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READINGS IN COMMUNICATION



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Thomas H. Feeley & Yixin Chen
An Introduction to Health
Communication

University at Buffalo, The State University of New York

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“In the sick room, ten cents worth of human understanding equals ten dollars of medical science.”
—Martin H. Fischer

Guide to Comprehension

As you read this chapter you should focus on the following issues explored by the author:

- What general definition of health communication do the authors suggest? Why might this field be best understood by examining the processes it studies?
- What sorts of issues are examined in patient-provider communication? Who is represented by the term provider? What communication challenges do providers face?
- What are the fundamental goals of health communication campaigns? How does research on binge drinking exemplify some of the potential issues surrounding a health topic? What types of messages do these campaigns typically rely on?
- What processes are examined by health and medical informatics? How does research cited in the chapter illustrate the potentially unequal effects of medical information technology?
- Why is health program evaluation complex?
- Why might you want to consider a career in the field of health communication?

Overview

This chapter introduces the study of health communication. Feeley and Chen begin by providing a definition of health communication, suggesting that the field is best understood by examining the major areas of study within the field. To that end, they discuss three areas representative of the varied research interests of health communication scholars. They begin by exploring patient-provider communication, and move on to discuss the areas of mass communication health campaigns and health and medical informatics. Health program evaluation, which the authors suggest could perhaps be considered a unique field on its own, is also discussed, as are several of the unique challenges faced by researchers in this area. The article concludes with a discussion of health communication careers and some final brief remarks on the field.

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Health Communication

Introduction

The field of communication research has two primary foci: (1) Examining the production of human communication (e.g., communication forms, communication channels, and message features), and (2) the effects of communication on human beings. The *production* of human communication can include the study of communication forms (e.g., texts, audio, and video v.s. verbal and nonverbal), communication channels (e.g., print media, Radio, TV, Internet and social media) and message features (e.g., message credibility, vividness, and sensation) while communication *effects* is concerned with the influence of communication forms, communication channels, and message features on a series of outcomes, which can include human cognitions, emotions, decisions, and behaviors.

By now you probably realize communication is a broad and dynamic area including but not limited to interpersonal communication, group communication, organizational communication, mass communication, intercultural communication, and international communication. Of course these focal areas of communication create the identity problem communication has with other disciplines (see chapter 1 “The History of the Communication Major in American Higher Education” for discussion on identity problem) and lay persons. What does a communication major represent as a degree program? Is communication the study of media production and media effects? Is it the teaching and learning of communication skills such as speaking and writing? Am I going to work for journalism, advertising or public relations industry if I major in Communication? To add to this confusion we introduce the area of health communication, another sub-field of communication that falls under the aegis of the communication discipline.

Definition of Health communication

Health communication, *the study of communication as it relates to health* (Ratzan, Payne, & Bishop, 1996), is a relatively new subfield but one of the fastest growing areas of communication. A formal **definition of health communication** was advanced by the U.S. Department of Health and Human Services (2000): Health communication is the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues. The scope of health communication includes disease prevention, health promotion, health care policy, and the business of health care as well as enhancement of the quality of life and health of individuals within the community.

The current chapter has two primary goals. The first goal is to introduce to the undergraduate students the field of health communication and familiarize the students with the *study* of health communication. The University at Buffalo does not have a formal degree program in health communication (only in communication). It is not our intention to convince one to become a major in communication or health communication. In practice a graduate degree in health communication is preferred training for a career in the health communication field. A second goal of this chapter is to introduce to the students what health communication scholars *do*, what topics they study, and what possible careers are in health communication.

