Rhetoric of Health & Medicine
Vol. 7, No. 4, pp. 365–370
DOI: 10.5744/rhm.2024.2613

The Waiting is the Hardest Part

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As we prepared volume 7 issue 4 of *RHM* for publication, we found ourselves in the throes of concurrent familial health crises. In Kim's case, her husband was told that he had an aggressive form of rectal cancer after a routine colonoscopy and would likely require chemo, radiation, and surgery, though he would need a series of tests and consultations with specialists to determine precise next steps. In Cathryn's, a loved one's mental health was in acute crisis, and she and her family waited for news on abysmally inadequate residential treatment options. While the two situations bore very little similarities in terms of potential prognoses or treatments, both cases left us deeply immersed in something that many readers know well—when facing such things, the waiting for the outcome can be the most difficult thing: Waiting for appointment dates to arrive, waiting for various test results to be released, waiting for support services to come through, waiting for visiting hours to open, waiting to see some improvement, waiting to hear from a specialist, waiting to talk with a care team, waiting to see if a different treatment or medication or surgical procedure "takes" —so much waiting. And these forms of waiting, naturally, are quite different from more benign, annoying kinds, like waiting for a package to arrive or waiting in a long line at the airport security gate or even waiting for a care provider to join you in the room while you sit there in the paper gown under the strange, insect-like din of halogen lighting. This kind of waiting spans and seems to consume whole days, weeks, even months.

Health and medical waiting means waiting to know what life will look like in the coming months and years, or waiting to know if life can even continue at all. It's waiting to make any further plans; it's subjugating all else under this new and pressing "what next." Bryna Siegel Finer (2023) expressed the agony of how time changes in the throes of illness. As she explained, her cancer diagnosis came with a long line of phone calls informing her of various appointments. "No one asked what my calendar looked like or if I was available to do these things," she bemoaned, and even when waiting for the various parts of a treatment protocol to fall into place, "life continues to go on. Your alarm goes off in the morning and you get out of bed. You continue to put laundry in the washing machine, to feed the dog, to go through all the minutiae of life" (p. 94).

The extremely relatable experience of waiting "for potentially threatening medical test results" is "paradoxically when patients are least likely to be receiving formal interventions owing to the practical and cost implications of organizing support during the brief weeks of a medical waiting period," explained Jacky Bolvin and Deborah Lancastle (2010, p. 67). What's worse, they lamented, is that "patients are often told to 'stay positive' or 'not think about it' without evidence that doing so would help, or guidance about how one should go about achieving these states" (p. 68). While very little exists in terms of empirically proven ways to cope with this kind of waiting, Henrietta DL Ockhuijsen, Agnes van den Hoogen, Nickolas S Macklon, and Jacky Boivin (2013) found that positive reappraisal, or "a set of strategies in which the significance of the event is reinterpreted in a more positive way" (p. 6) is one of the only coping mechanisms that has shown to increase wellbeing during stressful periods of medical waiting. That is, when patients are asked to think about their current medical predicament as a natural or even necessary part of their life story, that tactic has been found to be somewhat helpful.

Likewise, there is often a disconnect between what patients and families perceive as unacceptably long periods of waiting and what healthcare providers perceive. For those who work in healthcare directly, noted Leslie Rittenmeyer, Dolores Huffman, and Chris Godfrey (2014) "waiting is part of the culture, and is considered routine and normalized," yet for patients and their families, waiting is "personal, fearful and sometimes tortuous," and can be accompanied by "feelings of frustration and anxiety"—something that they argued can be addressed through empathic intervention (p. 218).

What seems clear in all the (admittedly slim) literature on waiting in medical contexts is that it is an undertheorized area, and more work could be done to develop patient-centered approaches to easing the psychological burden on patients and their families as they perform interminable waiting. As individuals with recent experience with this waiting, who also co-edit a rhetoric of health and medicine journal, we wonder: How can rhetorical frameworks in health and medicine work toward better supports for patients and their families? And how can what is learned in health and medical contexts about support influence the ways that other periods of waiting are theorized and supported, such as, for example, waiting on decisions in academic publishing?

By the time Kim and her family learned that her husband had been misdiagnosed and that he had a less aggressive form of cancer that would not necessitate the life-altering surgery, grueling chemotherapy, or rigorous radiation that had been forecasted, they'd spent several weeks waiting for scans, results, appointments, and tumor board conferences—all while agonizing over the situation and the potentially worse news to come. At the time of this writing, Cathryn's family is still wading through seemingly endless waiting. CE Mackenzie (2022) argued in volume 4 issue 4 of this journal that traditional healthcare "has privileged the cured condition," which can take attention away from "the temporal uncertainties of the moment" and ignores that "human experience hums within the mess of now, that we may or may not arrive at scripted destinations" (n.p.). The contents of volume 7 issue 4 similarly showcase the novel thinking and vast terrain that RHM research takes on, and we hope that these studies inspire expansive new work in the field, including engagements with time and temporality that take up waiting. Our own recent, agonizing experiences with waiting have been lightened by reading and editing such strongly creative engagements with difficult-to-penetrate health and medical topics. This work gives us hope.

