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MANIFESTING METHODOLOGIES FOR THE RHETORIC OF HEALTH & MEDICINE

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Keywords: methodology, rhetoric, mixed methodologies, theory building, methodological mutability, values, practices

As E. Johanna Hartelius (2009) argues, the rhetoric of medicine, as an area of rhetorical inquiry, "currently finds itself in a sort of sub-disciplinary self-reckoning. It faces a critical exigence of identity, like all inquiries do in their own time" (p. 458). Contributing to this exigence are a number of challenges: accounting for broader health practices; persuading other researchers and practitioners of our work's value; identifying our unique contributions (including methodological) while acknowledging and embracing cross-disciplinary and interdisciplinary influences; and defining our area of inquiry in relation to other scholarly movements, including some that served as our antecedents.

We offer this collection as a contribution to the ongoing, self-reflexive discussion of how we might characterize and advance what we're calling the Rhetoric of Health & Medicine (RHM). Although a number of scholars have begun this discussion around the scope and purposes of what we do, the topics and discursive-material practices we study, and the methodologies we build, adapt, and employ, it is this latter means of characterization that the essays in this volume extend. In attempting to further characterize rather than rigidly define, this collection seeks to keep open questions about our scholarly identity while advancing common threads of concerns, approaches, and contributions. In order to achieve this, we define broadly our key terms of methodology, rhetoric, and health and medicine. We will unpack each of these in sections that follow, but to summarize here, we view methodologies as multidimensional, value-laden frameworks for approaching, studying, and making sense of phenomena (see Sullivan & Porter's [1997] similar characterization, p. 26). We share Burke's expansive notion of rhetoric as

the "use of language as a symbolic means of inducing cooperation in beings that by nature respond to symbols" (p. 43; see Segal's [2005] discussion of Burke, 1968, pp. 5, 12). Our view of health and medicine encompasses rhetorical interactions across varied and overlapping cultural spheres, including those related to health and medical research, clinical medicine, health and medical policymaking, consumer health and personal health management, health advocacy, and community-based health practices.

In this introductory chapter and the larger collection, we argue that the RHM can and should be recognized for its methodological contributions (along with other types), contributions that include new or extended concepts, hybrid forms of inquiry and analysis, and self-reflexive forms of engagement. These contributions help to answer Hartelius' (2009) call for what distinguishes RHM, as well as what it can offer back to rhetorical studies, writ large, and other areas. Accordingly, the essays in this collection emphasize questions of why we study health and medicine, the methodological, moves and decisions, resources and challenges, and engagements that shape our research, and what makes our research both rhetorical and potentially useful to a range of stakeholders.

Such methodological questions have framed a number of ongoing discussions about RHM, including those sponsored by the Association of Rhetoricians of Science, Technology, & Medicine (ARSTM) and the Discourses of Health & Medicine Symposium sponsored by the University of Cincinnati. Some of this scholarship has explicitly advanced methodological arguments as part of its primary contributions; examples include Schryer and Spoel's (2005) argument for employing rhetorical genre theory to study professional identity formation through health care discourse; Keränen's (2011) call for biocriticism as the "sustained and rigorous analysis of the artifacts, texts, discursive formations, visual representations, and material practices positioned at the nexus of disease and culture" (p. 225); Bellwoar's (2012) use of cultural-historic activity theory to track the "chains of reception" that shape patients' interpretation and use of health care texts; and Graham's (2015) development of rhetorical-ontological inquiry to study the medical rhetoric around pain medicine. A recent special issue of the *Journal of Medical Humanities* (Keränen, 2014a) develops methodologies for identifying, studying, and engaging health and medicine's publics, and recent special issues of *Communication Design Quarterly* (Meloncon & Frost, 2015) and *Communication Quarterly* (Landau, 2015) explore methodological intersections of RHM with communication design and health communication studies, respectively. It is this thread of methodology-focused scholarship that the current collection most directly extends, in the process advancing the discussion of RHM's identity around how and why we do what we do.

Before we return to a fuller discussion of methodology and a preview of this collection's specific methodological contributions, we want to provide our rationales for calling this emergent scholarly movement a "field of inquiry," for situating it under the umbrella of rhetorical studies, and for calling it the "Rhetoric of Health & Medicine."

Characteristics of RHM

Several scholars, including Hartelius (2009), have characterized RHM as subfield of rhetorical studies. In their entry for the *Oxford Research Encyclopedia of Communication*, Malkowski, Scott, and Keränen (2017) describe it as an "emerging interdisciplinary subfield" (rhetoric itself being interdisciplinary) that "seeks to uncover how symbolic patterns structure thought and action in health and medical texts, discourses, settings, and materials" (n.p.). In their *Communication Design Quarterly* special issue introduction, Meloncon and Frost (2015) go a step further to declare that RHM is an emerged field (and not just an emerging subfield) that is continuing to "build a meaningful, connected" body of work (p. 12).