Health Communication Areas of Study

Like any area of communication, it is easier to conceptualize the field by what one in the field *does* and *researches* rather than attempt to define an area. For example, Feeley earned his Ph.D. in communication, specifically interpersonal communication, in 1996. However if you asked him what he studied in 1996, he would answer, “deceptive communication” as his dissertation examined lie detection in interpersonal communication. Feeley and Chen’s current research involves effects of persuasive communication on health beliefs, attitudes and behavior and the impact of receiving and providing social support on health and well-being (e.g., Chen & Feeley, 2012). Other scholars in health communication study medical communication, messages framing for health promotion, or the role of Internet in health information seeking, to name only a few areas. Thus, health communication may be better understood in context of the four primary areas of study including patient-provider communication, health communication campaigns, health and medical informatics, which would be discussed below -- understanding these four areas hardly represents an exhaustive list of health com-



Patient-Provider communication explores the impact of health providers' communication skills. Effective communication in the health care process is crucial to achieving positive outcomes.

munication fields. If we return to the definition of health communication (“the art and technique of informing, influencing, and motivating individual, institutional, and public audiences about important health issues”) there are seemingly endless areas of scholarship within this broad definition.

The study of health communication dates back to the 1970s (e.g., Costello, 1976) but degree programs and coursework in communication departments is only 20 years old (e.g., Kreps & Thornton, 1992). The reader is cautioned again that the four areas discussed in the next few pages are meant to be representative of the field of health communication. A quick glance at the fields' major journals (e.g., *Journal of Health Communication*, *Health Communication*) will provide the reader some perspective on the breadth of the field. A total of 51 health topics have been identified in the 22 years of research published in *Health Communication*, in an article which appeared in its 100th issue (Kim et al., 2010). Some examples of these topics are: health in general; smoking; alcohol; cancers; AIDS/HIV/safer sex; organ donation; drugs/narcotics/marijuana; death/terminality; diabetes; obesity/diet.

Patient-Provider Communication

The earliest research in health communication most likely can be traced to research on patient-physician communication (Cegala, McGee, & McNeilis, 1996). Recent research in this area has replaced the term physician with *provider* in recognition of the growing numbers of health care professionals (e.g. nurses, physical therapists, pharmacists, etc.) involved in patient care who are not physicians. **Patient-provider communication** involves “creating shared meaning about health care and conditions in the patient and provider encounter” (Sparks & Villagran, 2010, p. 5). Research in patient-provider communication is concerned with the skills and forms of communication in the patient-provider (p-p) relation and if health *outcomes* (e.g., patient adherence and understanding of illness, patient decision regarding possible treatments) differ meaningfully as a function of the p-p relationship. Is the provider articulate, compassionate, and speaking at the level of the patient? Research indicates important differences in patient health that can result from vary-

Advancing Communication Science: Communication in Patient-Provider Interactions

Though many people consider the outcomes of healthcare to be largely contingent on factors like diagnostic tests, surgical interventions, or use of prescription drugs, research in health communication clearly illuminates a critical factor that cuts across almost all facets of health care—communication.

Interactions between patients and their healthcare providers serve as the foundation of the health care process. Perhaps the most critical issue examined by health communication researchers in the domain of patient-provider communication is the influence of communication between patients and providers on health outcomes (e.g. patient understanding, adherence to provider recommendations). Often the presence and quality of communication proves critical.

UB Communication Department Chair, **Dr. Thomas Feeley**, collaborating with researchers at Roswell Park Cancer Institute and Independent Health Association, conducted research on screening for colorectal cancer—one of the leading causes of cancer deaths in the U.S. Specifically, the researchers attempted to explore the role of communication in influencing whether patients went through with colorectal cancer screening.

Utilizing focus groups of patients, physicians, and other providers and staff, Feeley and his colleagues found a clear pattern—the more discussion between a patient and providers about colorectal screening, the more likely that a patient followed through on physician recommendations and actually completed the test. When communication was reduced in quality or duration (e.g. the physician was hurried or distracted), persuasive efforts critical to convince patients to complete the recommended screening were hindered.

Studies like this not only illustrate the importance of communication processes in health care, they provide crucial insight into the specific aspects of information and dialogue that play a key role to achieving desirable health outcomes.

