

Health Communication Research Reconsidered: Reading the Signs

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Organizational Aspects of Health Communication Campaigns: What Works? By Thomas E. Backer & Everett M. Rogers (Eds.). Newbury Park, CA: Sage, 1993. 249 pp. \$42.95 (hard), \$21.95 (soft).

Images of Disability on Television. By Guy Cumberbatch & Ralph Negrine. London: Routledge, 1992. 180 pp. \$69.95 (hard).

Persuasive Communication and Drug Abuse Prevention. By Lewis Donohew, Howard E. Sypher, & William J. Bukoski (Eds.). Hillsdale, NJ: Lawrence Erlbaum Associates, 1991. 349 pp. \$59.95 (hard).

AIDS: A Communication Perspective. By Timothy Edgar, Mary Anne Fitzpatrick, & Vicki S. Freimuth (Eds.). Hillsdale, NJ: Lawrence Erlbaum Associates, 1992. 236 pp. \$49.95 (hard).

Gerontology and the Construction of Old Age: A Study in Discourse Analysis. By Bryan S. Green. New York: Aldine de Gruyter, 1993. 226 pp. \$47.95 (hard).

Promoting Cultural Diversity: Strategies for Health Care Professionals. By Kathryn Hopkins Kavanagh & Patricia H. Kennedy. Newbury Park, CA: Sage, 1992. 162 pp. \$32.00 (hard), \$16.00 (soft).

AIDS: Effective Health Communication for the 90s. By Scott C. Ratzan (Ed.). Washington, DC: Taylor & Francis, 1993. 268 pp. \$39.50 (hard).

Case Studies in Health Communication for the 90s. By Eileen Berlin Ray (Ed.). Hillsdale, NJ: Lawrence Erlbaum Associates, 1993. 311 pp. \$79.95 (hard), \$24.95 (soft).

Mass Media Images and Impact on Health: A Sourcebook. By Nancy Signorielli. Westport, CT: Greenwood Press, 1993. 220 pp. \$55.00 (hard).

Perspectives on Health Communication. By Barbara C. Thornton & Gary L. Kreps (Eds.). Prospect Heights, IL: Waveland Press, 1993. 237 pp. \$14.95 (soft).

Tele-Advising: Therapeutic Discourse in American Television. By Mimi White. Chapel Hill: University of North Carolina Press, 1992. 218 pp. \$29.95 (hard), \$10.95 (soft).

I

Few positions are more precarious than that of the little guy in associations based on such unequal sizes and distributions of might. The power brokers need our expertise, but we are so little in comparison, so quickly bedazzled, and often silenced, by promises . . . so easily swallowed up . . . we are small, though our ideas may be powerful. If we merge, we are lost. (Gould, 1993, p. 55)

The books reviewed here comprise a broad cross-section of current research in health communication, a subfield that seems to be coming into its own with a "critical mass" of scholars, divisions in the professional societies, and a journal. More than half of the volumes are edited works, and it is fair to say that they draw together a "who's who" of American health communication researchers. The studies range from microscale clinician-client interactions to the small-group level of professional development and continuing education; to studies of hospitals, nursing homes, and other care delivery organizations; to the "mass" society level of public health campaigns and media portrayals of medicine.

These books demonstrate that, given the growing interest in health care as a communication research context and the present political and economic concerns with the American health care system in the country at large, health communication research finds itself at a critical crossroads. Several questions should be asked of this emerging crossroads. Can communication researchers do more than just apply "off-the-shelf" social-psychological theories about interaction and media use in a new context? Does health communication research offer explanatory power beyond that of the frameworks already proposed by psychologists, medical sociologists, anthropologists, and economists? Can it make a contribution to our understanding and practice of health care that does not simply reinforce or repeat the dominant assumptions, practices, and biases of the existing system? In Gould's terms, can health communication research develop and nurture its own agenda in the face of the "big guy" of American medicine?