Regardless of how we classify its degree of development and relation to longer recognized fields, we can now discern a substantial and quickly growing body of scholarship (self) identified as RHM, published since the 1990s, and captured by Meloncon and Frost's comprehensive literature review along with a number of bibliographic essays (Segal, 2005; Eberhard, 2012; Jensen, 2015) and encyclopedia entries (Segal, 2009; Keränen, 2010; Keränen, 2014b; Malkowski et al., 2017). Anchored by rhetoricians in communication studies, rhetoric and composition, and technical/professional communication, this work has appeared in a number of monographs, edited collections, articles and book chapters, and, perhaps most visibly, journal special issues. The latter include *Technical Communication Quarterly* ("Medical Rhetoric," Heifferon & Brown, 2000; "Online Health Communication," Koerber & Still, 2008), the *Journal of Business and Technical Communication* ("The Discourses of Medicine," Barton, 2005), *Written Communication* ("Writing and Medicine," Haas, 2009), *Present Tense* ("Medical, Gender, and Body Rhetorics," Prenosil, 2012), *Poroi* ("Inventing the Future: the Rhetorics of Science, Technology, and Medicine," Keränen, 2013), the *Journal of Medical Humanities* ("Rhetoric and Biomedicine," Lyne, 2001; "Medicine, Health, and Publics," Keränen, 2014a), *Communication Design Quarterly* ("Rhetorics of Health and Medicine," Meloncon & Frost, 2015), and *Communication Quarterly* ("Forum on the Rhetoric of Health & Healing," Landau, 2015). Along with journals and presses, RHM work has been sponsored and supported by a number of professional organizations and forums. These include several ARSTM preconferences focusing on rhetorical studies of medicine, seven Rhetoric Society of America (RSA) Summer Institute seminars and workshops, the Conference on College Composition and Communication (CCCC) Medical Rhetoric standing group, the biennial Discourses of Health & Medicine Symposium, the Rhetoricians of Health and Medicine website (http://medicalrhetoric.com/), and the Flux Facebook group.

Although we are confident in identifying RHM as an emerged movement, we are not as comfortable calling it a disciplinary one, instead preferring to call it a field of inquiry guided by rhetoric but shaped by and drawing upon a range of disciplinary and interdisciplinary bodies of scholarship. Disciplines tend to align and standardize, while fields of inquiry are more likely to advance knowledge in

an indeterminate manner. Even while we seek to characterize RHM's collective values, approaches, and contributions, we do not want to lose the methodological flexibility, rich explanatory power, and potential expanded influence gained from bringing together diverse goals, perspectives, and approaches, whether in our own mixed methodologies or our roles in transdisciplinary and/or community-based research ventures. Scott, Segal, and Keränen (2013) capture this goal in calling on the field to stake a "scholarly claim in a way that clarifies our unique contributions" while encouraging methodological collaboration and experimentation, including the merging of critical-analytic and social scientific approaches (p. 2).

We also think it is important to value and extend the various scholarly traditions and conversations (disciplinary, interdisciplinary, and otherwise) that have informed research in our area of inquiry. Rhetoricians of health and medicine have been influenced by and have adapted methodologies, theories, and research findings from (but not limited to) the following: other interdisciplinary areas, such as the medical and health humanities (including narrative medicine), science and technology studies (STS), and cultural studies; various disciplines and subdisciplines, such as rhetoric and composition (including the rhetoric of science and technology), technical and scientific communication, communication studies (especially health communication), anthropology, sociology, philosophy, and history; and various health and medical fields or areas of practice such as public health, clinical medicine, and biomedical research (for overviews of these influences, see Segal, 2005; Meloncon & Frost, 2015; Lynch & Zoller, 2015; Malkowski et al., 2017).

In order to make sense of complex, high-stakes phenomena, RHM scholarship tends to employ mixed methodologies that integrate theories and methods from a number of scholarly traditions and research practices, ranging from cultural and critical theories such as new materialisms to various forms of community engagement and participant observation to software-aided qualitative and quantitative analysis of large data sets. Although we have experienced some tensions among methodological approaches in forums such as ARSTM preconferences and the Discourses of Health and Medicine Symposium, we echo Meloncon and Frost's observation that RHM scholars have embraced the "messiness" of methodological variation. They observe that, "Unlike the debates happening between medical humanities and health humanities about boundaries and territories (see Crawford, Brown, Naker, Tishcler, & Abrams, 2015), the rhetorics of health and medicine are comfortable navigating a myriad of sites and locations and texts" and "working with a host of actors within health care from patients to care givers and nurses to policy makers" (p. 8). Meloncon and Frost go on to explain how the "capaciousness" of rhetoric "affords scholars lots of room to maneuver and find their own voice, while still feeling as though they belong to a specific community. . . . Moreover, the capaciousness of rhetoric and the long standing belief that it is a useful tool in both creating and critiquing discourse helps us to mark the territory of the field" (p. 8).

At the same time that RHM has embraced the usefulness of various methodologies, research sites, and collaborators in knowledge making, we have also brought to bear our expertise in rhetorical theory and *techne* to make unique contributions to the study, understanding, critique, and engagement of health and medicine.

Several scholars have offered useful explanations of such rhetorical contributions. Echoing Burke, Keränen (2012) references our rhetorical expertise about "how specific symbolic patterns structure meaning and action in health and medical contexts and practices" (p. 37). In citing this point, Meloncon and Frost add that rhetoricians can also help explain how "discourses create situations and allow participants and users to act on them" (p. 8). Expanding on these depictions and on that offered by Malkowski et al. (2017), we characterize RHM as having several interrelated qualities:

- It focuses on the persuasive agents and functions of health and medical discourse, asking "who [or what] is persuading whom of what?" and "what are the means of persuasion?" (Derkatch & Segal, 2005, p. 139). In studying such phenomena, our field of inquiry recognizes rhetoric as constitutive action that works with other agents to shape phenomena and knowledge about them, and it draws on various theories of persuasion (from a number of rhetorical traditions, including interdisciplinary ones such as rhetorical-cultural theory) and various analytic approaches (from traditional rhetorical criticism to hybrid approaches that involve rhetorical and other types of analysis, such as qualitative and new materialist).
- Guided by a saturated attunement and responsiveness to the phenomena it studies, RHM is characterized by what we call a "methodological mutability"—a willingness and even obligation to pragmatically and ethically adjust aspects of methodology to changing exigencies, conditions, and relationships. In this volume, for example, both Pigozzi and Bivens discuss how they adjusted their informed consent processes and subsequent data collection methods based on their emergent sensitivity to research subjects' needs and wishes. Experimenting with new forms of mixed methodologies, and undertaking methodologies that involve layers of institutional approval, also sometimes prompt RHM scholars to adjust what they borrow, adapt, and implement as they go along.
- It poses what Segal calls "prior questions" about health and medical discourses and phenomena. Prior questions, Segal (2005) explains, take a step back from the procedural questions typically posed by health and medical experts and practitioners to inquire about what makes certain meanings possible in the first place.[1] In her rhetorical study of complementary

and alternative medicine (CAM), for instance, Derkatch (2016) supplements more common questions around how CAM research might lead to practice applications with the prior questions about how such research "presupposes" particular "models of practice" and thereby poses views of "patients as particular kinds of decision makers" (p. 191).

