "independence" into something different than how the goal of "self-sufficiency" is explained in government policy. While "self-sufficiency" is explained in said policy only in economic terms, "independence" in the BRP organizational documents is associated with "participat[ing] in the community." While "independence" is arguably still under the umbrella of "self-sufficiency," which Easton-Calabria (2018) has described as a goal that limits refugees' capacity for a fuller well-being, "independence" as contextualized by the BRP gestures to a more expansive resettlement goal than the economic goals prioritized at a government level.

Defining Volunteer Roles in Health Resettlement

The BRP organizational understanding of resettlement offers a glimpse into the values operating outside of the top-down government structure, but what is especially revelatory in this case study is what happens in health resettlement with the presence of teams of volunteers who are actively engaged in multiple aspects of the resettlement process, and who operate with little to no oversight in the BRP's very loose hierarchy (as discussed in Chapter 1). Even when considering volunteers who are more formally affiliated with VOLAGs, and not community sponsorship groups, scholars have argued that volunteers are some of the most important players in the resettlement process due to their connections within the community and their understanding of cultural practices that can be a resource for refugees (Eby et al., 2011; McAllum, 2017; McKinnon, 2009; Thomson, 2014). Because volunteers have such a high level of influence, analyzing their discourses becomes key to any understanding of resettlement. Within the BRP, since the question of when resettlement is achieved is left up to the volunteers, their perception of health resettlement has a greater impact on the process than any of the previously mentioned policies.

How volunteers understand their role reveals clues to how they perceive health resettlement as a process; as volunteers talk about what they do, and why, they establish what they prioritize and what outcomes they aim for. While the BRP organizational documents situate resettlement toward a goal of independence, little guidance has existed for volunteers regarding how to reach that goal with newcomers, or even regarding the specific parameters of their volunteer role. Instead, the volunteer roles have largely been allowed to grow and adapt organically based on how volunteers perceive the needs of each particular sponsored family. Though multiple interviewed volunteers talked about how their volunteer role shifted over time in response to contextual interactions and emerging needs, Rania, an Egyptian woman who has been working as a liaison with the al-Hassan family since their arrival in Blacksburg in fall 2016, provides the clearest explanation:

> [B]ecause [the role] wasn't so structured right from the beginning, I felt there was room for me to kind of share some of the things that I'm familiar with, like culture and cultural practices, and started doing some of those things…. So it was like that and then it kind of grew. So in the beginning my role was not well defined of what I was going to be doing.

> But I think as I grew into that role of helping out with cultural interpretation and translation and kind of doing it in a professional way, I think that helped me take on a role as a family coordinator or a co-family liaison with the family. So I don't know, it kind of grew organically, but it wasn't anything preconceived. I did not come with that expectation that I was going to grow into that role. It kind of evolved and happened very naturally.

Instead of describing a static role with a defined job description and/or clear boundaries, Rania describes a nebulous role that is able to adapt and shift based in part on volunteer awareness *and* family need. Thus, the volunteer role is kairotic, responding to the resettlement situation at hand instead of adjusting to pre-defined duties. And, as Rania describes, a role that is allowed to emerge situationally creates space for volunteers to bring their own interpretations to the process.

While there exists an organizational policy and goals which presumably could provide a more rigid structure for volunteers, what volunteers actually *do,* and why, is developed mainly in conversation and collaboration with other volunteers either within their family team or across family teams. When asked where they turned for guidance in moments of indecision or confusion, none of the interviewed volunteers even mentioned a BRP policy, and only one said she occasionally consulted with members of the BRP Board. Instead, interviewed volunteers said they made decisions by conferring with other volunteers in similar roles (e.g. medical coordinators for other sponsored families). Absent a more rigid organizational structure, the influence that volunteers have on resettlement is then amplified for the BRP, as their personal judgment, values, and expectations become the primary drivers of the process.

Because some BRP volunteers perform the "on-the-ground" work of resettlement in ways that other volunteers (such as those in leadership positions who are not on family teams) may not, an organizational understanding of a volunteer's role may be in sharp contrast to how volunteers themselves understand their role(s). Focusing on volunteer perceptions of health resettlement, and their role within it, provides insight into how health resettlement is approached by volunteers. If the government positions resettlement as a process of reaching self-sufficiency, is this framing also replicated in how volunteers approach resettlement? In this section, I present both volunteers' understanding of the goal of health resettlement as an independent performance of technical and logistical discursive tasks (such as making a doctor's appointment), and how the rhetorical framework they use to situate this goal—namely, a rhetoric of responsibility—justifies their own involvement as agents in the process.

Volunteers Constructions of the Health Resettlement Process

Mirroring the BRP mission statement and policy, volunteers view the goal of resettlement as a particular kind of independence. When conducting my interviews, two of the key questions I asked volunteers were "What do you think it looks like for someone to be resettled?" and "What do you think resettlement looks like in terms of health?" In their responses, all but one volunteer associated health resettlement with independence (sampled below):

> Rania: We didn't really have any formal way of orienting [volunteers] so that they can handle and deal with helping those families achieve some kind of independence and take care of their health.
>
> Hannah: The latest thing is we're trying to move them towards medical independence.
>
> Karla: "You are resettled. You can take care of that." That would be what I would picture and how to say it otherwise, independent.

> Sahar: It's different from the families who are…who has education with the ones who doesn't have education. If you have education, you know, very soon you can be independent, you know, move on and do stuff by yourself.
>
> Leah: I hope by the end of this year that they will be able to handle things on their own with very limited assistance. That's our goal.
>
> Lakshmi: The end goal of my involvement is to make her much more independent than she is now.

Unlike in any of the governmental or organizational policies, the goal of "independence" for volunteers was one in which they were directly implicated. While the BRP mission statement may talk about independence as a goal, the BRP volunteers talk about independence as a goal *and also* that they are involved in an action to reach it; in these responses, they are helping, moving, trying, and making in relation to the independence of the resettling person. Even as volunteers discuss independence, there is a clear sense that this goal is a both a team effort—not just something to be achieved by the resettling person—with multiple uses of a third-person pronoun ("*our* goal," "*we're* trying") by individual volunteers as they explain what they understand as "resettled." In other words, volunteers position themselves here as active agents in the resettlement process.

Thus, when volunteers elaborate on what they understand "independence" to mean, they are not just describing a desired outcome, but what they as resettlement agents are actively assessing to determine if they can divest themselves. As Lakshmi notes above, independence marks the "end goal of [her] involvement" as a volunteer; contrary to resettlement policy, which defines a brief window for resettlement after which services are ended or reduced, volunteers offer services until they believe resettlement is achieved. And with the flexibility built into their roles, volunteers' descriptions of the independence that marks their perception of health resettlement become indicators of what they find most important—what they cannot divest from until they are achieved. Volunteers describe independence (and thus, their vision of health resettlement) in three broad categories: knowledge, ability, and actions.

Knowledge

At its most basic level, health resettlement is marked by volunteers as having a particular kind of medical knowledge. In one instance, Sahar, who volunteers as a translator for women relocated from Afghanistan, describes a limited technical knowledge as an example of non-independence:

> You go to see a doctor with them, you know, they think that from [the] neck down…it's just "heart." [The doctors] say, "Okay, where does it hurt?" [The resettling person/patient] said "heart," but it's not heart, really. You know, so educating about everything, you know, is very important.

In her anecdote, Sahar explains that this particular person describes her anatomy from the neck down (though presumably only in the torso) as "heart," which is a lack of knowledge that Sahar believes is "very important" to rectify. As she tells the story, Sahar does not just say that the person does not know how to differentiate between various internal organs, but instead locates the person as a patient speaking to a doctor; the lack of knowledge becomes important because it impedes the doctor's ability to diagnose the health problem. It is not only about the abstract knowledge of anatomy, but about how this knowledge is situated in, and impacts, health discourse. It must not only be known, but communicated, specifically in the context of the clinical interaction.

Ability

Building on a possession of medical knowledge as a marker for health resettlement, volunteers also describe an ability to solve problems or make decisions based on that knowledge. That is, it is not only important to have the knowledge, but to be able to apply it to particular situations. Asal, a volunteer liaison for a resettling Afghan woman named Nazmeen, explains an application of knowledge in context:

> And those are harder kinds of questions and harder problems for her to solve, and definitely people helping her. But not for, "Oh, I need to see this doctor"....like getting past that, that would be really a bar, and I'm hoping that they get there, maybe within a few years. We'll see. That's, that's my—that's my hope.

Just before a pivot to describing a medical situation, Asal describes a “harder kind” of question (specifically about deciding where to send her daughter for high school) that, presumably because of its complexity, could require outside assistance without detracting from one’s independence. However, according to volunteers, a problem like determining when to see a doctor—if one is independent—should not require anyone else’s help. Asal describes more basic problem-solving ability as a “bar” for Nazmeen to “[get] past,” inviting the visualization of a fixed point to be reached and overcome.

Action

Where knowledge and ability ultimately manifest, for volunteers, is *action*—specifically, discursive action. Without a discursive performance from a resettling person that reveals their knowledge, or that they can apply the knowledge contextually to make healthcare “happen,” volunteers are unable to judge whether these resettlement benchmarks have been achieved, and therefore cannot assess their own role as agents in the process. Thus, it follows those discursive actions are what volunteers most consistently indicate as marking independence and health resettlement. Blythe, for instance, says that health resettlement for her is marked by “attempting to make phone calls” and “just setting appointments,” discursive tasks which seem mundane, but that Blythe describes as occupying most of her volunteering time as a medical coordinator, even three years after the family she works with was relocated to Blacksburg. Additionally, these discursive tasks are read by volunteers as rhetorical—not only actions that make healthcare happen, but also that persuade volunteers that resettlement has been achieved.

In another example, Hannah offers a detailed list of the actions she associates with health resettlement:

> I guess it would mean that they could schedule doctors’ appointments on their own, which they’ve started to do a bit. As they check out from appointments if they need a follow-up they have started to schedule on their own which is great. Sometimes they schedule at a time when there’s a conflict so it doesn’t work out and I have to reschedule it, but other times it’s okay. And then also being able to interact with the pharmacy independently.

Here, Hannah describes the discursive tasks involved in a typical clinical visit, including before (scheduling), during (checking out), and after (“interacting with” the pharmacy). And while Hannah describes her role at length in the beginning of her interview, she also reveals here how her role intersects with her understanding of health resettlement: if the discursive task is not successful (e.g., if the follow-up appointment is not scheduled at an available time), it is Hannah’s job to intervene (e.g., reschedule the appointment).

For all the interviewed volunteers, it is the actions, more than the knowledge or ability, that mark resettlement—and that mark when and how they intervene as volunteers. For volunteers, the independence they work toward as the goal of health resettlement is not just demonstrated by *having* certain knowledges or abilities, but *acting* on those knowledges and abilities. Specifically, volunteers largely focus on tasks that revolve around the clinical experience of medicine: the pre-visit (making the appointment), the visit itself (getting there, taking notes), and the post-visit (picking up medications and taking them correctly). Though these tasks are seemingly mundane or commonplace—prefaced by some volunteers as something to "just do"—the positioning of these technical tasks as the unreached markers of a years-long health resettlement process suggests their complexity. Revealing the complexity hidden in these tasks—including the medical and technical knowledges necessary to perform them to volunteers' satisfaction—helps explain how the shared goal of "independence" has many facets that may *not* be shared between volunteers, or between volunteers and organizational leadership, particularly as it is volunteers personally interacting with the resettling families who feel compelled to intervene if tasks are not achieved.

As self-positioned agents in the process, volunteers not only look for these markers of resettlement, but position themselves as responsible at the same time they position refugees as unable to perform certain actions. This is contrast between a rhetoric of self-sufficiency, which is used by policy to describe health resettlement, and a rhetoric of responsibility, which—despite tying health resettlement to a notion of independence—is used by volunteers to frame their intervention into the health resettlement process.

Volunteers' Responsibility to Ensure Health Resettlement

Volunteers tie the outcome of health resettlement to themselves and their own roles, and specifically to the tasks they feel it is their job to perform, demonstrating a deep-seated obligation toward the resettling families sponsored by the BRP. This personal interaction and concern brings us back to the work of Emmanuel Levinas. Positioning Levinas's obligation to the face of the Other as a *rhetorical* obligation, Diane Davis shifts the ethic of responsibility to a rhetoric of responsibility—an "underivable obligation to respond" (15). As I will discuss in this section, how volunteers position themselves in the process of health resettlement is also understood best as a rhetoric of responsibility. Unlike a resettlement rhetoric that focuses only on how refugee identity is constructed, incorporating a rhetoric of responsibility *as* a resettlement rhetoric reveals the positioning and ethical obligation of volunteers in this process. Not only do volunteers position themselves as being responsible for responding to refugee needs, but they position themselves as proxy agents when necessary—as someone who can take discursive action on refugees' behalf. Volunteers grapple with feelings of failure when they feel they do not meet their "obligation to respond" to refugees' health needs, but avoiding this failure becomes the framework for how they discuss such an obligation, communicate health issues, and make decisions about how to intervene. Ultimately, a rhetoric of responsibility constitutes a particular identity for volunteers that creates tension around "letting go."

As they discuss their roles in the resettlement process, volunteers express a personal responsibility within their role to make sure the logistical tasks of health resettlement are achieved. Hannah, the medical coordinator for the al-Hassan family working alongside Rania and Karla describes a time when her role as a medical coordinator was particularly difficult. She relays an anecdote about missing a routine flu vaccination:

> This year was a little bit messed up because some of the kids briefly lost their insurance due to some weird stupid computer issue or something…. I think it's all fine now but it was right around flu shot time. Some of the kids got kicked off their insurance for some reason, and so this was the first year that I didn't take charge and just schedule appointments for everybody. It resulted in some of them getting a flu shot and some not. And then their youngest girl got the flu and I was like, "Oh my gosh." I looked up her MyChart [electronic health record] and she was not one of the ones that got vaccinated. I had to really control my thoughts and emotions because that basically started a whole chain of guilt… It was like, "Oh my God, I didn't make them all go get their flu shot." So then I texted Karla and Rania about my feelings about this, and I said, "I'm trying really hard not to feel guilty." They were very supportive and they said that they've also struggled with this… So I think all volunteers probably struggle with the guilt of "Should I have done more? Should I have done something different?"

