spectra

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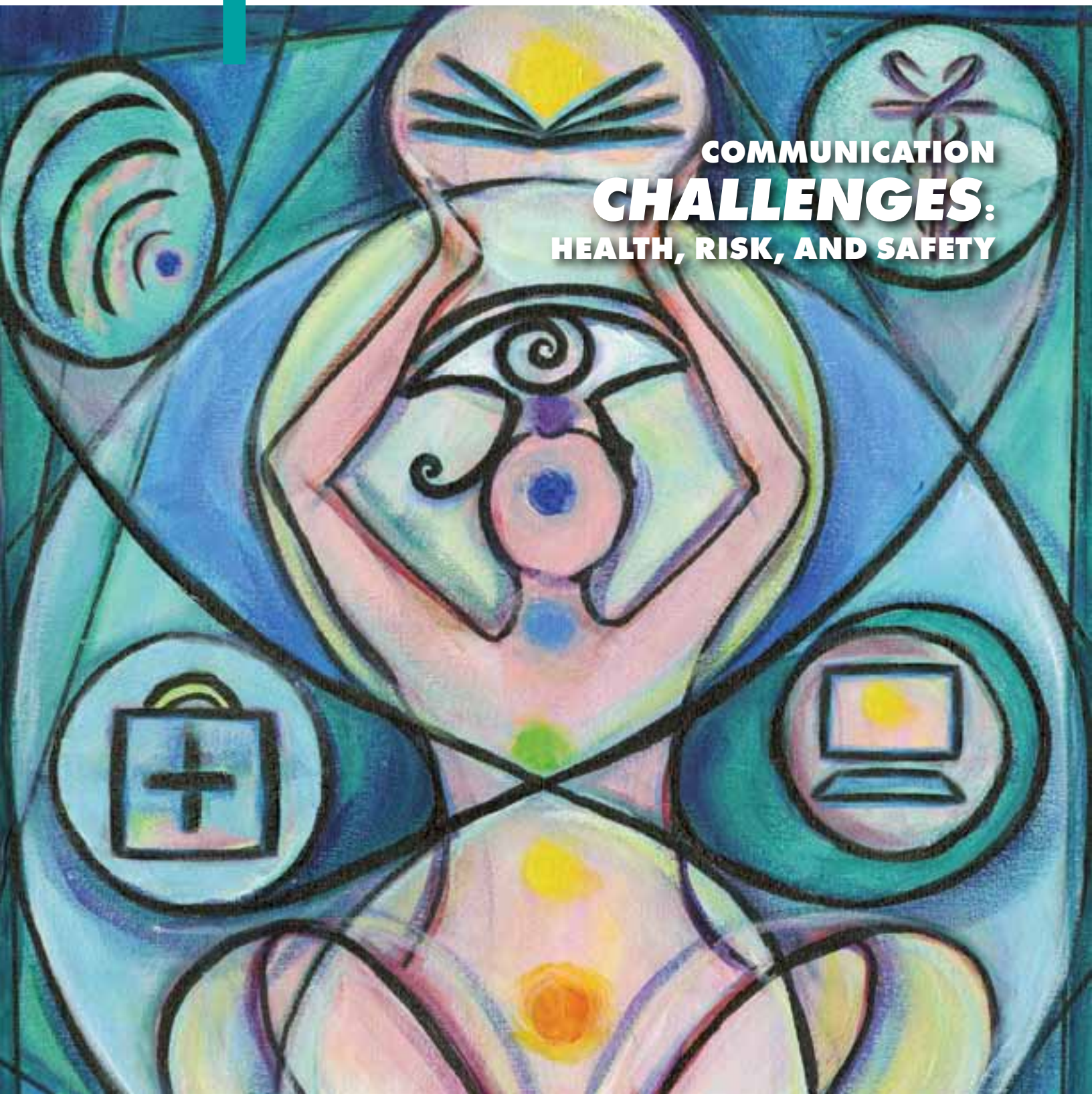

COMMUNICATION CHALLENGES: HEALTH, RISK, AND SAFETY

ABOUT spectra

Spectra, the magazine of the National Communication Association (NCA), features articles on topics that are relevant to Communication scholars, teachers, and practitioners. *Spectra* is one means through which NCA works toward accomplishing its mission of advancing Communication as the discipline that studies all forms, modes, media, and consequences of communication through humanistic, social scientific, and aesthetic inquiry.

NCA serves its members by enabling and supporting their professional interests. Dedicated to fostering and promoting free and ethical communication, NCA promotes the widespread appreciation of the importance of communication in public and private life, the application of competent communication to improve the quality of human life and relationships, and the use of knowledge about communication to solve human problems.

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In this issue

spectra DID YOU KNOW

Several Communication scholars have recently delivered TEDx talks that address Health Communication-related topics. View these and other TEDx talks at www.natcom.org/commtedx/.

THE *Political Economy* OF *Higher Education*—PART 1

By Carole Blair, Ph.D.

In addition to *embracing* opportunities, we may have to be in the business of *creating* them.

IT IS AN HONOR TO SERVE AS PRESIDENT of the National Communication Association, the learned society that has nurtured my career, taught me to think like a scholar, and offered many gifts of camaraderie and collegiality. When I was a candidate for Second Vice President, my statement declared a focus on what NCA should do "for the membership," words I took then and take now to be the most "important words for anyone who serves this association."

In November 2014, we celebrated NCA's centennial and reflected on our field's past and present. And now, it is time to think seriously—and bravely—about our future. The 2015 convention theme, "Embracing Opportunities," is a serious gesture toward that commitment. We should recognize that this decade has not been kind to academics, though, particularly in the humanities and social sciences. And so, in addition to *embracing* opportunities, we may have to be in the business of *creating* them.

We are surrounded by talk of the "inevitabilities" of low budgets, of large contingent faculty workforces, of unsympathetic and ungenerous administrators, and, indeed, of "crisis" among a shrinking and intimidated professoriate. This decade's "governance" mantra—by which you're probably as exasperated as I am—is "Do more with less." That spirit-killing dictum, of course, is precisely *not* what we should be hearing in this time of threats to faculty governance, increasing workloads, demands for time-consuming assessments of the work we no longer have time to do, and sometimes even deteriorating physical workplace conditions.

It is more than time to address these issues, and not in a narrow or unitary way. Every single component of the academic workforce—yes, especially contingent faculty, but literally everyone—is at risk. So is a giant moral and economic engine of U.S. society—its enviable system of higher learning. It is strikingly clear that government officials, boards of trustees, and even academic administrators either are not in a position to address these conditions or simply have not developed a strong interest in doing so.

The counterforce must be cooperating learned societies such as NCA, professional academic associations that were formed not just to advance and promote scholarship in particular disciplines, but also to establish and enact professional standards. In the heyday of the professionalization of higher education—from the 1870s to the 1940s—universities and colleges lacked the capacity (as they still do) to determine standards for scholarship and education for their many and diverse disciplinary areas. Expectations needed to be set and enforced by the academic professions themselves. Thus began a cooperative, mutually beneficial relationship between academic workplaces and learned societies. Today, though, many of our institutions have abdicated commitments to even the most profoundly mundane of academic workplace standards.

What can NCA and its sister organizations do? Many such organizations have within their mission statements a sentence like this one: "NCA serves the scholars, teachers, and practitioners who are its members by enabling and supporting their professional interests in research and teaching." The notion of supporting "professional interests" certainly can be interpreted more expansively than offering venues for publication, professional development, and networking. Such support could also include making serious demands against substandard or unfair labor conditions, as well as against the de-professionalization of the professoriate.

Professional academic associations obviously are not and cannot be unions. Nor should we wish for them to duplicate or interfere with the work of organizations like the American Association of University Professors (AAUP). Our capacities for intervention are different. Although AAUP has a strong interest in arguing for unionization, we understand that our members and institutions need additional solutions, because organizing for collective bargaining isn't even a plausible objective in the 24 U.S. states with so-called "right-to-work" laws. Researching and making recommendations to improve academic labor conditions on the ground might be one way to proceed, and there are surely many others.

Over the next three years (at least), the elected leaders of NCA—First Vice President Christie Beck, Second Vice President Stephen Harnett, and I—have pledged to undertake a series of initiatives to address issues related to the political economy of higher education. We hope that leaders of other learned societies will join us in pursuing these initiatives.