- It accounts for the mutual conditioning or interanimation of the discursive and material (e.g., forms of embodiment, technologies, objects) dimensions of health and medical practices, including what Hayles (1999) describes as a feedback loop between inscription and incorporation practices.[2] We can see such an accounting in the field's turn to new materialisms, such as Teston's (2016) study of how the "background" lab technologies for direct-to-consumer genetic testing products frame possible understandings and decisions of their users, as well as Graham's (2015) rhetorical-ontological inquiry into the materialization of pain science research, including the institutional "modes of calibration that bring together researchers and practitioners who subscribe to different approaches to pain" (p. 2).
- Relatedly, it resists simple claims about rhetorical agency, instead accounting for its distributed nature and indeterminacy in the face of biopower. We can see examples of such nuanced arguments in Angeli's (2015) study of distributed cognition and memory in emergency medical situations, and in Owen's (2015) discussion of how women's birth plans can be disregarded in institutional birthing settings but still enable a kind of self-educational empowerment.
- It typically examines the discursive-material practices of health and medicine as multilayered, or situated among and along multiple scales of context (e.g., historical, cultural, institutional, local, interpersonal). In *Our Bodies, Ourselves and the Work of Writing*, for example, Wells (2010) interprets the historical changes in and multilayered sponsors of and contributions to the collective's distributed writing practices. Increasingly, as in Bloom-Pojar's chapter in this volume, RHM studies are analyzing interworking transnational and local scales of influence.
- In addition to theories of persuasion and rhetorical analysis, it employs rhetorical *techne*—or the productive art of making and adapting knowledge—to study, make sense of, and in some cases suggest improvements to health and medical discourses. We can see this in Emmons' (2010) call for a "rhetorical care of the self," which encourages us to actively question and dialogue about the ways we are interpellated as self-regulating health consumers (p. 17). We can also see it in Reynolds, Mair, and Fischer's (1995) study of mental health records, presented so that mental health practitioners can better understand, assess, write, and make decisions about such records.
- It is explicitly interested, taking care to articulate the values and ideologies, ameliorative or otherwise, driving the inquiry and its methodologies, including the researcher's relative positionality. This is hardly surprising given that the exigency for much of this work comes from scholars' own experiences with illness and health care.

Segal (2009) references a "rhetorical frame of mind" that comes from a deep and disciplined study of rhetoric, a frame of mind that can attune scholars to pose "prior questions" about discursive practices, explain how they attempt to persuade, and assess their persuasiveness (p. 239). We would add here that for researchers of health and medicine, a rhetorical frame of mind includes being attuned not only to the available means of persuasion in the discourses we study, but also to the available means of inquiry and interpretation offered by various combinations of methods we might employ, based on the specific questions we ask and the concrete challenges of answering them. Unlike Segal (2005), we avoid the argument that rhetoricians of health and medicine necessarily use what has been traditionally identified as "rhetorical theory"; following Meloncon and Frost (2015), we want scholars studying persuasive discourse from a number of perspectives and traditions to feel at home in this field (p. 12). This preference for on viewing RHM scholarship more holistically and broadly allows us to see a fuller constellation of both scalable and mutable contributions to the emerging field, as well as to rhetorical studies and other areas.

Scalability becomes an important component to any emerging or new field because it enables the systematic and cross-pollinating growth of intellectual space, including methodologies. Over the last several years, this growth has already been evident as scholarship has moved into a myriad of new sites and locations to gather data around a vast array of discourses of health and medicine that represent an even broader set of voices, including many voices that had been previously unheard. Although RHM scholars have raised useful starting points for identifying our characteristic or common moves, these will be refined and extended as the field grows, largely through the work of younger scholars such as the ones contributing to this collection.

We believe it is important to include and even foreground the term "health" in RHM. Earlier versions of what might be called "medical rhetoric" scholarship tended to mirror rhetoric of science scholarship in focusing on the rhetorical production and reception of influential texts from biomedical research and clinical medicine. An emphasis on broader health practices foregrounds the myriad of actors (especially flesh-and-blood people) with varying relationships to and stakes in health, illness, and wellness rather than solely focusing on the medical establishment and the medical model of care. Segal (2009) documents how RHM grew from these roots to more broadly cover "health and illness more generally" (p. 227). We have since seen arguments for and examples of studying a "broad array of health publics, their *nomoi*, and their discursive practices, some of which only partially intersect with medical institutions" (Scott et al., 2013, pp. 1–2). In affirming this expansion of our scope to consider health-related practices more broadly, we find helpful Paula Treichler's (1999) analysis of AIDS discourses and constructions as illustrating a "continuum, then, not a dichotomy, between popular and biomedical discourses" (p. 15), and we would add between contexts marked as medical and people's everyday encounters with, experiences of, and negotiations of health and illness.

As we have indicated, the expanded scope of RHM scholars into broader health publics and practices has been accompanied by a proliferation of alternative and hybrid methodologies. We now turn to a more focused discussion of methodology in order to more fully discuss the implications of this development and to offer some modest recommendations for how our scholarship could explicitly address its multiple methodological dimensions.