More information about Dr. Feeley and his research can be found on the communication department website at communication.buffalo.edu. A full discussion of this research, including a detailed discussion key elements of communication in this scenario can be found in the article:

Feeley, T.H., Cooper, J., Foels, T., & Mahoney, M.C. (2009): Efficacy expectations for colorectal cancer screening in primary care: Identifying barriers and facilitators for patients and clinicians, *Health Communication*, 24(4), 748-315

ing forms (both content and quality) of communication in the health care provider (physician, nurse, social worker, nurse practitioner).

It stands to reason that patients are more likely to adhere to provider recommendations if patients *understand* provider instructions/recommendations and also if patients *trust* and respect the communication source. Some authors (e.g., Zoppi & Epstein, 2002) make a distinction between communication to a patient and relating to a patient. The quality of the communication between a patient and a physician conditions the relationship and physicians (and other health care

professionals) who have satisfactory relationships with patients are more likely to enjoy their work and stay in the health care field (Zoppi & Epstein, 2002, p. 319).

It is worth noting the communication challenges confronting the physician. S/he must (often in a 12 minute consultation) understand and diagnose the patient, communicate the problem and treatment plan(s) to the patient, manage the health care "team" that can consist of nurses, consultants (e.g., pathology, radiology, surgery), and possibly collaborate with the patient's primary care physician (family medicine, internal medicine, pediatrics, OB/GYN). What is more, the physician must communicate and manage patient care in an often busy and stressful health care environment such as an emergency room, clinic or office site. Many patients are usually not in the best of moods when they are ill and may have been waiting, perhaps hours, to see the attending physician.

Research in medical education is concerned with communication skills training at the medical school and residency level. As early as the medical students' first month of medical school, the physician-in-training is undergoing skills training often using *standardized patients* (e.g., Manyon, Feeley, Panzarella, & Servoss, 2003). Standardized patients are trained individuals or "actors" who act out an ailment while the student/resident trainee performs the physical exam or check-up which includes a medical history of the patient. Recent research by Feeley and his colleagues (Feeley, Manyon, Servoss, & Panzarella, 2003) has examined the utility of different vantage points in evaluating the first year medical students' communication skills. Feeley et al. considered the perspective of two clinical faculty members (one in the exam room and one viewing a video monitor in an adjacent room), the standardized patient and the student him or herself. The trainee is challenged with integrating the technical and basic science knowledge with clinical communication skills while the standardized patient asks directed questions of the trainee (Manyon et al., 2003).

Effective p-p communication relies on the communication skills of not only providers, but also patients. Research has found that patients who possess better communication skills generally enjoy more effective communication with their providers (e.g., Martin et al., 2011). Such patients are more assertive or willing to challenge health care providers during the p-p interaction. Also, they are more actively involved in the decision-making process of treatment and care and are more satisfied with their relationships with their providers.

Thus, as Ratzan and his colleagues (1996) suggest, at the patient-provider level of analysis, health communication is examined at the interpersonal, dyadic or one-to-one level of analysis. Clearly health communication overlaps with interpersonal communication and as the next section suggests, mass communication.

Patient-Provider Self Reflection

When was the last time that you visited a health care provider?

Did s/he take time to listen to your health concern?

Did you understand what s/he said?

Was your health concern solved by that visit?

Did you feel satisfied with your interaction with your provider?

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Promoting Health through Mass Communication Campaigns

A popular method to educate and often times *persuade* individuals regarding health is the use of messages delivered via mass communication channels. Such efforts are known as **mass communication health campaigns**. Awareness and education are fundamental goals in health communication messages. Consider an example with college students and alcohol abuse or more specifically, binge drinking. Binge drinking is defined as a male drinking 5 or more drinks and females drinking 4 or more drinks in one episode. Binge drinking still remains widespread and troublesome among college students, with a 37% rate of binge drinking in 2010, remaining almost the same as their 1993 rate (Johnston, et al., 2011). Binge drinking among college students is associated with a number of negative outcomes, including driving under the influence, unintentional injury and deaths, unprotected sex, academic problems, health problems, and psychological problems (R. Hingson, Heeren, Winter, & Wechsler, 2005; Wechsler, et al., 2002).