The books reviewed here fall into three general topic areas: (a) case studies and texts for professional education, (b) information/communication campaigns dealing with specific public health problems, and (c) the portrayal of health and health care in popular culture, especially in the media. In this review essay my objective is not to review each book in detail; each has specific points to make and its own particular strengths. Rather, I want to consider them together as a point of departure for a re-assessment of the current state of health communication research. I want to discuss their common themes and concerns, and to point out issues that have been overlooked. I also want to consider how well they—and the specialty they represent—can respond to the questions posed above.

II

At first glance, the volumes share several similarities. One is struck by how few of the authors make serious attempts at theory building per se, despite their avowed commitment to theory-based research. In *Case Studies in Health Communication for the 90s*, Ray characterizes health communication research as an ideal opportunity for “wedding theory and application” (p. xvi), but her book is composed mainly of case descriptions with little more than discussion questions to frame or integrate their principal points. The book would be an excellent adjunct text in a health communication course or professional education context (it is obviously designed for these purposes), but it does not propose a coherent scheme for organizing the array of cases it presents.

Several of the researchers attempt to synthesize existing studies, which is an important start. Freimuth's comprehensive and helpful essay (in Edgar, Fitzpatrick, & Freimuth) categorizes and compares the various theories that have been applied in the design of AIDS information campaigns. Her chapter reveals the enormous extent to which health communication research has relied on “classic” social-psychological theories in the course of its development. In the same volume, Wartella and Middledstadt summarize the history of media effects research vis à vis public health campaigns in a concise chapter that will be useful for teaching both in and out of the health care context.

Thompson and Cusella (in Donohew, Sypher, & Bukoski) recap the “findings” of a conference on Persuasive Communication and Drug Abuse, sponsored by the National Institute on Drug Abuse and the Center for Prevention Research at the University of Kentucky. They list 29 “notable insights” from the conference, and make 32 “provocative suggestions” for what to do next. They do not offer a single organizing perspective for the use of persuasion in fighting drug abuse. Instead, they conclude that many diverse perspectives are needed to understand this complex problem.

Backer and Rogers entitle their final chapter “Synthesis,” and provide

12 suggestions (what might be considered "design points") for putting together effective health communication campaigns, based on the campaign case studies they present. And in her final chapter, Nancy Signorielli synthesizes the results of the empirical studies that have been conducted to date on images of health in the mass media (making this book an essential bibliographic reference for those studying health care portrayals, especially on television).

Despite these broadly useful summaries, however, the authors and editors here avoid comprehensive *conceptual* syntheses or new explanations for communication processes in health care. Collectively, the books lack a "big picture" perspective that would help define either the boundaries for study or the major questions of the specialty, apart from vague claims about the "importance" or "central role" of communication in health (e.g., Thornton & Kreps, p. 1). Many of the individual authors seem overwhelmed by the sheer volume of possible variables, issues, actors, and dynamics that could be taken into account.

Subsequently, the theorizing in these books tends to depend on existing (mostly cognitive and social-psychological) theories and constructs that, with a few exceptions such as the health belief model, have been developed in other research contexts. They include standard attitude change models (e.g., belief/attitude/intention/behavior, dissonance theories, consistency theories, expectancy-value theories, social learning, information-processing theories, the health belief model, and the elaboration-likelihood model); familiar ethnographic constructs (e.g., Goffman's notion of stigma); and middle-range theories of organizations and social marketing (e.g., Weick's theory of organizing, diffusion of innovations, agenda setting, and systems theory).

This is not to say that some researchers are not trying out new ideas. One of the best chapters in any of these collections is a review essay by Matthew McAllister (in Edgar et al.). He traces the "medicalization" of both everyday behavior and of presumptively deviant behavior as a form of social control, and shows how medicalization is reflected in and reinforced by news coverage. McAllister's concept could be applied equally well to the study of family interaction, health education, health care professions, the management of health care organizations, or linkages among health care institutions.

Similarly, a few of the case studies in the Ray collection suggest constructs that, with more development and elaboration, could have a great deal of theoretical impact. For example, Hardesty and Geist explore "dirty work" in hospitals—not just the unpleasant personal tasks that the phrase usually suggests, but also the explanation of unpleasant financial realities and "DRGs"—diagnostic related groups—to patients. Katherine Miller's very interesting, but still sketchy, notion of "tempered idealism" could be at work in all kinds of communication relations, from nurse-physician interaction, to small-group and organizational processes, to media portrayals of the medical profession.

