

# **COMMUNICATIONS PRIMER**

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*We use the style of reporting [research] that is most natural to legislative policymakers and their staffs: the anecdote. This may seem somewhat ironic, given that by conducting an evaluation in the first place one has deliberately moved away from the anecdote as a credible response to a policy question.*

*Eleanor Chelmsky  
U.S. Congress General Accounting Office, 1994<sup>1</sup>*

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Redressing the imbalance between the communication of privately- and publicly-funded health services research is an important part of CHSRF's role. In a 1995 survey of its researchers,<sup>2</sup> the Social Science and Humanities Research Council obtained self-reports that only 6.7 percent of the average researcher's time is spent on communicating results outside the academic community. CHSRF's goal is to improve this situation and increase the profile of publicly-funded, peer-reviewed research in health system decision making. This primer focuses on ways to improve communication between applied health services researchers and health system managers or policy makers who are the focus of CHSRF. One element of this improved communication involves building partnerships between decision makers and researchers during the early stages of research design so that results may be better communicated at the conclusion of the project.

The first section of the primer outlines some principles of persuasive communication. CHSRF-funded investigators are encouraged to incorporate these into their communication efforts. The second section of the primer reflects these principles in the specific reporting requirements and expectations for investigators, and includes a description of the resources that CHSRF will make available to assist investigators.

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### Look Who's Talking

In an interview that aired on CBC's Marketplace television program on November 11, 1997, Judy Erola, President of the Pharmaceutical Manufacturers Association of Canada, was asked to respond to the claim that the marketing costs for a new drug were equivalent to its research development costs. She confirmed that this was the case, but preferred to label the additional costs as 'education'.

Whatever the label, the communication of research results clearly receives more attention among pharmaceutical companies than it does among publicly-funded research enterprises. The proportion of public health research funds committed to communication of results hardly reaches 1 percent, never mind 50 percent—\$1.1 million on dissemination versus \$343.5 million on research projects and programs according to one 1993/94 estimate.<sup>3</sup> Insofar as research contributes to the pool of ideas that inform health care decision making, then publicly-funded research is likely under-represented in this market place of ideas.

# PERSUASIVE COMMUNICATION

## The Source

Researchers enjoy a high degree of credibility for their expertise as individuals, but somewhat less for their harmony as a group. The critical assault and healthy dissension that is the nutrient of many scholarly settings appears contradictory and contrary to many outside the research community.

The coherence of the researchers' voice is somewhat improved by the aggregation of applied researchers with different disciplines and approaches into centres and institutes<sup>5</sup>. This facilitates working out differences internally before communicating messages to those outside the research domain. The reputations of these identifiable sources of research communication are used by 'outsiders' in their assessment of the credibility of the information.

Another advantage of such aggregation is obviously the spread of fixed costs for communications infrastructure across many investigators. The costs of maintaining writers, document production facilities, mailing and contact lists, the capacity to organize round tables and presentations are substantial; they are perhaps best shared across multiple investigators.

### The SCAM Approach

The marketing and advertising literature outlines at least four considerations when designing a plan for persuasive communication<sup>4</sup>:

- the **Source**
- the **Channel**
- the **Audience(s)**
- the **Message**

### Who Said You Don't Judge a Book by its Cover!

In the late 1980s, Blue Cross/Blue Shield (BC/BS), health care insurers in the U.S., contracted with the American College of Physicians (ACP) to use the practice guidelines produced by ACP. When members of the ACP were surveyed about the relative credibility of practice guidelines produced by more than ten different organizations, the highest ratings went to their own ACP guidelines (82% had confidence in these). In a powerful demonstration of how 'source' affects receptivity to research, the lowest ratings (6%) were given to those same guidelines re-packaged under the BC/BS cover!<sup>8</sup>

Usually, however, the more distant the source of a communication from the world of the decision maker, the less influential is the communication<sup>6</sup>. Hence, pharmaceutical companies and others often use local 'influentials' or 'opinion leaders' to carry their message forward<sup>7</sup>. Researchers could do well to use such opinion leaders, either locally or within larger networks, as credible sources for communicating their research. In order to ensure the success of this approach, it is important to lobby, liaise and communicate with the opinion leaders themselves.

Finally, the more sources from which a message emanates the more likely it is to be heard and incorporated into planning and decision making. Therefore, choosing the *selection* of sources for the communication of results is more appropriate than deciding on a single source. Finding sources

that are congruent with the preferences of the

audience is important; insurers in the U.S. are obviously not congruent with the predilections of some U.S. physicians (see box).