Stewart, Lederman, Golubow, Cattafesta, Goodhart, Powell, and Laitman (2002) examined the effects of normative influence on binge drinking. The premise of their research is that college students tend to overestimate the prevalence of binge drinking in the college student population and previous survey data bear out this relationship. If one perceives an illicit behavior as more common s/he may find greater self-justification to engage in the behavior. The students attempting to curb binge drinking in the Stewart et al.'s (2002) study had a primary goal to have other students *notice* their mass media messages (via T-shirts, newspapers, flyers). Their second goal is to have students *learn* from their message campaigns. A third goal is to have students *change* or *reinforce* their behavior as a function of the message content. That is, the ultimate goal is to have binge drinkers discontinue or reduce binge drinking behavior and to have non-binge drinkers reinforce their decision to drink responsibly.

Mass communication can be used to educate about nascent public health issues such as obesity, smoking, STDs, and gambling. Mass mediated messages benefit from the potential to reach large and hard-to-reach audiences in a cost-effective way. The tendency however may be to overestimate what can be reasonably accomplished in an advertisement. A health communication campaign must first attract the attention of an audience member (a targeted audience member), s/he must also actively attend to the message (i.e., process the message), yield to the message (find it credible), and finally use this information, in some part, when considering the target health behavior (e.g., "should I quit smoking?"). All this in a 30 second TV commercial or 15 second radio PSA is a tall order.

Mass communication campaigns rely on education and *appeals to logic and emotion* to influence audiences. The audience *learns* of the benefits of certain behaviors (e.g., 6 lives can be saved from one cadaver organ donor) or the harmful effects of behaviors (e.g., alcohol and drug abuse is often associated with delinquent behavior; smoking is a major cause of lung cancer). At the same time mass communication uses emotional appeals to gain audience attention (e.g., "this is your brain on drugs") and pique the audience's attention. Typical methods include threat or fear appeals about the deleterious effects of certain ill-advised behaviors (e.g., gateway effect of marijuana to harder drugs). Although interpersonal

Alcohol Fact Sheet: Do you know?

- Alcohol consumption ranked third among the leading causes of death in the United States, claiming 85,000 lives in the year of 2000, following tobacco use (number one cause), and poor diet and physical inactivity (the 2nd cause) (Mokdad et al., 2004).
- Alcohol consumption is associated with a higher risk of breast cancer (Singletary & Gapstur, 2001).
- Alcohol consumption, specifically liquor consumption of three or more drinks per day, is associated with increased rate of pancreatic cancer mortality independent of smoking (Gapstur et al., 2011).

Advancing Communication Science: Risk Perception and Promoting Vaccination

In 2009, few topics received as much media attention as the H1N1 influenza virus. A decision by the World Health Organization (WHO) in June of that year to declaring an outbreak of H1N1 in Mexico a pandemic and elevating the organizations influenza alert status to its highest level prompted widespread fears of a potentially disastrous global H1N1 pandemic.

Governments, municipalities, and other social entities that represented venues for large scale public interaction—including college campuses across the country—worked on plans to address the threat of an H1N1 outbreak. UB, for instance, created a special 'campus emergency response infrastructure', directed any students experiencing flu-like symptoms to 'self-isolate', and urged course instructors to consider altering any attendance policies (e.g. on missing an exam) that might prompt any symptomatic and potentially infectious student to attend class.

Though understandably a legitimate cause for concern, these conditions also represented a unique opportunity to examine the knowledge and perceptions of a population at risk in the event of an H1N1 outbreak: college students. UB Communication Associate Professor **Dr. Z. Janet Yang**, surveyed 371 college students regarding their perceptions and knowledge of the virus and the H1N1-associated vaccine.