Dimensions and Discussions of Methodology

Like Rickly (2007), we adopt Harding's (1987) notion of methodology as "a theory and analysis of how research does or should proceed" (p. 3), which Harding distinguishes from the more common notion of method as "a technique for (or way of proceeding in) gathering [and analysis] of evidence" (p. 2). Further, we embrace the importance of "messiness." Drawing on Law's concept of "mess in social science research," Rickly (2007) calls on teachers and scholars in composition, rhetoric, and technical communication to embrace methodologies that are "less static, less rigid, and more malleable" (p. 3). Given the high-stakes discursive-material practices, dynamics of (bio)power, and subjectivities taken up by our research, we think scholars of RHM are uniquely positioned to answer this call.

Scholars in RHM can heed Rickly's call, and the related exhortation by Sullivan and Porter (1997) to treat methodologies as rhetorical constructions and modes of invention (p. 10), by acknowledging and emphasizing in our publications and other accounts the rhetorical aspects of methodology in our research sites, processes, and interactions. Like rhetoric more generally, methodologies, Sullivan and Porter explain, involve three interrelated dimensions: *ideology*, or networks of values, assumptions, and concepts that guide interpretation; *practice*, or "how people actually do constitute their relations" through discourse; and *method*, or the "procedures, heuristics, or tools that people use for inquiry" (p. 10). They go on to point out that traditional discussions of methodology in rhetoric and composition overlook the first two dimensions, in the process de-emphasizing the rhetorical nature of methodology (p. 11).

Like Sullivan and Porter, we want to encourage a more explicit accounting for our methodologies, including their ideological and practice dimensions. One way of doing so is to think in ecological terms. In arguing for an alternative ecological understanding of research in writing studies, Fleckenstein, Spinuzzi, Rickly, and Papper (2008) critique the standard "container" metaphor shaping discussions of methods because it does not provide enough flexibility and attention to the way that research is actually conducted in complex, messy locations that include a number of actors and ideologies. If research is by nature messy, then a researcher's processes should be approached in ways that account for such messiness. The "container" lacks the dynamic and multifaceted nature of research, which is why Fleckenstein et al. argue for ecology "because an ecology, responsive to the ambient environment, evolves with that environment (p. 414). The ecology metaphor can account for the methodological experimentation and responsiveness to the complex phenomena and sites that scholars in RHM may study.

We also draw on Jeffrey Grabill's (2006) adaptation of Sullivan and Porter's framework to call for more discussions of research location and practice (see pp. 153–154). Grabill points to a number of practice-level interactions and negotiations that were at the heart of how he enacted his community-based research but that are "sometimes invisible given the ways we talk about methodology"; these include exigencies for initiating a study, gaining access to people and practices, "studying up" or learning about the issues and stakeholders, building relationships and negotiating power dynamics, facilitating participation of and communication among all those involved, and ensuring sustainable impacts (p. 161). Through such examples of research practices, Grabill suggests a view of methodology not just as a *techne*, or the contextually contingent production of knowledge guided by theories and principles (see Atwill, 1998), but also of *metis*, or the "cunning intelligence" enabling opportunistic and tactical responses to changing conditions (see Detienne & Vernant, 1991). Making our practices more transparent and thinking in terms of various ways to enact knowledge are critical methodological moves for studies in RHM.

Some (though certainly not all) RHM scholarship has conformed to scholarly conventions reinforcing one-dimensional, "cleaned up," "smoothed out," and somewhat detached accounts of methods, practices, and methodologies. This is unfortunate because the richness of such research and the complex problems and practices it engages beg for more robust discussions of guiding values and assumptions and more contextualized, opportunistic, and practice-level enactments and adjustments. At the same time, other rhetoricians (e.g., Fairhurst, 2014; Jacobs, 2012; Teston, 2012) are contributing a growing number of studies that offer richer accounts that uncover the nuances and complexities of research methodologies. For example, although they discuss their community-based fieldwork in Rwanda within such standard process "containers" as research design, data collection, and data analysis, and although they seem largely concerned with arguing for the validity of their approaches, Walton, Zraly, and Mugengana (2015) capture some of the messy contextual factors that led them to make such adjustments as ensuring participant confidentiality, expanding the scope of transcription notes, and experimenting with creative forms of sharing initial findings. We hope this collection contributes to alternative conventions that encourage open and concrete discussions of the how, why, and effects of our messy, context-responsive decision making, such as opportunistic workarounds of access challenges or ethically driven adjustments to participant engagement. For additional models of scholarship attuned to the messiness of research, we can also look to other health-related disciplines. For example, public health scholars Dickson-Swift, James, Kippen, and Liamputtong (2007) interviewed 30 qualitative health researchers to gain a better understanding of the challenges they faced. Their findings indicated a myriad of problems, ranging from building rapport with

participants to ethical considerations in coding data to the self-care needed to consistently engage such high-stakes topics.

Too little attention is given to documenting and explaining decisions made during the research process; in studies of health and medicine, where researchers are often faced with unexpected, high-stake, and emotionally challenging situations, this type of vulnerability, reflection, and frankness is perhaps needed more acutely. Yet exposing the values, practices, adjustments, problems, and messiness of research will be crucial to helping rhetoricians of health and medicine, along with any collaborators, enter into and work with complex research sites.

Turn to Mixed Methodologies

Over the past 15 years or so, published RHM studies have increasingly included discussions of and rationales for mixed methodologies—in terms of humanistic and social scientific research practices, guided and grounded research design, indirect and direct engagements of research "subjects," useful and applied research implications, etc. This is not to say that studies drawing more squarely on one disciplinary tradition and methodology have not made important contributions to RHM. But many RHM scholars have found that multiple methodological approaches and methods for collecting, analyzing, and otherwise engaging phenomena and "data" about them are needed to understand and tackle health and medicine's "wicked problems" (i.e., complex and ill-defined problems that resist transferrable and sustained solutions; see Conklin, 2005). Because "meaning and knowledge making can come from traditional (e.g., scientific studies) and nontraditional sources (e.g., online patient communities)" RHM scholars must employ a number of ways of accessing and engaging such sources (Meloncon & Frost, 2015, p. 8).