First, however, we should contemplate what might happen if we could be sure that:

- Our members would not do or feel obliged to do uncompensated work for their own or other institutions.
- Academic personnel actions of all kinds (from hiring to tenure and promotion and/or disciplinary action) were fair and transparent.
- Our members would be provided by their workplaces with the resources they need (time, money, assistance, etc.) to do the work of the academy at every level and rank, and in all types of higher education institutions.
- Our institutions were as committed as academic associations are to dismantling the two-tier faculty system by means other than simply hiring more contingent faculty.
- Our members could participate in shared governance of their workplaces in meaningful and consequential ways.

The "inevitabilities" may not be inevitable, if we act as an association, or better still, with allied associations, to hold our academic workplaces to the highest (not the lowest) of standards, so we all can work under the best possible conditions with the best possible resources—resulting in optimal outcomes for institutions, scholarship, education, and the entire academy, which is a topic I will address in my next column. ■

Spotlight

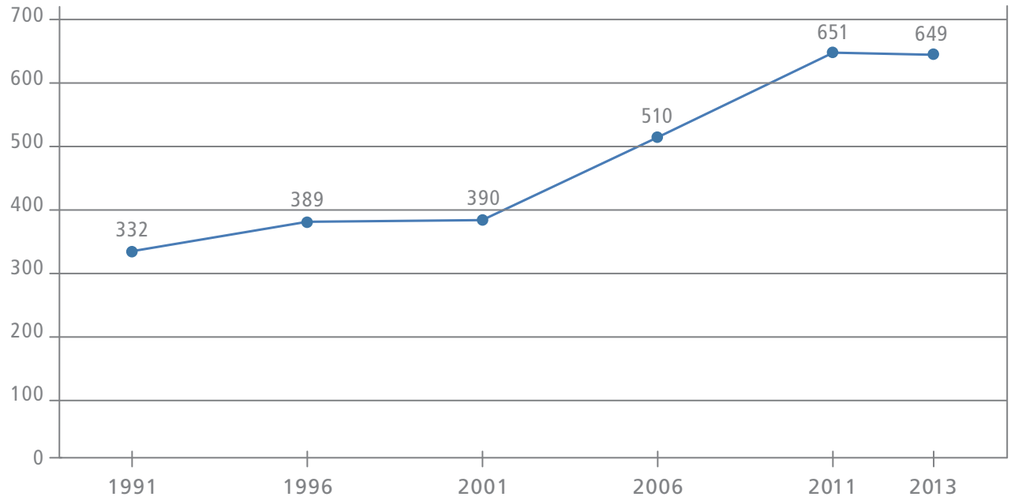
DATA ABOUT THE DISCIPLINE

Following the December 2014 release of the National Science Foundation's 2013 Survey of Earned Doctorates (SED), NCA released *A Profile of the Communication Doctorate II: The 2013 National Science Foundation's Survey of Earned Doctorates.*

Key findings about Communication from the 2013 *SED*:

- The number of Communication doctorates conferred by U.S. academic institutions remained steady from 2011 to 2013.
- Of the 52,760 doctorates reported in the 2013 SED, 649 were classified as Communication doctorates. By comparison, in 2011 only 49,010 doctorates were awarded in the United States; 651 of these doctorates were in Communication.
- The number of women completing Communication doctorates in 2013 declined slightly from 2011. In 2011, 64.2 percent of doctoral recipients were female. In 2013, the percentage of doctoral recipients who were female was 62.1 percent.
- In 2013, one in five Communication doctoral degrees was awarded to non-U.S. citizens holding temporary visas.
- In 2013, less than half (46.2 percent) of the new Communication doctorates had received B.A. degrees in Communication.
- In 2013, the median age of new Communication doctorates was 33.5.

Number of Ph.D.s Conferred in Communication



Source: 2013 SED, Table 12. Available at http://www.nsf.gov/statistics/sed/2013/data/tab12.pdf

IN OUR JOURNALS

Jennifer J. Bute and Maria Brann, "Co-ownership of Private Information in the Miscarriage Context," *Journal of Applied Communication Research* 43 (2015): 23-43.

Communication about miscarriage is often considered taboo. As a result, couples may not disclose their miscarriage experience despite the positive health outcomes associated with discussing pregnancy loss with friends and family. Bute and Brann's article explores the ways in which couples co-own and co-manage disclosure of a miscarriage experience. Through in-depth interviews with 20 couples, Bute and Brann found that couples frame miscarriage as a shared but distinct experience, sharing rights of ownership over the information about their loss. The authors also found that couples negotiate privacy boundaries in their communication about miscarriage. Couples actively engage in the development of privacy rules, which center on issues of social support and others' need to know about the loss.

Brad Millington, "Smartphone Apps and the Mobile Privatization of Health and Fitness," *Critical Studies in Media Communication* 31 (2014): 479-493.

Millington's essay examines the use of health and fitness-themed smartphone apps such as MyFitnessPal. These personal apps connect individual users to communities of like-minded consumers and are often utilized on the go, as the apps capitalize on the portable nature of smartphones. This study highlights the value placed on self-improvement, as activities such as exercise monitoring are recognized as a means for achieving health and fitness goals. Millington also offers critical reflections on this approach to health and fitness promotion. He suggests that health consumerism and the Internet are inextricably linked, as new technologies improve the ways in which people monitor and discuss health and fitness while also creating demand for additional technological advancement.

Erin K. Willer, "Health-care Provider Compassionate Love and Women's Infertility Stressors," *Communication Monographs* 81 (2014): 407-438.

In this study, Willer examines the relationships between whether a doctor expresses compassionate love when communicating with patients, and the relational and psychological stressors experienced by women struggling with infertility. Willer also identifies effective health-care provider compassionate messages. Compassionate love is defined as care, concern, support, and understanding, especially during times of distress or need. Doctor compassionate love was found to be directly associated with positive affect during treatment, perceived lower treatment stress, and higher self-esteem. In addition, participants identified five categories of effective health-care provider compassionate messages: offering hope, privileging patient ahead of self, practicing patient-centeredness, empathizing, and nonverbally communicating.

TEACHING AND LEARNING

A common link among people in the Communication discipline is teaching, whether at an elementary school, community college, or research institution, in a traditional or online classroom. As more teachers integrate online components and other forms of technology into their classes, teachers are faced with new challenges and opportunities for growth, such as finding the best way to present complex information and meet the demands of a more tech-savvy student population. Meeting these challenges is the focus of eTools, a new addition to NCA's Virtual Faculty Lounge. eTools is a monthly essay series designed to provide educators with practical advice on how to use technology in the classroom.

The eTools series, available to NCA members, includes short essays on emerging topics, such as the essay written by Shannon VanHorn on using Livebinders in the classroom, or Kimberly Weismann's essay on using Padlet as an online environment for sharing and editing documents. Jonna Ziniel's essay discusses how to best integrate Google Docs in the classroom, while Danielle Stern talks about the pedagogical uses of Instagram. These articles provide insight into the ways technology can be used to stimulate engaging conversations about theories and concepts, better collaborate with others, and foster relationships in online classes.

The eTools series is just one of several resources available to members via the Virtual Faculty Lounge. The Virtual Faculty Lounge also provides assessment resources, course teaching tips, sample syllabi, sample assignments, and more. To access the eTools series, visit www.natcom.org/virtualfacultylounge/.

COMMUNICATION CHALLENGES: HEALTH, RISK, AND SAFETY

Experts in communication have much to offer in exploring both how we can best communicate about health concerns, and the positive outcomes that can be achieved…

A VARIETY OF HEALTH, RISK, AND SAFETY ISSUES made their way into the nation's collective psyche in 2014, greatly increasing awareness of concerns ranging from Ebola to cyberbullying. In part, this greater awareness was driven by the ability to spread information (and misinformation) quickly via the traditional media's 24/7 news cycle, and through new media that allowed the general populace to become both news consumers and news makers. Controlling the messages associated with health issues has thus become a more urgent priority at the very moment when the online communication about these concerns has increased exponentially. Experts in communication have much to offer in exploring both how we can best communicate about health concerns, and the positive outcomes that can be achieved through best practices in communication.

The articles in this special issue of *Spectra* explore the intersections of health and communication, with articles that focus on how we communicate about specific health issues, and on the importance of communication in addressing some of the larger health concerns facing society today.

Marsha Vanderford, Associate Director for Communication at the Center for Disease Control and Prevention's Center for Global Health, opens the magazine by taking readers to the front lines of global health and humanitarian emergencies, detailing how agencies here and abroad have coordinated their communications efforts to better respond in times of need. According to Vanderford, recent collaborations "illustrate the kinds of bridges that can be built to increase the impact of emergency communication as an important component of risk management during public health emergencies and disasters." Already, these collaborations have proved extremely useful in confronting the Ebola crisis.

