



Research in Brief

Communication and Health: An Interrogation

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ABSTRACT “Health” is a highly prized positive value, a commodity and an industry—and also a topic of robust public and academic interest. This article aims to open a conversation about what a communications-oriented approach to health might look like. It reviews the *Canadian Journal of Communication* from its inception for instruction on how health-related topics have been examined by communication scholars, observing the lack of common questions and approaches when it comes to health and Canadian communication scholarship. The article suggests that alongside issues related to the ‘right to health’ and the ‘imperative of health’ (which is bound up with self-monitoring, lifestyle risks, and what I call the language of betterment), we might also important questions around promotion, packaging and embodiment.

KEYWORDS Communication; Cultural analysis; Health; Promotion; Media

RÉSUMÉ [TO COME]

MOTS CLÉS [TO COME]

Establishing that “health matters”—publicly and as a research enterprise—is an exercise in demonstrating the obvious. Health coverage in the news media, for example, is a commonplace. A search on the database Canadian Newsstand Complete for the term “health” in a newspaper *headline* brings up 700 results for the month of June 2013. Subjects include public health, mental health, health care, and health and wellness, along with a range of health issues having to do with particular parts of the body—breast health, heart health, and the like. Searching for Canadian newspaper headlines on specific health issues, such as obese or obesity, results in a total of 411 hits over the past year. Many Canadian newspapers have health as a topical beat, with some newspapers (such as the *Globe and Mail*) housing a designated health editor and accompanying team of health reporters. And the interest in health communicated by our media outlets is bolstered, as well as mirrored, by the ubiquitous health-related websites, blogs, Facebook pages, Pinterest pages, YouTube channels, and self-tracking

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tools (e.g., apps and mobile devices) available to Canadians for monitoring and directing their bodies in the pursuit of good health.

Health equally matters in the academic realm. In Canada, several universities have explicitly identified “health” as part of their strategic plans and/or themes,¹ and several communication programs specifically offer “health” as an area of research or research expertise (e.g., health and communication, critical health studies, and health informatics).

And so, health matters. As Richard Klein observes, health has become a highly prized “positive value that one cannot but choose, as when Socrates argues that one can only choose the good” (2010, p. 15). Health has also become a commodity and an industry, “defined by a public discourse that reflects pharmaceutical, governmental, insurance, and media interests—not necessarily in that order” (p. 16). In light of this robust public and academic interest in health, what does it mean to be a communication scholar studying health? How has the concept of health been treated, and how is it framed in the Communications literature? More specifically, *what types of questions should a scholar interested in communication and health be asking?* Are these questions any different from what, say, a sociologist or a population health researcher might ask? And if they are different, *how* are they different?

This article takes up these mighty questions with a modest goal: to probe the topic of communication and health with the hopes of opening a conversation about what a communications-oriented approach to health might look like.

Communication and health

My interest in the question of *communication* and health emerged, in part, from my own experience as a communications scholar researching and teaching in this area. I was assigned to teach a graduate seminar in Health Communication at my home university and in the course of developing the syllabus was confronted by my own uncertainty over what must be included. Is “health” merely an object to which a set of analytical questions should be applied? Is there a distinct analytical approach (or set of approaches) to health-related topics that other communications scholars take? And, in an academic environment characterized by streamlining course offerings because of budgetary constraints, is there some justification for a graduate *communication* course related to health—especially when our students could merely trudge up two flights of stairs from the Communication Studies department in the Social Sciences building and take a health course in sociology (or anthropology)?

The uncertainty about how to best frame health from a communication scholarly perspective was amplified by the fact that various communication scholars who deal with health issues in their research do not self-identify as health researchers. In teaching graduate courses in Communication and Health and also spearheading a faculty-sponsored speaker series (unimaginatively dubbed with the same moniker), I have over the past two years invited four different professors of communication to lecture on their health-related research. All four agreed to speak—but not before first providing the caveat that “I don’t consider myself to be a health researcher.” That four separate communication scholars who have published on various aspects related to health (ranging from public health crises, obesity, and mental health to risk, geneticization



and communication around vaccines) would all provide the same disclaimer is, perhaps, unremarkable—although it struck me as curious, particularly since I have also made this disclaimer (even while holding a Canadian Institutes of Health Research Canada Research Chair on to marketing, policy and health). Clearly, there is some discomfort in being labelled a *health researcher* instead of a *communication scholar researching health*, a discomfort that in my estimation is appropriate. Health communication, I propose, is entirely different from Communication and Health.

