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WHERE CAN HEALTH COMMUNICATION BE FOUND?

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On the face of it, "health communication" seems to be an obvious field of research with sites easily located throughout our society. One need only open the doors of a doctor's office or enter the corridors of a hospital to discover an abundance of symbolic interaction; but is this health communication?

There is increasing evidence that the activities at these sites have very little to do with improving the health of America's people. For example, Duncan Neuhauser (1974) of the Harvard School of Public Health finds that the marginal health value of added medical care is zero. Herman Somers, in the 1975 Eilers Memorial Lecture, concludes that in terms of dealing with our mortality rates, "The availability of medical care is clearly not the problem." Victor Fuchs, the economist, finds in his study titled Who Shall Live? (1974) that health impacts of new medical inputs are very slight and concludes that "the greatest current potential for improving the health of the American people is to be found in what they do and don't do for themselves." Anne Somers (1972) notes that "most of the nation's major health problems--automobile accidents, all forms of drug addiction including alcoholism, venereal disease, obesity, many cancers, most infant mortality--are primarily attributable not to shortcomings of (medical) providers but to living conditions, ignorance, or irresponsibility of patients. No amount of additional funding or even reorganization of the (medical) delivery system is likely to have much impact on this problem (p. 161)."

In view of these findings, it would seem questionable to characterize symbolic interaction in medical settings as the principal data for health communication studies. Indeed, if one looked at a field of research titled "health communication" and found it largely reflecting interaction in medical settings, it would clearly seem to be inappropriate. Therefore, we need to develop a new conceptual framework for characterizing this discourse in medical settings. For example, this interaction in medical workplaces might better be understood as "phatic communion" as defined by general semanticist Irving J. Lee and his mentor, Alfred J. Korzybski. They attempt to identify a special kind of symbolic interaction that is mainly designed to replace silence.

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Lee (1941) describes phatic communion: "The work songs, the gossip around work tables, the verbal play of road gangs and loggers, the pleasantries that accompany group efforts are to be understood as the use of speech which may not only ease the effort but also establish rapport between individuals (p. 218)."

Another approach to the common academic misuse of "health communication" might be to follow the lead of our sociological colleagues. They have a subfield called "medical sociology" that is not to be confused with the sociology of health. Perhaps we need a similar category called "medical communication." This distinction between medical interaction and health communication is not just an academic nicety. It is a very important distinction in terms of policy and programs. For example, if scholars consistently mislabel symbolic interaction in medical settings as health communication, they could lead less learned people to believe that large personal and public investments in medical care would have a significant impact upon their health status. While this is obviously untrue, it is possible that our mislabelling may have contributed to the national commitment of more than three hundred billion dollars (11 percent of the GNP) for medical care in the mistaken belief that this huge investment will "produce" health. It is critical, therefore, that responsible scholars carefully distinguish the study of health communication from the forms of phatic communion and other interaction characteristic of medical settings.

If one is unlikely to find significant health communication in modern medical facilities, where should we look? Fortunately, the evidence is quite clear in terms of modern Americans and their physiological health status. The major manipulable determinants of their health are four:

1. Individual behavior - What we eat, smoke, and drink, and how we exercise has a great deal to do with our health in terms of both morbidity and mortality.
2. Social relationships - The nature of our relationships at home and work provide the basic context for well-being and host resistance.
3. Physical environment - Our mortality is now intimately connected to the structure of our automobiles and highways. Similarly, the contaminants in our food, air, water, and cigarettes are critical determinants of our succumbing to cancer.

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4. Economic status - The most accurate predictor of poor health status is low income, especially in urbanized areas.

Taken as a whole, these four determinants are the major factors that shape our health status. This, of course, is why such eminent health authorities as Neuhauser, H. Somers, Fuchs and A. Somers are so clear that there is little relationship between medicine and health status in our modernized society. Recognizing these four basic determinants of health in a modern society, where then would one study health communication?

In terms of individual behavior, one could study the interaction within self-help groups designed to assist people in controlling diet or stopping smoking. Similarly, we could study the messages of the tobacco industry and the uses of popular media to affect eating habits.

The effects of social relationships of health could be examined through studies of health status and patterns of work communication in unionized and unorganized work-places. We could study the relationship between status and the communication webs within which individuals exist at the primary associational level. For example, what is the relationship between health status and the number and character of associational relationships at the family, extended family, neighborhood, club and community level? The great epidemiologist, Dr. John Cassel (1974), hypothesized in his final years that social disorganization at the primary level may be a major influence on disease susceptibility.