Katherine Rowan delves into the question of why some health issues generate public attention, while others do not. She says that "hazards that are novel, geographically proximate, acute, and conflict-ridden are more upsetting—and more newsworthy—than those that are familiar, remote, chronic, and uncontroversial." Citing the need for better risk communication, Rowan notes that if "anger, fear, and outrage were triggered solely by numbers of deaths, news coverage and conversation would be focused on pedestrian traffic deaths caused by drivers travelling at excessive speed—not on Ebola." Rowan's risk communication model may help those involved in motivating actions to help fight what she calls "winnable" health battles.

In her article on increasing awareness about personal safety as a public health issue, Carol Bishop Mills examines how the rise of social media has generated both positive and negative public awareness of safety concerns. Describing the extraordinary use of social media to generate activism around a range of issues, from protesting the deaths of Michael Brown, Eric Garner, and Ethan Saylor, to combatting teen and young adult suicide, Mills says that "Perhaps social media advocacy can make a difference." She asserts that Communication scholars are uniquely positioned to address some of the critical public safety issues of the day, noting "We are able to do research, to share our findings with schools and communities, and to use social media to get our messages out even more broadly."

Christy Ledford concludes this special issue of *Spectra* with an exploration of the critical role communication plays in patient compliance (or non-compliance) with treatment recommendations. Ledford says that today's patients are bombarded with messages about prescription medications by providers, the press, and online outlets, highlighting the importance of adequate and recurring physician communication. And, Ledford says, Communication scholars can help craft solutions, as physicians could benefit from increased training on how to best communicate with patients about treatment plans.

What binds these articles together is their portrayal of the vital contributions communication can make in helping to mitigate some of our most challenging health and safety concerns. In their descriptions of a range of challenges—from the global struggle to combat Ebola, to interpersonal efforts to ensure compliant prescription drug use—the articles illustrate that communication is key to informing the public and promoting health and well-being in our society.

We hope you enjoy this issue of *Spectra*. ■

—LaKesha N. Anderson, Ph.D.
Assistant Director for Academic and Professional Affairs
National Communication Association

EMERGENCY RISK COMMUNICATION:

REFLECTIONS ON A YEAR OF

Accelerating Global Engagement

We can look back on some events that set the stage for the Ebola response and accelerated the coordination between agencies that eventually became deeply engaged in related communication support.

By Marsha L. Vanderford, Ph.D.

THE YEAR 2014 WILL BE REMEMBERED for a long time as the year of the West African Ebola outbreak. I suspect that at the U.S. Center for Disease Control and Prevention (CDC) Center for Global Health, my colleagues and I will recall it as the year in which emergency communication activities accelerated and expanded globally. Emergency communication has proven to be a critical function in managing the Ebola outbreak by efforts to inform decision making and protect health through social mobilization, health education, risk communication, media relations, behavior-change communication, and community engagement.

In the years to come, I expect that scholars will conduct dozens of analyses to assess the role and effectiveness of communication during the Ebola crisis. The time for comprehensive retrospective analysis may not yet be at hand. However, we can look back on some events that set the stage for the Ebola response and accelerated the coordination between agencies that eventually became deeply engaged in related communication support. Such reflection may yield some lessons that can serve us well in the future.

COMMUNICATION RESOURCES FOR FIRST RESPONDERS

On March 20–21, 2014, a small group of representatives from public health and humanitarian assistance agencies met in New York City at the headquarters of the United Nations Children's Fund (UNICEF). The meeting was convened by UNICEF and the International Federation of Red Cross and Red Crescent Societies (IFRC). It was the second of a series of meetings to develop quick-reference communication resources for humanitarian workers expected to rapidly perform communication functions in communities impacted by humanitarian disasters. Risk communication experts from the World Health Organization (WHO), CDC, and academe were also at the table.

Communication officers from these organizations have collaborated on earlier and ongoing projects. For example, as U.N. sister agencies, WHO and UNICEF communication staff share roles in response to international humanitarian disasters, as they did in the aftermath of Typhoon Haiyan (2013) and the Haiti earthquake (2010). CDC, UNICEF, and WHO are partners in the Global Polio Eradication Initiative, coordinating media relations and social mobilization campaigns to eliminate polio from the last several countries where cases are still occurring.

This project, however, was different from the usual coordination of messages and clearance of co-branded materials that occur routinely between agencies working in parallel fashion to achieve common goals. At the UNICEF/IFRC meeting, the group was contributing diverse communication expertise to create a common set of resources that would have implications for all of the agencies during public health emergencies. Each representative brought to the table different emergency response roles and urgent events that have public health consequences. Each organization has specific expertise and approaches to emergency communication and community engagement. Representing CDC, and having served as the agency's communication lead for dozens of public health emergencies, I brought CDC's perspective to the discussion. CDC's approach highlights the importance of unified communication systems and the agency's signature risk communication guidelines, *Crisis and Emergency Risk Communication (CERC)* (http://emergency.cdc.gov/CERC/index.asp).

Based on a growing body of Western-based risk and emergency communication literature, *CERC* has been a foundation for U.S. public health emergency risk communication practice for over a decade—providing guidance through major health and safety threats such as SARS, Hurricane Katrina, H1N1, and MERS corona virus.

During the discussions, UNICEF leadership drew upon its Communication for Development (C4D) model (http://www.unicef.org/cbsc/index_42148.html). Deeply embedded in human rights values, C4D has been employed by UNICEF to achieve behavior and social changes that have increased the well-being of children and women around the world. The community-based approach has been applied to promote a range of health and development goals, including education for girls in Niger, prevention of sexual abuse against girls in Mozambique, promotion of hand hygiene in Haiti, and reduction of maternal mortality in Cambodia.

WHO came to the table as the agency assisting 196 Member Parties to achieve compliance with the International Health Regulations (IHR) (http://www.who.int/topics/international_health_regulations/en/). Defined as one of eight IHR core capacities, risk communication is identified in the WHO regulations as a critical function for managing Public Health Events of International Concern. Risk communication has persisted as an area of vulnerability for many countries, with deficits identified in development of emergency communication plans; communication coordination among agencies; creation of standard operating procedures to speed the release of information to the public; availability of accessible and relevant emergency public health information, education, and communication materials tailored to the needs of local populations; and ongoing evaluation of emergency risk communication efforts.

IFRC initiated the meeting as a means to arm its volunteers and staff with simple, "just-in-time" tools to meet communication challenges in the first days of a humanitarian crisis. Often the first organization on the ground following a disaster such as a typhoon, earthquake, or flood, IFRC needs resources that its staff can use to rapidly and effectively communicate with survivors to protect the health and safety of affected communities. As creators of other innovative, field-based tools such as the Rapid Mobile Phone-based (RAMP) survey toolkit (http://www.ifrc.org/ramp), IFRC encouraged the group gathered in New York City to think creatively about ways to combine their expertise, think beyond each organization's traditional approaches, and identify the essential elements needed by front line disaster workers facing communication challenges.

As the meeting was concluding late Friday afternoon, the co-created, draft tools were moving to revision, improved by a combination of input from each agency. At that moment, one of the IFRC representatives was called away from the meeting by an email about an emerging outbreak of Ebola, the first in West Africa. Little did the group realize on March 21 that her early departure and the meeting itself were harbingers of new relationships and communication challenges that would consume our agencies' energies in the ensuing months.

INTERAGENCY SUPPORT FOR THE EMERGENCY COMMUNICATION NETWORK

Coincidently, a week later, several members of CDC's global health communication staff participated in another collaboration with international public health agencies and humanitarian aid counterparts. On March 28, 2014, 28 public affairs specialists, health communication and education specialists, and social mobilization experts from 17 countries gathered with trainers from a dozen partner organizations in a suburban hotel outside Geneva to begin nine days of intensive training in public health and disaster response. Sponsored by WHO, the course was designed to broaden the specific communication expertise of participants, provide them with broad multi-disciplinary and multi-organizational context for global emergency response, and prepare them for the hazardous and hard duty required in humanitarian disasters. I served as one of the trainers/evaluators for risk communication.

The participants who "passed" the training would become certified members of WHO's new Emergency Communication Network (ECN). Members of the ECN are prepared to rapidly, safely, and effectively deploy under the WHO umbrella to public health emergencies around the world to provide communication expertise during emergency and humanitarian emergencies. In a blitz of six 12-hour days of classroom instruction, participants were exposed to critical concepts in a dozen topics: principles of crisis and risk communication, organizational roles in humanitarian response, basics of epidemiology, guidelines for community engagement and social mobilization, the use of communication for development (C4D) in emergencies, spokesperson guidelines for media engagement, policy development in humanitarian law, field-use of AV equipment, tips on negotiation, conflict management, and resources for personal safety and security.