Health communication vs. Communication and Health

What, then, is a communications-oriented approach to health? The first point of clarification is that Communication and Health is not synonymous with health communication. Health communication is predominantly focused on how communications interventions can work to direct and/or modify behaviour. Epidemiological in orientation, health communication typically focuses on individual or population health initiatives designed to generate a particular outcome. Journals such as *Health Communication* and the *Journal of Health Communication* do not represent what I propose might be the type of approach characterizing research on Communication and Health. The most-read article in *Health Communication*, for instance, is “A Meta-Analysis of the Effectiveness of Health Belief Model Variables in Predicting Behavior” (Carpenter, 2010). The most-read article in the *Journal of Health Communication* is “Interventions for Individuals with Low Health Literacy: A Systematic Review” (Sheridan et al., 2011). Other recent articles in *Health Communication* detail an experiment to investigate “readers’ responses to print news stories about the issue of bed bugs” in order to motivate behaviour into taking protective action (Goodall & Reed, 2013, p. 63); provide a meta-analytic review designed to help find the best means of encouraging vaccination (O’Keefe & Nan, 2012); and describe a randomized trial designed to test “a novel recruitment message to increase enrollment into a smoking cessation treatment program” (Schnoll et al., 2011). The aim of such research is to apply communication to predict, modify, control, or motivate behaviour in relation to health—or to measure the impact of communication on similar ends. Such research aligns squarely with *Health Communication*’s stated mandate to “improve practical communication between caregivers and patients and between institutions and the public” (*Health Communication*, 2013). The mandate is administrative in nature. And health communication research is largely administrative research. In contrast, Communication and Health falls under the critical approach to communication. If health communication is primarily epidemiological, Communication and Health deals with its packaging—a point that distinguishes it from more sociological approaches and one that I shall address shortly. But as a placeholder, a Communication and Health approach asks, what does it mean to mobilize health? How do we theorize health, frame it, *package* it, and promote it? How does communication represent health, and how do the two entwine in the creation of particular subjects and objects of concern?

Communication and Health in the Canadian Journal of Communication

It is, perhaps, instructive to review the *Canadian Journal of Communication* (CJC) for direction on how health-related topics have been examined by communication schol-





ars (rather than the health researchers in the *Health Communication* journals). How has the concept of health been treated, and how is it framed, in the *CJC*—and does this treatment provide any tips on a communication approach to health topics?

The earliest treatment of a “health” issue in the *CJC* was almost four decades ago, with Ross Irvine’s 1976 article titled “Advertising, Alcohol and *Maclean’s*.” This 3.5 page piece argues that “journalists should take a few moments to look at advertising” (p. 9) and specifically the advertising in *Maclean’s* magazine, given that “[a]ds for beer, wine and liquor accounted for over 20 percent of the magazine’s content” (p. 10). Alcoholic beverage advertising was (at that time) “*Maclean’s* largest single source of advertising money” (p. 10).

Irvine affirms that “[s]ince it must be assumed alcohol ads increase consumption, the media which carry these ads must bear some responsibility for the increasing number of problems related to alcohol.” He argues that “by carrying beer, wine and liquor ads *Maclean’s* plays a role in fostering increased alcohol consumption” (i.e., alcoholism) (p. 11). The challenge, however, is that the magazine cannot easily move away from such advertising because “over 40 percent of its advertising revenue comes from the alcohol industry” (p. 11)—as is the case with many other magazines.

Irvine’s paper has no citations; it’s an opinion piece. But it grapples with alcoholism as a public health problem, including its costs to taxpayers, Children’s Aid Societies, business (in terms of lost productivity), and individuals and families (in terms of addiction and illness). His conclusion is less a call to action than a push for certain questions:

There is little doubt advertising influences behavior. Now we must ask: How does it affect behavior? What behaviors are affected? What is the cost of this changed behavior in human and dollar terms? Who is responsible? And, what role do the media as the largest distributors of advertising play in the whole system? (Irvine, 1976, p. 12)

In some regards, Irvine’s conclusion anticipates what the novelist and playwright André Alexis observes as characteristic of the humanities today: “Much thinking, in the humanities, has shifted from the answer-oriented to the question-centered” (Alexis, 2013). But the questions Irvine poses are quite particular, because the role of communication is fundamental to the health problem being assessed. In some respects, Irvine presents a standard media effects framework in terms of relating the social problem of alcoholism with media (more advertising = more consumption = more alcoholics). But Irvine affirms that the issue has to do with first mapping the effects and then, more importantly, raising core questions of *responsibility* and *significance* when it comes to alcohol advertising. While sociological treatments of alcohol and health might observe how alcoholism has historically moved from being a public nuisance to a health problem, Irvine’s article—“Advertising, Alcohol and *Maclean’s*”—is fundamentally about troubling promotion.³ And this, as I will argue, is key to a communication approach to health.