As Hannah describes, because she did not make an appointment for all the members of the al-Hassan family to receive flu vaccinations, she was left feeling deeply guilty and questioning her actions when the al-Hassan's youngest daughter came down with the flu. Hannah's anecdote highlights a challenging time in her volunteer role, yet what it also captures are elements of a rhetoric of responsibility that motivate both her fear and her intervention. In Hannah's story, she first establishes the youngest al-Hassan daughter getting the flu as a health failure—a negative health outcome that Hannah believes could have been prevented. Then, Hannah centers her feelings of guilt, and her effort to *not* feel guilt, as the focus of the story. Finally, Hannah positions herself as having an agential role throughout the narrative, from her forceful language of "I didn't take charge" and "I didn't make them" to her questions reflecting on whether there was more *she* should have done in the situation. In other words, Hannah makes a rhetorical move to demonstrate that she occupied a position of knowledge and responsibility that the al-Hassan family lacked. Yet later in her interview, Hannah expresses a deep discomfort with the idea of giving medical advice or instruction. This additional context suggests that Hannah's forceful statements here are not about actually "making" the al-Hassan family do anything, and instead are meant to indicate her regretful awareness of what she might have done—specifically, making the appointment—to prevent this outcome, given the positions she perceives herself and the family to occupy. In other words, Hannah is motivated as an agent in the health resettlement process to provide discursive intervention, largely to avoid feelings of guilt; like in Levinasian terms, it is not so much a choice but an obligation.

A central aspect of a rhetoric of responsibility exhibited by volunteers is in how volunteers described what has colloquially been described in BRP meetings as "failure": when a resettling person faces a negative health outcome when the goals of medical resettlement are not reached. In Hannah's anecdote, the failure was one of the children coming down with the flu. Other volunteers describe "failures" of varying degrees of severity. For Blythe, failure in the form of poor preventative care has long-term consequences on kids, as she describes when explaining the boundaries of her role as a medical coordinator:

> It's more than just me making appointments. It's are you eating right? Are you exercising? Are you sleeping? Putting four girls in a room and I live next door, I can hear them. It's 11 o'clock and I hear the 10-year-old. You need to go to bed, so there are those issues that are coming up which I don't know if they will affect their medical health, mental health.

By describing her concern about what is going on within the family's house late at night—literally next door to her—Blythe's role as volunteer transcends her rhetorical obligation to make appointments or otherwise perform the tasks of making healthcare happen. Instead, she is worrying about her role in relationship to a private household space that has no clear connection to the clinical interaction, but still is connected by Blythe to long-term health outcomes that she feels responsible to prevent.

In the most extreme example of what difference their rhetorical intervention could make, Leah expresses her concern about a "failure" during a mother's pregnancy that could potentially lead to the loss of life:

> So [Halah] was losing weight rather than gaining weight in pregnancy because she didn't want to eat because if she ate it meant her sugar would go high which meant she would have to go on insulin.
>
> …
>
> That is a difficult thing for volunteers to be put into that place but it's important that they have the training to be able to handle that when they are dealing particularly with life and death issues. Because this is not only life threatening to the baby but it was life threatening to the mother…. I did storytelling, every way that I could to get the family on board.

As Leah describes trying to intervene in a decision a pregnant, diabetic mother has made to avoid taking insulin during her pregnancy, Leah immediately brings her own feelings of responsibility in that situation ("I did storytelling, every way that I could") of "life and death issues" back to the organizational responsibility. Leah is not just thinking of this scenario as an aberration, but as something volunteers should be specifically trained to handle. Overall, one of Leah's recurring critiques of the BRP organization is the lack of training and guidance about what to do in situations that volunteers see as high stakes—situations where "letting go" could mean a serious health consequence.

In each instance, volunteers describe a consequence of varying degrees of severity, highlighting the importance of their role as well as offering insight into the fear of consequences that become a central element of a rhetoric of responsibility. Volunteer descriptions of "failure" emphasize which consequences they consider acceptable, and which consequences are bad enough to warrant intervention in their volunteer role. The concern over these consequences reveals a particular kind of moral approach to health and health expectations in resettlement. What volunteers describe as a negative outcome is often weighed against their own understanding or perception of what it means to have a "good" health outcome.

How volunteers feel responsible to intervene, and in which scenarios, reveals moral judgments about "good" and "bad" health. In *Against Health*, Metzl and Kirkland (2010) argue that health is a "normativizing rhetoric" (p. 5) by which people can judge themselves against others; that is, one understands one's own health by making value judgments about how "healthy" others are. In the case of BRP volunteers, because they are tasked with the process of moving someone from a perceived state of dependence to a state of independence, these value judgments become not just a way to measure one's own health but a moral obligation to shape health in another. Anecdotes such as Leah's bring a starker clarity to what "responsibility" means for certain volunteers: the flu shot may be a smaller concern, but facing the risk of serious pregnancy complications, or even death, forces volunteers into a position where it is now *im*moral to avoid intervention. Volunteers' concern that a lack of execution (not necessarily knowledge) of preventative medicine and regular health maintenance will have disastrous consequences on the lives of refugee families. This concern motivates the way volunteers approach health problems, make decisions about when and how to intervene, and communicate about health issues with the families.

And, in this concern, a *moral* responsibility becomes a *discursive* responsibility. It is not just that volunteers are making interventions based on the "good" or "bad" outcomes they feel responsible for, but that—like Diane Davis's interpretation of Levinas as a rhetorical obligation—volunteers associate their intervention with their emotional investment and moral responsibility. Thus while BRP leaderships may insist that to "let go" means that a volunteer can continue to have a personal and emotional investment with a person without performing discursive interventions on their behalf, volunteers position their "letting go" of doing those tasks as equivalent to an emotional divestment, which is a failure of their moral-discursive obligation to respond. Ultimately, this responsibility—not only to respond, but to respond on behalf of—motivates volunteers to intervene as proxy agents when they perceive refugee clients to be at risk of health "failure."

Rhetorical Agency, Volunteer Proxies, and Moralizing Health

The way volunteers describe categories of *knowledge* and *ability* carry normative cultural value, but it is the shift to focusing on *action* that highlights how much of the goal of independence within health resettlement is driven by what volunteers understand as the "right" thing to do: making the right kinds of decisions; focusing on the right kinds of problems; knowing the right things; communicating the right way. These all point to an overall understanding of "independence" that aligns with a moralized understanding of "health maintenance." And since health maintenance requires actions to be taken, there must be actors to perform those actions.

If resettlement is rhetorically positioned as a process of change from one state of being to another—from "dependence" to "independence"—volunteers take on the responsibility not just of avoiding health failure, but of developing actors to remove the burden of responsibility from volunteers. As Rania describes, "I feel like our work from the beginning up to now was to prepare them. And I like to use the term 'agency' so that they feel they can do it. It's kind of coming from them why they need to do that and how." Rania here ties "agency" to the work of volunteers, and what she is looking for in the process of health resettlement. Overall, what volunteers are looking for is a certain performance of agency from sponsored families—one that aligns with larger conversations about how health performances become aligned, or unaligned, with ideas about what is "moral" or "good" that are measured by what is acceptable failure.

A conception of agency has been robustly debated in humanities disciplines. In rhetorical studies, the focus on agency is (unsurprisingly) a rhetorical one: What is the relationship between speaking and effecting change in a situation or audience? Who, or what, has this kind of agency? What are the ethical responsibilities of having agency? As I discuss in Chapter 2, while traditional models conceptualize agency as centrally located in an individual speaker, more recent work has introduced theories of a more decentralized model, in which agency is shared with the audience (Leff, 2012), distributed through a network of both human and nonhuman actors (Herndl and Licona, 2007), located in the rhetorical event itself (Miller, 2007), or otherwise located outside of an individual rhetor. While theories of distributed agency have been discussed in RHM (Graham, 2009), other work in the field remains focused on a largely individual idea of agency that is centered on the rhetorical strategies and performances of doctors and patients (Stone, 1997; Koerber, 2013; Arduser, 2017; Pigozzi, 2018), perhaps because of a strong individualistic focus in medicine itself.

With this individualistic focus, volunteers' goal in health resettlement becomes to foster a certain kind of agency—in this case, making healthcare happen through discursive actions—in someone else. As intermediaries in and outside of the clinical situation, most volunteers do not act as consultants but as proxies: they are the agents making appointments, communicating through the electronic portal, making sure the prescriptions are refilled at the right time, all on behalf of someone else. To fulfill their responsibility, volunteers must necessarily act as proxies, because they are limited by the constraints already placed on the rhetorical situations of clinical medicine. To make an appointment, one must initiate a dialogue in the right place, at the right time, and with the right people. To advocate or ask questions in an appointment, one must understand the boundaries of the physician-patient relationship. To pick up prescriptions, one must again know where, how, and when to get such medication. Additionally, all of these interactions come with the parallel action of knowing how to get and renew health insurance. In other words, because an autonomous requirement exists in medicine, what "counts" as independence for volunteers is the autonomous performance of healthcare-related tasks. Because these constraints cannot reasonably be adjusted by volunteers, what health resettlement becomes is a process of volunteers working to develop an agency in resettling people that conforms to the expectation of the medical environment in the United States.

While many rhetoricians have theorized rhetorical agency in medicine, Ellen Defossez (2016) argues for a rhetoric *of* agency in medicine; that is, how the concept of agency is built and discussed in health spaces, particularly regarding health maintenance. Agency, Defossez argues, is rhetorically configured not just as "the list of things that one *can* do in order to preserve or promote one's health," but also as what "one is socially and often morally *expected* to do" (p. 2). This rhetoric of agency captures the multifaceted goal of "independence" that volunteers seek, including not only knowledge and ability (what one *can* do) but also particular actions (what one is *expected* to do). Similarly, when volunteers describe independence as a goal of health resettlement, they are not looking only for the ability to make healthcare happen (*can*), but the healthcare actually happening (*should*). Thus, when volunteers describe sponsored families as not yet performing many of these expectations of health maintenance, they describe an absence of the appropriate agency needed to meet the moral responsibility of health.

The flattening of any distinction between *can* and *should* is also exacerbated by the responsibility which constitutes volunteers' role as helping someone reach independence. In one instance, while Karla is offering evidence of what it means to be independent in medicine, she uses the example of knowing how to use a thermometer: "Health-wise I think some judgment that has to be there, and know how to use a thermometer. They don't. They won't. I don't know which it is." Even though Karla does not know if the lack of thermometer use is because they do not know how to use it, the distinction doesn't matter; in either case, the thermometer is not being used, and thus there is a concern about meeting health resettlement goals. Because volunteers measure the capacity to act by the actual performance of that action, agency can only be understood by performance. Thus, agency for volunteers cannot be a capacity or an ability because a capacity alone cannot be perceived and constructed. Agency can only be interpreted through discursive action.

Thus, the moralizing discourse of medicine—the implication that certain actions *should* be done—meets the rhetoric of responsibility that frames the volunteer/refugee relationship through accountability for the Other. Because initiating and managing healthcare morally *should* be done, and volunteers are driven by a humanitarian ethic that motivates them to a relational position, volunteers must respond to situations where a person does not make healthcare happen in the appropriate way, whether because they cannot (due to lack of knowledge or ability) or because they will not. What a rhetorical understanding of agency reveals is that while health resettlement may be an expectation of normative, American health values, those expectations are *discursive*. That is, it is not enough that health is monitored or decisions are made. What also must occur are discursive tasks like calling the doctor or knowing which questions to ask at an appointment or scheduling a medication delivery. Because volunteers construct resettlement as a relational process between themselves and refugees, thus introducing their own responsibility, these discursive tasks become moralized—not in that it is a moral failing for a resettling person not to do them, but it is a (perceived) moral failing for a volunteer not to ensure that they happen, regardless of a client's own health beliefs or values.

The logistical tasks that volunteers describe as part of independence are also rhetorical tasks, where refugees must act as independent rhetors to make appointments, converse with doctors, talk with an insurance agency, and so on. Thus, when these tasks are not accomplished, volunteers must prevent "failure" by inserting themselves not only as agents, but as *rhetorical* agents, into the healthcare process to make sure health is achieved. If refugees cannot, to a volunteer's satisfaction, engage in the pre-visit, visit, and post-visit actions required to be health settled, volunteers feel a moral obligation to initiate those actions on a refugee's behalf. And because the language volunteers use to explain the moral imperative—like expressions of guilt and concern over failure—are directed at themselves and not the sponsored person, they position themselves as the agents who are deserving or undeserving of blame. To fail in this role as a volunteer is to cause (or allow) health failure, which is a moral failure.

Conclusion

At the end of her essay, Defossez concludes that “we should question to whom these forms of patient agency (and the time and cost they entail) are likely to be inaccessible. In other words, we should continue asking: who is well-equipped to become ‘an agent’ of her/his own health given current conceptualizations of patient agency, and what does this mean for those who are ill-equipped?” (p. 16). Understanding the process of health resettlement for refugees—and, particularly, how volunteers construct and guide this process—is one way to address these questions. Because the volunteers in this study understand health resettlement in a particular way, their assessment that refugees are “ill-equipped,” is misaligned with their sense of responsibility. Thus, their intervention follows from how they have constructed refugees as lacking the right kind of agency, and themselves as responsible for intervention.

If policy explains resettlement via a limited rhetoric of self-sufficiency that eschews a welfare relationship with the state, grassroots community organizations and volunteers—who see the process of resettlement happening on the ground—become concerned with what is happening in the margins of this rhetoric. Outside of the rhetoric of resettlement created by policy, I interpret the rhetorics of community resettlement to be created and found in the language used to describe what otherwise might be left implicit in the volunteer role, especially considering how important volunteers are considered in the US refugee resettlement process. Understanding these expressions as a formalized rhetoric of responsibility moves them beyond an individual expression of values or goals to instead demonstrate a pattern that motivates and constitutes the resettlement process (including health resettlement) more broadly. Just as a rhetoric of self-sufficiency constructs refugees in a particular way (Dykstra-DeVette, 2018), a rhetoric of responsibility constructs both volunteers and refugees within a particular relationship, which I will explore more in Chapter 5. The heavy reliance on volunteers in the resettlement process, plus a moralized concept of agency in medicine, combine to make volunteers feel too responsible to “let go” if there is still risk of health failure.

