CHAPTER 1

Introduction

When my 9-year-old daughter came home from her grandparents with a rash from poison ivy, I wasn't alarmed. She'd had it before. I smeared her with sticky white ointment from a tube promising to "soothe minor rashes and skin irritations." A few days later, however, Hannah awoke with one eye nearly swollen shut. The inflamed rash had spread to her face. I felt I had failed miserably as Dr. Mom.

I called the HMO and learned our regular doctor was out, but another doctor could see us at 11 a.m. In the meantime, I called Hannah's school to explain and brought her to the university with me. In the hallway, a colleague stopped to ask in horror, "Is that poison ivy!? You better get her to a doctor. It can cause blindness around the eyes like that." I felt even more frightened and guilty. The only comfort was that Hannah said it didn't itch much.

In the car, I mentally rehearsed what I would say to this doctor I didn't know: "The ointment worked last time. . . . She wasn't this bad last night. . . . Maybe I should have brought her in sooner. . . . I'm a good mom!" My guilt escalated when I realized these statements sounded more like a courtroom defense than an explanation of my daughter's symptoms. I wondered if my little girl was going to be all right and why I was feeling such a mixture of emotions.

How many instances of health-related communication can you identify in this real-life example?

You might have counted five or more, including the ointment label, the call to the doctor's office, the call to school, the colleague's frightened warning, and my daughter's comments. All of these fall within the domain of health communication.

In addition, the story hints at several factors that influence health communication—emotions, expectations about good parenting, effects of health maintenance organization (HMO) membership, the Dr. Mom image from commercials, and so on. All this before we even reached the doctor's office!

Episodes like the one described illustrate that health communication is a part of everyday life. Everyone is involved in some way. Our ideas about health are influenced by health care professionals, friends, family members, coworkers, educators, advertisers, entertainers, public health promoters, and

many others. Television medical dramas may influence what people expect from actual doctors and nurses. At the same time we influence the people around us with our own actions and thoughts about health.

One reason health communication is so dynamic and interdependent is that health itself is dynamic and interdependent. The World Health Organization (WHO) defines **health** as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948). This definition, unchanged for more than 50 years, reminds us that *healthy* is not the opposite of *sick*. Being healthy means more than that. It is a state of harmony and equilibrium between many aspects of life. Health involves inner feelings, physical abilities, and relationships with others. Throughout the book, you will be exposed to diverse theories about the nature of health and its relation to communication.

A central theme of this book is that one aspect of health communication affects others. To be effective in any arena, you must understand how various components of the health care system rely upon and influence each other. For example, a well-meaning campaign director unfamiliar with cultural ideas about health may create messages that are unappealing or offensive to the audience he or she is trying to reach. A marketing/public relations director who does not understand the dynamics of patient–caregiver communication is unable to help shape and promote services that meet the needs of internal and external shareholders. A caregiver ignorant about health care administration misses out on leadership opportunities and has relatively little chance to influence how organizations are run. Moreover, caregivers who do not communicate well between themselves can confuse patients with contradictory information.

Knowledge gaps are understandable, even among people who have been in health-related careers for some time. Ideas about health, health care, and prevention are changing rapidly. Whereas specialization was once encouraged, now effective health care scholars and practitioners are attuned to broader contexts. They consider situations from many perspectives. They understand the historical, cultural, and market pressures that influence health. They are skillful at encouraging feedback, listening, analyzing, experimenting with new communication techniques, and selling their ideas to others.

In Chapter 2 you will learn more about current issues in health care by going back in time. Following the evolution of medicine from ancient Egypt to 21st century managed care reveals a lot about where we are today. When you understand the philosophy and events that have shaped the modern system you are in a better position to decide what has worked well, where we went wrong, and where we should go from here.

Perhaps the most rewarding aspect of studying health communication is putting what you know to good use. Throughout the book, Communication Skill Builder sections present practical tips for communicating more effectively about health. Based on research evidence, you will learn about effective ways to communicate with diverse patients, present your concerns as a patient, avoid burnout, stimulate cultural diversity, manage conflict, work in teams, design health campaigns, and more.

It is an exciting and challenging time to be involved with health. Perhaps more than ever before, health care leaders are open to innovative ideas. They are also facing critical challenges—to control costs, attract clients, earn employees' loyalty, and more. The changes are both destabilizing and exciting. In Richard T. Pascale's (1999) terms, it can sometimes feel like "surfing the edge of chaos" (p. 198). The good news is that disequilibrium opens the field to new ways of thinking and behaving. People involved with health care today have the potential to reshape and improve the system. In Chapters 9 and 10 you will learn about innovative ways health care organizations are pursuing these goals.