In her book on therapeutic discourse in American television, Mimi White argues that the language of the confessional and of psychotherapy has become a routine feature of popular entertainment. She says that such "tele-advising" programs are not necessarily "simulated, and degraded, replacements of experiences that are, somehow, more 'authentic' or valuable in their original or previous cultural manifestation" (p. 179). Instead, they may constitute a new means of therapeutic communication in a cultural milieu pervaded by merging media forms. Again, the concept is worth exploring in other health communication situations, such as distance learning and consultation, professional education, perhaps most critically in the design of public health campaigns.

Gerontology and the Construction of Old Age by Bryan Green is essentially a discourse-analytic study of the influential texts and other materials of professional gerontology. It is similar to White's study of "tele-advising" and to Cumberbatch and Negrine's straightforward content-analytic study of the stereotyped and sentimental images of disabled persons promulgated on television in that it considers a health-related issue that figures prominently in the culture at large, especially in the media. Green's book is notable because it departs from the usual methodology of health communication research. His techniques are drawn primarily from semiotics and linguistics, and merit serious attention by health communication researchers who (like White, Cumberbatch and Negrine, and Signorielli) find themselves asking: How do certain conditions or circumstances come to be defined as health issues? How do people talk about a given issue, decide that it affects them personally, and then act on their decisions? Once established, how are those issues portrayed in the popular culture? Do those portrayals "feed back" into the health care system? Cultural studies offers promising new avenues for methodological exploration.

There is a need in health communication studies for such innovative, "nonmainstream" efforts. While there is no doubt that the social-psychological theory "classics" are relevant to health communication and that they have been valuable exploratory tools, they nonetheless leave certain basic premises undisturbed. Chief among these is the presumption that communication in health is mostly a matter of interaction between institutional message "sources" (e.g., medical research, professionals, government, foundations) and individual "receivers" (e.g., patients, their families, schoolchildren, employees). This is the heart of the "mass" communication paradigm, and it is undergoing systematic reassessment in other areas of communication research. Why not here?

Though there are a few exceptions (e.g., Freimuth, Stein, and Kean's study of telephone health information services [in Kreps], Krep's work on the Patient Data Query system of the National Cancer Institute [in Ray], and White's cultural study of therapeutic discourse in TV talk shows and home shopping networks), this literature, young as it is, already seems a bit "fossilized," divided into the traditional interpersonal and mass media domains of communication research of years past. In an age of niche mar-

keting, focus groups, narrowcasting, and interactive media—indeed, personalized mixes of interpersonal and mediated communication of all kinds—it is odd that health communication researchers continue to honor the old territorial boundaries, at least in their published work.

It is also curious that the institutional level of analysis is conspicuously missing from mainstream health communication research, as represented here. There has been almost no exploration of the communication acts, roles, situations, and media that characterize the institutional context of American health care (medical schools, nursing, emerging new health professions, drug and equipment companies, the privatization and growth of the hospital industry, insurers, and government payers/providers). Communication researchers might protest that sociologists and economists have already covered this ground; yet certainly there are macro-scale communication processes, relationships, and networks that explain why American health care exists as it does (and is so resistant to change). The mainstream studies are just not framed this way. No attempt is made to explain the total “system” in terms of communication—or vice versa.

III

Based on the preceding brief review, health communication at the moment has several special characteristics that distinguish it from other areas of communication research—what diagnosticians might call “pathognomonic signs.” The first is its consistently instrumental, interventionist (i.e., clinical) approach to research problems. This is unsurprising, given the instrumental, interventionist nature of health care itself, and the fact that communication researchers are prone to adopt the point of view and assumptions of the social worlds they study (witness the histories of advertising and public relations research, organizational communication, journalism, new media research, and political communication). The clinical orientation is reflected in a preoccupation with “outcomes,” which are offered as the main justification for conducting health communication research in the first place. In the introduction to her book, Eileen Berlin Ray makes the case that “communication at every point of health care by all health-care providers has the potential to critically influence the outcome. These outcomes include prevention, palliative care, as well as education” (p. xvi).