If integration is considered a “two-way street” (Ives, 2007; Smyth et al., 2010) between the community and the resettling person, a better understanding of volunteers’ role in health resettlement demonstrates how they operate at the intersection of the process. Volunteers are caught in the tension between independence (what is expected of refugees in the US) and responsibility (what is expected of the state and community in welcoming refugees) that is representative of broader conversations about refugee resettlement programs. For volunteers to “let go” of their role in health resettlement is to lose that connective piece, leaving people to deal with consequences volunteers find untenable. Thus, volunteers position themselves as active agents—and, in doing so, prioritize particular situations and communications over others—based on an individual responsibility to a refugee-background person, often regardless of how they are instructed or guided by the organizational structure.

But, perhaps crucially, the same volunteers that express the most individual responsibility for certain health outcomes are also the volunteers who express a desire to offload those feelings of responsibility. Leah, for example, expresses that “realistically, we’ve got to get out from underneath this. [The resettling family] [has] to take on the responsibility, and there will be certain things that they just won’t have.” Leah describes her role as a proxy agent, and her feelings of responsibility, as a burden to “get out from underneath”—as something that traps her.

What is prioritized by these volunteers is not out of preference but out of perceived necessity. This obligation drives one of the largest tensions between a goal of independence within a rhetoric of responsibility that focuses on health outcomes: If it is simultaneously part of the perceived volunteer role to promote independence, and also to prevent negative health consequences, it is no wonder that the BRP as an organization faces an internal anxiety about where, when, and how to define volunteer boundaries, and thus "letting go." For volunteers, "letting go" is not just about scaling back their involvement, but letting go of the "*feeling* of responsibility" (as Hannah expresses) they carry when certain rhetorical actions do not happen. This deeper moral conflict is harder for organizations like the BRP to address. And perhaps if responsibility were only a feeling, volunteers could exit out from under that burden. However, because responsibility is how volunteers position both their role and their relationship with refugees, they cannot "get out from underneath" without first changing that relationship.

Understanding how volunteers position themselves in the health resettlement process is useful for similar community resettlement groups. Because health in particular is fraught for volunteers—with some situations even described as life or death—organizational leadership asking volunteers to "let go" misses that the moral and discursive responsibility of health maintenance is easily taken on by volunteers themselves. Until these health risks are mitigated by some other means, or volunteers reframe their perception of refugee clients,, volunteers will struggle to "let go." Though no conclusive recommendations for better practice can be drawn here until refugee voices are included in the data, even just articulating the moral weight of the volunteer role could be useful in resolving organizational tension around the volunteer role and the goal of resettlement. By training volunteers to examine agency, ethical approaches, and acceptable risk, organizations can at least develop a shared vocabulary from which to pull when volunteers have conflicting ideas about when to withdraw or scale back their assistance.

For medical rhetoricians, understanding volunteers' role in health resettlement provides important insights into the actors and rhetorical situations that occur in community medicine. Volunteer involvement not only prioritizes certain rhetorical health situations above others, but also stretches the conception of who might be involved in healthcare situations beyond the physician and patient. Further, the volunteer role in health resettlement demonstrates the limitations of current rhetorical conceptions of agency in medical interaction, and the difficulties of trying to make certain rhetorical performances the goal of acceptable healthcare in the US.

Chapter 5

Relationships and Authority: Creating and Gathering Ethos in Medical Decision Making

In the previous chapter, I found that a rhetoric of responsibility motivates volunteers in contrast to the rhetoric of self-sufficiency that permeates resettlement from a policy perspective. Volunteers adopt this responsibility out of a feeling of moral and ethical responsibility to make "good health" happen, yet grapple with the tension of how much to intervene and when. It is necessary to understand this tension in relation to previous scholarship that argues for the importance of community relationships in the processes of resettlement and integration (Gonzalez Benson, 2017; Behnia, 2007; Elliott and Yusuf, 2014). Often the community relationships and networks that fill in gaps left by resettlement policy are fostered by volunteers, so if volunteers are feeling a tension about when and how to intervene, that tension is now playing a pivotal role in the process of resettlement.

This tension is captured in a quote from Leah, head of the volunteer team for a resettling family:

> Imad came into the country with every tooth in his mouth decayed, painful, terrible. And [the previous liaison] tried for ten months to get him to take care of that and he refused…. So when I became the liaison I reviewed that. We talked again. We went to so many dental appointments with him to get discussions, and it was a process. Eight months later we began the total extractions. But it took a long time.
>
> [S]o what do you do? It was a health risk for him…. The whole thing was a process I do not want to repeat.

Leah's concern reveals how much time and effort she spent on the ethical dilemma of this one healthcare concern. Although her question "So what do you do?" reads as rhetorical (in the colloquial sense) in this quote, later in our interview she asked the question and expected me to answer—what would I, as a fellow volunteer involved in medical coordination, do in this kind of scenario? Leah, like other volunteers, is years into the process of assisting with health resettlement (and resettlement generally), and yet still negotiating the tension that has become an ever-present part of her role. And while the previous chapter explored how volunteers act as proxy agents when they can, Leah's anecdote here captures the remaining issue: what volunteers feel responsible to do when they *cannot* act as proxy agents. Because Leah cannot herself make the medical decision she feels should be made—specifically, to get teeth extracted—she talks with Imad and takes him to appointments to have discussions with the dentist, sticking with the issue for eight months (in addition to the 10 months the previous liaison had tried). The state of Imad's teeth, in theory, has no effect on Leah's life; it does not cause her physical pain or poor quality of life. Yet this is an issue important enough to Leah to devote the better part of a year to persuading Imad to have his teeth extracted—and an issue difficult enough to have her question "So what do you do?" even after devoting significant time and effort to make that course of action happen.

What understanding the volunteer role—and the constitutive rhetoric of responsibility—in health resettlement reveals is how volunteers grapple with the individualistic values of health and resettlement while also trying to improve outcomes for both through their involvement. How they insert themselves into the health resettlement process affects how the volunteer role itself develops, but also fundamentally impacts the *relationships* of health resettlement—how volunteers position themselves in relation to resettling persons, as well as to medical professionals. Thus, this chapter asks: How do volunteers rhetorically position themselves in relationship to resettling refugees, as well as in relationship to health professionals? How does such positioning affect the process of health resettlement? These questions build on the conclusions of the previous chapter to move further toward a relational understanding of the rhetoric(s) of health resettlement.

This chapter will first explore the language volunteers use to signify their relationships with refugees and medical professionals, revealing relationship commonplaces that volunteers call upon for their rhetorical positioning and intervention in health resettlement. I find that because volunteers cannot position themselves as traditional medical experts in order to make good health happen, they instead use family relationship frameworks to explain and enact their relationality. My analysis will explore how volunteer responsibility is often positioned as how a parent might feel responsibility for a child, and comparisons to family caregiving relationships are used by volunteers to determine when and how to intervene. How volunteers construct their relationship with refugees influences how they intervene, but also how they enroll refugees into the discourse community of health in the US.

Within this analysis is a discussion of how volunteers understand ethos and expertise. Not only are volunteers trying to understand their own positioning in relationship to resettling refugees, but—as seen in Leah's quote at the beginning of this chapter—they are also trying to figure out which positioning will be *persuasive* toward the health actions and outcomes for which they feel responsible. As the interviews demonstrate, volunteers value rhetorical skills from sponsored refugees as evidence of their health resettlement, and thus volunteers leverage their positioning, and the positioning of others, to make those skills happen. Building on the analysis of family commonplaces, I argue that volunteers both leverage and compensate for their own relationality by gathering the ethos they believe they need to persuade a resettling person toward the volunteer's goal(s) for health resettlement.

Familial Commonplaces in a Rhetoric of Responsibility

The ways in which volunteers use a certain ethos come as a byproduct of how they understand their responsibility. That is, volunteers first use relational language to explain their feelings of responsibility, and later draw on this same language when discussing the ethical dilemma of if and when to intervene in a medical issue. Though I never asked volunteers specifically about how they conceptualize their relationships with the resettling families they assist, most of the volunteers interviewed related their volunteer position to a more common relationship framework, such as a friend, neighbor, or family member. Most commonly, volunteers draw upon familial relationships to explain their corresponding feelings of responsibility, such as in these quotes from Asal and Lakshmi:

> Asal: So some of the stuff—I will—It's just like really thinking about my own family. No different, Nazmeen, my own family.
>
> Lakshmi: So it's a tremendous responsibility, but I guess it's kind of—I think she's become my, you know, she's...I feel like she's a family member. That's how responsible I am.

In these expressions, volunteers Asal and Lakshmi explain their feelings of responsibility as the same as they would feel for their relatives. They highlight the relationships not just as one of the humanitarian service expected of resettlement organizations, but of a certain kind of intimacy and care. While volunteers such as Asal and Lakshmi could position resettling refugees as new neighbors—a term commonly used among refugee-related humanitarian groups (such as New

Neighbor Relief in San Diego, New Neighbors Partnership in NYC, and Good Neighbors of Capitol Hill in DC, among others), they instead position refugees as being “no different” than a family member.

A reframing of refugee/volunteer relationships to be one of family connection puts volunteers in more familiar territory, as they are able to make decisions, give advice, or intervene as they would feel comfortable doing with another relative. A familial relationship also suggests one of greater permanence, with volunteers commonly expressing that medical resettlement is a process that will take additional years, and that they are committed for that long haul. Asal, for instance, compares the volunteer/refugee relationship to “being a parent to a teenager,” reflecting both her feelings of responsibility as well as her long-term commitment to seeing that responsibility through in the way one might raise a child.

Such a relationship is a more socially established framework for taking on feelings of responsibility, especially in a biomedical environment that expects the family to be the locus of health responsibility. As Foucault argues in “The Politics of Health in the 18th Century,”

> The relations between parents and children were thus codified according to new—and very precise—rules…. [I]t had to be invested henceforth by an entire ensemble of obligations which were imposed at the same time on both parents and children: obligations of a physical order (care, contact, hygiene, cleanliness, attentive closeness); ...concern for healthy dress; physical exercise to assure the good development of the organism—a permanent struggle that constrained adults as well as children. The family...had to become a dense, saturated, permanent and continuous physical environment that surrounded, maintained, and promoted the child's body. (qtd in Lynch, 2014)

Foucault describes the “obligations” of parental health maintenance—ensuring that children are clean and hygienic, closely attended, and otherwise “healthy” in a continuous physical environment that exists outside the clinical encounter. These obligations also describe the same activities taken on by volunteers: Hannah feels guilty for not scheduling the flu shot that she believes could have prevented a child contracting the flu; Blythe worries about the girls next door staying up too late and not eating well. And (as established in Chapter 4) volunteers not only feel responsible, but actually intervene: Hannah becomes more vigilant in staying on top of appointments, while Blythe feeds the girls breakfast in the morning. Yet, as Foucault notes, the obligations imposed on parents are accompanied by obligations imposed on children; the two parties are mutually constrained. Similarly, by invoking a parent/child relationship to understand and motivate their responsibility, volunteers place obligations on refugee clients. These obligations may be beneficial in improving health outcomes, but this discourse also places refugee clients in a subjective position by expecting that these obligations (i.e., listening to volunteers’ health advice) will be fulfilled.

Resettling refugees and volunteers within the BRP are already in a complicated power dynamic, as volunteers in community sponsorship can act as gatekeepers to services and networks. The lack of other avenues for long-term refugee assistance leaves refugees with few options outside of accepting relationships with BRP volunteers. Using a familial commonplace in a rhetoric of responsibility does not alleviate this power dynamic, and arguably makes it even more complicated; instead of a new neighbor able to make their own health decisions, resettling refugees are positioned as dependents in a caretaking relationship. And while I cannot speak more conclusively without interview data from refugee clients, the behavior I have observed as a volunteer suggests that resetting refugees may not always share the relationship framework that volunteers use to position themselves. Despite the power dynamic, BRP clients have "fired" volunteers from their family teams, asking other BRP members (usually those in leadership positions) that they would prefer a different liaison or medical coordinator. One family chose to leave Blacksburg entirely due to conflict with BRP volunteers. These decisions have often been met with feelings of resentment from volunteers, likely exacerbated by the rhetoric of responsibility that they use to position themselves more as family than as service providers.

While positioning themselves as family members implies a commitment to an ethic of care—a commitment that is more attainable for community volunteers than for VOLAG caseworkers operating under more institutional restraints—the danger of tying a familial commonplace to their constitutive rhetoric of responsibility is that volunteers risk both infantilizing refugee clients *and* fracture in their role if that relationality is not shared in the way they expect. As discussed in the previous chapter, volunteers feel responsible to move resettling refugees toward a certain rhetorical performance of agency, which may be understood as helping refugees become members of a certain medical discourse community in the United States. However, analyzing the familial commonplace volunteers invoke reveals that the health resettlement process volunteers expect is not only about discourses of medicine but also about discourses of relationships. If a discourse community is based around shared assumptions and knowledges around genres and discursive conventions (Swales, 1990; Bizzell, 1992; Borg, 2003; Beaufort, 1997), volunteers set an expectation of familial discourse that may not be reciprocated. In one extreme circumstance, a BRP liaison quit, in part because—despite being informally adopted by the daughter of the family as her "grandmother"—communication conflict with the family's mother about health practices, such as taking medications as prescribed or going to scheduled appointments, led to the volunteer feeling like there was not a reciprocal understanding of the kind of obligations expected in that “familial” relationship (i.e., the volunteer would instruct and the client would listen). Thus, although there is a rhetoric of responsibility that motivates volunteers to a greater investment in care, such a rhetoric also invites a different kind of power dynamic and paternalism that may work against volunteers’ long-term discursive goals for health resettlement.