On the seventh day of the training, the participants boarded a bus to a military base in Avully, Bernex, (a.k.a. the fictional country of "Zambre"). Only 30 miles outside Geneva, the base appears to be on a different

As part of a simulation exercise, Emergency Communication Network participants gather for a briefing on the situation in "Zambre" after an earthquake. Photo courtesy of World Health Organization.

continent. Built as a community disaster setting, "Zambre" was a scene of collapsed buildings and ruined roads.

At the military base, the participants were tested on their ability to apply classroom lessons during three days of disaster simulation. Each participant was assigned to a multi-disciplinary, international communication team, living and working out of a bunker. All teams included members from different organizations, with diverse communication approaches and specialties. All teams included members with varied abilities to speak one another's languages.

The teams fulfilled "short-fuse" communication tasks, working out of bunkers, out of doors, and often without electronic connectivity. They organized themselves to host press events and interagency meetings, engaged affected communities, and reported to WHO headquarters. Actors roamed the site portraying displaced victims of the disasters, local officials, and rogue agents who hijacked team cars and threatened participants' safety. (Additional descriptions of this training can be found at http://blogs.cdc.gov/global/2014/06/11/communication-matters-in-global-health-deployments/ and http://www.unspecial.org/2014/05/communications/.)

On the last day of the course, each participant met with our team of evaluators, who provided feedback on the participant's ability to work under extreme pressure, with little sleep, in harsh/sparse conditions, as part of an international team. Not everyone passed.

EPILOGUE AND LESSONS LEARNED

The meeting at UNICEF headquarters and the ECN training were both designed to build relationships, capitalize on multiple organizations' resources, and build deeper global capacity for effective emergency response. The international response to Ebola arrived on the heels of these events, and provided concrete illustrations of the benefits that can result from multi-organizational training and jointly produced resources.

Two months after the ENC training, one of the CDC graduates, Donda Hansen, deployed to the WHO African Regional Office (AFRO), the first ECN deployee to work specifically on Ebola. Because Hansen had been through ECN training, she was more familiar with the WHO's organizational structures and requirements, had existing relationships with WHO leadership, and could better develop and execute communication strategy more rapidly than otherwise would have been possible.

Within six months, nearly half of the ECN graduates were deployed for Ebola response communication, including

CDC's other ECN graduate, Justin Williams. Their ability to work within the U.N. system, and alongside other communication staff deployed from different responding organizations, has been enhanced by the ECN training, and they now have an increased understanding of the roles of other agencies involved in global humanitarian response. But the ECN training accomplished more than enhanced surge capacity for Ebola-impacted countries. The relationships built in Avully have turned graduates into a trusted network of input, shared materials, and support for individuals in the field and at home, and for the organizations they represent.

Six months after the meeting at UNICEF headquarters in March, several of us who had been present in New York found ourselves together in Dakar, at the September Forum on Ebola Communication. Working with others from international agencies, nongovernmental organizations (NGOs), news media, and West African governments, we developed a *Framework for Action* that highlighted areas of needed communication action to improve the impact of outreach to communities with cases of Ebola. The relationships initiated at the March meeting and strengthened in Dakar have evolved since September into regular international interagency Ebola communication coordination calls (IIECCC) in which WHO, IFRC, CDC, and UNICEF continue to share Ebola communication plans, debrief on our agencies' activities, pool Ebola communication resources, provide input on each organization's messages, and leverage channels and staff.

The evolution of the IIECCC forum has demonstrated the importance and hunger for coordination among international organizations providing critical communication support to Ministries of Health in Liberia, Sierra Leone, and Guinea. From September to December 2014, the number of organizations represented on the IIECCC has grown from three to almost 20: CDC, WHO, IFRC, UNICEF, PAHO, U.S. Department of Defense, BBC Media Action, The Warning Project (Canadian NGO), IOM, CORDS, World Bank, UNESCO, Speak Up Africa, USAID, UN Mission for Ebola Emergency Response, UN AIDS, and International Medical Corps. Although the Center for Global Health at CDC convenes the calls, no single agency is its designated leader. Attendance and follow-up tasks undertaken by participating agencies are voluntary, and the agenda is driven by group discussion and concerns.

Interagency coordination has been called "the most tenacious problem in disaster response" (Sellnow and Seeger, *Theorizing Crisis Communication, 2013*). The collaborations described in this article haven't overcome all the communication coordination challenges in West Africa. But they do illustrate the kinds of bridges that can be built to increase the impact of emergency communication as an important component of risk management during public health emergencies and disasters.

When scholars analyze the Ebola response in years to come, communication coordination will certainly be among the topics of investigation. With hundreds of agencies responding to Ebola, one of the conclusions of anticipated scholarly analyses can be predicted: the importance of expanding and deepening communication coordination for effective global emergency response. ■

MARSHA L. VANDERFORD is Associate Director for Communications at the U.S. Center for Disease Control and Prevention (CDC), Center for Global Health. Since 2010, Vanderford has led and coordinated the external communication strategy for CDC's global health programs, and supports communication capacity for CDC's overseas offices. She has provided technical assistance to the World Health Organization and other international partners in risk communication capacity building and response. Vanderford also provides leadership for CDC's coordination with international agencies during public health emergencies. Prior to her role in global health, Vanderford served as Chief of CDC's Emergency Risk Communication Branch, leading CDC's agency-wide communication response during public health emergencies, including the 2010 Gulf of Mexico oil spill and the 2009-10 H1N1 Influenza pandemic. Prior to joining CDC in 2000, Vanderford was a Professor at the University of South Florida, with joint appointments in the Departments of Communication and Family Medicine.

WHY SOME HEALTH RISKS Upset Us AND OTHERS DO NOT:

RISK *PERCEPTION* AND RISK *COMMUNICATION*

By Katherine E. Rowan, Ph.D.

IN 2014, ONE HEALTH HAZARD dominated U.S. news: Ebola. According to the World Health Organization, by the end of 2014, nearly 8,000 people around the world had died of Ebola hemorrhagic fever, a rare, often deadly disease caused by one of several Ebola viruses. Of those nearly 8,000 deaths, only two occurred in the United States. And yet, in 2014, *Time* magazine named Ebola healthcare workers its "Person(s) of the Year" and the Associated Press ranked Ebola's outbreak in West Africa as its No. 2 news story.

Attention to Ebola in the news, on the Internet, and in conversation exemplifies one of the most intriguing aspects of risk communication—the study of how people create, or fail to create, shared understanding about uncertain loss or danger. As Risk Communication scholar Peter Sandman explains, the hazards that kill us are not necessarily the hazards that upset us. That is, the number of people hurt, ill, or killed is not the principal factor causing worry, fear, or news coverage about illnesses and other health hazards.

If anger, fear, and outrage were triggered solely by numbers of deaths, news coverage and conversation would be focused on pedestrian traffic deaths caused by drivers travelling at excessive speed—not on Ebola.

Consider pedestrian deaths from motor vehicles in the United States. From 2003 to 2012, more than 47,000 pedestrians died nationwide—or one pedestrian every two hours, according to a 2014 report from the American Association of Retired Persons. The report says that when hit at 45 miles per hour, only 35 percent of pedestrians survive. If anger, fear, and outrage were triggered solely by numbers of deaths, news coverage and conversation would be focused on pedestrian traffic deaths caused by drivers travelling at excessive speed—not on Ebola.

To understand why some hazards gain attention and others do not, it's useful to consider risk perception research from the 1980s. In that era, scholars such as Paul Slovic, Sandman, and Baruch Fischhoff studied factors predicting risk perception. To those familiar with journalism, these factors will resonate: hazards that are novel, geographically proximate, acute, and conflict-ridden are more upsetting—and more newsworthy—than those that are familiar, remote, chronic, and uncontroversial. Ebola in 2014 met many of these criteria, certainly more than news of pedestrian traffic accidents. For example, the arrival of Thomas Eric Duncan, the first person to die of Ebola in the United States, made Ebola more geographically proximate to U.S. residents than it had been previously. Ebola is an unfamiliar disease that strikes quickly, as compared to slow-onset diseases, and management of Ebola has been full of controversy.