Meloncon and Frost (2015) point out that many who position their work in RHM view their methodologies as "inter-, cross-, and trans-disciplinary," emphasizing that such work can still contribute to more field-specific conversations and understandings (p. 11). The authors "encourage a more active and critical engagement in both the practice (our teams and in authorship) and in scholarly orientation (reading across boundaries)" of such work (p. 11). In order to answer rhetorical questions about health and medicine's discursive-material practices, RHM scholars have turned to various scholarly traditions—perhaps most notably the rhetoric of science and technology, technical and scientific communication, critical/interpretive health communication, STS, disability studies, and the medical and health humanities. Accordingly, RHM scholars have also incorporated and merged from these traditions a number of approaches to defining scope and foci, accounting for historical and cultural "contexts," identifying and engaging rhetorical actors or actants and their relationships, positioning themselves, collecting and analyzing "data," and presenting their analyses and arguments. We can see different combinations of these approaches—all of which use rhetorical theory to make

sense of and explain persuasive practices—in rhetorical historiography (Johnson, 2014), rhetorical-cultural analysis (Scott, 2003), cultural-historical activity theory (Bellwoar, 2012), critical contextualized transnational analysis (Ding, 2014), rhetorical-ontological inquiry (Graham, 2015), feminist methodologies and disability studies (Elmore, 2013; Moeller, 2014), grounded rhetorical-genre analysis (Teston, 2009), genre-based discourse analysis (Schryer, McDougall, Tait, & Lingard, 2012), participatory rhetorical analysis (Lay, 2000; Kuehl & Anderson, 2015), and community-based participatory research (Zoller & Meloncon, 2013). RHM studies can and do define the aims and scope of their research in various ways; collect data through archival, qualitative, quasiethnographic, and/or quantitative methods; and move deductively, inductively, and/or abductively in their analysis.

Grabill argues that attending to the rhetorical nature of methodology can be a "mechanism for rhetorical agency with a research project" (p. 151). We add that fuller accounts of methodology, mixed or otherwise, can similarly promote research agency, particularly for other scholars who seek to understand the how and why of conducting RHM research. Such attention would involve more than a drive-by summary of methods, narrowly defined, but would entail a more thorough and nuanced explanation of the exigencies, values, epistemological assumptions, limitations, affordances, and adaptations of methodology. This would help to contextualize and show the power of RHM scholarship to various audiences, and, just as importantly, it would provide exemplary models for training and teaching other rhetorical scholars.

Another way such studies could broaden their usefulness and agency is by achieving a version of what Barton (2001) calls "disciplined interdisciplinarity." Barton borrows this term from Klein to call for observational studies of medical discourse that contribute to both medicine and language studies and that are guided by the prospective design principles of representativeness and generalizability. We could extrapolate from her call a broader one to integrate (rather than just assemble) different approaches around "points of mutual interest" with the aim of producing knowledge recognizable and valued by the different scholarly areas (p. 314). We add that such contributions might also be recognizable and valued by health publics, health and medical policymakers and practitioners, and other stakeholders involved.

Theory Building as Methodology

Theory building is another way RHM and the studies in this collection can develop sustainable scholarship and advance Leach and Dysart-Gale's (2010) call to form a "corpus of rhetorical analysis in health and medicine for use by scholars and students" (p. 8). A more expansive view of methodology accounts for theory in several ways—as part of an ideological network of interpretation, as a tool for analysis, and as a product of a study, as with methodologies employing grounded theory. We argue that theory building should be recognized as an important

methodological goal and practice for RHM scholarship, and that it should not be viewed as antithetical to our area's careful attention to context-specific embodied and material practices. Indeed, without an inventive approach to theory, we lose our ability to notice different things in familiar phenomena and sites, and to make sense of the happenings in less familiar sites. Further, foregrounding theory-building elements of our methodologies can help us avoid too-simplistic assumptions about the roles and limitations of theory in rhetorical analysis, grounded theory, and other approaches, while simultaneously encouraging more specific explanations of such approaches. In other words, theory building gives a necessary force to our existing methodologies that encourages and supports alternative and innovative ways of doing the work of research.

In her discussion of "how to have theory in an epidemic [of AIDS]," Treichler (1999) exhorts scholars to recognize that "[a]t the end of the day, theory is another word for intelligence, that is, for a thoughtful and engaged dialectic between the brain, the body, and the world that the brain and the body inhabit" (p. 6). In this way, she adds, theory is a lens for understanding and interpreting "people's lives" (p. 6), including how signification, representation, persuasion, and other functions of language "facilitate and constrain" our meaning-making and embodied experiences. Theories of rhetoric, or the persuasive use of language, can be especially powerful, given that language "is one of the most significant ways we know reality, experience it, and articulate it" (p. 8). Although he doesn't reference theory building explicitly, Dolmage (2014) goes further to suggest that theory and interpretation are forms of care, stating "to care about the body is to care about how we make meaning" (p. 4).[3] In her review essay arguing for the value of critical affect theory to rhetorical studies, Rice (2008) proposes that such theory can help us tap into and examine "the physical life of social bodies," such as the transmission of anxiety or love among bodies (pp. 202–203), as well as "language beyond official content," or the nonexpressive and nonrepresentational ways that people intimately experience the effects of social language (pp. 208–209). Rather than eliding embodied experience, then, theory can be a means of thoughtfully attending to and caring for it.