One of the clear findings of the study was college students typically overestimated their knowledge about the vaccine. Perhaps unsurprising given the that while media frenzy surrounding the virus was pervasive and served to inform the public, many elements of the resultant coverage were conflicting, of mixed accuracy, and often alarmist and hyperbolic. Dr. Yang's study suggested that to communicate effectively, it is important to emphasize the difference between perceived knowledge and actual knowledge.

Another key finding of the study, was that actively seeking information about the risks associated with H1N1 and the vaccine, positively influenced their intentions to get vaccinated—suggesting campaigns that effectively prompted individuals to seek out information stood a good chance of successfully promoting vaccination. Dr. Yang also urged promotion of flu vaccination as a socially desirable behavior and a need to monitor emotional responses to potential risks

More information about Dr. Yang and her research can be found on the communication department website at communication.buffalo.edu. A full discussion of this study, including more details on how emotion and risk were processed by students, and frameworks the study was grounded in—the risk information and seeking processing model and the theory of planned behavior—can be found in the article:

Yang, Z. J. (2012), Too scared or too capable? Why do college students stay away from the H1N1 vaccine?. *Risk Analysis*, 32, 1703–1716.

channels such as p-p interaction may be more effective than mass communication channels in delivering health messages and motivating behavior change, well-implemented health communication campaigns are able to generate small-to-moderate effects not only on health knowledge, beliefs, and attitudes, but also on behaviors, thanks to the wide reach of mass media (Noar, 2006).

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Health Communication

Health and Medical Informatics

Technology has been a large factor in shaping the face of present health care and patients' management of illness. Many patients have electronic health records, surgeons follow-up patients via the internet, and the chronically ill often use the web to better understand their illness and share their concerns and fears with like others. **Medical and health informatics** is concerned with the role of communication technology in transfer of information between people (e.g., patients) and information sources (e.g., health care provider). The University at Buffalo introduced in 2003 a graduate certificate program in medical/health informatics in the School of Informatics.

In this information age, individuals can find all sorts of health information online. Oftentimes, the problem with searching health information online is not a lack of information, but an overabundance, which may overwhelm individuals with limited online health information-seeking ability (Bawden & Robinson, 2009). Also, health information on the Internet ranges in quality, and some of it is inaccurate, misleading, or even dangerous (Capel, Childs, Banwell, & Heatford, 2007). Thus, the ability to navigate the tremendous amount of health information online, to judge the quality of such information, and to make informed decision as to treatment and health management may be crucial for a better health status.

One example of a study undertaken at the University at Buffalo might illustrate research in health informatics. Dickerson, Reinhart, Feeley et al. (2004) surveyed over 300 patients attending three inner-city primary care clinics in downtown Buffalo, New York. The interviewers surveyed patients about their experiences (or lack thereof) using the internet for health information. Results show approximately 35% of patients use the Web to search health information, an estimate far lower than some authors contend. It was also found that education and race significantly predicted if one searches the web for health purposes. African-Americans and the less educated and were less likely to report searching the web for health information in the last calendar year. The Dickerson et al. study also showed that it is training and education more than income or ability to pay for a PC or internet connection that prevents certain individuals from taking advantage of the internet as a health resource. Many patients reported relying on friends or family members to conduct their searches for health information.

Another example may help to sharpen the focus of health/medical informatics research in health communication. Feeley, Rizzo, and Osborne (2004) document a free-of-cost website for individuals without health insurance who are in need of health care or health services. The website provides an online repository of free or reduced-cost health care services. The benefits of a web-based databank of information are ease and facility of data management. Within a few clicks the host becomes aware of the areas of health services most needed and in what zip code. As an illustration, Feeley et al. reported an unexpectedly high number of individuals searching for information on mental health services.