Irvine’s brief opinion piece in 1976 did not indicate a simmering interest in health in Canadian communication scholars: the *CJC* was silent on such issues for another 16 years, until the publication of Maurice Charland’s article on the fluoridation controversy



in Montréal in 1992. Charland's article uses postmodern theory to "think critically about the status of public discourse, about the goings-on and the givens of what has been termed 'the rhetorical situation' " (1992, para. 2). His goal, ultimately, is to ask "What then can be said of rhetoric and public address under postmodern conditions?" (para. 20); and as such, the public health issue of fluoridation is absolutely secondary to his analysis. As Charland states at the outset, "I will employ postmodern theory to characterize and explicate a relatively minor controversy: the debate in Montreal over water fluoridation" (para. 3). Yet it is not merely the controversy over fluoridation that is minor for the purposes of fleshing out an approach to *Communication and Health*; it is the fluoridation case itself. Since Charland's aim is to unveil the complexity of deliberative rhetoric within postmodernity, any range of "controversies" would work to illuminate the various language games that constitute public debate when examining the "descriptive game" of science and the "prescriptive game of public policy" (para. 11). His conclusion, that public discourse is comprised of "a jumble of discordant voices" (para. 20), does not provide much to direct the would-be *Communication and Health* scholar.⁴ In this instance, the public health issue of fluoridation is simply an object to which larger cultural questions might be addressed.⁵

From there, the treatment of health issues in the *CJC* remains equally spotty: one article on the role of the media in promoting images of disability in 1993 (Dahl, 1993); one on Canadian newspaper coverage of cocaine and tobacco in 2004 (Hathaway & Erickson, 2004); and one on virtual communities of practice in 2005, in which case studies of two communities of practice (one health, one financial) were used to contribute to organizational literature (Tremblay, 2005). In 2006, the *CJC* offers two articles pertaining to health issues—one focused on SARS, print media, and risk (Leslie, 2006), and one on interpersonal communication and risk when it comes to bareback sex and gay men (Haig, 2006). By the time the *CJC* publishes a special issue devoted entirely to health in 2007, the journal—from its inception in 1974 and for the 33 years following—had offered a grand total of seven health-related articles. Health issues are clearly not central to the Canadian communication studies scene historically. As mentioned, some of these articles were precisely that: health-related (e.g., Charland and Hathaway & Erickson). Others were short opinion pieces (such as Irvine and Dahl). Similar to Irvine's 1976 piece, Dahl's (1993) article on disability is short—a mere three pages. It suggests that the mass media promote certain images of the disabled due to their selective coverage—and it is a coverage that creates "heroes by hype" (para. 7). Dahl uses the example of the media coverage of disabled marathoners in Canada in the 1980s to illustrate the "power of the media in manipulating public response." She affirms:

While many marathoners crossed Canada for causes, it was only the young, attractive men with dramatic visual disabilities (Fox, Fonyo, and Hansen) who received orchestrated backing and media coverage. Promoters and handlers "packaged" the young man and directed the programs and publicity en route. A star was created. (Dahl, 1993, para. 7)

Disability is a health-related issue, and Dahl's reference to its "packaging" captures how this might be understood as an instance of *communication and health*. Dahl is careful not to paint a direct effects model of communication—but she does observe





that the model of “disabled as superstar” is troubling. Advertisers, she says, “do not seem to think in terms of disabled people as customers—drinking beer, brushing their teeth, or buying a car.” Dahl concludes that the mass media—through their ability to create “typifications” through representation—can help to create a more “acceptable and realistic typification of people with disabilities as ‘average’ people” (para. 11). For the purposes of this article, the operative point is not simply the entwined nature of communication and health, but rather that issues of packaging and promotion—and its problematization—are necessary to the conversation. Dahl “troubles” the packaging and promotion of Terry Fox as a disabled superstar. She questions the ways that advertising (promotion) overlooks disabled people and—like Irvine—she asks readers to consider the implications of media representations and broader cultural norms when it comes to issues of health.

Disability and alcoholism are, of course, utterly distinct matters related to health, and I do not mean to suggest that they can be painted with the same brush. But while the more sociologically oriented work examining health, such as Metzl and Kirkland’s *Against Health: How Health Became the New Morality*, counsels readers to “pay attention to the uses of health in their daily lives[,]” asking “Where does the term appear? ... To what means and to what ends?” (2010, p. 3), a communication and health approach, like Irvine and Dahl’s “think pieces,” must also include another layer of consideration—namely, how the health issue has been packaged and promoted, and what this means. To be clear, neither Irvine nor Dahl foregrounds the issue of health or the idea of “troubling promotion” in their respective pieces—the affinity is suggested for the purposes of this article.