Drawing on these observations, we want to advance a view of theory as a framework for thinking, feeling, interpreting, and creating—as a mode of inquiry that can help us pose questions, discern language's functions and impacts, and provisionally help us know. This expands the familiar notion of theory as a "tool to think with" by incorporating affective elements of meaning making and by acknowledging theory-building as a fuller methodology with guiding values. Further, theory—and theory building as a process—can function as frameworks for caring and inventing more beneficial experiences and interactions with health and medicine. In other words, theory building can also be seen as a framework for imagining a better world.

In discussing theory building in empirical rhetoric and composition research, Schriver (1989) foregrounds the ideological dimension of such research, stating

that "All empirical work is a subjective and social act, influenced by particular communities' belief systems, work agendas, and assumptions about what is important to study" (p. 273).[4] In casting empirical research as a creative, rhetorical practice, Schriver points out several types of theory-building moves, including the following:

- "Making [and testing] speculations based on existing theory" with new research (i.e., data collection and analysis);
- Developing theory to explain and test a new, surprising observation;
- Reexamining a theoretical framework and its assumptions after "[n]oticing an incongruity in the way an interpretive community conceptualizes" the framework;
- Proposing alternative explanations through different or modified theories, and conducting research "designed to discriminate among the theories";
- Using an analogy or metaphor to explain a phenomenon; and
- Reconsidering "aesthetic issues [e.g., clarity, simplicity] of an existing theory" (pp. 280–281).

We would add these theory-building approaches:

- Noticing and addressing interpretive gaps or "blind spots" of an existing theoretical framework;
- Extending a theoretical concept by fleshing out its nuances and contingencies; and
- Bringing together and relating or merging frameworks or concepts from different theoretical traditions.

We think several of these moves can also apply to RHM scholarship that is not primarily empirical, including historical, rhetorical-cultural, and mixed-method studies. In addition, some studies employ more than one of these theory-building moves, even if they do not explicitly identify such moves.

We want to echo Schriver's caution that theory-building contributions, like those of other methodologies, include "guarded claims and qualified conclusions" that are grounded in the systematic, reflective, and careful examination of discourse and other phenomena, and that avoid exaggerating the interpretive value of a particular theory (p. 274). Molloy (2015) offers a noteworthy example of such methodological care in her field study of the day-to-day social-rhetorical interactions of people with chronic mental illnesses at an outpatient facility. Through thoughtfully designed and adjusted on-site observations and interviews with participants, Molloy developed the notions of "recuperative ethos" and "agile epistemologies" to understand and value the rhetorical performances of outpatients as efforts to recover credibility and "productively disrupt underestimations" of their "rhetorical ability" (p. 144). Instead of only applying classical

rhetorical, vernacular, and multiple ontologies theory, she substantively *adapts* it, building new, more nuanced concepts with more specific explanatory power for the interactions under study—not to mention a new understanding of rhetorical agency. In highlighting her values of reducing "stigma's menacing effects," Molloy ends with the modest suggestion that her concepts and focus on overlooked sites of vernacular interactions might be useful to other studies of protected and stigmatized patient populations, but hopes that such studies "sharpen the definitions of these terms and that their continued refinement is informed by everyday talk from diverse participants who would otherwise remain unheard" (p. 160). Another noteworthy example of theory building, and one derived from historical research, is Jensen's (2010) study of sex education rhetoric. As Jensen (2015) explains in a follow-up article to her book, her research examines Progressive Era arguments for "social hygiene" education to "situate and categorize contemporary arguments about sex education curricula" and to qualitatively study such arguments, including the ways they argue for comprehensive sex education using "science-based appeals" (p. 524). By making cross-historical speculations based on existing theories of rhetorical ecologies, and by fleshing out more specific ways rhetorical ecologies function, Jensen develops what she calls a "percolation model" of rhetorical ecologies, which explains how "historical arguments about health percolate up at distinct, chronologically disjointed moments" (p. 524).

Rhetoricians of health and medicine should continue to traffic in a variety of theoretical traditions, whether by testing, extending, adapting, complexifying, merging, distinguishing contributions among, and/or proposing alternatives to theories and concepts. Promising directions for theory building in RHM include but are not limited to the following: ways to identify and engage health and medicine's stakeholders (e.g., Scott, 2014; Lawrence, Hausman, & Dannenberg, 2014; Pigozzi, this volume); ways to explain the rhetorical circulation and transformation of health and medical discourses and practices (e.g., Bellwoar, 2012; Ding, 2014; Johnson, this volume); ways to account for the possibilities and limitations of participants' rhetorical agency in the face of biopower and "rhetorical disability" (e.g., Owens, 2015; Koerber, 2013; Molloy, 2015; Bivens, this volume); ways to account rhetorically for health and medicine's material and affective dimensions (Graham, 2015; McNely, Spinuzzi, & Teston, 2015; Edwell, this volume); and ways to define and attend to the ethics of health and medicine research and practice (see Meloncon & Frost, 2015, p. 11; Opel, this volume). Regardless of its various trajectories in RHM, we hope theory building as a methodology will be approached as continuing rather than having an end point, as pluralistic rather than canon forming, as measured and nuanced rather than universalizing and flattening, and as ethically responsive rather than self-indulgent.

Overview of Chapters

The volume features chapters drawn from larger, ongoing studies by both well-established and younger, emerging scholars. The volume's chapters address a range

of methodological questions through which RHM has been shaped, including (but not limited to) questions about

- how to account for the sometimes unpredictable circulation and uptake of health and medical rhetoric;
- how to engage health and medical practices and their stakeholders ethically and responsively;
- how to foreground our contributions in collaborative research involving health and medical professionals and publics; and
- how to build new hybrid concepts with explanatory power for both rhetoric and for health and medicine.