Contemporary research on risk perception and risk communication abounds. Recent work is exploring ways in which both experts and lay persons use heuristic or intuitive bases, along with analytical processes, to make risk judgments. For example, Yale University's Dan Kahan has tested his "cultural cognition" account of why the science explaining some physical hazards becomes politicized, whereas the science explaining other health risks does not. In a 2010 essay in *Nature*, Kahan tells the story of a 1950s psychology experiment in which college students watched film of a football game. Students asked to comment on the opposing team's performance were more likely to observe illegal plays than were students commenting on their own team's performance. Kahan and his associates say similar processes occur when people perceive risks. We engage in "protective cognitions" and resist evidence when that evidence seems to threaten "our side" (i.e., our preference that industry, government, science, or business "wins" as a result of a finding). Research, however, is identifying ways to support careful thinking about health risk. In a special issue of *Health Communication* on message design, Northwestern University's Daniel O'Keefe offers principles for ensuring that research on message strategies is evidence-based. In that same issue, Elisia Cohen of the University of Kentucky and her colleagues offer advice on tailoring health communication campaigns to specific communities' needs.

THE CAUSE MODEL FOR RISK COMMUNICATION

Another framework for analyzing risk communication is one that I developed and refer to as the CAUSE Model (see Figure 1). Following Lloyd Bitzer, who maintained there are distinctive "rhetorical situations," my colleagues and I argue that the prospect of a physical hazard and its management creates predictable tensions communicators can address. These tensions are suggested by components of all human communication (i.e., sources, messages, topics, channels, and contexts) and indexed by the letters in the word, CAUSE. When people communicate about an uncertain danger, a lack of trust or *confidence* in the message source (the C) is likely. Often there are challenges to gaining *awareness* (the A) of the hazard, its symptoms, or treatment options. Third, even when awareness exists, deep *understanding* of the danger, science, and policy surrounding these matters may not (the U). Fourth, because risk communication situations involve issues where people disagree, there is a need to build *satisfaction* with solutions (the S). Finally, because risk communication situations are ones where people need to move from agreement to *enactment*, risk communication involves motivating enactment (the E).

Figure 1. CAUSE Model

GOAL	CHALLENGE		
	EASY	DIFFICULT	VERY DIFFICULT
Earn **C**onfidence		✓	
Create **A**wareness	✓		
Deepen **U**nderstanding		✓	
Gain **S**atisfaction			✓
Motivate **E**nactment			✓

The author's CAUSE Model, which displays the goals associated with communicating risk, and the relative difficulty associated with meeting each goal.

The CAUSE Model is best used as a tool for reflecting on obstacles to communicating risks and as a guide to research on tested methods for addressing each obstacle. Many think the main obstacle to effective risk communication is the "U," or an audience's lack of understanding about health and risk. In contrast, many who have been harmed by physical hazards believe that a communicator's or institution's lack of character is the principal problem (i.e., the C). Most likely, health risks need to be analyzed through several lenses: as matters of character or justice, science, policy, and strategic communication. Often, earning an audience's confidence—by establishing that the message source cares about the audience, has good character, and has relevant competence—must occur before education is possible. The old saying, "I don't care how much you know until I know how much you care" captures this point.

EARNING CONFIDENCE IN RISK MESSENGERS AND INSTITUTIONS

Lack of trust or confidence in message sources is the principal tension in many risk communication situations. Because physical hazards and their management are frightening, audiences question the motives and competence of officials and many advice givers. Therefore, risk communicators, as Sandman says, should assume they must earn, not expect, confidence. Earning confidence in the trustworthiness of an organization is a process the University of Houston's Robert Heath calls "building credibility infrastructure." Both Heath and Sandman argue that the more transparent or "monitorable" an organization's activities are, the more audiences will have confidence in its messages. Another step that earns confidence is to acknowledge an audience's fears when a novel health hazard such as Ebola emerges and avoid "we have everything under control" sorts of statements. Instead, Sandman, Matthew Seeger at Wayne State University, and Tim Sellnow at the University of Kentucky recommend that spokespersons assert the importance of the public's safety and vow to work hard to ensure it.

Physicians and family members need to earn confidence as well. Scholars such as Christy Ledford, Uniformed Services University of the Health Sciences, are assisting physicians in earning confidence by listening. Ledford explores "difficult topics," such as religion, that are raised by patients in clinical

Some of the most important health challenges are not emotionally vivid—especially slow-onset hazards. Because our brains focus on acute events, we struggle to think about slow-onset problems. It surprises us, perhaps, to learn that the risk of adolescent suicide has increased since the 1950s, or that a sedentary lifestyle is a health risk.

encounters. Daena Goldsmith and Gregory A. Miller at Lewis and Clark University have analyzed couples' communication about cancer. They found that couples found it hard to talk openly about the degree of burden cancer imposed on them. Goldsmith and Miller recommend that support organizations identify difficult-to-discuss topics and offer guidance on their management.

To heighten confidence, news coverage of health risk and illness can and should improve. Sharon Dunwoody at the University of Wisconsin, Christopher Clarke at George Mason University, and their colleagues examine steps for reporting uncertain health risks. Journalists are taught to cover "both sides" of the news; however, this approach can cause unwarranted uncertainty if coverage implies, wrongly, that the scientific community is divided on a topic—the benefit of vaccination is a good example. Dunwoody, Clarke, and Graham Dixon at Washington State University and Avery Holman at the University of Utah have tested "weight of evidence" news coverage where a news story reports the greater evidence about vaccination or other health risks. There are indications that this step assists audiences in seeing which statements in a news story are supported.

GAINING AWARENESS OF A HEALTH HAZARD

Because audiences are often not aware of health hazards, symptoms, or available treatments, risk communicators need resources for raising awareness of these matters. Some of the most important health challenges are not emotionally vivid—especially slow-onset hazards. Because our brains focus on acute events, we struggle to think about slow-onset problems. It surprises us, perhaps, to learn that the risk of adolescent suicide has increased since the 1950s, or that a sedentary lifestyle is a health risk. The health risks associated with climate change are another example of slow-onset hazards: climate change exacerbates flooding, especially in coastal cities with older infrastructure. Flooding leads to mold and waterborne diseases.

Vivid, accurate, and emotion-evoking stories are effective for enhancing awareness of slow-onset hazards. On the other hand, vivid stories need to be used carefully. Christianne Esposito-Smythers at George Mason University has studied evidence-based methods for addressing suicide risk among teens. She and her associates find that front-page coverage of adolescent suicide exacerbates this risk. Esposito-Smythers encourages journalists to access the Centers for Disease Control and Prevention's guidelines for responsible coverage of suicide. She and Harvard University's Catherine R. Glenn show that screening for high-risk individuals is essential to creating awareness about those most vulnerable.

DEEPENING UNDERSTANDING OF COMPLEXITIES

Because health risks are complex, an important challenge is to anticipate likely complexities. Two sources of confusion are *key terms* not fully understood—consider cancer, heart disease, high blood pressure, dietary fiber, and sedentary life style—and *risk statistics*. To make key terms clear, communicators need to move beyond defining and giving single examples. A term is more likely to be understood if communicators take four steps: explain what it does *not* mean, explain what it does mean, give a range of varied examples, and discuss a false example. For example, patients are encouraged to eat more fiber. If fiber is illustrated with a single example—whole grains—patients may wrongly infer that dietary fiber equals grains. Instead, if dietary fiber is defined as plant material and is illustrated with a *range* of *varied* examples—carrots, peanuts, green beans, whole grains—patients are more apt to apply the term correctly. Communicators can also discuss a "false example": Tough meat can be "fibrous," but to have the needed salutary effects, dietary fiber must be plant material, not meat.

A second challenge in understanding health risks is their mathematical nature. To communicate the risk of common illnesses, organizations may say females have a "1 in 1,000" chance of dying from disease x. This sort of sentence may not make the implications of the risk clear to those most affected. In contrast, Lisa Schwartz and her associates at Dartmouth College have designed decision aids. For example, they ask women who never smoked to imagine 1,000 women like them. Then, they list ages and likely deaths at each age from each illness over 10 years for women in this category. Figure 2 illustrates the actual risk of death resulting from several diseases within 10 years among women at various ages who have never smoked. The chart helps users see that vascular disease (heart attack, stroke) is a health risk as one ages.

