Special Issue Introduction

Charting an Emerging Field: The Rhetorics of Health and Medicine and Its Importance in Communication Design

Lisa Meloncon
University of Cincinnati
Meloncon@tek-ritr.com

Erin A. Frost
East Carolina University
froste@ecu.edu

ABSTRACT
The introduction to this special issue on the rhetorics of health and medicine charts the formation of an emerging field and its importance to communication design.

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The introduction to this special issue on the rhetorics of health and medicine charts the formation of an emerging field and its importance to communication design. In today's often bewildering world of scientific, technological, cultural, and political change, health and medicine faces human problems and possibilities that transcend traditional academic disciplines and boundaries. For many years, an often-overlooked aspect of health and medicine was the communicative dimension, that is the discourses—oral, written, visual, and technological. When we speak of discourses, we are thinking about lab notes, case reports, electronic medical records, patient notes, regulatory documents, insurance claims, online health information, patient education materials, and pharmaceutical advertisements, to name but a few. Because of its everydayness, the written and verbal exchanges between patients, doctors, providers, administrators, and other such stakeholders is often overlooked. In large part, however, these exchanges and other forms of communication are one of the most important dimensions of health and medicine, particularly when considering how to improve patient care and to encourage greater participation in prevention and wellness programs.

In recent years, health communication has grown in visibility because of the proliferation of technologies and the ease at accessing information. The federal government finally recognized the importance of health communication "as a critical area," in the renewal of Healthy People 2020 (U.S. Department of Health and Human Services, 2014). In addition, the formation of the non-profit, Patient-Centered Outcomes Research Institute (Patient-Centered Outcomes Research Institute, 2015), the continuation of the federal Agency for Healthcare Research and Quality (U.S. Department of Health and Human Services, 2015), and initiatives such as the Institute for Patient- and Family-Centered Care (Institute for Patient- and Family-Centered Care, 2015) all demonstrate the need for experts who work on the discourses produced in health and medicine.

The ongoing emphasis on communication at the national, governmental level mirrors an increasing interest at the academic level. Barton (2005) noted "the research literature of medicine is vast, even in the area of medical communication, with work in a wide variety of fields, including history, sociology, anthropology, linguistics, literature, communication studies, and behavioral science" (p. 245). In the ten years since Barton's statement, scholarly investigations have not only continued in these areas, they have grown in the areas directly related to the readership interests of CDQ. Scholars in communication, technical and professional communication, and rhetoric and composition have recognized that we have the potential to play increasingly important roles on interdisciplinary health research teams, to help improve patient-centered language and practices across a multitude of media and document types, and to contribute to solving such problems as the health literacy crisis that leaves some 90 million Americans unable to process the most basic health information (Berkman, Sheridan, Donahue, Halpern, & Crotty, 2011).

Part of our roles as scholars is to also bring into focus that health and medicine are an important aspect of culture because "[i]n establishing the power of the norm, medicine is a crucial discipline, because medical knowledge mediates between the order of the body and the order of society" (Mol, 2002, p. 60). This order is maintained through multiple types and kinds of communication practices and products. What rhetorical studies have taught us is that the discourses produced in health and medicine "not only deliver information, they structure it as well" (Derkatch & Segal, 2005, p. 139). As such, communication about health and medicine is ever more important in shaping our understandings of our cultures, our politics, and ourselves.

Because of its importance, we wanted to chart the current landscape and diversity of work being done around issues of health and medicine. We both knew of a lot of interesting work going on, but we wanted to craft a call that was inclusive of this diversity in theoretical or methodological orientation and to a diversity of method. We had few expectations of what we may or may not receive as far as submissions were concerned. But once the call closed and we started reading the submissions, we realized that this issue would help to broadly define an emerging research area.

RHETORICS OF HEALTH AND MEDICINE: A BRIEF HISTORY

In the 2013 commentary in Poiroi, Scott, Segal, and Keränen advocated for naming this emerging field: rhetorics of health and medicine (n.p.). They called on scholars to use this name to help identify and build a body of scholarship. While all names can inspire dialogues and strong opinions, we are situating this special issue under this larger umbrella. One of the binding approaches to the essays presented in this special issue and to a larger body of scholarship is the focus on "how specific symbolic patterns structure meaning and action in health and medical contexts and practices" (Keränen, 2012, p. 37). Moreover, scholars are attempting to understand how the discourses create situations and allow participants and users to act on them, as well as constitutive aspect as to how these discourses create and perpetuate situations.

What we, and Scott, Segal and Keränen, are referring to as the rhetorics of health and medicine has a longer history under different names. The longest traditions are found in Communication studies where "health communication" has had a scholarly publishing presence since the late 1980's. The journal, *Health Communication*, started in 1989 and is now published 10 issues a year. But like many research areas health communication research is not a singular monolithic entity as evidenced by the analysis of the articles published in the journal (Kim, J.-N., Park, S.-C., Yoo, S.-W., & Shen, H, 2010).