The remainder of Chapter 1 is divided into four sections. The first defines health communication. The second section introduces two approaches to health care—the biomedical and the biopsychosocial models. The third outlines the importance of studying how (and why) people communicate as they do about health. The chapter concludes with a look at current issues that underline the importance of understanding health communication.

WHAT IS HEALTH COMMUNICATION?

Health communication is shaped by many influences including personal goals, skills, cultural orientation, situational factors, and consideration of other people's feelings. The definitions presented in this section emphasize the interdependence of these factors. As you will see here and throughout the book, communicators influence—and are simultaneously influenced by—the people and circumstances around them. They rely on others to help them meet goals, develop a satisfying awareness of self and others, and make sense of life events.

Defining Communication

To attempt a conversation with someone who does not understand you is usually neither satisfying nor productive. There is more to effective communication than putting thoughts into words. Understanding other people's perceptions and clearly expressing your own are important aspects of communication. The definition of **communication** offered by Judy Pearson and Paul Nelson (1991) underscores these concerns: "Communication is the process of understanding and sharing meaning" (p. 6). The significance of this definition becomes clear when we examine communication in terms of process, personal goals, interdependence, sensitivity, and shared meaning.

Process Defining communication as a process recognizes that people are involved in an ongoing effort to understand each other and the world around them. Meaning is interpreted in light of past, present, and future expectations.

Box 1.1 PERSPECTIVES
True Stories About Health Communication Experiences

In Perspectives boxes you will read about the real-life experiences of people involved with health communication. These true accounts represent the viewpoints of patients, loved ones, caregivers, executives, social activists, health campaign managers, and others. They provide insight about how people of different races, cultures, ages, languages, abilities, sexual orientations, and education levels experience health communication. See Box 1.3 for the first in a series of Perspectives boxes that appear throughout the book.

Some factors that influence communication are set in motion before a word is ever spoken. Consider the scenario at the beginning of this chapter. As I chatted with my daughter on the way to the doctor's office I was already wondering what would be said during the visit. The physician also approached the transaction with assumptions and expectations. In many ways, the groundwork for communication episodes begins to take form long before the participants even meet.

Just as communication has no set beginning, it has no definite ending either. People may reevaluate the meaning of a conversation long after it has ended. For instance, you might say to a friend: "When I began physical therapy, I thought my therapist was mean. But now I realize he was doing me a favor by making me work so hard."

As a process, communication is influenced by its placement in the ongoing stream of life and events. Good communicators realize that it is often helpful to know what people expect going into a communication episode and how they feel about it later. In health care situations this may mean collecting information about events leading up to an illness or health care visit and making follow-up phone calls or visits to answer any questions or concerns that arise later. In Chapters 3 through 5 we will explore the nature of patient–caregiver communication and look at health through the eyes of professional caregivers and patients.

Personal Goals Researchers have found that participants approach health encounters with a range of goals and expectations. The main goal of caregivers is presumably to maintain or restore patients' health, but caregivers may have other goals as well, such as saving time, preventing burnout, displaying their knowledge, and so on. Likewise, patients may have many goals including the need to vent emotions, to be forgiven, to be reassured, or simply to be healed.

As I drove my daughter to the doctor, my confidence as a parent was shaken. I craved reassurance that I had not made her condition worse.

Although I didn't take my colleague's warning about blindness too seriously, it did escalate the anxiety I felt about my child. These concerns influenced my goals for the encounter. Emotions and identity are tied to how people behave in medical settings.

One measure of effective communication is how well participants feel their goals have been met. Knowing what people expect from a health encounter is a useful way to increase participants' satisfaction.

Interdependence Although it is important to consider personal goals, communication ultimately relies on how well people work together to coordinate their goals and establish common understandings. Defining communication as "understanding and sharing" emphasizes that no one communicates alone. Communicators are **interdependent**; that is, they rely on each other and exert mutual influence on communication episodes.

Communication is a process of acting, reacting, and negotiation. For example, if the waiting room receptionist seems curt and unfriendly, patients are likely to feel defensive. This may affect their willingness to be open about embarrassing or frightening concerns.