Constructing a Familial Ethos

As Leah’s example about dental work at the beginning of this chapter illustrates, volunteer responsibility extends not only to their judgment about if and when they should intervene to perform healthcare tasks, but also to the process of persuading a resettling person toward certain health outcomes or decisions. Though volunteers likely use many different rhetorical strategies in these persuasive scenarios, my focus in this section is on how volunteers invoke a particular kind of ethos as they explain how and why they feel responsible to be persuasive at all. Rhetoric of health and medicine scholars have rigorously explored the concept of ethos, which is, as Judy Segal defines it, how a rhetor uses character as a means of persuasion (2005, p. 17). For medical and health scenarios, RHM scholars have investigated ethos as something that can be lost or overlooked due to a particular health or social status (Johnson, 2010; Pryal, 2010; Harper, 2020), ethos as something that can be proven or recuperated by patients through demonstration of medical knowledges and jargon (Segal, 2008; Molloy, 2015), and ethos as it is leveraged by medical professionals to persuade or dismiss the concerns of patients (Kopelson, 2009). As I mentioned in Chapter 1, the volunteer/refugee dynamic potentially mirrors the asymmetry in physician/patient interaction in how ethos is leveraged for persuasive intervention. Healthcare providers are also concerned with the ethical boundaries of relationality, agency, and decision making (hence the traditional bioethical principles that are meant to be a framework for providers), and are concerned with getting patients to act on a particular knowledge.

For BRP volunteers, a rhetoric of responsibility includes constructing themselves into a similar kind of authority—though, as I will discuss in this chapter, the position comes with discomfort—particularly in comparison to refugee clients, who lack that authority. However, what is compelling about how ethos is utilized by health resettlement *volunteers* is that they fall into neither category, not able to leverage the embodied knowledge of the patient nor the institutional knowledge of the physician. It is necessary to discuss this third position, as focusing solely on patient/doctor relationships in refugee resettlement does not fully capture the process. Thus, I discuss the ways in which volunteers describe their own character as a means of persuasion, particularly considering the rhetoric of responsibility that is motivating volunteers throughout the process, and how this responsibility informs, and is informed by, the rhetorical positioning volunteers adopt.

The volunteers interviewed for this project all discussed at least one instance where they had to decide when, how, and at what level to intervene in order to avoid what they saw as a risky health consequence. In these explanations, too, the example of familial relationships was often given. When my conversation with Asal turned toward volunteer responsibility, she described how she felt the BRP organization should vet potential volunteers based on how they might "manage" that responsibility. She suggests, for instance, that BRP ask potential volunteers:

> How would you describe your parenting style when [your children] were high schoolers? Because this is...not like babysitting a baby. It's more close to, you have a person—a

> college student or a high schooler, middle schooler, kind of like—they are exercising independence, they want to buy their own things or they want to go to places. And how did you manage them?

Asal describes the potential volunteer/client relationship as that of parent/child—in this case, a teenager who is beginning to exercise independence but not considered fully capable of "managing" themselves. Examples like Asal's demonstrate how the positioning that happens due to feelings of responsibility can shift to an inappropriate position of authority. The implication of adopting this character, or ethos, in relationship to resettling refugees, is that the persuasive strategies utilized by volunteers are now limited. In a parental role, one can make healthcare decisions for their child. In a volunteer role, one cannot make healthcare decisions for a refugee. To make "good health" happen, volunteers must persuade in a way they would not if refugee clients were actually their children. If responsibility motivates volunteers toward a familial commonplace, but the familial commonplace does not actually provide volunteers with the rhetorical strategies to establish a persuasive ethos.

Yet volunteers still lack a more prescriptive understanding of what the volunteer/refugee relationship is, leaving them with a familial ethos they rely on to "manage"—or, as Karla puts it, to "deal with"—situations they feel require their intervention. Volunteers also use this familial ethos to rationalize why they *should not* intervene, as described by both Asal and Hannah. Asal says, for instance, that "[e]xactly the same thing happens with teenagers. You let them have failures, and you have to go with the shovel and clean up." Asal describes her relationship with a refugee client as one that 1) involves "failures" on the part of the refugee, and 2) is "exactly the same" as what happens with teenagers in regard to her responsibility—that is, to clean up whatever perceived mess is caused by the failure. Asal's comparison speaks back to the tension volunteers experience between avoiding health "failure" at all costs and allowing them to happen. Similarly, Hannah explains that "until [the client] make[s] a little mistake and deal[s] with the consequences, [they] might not really get it…. [Y]ou [the volunteer] can't do everything for [the client] or they won't become independent." Hannah ties her responsibility as a volunteer not only to preventing health failure, but to the goal of health independence, balancing a client "getting it" versus the consequences of "a little mistake." Both Hannah and Asal position themselves as being in a position of authority from which to decide to intervene, regardless of which decision they ultimately make.

According to these volunteers, just as good parenting means letting children experience certain consequences, good volunteering means letting refugees experience certain consequences. A rhetorical framework of familial responsibility here leads to a (perhaps inevitable) paternalism as volunteers balance the competing rhetorics of self-sufficiency ("independence") and volunteer responsibility. Not only do volunteers determine whether health resettlement has been achieved based on their own perception of health goals and good health, but they also determine the best way to achieve those goals by drawing from an expertise—parenting—that fits the responsibility of care they feel their role requires. If refugees are supposed to gain a certain level of independence that is guided by the volunteers, volunteers adopt what they perhaps see as the closest proximal relationship to that kind of expectation, which is one of a parent raising a childhood to independent adulthood.

And while some volunteers use a familial commonplace as a direct representation of their relationship with refugees (”my family, no different”), others use the framework of familial relationships to explain how the volunteer/refugee relationship is something adjacent to it. That is, instead of using a parent/child relationship as a straightforward comparison for how they perceive their relationship with resettling refugees, some volunteers explicitly state that they were performing a certain role or task because they *did not* have a familial relationship with the resettling person. For instance, Lakshmi states, “I don't even do quite as much for my daughter or son but it's similar. What I would do for them.” Although Lakshmi is not positioning herself in the same parental way that Asal does, for instance, she still invokes the familial commonplace to describe her feelings of responsibility as “similar” to what she would do for her children. Despite not being an exact comparison, that is the closest explanation she uses, which makes the familial commonplace relevant as far as understanding the responsibility that influences volunteer/refugee relationships.

Other volunteers also use the familial commonplace as a foil to how they position themselves as a volunteer. For example, Leah notes that “[i]f it were my son I would have [intervened], but he’s not my son.” Leah draws on what she *would* do in a parent/child relationship—that is, make particular health interventions—then stresses that since the refugee client is *not* her son, she will not intervene in the same way. Similarly, Rania tells me that she does not “see [herself] as their mother” or “put [herself] in that position.” Like Leah, Rania uses the familial commonplace to situate what her relationship is not (i.e., one of motherhood). Rania’s additional note that she does not “put [herself] in that position” also speaks to a deliberate engagement *and positioning* as a volunteer. Despite the responsibility she feels, Rania sets a boundary for the relational position she will (and will not) occupy. Even Asal, who compares her relationship with Nazmeen to one of a parent and teenager, later in our interview uses the same rhetorical positioning to explain what she does not want to become:

> You're helping them, you should consider that they also make choices and you, you are helping your parents? Let them be your parents. You're just helping them. Me giving

> money or me taking you to the doctor, or all of this, it—none of it entitles me to become the person who I shouldn't be. Like in this case, for example, I should never become Nazmeen's—what do they call it? Guardian.

Asal describes a different kind of familial relationship: one in which *she* is the child, helping aging parents. Like being an adult to her children, she is "helping" her parents by giving them money or taking them to the doctor. Yet, crucially, her parents remain her parents and not her dependents in the same way. She explains that none of the assistance she offers them "entitles [her] to become the person who [she] shouldn't be"—in other words, offering assistance does not mean she has authority over them the way she does with her children. Using this relationship as a comparison for her relationship to Nazmeen, and particularly what her role as a volunteer does *not* entitle her to, is another example of a volunteer making a conscientious choice to set a boundary for their own intervention. Because Asal describes her volunteer role in comparison to both parenting teenagers and taking care of aging parents—each situation invoking different kinds of authority and expectations—she especially is a good example of the tension between "managing" and "allowing" failure.

For volunteers who do not adopt the familial framework, there is still a struggle to explain their own relationship and ethos in terms that correspond with already established relationship frameworks. For instance, after Leah explains that one of the resettling people she assists is "not her son" and not treated like she would treat a son, she searches for other ways to frame their relationship and compares it to one she might have with a neighbor:

> And finally, finally [Imad and I] worked and found the truth of the [health] matter and got into a better place with that problem, but it took a long time. Whereas if I had taken

> my neighbor in and they heard the instructions most likely we would have been immediately on the right path.

Much of the rhetoric around community involvement in resettlement is about being "good neighbors" as volunteers and community members to welcome resettling refugees. Yet Leah makes a distinction that her interactions with, and relationship to, a person for whom she has taken on this position of responsibility is different than the neighbor relationship to which she is accustomed. For Leah, what makes the relationship framework different is the immediacy of being "on the right path" with medical decision making. In other words, Leah feels she cannot have a neighborly relationship with a resettling person, and must adopt a position of authority of some kind, because she feels the person is still in a position to need persuasive guidance about health matters. Leah acknowledges that a neighbor would be easier to persuade toward certain health actions, presumably sharing a similar level of knowledge, values, and understanding as she does.

Similarly, Karla uses a marker for what her relationship as a liaison is not:

> Because I try to picture the family I'm working with now. They're going to have children for a long long long time and I don't plan on never seeing that. I plan on being connected with all of them until they graduate from high school really, but I don't plan on being the person that the family needs to have. I would rather be you know eventually more like a friend.

Karla uses a friendship relationship as an indicator of resettlement—when she no longer needs to be a liaison and can "just" be a friend, at the level of involvement, responsibility, and consultation that one might expect in a relationship with a friend. That is not to say that Karla does not see herself as a friend now to the refugee family whom she assists, but that she views their current relationship as something in addition to friendship.

These interviews reveal a confusion in the relationships that are constituted by a rhetoric of responsibility in the health resettlement process. Volunteers simultaneously perceive their relationships as drawing from their own parental, familial, or and/or cultural experiences, while also noting that they are not in a position of guardianship; other volunteers use everyday relationships one might have with a family member, neighbor, or friend as an explanation for what their relationship with a resettling person is not (yet, if ever). Thus, as volunteers move toward markers of medical resettlement and offloading their feelings of responsibility through the achievement of those markers, they also work toward a changing kind of relationship.

Even at time of these interviews, though volunteers still uniformly (and emphatically) express how much work still needs to be done three or four years into the process of medical resettlement, they also discuss moments of shifts in their relationships with refugees driven by different needs and contextual circumstances. Sahar, a long-time translator for the BRP, explains that

> what [I] have with [the families] is not just translating—it's bonding. I guess all of us [volunteers] have that kind of bond. So it's not just that I call them because they need something. It's just, I call and say, "Hi, how are you doing?" And they are almost at the point that, you know, they need my help not much. I mean, very little. But we are just saying hi to each other, they come visit me, I come visit them, and you know. Something like that.

Sahar notes that her relationship is not "just translating," but also something outside of that role (and outside of any volunteer role entirely). While resettling families still need her help occasionally, they are moving more toward a relationship that is not built on health resettlement goals. Though Sahar does not give this relationship an explicit label, she describes a much more neighborly or friendly relationship that is developing—one in which people casually visit each other and call just to say hi. This shift speaks to a goal for health resettlement that is not just about healthcare actions by a resettling refugee, but also about reaching a new and different stage in the volunteer/refugee relationship. Like Sahar, Leah's role has shifted over time; she explains that "[Imad's] famous line is, 'You are my only friend.' Obviously I'm not his only friend, but that's the way he says, 'I need you to be a friend.' And he says 'friend' and not 'liaison.' Then when he says that I know I need to find time to go meet Imad and just listen." Unlike Sahar, however, Leah describes a scenario where she is explicitly invited into a different relationship, one which she clearly recognizes as distinct from her relationship with Imad as a liaison.

While Sahar describes the shifting relationship over time as needs change and decrease, Leah describes a relationality that fluctuates based on the role Imad invites her into—friend or liaison, expert or listener. Out of all the interviewed volunteers, Leah has the widest variety of descriptions for her relationship with the resettling family with whom she works. However, even with this variation, Leah is still in the position to either accept or reject these roles, especially considering Leah's role as the primary link between Imad and his family and the BPR organization overall. Though Leah sees room to act as a friend, the way she rhetorically positions her relationship with Imad is not as friends, neighbors, or family. It is something that is inadequately captured by those understood positions, yet triangulated by them and perhaps only understood in comparison to them.

In Leah's examples, she cannot treat Imad (and, by extension, his family) as a neighbor, because a neighbor would be able to follow health advice independently; she cannot treat him as a son, because she does not have the authority to treat him as a son; she can treat him as a friend, but when specifically invited to do so. The contextual nature of how Leah, and the rest of the volunteers, accept or reject certain relationality (will or will not act as parent; will or will not take on responsibility; will or will not act as medical expert) demonstrates how these roles are co-constructed between refugees and volunteers (Powell and Takayoshi, 2003). Just as volunteers construct roles for themselves and refugee clients—and the corresponding obligations in those roles—they are also responding to the roles and relationships created for them by refugee clients. Or, in some cases, responding to the role that they *think* is being created for them, such as a close family member, or medical expert, or self-sufficiency czar. The difficulty in such contextual responsiveness is that it leaves volunteers in a state of flux: they feel deeply responsible but lack the clear commonplaces through which to ground that rhetorical relationship.

Eschewing Medical Ethos

Thus, volunteers rely on the commonplaces of existing relationships—and a familial commonplace most particularly—to inform or describe their volunteer/refugee relationship. They use this commonplace when they are describing whether to intervene in health resettlement, but also when they are explaining their own ethos and expertise within their relationship with a resettling person. Particularly in situations of medical decision making, or everyday health practices, volunteers face difficulty in how much to leverage their own knowledges and where those knowledges fall short. Whether by design or circumstance, in performing their perceived roles, medical volunteers often find themselves in situations where they are either asked to advise on health issues or feel responsible to do so if even not explicitly asked. Leah's earlier example of spending eight months working to persuade Imad toward tooth extraction demonstrates a situation where a volunteer is not asked for advice, yet intervenes anyway. In another example, Rania encourages volunteers to expect and be ready to provide medical advice as “people of authority” or “people of more knowledge”:

> They are constantly asking [the volunteer team], “What do you think I should do?” So we shouldn’t take it like they are just dependent and being weak. They do value a group kind of process to be able to make that decision, so taking a lot of things in consideration, listening to the elders or the people of authority or people of more knowledge. They want to weigh that opinion in, so we need to be able to understand and that would change the way we work with them you know. I think it’s very important.