Emerging areas of research can often be tracked through special issues of journals, much like this very one. In 2000, Heifferon and Brown guest edited an issue *Technical Communication Quarterly* and in 2005 Barton followed with one in the *Journal of Business and Technical Communication* and a topical focus in *Writing Communication* in 2009. In 2014, Keränen edited an issue of the *Journal of Medical Humanities* on with an emphasis on publics. What helped to feed this work was a group of scholars who sought each other out. Scholars have continued to meet at special interest groups, pre-conferences, and other events, and in 2013 the first stand-alone conference was held at the University of Cincinnati, Discourses of Health and Medicine (http://medicalrhetoric.com/

symposium), which was an impetus for this journal issue.

It was also during the 2000s that the first monographs appeared (Bennett, 2009; Berkenkotter, 2008; Scott, 2003; Segal, 2005; Stormer, 2002). By 2010, the field was beginning to see a steady rise in the number of books across a range of subjects. For example, we have produced a handful of books looking at topics associated with gender such as depression (Emmons, 2010), breastfeeding (Hausman, 2011; Koerber, 2013), and childbirth (Seigel, 2013; Owens, 2015). We have added theoretical dimensions (Fountain, 2014; Graham, 2015), and we have examined genes and cells (Happe, 2013; Hyde & Herrick, 2013; Lynch, 2011); intercultural issues, (Ding, 2014), disability (Meloncon, 2013; Walters, 2014), and mental health (Johnson, 2014). Two edited collections that afford a range of approaches and topics also appeared which helps to frame the field to those unfamiliar with it (Heifferon & Brown, 2008; Leach & Dysart, 2010).

The field's production is more impressive when the books are read alongside the growing number of articles. While rhetorical analysis can take on a number of forms, we have examined specific rhetorical features such as tropes and figures (Angeli, 2012; Jensen, 2015; Popham, 2014) and appeals (Kopelson, 2013; Molloy, 2015), as well as attention to narrative (Arduser, 2014; Segal, 2012; Teston et al., 2014). We continue to investigate genre (Schuster et al, 2013; Schryer et a. 2012; Skinner, 2012), to look at visual dimensions (Donovan, 2014; Welhausen, 2015), to reflect on methods (Angeli, 2015; Meloncon, 2013; Teston 2012), and to consider the public and political aspects of discourse (Arduser & Koerber, 2014; Derkatch & Spoel, forthcoming; Welhausen & Burnett, forthcoming; Lawrence, Hausman & Dannenberg, 2014).

We also have a growing body of work in online health communication (Arduser, 2011; De Hertogh, 2015; Grant, et al., 2015; Koerber & Still, 2008; Kopelson, 2009, Moeller, 2014, Owens, 2011, Segal, 2009). Finally, scholars are producing interesting case studies that interpret language and communication around specific topics, such as specialized providers (Burleson, 2014), obesity (Guthman, 2013), pain (Graham & Herndl, 2013), vaccines (Lawrence, 2014), patient use of information (Bellwoar, 2012), and literacy (Willerton, 2015).

The vitality of this scholarship underscores the vitality of the emerging field, but it also illustrates one of the problems. That is, scholarship is spread across numerous journals that in some cases aren't well known outside of the narrow disciplines or specialties we sometimes inhabit. But, the importance of sketching out this bibliographic history is to set the stage for the importance of the articles collected here. This issue marks another moment in the scholarly history of this emerging field. In doing so, we openly acknowledge that there is not consensus on what to call this emerging field. We have chosen to advance the rhetorics of health and medicine simply because we—those of us involved in this enterprise—need to settle on some term that we can rally around and consistently use and mark what we do, even as we still debate it.

Unlike the debates happening between medical humanities and health humanities about boundaries and territories (see Crawford, Brown, Baker, Tischler, and Abrams, 2015), the rhetorics of health and medicine are comfortable navigating a myriad of sites and locations and texts to destabilize the paradigmatic privilege of doctor and patient. We are comfortable working with a host of actors within health care from patients to care givers and nurses

to policy makers. Moreover, rhetoricians of health and medicine understand that meaning and knowledge making can come from traditional (e.g., scientific studies) and non-traditional sources (e.g., online patient communities).

One of the reasons that we make this move is because we are comfortable with the humanistic emphasis implicitly, if not explicitly, associated with rhetoric. While some may argue that we need to only focus on "health," the inclusion of both terms allows the field to prioritize the humanistic viewpoint, while also signifying the critical gaze we offer to the physician centric point of view and the influence of the biomedical institution and industrial complex. There is a driving need to better understand the human side of health care through a variety of disciplinary perspectives that are most notably humanistic and social science in orientation. "The knowledge the humanities offer us is like no other, and cannot be replaced by scientific breakthroughs or superseded by advances in material knowledge" (McClay, 2008, p. 38). For example, a patient with a terminal illness may rely on science through medications and treatments to help alleviate symptoms and discomfort. We have a long history of evidence that pain medications can educe discomfort in patients, but this is a distinctively scientific view. What the humanistic aspect of it can bring is an understanding of how a patient reacts to and experiences both the pain and the medication in her daily life and also how her experiences effect those around her. This understanding advances knowledge by providing insights into the human condition, its perseverance, its dignity in times of distress, and this knowledge can potentially improve end of life discussions as well as decisions and the types and kinds of medication used to prolong life. Issues of quality of life are distinctively humanistic is within the realms of the rhetoric of health and medicine.