To recap, a total of seven *CJC* articles on widely disparate “health” topics were published between 1974 and 2007, articles in which health may be, for the most part, “secondary” (as a “case” or object that could easily be replaced by other cases or objects) or “opinion pieces” topics. The 2007 special issue on health (which contained over twice the number of articles as had been published in the previous 32 years combined) functioned to illustrate the growing centrality of health to Canadian communication scholarship, and also the myriad approaches to tackling the question of health. As then-editor Kim Sawchuk detailed in her characterization of the special issue:

The 15 articles in this issue highlight a set of overlapping themes and research approaches to health, including the ethnography of institutions and practices, discussions about community health promotion, analyses of competing rhetorics of care, discourses on technologies and bodies, an interrogation of national health policy, the visualization of bodies and diseases, the reporting of health news, and the economics and politics of medical knowledge. (Sawchuk, 2007, p. 329)

Whilst the themes overlapped, the special issue also illustrated the rich and varied approaches and “topics” pertaining to health: participatory action research, discourse analysis, rhetorical analysis, “natural history” approaches, and health-related topics ranging from HIV, breast cancer, and depression to health promotion and newspaper reporting on health. In these 15 articles, the focus on health embraces the issues at the micro, meso-, and macro level. One might suggest that the special issue (in itself)





leaves one with a sense of *Ferment in the [Communication and Health] Field*, but not a sense of specific questions that should be asked or what lies outside the scope of this terrain. To be clear: this is not a criticism of the *CJC*'s special issue, which captures the robust potential of communication questions applied to health. But the issue equally underscores a few other points as well: namely, that "health" is an ambiguous concept (Metzl & Kirkland, 2010); that the communication approaches to health prove diverse and varied; and that there is not a clear set of common questions that Canadian communication scholars seem to be asking when it comes to health. Perhaps this flags an opportunity to develop and justify a communications-oriented approach to health—not in a prescriptive sense, but in an analytical one. Or, at the very least, to start a conversation about how health and communication entwine more broadly.

Troubling health, troubling promotion

"Health" encompasses many things. Historically, health was understood to be the absence of disease. Yet in 1946, the World Health Organization reframed the focus so that health became defined as "a state of complete physical, social and mental well being" (WHO, 1948). Health was recognized as a "human right" in the Universal Declaration of Human Rights (1948) and in multiple subsequent UN declarations and commissions. Indeed, resolutions of the UN Commission on Human Rights in 2001 to 2005 recognized "the human right to the highest attainable standard of health" (R. Elliott, 2012, slide 13).

This broadened definition of and right to health, however, is not without difficulties. As Richard Smith observed in a *BMJ* blog, the WHO's definition of "complete physical, social and mental well being" would leave "most of us unhealthy most of the time" (Smith, 2008).⁶ Recent scholarship has further problematized the assumption that health is a single or "fixed entity that can be transported from one setting to another" (Metzl in Metzl & Kirkland, 2010, p. 1). "Health," cautions Jonathan Metzl, "is a term replete with value judgments, hierarchies, and blind assumptions that speak as much about power and privilege as they do about well-being. Health is a desired state, but it is also a prescribed state and an ideological position" (2010, pp. 1–2). It is bound up with moral judgments about people and actions (Berlant, 2010; Connell & Hunt, 2010; Hunt, 2003; Lebesco, 2010), and it is often grounded in broader expectations of one's *responsibility* to be healthy. As Foucault observed many decades ago, "the imperative of health [is] at once the duty of each and the imperative of all" (1980, p. 170).

The healthy body is, above all, a working body, both on a cellular and a cultural level. David Harvey observes that "under capitalism sickness is defined as the inability to work" (cited in Berlant, 2010, p. 28). The social importance placed on the literal and figurative "working body" is such that even individuals who are ill typically provide "accounts"⁷ of themselves as en route to being healthy, feel compelled to appear healthy, and deny weakness in order to represent themselves "as worthy individuals, as more or less 'fit' participants in the activities of the social world" (Radley & Billig, 1996, p. 221).

And so, the healthy body "works." This means, among other things, earning money so that one might fulfill one's role as a citizen consumer and not burden Canada's health care system (C. Elliott, 2007). That illness might *result* from the ways that we press "pause" on the stressful elements of this working existence—by smoking, overeating,





watching television in lieu of exercising, or eating pints of Häagen-Dazs—has been observed by some critical scholars (Berlant, 2010), as has the fact that biomedical definitions of health have utterly obscured “alternative approaches to well-being, namely those that emphasize the centrality of pleasure” (Klein, 2010, p. 7). In light of this, scholars such as Richard Klein further challenge us to “imagine another world in which public policy declared that pleasure is the principal means to health” (p. 19); indeed, Klein suggests that “we could do more for public health if the government spent a fraction of what it spends curbing smoking on promoting dancing” (p. 18).