In contrast, pleasing communication can alter a health care encounter for the better. In the poison ivy episode the receptionist who greeted us was friendly and sympathetic. She showed my daughter a rash on her own arm, caused by poison ivy in her garden. The waiting room was quiet and pleasantly decorated, and it was not long before a nurse called Hannah's name. The nurse smiled and joked with us, greatly easing the anxiety we felt. By the time the doctor entered the examination room, my daughter and I were much less anxious than before.

Being friendly and receptive in health care encounters will encourage others to be friendly and open in return. It is unrealistic to expect people to be honest, trusting, and friendly when they feel discouraged by the behavior of people around them. Interdependence also serves to emphasize that everyone involved in the communication has some influence on it. Patients, family members, receptionists, and others often affect health communication as much as doctors do.

Sensitivity Many theorists consider that the best communicators are sensitive to other people's feelings and expectations. Sensitivity enhances health communication on many levels. Research shows that public health campaigns are most effective when they are designed with the audience's concerns and resources in mind (Murray-Johnson & Witte, 2003). By the same token, people are usually most satisfied with physicians who listen attentively and seem to understand what they are feeling (Grant, Cissna, & Rosenfeld, 2000; Tarrant, Windridge, Boulton, Baker, & Freeman, 2003).

Being sensitive means looking and listening carefully. It also means interpreting the cues offered by other communicators. Whether Hannah and I realized it or not, we were probably presenting a number of cues that we were

anxious about the visit. My arm around her shoulders, her hesitant smile, our tone of voice—all of these might have cued the staff that we were apprehensive. They were sensitive to the cues and responded in a way that was culturally appropriate and pleasing to us personally.

Sensitivity is more difficult when communicators do not share the same cultural expectations. In a different culture, a well-intended joke might seem offensive rather than kind. Interpreting subtle cues and responding to them in a sensitive way requires an awareness of **cultural display rules** (ways of showing emotions in different cultures) and an understanding of personal preferences and cultural expectations. To be effective, health communicators must be concerned enough to pay close attention to people's behavior and knowledgeable enough to recognize cultural and personal preferences that make people different.

Shared Meaning What an action means depends on the people and the circumstances involved. For instance, trading friendly put-downs with a friend means you like each other, but the same put-downs from someone you barely know might make you angry. Meaning exists in the participants' mutual interpretation of it. In other words, meaning is shared.

So how do people know if they are sharing the same meaning? Usually, they can tell by the way other people respond. A nod of the head, a smile, an angry look, or a question may signal how a conversational partner is interpreting the conversation. People send and receive messages constantly, although they may not be aware of it. Hannah and I were not trying to look anxious, but we probably showed that emotion in several ways. Likewise, our willingness to engage in humor and light conversation was displayed when the receptionist held out her arm and we both smiled, moved closer, and relaxed our rigid posture. Had we behaved differently, the receptionist would probably have treated us differently.

Because communication is a cooperative process, it is inappropriate to blame one partner or the other when communication between them is unsatisfactory. In the past, scholars often blamed doctors for being insensitive to patients' wishes. However, theorists such as Teresa Thompson (1984) and Gary Kreps (1990) caution that patients should not be considered the underdogs in health situations. Patients are active agents who can influence the way health communication is conducted. For example, doctors are sometimes criticized for doing most of the talking in medical encounters. At the same time, however, patients are known to be particularly submissive around doctors. Whether patients realize it or not, they may contribute to the very dynamic they dislike.

Defining Health Communication

Kreps and Barbara Thornton (1992) define **health communication** as "the way we seek, process and share health information" (p. 2). People are actively involved in health communication. They are not passive recipients of information. Instead, people seek and share messages and mingle what they hear and see with their own ideas and experiences. A great deal of health communication involves professional caregivers such as doctors, nurses, aides, therapists, counselors, and technicians. But we serve as caregivers for friends and loved ones as well. Chapter 7 demonstrates the value of social support when we are ill, healthy, and even (perhaps especially) when we cope with death and dying.

Box 1.2 THEORETICAL FOUNDATIONS
The Basis for Health Communication

He who loves practice without theory is like the sailor who boards the ship without a rudder and compass and never knows where he may cast.

—Leonardo da Vinci

As we explore the field of health communication, theories connect the dots just as constellations reveal patterns in the stars. Good theories make sense of diverse information and help us to get our bearings. They help us know, in advance, where we are headed and what paths are available to us. A Theoretical Foundations box in each chapter showcases a theory relevant to health communication. These theories address such issues as these:

- What is health?
- How do we make sense of health crises?
- What behaviors enhance and compromise coping efforts?
- How do interpersonal relationships influence health?
- How does multiculturalism influence health and health care?
- How can health care organizations stimulate teamwork and innovation?
- In what ways do the media influence our health?
- How do people respond to public health campaigns?
- What factors influence people to become more knowledgeable and proactive about their own health?