There is also a capaciousness to rhetoric that affords scholars lots of room to maneuver and find their own voice, while still feeling as though they belong to a specific community. A variety of approaches can find there way under the tent of rhetoric of health and medicine including disability studies, feminist approaches, visual communication and rhetoric, theoretical approaches from science and technology studies, quantitative approaches, as well as textual and qualitative approaches from scholars in sociology, anthropology, literature, history, and art. 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.

This issue is a perfect example of this staking out a territory. The essays included (discussed in the next section) illustrate the wide variety of approaches that can be taken. However, what binds the diverse texts and approaches together is their emphasis on understanding the contextual situations of the discourse and understanding what those contexts (including language, place, people, and actions) mean for health and medicine.

When we speak of humanistic and rhetorical, one of the defining features of that orientation is the potential and possibility of affecting change. Rhetoric of health and medicine also has an applied component that appeals to many scholars who what to influence the delivery of care and potentially improve patient and community outcomes. Particularly in health and medical discourse, opportunities exist for research—such as that presented here—to make significant change. Take for example the ongoing emphasis in health literacy and the need to improve all sorts of communication

channels for patients. McNaughton, et. al., (2015) discovered that patients with low health literacy who had suffered acute heart failure were 35% more likely to have died within 21 months after hospitalization. To move to another example, research on poor information design of medication leaflets and labels (Dickinson, Teather, Gallina, & Newsom-Davis, 2010) has potential to enable improved health outcomes through increased health literacy. It is in this practical focus that the rhetorics of health and medicine most directly align with work occurring in communication design.

Rhetoricians of health and medicine can potentially expand the scope to how discourse is created, used, disseminated, and also critiqued. We offer a unique viewpoint on how to communicate and educate. We want to expand the sometimes myopic vision that generally plagues the current medical system where patients, families, care givers, and others views are often discounted in favor of a positivist hierarchical view that doctors and science are the only viewpoints that matter. By upsetting that paradigm, rhetoricians of health and medicine, and their scholarship, can directly intervene into many of the problems plaguing our health care system.

VISION FOR THE ISSUE: BREADTH OF AN EMERGING FIELD

We had few expectations when we sent out he call for the special issue. By that we mean, we did not have a preconceived idea of what types of kinds of essays that we would include. The one thing we did know as we were working through the task of selecting proposals was that we wanted to find a diverse range of voices and/or topics. We wanted to have representation from across the different disciplines and fields working in the rhetorics of health and medicine, as well as a diverse range of topics and approaches. Thus, we opted to go with the concept of breadth rather than depth around a specific topics, idea, or methodological approach.

In addition to deciding our broad approach, we made several other decisions that merit mentioning. As is a general standard, essays were blindly reviewed by two other scholars, one that was considered an expert in the subject matter of the essay and a more general reviewer from the CDQ reviewer pool. We took this approach because we wanted to present a collection of essays that would appeal to those who identify as working in the rhetorics of health and medicine, while also showing the importance of the breadth of the work in this area for broader audiences. As we discuss in the next section when we introduce the essays, we hope CDQ readers can see how the methodological choices and methods used in the rhetorics of health and medicine have much to offer back to the multiple audiences who read this journal.

The essays included here explicitly and implicitly point to different ways that ideas, texts, methods, practices, and technologies work in a variety of healthcare contexts, and more importantly, how that information is designed. The essays also bridge theory to practice. While often accused of being esoteric or disconnected, theory provides scholars the opportunity to view the world differently, and in doing so to offer ways to improve situations or to invoke action. In the case of health and medicine, the scholastic emphasis and unifying feature of looking at discourses—written, oral, visual, material—means that our theoretical orientations can work toward improving the function and use of those same examined discourses.

Finally, focusing on breadth of the emerging field enables us to emphasize the possibilities of the field and what it is capable of

doing. Most scholars working in this area would describe the work they do as being applicable to "real-world" contexts in ways that other scholarship may not be. In thinking through issues of what it is that we do and what our work is capable of doing, the essays in this issue provide a landscape of possibilities and potential.

INTRODUCTION TO THE ESSAYS

Health and medicine practice and care takes place in a variety of locations, but rhetoricians have been slow to take up the examination of actual places. "There is a rich and growing body of research across social, cultural, and health geographies that makes space for and foregrounds place in much more explicit ways and the situated nature of being and becoming urgently require the theoretical insights of those who specifically focus on the nature of space and place" (Atkinson, Foley, & Parr, 2015, p.2). In an answer to this need, we have the international perspective of Connellan (Art, Architecture, and Design), Riggs (Social Work and Social Planning), and Due (Pscyhology), who take us on a critical tour of a mental health facility in Australia by examining the mental health physical space from the perspective of glass. They ask the provocative question of whether glass can speak? After a short history of architecture, they offer insights from their ethnographic study and show how glass can be a medium for communication. In the call for papers for this issue, we encouraged submissions that were not traditional and pushed the limits to how we think about discourse. This essay does that, and we encourage readers to take their questions, insights, and analysis as a way to encourage innovative considerations of material aspects of spaces. More specifically, this essay can prompt (re)considerations of the materiality of the spaces and the impact those spaces have on the communication design of discourses in health and medicine.