Because each chapter includes an abstract, we will introduce the rest of the collection not by offering chapter summaries but by discussing examples of common methodological and topical threads. Although we attempt to point to a range of examples for each thread, these are meant to be illustrative rather than comprehensive; readers will undoubtedly find additional examples across other chapters.

First, the chapters in this collection *leverage and integrate conversations and methodologies from various traditions*, but in ways that *suit the specific phenomena under study and, often, that extend conversations across multiple domains*. One especially inventive example of this is Gouge's discussion of patient noncompliance, which merges ideas from rhetoric, disability and queer theory, feminist new materialisms, and urban design to argue for valuing and flexibly responding to patients' divergent paths or behaviors as rhetorical responses; her research has implications for RHM scholars but also health care experts working on the wicked problem of noncompliance. Through an extended historical example of how proteins became an important health concept and category, Johnson uses infrastructure theory to explore the "background resources" that shaped the rhetorical knowledge work of nutrition research and nutritional consumer information. Hartzog analyzes how the genetically modified mosquito functions as a rhetorical boundary object for negotiating tensions by malaria researchers; her analysis not only couples the rhetorical notion of *topoi* with the sociological notion of boundary object to understand rhetorical tensions in health-related malaria research, but also serves as a case study for negotiating tensions and forging productive boundary spaces between the RHM and the rhetoric of science and technology (RST). In his chapter, Gruber extends work on neurorhetoric—which "evaluates the potential for new brain findings to contribute to rhetorical theory"—to discuss how rhetoricians might work on cross-disciplinary projects that more playfully "expose alternative material realities ultimately benefitting both neuroscience and rhetoric." In order to reprioritize and reinfuse the material body and embodied experience in RHM research, Meloncon develops the interdisciplinary approach of "performance phenomenology," which integrates phenomenology's emphasis on first-person lived experience with performance theory's emphasis on the actions and relational interactions of embodied beings like patients and providers.

Second, the chapters in this collection attempt to *foreground methodology in its multiple dimensions*. They feature *explanations of research exigencies and the values undergirding their research questions, designs, and interpretations*, with some guided by the social justice concern with ensuring the agency of the most vulnerable. To illustrate this emphasis in terms of research values, Pigozzi, in her discussion of participatory research involving a local Latino/a community, discusses ethical principles and cultural knowledge crucial to negotiating informed consent with participants, particularly when they have "therapeutic misconception" about their potential benefits from participation. Bivens similarly emphasizes the ethics of informed consent, discussing how she watched and listened for "microwithdrawals of consent" by new mothers in neonatal intensive care units. In her compilation of ethical concerns for researching health care in networked digital contexts, Opel emphasizes the values of protecting vulnerable populations, anticipating and defining possible harms contextually, and consulting a number of sources beyond review boards in ethical decision-making. Happe calls on communication scholars (including rhetoricians) researching racial disparities in health to replace starting with "race" as a static analytic concept with accounting for race and racialization as shaped by communication in specific contexts; offering an example of a "prior question," Happe illustrates this shift by preceding the goal of crafting better health campaign messages for different groups of women with the question of how health communication shapes identity-based group membership in the first place.

In addition to foregrounding methodological values, the chapters in this collection *argue for and/or enact exposing the messy, "behind the scenes" decision-making, negotiation, and adjustments of their methodologies in action*. Some chapters go further in also providing new rhetorical *techne* or heuristics for planning and conducting methodological practice. Gruber calls for an approach to neurorhetorics that embraces a playful, wild, or messy methodological pluralism that does not "overlook [or hierarchize] how multiple approaches change what is seen, how it is seen, how it is written, and why." Both Pigozzi and Bivens discuss ways they adjusted their informed consent process and data collection in response to the unique circumstances and needs of their participants. Angeli also foregrounds the ways she adjusted her data collection, in this instance due to the challenges of identifying the most important regulatory stakeholders and getting permission from multiple IRBs to conduct some of her planned observations. In discussing examples of her "assemblage mapping" and offering readers a step-by-step guide for making their own, Angeli also shows how such tools for determining institutional relationships and entry points were created out of and can shape the changing dynamics of research practices. Like Angeli, Edwell offers readers a heuristic to guide methodological practice, in her case around the process of researching "emplaced" rhetoric, including demarcating "site" boundaries and determining modes of experiencing place(s). Beyond the multiple historical lenses they explain, Wells and Stormer offer several strategies and resources for doing historical work which counter the logistical challenges around accessing protected information in archives.

Instead of or in addition to tools for planning and implementing methodological approaches, other chapters *build and contribute revised or new theories or conceptual resources*. Gouge repurposes the urban landscape notion of "desire lines" to theorize patients' divergent responses to treatment plans and protocols as rhetorical enactments of emergent knowledge and agency rather than "things to fix." In his chapter, Ehrenfeld develops the concept of "ecological investment" to capture how the "constituent parts of complex ecologies seem to 'invest' in the maintenance of . . . infrastructures" supporting the circulation of medical rhetoric, and how specific rhetors also invest in these infrastructures, thereby "altering the[ir] embodied, material relations." One of the exigencies for developing this concept, Ehrenfeld explains, was the limitation of existing theories to account for and situate an individual rhetor's contributions to and agency in rhetorical ecologies; another exigency was to historically complicate the too-simple ways that notions of rhetorical ecologies have "functioned as universalizing [rather than historically specific] metaphors." Other examples include Bivens' notion of "microwithdrawals of consent" to capture the embodied signals of participants that require consent to be constantly negotiated, Bloom-Pojar's notion of "vernacular medical terminology" as a way to value the lay translingual discourse of patients and communities, Gruber's notion of "neuro-rhetorical performance" as a cross-disciplinary invention practice, and Johnson's notions of "republication" and "translation" to trace and explain the invisible work of creating or changing an infrastructure to support health knowledge.