The belief in the power of communication to affect outcomes is the basis of the second “sign.” Throughout these volumes there is an overarching sense that something is profoundly wrong (“sick”?) with the way that medicine is practiced and health care delivered in the U.S. By the same token, it is believed that this problem can be “cured” or at least mitigated by improved communication behavior—especially by clinical professionals. Many of the studies convey the feeling that there is a gap between the

ideal of medical care and its reality, and that better communication can "repair" the gap. Communication, to put it bluntly, is therapeutic.

This belief is demonstrated by the number of authors whose research is apparently motivated by their personal health care experiences. They identify themselves as clinicians or friends of clinicians, as hospital personnel, as patients, or as family members of patients, and use their life experiences as research data (e.g., Glass, in Thornton & Kreps; Miller & Aydin, et al., in Ray). They find that the situations they study (e.g., pediatric cancer treatment, undergraduate medical education, and organizational "downsizing" in a large private hospital) are dysfunctional—even pathological—insofar as the people in them lack appropriate communication skills or sensitivities: Better communication is the basic "prescription."

The clinical orientation and the belief in communication as therapy lead to the third, and most troubling, "pathognomonic" characteristic of health communication research: the fact that its knowledge interests are subordinate to those of clinical medicine.

This characteristic can be traced to an internal contradiction in the field's focus on the treatment/compliance duality—the dynamic between treatment decisions made by clinicians/providers and compliance with those decisions by patients/clients. In this context, researchers often make statements about their desires to empower patients, to help redress the imbalance between the interests of health care consumers and those of dominant health care system (e.g., the COAST model advocated in the Ratzan volume).

Paradoxically, however, "negotiation" and "collaboration" between patients and providers often favor the provider. In all but the most extraordinary clinical situations the knowledge claim of the provider (i.e., the clinician's view of the case) takes precedence over that of the client, from diagnosis through prognosis. The provider's claim is privileged in the process of communication with the patient, since the provider almost always sets the terms of the problem, the parameters for its management, and what behavior is needed for its resolution, before "negotiation" can even start. Patients who question those terms are negatively labeled: "difficult" at best, "noncompliant" at worst.

The difficulty arises from the fact that very few communication studies presume to question systematically the social relationships, institutional arrangements, and assumptions that support the provider's privileged claim in the first place. Without an examination of the conditions or warrants for the privileged knowledge claim, "collaboration" becomes a mechanism for *more* provider control, not less. And for communication researchers, this means that patient compliance behavior, not treatment, remains by default the focal subject of study and modification, despite well-intentioned concerns about patient interests.

A typical example of such confounded purposes is found in a case study by Marshall (in the Ray volume) describing the procedures for

teaching so-called "patient-centered" interviewing to medical residents. The training involves simulated patient interviews, which contain specific cues that are meant to prompt the resident to "handle" the patient in various ways. Despite the instructor's disingenuous (and repeated) insistence to his trainees that more clinician sensitivity gives patients more "control" over the clinical encounter, the benefits that accrue from such sensitivity are said to include "an efficient use of time" (p. 19), increased "patient satisfaction and compliance," improved "quality of the patient's diagnosis and treatment," and a reduction in "'doctor shopping' and malpractice suits" (p. 18). Such benefits obviously affect patients, but they also obviously represent the provider's view of the "outcome" agenda. "Patient-centered" in this instance seems to be code for making patients more comfortable and therefore more compliant with the physician's directions.