Moving to a different kind of space, there are three essays that are inter-related—Lazard & Mackert, Mogul & Balzhiser, and Burleson—around issues of online space. These essays take up the issue of online health information from different, yet complementary perspectives. Lazard and Mackert provide a comprehensive review and synthesis of literature about how to design online health information. They only focused on the theory-driven and tested research, and they found that the design principles, which directly impact increased attention, favorable evaluations, and greater information processing abilities, include: web aesthetics, visual complexity, affordances, prototypicality, and persuasive imagery. Their discussion of these topics should be a starting place for online health communication design in the coming years.

Following Moeller's (2014) call for more historical examinations of online information, Mogul and Balzhiser evaluate direct-to-consumer pharmaceutical advertisements, and their analysis provides an important case study on why rhetorical analysis is needed, while also pointing to how healthcare consumers are created. Burleson's empirical study on 17 websites if top hospitals specifically takes on how they communicate with their patients through an in-depth look at the role of hospitalists. It will probably come as no surprise that Mogul and Balzhiser and Burleson find that there is much room for improvement, which opens up space and exigency for the work of communication designers.

In an entry written by a new scholar, Novotny offers the case study of reVITALize Gynecology infertility initiative, a health intervention project, to illustrate the expansion of the feminist research approaches. Novotny's analysis of the reVITALize

initiative illustrates that public stakeholder input is vital to health intervention projects. By using a feminist approach, Novotny shows that while the initiative appeared to welcome public participation, it was in fact limiting their participation. A strength of Novotny's essay is its ambitiousness in combining theoretical orientations to expand the way research is currently done.

While Novotny's essay shows the limitations of health intervention, Kuehl and Anderson's case study illustrates both successes and failures. In their essay, Kuehl and Anderson analyze how a hospital designed public communication through promotional efforts regarding their no-cost, volunteer doula program. Using the rhetorical concepts of presence and absence, their analysis found a number of communication design ideas that worked successfully, while also finding and recommending ways to improve the material. In some ways, this essay complements Lazard and Mackert by providing specific ways to improve communication design. Read together, Novotny and Keuhl and Anderson offer examples of ways to incorporate theoretical models into the analysis and design of health and medical discourse.

Finally, Atvgis et al. take us in another direction to the rural areas of West Virginia as they report on assessing the accuracy of a trauma patient protocol system, M.I.S.E.R (Mechanism of injury, Injury to the patient, vital Signs, Environment, and Response to treatment). Acronym based protocol systems are design to reduce error in a crisis communication situation, and Atvgis et al. set out to use M.I.S.E.R. to increase the efficiency of communication from field personnel (e.g., paramedics) to medical command (e.g., those at the receiving hospital). Their findings show that different combinations of technology and media do effect the transmission of information. As a data driven case study, this essay provides of model of field based research methods that improved the design of communication through detailed data analysis. While some may push back against quantitative studies, Atvgis et al. demonstrate the value of a different kind of humanistic approach.

All of the essays directly and indirectly implicate the importance of care. In a recent commentary, St.Amant (2015) declared, "in many ways, medical and health information connects to one central principle: care" (p. 39). Care is a great way to center and help contextualize what it is that we do, and the approach to care would be a distinctly humanistic enterprise, that is, in helping us understand the deeply human aspects of what it means to be a patient or care giver or any other person within the health care system and what those people experience in that system. "Care is integrated with and arises from relationship—in the knowing and feelings of others. Therefore, considerations of care are bound up in epistemological concerns and cannot be easily segregated from human experience" (Hamington, 2004, p. 33). This is what we do as researchers quite well. Connecting our work to care and empathy illustrates the importance of the rhetorics of health and medicine as key to understanding or to gaining insights into what it means to experience the healthcare system.

Care is an important concept that provides a unifying point across disciplines and approaches. Jones (2013), a designer, recently wrote a practiced based book, *Design for Care*, which argues that design practices and methods can improve healthcare. Jones claims that design and designers are essential to improving healthcare to enable "better communication, understanding, and knowledge transfer between healthcare fields and work experiences" (p. xvi), which is not so different than the aims of researchers and practitioners in

the rhetorics of health and medicine and in communication design. Jones' stance lacks an awareness of the writing and communication research that is essential to his achieving his own goals, but he does acknowledge that "design, in all of its disciplines and methods, is finally emerging in new and influential roles in all types of healthcare services" (p. xvi).

Thus, what is useful about Jones' work broadly is that it opens up a space for communication design to intervene in healthcare. These essays, as representatives of the rhetorics of health and medicine, are examples of the type of everyday communication design interventions that can impact patients directly. What communication design from a rhetorical perspective can offer healthcare is a focus on patient experience, which includes an empathic focus found through our methods. To talk of communication design as it relates to health and medicine is not a new or novel approach. But what is particularly important about the essays in this issue is how they intervene into existing conversations in design and in medicine.

