

Moving from information transfer to information exchange in health and healthcare

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This paper examines and challenges the commonly accepted practice of one-way **information transfer** in health information dissemination, beginning with a description of its main assumptions and key problems. The authors present three case studies that demonstrate the limitations of information transfer before describing the benefits of embracing **information exchange** (dialogue) in health communication.

Information exchange is based on a two-way dialogue where both layperson and “expert” voices are valued. Valuing the layperson’s opinion can improve health outcomes by a) putting the expert’s view into context; and b) increasing the layperson’s involvement and buy-in.

Information transfer (monologue)

Assumptions – Health communication practices reflect the belief that the link between communication and change is linear and uncomplicated, based on the assumptions that:

- changes in knowledge will translate into changes in behaviour;
- providing information is sufficient to produce improved health outcomes; and
- social context does not affect a person’s ability to act on information.

Key problems – The effectiveness of one-way communication is limited by three key problems:

- **The focus on the individual** denies broader social and environmental influences on health. This focus a) results in blaming the victim by denying social context; and b) assumes individuals should mould their health choices to some idealized standard.
- **The privileging of expert over lay perspectives** in clinical, public health, and policy-making environments dismisses the importance of lay knowledge and context, which are critical for knowledge uptake.

Key messages

- Information transfer (one-way monologue) is insufficient to change health behaviour or improve uptake of research by policy makers.
- People working at all levels of the healthcare system must adopt the idea of information exchange, which acknowledges context and lay knowledge and involves a respectful dialogue between “experts” and the people they want to influence.

- **The one-way pattern of information transfer** implies the information provider exercises power over the recipient.

Three studies

While the structure and practices of **information transfer** give experts the power to define truth, in each of the three studies examined by the authors lay groups resisted the expert advice.

Study 1: Doctor-patient encounters

This study examined doctor-patient perceptions of clinical healthcare delivery to women in a medically underserved, poverty-stricken U.S. region. Both groups reported the problems of information transfer were prevalent: individualism (ignoring the social context); privileging of “expert” opinion (reinforcing the physician’s power); and one-sided communication (devaluing women’s active role in their healthcare).

While physicians followed the practice of constructing their patients’ health through diagnosis and treatment, when questioned both doctors and patients questioned this practice.

Study 2: Health promotion and sun safety for urban Ontario women

This study showed that “risky” behaviours such as tanning are quite complex, and understanding the social context is critical to changing behaviour. While struggling between societal pressures and health expert opinions, women chose to redefine safe behaviour for themselves. They modified the recommended behaviour to accommodate the health warning and their desire to be tanned (for example, they spent time in the sun rather than “tanning”).

Study 3: National health policy-making regarding skin cancer and sun safety in Australia, Canada, and England

This study demonstrated that the three assumptions of information transfer are not only entrenched at the doctor/patient and health promotion/population levels, they are also embedded to some degree in interactions between international researchers and policy makers. Decision makers resisted the simplified consensus of researchers and sought out broader, more contextual evidence.

Need for two-way dialogue

The authors contend we must adopt the two-way dialogue of **information exchange** at all levels of healthcare, from doctor/client exchanges in the clinic to researcher/decision maker interactions during policy formation. They point to recent

AIDS and breast cancer research that was grounded in the realities of end users and that resulted in unique and innovative policy decisions. While the information exchange revolution will take time to reach all levels of healthcare, the authors argue that a good first step is to broaden our view of health information dissemination to include laypeople.

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