Each Theoretical Foundations box poses questions that invite you to analyze the theory as it applies to your experiences and beliefs. You will also find a list of resources to help you continue your exploration of the ideas presented.

Implications

Communication, then, is an ongoing process of sharing and creating meaning. The challenge is not merely to put thoughts into words, but to cooperate with others in developing a shared understanding of what is happening and what it means. This perspective has implications for the study of health communication.

First, it is important that participants in a health episode strive to understand the expectations they bring to bear on the encounter. Whether they communicate face to face or through mass media, their expectations reflect personal experiences, emotions, and cultural beliefs.

Second, whether communication is effective or not depends on circumstances and the participants' goals. It is impossible to present communication skills that work in every situation. Instead, becoming a better communicator requires developing a range of communication strategies and using them appropriately.

The following section introduces two approaches to health care that are fundamental to considering how and why people communicate as they do about health.

MEDICAL MODELS

What causes ill health? If your answer is germs you have probably been influenced by the biomedical model, which is not surprising considering that it has been the basic premise of Western medicine for the last 100 years. But if you believe illness is caused by a variety of factors, including a person's frame of mind, your views more closely reflect the biopsychosocial model, which is gaining favor in today's health care system. Following is a description of each model and its impact on health communication. By way of illustration we will return for a final time to the poison ivy episode to see what the doctor said.

Biomedical Model

The **biomedical model** is based on the premise that ill health is a physical phenomenon that can be explained, identified, and treated through physical means. Biomedicine is well suited to a culture familiar with engines and computers. "Repairing a body, in this view, is analogous to fixing a machine," writes Charles Longino (1997, p. 14). Physicians are like scientists or mechanics. They collect information about a problem, try to identify the source of it, and fix it. For instance, while the doctor was examining my daughter's poison ivy reaction, he asked these questions: "When were you exposed to the poison ivy?" "When did you first notice the rash?" "Does it itch?" "Is it spreading?"

Health communication influenced by the biomedical model is typically focused and specific. Doctors' questions require only brief answers (i.e., "Last weekend." "Sunday." "No." "Yes."). Patients may have little input, and talk is largely restricted to physical signs of illness (Roter et al., 1997).

At its best, the biomedical approach is efficient and definitive. Medical tests and observations may yield evidence that can be logically analyzed and treated with well-established methods. One criticism of the biomedical model, however, is that it marginalizes patients' feelings and social experiences, sometimes to the extent of treating people as impersonal collections of parts or symptoms. As you will see Chapter 5, people are often dissatisfied when caregivers do not listen to their concerns surrounding an illness, and they may not trust diagnoses if they feel the doctor did not fully understand the problem.

Biopsychosocial Model

The **biopsychosocial perspective** takes into account patients' physical conditions (biology), their thoughts and beliefs (psychology), and their social expectations. From this perspective illness is not solely a physical phenomenon but is also influenced by people's feelings, their ideas about health, and the events of their lives.

Caregivers influenced by the biopsychosocial model are likely to be concerned with patients' thoughts and emotions as well as the physical conditions of their illnesses. For example, consider this dialogue.

Doctor: That must really itch. Is it driving you crazy?

Child: (giggling) Not really.

Parent: I thought the ointment would help, but the rash seems to be getting worse.

Doctor: That was a reasonable treatment. I'm not sure why it didn't help. At any rate, I can put your mind at ease . . .

With his comments the doctor addressed Hannah's (itchy) feelings and my concern. His reassurance that the ointment was "a reasonable treatment" did not take long but was immensely comforting to me. Hannah and I left feeling that the doctor had respectfully addressed the situation *and* our feelings. Plus, we had a prescription for medicine that cured the rash overnight. The biopsychosocial approach is supported by evidence that people's thoughts and emotions have an influence on their overall health. Researchers have long known that emotional stress tends to elevate people's heart rates and blood pressure. They are now finding that excessive stress reduces the body's resistance to disease (Goodkin, Fletcher, & Cohen, 1995) and can cause depression and mood changes (Herbert, 1997). On the bright side, health is enhanced by good humor, a positive attitude, and social support (Fontana & McLaughlin, 1998; Goodkin et al., 1995).

The biopsychosocial approach is appealing for its thoroughness and personal concern. The case study in Box 1.3 points out how grateful people can be