In this issue:

In the lead article for this issue, Christa Teston and Addison Torrence share the results of a scoping study they conducted that examined recent rhetoric of health and medicine (RHM) research article publications that predate the *RHM* journal. Relying on a corpus of 250 articles published in various venues from 2006 to 2020, they examine RHM researchers' methodological and evidential choices and compare the contents of the corpus to newer RHM research. Comparisons such as theirs, the authors argue, promise to clarify the ways that RHM scholars have worked to make their research more durable, portable, and responsive to critically important issues. Their work presents an excellent model for future researchers interested in conducting scoping studies in the field. Indeed, they make their analytic protocol and corpus available for researchers interested in expanding on the work they've done. Notable for its methodological innovations as well as its findings, this article would make an excellent addition to courses in the rhetoric of health and medicine as well as in research methods in writing studies, technical communication, and communication studies.

Next, we are very pleased to include another example of a rigorous and interesting methodological approach—Kristin Kondrlik and Cara Byrne's "We can be heroes: Identification, superheroes, and the visual communication of agency in online children's books about COVID-19." In this article, the authors examine 147 children's picture books about COVID-19. Arguing that children must, of course, rely on adults in their lives to interpret health information, their analysis reveals the ways that these documents overpromise agency to children who too often do not have the capacity to make health decisions on their own. Showing how the texts rely on identification, the authors caution that using identification to instantiate health behaviors in children fails to acknowledge children's limited agency, does not go far enough in stressing the risks associated with infection, and obscures scientific discourses. Their analysis asks readers to meditate on the ways that public health messaging fails when it overemphasizes individual decision-making at the expense of communally-driven ideas.

We are also fortunate enough to have Jennifer Edwell's essay "Religion and RHM: Protestantism, Theo-Moral Physiology, and the Conception of the Premature Infant" in this issue. Delving into the underexplored area of religion and its applicability to the rhetoric of health and medicine, Edwell specifically reflects on the role Protestantism has played in the invention of the premature infant as a medical figure in the United States. Demonstrating that discourses surrounding premature birth are diffuse with Protestant rhetorics and beliefs, she coins the term "theo-moral physiology" to account for religiously-informed medical understandings. Cautioning RHM scholars against the impulse to conceive of the rise of

American biomedicine as a secular project, her work in this essay demonstrates how modern medicine has evolved in ways that are deeply enmeshed with contemporary religion.

Also in this issue, Megan Poole, Shavonnie Carthens, Eboni Neal Cochran, and Abigail Koenig delve into the critical realm of environmental justice concerning public health. Their focus is on the feminist coalition, Air Justice, which emerged with the aim of advancing environmental health literacy and simplifying public notices into easily understandable language. By examining this organization, the authors explore the concept of health literacy as a social activity facilitated by diverse intersectional alliances. This perspective offers rhetoric of health and medicine (RHM) scholars a localized scholarly approach that mirrors the complex and varied contexts of the communities with which they engage.

We are also happy to include Josh Chase's review of *Strategic Interventions in Mental Health Rhetoric,* edited by Lisa Melonçon and Cathryn Molloy,[1] which demonstrates the value of the book across disciplinary subfields, observing that it adds to "the growing body of scholarship on the rhetoric of health and medicine (RHM), mental health rhetoric (MHR), and mental health rhetoric research (MHRR)." Chase points out that the book grapples with how mental health is dealt with publicly and within various academic contexts. Across its seventeen chapters, the book draws on a wealth of (inter)disciplinary knowledge and considers the contexts of discourse and culture to offer a variety of rhetorical interventions that could improve mental health management.

Finally, Joe Hatfield's provocative review of Alexandre Baril's *Undoing Suicidism* will offer readers an opportunity to reflect on an incredibly fraught topic. In a potentially incendiary argument, the author contends that a focus on prevention undercuts the agendas meant to help suicidal people and that doing more to support assisted suicide as an option could be a better avenue—one that could even save lives. While this argument is a difficult one for us to fully embrace, the review helps us think about the ways that oppressive structures limit the care that those with suicidal ideations are able to access.

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[1] *RHM* co-editors give the Reviews Editor full control over book reviews and neither select the content for review nor oversee the process of editing reviews.

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