In terms of the physical environment, what are the effects of campaigns to persuade legislators to enact airbag laws and auto riders to "buckle up"? How do people come to understand the technical information necessary for guiding them through the complexities of carcinogenic environments?

Regarding economic status, what information sources provide public understanding that adequate income is more healthful than new hospitals for the poor?

Obviously, these are only a few of the researchable questions that focus on communication affecting health. Some of these questions are already under study. Unlike issues of medical communication, these are the critical questions whose answers could guide the policies of community associations, private institutions and governments that seek to support a more healthful society.

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Having defined the four arenas within which significant health communication is carried on today, it is also important to recognize that there are particular populations characterized by poor health. Health communication studies regarding these populations are the most significant from a policy perspective. It is clear that the American population of lowest health status and greatest health risk is low income people. Our research libraries are filled with studies demonstrating that to be economically poor, especially in urbanized areas, results in low health status. These same libraries are also filled with studies demonstrating that achieving adequate income is the most effective "cure" for the maladies of impoverishment.

In the face of these research findings, there have been thousands of health programs developed and focused on the poor during the last several decades. These programs seek to influence low income people in terms of their decision making about diet, use of anti-hypertensive drugs, prenatal care, use of drugs and alcohol, avoidance of lead paint, etc. In each case, those who are not poor are attempting to communicate what they believe to be appropriate behaviors to those who are poor, with no attempt to deal with the income of these impoverished people.

The tools for this communication have generally been school systems, mass media, and social agencies. Each becomes a medium through which "good" health behavior is communicated from concerned and knowledgeable groups to impoverished individuals. Each of these mediums is a large institution controlled by the non-poor.

Consider these communication tools from the perspective of the impoverished citizen in an urban neighborhood. She lives in a situation where her income is inadequate, arson is prevalent, feral dogs roam the streets, autos rule the public space, schools produce ignorance, young people have no economic future, crime is epidemic, and drugs and alcohol are the cure. It is to this person, in this context, that the institutional messages of good health are sent. The radio tells her to eat a balanced diet as the supermarket closes down and moves to the suburb and food stamps are cut. The school tells her children about the danger of drugs while the neighborhood is becoming dependent upon the economy of drugs to replace closing factories and reduced government income supports. The local social agency tells her about birth control while her only surcease from the devastating environment is the love of a child.

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It is reasonable to hypothesize that the cause of her malady is powerlessness rather than a lack of behavioral advice. She is, in fact, without the associational or political power to change her economic status, the primary determinant of her poor health. From this perspective, she needs, more than anything else, the possibilities of empowerment that grow from political and associational communication with her peers and potential allies. Her health may literally depend upon this form of interaction and its conversion to new forms of economic and political capacity.

Nonetheless, the health message she hears is from "ethereal" voices telling her to eat a balanced meal. There is a kind of irony to health communication through these mediums. Indeed, there may even be a paradox. I would like to hypothesize that for those who are most impoverished, politically impotent and organizationally powerless, behaviorally oriented health communication transmitted through large systems is itself unhealthful. Is it not reasonable to believe that instructing powerless people to engage in impossible behavior through institutional loud speakers controlled by the powerful is actually counterproductive and even iatrogenic?

Imagine, if you will, an isolated and fragmented family that has been injected, treated, cured, cared for, educated, administered and manipulated toward "compliance" with the goals of others, while being denied the social or political tools to define or achieve goals of their own. And now they hear the voices from beyond that tell them how to eat, how to live, and what to do with their sex life. It may be that the only affirmation of selfhood that remains is to defy the alien voices that would tell them how to live impossible lives. Perhaps people say, "I will have a baby. I'll eat what I want. I'll alleviate the pain of daily life my way. I am somebody."

This is an empirical question. It is also a profound question for it asks whether it is possible to communicate "correct" health information with good motives and contribute to the opposite of the desired effect. Is it possible that the powerless can be sickened by the confirmation of their impotence by the overpowering voices from megaphonic institutions beyond the control or ken of folks at the neighborhood level?

Perhaps we can hypothesize that health is an indicator of the power, competence, and capacity of a people. Good health may tell us that people control tools and messages; poor health may tell us that

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tools and messages control people. It may be reasonable, then, to hypothesize that those in greatest need of improved health are the victims of health communication. Could it be that for those in greatest need, their health does not depend upon receiving messages? Could it be that their health depends upon controlling the microphone? It is this question that may be the most significant research issue if the health of people is the basic concern of our health communication research.

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