Figure 2. Risk of Death Over 10 Years Among 1,000 Women Who Have Never Smoked

AGE	VASCULAR DISEASE	LUNG CANCER	BREAST CANCER
45	3	1	4
65	40	7	9
85	307	8	12

Decision aid and data from Lisa Schwartz and Steven Woloshin, Dartmouth, Journal of the National Cancer Institute, *2002.*

GAINING SATISFACTION WITH SOLUTIONS

People can understand a health risk but still not agree to take actions. One reason for lack of agreement is ambivalence, which George Mason University's Xiaoquan Zhao and associates have investigated. Another set of obstacles is identified in Kim Witte's Extended Parallel Process model. The model says that to address a health risk, people must feel it is severe and feel susceptible to it. They must also believe the recommended solution will work and that they can enact it. Sandi Smith at Michigan State University and her associates found that lawn care workers at risk for hearing loss agreed to protect their hearing when exposed to brochures that addressed each aspect of Witte's model. Recently, the CDC has been casting certain health hazards as "winnable battles." Such phrasing may enhance belief that health risks that initially seemed insurmountable are not.

MOTIVATING ENACTMENT

People may agree that they should take recommended steps for their health, but still not enact them. Melanie Booth-Butterfield at West Virginia University and others have studied communication strategies for breaking bad health habits and building new ones. Promises to "get healthy" are too vague to ensure change. More specific steps, such as planning to purchase fresh fruit with each grocery store visit, are more likely to become routine.

Much remains to be done to ensure that health risk communication is thoughtful and evidence-based. The increasing number of tested approaches, and tools such as CAUSE, can support Communication scholars' efforts to help fight "winnable battles" in the management of health risk. ■

KATHERINE E. ("KATHY") ROWAN is a Professor of Communication at George Mason University. Her research concerns science and risk communication, particularly effective methods for earning trust and explaining complexities. Her work has appeared in journals such as *Health Communication, Risk Analysis, Communication Education, Journal of Applied Communication Research,* and *Nature Climate Change*. In 2012, Rowan was elected a Fellow of the American Association for the Advancement of Science. She directs George Mason University's graduate program in Science Communication and is a member of the university's Center for Climate Change Communication and its Center for Health and Risk Communication.

USING

Social #Media

TO ADDRESS SAFETY-RELATED PUBLIC HEALTH CONCERNS

By Carol Bishop Mills, Ph.D.

2014 WAS ANOTHER YEAR CHARACTERIZED by national attention on critical public health issues—a major infectious disease outbreak scare (Ebola); campaigns against heart disease, smoking, obesity, cancer, and diabetes; numerous food-borne illness outbreaks (e.g., salmonella in peanut butter, e-coli in beef, and listeria in candied apples); and debates about the effects of genetically modified foods. And once again, the effectiveness of the flu vaccine came under question, as multiple strains emerged simultaneously, some not fully covered by the vaccine. In both corporately controlled media and social media, these stories became part of our daily lives.

For the most part, then, it appeared to be a year like many others in terms of public health and communication. However, issues of personal safety—the right to exist free of verbal and physical violence—also became an increasingly prominent public health concern, making its way into our nation's consciousness and prompting often-heated discussion.

In 1979, the Surgeon General issued *Healthy People,* a report that identified personal safety as a critical public health issue. The report recognized that health concerns are about whole person wellness, encompassing emotional, mental, and physical health. Concretizing that report, the U.S. Department of Health and Human Services' 1980 report, *Promoting Health/Preventing Disease: Objectives for the Nation,* included these two violence-related goals: to reduce the homicides of young black males, and to reduce the suicide rate among all teens.

Thirty-five years later, these reports seem especially relevant. Issues of racialized violence, disability-related violence, and teen suicides related to bullying have become extraordinarily prominent, and new forms of media have enabled us to become not just receivers of related information, but also creators of the messages. With social media, anyone can share their information, feelings, and beliefs. People can react to and re-create or rewrite the stories themselves.

RACIALIZED VIOLENCE: #MIKEBROWN #BLACKLIVESMATTER AND #ICANTBREATHE

Regardless of where people stand politically on the issues of non-indictments in the deaths of Michael Brown and Eric Garner, they would have to be completely unplugged to have avoided knowledge of what happened. On August 9th, an 18-year-old unarmed black male was shot at least six times by a police officer in Ferguson, MO. Initial reports indicated that Michael Brown was stopped because he was suspected of robbing a nearby convenience store. Other reports said he was stopped for walking in the middle of the road.

Moments after the encounter with the officer, Michael Brown was dead. During the two weeks that followed, there were riots and protests in the city. Media coverage was intense, addressing everything from questioning the racial motives of the shooting to focusing on the chaos, rioting, and looting in Ferguson. PBS Newshour reported that within 24 hours, the hashtag #mikebrown had been used over 100,000 times on Twitter. It was on social media that we first began to see how the effects on people in the community, and throughout the country, were manifesting as a public health concern.

The World Health Organization characterizes a healthy community as "one that is safe, with affordable housing and accessible transportation systems, work for all who want to work, a healthy and safe environment with a sustainable ecosystem, and that offers access to health care services which focus on prevention and staying healthy… Health is more than the absence of disease, and is defined broadly to include the full range of quality of life issues." As the voices on social media emerged using the hashtag #mikebrown, it was clear that many people saw the shooting as targeted violence; that they thought black men were unsafe in their own communities.

In targeted Twitter posts, users openly challenged the role of the media in perpetuating the stereotypes they believed had both led to the violence and were being used to justify it: #iftheygunnedmedown amounted to twitter activism, with users posting "socially acceptable" pictures of themselves—wearing suits or graduation attire, going to church, etc.—next to less "acceptable" pictures of themselves—posturing for a sport, making angry faces, throwing a peace sign (that could be mislabeled a gang sign). They asked, "What picture of me would the media have used?"

Not quite one month before Michael Brown's death in Missouri, an older black male, Eric Garner, died from a chokehold while being arrested by New York City police officers. While Garner was on the ground, a video captured him saying "I can't breathe" multiple times. Three hundred thousand Instagram and Twitter posts

featured the hashtag #ICantBreathe, and there have now been more than 1 million tweets about Eric Garner's case. These tweets are powerful because they focus not just on a death, but on a direct health issue: a man was telling officers he could not breathe, yet he was ignored.

Twitter activism moved to peaceful protests around the county, and several athletic teams, including the Phoenix Suns and the Georgetown men's basketball team, wore tee shirts with the motto "I can't breathe." Media coverage of these stories was important in that the controlled media was picking up stories with a social media epicenter.

New media allows us to look at the tweets, examine the photos, and talk about the images on television and on mainstream news sites, compare them—and talk about agendas, politics, and bias, and how they impact public safety and health.

DISABILITY-RELATED VIOLENCE: #MOMMYITHURT #JUSTICEFORETHAN

Thirteen years ago, I was a new assistant professor at Northern Illinois University when I gave birth to my second child, a gorgeous little girl who came with the surprise of an extra 21st chromosome: Down syndrome. Since her birth, I have been an advocate for disability rights, and more importantly a mother who loves her daughter. So, when I heard about children with her disability who were denied heart transplants based on medical practitioners' beliefs about quality of life, I would write letters and send emails. And, when I would read about mistreatment in schools, I would again begin to advocate. I even served as a communication expert on the Executive Board for the National Down Syndrome Congress.

In 2013, Ethan Saylor, an adult with Down syndrome who had significant support needs, tried to return to a theater to watch a movie he had just left for a second time. His mother was getting the car. Approached by three off-duty officers who were working as security and asked to leave the theater, the young man refused. Saylor had sensory issues and hated to be touched. His aide pleaded with officers not to touch him. They ignored her. Saylor became agitated, and the officers pinned him to the floor and handcuffed him. He died of asphyxiation.

As he was dying, Saylor kept saying, "Mommy, it hurt." Although this case did not receive the same media or social media attention as the Michael Brown and Eric Garner cases later generated, #mommyithurt became a hashtag and rallying cry for advocates to continue to press for changes in police training. In 2014, the U.S. Justice Department began an investigation, and Maryland became the first state with mandatory disability education training for law enforcement officers.

There are no hard data, but anecdotally it does appear that social media empowered advocates to make a change at least in one state, and hopefully others will follow. As for me, it was a painful reminder that even though my daughter attends our community middle school, takes dance lessons with her friends, and is a full member of our community, the world outside may not always "get it." Perhaps social media advocacy can make a difference.

BULLYING, TEEN IDENTITY, AND SUICIDE: #BULLIES #STOPBULLYING

The Brown, Garner, and Saylor cases are vividly illustrative of safety-related public health concerns, yet they are not the only examples. In fact, the same social media that helped galvanize responses and support in those instances can actually serve to threaten public safety and health, especially when it comes to bullying and harassment. Victims of bullying can be targets because of their weight, sexual orientation, socio-economic status, or even because they happened to be in the wrong place at the wrong time.