Evaluation in Health Communication Research

Perhaps now a field unto itself is health program evaluation. **Evaluation** is necessary to know if a health communication program *worked* and hopefully *why* and *what* aspects worked. Evaluation is important because

it manifests whether the program has reaches its targeting audience and satisfied its communication goals, and what needs to change or improve to make it more effective. The following nine steps are recommended for conducting outcome evaluation (U.S. Department of Health and Human Services, 2002, p. 110)

1. Determine what information the evaluation must provide.
2. Define the data to collect.
3. Decide on data collection methods.
4. Develop and pretest data collection instruments.

5. Collect data.
6. Process data.
7. Analyze data to answer the evaluation questions.
8. Write an evaluation report.
9. Disseminate the evaluation report.

Advancing Communication Science: Evaluating Compliance Gaining in Organ and Tissue Donation

Health program evaluation is crucial to effective health care practices at all levels. From the planning and design behind a large scale health campaign to the one on one interactions between providers and patients, it is essential to assess what works and what does not and—more importantly—to understand the reasons why. There are several challenges that underlie the necessity of health program evaluation. Many times, practices later revealed to be ineffective have good intention and seemingly sound justification behind them. Sometimes it is simply difficult to differentiate between what is believed to be effective and what is actually most successful. Further underscoring the necessity of such evaluation are the high stakes often attached to success or failure in health care.

One health issue where the stakes are often very high is organ and tissue donation. In the U.S., there currently exists a significant shortage of organs available for transplant compared to those individuals in need. UB Communication Research Assistant Professor **Dr. Ashley Anker** explores several aspects of health communication in her research, and has done extensive work on organ and tissue donation.

Collaborating with Dr. Thomas Feeley, Dr. Anker conducted a study examining the strategies used by the individuals charged with obtaining the final consent for organ donation from a deceased's family, sometimes referred to as organ procurement coordinators. These professionals face a delicate, urgent, and challenging task. It is important to note that though organ and tissue donation generally remains an issue with high levels of public support, for many reasons, there remains a significant percentage of situations in which a deceased's family decides not to consent to a request for organ and tissue donation. 102 organ procurement coordinators were interviewed as part of the study, and asked to describe their communication when attempting to obtain familial consent. The researchers used content analysis (for a brief review of content analysis, see the chapter in this text on scientific research in communication) of the interviews to identify the strategies used and place them into categories drawn from scholarship and research in compliance gaining—a form of persuasion. These strategies were then analyzed for efficacy using the rates of successfully obtaining consent reported by the agency each procurement reporter was employed by over a 3 year period.

The study identified seven specific strategies that showed significant relationships with successful consent rates. 2 strategies—providing additional support and gaining early intervention with families—were positively associated with successfully obtaining familial consent. On the other hand, 5 strategies—engaging in role play training, seeking relevant information for families, discussing benefits as a persuasive tactic, and emphasizing the need for donation among specific racial or ethnic groups were negative predictors of successful consent.