Health information must be timely, accessible, accurate and understandable. The proliferation of information found online and accessed via mobile devices increases this demand. Thus, research at the intersection of communication design and the rhetorics of health and medicine, such as evidenced here, is focused on patient experience and improving the design of information. Improved communication design can help patients

• Better understand their own health and treatment

• Maintain their own health records

• Facilitate care options by participating in shared decision making

Patients who can understand, maintain, and facilitate their care more easily could potentially achieve two important goals in healthcare: getting better outcomes for patients through compliance, particularly for patients with chronic conditions, and reducing overall heath care costs.

The rhetorics of health and medicine bring a unique viewpoint to bear on the numerous discourses—written, visual, verbal, technological, or material—produced in health and medicine and that viewpoint exposes how discourse helps and hinders the delivery and consumption of care.

LOOKING FORWARD

We hope that the essays here offer the opportunity for reflection on the breadth of the work being done in the rhetorics of health and medicine and how this emerging field is complementary to communication design. The essays in this issue are examples of the many directions that scholars can take to build on and to extend, and as we come to close this introduction, we leave you with additional thoughts on where we should go next.

While we were received a host of proposals for this issue and we are also aware of numerous ongoing projects, we were surprised and are surprised at the dearth of work that is specifically taking up the issues of ethics. It could be that we have an implicit ethical stance in all of our work, but our research allows us to intervene comfortably in ethical discussions, particularly the growing conversations about bioethics.

Another direction of new engagement that is critical and not yet receiving the attention it is needs is technology and its impact on and in health and medicine. Hausman (2014) merges together feminist approaches with critiques of technology in her examination of the visualization of fetuses, and it signals the ripe ground ready for exploration. Following sociology (see Lupton, 2014), scholars could examine areas such as wearables (there is an upcoming *Rhetoric Society Quarterly* issue on this topic that includes a rhetoric of health and medicine perspective), the impact of EHRs, big data, and the influence of technology on agency, to name but a few.

One area that the rhetorics of health and medicine can contribute back to other related fields and disciplines is in our work with methodologies and methods. The essays in this issue took on a number of methods and methodological orientations. However, potential also lies in thinking through our methodological approach of entering specific sites and locations by using the insights from Smith's (2012) work with indigenous peoples. While Novotny's essay gives us a take on feminist methods, we feel there is also an underexplored dimension to what a feminist orientation can offer to the way we research in the rhetorics of health and medicine. For example, feminist perspectives reveal insights into ideological perspectives of the other that are extremely important in a healthcare industry that maintains persistent hierarchies and classes.

Another area in need of additional work is with regard to theory. While there are some great models on what theory can bring to research in this area (see Scott, 2003), we could benefit from a closer alignment with critical theory (see Zoller, 2005), queer theory, and disability studies, as well invoking a theoretical stance to understand communication design in different ways. Kuehl and Anderson's use of presence and absence from rhetorical theory opened up new avenues in the way information could be designed more effectively. Looking to these theoretical approaches can help the emerging field be more critically aware and push against normative and hierarchical discourses found not only in the medical encounter but also found in community based research or locations of health disparities.

We also need to consider engagement with different types of evidence, communities, patients, and other active participants in healthcare, and we need to determine ways to move the work we do across disease domains. Both of these push the established boundaries, but if accomplished will allow the field to have an impact. For example, will our findings hold up when we use the same approach in another area? Can we port the approach to one particular subject to other areas? What are the stakes if we can or if we can't? These sorts of questions about the broader implications of our research are the logical next steps in research as our canon builds.

Many readers of this journal and those in the rhetorics of health and medicine will claim to be inter-, cross-, and trans-disciplinary, and we want to encourage a more active and critical engagement in both the practice (our teams and in authorship) and in scholarly orientation (reading across boundaries). This is not a call to end disciplines; it's actually the contrary. Collaborative work across disciplines brings insights that a single view cannot, which is something evident in Lazard and Mackert's cross-disciplinary investigation into "best practices" of online health communication design. We need to embrace this as we move forward and more importantly, to write about it—both the good and the bad and the ugly of the research process and the findings.

We need to focus specifically on what it means to work in the area of rhetorics of health and medicine and how those of us who may not take a completely "rhetorical" approach can still feel at home. The inclusion of the piece by Atvgis and colleagues illustrates that there are similarities in research methods and methodologies even when the authors themselves may not consider their work rhetorical. But what was striking about Atvgis et al. was their considerations of the final outcomes and how to improve patient care in rural settings, which is similar to approach and implications as Angeli's (2012) work in emergency medical services. In other words, there is an approach and orientation that moves us past defining what we do through a singular term, but engaging in conversations about boundaries, definitions, and what it is that we really do keep a field vital and flourishing.