## The Channel

Traditional academic journals are not the best channel of communication to reach most decision makers. Other channels that have a higher probability of gaining the attention of decision makers include:

- ▶ trade journals
- ▶ newsletters
- ▶ web pages
- ▶ television, radio, newspapers
- ▶ conferences
- ▶ seminars and round tables
- ▶ one-on-one meetings and exchange
- ▶ presentations to selected groups of decision makers

One-on-one and face-to-face interaction consistently emerge from the research transfer literature as the most persuasive channels of communication,<sup>7,9</sup> but this may only be feasible for researchers with their local decision makers and media. Therefore, for communication beyond local audiences, presentations at ‘one-of’ round tables, seminars and conferences often have to suffice.

Newspapers and other media potentially offer a wide but sometimes short-lived impact<sup>10</sup>. Nevertheless, newspapers and other written channels such as web pages, newsletters and (trade or scholarly) journals have the distinct advantage of permanency, offering recipients the opportunity to access the information when needed, as well as when offered.

A portfolio of channels can therefore:

- ▶ alert decision makers to the availability of the research
- ▶ provide venues for clarification of its implications
- ▶ ensure ‘hard copy’ availability when the window of opportunity opens for the use of the research results in decision making.

## The Audience(s)

Much of the publicly-funded research enterprise is appropriately directed to discovery and exploration, with no premature constraint about its potential application. The audience for the results of this work is largely other researchers interested in following up with more studies. The language and format of these ‘researcher-to-researcher’ communications justifiably reflects the cloistered and select nature of the audience.

However, health services researchers, or at least those with a focus on the application of their work to decision making, consider a more complex set of audiences. They are wary of generalizing from their researcher-to-researcher experiences for their researcher-to-practitioner communications<sup>11</sup>. When it comes to communicating research results, what is sauce for the (researcher) goose is usually indigestible for the (decision maker) gander! One of the main objectives of CHSRP is to bridge this communication gap between researchers and decision makers.

In addition to his or her scholarly colleagues, there are at least three other potential audiences for the applied health services researcher:

▶ Direct interaction with relevant **local and provincial decision makers**

Ongoing linkage and exchange between researchers and decision makers expands the common ground for communication and defines a common language for interaction. Direct involvement of decision makers in the research process from the early stages is consistently a major predictor of results uptake.<sup>12,13</sup> Co-sponsorship is a concrete expression of interest; involvement as a co-investigator is a further measure of commitment from this audience.

▶ Dissemination to other **national and international decision makers**

Ongoing communication may only be feasible with local decision makers. Reaching managers and policy makers in other parts of the country or internationally requires a different approach. Knowledge about the reading, conference-attending, and general information acquisition habits of this more dispersed audience can inform these dissemination efforts.

▶ Marketing to **the media and other knowledge purveyors** who influence decision makers

Politicians, policy makers and managers are necessarily influenced by the agendas set in the media. National, local and ‘trade’ media are therefore all potential outlets for research results that have clear implications for decision making. Understanding how to appeal to this audience, while retaining the integrity of the research is, as stated by Eleanor Chelimsky in the opening quote, one of the ironies of applied research.

Not surprisingly, one-size-fits-all communication strategies are rarely successful. Each of the above audiences responds to tailored approaches, and the investigator is well advised to explore with representative members of each audience their preferred formats, timings and/or locales for communication of research information.

## The Message

The sensitivity of the message to the audience being addressed is always important. Ellwood’s experience with HMOs is just one example of many where attention to the ‘packaging’ of the message makes a difference as to whether the substantive contents are heard (see box). Stating that “more research is needed” does little to help a decision maker faced with a demand for a decision now; stating that “although more research is needed, current evidence suggests ...” is more congruent with the decision maker’s obvious need to be pointed in a particular direction.



### **HMOs: CRUNCHY GRANOLA OR BUSINESS ENTERPRISE?**

Paul Ellwood is often credited as the godfather of the Health Maintenance Organization (HMO) concept in the U.S. His experience illustrates the influence of how a message is delivered on the receptivity of the audience. Under Nixon’s Republicans, he made ground with the HMO concept by highlighting its competitive potential and emphasizing its role in enhancing market forces. Under Jimmy Carter’s Democrats, he advanced the idea by stressing its community roots and potential for local empowerment. The central design remained unchanged, only the chosen headline that grabbed the decision maker’s initial attention was altered<sup>14</sup>.

In his classic study of the diffusion of medical innovations, Rogers pointed to a number of message characteristics that influence the likelihood of uptake<sup>15</sup>. Among these are:

▶ **Complexity**

The less complex the message, and the adaptations and changes in practice implied by it, the more likely is its adoption.

▶ **Trialability**

The more practitioners are able to try out the recommended change while reserving the right and ability to revert to old approaches, the more likely is its adoption.


▶ **Observability**

The more that there is a chance for practitioners to observe the consequences of a change implied by a message (e.g., improved health or lower costs) the more likely is its adoption.

▶ **Compatibility**

The more the message is couched in language or implies change that is compatible with the culture of the practitioner's environment, the more likely is its adoption.