Another way the studies in this collection reflect and extend the larger body of RHM work is by *incorporating into their analyses multiple layers and scales of health and medical practices, contexts, and influences*. In his rhetorical-historical study of Dr. Emma Elizabeth Walker's social hygiene lectures in the early 20th century, Ehrenfeld turns to models of ecology and circulation to capture the relationships between Walker's health promotion rhetoric and cultural forces (e.g., "obscenity laws, habitation patterns, utopian movements, professional medical communities") that shaped the ecology in which this rhetoric circulated. In their chapter, Wells and Stormer argue persuasively that, in its increasing focus on contemporary issues, RHM is losing the rich knowledge, conceptual resources, and methodologies that historical studies and historiography offer. In addition to providing resources for making knowledge and persuading from both familiar and strange historical practices, they explain, historiographic methods can "situate the present as a historical moment" by bringing together materialist, axiological, practical, analogical, and cultural viewpoints that enable a dialogue between the present and the past.

Some chapters study local health and medical practices as also having transnational or transcultural dimensions. For example, Bloom-Pojar interprets the translingual health practices of a clinic in the Dominican Republic as transculturally

situated, both in terms of the transnational group of providers, translators and other helpers, and patients, but also in terms of the different cultural sites and sources of language-use in and around the locale. Such transcultural dimensions were reflected in the different types of Spanish spoken (e.g., "professional, American, Dominican, campo, and medical"). Bivens explains how her attunement to patients' microwithdrawals of consent in her study of a Danish neonatal intensive care unit prompted her to change the way she negotiated consent in a follow-up study at a similar U.S.-based site. In her analysis of global malaria research, Hartzog analyzes how global malaria researchers "employ strategies of boundary work to demarcate a certain set of behavioral and taxonomic characteristics that they see as relevant to the control of malaria," thereby creating an inventional framework that replaces the more established *topos* of "evolutionary relatedness" of mosquito species with that of "vector capacity." One reason we decided against grouping these chapters into a discrete "global" section was to signal that transnational and transcultural work should be embedded throughout the fabric of RHM rather than existing in a single thread.

A number of chapters *develop new concepts and approaches for studying the mutually conditioning relationships between discursive and material (e.g., forms of embodiment, technologies, environments, objects) constituents of health and medicine*, with several contributors spotlighting embodied subjects and experiences in their studies and methodological arguments. Edwell's methodology for emplaced rhetorics, for example, goes further than contextualizing symbolic representation by making the interaction of bodies in spaces and environments the primary object of study. Bivens' studies carefully attends to the ethics of collecting data in sensitive research spaces and in response to embodied acts of microwithdrawal. As suggested by her title of "Bringing the Body Back," Meloncon's methodology most intensely prioritizes the body and embodied performance in both research practices and publications, particularly at the level of "the small agencies, the small moments, the small feelings." For her part, Happe critiques the material effects of research assumptions and approaches that essentialize race by displacing historical, contextualized communication processes and behaviors.

Finally, a thread of *ethical concerns* is woven through several of the chapters. Opel explains how research ethics need to be updated when moving into online settings. In addition to synthesizing relevant ethical considerations, she offers a case study that illustrates the nuances of an updated orientation to Health 2.0. Both Meloncon and Gouge provide theoretical orientations that include ethical dimensions as major exigencies for theory building. Bivens, Pigozzi, Angeli, and Edwell all explicitly discuss enactments of ethical responsiveness when they describe their methods, practices, and ideologies. In short, this volume provides an up-to-date view on the importance of ethics in RHM research.

Although the volume's chapters have multiple points of convergence, we have ordered them to create the following conversational progression: 1) exploring the roles and forms of historical inquiry (Wells & Stromer; Ehrenfeld; Johnson) since in some ways this has been and should continue to be the foundation of the field; 2) reframing key research concepts, particularly around forms of embodiment (Happe; Meloncon; Gouge); 3) developing more contextually attuned and responsively ethical research practices (Bivens; Edwell; Opel), and including more fully participatory ones (Angeli; Pigozzi; Bloom-Pojar); and 4) positing new relationships between RHM and other fields (Hartzog; Gruber).

Through the various methodological contributions we've been overviewing, the chapters in this collection offer a version of what Hartelius calls "sustainable scholarship," advancing the larger goal of recognizing RHM as a pragmatically multifarious and discernable area of study that can inform rhetorical studies and other areas, such as the medical humanities, medical education, health communication, health policy-making, medical research, and the practice of medicine. Although we believe, and have tried to explain and show how, RHM scholarship has developed a somewhat unique combination of methodological orientations, we also echo Scott et al.'s (2013) hope that our emergent field will "carve out an expansive focus on the exigencies, functions, and impacts of health-related discourse; attend to the movement, surrounding networks, and ecologies of this discourse; and work with other scholars/researchers, both inside and outside disciplinary rhetorical studies, toward a variety of goals" (p. 1). We offer this collection as an advancement of this hope—one that foregrounds methodology in the richness of its multiple dimensions.

Notes

1 We might relate this approach to what Teston (2016), citing Michael Lynch, describes as rhetorical ontography, which "inquires into how, when, and for whom such questions become important or come to be asked in the first place" (n.p.).
2 Hayles (1999) explains that "changes in experiences of embodiment bubble up in language" while, at the same time, "discursive constructions affect how bodies move through space and time" (pp. 206–207).
3 We thank Catherine Gouge for making and sharing this observation with us.
4 Schriver (1989) goes on to mention another aspect of some empirical research that often gets de-emphasized in published overviews of studies' methods—the alternate use of inductive and deductive inferencing, the latter guided by theoretical propositions and concepts (p. 280).

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