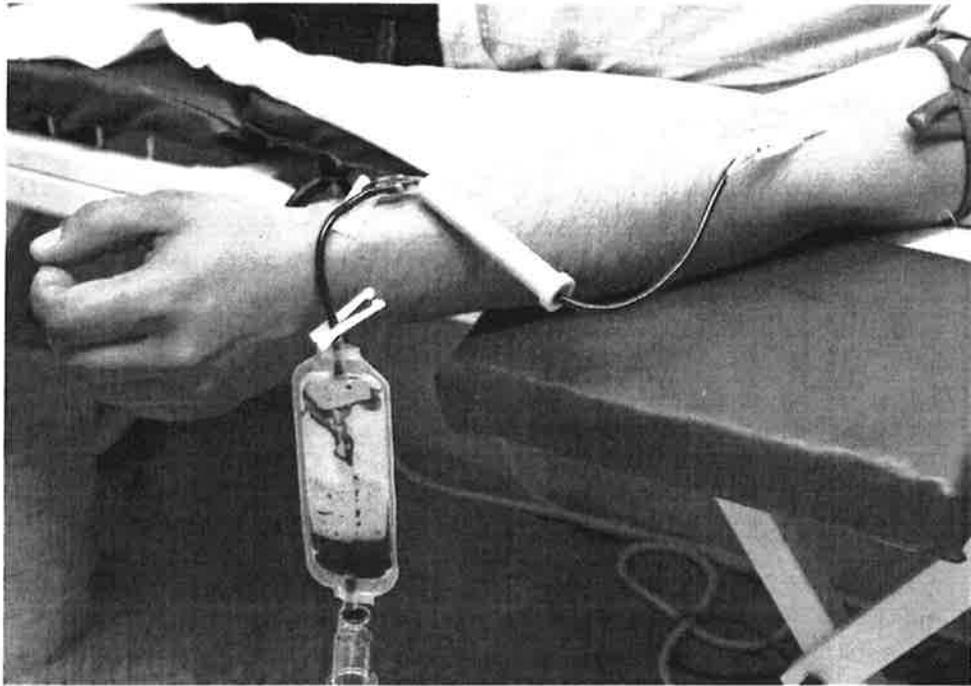
More information about Dr. Anker and her research can be found on the communication department website at communication.buffalo.edu. A full discussion of the research discussed above can be found in the article:

Anker, A. E., & Feeley, T. H. (2011). Difficult communication: Compliance-gaining strategies of Organ Procurement Coordinators. *Journal of Health Communication, 16*(4), 372-392.

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Health Communication

High stakes are often attached to success or failure in health care



Much research in health communication relies on an intervention to improve health outcomes. *Interventions* are planned activities or practices designed to achieve a desired outcome (e.g., improved mental health, weight loss) that may not be possible in the absence of the intervention. For example, Feeley, Servoss, and Fox (2003) reported a health and wellness program in Buffalo, New York designed for mental health of chemically dependent individuals that provides exercise and fitness regimen on a volunteer basis. Their results indicate that individuals who more often use the program (i.e., “heavy users”) report higher quality of life after 3 and 6 months’ time compared to those who use the program less often (i.e., “light users”). Although Feeley et al. found patients’ quality of life improved, what is less clear is the active agent for increasing quality of life. Some call this the chicken and egg problem; that is, are those individuals who use the facilities more often simply more ready for improvement (dubbed “readiness for change”), perhaps both physically and psychosocially, than those who do not use the facilities or those who use it less often? A stronger evaluation protocol could have tested for this alternative explanation.

Many health communication studies or programs are not interventions per se. Recall the Dickerson et al. (2004) survey of patients was not an intervention – patients simply selected themselves to be in one group or another (i.e., one group uses the net for health while one does not). Evaluation is typically concerned with *formative* and *summative* evaluation. **Formative evaluation** helps form or shape the intervention and typically precedes or coincides with summative evaluation. For example, to best influence a teen audience you must understand teens’ beliefs about smoking (e.g., “smoking is cool”) and target these beliefs. **Summative evaluation** is charged with determining if a campaign worked and why or why not it worked or did not work.

Methods to Studying Health Communication

The three most popular methods to studying health communication are: (1) focus groups where researchers gather 6-12 focal individuals and ask their perceptions, experiences, and intentions about a health behavior, (2) experimental de-