Finally, certain aspects of a message lead to greater or lesser appeal to the media. Besides the obvious need for KISS (Keep it Simple Stupid) in messages to the media, researchers need to be aware of and adapt to inherent biases that are integral to the way the media operates (see box). Some of these biases are directly contrary to the accurate reporting of research; others, however, can be taken into account to maximize both the likelihood that a research communication will gain coverage and that the coverage will be accurate.



**The Media and the Message**

In a remarkably frank self-assessment of the media's limitations, a pair of Globe and Mail editorials in 1993<sup>16</sup> outlined the following biases:

- ▶ Representation bias  
Because of the need for a quick contact via the rolodex, identifiable contact groups are better represented than others.
- ▶ Certainty bias  
Bold statements that are definitive are better covered than hedges that imply uncertainty.
- ▶ Action bias  
Clear statements of (say) a six-point plan get more coverage than proposals for ill-defined incremental change.
- ▶ Quantification bias  
Statistics (whether valid or not) are quoted to give perceived objectivity.
- ▶ Identified individual bias  
Tying the message to an identifiable 'victim' or case provides the human interest upon which media coverage is so reliant.
- ▶ Conflict bias  
The propensity is to cover the extremes on an issue, not the considered commentary.

## Summary

All the elements of SCAM should be considered when investigators design a research communication plan. The local focus is on ways to improve ongoing linkage and exchange between researchers and decision makers; the wider focus is on communication that is persuasive for the targeted audience(s).

## REFERENCES

1. Chelimsky E. Chapter 1 in *Effective Dissemination of Clinical and Health Information: Conference Summary*, L. Sechrest et al (eds). Washington DC: Agency for Health Care Policy and Research, 1994.
2. Social Science and Humanities Research Council, *Academic Survey: How Researchers Communicate Their Findings*. SSHRC News, Fall/Winter 1994, pp 4-8.
3. Federal/Provincial/Territorial Advisory Committee on Health Services Working Group on Health Research, *Health Research Data*. Ottawa: Advisory Committee on Health Services, 1995, pp 10-17.
4. Winkler J., Lohr K., Brook R. *Persuasive communication and medical technology assessment*. Archives of Internal Medicine 1985; 145:314-317.
5. Frenk J. *Balancing relevance and excellence: organizational response to link research with decision making*. Social Science and Medicine 1992; 35:1397-1404
6. Greer A. *The state of the art versus the state of the science: the diffusion of new medical technologies*. International Journal of Technology Assessment in Health Care 1988; 4:5-26.
7. Soumerai S., Avorn J. *Principles of educational outreach ('academic detailing') to improve clinical decision making*. Journal of the American Medical Association 1990; 263:549-556.
8. Tunis S. et al. *Internists' attitudes about clinical practice guidelines*. Annals of Internal Medicine 1994; 120:956-963.
9. Fooks C., Cooper J., Bhatia V. *Making Research Transfer Work*. Toronto: Institute for Clinical Evaluative Sciences, 1995.
10. Judge K. et al. *Public opinion, the NHS, and the media: changing patterns and perspectives*. British Medical Journal 1992; 304:892-895.
11. Haynes B. *Loose connections between peer-reviewed clinical journals and clinical practice*. Annals of Internal Medicine 1990; 113:724-727
12. Weiss C. (ed). *Using Social Research in Public Policy Making*. Lexington, Ma: Lexington Books, 1980.
13. Charles C., Schalm C., Semradek J. *Involving stakeholders in health services research: developing Alberta's resident classification system for long-term care facilities*. International Journal of Health Services 1994; 24:749-761.
14. McClure W. *Health care cost commission: choices for medical care*. Minnesota Medicine 1972; April:261-271.
15. Rogers E. *Diffusion of Innovations* (3<sup>rd</sup> Edition). New York: The Free Press, 1983.
16. Globe and Mail. *Editorial: Theatre of the absurd (1) and (2)*. February 11 and 12, 1993.

## BIBLIOGRAPHY

Fooks C., Cooper J., Bhatia V. *Making Research Transfer Work*. Toronto: Institute for Clinical Evaluative Sciences, 1995 (<http://www.ices.on.ca>).

Huberman, M. and Thurler, G. (1991). *De la recherche à la pratique. Éléments de base*. Berne, Peter Lang Sa, Éditions scientifiques européennes.

Lomas J. *Improving Research Dissemination and Uptake in the Health Sector: Beyond the Sound of One Hand Clapping*. Hamilton: McMaster University Centre for Health Economics and Policy Analysis, Policy Commentary 97-1, 1997.

Sechrest L., Backer T., Rogers E., Campbell T., Grady M. (eds). *Effective Dissemination of Clinical and Health Information*. Washington DC: Agency for Health Care Policy and Research, 1994.

Winkler J., Lohr K., Brook R. *Persuasive communication and medical technology assessment*. *Archives of Internal Medicine* 1985; 145:314-317.