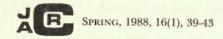# Journal of APPLIED COMMUNICATION Research

Special Issue:
VALUES IN HEALTH COMMUNICATION

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- A SOCIAL SCIENCE PERSPECTIVE
- EXPERIENTIAL ETHICS
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WHERE CAN HEALTH COMMUNICATION BE FOUND?

JOHN McKNIGHT

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

There is increasing evidence that the services of medicine have very little to do with 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 (1974), the economist, finds in his study titled *Who Shall Live?* 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 heart disease, and 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."

In view of these findings, it would seem questionable to characterize symbolic interaction in medical settings as health communication. Certainly, if one looked at a field of research cicled "health communication" and found it largely reflecting interaction in medical settings, it would clearly seem to be inappropriate. Perhaps, therefore, we need to develop a new conceptual framework for this dis-

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course in medical settings. Perhaps this medical interaction might better be understood as "phatic communion" as defined by general semanticist Irving J. Lee (1941) and his mentor, Alfred J. Korzybski. They attempt to identify a peculiar kind of symbolic interaction that is mainly designed to replace silence. Lee describes phatic communion as "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."

Another approach to the common academic misuse of "health communication" might be to follow the lead of our sociological colleagues. They have a sub-field called "medical sociology" that is not 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 practice. For example, for scholars to consistently mislabel symbolic interaction in medical settings as health communication 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 three hundred billion dollars (11 percent of the GNP) for medical care. It is undoubtedly the case that many people believe that this huge investment is designed to "produce" health. Therefore, it is critical that responsible scholars carefully distinguish the study of health communication from the forms of phatic communion and other interaction characteristics of medical settings.

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

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

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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 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 on 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 health status and the communication webs within which individuals exist at the primary associational level. What is the relationship between health status and the number and character of associational relationships at the family, extended family, neighborhood, club and associational 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 certain populations are characterized by poor health and that health communication studies regarding these populations are especially 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 over and over that to be economically poor, especially in urbanized areas, results in low health status. Conversely, the libraries are also filled with studies demonstrating that adequate income is the most effective "cure" for the maladies of impoverishment.

In the face of these research findings, there have been numerous programs developed and focused on the poor for several decades. These programs seek to influence low income people in terms of decision making about diet, use of anti-hypertensives, 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.

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 citizen in a poor 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 place, 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 or 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.

The center of her malady is powerlessness. She is, in fact, without the associational or political power to change her economic status and improve her health. 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 literally depends upon this form of interaction and its conversion to new forms of economic and political capacity.

Nonetheless, the health message she hears is from an "ethereal" voice 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. It could be hypothesized that for those who are most impoverished, politically impotent and organizationally powerless, this form of health communication is unhealthful itself.

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It could be that instructing powerless people to engage in impossible behavior through institutional loud speakers controlled by the powerful is actually counterproductive. 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 devoid of social or political tools to define or achieve goals of their own. And now she hears again the voices from outside that tell her how to eat, how to live and what to do with her sex life. Perhaps the only affirmation of her selfhood that remains is to defy the alien voices that would tell her how to live.

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 yet be counterproductive. 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 tools and messages attempt to control people.

It may be reasonable 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 a concern of our health communication research.

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