Table 1: Career Opportunities and Training in Health Communication

Careers in Health Communication	Training Activities
<p><i>Research</i></p> <ul style="list-style-type: none"> • Investigator • Research Assistant <p><i>Public Relations</i></p> <ul style="list-style-type: none"> • Marketing/Advertisement • Graphic Design • Computers <p><i>Administration</i></p> <ul style="list-style-type: none"> • Project Manager • Finance/Accounting 	<p><i>Degrees</i></p> <ul style="list-style-type: none"> • Ph.D., Communication, Public Health, Epidemiology, Psychology, Biostatistics • M.A./M.P.H., Communication, Public Health, Biostatistics, Educational Psychology, Marketing • B.A., Communication, Business, Psychology, Statistics <p><i>Courses:</i> Statistics, Public Health, Research Methods, Mass Communication Theory, Communication Theory,</p> <p><i>Internships:</i> Research Institutes, Public Health Agencies, Market Research Companies, University Departments or Units in Research</p>

signs, which are used to compare intervention groups to non-intervention groups or control groups and seek to establish causal relationships, and (3) surveys, which try to understand the correlations between health outcomes and possible antecedents.

Careers in Health Communication

There are many career opportunities in health communication that an undergraduate could begin to prepare him or herself for now. Table 1.1 below lists careers and training possibilities to prepare for a health communication position. Clearly any vertical movement in the health communication field would require a graduate degree, preferably a doctoral degree (Ph.D. or D.P.H.). There are however attractive junior level opportunities in health communication, especially in the areas of public communication (i.e., marketing, public relations, and computer and IT support) and research assistance (e.g., data collection, coding, and literature search).

Why a career in health communication? There are several answers to this question. First, you can make a significant difference in other people’s life. The problems of alcoholism, obesity, diabetes, and hypertension in the U.S. are at epidemic levels and many problems are avoidable with proper diet and self-control. The problems are partly structural, however, as fruits, vegetables and healthy foods are often inaccessible and too costly for many individuals who live in certain urban and rural areas. Second, it is an interesting and challenging career, which requires extensive knowledge of health, an excellent command of communication skills, and probably a good grasp of communication technology as well, considering its interdisciplinary attribute and the impact that technology has had on health care management and clinical decision-making. Last but not least, the U.S. is facing an aging population and health care reform, creating a higher demand for health care services which, in turn, makes a career in health communication both promising and rewarding.

Coda

Health communication is a burgeoning sub-field of communication that is undergoing fast development and integrates interdisciplinary efforts from scholars and professionals from communication, public health, medical science, marketing, and engineering, to name a few. Health communication is a dynamic area of study that seeks to understand communica-

tion processes during the clinical visit, aims at promoting healthy behaviors through mass communicated messages, and is concerned with the role of technology in the communication of information between patients and health care providers.

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12 Health Communication

Putting Things in Perspective

Feeley and Chen's introduction of the health communication field helps us obtain a better understanding of the particular issues explored by scholars of this field, and also helps to reinforce the importance of communication in the health care process. By discussing the primary areas of health communication research and examining representative studies in each area, we can see useful examples of the significant potential influence of communication on health care outcomes. Health care professionals attempting to seek the best possible outcomes for their patients must not only be concerned with proper diagnosis and treatment, but must also effectively communicate with patients. Carefully-designed and well-implemented health communication campaigns are able to reach large and hard-to-reach audiences in a cost-effective way, and generate small-to-moderate effects not only on health knowledge, beliefs, and attitudes, but also on behaviors. Similarly, patients may also improve health care outcomes through proactive communication and information gathering opportunities provided by advances in communication technologies. The discussion in this chapter also highlights the need for health communication to address the real world factors surrounding a particular issue. Research efforts in health communication present practitioners, patients, and scholars with significant opportunities to better understand the various communication strategies which can lead to improved health outcomes.

Key Terms & Concepts

2 foci of communication —2

Health communication —2

Describing a field in terms of what it studies —2

Patient-provider communication (PPC) —5

Challenges in PPC —5

Provider communication training —5

Mass communication health campaigns —6

Message types used in a health campaigns—6

Medical and health informatics (MHI) —8

Evaluation in health research —8

Steps in health outcome evaluation—8

Formative and summative evaluation —10

Careers in health communication—11

Benefits of a career in health communication —11

Training for a career in health communication —11