Klein’s call for an Epicurean approach to health, focused as it is on *feeling* good instead of regulating, denying, medicating, and objectifying the body, certainly troubles current understandings of health—but his alternative approach to well-being is a minor chord. Promoting pleasure as critical to health is absent from the current framework for health, in which “health has become a commodity and an industry” (p. 16). We might argue that the former, Epicurean perspective relies on the *language of pleasure*, while the latter, commodity perspective rests on a *language of betterment*. To be “better,” on an individual level, means to constantly seek to improve oneself. In the context of “health,” it embraces a mixture of self-monitoring and self-restraint. Not only does this open up a range of commercial sales possibilities (i.e., the purchase of tracking tools, pharmaceuticals for health, health magazines, diet products, gym memberships, personal trainers, exercise equipment) in which promotion and health intertwine, it also mobilizes a range of anxieties, because pursuing “health” means navigating an expansive array of everyday risks. Individuals “come to be assessed, or are invited to assess themselves as being ‘at risk,’ ” argues Alan Hunt (2003, p. 167), and in the health arena it is often the little, everyday, or “lifestyle risks” that capture a sizeable amount of personal attention, media space, and public policy recommendations. This occurs, in part, because of the ever-expanding universe of items that have been swept up in the risk discourse.

Individual lifestyle choices such as smoking, drinking, and driving without a seat belt are now generally accepted as risky behaviours (and also as social problems), but consumers have been equally invited to apply “risk” to a number of other previously benign items and choices. “Salty foods cause 9,000 to 16,000 premature deaths and some \$3 billion in health care costs and productivity losses annually,” cautions the July/August 2013 editorial in CSPI’s *Nutrition Action Healthletter* (Jacobson, 2013, p. 2). Eating pizza is thus transformed into a risky activity. So, too, is purchasing large sodas—that is, if one gives credence to New York Mayor Michael Bloomberg’s highly publicized proposed ban on the sale of sweetened drinks in containers larger than 16 ounces in restaurants, stadium concession stands, and movie theatres. Bloomberg’s large-soda ban sought to broaden the realm of risk by reframing the purchase of big, sugary drinks from a value-added choice (that fills a consumer need) to an obesogenic one.⁸ Or consider the equally controversial proposal unveiled by the Ontario Medical Association (OMA) in October 2012. In a press conference, OMA president Dr. Doug Weir outlined “aggressive new measures” to combat the obesity epidemic. These included:

- Increasing taxes on junk food
- Restricting marketing of fatty and sugary foods to children





- Placing information next to retail displays of high-sugar, high-fat foods to advise consumers of their associated “health risks”
- Placing “graphic warning labels” on pop and high-calorie foods of poor nutritional value. (OMA, 2012)

The OMA’s proposals speak to a discussion of communication and health (and the concept of troubling promotion) by implicating food *marketing* to children in the obesity epidemic, and by suggesting that communication is both part of the problem and part of the solution to obesity. The OMA suggests that *communication is part of the problem* because marketing high-sugar and/or high-fat foods contributes to obesity. The association further suggests that *communication is part of the solution* via its proposals to deter poor consumer choices with “graphic” warnings and “health risks” signage alongside retail displays of foods of poor nutritional value. Indeed, the impact of graphic warning labels, “health risks” information, or increased taxes on consumers’ behaviour is precisely the kind of health intervention that a health communication researcher would be interested in. A Communication and Health researcher, however, would also ask *what does it mean*, questioning the role of packaging, promotion, and the relationships existing between communication and health. Here, one might observe how the OMA’s proposed “graphic warning labels” on high-calorie, low-nutrient foods stand alongside Bloomberg’s large-soda ban and CSPT’s “death by salty foods” in illustrating the expansiveness and banality of “everyday risks”—and also how such risks are presented as the justifiable basis for policy decisions.

Equally important are the warning labels themselves, standing as prime examples related to packaging, promotion, and health. The OMA’s proposed graphic warning labels included a grape juice drink box marred by a graphic image of a child’s ulcerated foot and the warning “Excess consumption of this product contributes to obesity, Type 2 Diabetes and other related complications”; a chocolate milk carton cautioning that “Liquid calories are a significant cause of obesity and related illness”; and a pizza box stickered with a diseased liver and the warning that “Excess consumption of this product contributes to obesity and resulting Non-Alcoholic Fatty Liver Disease.” Although these proposed labels were lampooned by the media and the Canadian public, for the purposes of this article it is the OMA’s *intent* that matters, which was to make the consumption of chocolate milk, grape juice, pizza, soda, and other foods a type of “risky” behaviour.