University of Wisconsin scholars Xu, Jun, Zhu, and Bellmore used a new computer algorithm to identify more than 50,000 bullying-related tweets sent each day. Given that there are over 200 million tweets daily, 50,000 seems like a small number, yet it does not to those people who are victims, witnesses, or even bullies themselves. Moreover, this study did not capture bullying that occurred on Instagram or Facebook, or even on private Twitter accounts, and it included only a limited range of searches.

Cyberbullying is a critical area for public health and communication. Historically, people who were being bullied at school or work could retreat to their homes and escape, at least temporarily. With our 24/7 access and use of technology, victims can no longer get away. When they log in to accounts, they can be affronted anywhere, at any time. Moreover, we know that compared to traditional bullying, cyberbullying is problematic because it is captured in virtual space and can be revisited and repeated, copied, virally grown. As one young woman stated, "Even if I destroy my computer, it is still there."

Given the anonymity and virtual space of online communication, bullying no longer requires an existing imbalance of power between bullies and victims—in fact, it can serve to create such imbalances. Multiple studies have demonstrated that from behind a keyboard, people feel empowered to say cruel things that they would be ashamed or afraid to say in person, yet the damage is not mitigated by the digital nature of the attack; the victim feels as hurt as he or she would in traditional bullying situations.

For teens and young adults, suicide is the third leading cause of death, according to the U.S. Center for Disease Control and Prevention. Although mental illness plays a role in many teen suicide cases, research published in the American Medical Association's *JAMA Pediatrics* indicates that bullying raises rates of suicide among children and teens.

Suicide is not the only reason for concern. Victims can suffer depression, are more likely to skip school, may forego social opportunities, and have long-lasting damage to their self-esteem.

Thankfully, the same social media that makes bullying much easier also provides a platform for victims to fight back! Several online campaigns, many using celebrities, have been launched to #stopbullying. The hashtag is used to support others, share stories, and encourage victims to find allies. YouTube is filled with encouraging videos and public service announcements, and Facebook has several open support groups.

However, far too few victims report the abuse. Guilt, shame, and fear keep them from coming forward. Some schools have enacted policies, and states have enacted laws, to combat bullying attacks online, yet we have a long way to go in not just criminalizing bullying once it comes to light, but working with our youth to stop bullying before it begins.

#BULLIES

Cyberbullying is a critical area for public health and communication.

#STOPBULLYING

#PUBLIC**HEALTH**

We cannot forget that many public health issues are pervasive; threats to the fundamental right to safety constitute one such issue. As Communication scholars, we are uniquely positioned to address them.

#PERSONAL**SAFETY**

THE ROLE OF COMMUNICATION SCHOLARS: #PUBLICHEALTH #PERSONALSAFETY

Sometimes I find myself thinking about Jean Piaget, the storied psychologist who studied his own children while he was formulating his theories. I study health, relationships, and teasing and bullying, all in the context of the Communication discipline. I talk with my children about important issues in the media and how those issues relate to their lives. We live in a diverse community, and I encourage my children to be kind and thoughtful, and we regularly talk about the ways disability and diversity affect our lives. And mostly, my children *are* kind and thoughtful. But we have more work to do. And, we are doing it... day by day, empathy exercise by empathy exercise, with love and understanding, and with consequences and reparation.

There are no magic bullets, but that does not mean I get to dodge the tough subjects. And, as Communication scholars, none of us should! In fact, while it is easy to be captivated by big stories such as Ebola, they disappear, and we wonder why the panic ensued. We cannot forget that many public health issues are pervasive; threats to the fundamental right to safety constitute one such issue. As Communication scholars, we are uniquely positioned to address them.

We are positioned to research and disseminate information on diversity, communicating with different groups, developing empathy, and sharing thoughts without escalating violence. We are positioned to talk about important public health issues, not just in our homes and with our children, but in the larger world. We are able to do research, to share our findings with schools and communities, and to use social media to get our messages out even more broadly.

Tonight, like many nights, I will talk with my children about their day. I will love them, and I will study them. And, when they are fast asleep (or reading their Kindles under the covers), I will go back to researching, writing, and hoping to contribute to the larger world. Hoping that one day, as a field we can make a real difference so #everyonecanbreathe. ■

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TAKE TWO DAILY AND CALL ME IN THE ~~MORNING~~ CASE THAT YOU DECIDE YOU WANT TO STOP/CHANGE/TRY SOMETHING ELSE

By Christy Ledford, Ph.D.

JUST BEFORE THANKSGIVING, while rounding with our inpatient pediatrics team, I met Camryn, a 15-year-old diagnosed with Type 1 diabetes. She had been admitted to the hospital because her blood glucose (sugar) had climbed above 400 and she was feeling it. Her hospital stay had a singular purpose: Discover the reason for the high glucose (poor control) and leverage the resources of the hospital environment to lower the glucose to within guidelines. Then she could go home.

For a patient to successfully take actions that align with the agreed-on treatment plan, he or she must know what that plan is, must be appropriately motivated to follow it, and must have the resources to do so. Communication is critical to achieving these three requirements for adherence.

The pediatric team discussed with Camryn and her parents the possible causes of her high blood sugar. Most notably, they were testing for the possibility of an infection, but all the tests were coming back negative. The attending physician was especially troubled by a long-term test result (Hgb A1c) that showed her sugar had not been controlled over the previous three months. At this point in the interaction, the attending physician also interjected that not taking her insulin could have caused the spike and asked Camryn directly, "but you have been taking it correctly, right?" She nodded and whispered a "yes." With that, the team reaffirmed the plan for discharge, pending further blood culture results and glucose tests.

Following this interaction, I confronted the attending physician about his approach to her adherence. Why had he just let it go after she answered so reticently? Did he think she had told the truth, especially with her parents standing there, listening? Why had he used a leading question?

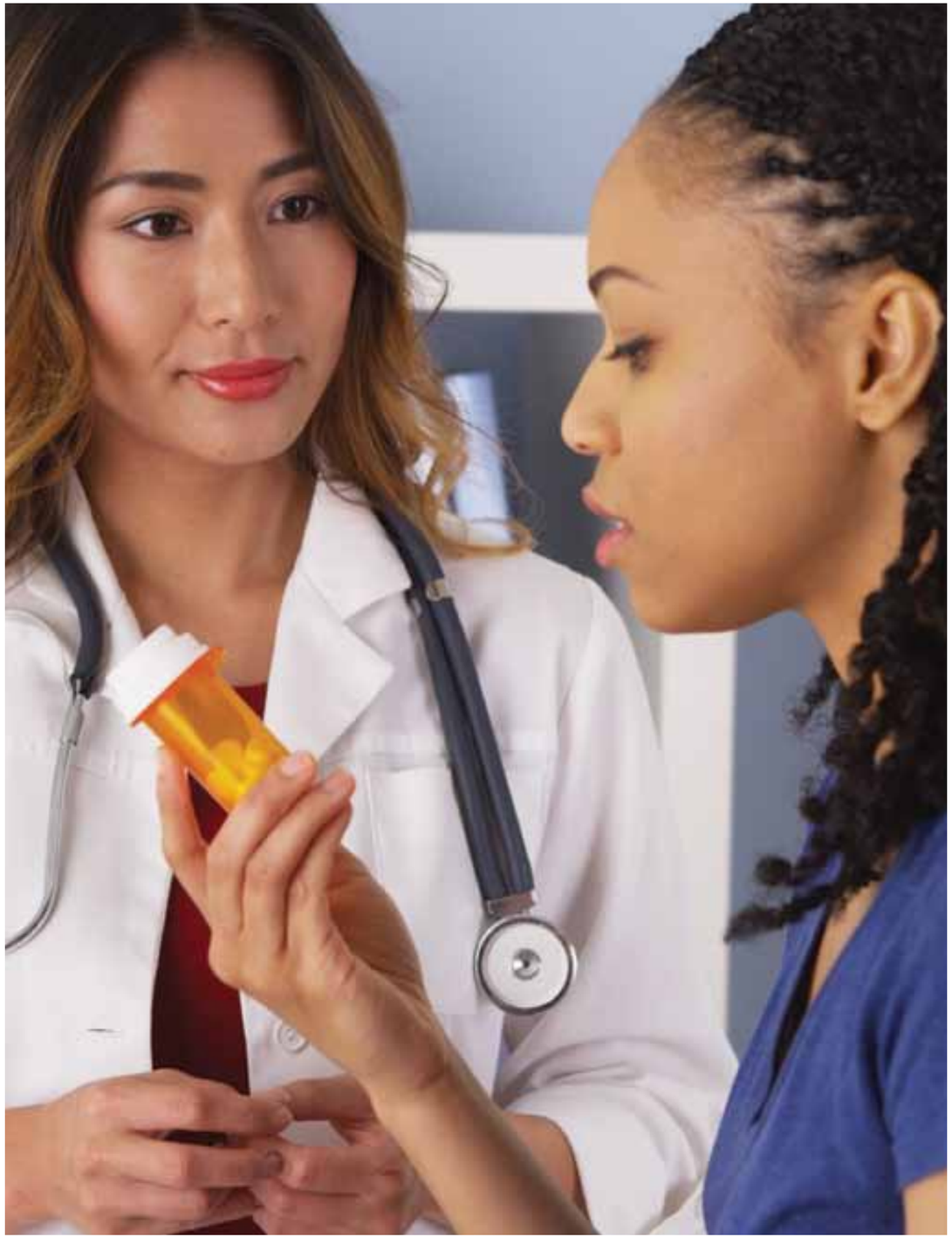
He responded that he didn't believe her; he knew that she hadn't been taking her insulin. It was obvious in the history and the metrics. But then why hadn't he addressed the non-adherence? He said that he had. I was shocked. He told me that by just bringing it up, he had shown her that he knew what she had been doing, and that it needed to change. As a trained observer, that is certainly not what I had seen. As a researcher, I knew he wasn't using any evidence-based tactic. And as the mother of a teenage daughter, I questioned if Camryn even cared about the question before it was asked. Camryn's hospitalization illustrates the role of adherence in chronic illness, and how providers continue to wrestle with communicating about it.