Rania describes another facet of the situation, explaining that the refugee family with whom she works are regularly seeking volunteers’ expertise about medical care. Further, she emphasizes that seeking that advice should not be a sign of dependence (or a lack of independence), but instead as a deliberate part of a decision-making process. Where difficulties arise in the approach Rania suggests is in how volunteers understand their own medical expertise. Among the current BRP volunteers involved in healthcare, none is a medical practitioner, other than one liaison who is a retired veterinarian. This lack of formal medical education, combined with positioning themselves as responsible for preventing disastrous health consequences, leaves volunteers in another tension: If they feel like they have a responsibility to intervene, what ethos or expertise can they draw on to do so?

Because they are (generally) familiar with the medical system in the US, volunteers often discuss decisions among themselves before bringing it to the resettling person or advise on what is the best choice. Yet despite their own experience and general knowledge, the interviewed volunteers also express a deep discomfort with positioning themselves as medical authorities, with most emphasizing their lack of formal medical training. Hannah tells me, “I think all of us—me, Rania, and Karla—have some feelings of discomfort giving [medical] advice, because we’re not medical professionals and we don’t want it to be on us to make that decision.” She explains that she and the two liaison volunteers—the three people on the volunteer team most likely to be giving medical advice—are uncomfortable with it. It is unclear whether the discomfort comes from a lack of medical *knowledge* or a lack of *professional authority*, but ultimately Hannah notes the responsibility they want to avoid (“we don’t want it to be on us”) because they do not feel qualified to take it on. Blythe expresses a similar sentiment, saying that for future sponsored families, BRP should have “actual [medical] professionals involved in this [resettlement] process.” Even as they are the ones doing the job, the expressed desire for someone else—a professional—to be doing that job is another expression of the desire to not be responsible for health consequences as healthcare experts. In contrast, as discussed previously, volunteers are more willing to take on the responsibility of a *familial* ethos even as they reject a medical one.

Since volunteers are unwilling to position themselves as having an ethos based on medical expertise, the familial ethos becomes more valuable in the process of health resettlement as volunteers pull from experience as parents and family members to qualify their ability to intervene in health concerns. Understanding a volunteer/refugee relationship as informed by relationships with which they are already comfortable bleeds into how volunteers also see and use their own expertise in those relationships. In this case, the everyday medical tasks of child-rearing, such as vaccination, taking a temperature, knowing when to go to the doctor, and advocating on someone’s behalf, are experiences that most of the interviewed volunteers performed while raising their own children in the United States. As discussed previously, a parent/child relationship comparison appears frequently among volunteers; because all but one of the interviewees have children of their own, it makes sense that this is the relationship they use not only to interpret their feelings of responsibility but also to justify why and how they can persuade someone else. Even as volunteers distance themselves from professional medical knowledge, the familial positioning by itself is *tied* to a particular medical expertise. Yet because this expertise is largely unrecognized by volunteers, they look outward to find medical experts to consult and gather into the family team.

Finding Medical Expertise through Community Connections

To ensure that good health happens and to alleviate their own tension between responsibility and lacking the appropriate expertise, volunteers begin drawing on their own community connections to get the expertise the volunteer team needs. In coordinating healthcare and recognizing their lack of medical expertise, many of the interviewed volunteers spoke of the deliberate process of finding healthcare professionals who would be a good match for both the resettling person *and* the goals of the volunteer healthcare team, both in the clinic and outside of it. When I asked volunteers who, if anyone, they consulted when faced with a medical dilemma, some spoke of reaching out to healthcare professionals on their own for advice. Rania, for instance, describes seeking out a doctor to speak with about a medical issue a person was having:

> I felt like we can talk to [this doctor]. So I call him and I say, “This is the situation with [the resettling person]. Where should we go? Because I know [the person is] not going to want to go to the primary care [clinic] to ask ‘What’s the next step? Why do we need this?’”

In this particular instance, Rania first establishes that it is a doctor she feels like "[she] can talk to"—someone she feels will have a dialogue with her in a helpful way. Then she explains that the reason for seeking out this doctor is because she does not believe the resettling person will go to the primary care clinic to seek out a medical dialogue on their own. Rania is concerned with getting the person medical care, but here she describes the issue as a communication deficiency as well, making it especially important that she reach out to a doctor she can "talk to."

For interactions inside and outside of the clinical space, volunteers note the importance of not just having someone with medical training, but someone with medical training who also has a particular character. For instance, Sahar looked for a doctor who "explained [medical answers] very well"; Leah found a doctor who is a "real likeable person that [the resettling person] took an instant liking to"; Karla noted an incident with a doctor who was "smiling, laughing, joking around with [the family]." In these examples, volunteers are looking for more than just medical knowledge. What they look for in terms of patient persuasion toward the goals of health resettlement is a particular character: someone who is likeable, who can communicate well, who can joke around. According to volunteers, these characteristics inspire trust, give patients confidence, and make them feel good. What these volunteers prioritize, then, is not just technical knowledge, but an attitude and an interaction with their patients that promotes *trust*. Both Leah and Rania in particular talk about relationships of trust as being crucial to their own ethos in the volunteer/refugee relationship, which fits with a familial discourse of close connection. This importance extends into other medical interactions as well. Without trust, volunteers recognize that the medical knowledge from practitioners will lack the effectiveness it needs to persuade someone toward or away from a course of action.

Gathering Ethos: Curating Community Relationships for Persuasion

Despite a familial ethos—and even a familial ethos of parental “management”, or one of “allowing” consequences—there is a limit to what volunteers feel they can do while lacking medical expertise. Their responsibility in the face of potential health failure, combined with a lack of what they understand as medical expertise and a nebulous understanding of when to intervene, leads volunteers to gather a particular kind of ethos within the volunteer-medical care team. Relying on their adopted familial ethos, volunteers leverage their personal community relationships (such as a neighbor who is a doctor) to try and persuade people toward certain healthcare actions, always alongside volunteers’ more familial ethos. As Leah explains, “[Y]ou can’t make them do it. You just have to keep on trying to find who can make this picture clear to them.” Similarly, Lakshmi tells me, “[W]hen [Nazmeen] hears it from the nurse practitioner, it makes a little bit of difference compared to when I say it…. I think it’s kind of good if she hears it from both sides.”

In these examples, volunteers are framing the positive health outcome they seek—and thus, their larger health resettlement goals—as a process of persuasion. Leah focuses on “mak[ing] the picture clear to them,” while Lakshmi sees the value in “hear[ing] it from both sides.” As discussed in the previous chapter, there are rhetorical situations where volunteers feel they can act as proxy agents, such as communicating with doctors, making appointments, and picking up medications. However, the examples discussed in this chapter, namely decisions about treatment plans, surgeries, and taking medication, speak to the situations where volunteers *cannot* act as proxy agents. Whether constrained by their own ethics, their understanding of the volunteer role, and/or a medical culture that requires autonomous decision making, volunteers face scenarios where they are unable to intervene on behalf of a resettling person and must instead persuade them to a course of action. In these situations, volunteers demonstrate a process of long-term deliberation, looking for rhetorical strategies within their relationship, or even reaching outside their relationship to bring in someone else, in order to persuade the resettling person (or their parents) to decide to go forward with treatment.

In these persuasive moments, volunteers are worried both about health outcomes and consequences that they feel responsible for, but, recognizing their own position means they cannot decide *for* someone (as a parent might for a child), they also must worry about how to convince someone that a certain choice or action is the best one. Volunteers describe their process of deciding when to focus on a potential choice, based on the potential consequences it might have if the choice is made poorly. And once these decisions become a particular matter of concern, volunteers focus on what relationships might be influential. Is the message more convincing coming from a health professional? If so, what kind of relationship does that professional need to foster? Is the message more persuasive if it comes from children who express concern over their parents' health (or their own)? How aggressively should a volunteer try to persuade someone if the potential consequence could be severe? Because they have accepted an identity constituted by a resettlement rhetoric of responsibility, part of that identity becomes staging particular rhetorical situations with particular actors within it. Volunteers are describing *persuasion toward* a certain kind of health maintenance as part of a moral responsibility.

Thus, as volunteers explain in these examples, there is a process of *gathering ethos*—of "find[ing] who can make this picture clear to them" and realizing that "it's...good if [they] hear it from both sides." Even as volunteers are driven to intervene by their own responsibility positioning based on familial frameworks, they at the same time seek further legitimacy to make the appropriate healthcare decisions happen. If refugees are constituted as lacking the rhetorical skill to do so, part of volunteers' responsibility in the process of health resettlement becomes a curation of relationships—not only trying to position *themselves* in the proper or most effective way to a resettling person, but actively finding, adding, and removing others (whether volunteers or medical professionals) as part of the "team" of people working toward medical resettlement goals. In one team, volunteers express excitement over the addition of a care coordinator from a local clinic who has offered to do one-on-one healthcare education for the mother of the family. Another team works to find medical professionals who speak one of the languages in which the resettling person is fluent, hoping that removing a language barrier will lead to more direct and effective communication. Another team actively moves away from adding more volunteers, based on previous negative experiences that did not align with health decisions the liaison and medical coordinator thought would be best. This curation is not only a grouping or networking of people, but of their particular ethos, knowledges, and subject positions that can be aligned with the understanding of the volunteer team about how they will guide the health resettlement process, and intervene, or not, to prevent negative outcomes.

Although resettling people are fully capable of creating their own relationships, and have done so in my observations, each of the curation decisions made by volunteers influences the health resettlement process. In terms of logistics such as making appointments or keeping a calendar, the experience of medical resettlement might be similar for each resettling family sponsored by the BRP. But the curation by each team of volunteers makes the experience of medical resettlement unique for each family, not just because they each arrive with different levels of education or health needs, but also because each volunteer perceives different *persuasive* needs, and this influences which relationships become part of the process.

The gathering of ethos means volunteers are looking for the right combination of people and knowledges to be persuasive toward certain health resettlement goals. Thus, even as volunteers include medical experts, volunteers are still leveraging their own cultural expertise and familial ethos. In these instances, volunteers use their own positions within the volunteer/refugee relationship to encourage certain healthcare actions, recognizing that who the encouragement comes from is just as important as what is said. This awareness makes it especially important to volunteers that everyone with this ethos stays on the same page. Otherwise, volunteers risk conflicting messages that are counterproductive to the goals volunteer teams are working toward.

For example, both Karla and Leah told me stories about translators—a volunteer translator for Karla, and a hospital-provided volunteer for Leah—who disagreed with the approach taken by the liaisons in advocating for and/or advising the resettling person and encouraged a different course of action to the person instead. Both liaisons expressed the difficulty of mitigating that kind of involvement, arguing that people dealing with medical situations *ad hoc*, such as one-time translators, are trying to make decisions without the full context of the resettlement landscape. Leah explains,

> I also had to meet with the translator privately and say, “This is kind of what we’re dealing with. I appreciate your desire to defend someone that you have a cultural relationship to, but this is a life-and-death matter and we really need to work together.” So eventually [the translator] had to come to trust me…. [A]nd so there’s that you have to deal with as well.

In addition to the tasks discussed in Chapter 4 that volunteers are both performing and using to assess progress toward health resettlement, volunteers are also managers of the volunteer team.

In this example, Leah is again discussing a relationship of trust; not only is there a certain character she is looking for in figuring out how to persuade sponsored refugees, but she is also looking for relationships of trust within the volunteer team for the family. If Leah and the translator do not trust the other's judgment about when to intervene and in what way, the persuasive messaging may become less effective, which could have—in Leah's words—"life-or-death" consequences.

Volunteers acknowledge that as medical coordinators they must attend most, if not all, medical appointments in order to avoid information "falling through the cracks," as Hannah puts it. Otherwise, they risk missing the full context of someone's health history in relation to the health goals the volunteer team is working toward. If there is a revolving door of casual volunteers driving clients to medical appointments, information like medication instructions and health updates may not be effectively communicated back to the family medical coordinator or liaison(s). At the same time, volunteers dedicate so much effort to having all this information in order to be prepared to give the right advice, make the right connections with the doctors, and understand the "available means of persuasion" for a particular individual.

This cultivated network includes volunteers themselves. While some volunteers express that it would be better for healthcare professionals to relay medical advice on subjects like treatment plans or when to make an appointment, an anecdote from Rania demonstrates the ethos that volunteers carry despite lacking the technical knowledge:

> So the way they would call me in the beginning they would say like, "Ma'am"…. And I knew because they knew I came maybe from a more privileged class or education, all that. It's unspoken they just know it, you know. So I didn't want to have that. I mean, I have it, but I didn't want to keep that relationship going. So I said, "Oh don't call me that.

> It makes me feel older. It makes me feel like an auntie or something. Just call me by my name," and that changed something. So definitely they will assume that you know more. You are more educated.

Rania's anecdote is important, not only because it demonstrates the unique authority that volunteers do have (or at least a volunteer perception of that authority), but also speaks back to the discomfort some volunteers feel with accepting a relationship in which they are in a certain kind of authority. While personal or familial relationships may be accepted and leveraged for persuasion, other, more formal hierarchical relationships—such as one suggested by the word "ma'am"—are rejected. Because volunteers are already trying to thread the proverbial needle between self-sufficiency and responsibility, independence and dependence, figuring out the appropriate relationship is equally difficult and important. Too much of a formal, institutional authority and they risk losing the more informal relationship necessary for both trust and intervention into the everyday kind of health practice. Too little authority and they risk not being persuasive enough and being unable to prevent poor health outcomes. Gathering the kinds of ethos they need is a way to increase the chance that persuasion will happen, without sacrificing the unique position they have as a volunteer—a position which includes knowing which people to gather to the volunteer team, and when, and for what purpose.