We want to encourage scholars in this area and considering working in this area to critically engage with the growing body of scholarship that already exists. Even though it may true that many specific sites and case studies are unique, it is likely that those sites and the findings do connect in some ways to existing scholarship. We would question the premise that there's "nothing on my topic" in the literature. By taking the time to engage with and find the similarities with existing scholarship, we can grow a rich and rigorous body of work quicker, and that work will have a greater chance of having an impact across disciplines, within medical care, and potentially, on patient outcomes.

There are also rich opportunities to more explicitly merge together communication design and the rhetorics of health medicine. Not only through examining visuals (see citations in the "History" section), but a more involved examination of how user experience intersects with patient centered-care. For example, what would each field gain by invoking the scholarship

Ultimately, we hope that this special issue will inspire future conversations. Communication design can benefit from the perspective of the rhetorics of health and medicine, and health and medicine in general need communication design and the rhetorics of health and medicine. We want to encourage useful conversations and disagreements that lead to intellectual ambitiousness and that open detailed, critical dialogue about the work we do, but also, a critical and reflective approach to just doing the work we do. Scott, Keränen, and Segal (2013) called on scholars to name their work and advocate for defining a scope of research. This introduction and issue are an extension of their call. We would take it one step further to claim that there is a field of rhetorics of health and medicine and work toward building a meaningful, connected canon that has direct and relevant connections to communication design. This issue is a step in that direction.

REFERENCES

Angeli, E. (2012). Metaphors in the Rhetoric of Pandemic Flu: Electronic Media Coverage of H1N1 and Swine Flu. Journal of *Technical Writing and Communication, 42(3),* 203-222. doi:10.2190/TW.42.3.b

Angeli, E. L. (2015). Three Types of Memory in Emergency Medical Services Communication. *Written Communication, 32 (1),* 3-38.

Arduser, L. (2011). Warp and Weft: Weaving the Discussion Threads of an Online Community. *Journal of Technical Writing and Communication, 41(1)*, 5-31.

Arduser, L. (2014). Agency in illness narratives: A pluralistic analysis. *Narrative Inquiry, 24(1),* 1-28.

Arduser, L., & Koerber, A. (2014). Splitting women, producing biocitizens, and vilifying obamacare in the 2012 presidential campaign. *Women's studies in communication, 37(2),* 117-137.

Atkinson, S., Foley, R., & Parr, H. (2015). Introduction: Spatial Perspectives and medical humanities *Journal of Medical Humanities, 36(1),* 1-4.

Barton, E. (Ed.) (2005). The Discourses of Medicine [Special issue]. *Journal of Business and Technical Communication, 19(3),* 245-248.

Bellwoar, H. (2012). Everyday Matters: Reception and Use as Productive Design of Health-Related Texts. *Technical Communication Quarterly, 21,* 325-345.

Bennett, J. (2009). *Banning queer blood: Rhetorics of citizenship, contagion, and resistance.* Tuscaloosa, Al: University of Alabama Press.

Berkenkotter, C. (2008). *Patient tales: Case histories and the uses of narrative in psychiatry.* Columbia, Sc: University of South Carolina Press.

Berkman, N. D., Sheridan, S. L., Donahue, K. E., Halpern, D. J., & Crotty, K. (2011). Low Health Literacy and health outcomes: An updated systematic review. *Annals of Internal Medicine, 155,* 97-107.

Burleson, D. (2014). Communication Challenges in the Hospital Setting: A Comparative Case Study of Hospitalists' and Patients' Perceptions. *Journal of Business and Technical Communication, 28(2),* 187-221.

Crawford, P., Brown, B., Naker, C., Tishcler, V., & Abrams, B. (2015). *Health Humanities.* Basingstoke, Hampshire: Palgrave Macmillan.

De Hertogh, L. B. (2015). Reinscribing a new normal: Pregnancy, disability, and health 2.0 in the online natural birthing community, Birth Without Fear. *Ada: A journal of gender, new media, and technology, 7*, n.p.

Derkatch, C., & Segal, J. Z. (2005). Realms of rhetoric in health and medicine. *University of Toronto Medical Journal, 82(2)*, 138-142.

Derkatch, C., & Spoel, P. (in press). Public Health Promotion of Local Food': Constituting the Self-Governing Citizen-Consumer. *Health: An interdisciplinary journal for the social study of health, illness, and medicine*, in press.

Dickinson, D. P. S., Teather, J., Gallina, S., & Newsome-Davis, E. (2010). Medicine package leaflets: does good design matter? *Information Design Journal, 18(3),* 225.

Ding, H. (2014). *Rhetoric of a global epidemic.* Carbondale, Il: Southern Illinois University Press.

Donovan, C. (2014). Representations of health, embodiment, and experience in graphic memoir. *Configurations, 22(2),* 237-253.

Emmons, K. (2010). *Black dogs and blue words: Depression and gender in the age of self-care.* New Brunswick, NJ: Rutgers University Press.

Jones, P. H. (2013). *Design for care: Innovating healthcare experience*. Brooklyn, NY: Rosenfeld Media.

Fountain, T. K. (2014). *Rhetoric in the flesh: Trained vision, technical expertise, and the gross anatomy lab*. New York: Routledge.