The World Health Organization defines adherence as "the extent to which a person's behavior corresponds with agreed recommendations from a healthcare provider." Camryn's actions may have diverged from the treatment plan she and her parents had chosen with her provider in two ways. First, patients may be intentionally non-adherent. This includes primary non-adherence, in which the patient never initiates the agreed-on recommendation, and non-persistence, in which the patient stops or changes how they carry out the recommended plan. It is also possible that Camryn's non-adherence was unintentional. This includes forgetting medication or taking it improperly, such as taking short-acting insulin at a time of day when long-acting insulin was intended to be administered. Generally, unintentional non-adherence results from misunderstanding rather than from choice. Regardless of whether non-adherence is intentional or unintentional, it results in negative health outcomes. Non-adherence is associated with increased complications, hospitalization, and mortality.

This story is not isolated. Our health system feels the impact of the failures of treatment that result from non-adherence. In Camryn's case, the impact included two nights of hospitalization, care by an inpatient team, multiple rounds of tests for infection, and the medicine needed to correct the sugar spike. In 2009, the New England Healthcare Institute estimated that costs associated with non-adherence are as high as $290 billion annually.

For a patient to successfully take actions that align with the agreed-on treatment plan, he or she must know what that plan is, must be appropriately motivated to follow it, and must have the resources to do so. Communication is critical to achieving these three requirements for adherence.

For example, physician counseling regarding medication can improve patient understanding of medication instructions and adherence to those instructions. Patients trust physicians and select them as their preferred source of health information, especially information about prescription medication. For patients to adhere to medication instructions, they must first receive full information regarding dosage, duration, and drug interactions. Patients who receive less counseling about new medication are less likely to adhere to medication regimens.



Interventions should not focus only on physicians. Patient participation in encounters increases patient recall of treatment recommendations.

As patients encounter information through the media or by conducting searches on the Internet, providers will increasingly need to be able to adapt their medication counseling.

Although many physicians may relegate appropriate counseling of these risks and effects to other resources, there is some evidence that other means of patient education have less impact. The importance of effective physician communication at time of prescription is magnified by studies showing that patients struggle with reading drug labels and instructions. Receiving initial risk messages from the physician also increases the potential for message repetition and retention via pharmacy and health educator interactions and materials.

After patients leave an appointment with a prescription in hand, they are bombarded by messages about their health and medicine. These messages may challenge the information their own provider shared and thus may affect their motivation to adhere to the agreed-on treatment plan. Sources of drug information may include direct-to-consumer advertising from the pharmaceutical company, news stories about Food and Drug Administration alerts, or personal narratives of patients who share the diagnosis. In the ever-changing landscape of medical science, these media or personal narratives can introduce information that tells an incomplete story about a medicine. In their 2013 study, "Conflicting medication information: prevalence, sources, and relationship to medication adherence," published in the *Journal of Health Communication*, Carpenter and colleagues showed that when patients encounter information that conflicts with healthcare provider medication information, their adherence decreases.

Stories about medication risk capture media and public attention. When a doctor prescribes a medication and the patient experiences side effects, the media needs to publicize the potential of increased harm to patients. The FDA encourages and facilitates that media publicity through its surveillance programs. However, the excitement of the narrative may overshadow the science, causing the reader to miss or ignore it.

The FDA garnered media attention when it issued a public health advisory in October 2003 that directed pharmaceutical manufacturers to revise the labeling of selective serotonin reuptake inhibitors (SSRIs) to include an increased risk of suicidality in children and adolescents. SSRIs are antidepressants that include a variety of medications marketed by multiple pharmaceutical companies under different brand names (including Prozac, Paxil, and Zoloft). Whereas one SSRI, fluoxetine (Prozac), was FDA-approved for use in children and adolescents, providers were able to prescribe the other SSRIs off-label for this age group. The new warning applied to SSRIs as a class and included fluoxetine. Providers became wary of the media coverage about the increased risk and its implications, and some parents refused to treat their children's depression with SSRIs after they heard about the increased risk.

Similarly, revised risk warnings for varenicline (brand name Chantix), a medication used to help people stop smoking, first surfaced in the media in November 2007. The FDA issued an "early communication" that noted the agency was evaluating post-marketing reports related to changes in behavior, agitation, depressed mood, suicidal ideation, and suicidal behavior. The media published repeated accounts of military veterans who had received the medication as part of a drug trial and then became aggressive and suicidal. The role of veterans captured the attention of Congress, which conducted hearings on both the medication and the participation of military veterans in drug trials.

These themes are frequently repeated in the news media. Hormone replacement therapy, Avandia (rosiglitazone), Vytorin (simvastatin and ezetimibe) – each has been cheered, then vilified, and then quietly returned to use. In these cases, the public received messages regarding dramatic side effects of the drugs without being provided with the complete medical histories of the patients who had experienced those side effects. Providers face the challenge of helping patients understand such stories both by explaining the related medical science, and by applying that science to specific patient cases. But providers rely on patients to come to them to ask for this counsel.

As people move through this information environment, they must decide every day whether they will take the pill that the doctor said could make them better. Though this is a daily choice for the patient, the physician isn't likely to see the effects of those decisions until months later. Monitoring adherence is a challenge to the provider. Adherence can be assessed by direct methods, such as measuring levels of biomarkers in the blood, or by indirect methods, such as patient self-reporting. Although routine blood tests can reveal the effects of medication, they are also influenced by diet, exercise, and potential viruses. Treatment efficacy relies on the patient's full transparency regarding medication use, and on the provider's ability to discern how that action has resulted in change.

Although the literature provides evidence on how we can better communicate with patients to increase adherence, my experience with the pediatric team and attending physician illustrates that we need continuing medical education to improve current practice. Current guidelines for pharmacotherapy curricula do not provide a specific process for presenting patients with information about prescription medication, instead nebulously suggesting, "Provide patient education as necessary." Research supports presenting medication name, directions for use, reason for medication, side effects, and duration of use.

Interventions should not focus only on physicians. Patient participation in encounters increases patient recall of treatment recommendations. Successful interventions have included patient education, specifically the distribution of a patient handout. This type of patient intervention may influence patient activation—patients' knowledge, skills, and confidence to self-manage their own care. As patients encounter information through the media or by conducting searches on the Internet, providers will increasingly need to be able to adapt their medication counseling not just by addressing their patients' health status and health literacy, but also by taking into account their patients' media and science literacy.

As we move forward in our health system to improve clinician training, I am optimistic that we can positively affect the lives of patients such as Camryn. However, I worry that I will see her in that hospital bed again in the coming year. ■

Disclaimer: The opinions and assertions contained herein are the private views of the author and are not to be construed as official or as reflecting the views of the Uniformed Services University of the Health Sciences, or the Department of Defense at large.

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