The OMA’s recommendations present another layer of complexity because some of the very foods they indicted—and literally labelled as disease causing—had been promoted by other experts and authorities as healthy foods. While the OMA asked Canadians to view chocolate milk, grape juice, and pizza as harmful, the Dietitians of Canada had long been promoting chocolate milk as a positive food for children and athletes. Canada’s Heart and Stroke Foundation similarly endorsed various brands of grape juice with its Health Check symbol—a symbol that the foundation promotes as signalling that the product has been evaluated by registered dietitians and therefore contributes to an “overall healthy diet.” Moreover, Canada’s Food Guide for Healthy Eating—which exists to “promot[e] the nutritional health of Canadians” (Health Canada, 2011)—specifically lists both fruit juice and chocolate milk as servings for a





fruit and a “Milk and Alternatives,” respectively. Given this, which set of experts should one believe? The Ontario Medical Association, registered dietitians, or Health Canada?

A brief remark on the *foods* pilloried by the OMA and their *actions* for effecting change is also warranted. Brembeck and Johansson observe that “[f]ood and eating is a highly moral area. There are clear perceptions of right and wrong, good and bad, healthy and unhealthy, and adults have taken the responsibility for children’s eating” (2010, p. 810). Yet advances in science, nutritionism,⁹ and especially food marketing mean that what counts as healthy food is far from straightforward. Part of the controversy over the OMA’s proposals was that they pulled what had been previously understood as benign (if not health-promoting) foods into a *moral* arena by linking them with cigarettes. Parents purchasing chocolate milk and the like for their children suddenly were recast as “bad” or irresponsible for feeding them obesogenic and diabetes-inducing foods. Simultaneously, the OMA’s platform troubled the (apparently) “clear perceptions” of good and bad, healthy and unhealthy foods suggested by Brembeck and Johansson, upending the recommendations of both Canada’s Food Guide and dietitians. Taken as a whole, the OMA’s aim to combat the “wholly preventable disease” of obesity, starting with its press conference and its “aggressive” policy measures, *literally* becomes one of troubling promotion—and on multiple planes.

The question of communication

In the 30th-anniversary issue of the journal *Sociology of Health and Illness*, Clive Seale published a comparative content analysis of leading journals of sociology and medical sociology in the U.S. and the U.K. His article, “Mapping the Field of Medical Sociology: A Comparative Analysis of Journals,” found clear distinctions between the American and British traditions, and between medical and general sociology. “Medical sociology journals on both sides of the Atlantic focus on individual experience,” Seale reported, while general sociology journals focus “more on social systems levels of analysis” (2008, p. 677). British medical sociology was found to be “relatively atheoretical” and American medical sociology “relatively apolitical” compared to their general sociology counterparts (p. 677). “Mapping the field” prompted Seale to suggest a future, fruitful direction for the sociology of health—which to is to explore health issues from a social problems perspective, drawing in “topics of globalization, internationalism in health care and social systems–level analysis” (p. 693).

Seale’s comparative analysis, along with his proposed direction for medical sociology, hints at why a discussion of *communication* and health is necessary. That sociologists ask different questions than communication scholars is obvious, but the “social problems” perspective does not, by definition, interrogate the ways that “health” issues are communicated, packaged, framed, represented, and subjected to PR spin. Certainly, there is overlap between sociological and communication questions (e.g., questions pertaining to social problems, governmentality/healthism, risk, identity, etc.), but my sense is that something different blooms in positioning communication as a primary frame of reference for health. Communication and health starts from the perspective that health is a sociocultural phenomenon, but its very “embodied-ness” pushes against the notion that health is simply an “object” to be studied like any other object: something seems inherently flawed in approaching “health” as one might ap-





proach a study of television or Twitter. If we further consider that “media” in nineteenth-century usage “often meant the five senses” (Peters, 1999, p. 156), the bodily aspects of health *and* communication connect even more closely. Sight, hearing, smell, taste: alongside many other bodily and mental components, these too constitute a healthy body (when working properly). When the senses falter, problems arise (e.g., blindness, deafness, obesity). Furthermore, if we consider “media” in both its historical sense of dealing with *bodily* aspects *and* in its modern sense, then a double layer ensues: contemporary “media” becomes the vehicle through which concerns over those bodily aspects of health become emphasized, promoted, distorted, and circulated.

Of course, “troubling promotion” when it comes to health does not suggest a unilateral sending of a message to the public. Promotion is dialogical, and interesting questions can arise from examining the packaging/promotion of health in creation networks like YouTube (with over 1.7 million channels on “health”), curation networks like Pinterest (with boards on healthy habits, healthy living, longevity), and the myriad other social media platforms available. Indeed, there are many questions that a communication scholar interested in health might ask—and given the burgeoning interest in health, it seems fruitful to start a conversation about what a Communication and Health approach might look like. This probe into communication *and* health intends to be a starting point for that discussion.