This network, curated by volunteers, reframes resettlement from an individual accomplishment (though of course there is still the self-sufficiency rhetoric embedded in the process) to a relational one, dependent on the rhetorical skills within relationships refugees have with others. Once volunteers feel that refugees have the rhetorical skills (agency, advocacy, deliberation, building relationships) to make healthcare choices that are informed in a manner and degree that they find appropriate, the responsibility can then be shifted off the volunteer and onto the refugee, marking resettlement. It is the deferment of responsibility based on satisfactory rhetorical performances that signals the end of volunteer involvement in these situations.

Managing Relationships and Rhetorical Expectations for Refugees

What volunteers prioritize in these cultivated relationships is connected to the discursive markers of health resettlement. Many of these resettlement markers are logistical tasks covered in Chapter 4, like making and showing up to an appointment. However, in addition, volunteers are also looking for an ability to gather the right kind of knowledges and expertise in the way they do in order to reach health resettlement goals. Volunteers express this as a communication issue; to reach a point of health resettlement, a resettling person should be able to communicate health issues with a medical professional *while also* managing the larger healthcare team, including knowing when to include or exclude professionals and their advice. Hannah, for instance, sees an aspect of health resettlement as establishing a long-term relationship with a doctor that is built on “[being] really forthcoming with your medical history and all of your medical conditions” because “[i]t’s a lot of stuff that connects together.” Lakshmi values similar discursive relationships with medical professionals, while acknowledging that communication management is a key element of these relationships:

> [O]ne of the problems she has is she has a long history of doctors she's been through. … And all the referrals, if you add them all up, and her medicines…. [I]t's becoming quite complicated at the moment. She's got a whole array of things. And the reason it hasn't been sorted out is that she needs—she's got one main physician, and that's good. But she's been referred to so many specialists, and somebody has to kind of, you know, wean down the specialists until she's getting good medical care. And that it all makes one coherent,

> sensible picture. And that hasn't happened for Nazmeen yet…. [T]his is a goal that's hard, and it's hard because of the communication.

The problem Lakshmi addresses is a large one: on average, refugees come to the US with more health concerns, particularly long-term health concerns, than other immigrant populations (Yun et al., 2012). Thus, for the good health outcomes expected by volunteers to be achieved, the process of health resettlement will almost inevitably involve a team involving a primary care physician or nurse practitioner, as well as specialists for various other health concerns. As Lakshmi notes, these teams can quickly become complicated. What Lakshmi is looking for as a marker of health settlement (and by extension, good health), is a "weaning down" of specialists until "good care" can be achieved. Instead of more specialists and expertise and advice directed at health problems to resolve them, Lakshmi recognizes that too much medical expertise works against "good care." It is the act of curation—of being particular about what kinds of ethos are gathered, and when—that volunteers describe as important, and also as what they hope resettling refugees will have the rhetorical skill to do.

Volunteers describe goals of decision-making, advocacy, asking questions, and honestly communicating with doctors even in moments of nonadherence. And although the reason for these goals—to achieve a certain standard of health in the US—is the same as the more logistical tasks, these goals are much more rhetorical in that they rely on a discursive exchange in certain situations with medical professionals in order to reach a certain outcome. Volunteers express a discomfort with the making of certain decisions based on their own expertise, which is framed in terms of previous experience but lacking the technical education. However, they feel more comfortable using their relationship with a resettling person to advise on navigating other, more knowledgeable relationships, like when talking to a doctor. Just as volunteers have expertise in everyday medical situations, including how to interact with doctors in a way that they feel is appropriately engaged, they prioritize the same kind of rhetorical savvy from refugees as indicators of having resettled into the US healthcare system.

As volunteers see it, health resettlement includes 1) an awareness of rhetorical situations in medicine and 2) an ability to navigate those situations with an amount of agency that is proactive in medical encounters, while 3) performing regular biomedical preventative care. For them, this looks like knowing when to ask questions of doctors and discern which medical advice to follow and when, while also scheduling yearly checkups and flu shots, semiannual dentist visits, and other health maintenance as discussed in the previous chapter. The rhetorical skills necessary to perform both these tasks and communications are, to volunteers, markers of successful integration into the discourse community of US medicine that expects a particular self-management. This serves the goal of health resettlement that volunteers describe as being able to "take care of yourself"—the personal expectation of health management. Divorced from the political goal of economic self-sufficiency, "taking care of yourself" medically, at least for volunteers, is not about being removed from government services like Medicaid but being able to monitor and communicate one's own health.

Scholars have theorized the intersection of the technical sphere into the personal through a biomedical shift, wherein increasing numbers of at-home health technologies, combined with the expectation that patients will take on shared decision-making, makes patients increasingly responsible for health maintenance (Clarke et al. 2003). Volunteers' anxieties about taking on this responsibility on behalf of someone else reveals how deep-seated this idea is; not only do they express feelings of guilt or worry over a range of health "failures," but one volunteer even confessed feeling that "[the family] would blame [her]" if a poor health outcome were to occur.

If it is considered good for people to maintain and monitor their own health in particular ways, and that maintenance is adopted by volunteers as expectations for health resettlement, it is no wonder that the prominent discursive expectations for resettling refugees are not just about doing what the doctor says, but about asking questions and advocating for yourself until you can make an informed and "empowered" (to use a volunteer's word) choice. Of course, as others have noted, "choice" is a limiting concept (Pender, 2018), and volunteers recognize this as well. Even as discursive and agential skills are prioritized, rejecting or refusing recommend treatment leads to volunteer intervention in the form of different persuasive tactics, such as volunteers removing themselves from a scenario, finding the right physician who can say the right thing in the right way, and/or urging the children to convince their parents.

Conclusion: Enrolling Refugees into a Discourse Community of Health

By understanding how volunteers understand, leverage, and gather ethos, we can better understand how resettling refugees are invited and enrolled into the discourse community of medical patients in the US. Scholars in refugee studies have largely focused on the health needs of refugees from a clinical perspective. Yet by examining health resettlement as a process driven by the values, expertise, and persuasive approaches of volunteers, resettlement can be better understood as an acutely local process. What the interview data in this project reveal is that, though volunteers understand health resettlement as what they might see as the ability to perform certain tasks, health resettlement is a process of integration into a discourse community—into a group that shares particular values and understanding about the genres (such as medical forms) and rhetorical situations (such as accepting or rejecting medical advice) that make up the expectations for patients. This discourse community influences how refugees learn to rhetorically navigate medical relationships, and plays a part in both health outcomes *and* in reifying what we recognize as normative health interactions.

Refugee studies scholars have argued for the importance of community resettlement volunteers because of the existing resource networks to which volunteers have access (Fratzke and Dorst, 2019; Lamba and Krahn, 2003). However, understanding the access given to these networks as a deliberately curated, rhetorically savvy process to achieve a certain health outcome illuminates how volunteers are not just resettlement assets but resettlement *curators*. Their role is more influential in guiding the process than merely being a gateway to community resources. This reframing allows closer critique of how volunteers approach the resettlement process, and how the rhetoric of responsibility that constitutes their role tangles with the policy-driven rhetoric of self-sufficiency that sets an expectation for self-management—and particularly when volunteers are positioning themselves in familial frameworks in relation to refugees. These interviews and analysis offer insight into how it is rhetorical skills within these situations, more so than English proficiency or technical medical knowledge, that become prioritized in the resettlement process by volunteers, and how they adopt the kind(s) of relationships they feel will be effective in making these skills happen.

Understanding the rhetorical work done by volunteers also moves concerns about resettlement and integration beyond English proficiency, which has implications for how we approach issues of health justice and equity for refugee-background persons in the United States. Not only are many health issues addressed by volunteers through gathering expertise that refugee newcomers would have a much harder time accessing, but volunteers are also correct in their assessment that the care received from the medical establishment is improved and/or better taken advantage of through discursive performances and relationships that are much less accessible without cultural mentorship. Considering many resettling refugees do not have access to this kind of cultural mentorship—and even when they do, cultural mentorship risks an associated paternalism—the rhetorical skill that volunteers contribute cannot be relied upon as the sole bridge to care access.

For rhetorical studies, and particularly studies in the rhetoric of health and medicine, investigating the process of health resettlement for refugee studies offers new perspectives on how expertise is leveraged in situations involving not only the patient and physician, but when others are involved in medical decision-making. Outside of refugee resettlement, understanding how ethos can be gathered and leveraged in this kind of third-party positioning can potentially reveal similar positions adopted by healthcare proxies and caregivers who find themselves in situations where they must focus on persuasion and not making decisions themselves. Outside of RHM scholarship, understanding how ethos can be gathered, especially within local communities, has implications for how rhetoricians approach public work and analyzing the presence (or absence) of particular actors as a process of curation. In the following chapter, I will highlight additional ways that curation and/in health resettlement have implications for rhetorics of health and medicine, and rhetorics of resettlement.

Chapter 6

A Way Forward for RHM, Refugee Studies, and Refugee Resettlement

Fig 3: Rescue.org graphic (International Rescue Committee, 2021)

In May 2021, the International Rescue Committee—one of the nine VOLAGs that manage resettlement in the US—posted a graphic to their social media accounts that reads, “How we treat *refugees* reflects who *we are*.” The implied message of the graphic is that the treatment of refugees is tied to the identity of the “we,” understood to be the host country and perhaps its citizens. Similarly, this dissertation has argued something similar: That the identity of the volunteer is not only revealed by the process of resettlement, but also shaped and constituted by the rhetorics of resettlement.

As both a researcher and a participant in the process of health resettlement for refugees, I have approached this project aiming to solve a problem that I believe has a rhetorical solution—or, at the very least, that a rhetorical understanding can help elucidate. Volunteers within the Blacksburg Refugee Partnership have struggled to understand their role and boundaries in health resettlement, leading to organizational disagreements; further, a lack of research into a community-sponsored resettlement model has left grassroots organizations to figure out best practices largely on their own. Thus I have asked, how do BRP volunteers understand the process of health resettlement, and how does this understanding compare to the federally defined resettlement process? What discursive roles and responsibilities do volunteers adopt within the process, and what impact does this have on community sponsorship? How do volunteers leverage these roles to facilitate the health resettlement process?

While a federal- and state-level policy understanding of resettlement relies on a rhetoric of self-sufficiency to establish its goal and purposes, community sponsorship makes space for a different constitutive rhetoric: namely, a rhetoric of responsibility that emphasizes volunteers *in interaction* with refugees and more fully acknowledges the "two-way street" of integration. Volunteers within the BRP understand resettlement not only through the commonplaces of self-sufficiency, but through their own designation as helpers—as people who have taken on responsibility in the absence of any other assistance being provided to resettling refugees, and in the spaces that a rhetoric of self-sufficiency has left out. For health resettlement, this responsibility is expressed through anxious concern for "life-and-death" consequences of what volunteers perceive to be health failures, motivating volunteers toward a conception of agency that marks resettlement by knowing the right ways and times to engage in the rhetorical situations of medicine. For volunteers, a proper health performance on the part of a sponsored refugee client is not merely patient adherence, but representative of the volunteer's own ethical responsibility in moving the client toward independence. Thus, volunteers set a high bar for what they consider "health settled" because these outcomes are a reflection of themselves. In other words, volunteers moralize the discursive tasks of medicine, flattening their own health ethics into their resettlement responsibilities. By carrying both the responsibility of care and the policy-driven call to self-sufficiency, volunteers become the embodiment of these conflicting resettlement goals.

Additionally, by analyzing the language volunteers use to explain the responsibility that motivates them, I find that their narratives about health resettlement reveal and constitute a particular kind of role and relationship with sponsored refugees. Specifically, volunteers both eschew medical expertise while also trying to establish relationships in which they are listened to regarding medical advice; this results in volunteers leaning on familial frameworks as they attempt to persuade resettling refugees toward the particular actions that establish the rhetorical agency that marks health resettlement. These familial frameworks allow volunteers to leverage expertise in a way with which they already feel comfortable. Yet even working within this familiar framework, volunteers express the limitations of it, recognizing that—unlike a relationship in which they *do* have familial guardianship—they must often *persuade* instead of making decisions on their behalf. Thus, volunteers must also gather ethos to supplement their own, curating the family volunteer team to include relevant medical experts. Gathering ethos in this way allows volunteers to keep their own particular familial-styled ethos while also leveraging the medical authority of others. In this way, volunteers separate medical authority from their own brand of rhetorical expertise, wherein they feel responsible for guiding resettling refugees toward a rhetorical competency with medical scenarios.

For community sponsorship, this study reveals that volunteers are not merely an asset to resettlement (as other studies have positioned them), but *shape* the process of resettlement, particularly in health. How volunteers understand their role and their relationship with refugees is developed in relationship to what refugees are not; if refugees resettling in the United State are not yet self-sufficient (as insinuated by policy), this establishes a deficit narrative to which volunteers feel compelled to respond. However, with only the generalized commonplaces of self-sufficiency (e.g., being able to do X without help) and no guidance for how self-sufficiency is actually reached—especially in health resettlement—volunteers locate the deficit at least partially in rhetorical action. Because volunteers have established a role that is supposed to help someone toward self-sufficiency, they then focus the markers of health resettlement on these rhetorical acts, establishing a role and relationship that address them.

Lessons for Community Sponsorship Groups

Given this theoretical understanding of processes of health resettlement, we can turn to its practical implications regarding resettlement groups' activities and training. An additional question to ask at this point is: What should resettlement groups do considering this information? As we see with the Blacksburg Refugee Partnership, a large problem is that the volunteer role is unclearly defined, and thus the values of the organization may or may not be shared—or implemented in the same way—by the volunteers.

For the BRP and other sponsorship groups, the interviews included in this study suggest focusing on the goals and outcomes that mark resettlement. Even within more comfortably understood terms such as “self-sufficiency,” there is obviously an ambiguity that compels different volunteers in different ways. Very rarely in any BRP meeting did we discuss the actual markers of self-sufficiency that volunteers were hoping to achieve; and, as shown from these interviews, often volunteers are setting those goals based on their own responsibility and not based on what is attainable or desired by the resettling person. It is not that any BRP volunteers hope for a result in which a sponsored person cannot make a medical appointment, ask questions of a doctor, or navigate an insurance switchboard—all possible markers of self-sufficiency. Rather, the tension is located between the goal of self-sufficiency and the process of being responsible (or feeling responsible) for preventing negative outcomes for an already vulnerable population.