Graham, S. S. (2015). *The politics of pain medicine: A rhetorical-ontological inquiry.* Chicago: University of Chicago Press.

Graham, S. S., & Herndl, C. (2013). Multiple Ontologies in Pain Management: Toward a Postplural Rhetoric of Science. *Technical Communication Quarterly, 22(2)*, 103-125.

Grant, L., Hausman, B. L., Cashion, M., Lucchesi, N., Patel, K., & Roberts, J. (2015). Vaccination Persuasion Online: A Qualitative Study of Two Pro-vaccine and Two Vaccine-Skeptical Websites. *J Med Internet Res, 17(5),* e133.

Guthman, J. (2013). Fatuous measures: the artifactual construction of the obesity epidemic. *Critical Public Health, 23(3)*, 263-273.

Haas, C. (Ed.) (2009). Writing and medicine [Special issue]. *Written Communication, 26(3).*

Hamington, M. (2004). *Embodied care: Jane Addams, Maurice Merleau-Ponty, and Feminist Ethics*. Urbana, Il: University of Illinois Press.

Happe, K. (2013). *The material gene: gender, race, and heredity after the Human Genome Project.* NY: New York University Press.

Hausman, B. L. (2003). *Mother's milk: Breastfeeding controversies in American culture.* New York: Routledge.

Hausman, B. L. (2010). *Viral mothers: Breastfeeding in the age of HIV/AIDS*. Rochester, MI: University of Michigan Press.

Hausman, B. L. (2014). Public fetuses. In T. Jones, D. Wear, & L. D. Friedman (Eds.), *Health Humanities Reader.* New Brunswick, NJ: Rutgers University Press.

Heifferon, B. (2014). A History of Medical Rhetoric in Technical and Professional Communication Programs. Paper presented at the *Council of Programs in Scientific and Technical Communication* Colorado Springs, CO.

Heifferon, B., & Brown, S. (Eds.)(2000). Medical rhetoric [Special issue]. *Technical Communication Quarterly, 9(3).*

Heifferon, B., & Brown, S. C. (Eds.). (2008). *Rhetoric of healthcare: Essays toward a new disciplinary inquiry.* Cresskill, NJ: Hampton Press.

Hyde, M., & Herrick, J. (Eds.). (2013). *After the genome: The language of our biotechnological future*. Waco, TX: Baylor University Press.

Institute for Patient- and Family-Centered Care. (2015). Retrieved from http://www.ipfcc.org/

Jensen, R. E. (2015). From barren to sterile: The evolution of a mixed metaphor. *Rhetoric Society Quarterly, 45(1),* 35-46.

Johnson, J. (2014). *American Lobotomy: A rhetorical history.* Ann Arbor, MI: University of Michigan.

Keranen, L. (2012). "This weird, incurable disease": Competing diagnoses in the rhetoric of morgellons. In T. Jones, D. Wear, & L. D. Friedman (Eds.), *Health Humanities Reader* (pp. 36-49). New Brunswick, NY: Rutgers University Press.

Keranen, L. (Ed.) (2014). Medicine, Health, and Publics [Special issue]. *Journal of Medical Humanities, 35(2).*

Kim, J. N., Park, S. C., Yoo, S. W., & Shen, H. (2010). Mapping health communication scholarship: breadth, depth, and agenda of published research in Health Communication. *Health Communication, 25(6-7),* 487-503.

Koerber, A., & Still, B. (Eds.) (2008). Online Health Communication [special issue]. *Technical Communication Quarterly, 17(3)*, 259.

Koerber, A. (2013). *Breast or bottle: Contemporary controversies in infant-feeding policy and practice.* Columbia, SC: University of South Carolina Press.

Kopelson, K. (2009). Writing Patients' Wrongs: The Rhetoric and Reality of Information Age Medicine. *jac: A journal of rhetoric, culture, & politics, 29(1-2)*, 353-404.

Kopelson, K. (2013). Risky Appeals: Recruiting to the Environmental Breast Cancer Movement in the Age of "Pink Fatigue". *Rhetoric Society Quarterly, 43(2)*, 107-133.

Lawrence, H. Y. (2014). Health bodies, toxic medicines: Vaccination beliefs and the rhetorics of health, illness and the body. Yale J*ournal of Biology and Medicine, 87(4),* 423-437.

Lawrence, H. Y., Hausman, B. L., & Dannenberg, C. J. (2014). Reframing medicine's publics: The local as a public of vaccine refusal. *Journal of Medical Humanities, 35(2)*, 111-129.

Leach, J., & Dysart-Gale, D. (Eds.). (2010). *Rhetorical questions of health and medicine*. Lanham. MD: Lexington Books.

Lupton, D. (2014). Beyond Techno-Utopia: Critical Approaches to Digital Health Technologies. *Societies, 4(4)*, 706-711.

Lynch, J. (2011). *What are stem cells? Definitions at the intersection of science and politics.* Tuscaloosa, AL: University of Alabama Press.

McClay, W. M. (2008). The burden of the humanities. *Wilson Quarterly, 32(Summer)*, 34-41.