Notes

1. For example, health is listed as one of the University of Toronto’s seven thematic areas, one of McGill’s seven broad Areas of Research Excellence (i.e., to “Support health research and improved delivery of care”), and is found in various thematic clusters of Queen’s University’s Strategic Research Plan. Health is one of the University of Calgary’s Strategic Research Themes (under the heading of “Brain and Mental Health”), is one of Carleton University’s four interdisciplinary strategic themes, and is listed in Simon Fraser University’s Strategic Research Plan under “Health and Biomedical Sciences.”
2. This general line of questioning was inspired by the thought-provoking book edited by Metzl and Kirkland, *Against Health: How Health Became the New Morality* (2010).
3. I am indebted to Sheryl Hamilton for the term “troubling”—she uses it as a conceptual framework for her excellent book *Impersonations: Troubling the Person in Law and Culture* (2008).
4. This is not a critique of Charland’s article; as noted, providing such direction was not his objective.
5. One might equally plunk in “television” in place of fluoridation. But Charland did not, and the fact that he did use a public health issue is worth noting.
6. The WHO’s definition of health prompted a December 2008 editorial in *BMJ*, which called for a “global conversation” on how health should be defined and invited anyone to comment on, challenge, or “try to enhance” the WHO’s original definition (Jadad & O’Grady, 2008). The results of that conversation were published in *BMJ* three years later with a new definition of health proposed as “‘the ability to adapt and self manage’ in the face of social, physical, and emotional challenges” (Godlee, 2011).
7. “Accounts” in this case is defined as “the activity of socially representing the world” (Radley & Billig, 1996, p. 223).
8. Note that the NYC Board of Health approved the ban in November 2012; it was overturned as “arbitrary and capricious” by a lower court, appealed, and ultimately overturned by New York State Supreme Court Appellate Division for the First District in July 2013.





9. Nutritionism is the tendency to evaluate food in terms of their nutrient and biochemical composition instead of more holistically. Key to nutritionism is the assumption that “a calorie is a calorie, a vitamin a vitamin and a protein a protein regardless of the particular food it comes packaged in” (Scrinis, 2008, p. 41). Nutritionism has been embraced by the food industry and has become a powerful means of marketing products.

References

- Alexis, André. (2013, February 2). What a good book can do. *The Globe and Mail*.
- Berlant, Lauren. (2010). Risky bigness: On obesity, eating and the ambiguity of ‘health.’ In Jonathan Metzl & Anna Kirkland (Eds.), *Against health: How health became the new morality* (pp. 26–39). New York, NY: New York University Press.
- Brembeck, Helene, & Johansson, Lena. (2010). Foodscapes and Children’s Bodies. *Culture Unbound*, 2, 787–818.
- Carpenter, Christopher J. (2010). A meta-analysis of the effectiveness of health belief model variables in predicting behavior. *Health Communication*, 25(8), 661–669.
- Charland, Maurice. (1992). Postmodern rhetorics of technology: The Montreal fluoridation controversy. *Canadian Journal of Communication*, 17(2), 177–190.
- Connell, Erin., & Hunt, Alan. (2010). The HPV vaccination campaign: A project of moral regulation in an era of biopolitics. *Canadian Journal of Sociology*, 35(1), 63–82.
- Dahl, Marilyn. (1993). The role of the media in promoting images of disability—Disability as metaphor: The evil cripp. *Canadian Journal of Communication*, 18(1), . URK: <http://www.cjc-online.ca/index.php/journal/article/view/718/624>
- Elliott, Charlene. (2007). Big persons, small voices: On governance, obesity and the narrative of the failed citizen. *Journal of Canadian Studies*, 41(3), 134–150.
- Elliott, Richard. (2012, January). NGO advocacy for healthy public policy. *Case study: HIV/AIDS Legal Network and Canada’s Access to Medicine Regime*. Public address at the University of Calgary, Calgary, AB.
- Foucault, Michel. (1980). *Power/knowledge*. New York: Pantheon.
- Godlee, Fiona. (2011). What is health? *British Medical Journal*, 343, DOI: [10.1136/bmj.d4817](https://doi.org/10.1136/bmj.d4817).
- Goodall, Catherine E., & Reed, Phillip. (2013). Threat and efficacy uncertainty in news coverage about bed bugs as unique predictors of information seeking and avoidance: An extension of the EPPM. *Health Communication*, 28(2), 63–71.
- Haig, Thomas. (2006). Bareback sex: Masculinity, silence, and the dilemmas of gay health. *Canadian Journal of Communication*, 31(4), 859–877.
- Hamilton, Sheryl. (2008). *Impersonations: Troubling the person in law and culture*. Toronto, ON: University of Toronto Press.
- Hathaway, Andrew D., & Erickson, Patricia G. (2004). A tale of two stimulants: Analysis of newspaper coverage of cocaine and tobacco in Canada. *Canadian Journal of Communication*, 29(1), 61–80.
- Health Canada. (2011). *The revision process*. URL: http://www.hc-sc.gc.ca/fn-an/food-guide-aliment/context/rev_proc-eng.php [February 11, 2014].
- Health Communication*. (2013). *Aims and scope*. URL: <http://www.tandfonline.com.ezproxy.lib.ucalgary.ca/action/aboutThisJournal?show=aimsScope&journalCode=hhth20> [Accessed April 19, 2014]
- Hunt, Alan. (2003). Risk and moralization in everyday life. In Richard Ericson & Aaron Doyle (Eds.), *Risk and morality* (pp.165-192). Toronto, ON: University of Toronto Press.
- Irvine, Ross. (1976). Advertising, alcohol and *Maclean’s*. *Canadian Journal of Communication*, 3(1), 9–12.
- Jacobson, Michael. (2013, July/August). Food industry 147, public health 122. *Nutrition Action Healthletter*.
- Jadad, Alejandro R., & O’Grady, Laura. (2008). How should health be defined? [Editorial]. *British Medical Journal*, 337, doi:10.1136/bmj.a2900.