Even health communication scholars' *own* knowledge claims are subject to clinical medicine's ability to set all the terms and conditions of inquiry. The Kavanaugh and Kennedy book illustrates the lopsided relationship. *Promoting Cultural Diversity* is designed for a nursing/professional education audience; the authors are nurses, and the preponderance of their references are drawn from the nursing literature, anthropology, sociology, and the popular press. Their purpose is to promote greater tolerance for cultural diversity among health care professionals; to accomplish this, they propose a communication-based framework for intercultural dialogue called the Interactive Decision Model, and provide a series of exercises for practicing intercultural communication skills. Yet virtually their sole theoretical tie to intercultural communication research (indeed, to communication research at all) is Kim and Gudykunst's *Theories in Intercultural Communication* (1988) (which is not even cited correctly throughout their bibliography).

To health communication scholars, who are acutely aware of the hierarchical "pecking order" of the health professions, the asymmetry is familiar. A communication PhD would not presume to question the medical decisions of a physician, but judging from some of the contributions here, physicians (and nurses and other allied health professionals) apparently believe that they are fully qualified to propose theories and conduct research about communication processes and relationships—without extensive reference to the existing communication research literature. (A personal anecdote: In my own days as a medical television producer, I recall a year of time and many client dollars wasted producing a diabetes patient education series. The endocrinologist sponsoring the program—who also insisted on being the on-screen talent—assumed that television is a simple and, in his words, "stupid" medium that "anyone" can do well. However, after two failed episodes featuring his rather wooden performances that no amount of cutaway editing or graphics could save, he had a change of heart. Once he began to accept direction from the TV "experts," he found that the programs were more polished, more enjoyable to work on—and more effective teaching tools.)

The dominant knowledge interest of medicine, then, poses a dilemma for communication researchers. "Better" communication—in the forms of negotiation or more empathetic interviewing—may make a patient feel better about her treatment. But does it really give her more control over her care? Or does it simply facilitate the management prerogatives of the provider? In taking a pro-communication stance, communication researchers may find themselves (perhaps unwittingly) on the dominant side of a skewed power relationship, with all the attendant problems such a position poses for conducting fair and socially responsible research.

To restate the main points, then, current health communication research has three distinctive characteristics: (a) it is *clinical*, that is, it takes an instrumental, interventionist approach; (b) it is *therapeutic*, based on a pervasive assumption that communication can remediate poor treatment and perhaps even bridge the disparity between real and ideal health care; and (c) its own knowledge interests are *subordinate* to those of clinical medicine, as demonstrated by its (perhaps unintended) bias toward provider interests, arising from the almost total hegemony of medical knowledge in the treatment context (indeed, in American culture at large). These three characteristics are abundantly evident in the volumes under review, and taken as a whole, they tend to reinforce the status quo of the American health care system.

IV

To close this essay, we can ask: How well do these volumes answer the questions posed at the beginning? First, regarding theory, it is clear that the predominant approach in health communication up to now has been the application of existing theoretical frameworks, not the development of new concepts or principles. Yet there are signs that new constructs, unique to this subfield, are emerging. This is one of the most encouraging messages in this set of books.

The answer to the second question, regarding the explanatory power of health communication research, depends to a large extent on the answer to the first question. Until health communication "finds its feet"—that is, can define its boundaries—the explanatory power question will remain unanswerable.

The third question concerns the ability of the specialty to maintain its own agenda and perspectives in the face of the American health care system: On this point the subfield seems most vulnerable. Health communication is certainly not the only area of communication research that finds itself "more citing than cited." But the challenge to health communication researchers, to echo Gould again, is not to merge completely with the knowledge interests and perspectives of clinical medicine, but to retain a sense of our own intellectual and theoretical priorities. The subfield is still the "little guy"; only clearly stated objectives and research aims—and

vigilance—will keep the specialty from being coopted by the large organizations, funding sources, and culturally powerful professions of health care, and allow it to contribute more than communication skills and management training for providers who want to reinforce their control over patient and organizational “outcomes.”

We must conclude, finally, that health communication research is nowhere near making as much of an impact on health care as we would like: We are still dominated by Gould’s “big guy” of institutional medicine. But by maintaining a sense of autonomy as the specialty grows, by developing a “big picture” of our intellectual territory and what Randall Collins (1992) calls “non-obvious” theory we can establish our own ground—and make a greater contribution to the experience of health and the practice of health care.

References

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