McNaughton, C. D., Cawthon, C., Kripalani, S., Liu, D., Storrow, A. B., & Roumie, C. L. (2015). Health literacy and mortality: a cohort study of patients hospitalized for acute heart failure. J *Am Heart Assoc, 4(5).*

Meloncon, L. (Ed.) (2013). *Rhetorical accessability: At the intersection of technical communication and disability studies.* Amityville, NY: Baywood.

Meloncon, L. (2013). Visual communication in environmental health: Methodological questions and compromises. *Communication Design Quarterly, 1(2)*, 34-37.

Moeller, M. (2014). Pushing boundaries of normalcy: Employing critical disability studies in analyzing medical advocacy websites. *Communication Design Quarterly, 2(2).*

Molloy, C. (2015). Recuperative Ethos and Agile Epistemologies: Toward a Vernacular Engagement with Mental Illness Ontologies *Rhetoric Society Quarterly, 45(2),* 138-163.

Owens, K. H. (2011). Rhetorics of e-Health and information age medicine: A risk-benefit analysis. *jac: A journal of rhetoric, culture, & politics, 31(1-2)*, 225-234.

Owens, K. H. (2015). *Writing childbirth: Women's rhetorical agency in labor and online*. Carbondale, Il: Southern Illinois University Press.

Patient-Centered Outcomes Research Institute. (2015). *Home - PCORI.* Retrieved from http://www.pcori.org/

Schryer, C., McDougall, A., Tait, A. R., & Lingard, L. (2012). Creating Discursive Order at the End of Life: The Role of Genres in Palliative Care Settings. *Written Communication, 29(2),* 111-141.

Schuster, M. L., Russell, A. L. B., Bartels, D. M., & Kelly-Trombley, H. (2013). "Standing in Terri Schiavo's Shoes": The Role of Genre in End-of-Life Decision Making. *Technical Communication Quarterly, 22(3), 195-218.*

Scott, J. B. (2003). *Risky rhetoric: AIDS and the cultural practices of HIV testing.* Carbondale, IL: Southern Illinois University Press.

Scott, J. B., Segal, J. Z., & Keranen, L. (2013). The Rhetorics of Health and Medicine: Inventional Possibilities for Scholarship and Engaged Practice. *Poroi, 9(1)*, Article 17.

Segal, J. Z. (2005). *Health and the rhetoric of medicine.* Carbondale ILL: Southern Illinois University Press.

Segal, J. Z. (2009). Internet Health and the 21st-Century Patient: A Rhetorical View. *Written Communication, 26(4)*, 351-369.

Segal, J. Z. (2012). Breast cancer and its narration: An accidental study. *Literature and Medicine, 30(2)*, 268-294.

Seigel, M. (2014). *The rhetoric of pregnancy.* Chicago: University of Chicago Press.

Skinner, C. (2012). Incompatible Rhetorical Expectations: Julia W. Carpenter's Medical Society Papers, 1895–1899. *Technical Communication Quarterly, 21(4),* 307-324.

Smith, L. T. (2012). *Decolonizing methodologies: Research and indigenous peoples* (Second ed.). London: Zed Books.

St.Amant, K. (2015). Culture and the contextualization of care: A prototype-based approach to developing health and medical visuals for international audiences. *Communication Design Quarterly, 3(2)*, 38-47.

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

Teston, C. (2012). Considering confidentiality in research design: Developing heuristics to chart the un-chartable. In K. Powell & P. Takayoshi (Eds.), *Practicing research in writing studies: Reflexive and ethically responsible research* (pp. 307-330). Cresskill, NJ: Hampton Press.

Teston, C., Graham, S. S., Baldwinson, R., Li, A., & Swift, J. (2014). Definitional multiplicity: Negotiating 'clinical benefit' in the FDA's Avastin hearing. *Journal of Medical Humanities, 35*, 149-170.

U.S. Department of Health and Human Services. (2014). Health Communication and Health Information Technology. In *Healthy People 2020*. Retrieved from http://www.healthy-people.gov/2020/topics-objectives/topic/health-communication-and-health-information-technology

U.S. Department of Health and Human Services. (2015). *Agency for healthcare research and quality*. Retrieved from http://www.ahrq.gov/

Walters, S. (2014). *Rhetorical touch: Disability, identification, haptics*. Columbia, SC: University of South Carolina Press.

Welhausen, C. A. (2015). Power and Authority in Disease Maps: Visualizing Medical Cartography Through Yellow Fever Mapping. *Journal of Business and Technical Communication, 29(3)*, 257-283.

Welhausen, C., & Burnett, R. E. (in press). Visualizing Public Health Risks: Graphical Representations of Smallpox in the Seventeenth, Eighteenth, and Nineteenth Centuries. In C. Kostelnick & M. Kimball (Eds.), *Visible numbers: The history of statistical graphics.* Farnham: Ashgate.

Willerton, R. (2015). *Plain language and ethical action: A dialogic approach to technical content in the 21st century*. New York: Routledge.

Zoller, H. M. (2005). Health activism: communication theory and action for social change. *Communication Theory, 15(4)*, 341-364.