- Klein, Richard. (2010). What is health and how do you get it? In Jonathan Metzl & Anna Kirkland (Eds.), *Against health: How health became the new morality* (pp. 15–29). New York, NY: New York University Press.
- LeBesco, Kathleen. (2010). Fat panic and the new morality. In Jonathan Metzl & Anna Kirkland (Eds.), *Against health: How health became the new morality* (pp. 72–82). New York, NY: New York University Press.
- Leslie, Myles. (2006). Fear and coughing in Toronto: SARS and the uses of risk. *Canadian Journal of Communication*, 31(2), 367–389.
- Metzl, Jonathan, & Kirkland, Anna (Eds.). (2010). *Against health: How health became the new morality*. New York, NY: New York University Press.
- O'Keefe, Daniel J., & Nan, Xiaoli. (2012). The relative persuasiveness of gain- and loss-framed messages for promoting vaccination: A meta-analytic review. *Health Communication*, 27(8), 776–783.
- Ontario Medical Association (OMA). (2012, October 23). Ontario's doctors call for urgent action to combat obesity epidemic [Press release]. URL: <https://www.oma.org/Mediaram/PressReleases/Pages/ActiontoCombatObesityEpidemic.aspx> [February 11, 2014].
- Peters, John Durham. (1999). *Speaking into the air: A history of the idea of communication*. Chicago, IL: University of Chicago Press.
- Radley, Alan, & Billig, Michael. (1996). Accounts of health and illness: Dilemmas and representations. *Sociology of Health and Illness*, 18(2), 220–240.
- Sawchuk, Kim. (2007). Editorial. *Canadian Journal of Communication* [Special issue], 32(3&4), 329–333.
- Schnoll, Robert A., Cappella, Joseph, Lerman, Caryn, Pinto, Angela, Patterson, Freda, Wileyto, E. Paul, Bigman, Cabral, & Leone, Frank. (2011). A novel recruitment message to increase enrollment into a smoking cessation treatment program: preliminary results from a randomized trial. *Health Communication*, 26(8), 735–742.
- Scrinis, G. (2008). On the ideology of nutritionism. *Gastronomica*, 8(1), 39–48.
- Seale, Clive. (2008). Mapping the field of medical sociology: A comparative analysis of journals. *Sociology of Health and Illness*, 30(5), 677–695.
- Sheridan, Stacey L., Halpern, David J., Viera, Anthony J., Berkman, Nancy D., Donahue, Katrina E., & Crotty, Karen. (2011). Interventions for individuals with low health literacy: A systematic review. *Journal of Health Communication*, 16(Suppl. 3), 30–54.
- Smith, Richard. (2008). The end of disease and the beginning of health. *BMJ Group Blogs*. URL: <http://blogs.bmj.com/bmj/2008/07/08/richard-smith-the-end-of-disease-and-the-beginning-of-health> [April 19, 2014].
- Tremblay, Diane-Gabrielle. (2005). Virtual communities of practice: Explaining different effects in two organizational contexts. *Canadian Journal of Communication*, 30(3), 367–382.
- World Health Organization (WHO). (1948). Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19–22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (*Official Records of the World Health Organization*, no. 2, p. 100) and entered into force on 7 April 1948. URL: <http://www.who.int/about/definition/en/print.html> [May 16, 2014].