The solution I propose for this tension is to establish clearer roles and boundaries for volunteers that can account for the many situations I heard in my interviews where volunteers felt an ethical responsibility to intervene. Explicit training in what to do if a person does not want to take life-sustaining medication, does not want to ask a doctor questions, or does not care about accessing their online health portal, among other scenarios, would be helpful for volunteers when these scenarios inevitably arise. There is no prescriptive, one-size-all solution for these scenarios that could be easily codified in organizational policy. Rather, bringing an awareness of these situations as rhetorical foregrounds volunteers' position within them, specifically the ethos that volunteers have and the different audiences they engage with in their roles.

Many of the volunteers I spoke with told me these difficult moments would have been easier with medical experts, which makes sense—having someone who has more knowledge about the consequences of not taking a medication, for example, is beneficial when trying to explain those consequences clearly. However, volunteers cannot sidestep their own position that requires explicit recognition of power dynamics and acknowledging the deficit narratives around refugee-ness that has motivated them to volunteer in the first place. Addressing this positionality directly, instead of waiting for volunteers to fill the gap by leaning on familial frameworks, would allow volunteers to enter the role more prepared for the messy intersections of responsibility and self-sufficiency. More explicit instruction on how to weigh these potentially competing constitutive rhetorics could allow volunteers to decide situations contextually, based on the years-long relationships formed with resettling families, while not relying solely on their own values, health or otherwise. Additionally, volunteers should talk more openly with sponsored families about their health goals even if they do not believe a resettling family has enough medical knowledge to make informed decisions. For instance, asking resettling refugees what they value in health, or when *they* want volunteers to intervene, could build a more equal foundation for the volunteer-refugee relationship.

Yet at the same time, community sponsorship groups should incorporate the volunteer feedback that medical experts should be more closely involved in the health resettlement process outside of only clinical interaction. This explicit curation of volunteer teams at the organizational level, instead of volunteers working within their own personal networks to try and find a medical professional who can consult as needed, would allow volunteers with no medical training to offload some of the identity muddling they experience as they work to make health "happen" for resettling refugees. If volunteers do not feel as immediately responsible for communicating medical knowledge—that is, if they can rely on a medical expert to do so—they may not feel as immediately responsible for health "failures." This may allow volunteers to conceptualize the volunteer-refugee relationship differently, particularly as they navigate healthcare situations.

Implications and Further Research: RHM Studies

For RHM studies, this dissertation points to an expanded understanding of medical situations that has implications for further research. For instance, focusing on resettlement volunteers and how they position themselves in medical coordination can apply to similar positions adopted by healthcare proxies and caregivers, populations that have gone understudied. Determining how these "third parties" in the physician-patient relationship shape medical interactions, narratives, and decision making can have important impacts on our understanding of agency and persuasion in health discourses.

Additionally, an understanding of gathered ethos contributes to ongoing conversations RHM about appeals to ethos. Molloy theorizes ethos as something that a speaker can repair or recover, defining “recuperative ethos” as “day-to-day discursive practices through which a person might regain credibility” (139). Building on this, “gathered ethos” addresses how resettlement volunteers *build* credibility in rhetorical situations where they might otherwise fall short. Specifically, their “day-to-day discursive practices” include selectively expanding their network of volunteers in order to have (what they consider to be) a group that can be the most effective in persuasion toward or away from medical decisions. This curation is based not only on particular medical expertise, but also on how members of the volunteer team, including themselves, communicate and approach difficult conversations. “Gathered ethos” has implications for public health and the variety of stakeholders in public health communication, but also for advocacy groups oriented around a shared health identity, like having endometriosis or Lyme disease.

Another way in which the findings of this study impact RHM is in further revealing the technical and discursive work that is required to make healthcare “happen.” Refugees and other newcomers to the United States are often in the unique position of having to start from proverbial scratch, making the barriers to access even more visible as they learn to navigate those barriers for the first time. While research has focused on language barriers to health access (Sangaramoorthy, 2o17; Brisset et al. 2014), even actions such as making a calendar appointment or calling the pharmacy should be considered technical actions that cannot be assumed by health providers or those assisting patients. Instead, understanding the processes of health resettlement illuminates our assumptions about health literacy and technical communication that affect other populations across the country. Ultimately, volunteers are trying to enroll resettling refugees into a medical discourse community that marks a health literate, health self-sufficient population in the US, which more clearly reveals the (sometimes unrealistic) expectations of that discourse community.

Future research on health resettlement may explore the implications of this enrollment on our conceptions of health citizenship as something in which to be “enrolled” as a goal for humanitarian practice. Understanding health citizenship not only as a rhetorical performance but also as a goal to be reached along the process of reaching political citizenship focuses on the discourses that move people toward certain health values and actions. This is particularly relevant for resettling refugees, since the implications of not performing these actions can include, as I mentioned in Chapter 5, volunteers quitting in frustration or exerting more influence to make those actions happen. Since volunteers are important links to community networks and healthcare access, losing those connections in community-sponsored resettlement may be a risk that sponsored refugees are also weighing as they make health decisions and decide what “health citizenship” will look like. Challenging volunteers’ implicit goals for health resettlement offers a broader examination of how health citizenship is deployed, defined, and performed. This study has sought to make these goals more explicit.

One way for volunteers and community sponsorship groups to address this problem is not only to worry about the risk of poor health outcomes, but also to recognize agency as it is already being performed by resettling refugees. Community sponsorship groups would benefit from discussing health risks not as *de facto* matters of concern, but as moments of rhetorical engagement—of discussion between similarly equipped rhetorical agents, not as volunteers engaging with the deficit-narrative refugee who is here only to be a receiver of health information. Tying “health resettlement” to normative upper-middle-class health actions places refugees in that deficit position, not just of health knowledge but of rhetorical knowledge as well;

refugees are then seen as being unable to productively discuss health actions or consequences because they do not fit the volunteers' expectation. When rhetorical agency is demonstrated through health compliance, performance, and knowledge, volunteers are less likely to know how to engage resettling refugees as rhetorical agents who are capable of collaborative (or independent) health deliberation. Future work may explore how both a rhetoric of self-sufficiency and a rhetoric of (volunteer) responsibility both reinforce a normative rhetoric of health citizenship, and push for a move to *rhetorical* health citizenship (as theorized by Spoel et al, 2014) in refugee resettlement, moving from humanitarianism to communitarianism.

What also emerges from the volunteer interviews is a spotlight on how different forms and methods of communication affect the resettlement process, which invites further studies on this topic that are more firmly situated in technical communication studies. Volunteers across family teams rely on a host of different communication methods: phone calls, texts, WhatsApp, and Telegram are popular communication tools between volunteers and refugees; teams use texts and Telegram; BRP teams generally communicate through email. And outside of communication with refugees themselves, volunteers are also in communication with doctors' offices and healthcare professionals, often via online healthcare portals that are associated with a major healthcare system in the area. This is an intersection of refugee studies and rhetoric that as yet is unexplored, and would be a compelling site for future research. Not only would such research potentially identify specific technical sites of health resettlement for refugees, but would also build on this dissertation by demonstrating the access/barrier points for refugees attempting to navigate the US healthcare system with little to no written literacy in English.

Yet the technical discourses of health resettlement are not just about the tasks involved in making healthcare happen, but also in risk communication, and in seeing volunteers as risk communicators. Volunteers have been placed in a role of expertise, and communicate as experts, including how medical risk should be managed and understood. Overall, volunteers look for a rhetorical agency exhibited by resettling refugees that is aware of and seeks to mitigate risk, and that is how they mark health resettlement and the end of their own responsibility. Risk, then, is where we see the tension between volunteer responsibility and refugee agency, as well as between persuasion and self-sufficiency. This study lays a foundation for technical communication studies scholars to more closely examine at-risk communication between non-experts trying to ethically navigate agency and expertise without formal training. In addition, interviews with resettling populations will be critical to analyze alongside volunteer interviews to more fully understand processes of health resettlement and taking on rhetorical agency.

Lastly, further research on this topic might speak to conversations in literacy studies as well. Scholars in literacy studies have focused on how literacy forms through concepts such as "literacy sponsors" (Brandt, 1998), and this dissertation work is ripe with potential for further discussions about how volunteers act as literacy sponsors—and particularly *health* literacy sponsors—for resettling refugees. Because language and communication barriers prevent resettling refugees from accessing needed health services (Morris et al., 2009), volunteers are focusing on teaching literate behavior within health interaction at the same time they are teaching some clients how to read and write for the first time. Additional research into how volunteers teach refugees about language behaviors, particularly in medicine, would be complementary to how this study has described volunteer health expectations for sponsored refugees.

Implications and Further Research: Refugee Studies

For refugee studies, this research has implications for how we perceive and approach the process of refugee resettlement. Community sponsorship programs are often met with skepticism as agencies are trying to implement them in the United States (IRC representative, personal communication, May 13, 2021). Much of the research about the influence and impact of resettlement volunteers has focused on non-US countries, including Canada (Behnia, 2012), Australia (Duncan, Shepherd, and Symonds, 2010), England (Yap, Byrne, and Davidson, 2010), Greece (Rozakou, 2012), Sweden (Mårs, 2016), Germany, (Karakayali, 2017; Florian, 2018; Schmid, 2019; Turinsky and Nowicka, 2019), New Zealand (McAllum, 2017, 2019), France (Schiff and Clavé-Mercier, 2019), and Austria (Kukovetz and Sprung, 2020), in part because there is a more robust infrastructure for community sponsorship internationally than there is in the United States.

Because community sponsorship is less well known in the US, there is a skepticism here that volunteers will be able to do the job required and outlined by policy regarding providing resources for resettling refugees. Thus, VOLAG staff worry that refugee clients will not have the assistance they need during the resettlement process. This dissertation research suggests that instead of not providing needed support, volunteers are more than willing to make sure care is provided. They feel responsible to make sure refugee clients have the assistance they need to maintain a high health standard, even years into the resettlement process. On the contrary, volunteers may benefit from a formal structure that details specifically when and how (and when *not*) to get involved in fraught medical situations so as not to overstep boundaries for the sake of humanitarian aid. Recognizing volunteers not just as neighbors but as having a cultural and rhetorical expertise can better introduce the idea that volunteers need training *as experts*, similar to how doctors or other professionals consider ethical engagement on a professional level. Their networks and how they gather and leverage ethos is part of their community embeddedness, but it is also a rhetorical strategy that volunteers are skilled in employing.

Importantly, understanding volunteers not only as resettlement assets but as resettlement curators has implications for how the field of refugee studies approaches the entire matter of volunteer research. While studies have focused on volunteer motivations (McKinnon, 2009; Behnia, 2012; Thomson, 2014; McAllum, 2017), volunteer training and organization (Duncan et al., 2010; Florian, 2018) and a small number have focused on volunteer values (Erickson, 2012; Schmid, 2019), none have focused specifically on how volunteers understand and define the goals of resettlement. While this is possibly because the goals are understood to be pre-defined by the corresponding resettlement agencies or various national and local governments, there is still abundant room for ambiguity in how volunteers should guide resettling refugees toward those goals. Treating volunteers as curators of resettlement affects how they are interviewed and what questions researchers should ask them, which could be particularly impactful if put in relationship with interviews with refugees about their experiences with volunteers. Crucially, including the voices of refugee-background individuals alongside resettlement volunteers will further illuminate not only how volunteers conceptualize a process of health resettlement, but how resettling refugees themselves navigate the process and interact with volunteers. This may reveal additional misunderstandings between refugees and volunteers as they engage in the health resettlement process and would provide a potential counternarrative to how volunteers describe the experience. As refugees are the group ultimately most impacted by resettlement, their experiences are vital to a full understanding of the process.

As I write this concluding chapter, the BRP is celebrating the five-year anniversary of that standing-room-only interest meeting in the Blacksburg library. Partly because of the Trump administration's whittling down of the refugee resettlement cap between 2016 and 2020, and partly because the pandemic forced volunteers away from providing the same hands-on interaction with resettling families, the organization has turned its attention toward the future. They are addressing questions that will impact the organization and resettled families: Will they sponsor new families in Blacksburg? What have they learned over the past five years? How will they operate differently going forward? These questions come while VOLAGs—and, presumably, the federal government—are figuring out how to rebuild the refugee resettlement program and expand community sponsorship opportunities. This study comes at a crucial time in the US resettlement program and speaks to both the strengths and challenges of placing the burden of resettlement increasingly on community volunteers, with a hope that future research will continue to explore the interpersonal ethic of community sponsorship amidst a background of self-sufficiency in refugee resettlement. While the research questions for this study focused on rhetorical approaches by and from volunteers, future research may ask questions such as "Which relational frameworks do sponsored refugees use to understand their relationships with volunteers?" or "How do refugee experiences with the healthcare system broaden a conception of patient agency, particularly from a rhetorical standpoint?" Answering such questions would add to an understanding of community-sponsored resettlement that can speak back to state and federal policies regarding refugee resettlement and move those policies toward a greater consideration for local experiences.

APPENDIX A

Interview Protocol for Volunteers, February 10, 2020

1. How long have you been working with refugees?
2. What are the duties of your job as prescribed by X (volunteer manual, resettlement guidelines, etc.)?
3. When you get involved in the process of resettlement, what are your goals for that process?
4. What do you think it looks like for a refugee to be resettled successfully?
5. I'm interested in the medical and health aspects of this process—how refugees learn to navigate the system, and how their health/medical needs are accounted for in the resettlement process. What do you think it would look like for a refugee to be resettled in terms of their health?
6. My goal is to understand the specific problems and challenges organizations face when trying to help refugees be self-sufficient in medicine. Do you provide support in terms of medicine or health care?
1. What do you do if someone calls you needing a doctor appointment, prescription interpreted, Medicaid form filled out, etc.?
7. When do you think you will no longer need to provide medical support?
8. What is a typical problem that you encounter in coordinating medical care?
9. What helped you figure out what to do? Is there a person, guidebook, or procedure that addresses questions or problems?
10. This policy says ____. How does this inform what you do? How do you feel about that? What would you change, if anything?

11. What would you like people to know about medical care for refugees?

APPENDIX B

The Blacksburg Refugee Partnership Policies and Procedures Guide

Blacksburg Refugee Partnership

Principles and Policies for Volunteers Version 1.0; February, 2018

Doing the work of resettlement with love.

This document provides an overview of some of the roles of BRP volunteers and in particular the principles and policies which are applied to all BRP decisions and volunteers. No names or contact information are included here so that this document can be freely disseminated. All volunteers can be provided with a list of names and contact information for each role described.

Mission

The mission of the Blacksburg Refugee Partnership (BRP) is to resettle refugee families in the Blacksburg region and assist them until they are able to meet their own needs and participate in the community independently. BRP support includes: housing; food and basic needs; health care planning and organization; education assistance including English Language Learning, tutoring, and school interfacing; childcare; translation; transportation; and employment searches.

Overview of BRP

BRP was formed in the summer of 2016 to support refugee families from war-torn countries. While each family is unique in their interactions with BRP, the following basic structure is common to all. For each family there is one or more liaisons who serve as the interface between the family and BRP. They are the first responders when the family has an issue and they help the family manage day to day issues. Liaisons are supported by a team dedicated to that family who help with: education (ELL and tutoring); healthcare; recreation (sports and other activities); translation; transportation; and childcare. In general, there is one or more team members for each of these elements. The family team is supported by the overall organization which contains committees for each area in which we work with families (health care, education, etc.) as well as a board of directors and committees for finances, fundraising, and other organization-wide activities.

An organizing committee meets monthly. Any volunteer is welcome to attend and participate in those meetings. All ongoing activities and new plans are discussed in these meetings. Some decisions are made. BRP is overseen by a board of directors. The board has eight members including a president, vice president, treasurer, and secretary. Board membership is modified by a board vote. There is also a finance committee which makes some of the finance decisions. The relative roles of the board, the organizing committee, and the finance committee are as follows. Of particular note is that both the board of directors and the organizing committee, with input from the finance committee, must be in agreement before any new families are partnered with.

Roles of the Board of Directors:

- Approval of Policies and Procedures
- Approval of major financial decisions
- Overall strategies and future planning of the organization
- Approval of financial ability to support new families

Roles of the Organizing Committee:

- Implementation of policies and procedures
- Volunteer coordination
- Day to day planning and coordination
- Approval of volunteer ability to support new families

Finance Committee:

- Approval of financial decisions less than $1K

Core Principles and Policies

Underpinning all of BRP's specific policies are the following core principles. These are formed to help achieve the ultimate goal of the families participating in the community independently and also to protect them.

- All decisions that impact the families we partner with are made by the families themselves. We will inform and educate them to the best of our abilities, but we cannot make their decisions; · Our activities in partnership with the refugee families always consider the ultimate goal of the families living independent of our support. As their abilities increase, our support should scale back in an appropriate and reasonable way;
- While we make every effort to help our families participate in our community, we make no attempt to influence their cultures and traditions;
- By accepting our support, the families agree to secure and maintain employment if appropriate or engage in educational activities at a level commensurate with Social Services requirements. They also agree to learn English.

Project-wide policies support these core principles and protect the families:

- All BRP volunteers must complete and pass a background check;
- Any information related to any family member's health, education, or legal status must only be shared in accordance with documented procedures and with people who are appropriately authorized to be privy to that information, and otherwise kept confidential (all volunteers will sign a form pledging to this policy);
- Information that could be used identify or locate any family member, in particular any pictures, can never be made public or posted in any social media.

General Guidelines with Regard to Working with the Families

BRP has as its mission to support refugee families during their transition, but BRP is also supportive of its volunteers. At any time if a volunteer experiences any concern or discomfort regarding their work with BRP or the families, they are encouraged to seek help. BRP has members with the appropriate background as well as community partnerships to help. Please do not hesitate to bring any concerns to a BRP board member or any member of the leadership team.

BRP offers volunteer orientation meetings twice monthly. These are the second Wednesday at 7pm and fourth Monday at noon. The meetings provide an overview of BRP's history, current state of the organization and families, lessons learned applicable to new volunteers, and question and answer time. These meetings are strongly recommended for any new volunteers.

As a general approach, working with the BRP families should be like any other volunteer-client relationship. In any situation in which one would normally call 911 or notify law or school officials, this should be done with no hesitation. The family liaisons and/or a BRP board member should then be notified. If a volunteer experiences a situation regarding the families that concerns them in any way, that volunteer should immediately notify a family liaison, a BRP board member, or an appropriate BRP leadership member. To the extent possible, individual volunteers should try to avoid being alone with the children, especially if they are new to the family.

BRP does not have project wide auto insurance (or any other type of insurance). Any time a volunteer drives a family member, they are required to have appropriate insurance that would cover those passengers.

As appropriate, car seats and booster seats should be applied according to Virginia code. Virginia code references the age of the child and Department of Transportation standards. Under age 18 they have to be restrained in the appropriate lap belt or lap and shoulder belt, no matter where they are seated in the vehicle. Under age 8 they have to be in either a booster seat or the appropriate child safety seat no matter where they are seated in the vehicle. Up to age 2 they should be in a rear-facing child seat. The transition from child safety seat (high back and two straps) to booster can be guided by the seat manufacturer's instructions and the fit of the child in the seat. Manufacturer's instructions will reflect Federal Guidelines. The installation should also be guided by the seat instructions. The latest Federal guideline is kids under age 12 should be in the back seat because of airbags.

Taking pictures with the children is permitted so long as there is permission from the parents and those pictures are kept private among the volunteer, BRP, and the families. No pictures of any member of the BRP families can be placed on social media.

Finances and Home Maintenance

When families first partner with BRP, there is a set of agreements that are discussed early in the process. The partnership generally requires that the families learn English, work towards independence, set up a bank account, and pursue education and work as appropriate. BRP initially pays for rent and one or more BRP volunteers usually co-sign a lease (the families generally have no credit history) and so we require that the home be taken care of appropriately. The following are the specific points discussed with the families. One or more BPR board members and the family liaisons are involved in the discussion. If possible, we ask them to sign a form agreeing to these. Depending on the education level of the adults and their ability to sign, we often wave do not ask for a that.

1. Each guest family will establish a bank checking account and receive orientation regarding its use.

2. Since the home provided is owned by an outside party and the rental is co-signed by a BRP member, it is important that the home be well kept and that an appropriate level of cleanliness be maintained. Any damage should be reported immediately.

3. Smoking is not permitted inside the provided home. Smoking is permitted outside the home as long as it does not impact the neighbors. The families pay for any required cleaning.

4. Younger children should be supervised when playing outside, at least by one of the older children (15 or older).

5. BRP will pay apartment and utility deposits. When those deposits are returned, BRP should be reimbursed by the guest as soon as possible.

6. BRP will deposit into the guest's bank account (or directly pay bills) sufficient funds each month to cover expenses for basic living costs (housing, utilities, food, telephones, etc.) and daily needs. The amount to be deposited will be discussed with the guest family as needed. Use of discretionary money will be negotiated between the guest family and BRP. A small weekly allowance may be established to allow the family some independence (e.g. bus fare, haircuts, etc.). Other expenses outside of the regular monthly ones (e.g., purchase of a pair of work shoes) will be approved on a case-by-case basis by the BRP liaison. This arrangement is temporary and the family is expected to be self-supporting as soon as possible.

7. Guest family will save and submit all receipts to finance liaison.

8. A guest family member must secure work as soon as possible or be focusing on an education. The amount of funding supplied by BRP will decrease in proportion to any earned income. The timing and amount of that decrease will be discussed with the guest family well ahead of time.

9. All members of the family must work to master English so that they may participate effectively in employment and education activities. School attendance is mandatory for all school-age children.

Education and Tutoring

The BRP education programs include English as a Second Language (ESL) training for the adults, tutoring in English and other school topics for the children, and interfacing with the public schools. As much as possible we try to be in contact with the teachers to make sure the tutoring is supportive of what the kids are doing in class. In the first months after children arrive, English is usually the priority. Tutoring occurs either at school or at home depending on the specific situation. For the adults, we encourage formal ESL with the program at Blacksburg Baptist Church or if possible, New River Valley Community College. BRP volunteers supplement the formal classes with one-on-one training at home. Very often the families are not accustomed to the routine of daily school activities. The importance of regular participation should be emphasized. Some education-specific guidelines follow.

1. Privacy: Privacy is extremely important. The parents have given permission to tutors and to a limited number of people in BRP to discuss their children's education with teachers and one another. Any questions, concerns, ideas, praise, etc., should be shared with those people, but otherwise please respect the privacy of the family.

2. Documentation: The BRP education lead maintains a google doc for each child. All tutors, in-home and in-school tutors alike, are encouraged to update those documents on a regular basis, hopefully once per week. Content should include what the child has been working on, what the child seems to be struggling with or mastering, strategies that have worked or not worked, and so on. Teachers also are given access to the docs, and some may update them as well. If preferred, comments can be sent to the education lead to be added to the document.

3. Communication: If for some reason a tutoring session will be missed, the education leads and any fellow tutors who would be involved should be notified as soon as possible, please text me (and your fellow tutors if you work in-home). If there are ever concerns about the kids or the family, please contact the education lead right away.

4. Gifts: It is not uncommon for volunteers to give gifts to the families. This should be done with caution, especially gifts from tutors to the students they work with. It can easily result in jealousy among the other children or kids feeling left out.

5. Resources: Each semester a training session is provided to all tutors. Slides from previous session as well as other valuable resources may be found in the google drive folder below as well as the following link.

https://drive.google.com/drive/folders/0AF-krnr2GlIyUk9PVA

https://globalteer.org/wp-content/uploads/2017/05/Child-protection-policy-May17.pdf

Health Care

For each BRP family, there is a designated healthcare coordinator. Though the position responsibilities vary based on the needs of the individual family, the healthcare coordinator generally schedules health related appointments for the family and interfaces with the Department of Social Services as necessary. (The logistics of transportation, childcare, and translation for medical appointments are managed with other members of the family team, but families are encouraged to use the bus whenever possible.)

Based on previous experiences, we request that local healthcare providers use phone translation services for appointments instead of hiring in-person translators. Families may also choose to bring a personal translator, especially when there are significant questions or concerns.

BRP works closely with local healthcare providers, especially Carilion, Lewis Gale, the Community Health Center, and New River Valley Community Services. We encourage family healthcare coordinators to use these resources whenever possible. Alongside these providers, BRP provides healthcare education and is better able to facilitate healthcare communications.

What the BRP medical team prioritizes:

1. Privacy
    a. The resettled families with which we work may choose to share medical information openly, even with relative strangers. However, this is not blanket permission for us to share their medical details openly. Volunteers should reference the appropriate consent forms if there's a question about when, where, and with whom medical information can be shared. Inappropriate disclosure of medical information may result in your relationship with the BRP ending. Should any volunteer have any concern about any health-related issue of the family members, they should report that concern immediately to a family liaison or health care coordinator.

    b. Privacy for resettled families is a paramount concern for the BRP and all family volunteers. All volunteers who may come into contact with sensitive medical information, like transporters and translators, will sign a form agreeing to not disclose any private information they hear or see. Medical information can be shared with the authorized persons the family has chosen; usually this is the healthcare coordinator or the family liaison. Unless the family has given permission, medical information is not to be discussed openly.

   c. For families who cannot yet speak or read English, assistance will be necessary in making medical phone calls or reading mailed communication in order to make sure important information is not missed.

2. Autonomy
   a. In America, having "autonomy" traditionally means making individual, independent decisions about our healthcare. The way medical decisions are made may look different for the families you will be working with. For instance, they may make decisions more collaboratively, seeking input from a wider range of people or allowing someone else— including BRP volunteers—to make a decision for them. Nevertheless, *it should be assumed that all medical decisions will be made by the person/patient unless they specifically say otherwise.* Even if their version of "autonomy" is not independent and/or relies on close relationships with others, that is still their choice. Medical coordinators should have conversations with the adults and teenagers they work with about their preferences so that the coordinators understand how the resettled family they work with normally makes medical decisions.
   b. Each doctor's visit generally requires patients to sign forms or verify information. Whenever possible, these forms should be discussed with the person using a translator, especially in cases of assumed risk or liability.

3. Education
   a. Because the US healthcare system is difficult to navigate even for native citizens, family medical coordinators should be prepared to explain basic concepts, like why a person must wait so long for a medical appointment, or how health insurance works, or why each doctor's office requires so many forms. Despite any gaps in knowledge, families should be full participants in the decision-making process, even if it takes longer to explain. Medical decisions should be made alongside, not for, family members. (See "Autonomy" above.)

   b. Medical coordinators and other healthcare volunteers may need to be aware of impromptu moments in which "cultural translation" is necessary. For instance, when a doctor's office requires a patient to sign a liability form that lists things that could wrong during a medical procedure, most people familiar with US healthcare understand what and why they have to sign. But for someone unfamiliar with US healthcare, the form may be understood as saying those negative outcomes *will* happen, and that signing it means you agree to those outcomes. Develop a relationship of trust with the people you work with so they will feel comfortable expressing concerns and questions to you.

It is hard—and maybe impossible—to anticipate all the medical needs, situations, concerns, etc. that will arise. Navigating the healthcare system will look different for each family. What is most important is to have a dialogue about the family members' preferences for healthcare and what their most important goals for medicine are.

Transportation, Childcare, and Translation

Volunteers who provide transportation, childcare or translation services to the BRP families should follow the general guidelines above. It is required that there be some introduction time with the families for any new volunteers providing transportation or childcare. These introductions can be done by liaisons or their designee.

Translation should always be done with emphasis on relaying the information being communicated. Often it is tempting to advocate for the family or to speak for them to expedite or facilitate discussions. While this is well intentioned, it should be avoided because it can actually lead to miscommunication. Especially in medical or school situations, but general, the job of the translator is to facilitate the communications, not to serve as a representative for the families or BRP.

Each week, the transportation signupgenius lead emails all of the transportation / childcare / translation volunteers the needs for that week. The email contains a signupgenius web page where volunteers can express their commitment to meet one or more of those needs. Volunteers are encouraged to do this as soon as possible so that no concerns arise about whether a doctor's appointment or other need can be met. One follow-up email is sent per week.

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