Using the power of a digital campaign to disseminate information about health to more people

by Camilla Cooke

The Australasian Medical Writers Association's 26th annual conference was held at the University of Sydney on Friday 16 and Saturday 17 October, 2009 [1]. The title of the conference was 'Medical writing in focus'. Camilla Cooke gave a plenary lecture titled 'Using the power of a digital campaign to disseminate information about health to more people'. Camilla Cooke worked on the digital campaign for Kevin Rudd's successful bid to become Australia's Prime Minister in December 2007. Her group was the first to run a political campaign mobi site, kevin07.mobi, a technique which was subsequently used by the Obama campaign [2].

EMWA and The Write Stuff thank the Australasian Medical Writers Association (AMWA) and Camilla Cooke for allowing us to publish the following report of the lecture written by Camilla which she has posted on her website [3]. Slides from the presentation are available on the AMWA website at www.medicalwriters.org.

The AMWA gave me the title '*Using the power of a digital campaign to disseminate information about health to more people'* for my plenary lecture**.** Not being sure how relevant this was to an audience of writers, I added 'And why you should care', in order to focus on the writer's role in the digital distribution of their work.

It's obvious to most of us that social media has gone bonkers. I'd spoken to a related organisation, the National Prescribing Service, a year before, and they had all gasped when I told them that Facebook had reached 3.7 million, and of course it's now > 8 million, Twitter > 1.5 million blaa blaa. In fact, I'm sick of hearing about 'social media'—it's up there with 'Australian working families' and 'we are facing the worse financial crisis since the great depression' No! Really? More interesting for this group are the health stats; health topics represent over 42% of Australian searches[1] and rising, 61%[2] of Americans consult the web on health and 41%[2] of them consult each other (non-medical professionals) whilst (to quote the European Journal of Integrative Medicine in May 09) "the evidence for most of the recommendations [on health websites] is weak to nonexistent". So whilst 'digital health' is exploding, with the rise of health and 'wellness' websites, content, services and communities everywhere online, this is a haven not only for the 'cyberchondriac' but also the 'cyberquack'.

Looking at the 'dissemination' of health content and messaging online, traditional digital media communications are being practiced extensively by commercial and government organisations across the health spectrum; specialist health digital agencies are proliferating (for example Big Pink recently opened in Sydney) and we've seen great banner advertising from Panadol and drive to web from Pfizer (with the 'getthefacts' campaign). A cursory glance in Google under 'menopause' brings up quite a range of paid ads—the pharmas are in there with 'Promensil', Blackmores is there, and Wellspring are offering a herbal remedy for $39.95 that gets rid of the menopause in 24 hours (fantastic! I'll take 2!). The government(s) are making great use of SEM (you can't MOVE at the moment without a government ad for the swine flu vaccine) and are, reassuringly perhaps, coming up tops in natural search on a lot of specific health issues.

It's not exactly 'health', but the recent Clearasil campaign (around digital 'friends' etiquette, running applications on both Bebo and Facebook) is fairly typical, and follows on from the Kotex U site that successfully engaged girls in conversations regarding teenaged female health. This sort of diversionary branding of content is becoming very typical and it's a great form of sponsorship, if you like, providing relevant value added content and obviously with applications and widgets yielding lots of viral opportunities, but this now also falls into the area of traditional marketing.

Where it's really at is, of course, the mainstream conversation in social media environments. 'authentic' is the new black. We've seen cheesy attempts at chatter (the recent Windows 7 party video from Microsoft made us all cringe but at least we knew it was fake). The Witchery 'man in the jacket' case was interesting, as it attempted to appear genuine (although I'm surprised if people thought it was—I thought it was about as convincing as the Godwin Gretch e-mail, just a little to convenient and so self-consciously casual, but perhaps the fact that I'm an ex-actress in advertising gives me excellent fraud credentials). Some of us were alarmed by the recent blatant agency advertisement for a paid job in astroturfing (or 'social infiltration'). More sinister still are the 'Champix/Chantix' video testimonials (a drug by x that is meant to help you give up smoking, and was subject to claims that it caused depression resulting in suicide in some cases). Melissa Sweet pointed out >

1 Hitwise July 08 (Australia)
2 Pew Internet & American Life Project June 09

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in The Australian Prescriber last year that these appeared 'spontaneously' from across the globe on You Tube. Now, we don't know if these are genuine or semi-genuine, but my point is that people will believe anything—you've only got to look at the continued success of horoscopes to see that. And they don't interrogate the 'evidence' of any 'evidence-based' medical facts very deeply.

People are definitely searching for information on health, but they read (and believe) what's in front of them, what comes up first in Google, what their mates say on Facebook. They buy miracle cures for $39.95. A University of Texas study in 2008 found that 5% of pages on breast cancer contained inaccurate information and that complementary medicines pages were 15 times more likely to be inaccurate.

So DO SOMETHING about medical misinformation. Medical writers should explain the importance of evidence-based sources in everything they write. Publishers of evidence-based medical information should use good digital marketing to reach people. Organisations should work with government to extend the use and awareness of a consolidated accreditation system and this should be extended to writers themselves. Make a virtue of the bewildering volume of medical content, and the public's curiosity by giving them a symbol they can trust.

But why should medical writers do this? What relevance has it to them? And my answer to this is; because they care. They wouldn't have joined the AMWA, membership of which excludes any "person whose sole work is directed to the promotion of a product or a commercial organisation". In other words, they are not in it just for the money, or they could have made a lot more. So if they care, they should also care about being *read*, not just *published*. They should care about bringing evidence-based content to the fore to compete with all the other material that is successfully reaching a public increasingly thirsty for health information.

In this day and age, it is no longer a question of handing over material to a publisher who is then responsible for 'disseminating' it—job done. We are all publishers, we are all broadcasters. I'm probably one of the worst practitioners, but what I think or write doesn't matter, what *they* write *does* matter. So my directive was: write a blog, tweet your articles, RSS your blog, tweet your blog, stream your tweets into Facebook, follow everyone relevant, join every relevant group, comment and link, edit Wikipedia and Medipedia, write Wikipedia and Medipedia, bookmark all your work, and create a Google virtuous circle. Social media is not a just a pastime for medical writers, it's a moral responsibility.

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References:
1. http://www.medicalwriters.org/index.htm
2. http://www.wpp.com/wpp/marketing/digital/obamas-digital-campaign.htm
3. http://camillacooke.wordpress.com/2009/11/05/why-medical-writing-needs-to-get-social/

Definitions box

Adrenergic

The suffix *–ergic* means to work by means of (from the Greek *ergos*, meaning to work). Thus, *adrenergic* means working by means of adrenaline. In the US, ergic is used to classify receptors, so that *adrenergic* receptors are receptors that respond to epinephrine (the US name for adrenaline). This usage of ergic does not meet the recommendations of the The International Union of Pharmacology (IUPHAR), which say that ergic should be reserved for the classification of neurones in terms of the neurotransmitter they store and release in response to action potentials. *Adrenergic* should therefore be used only to describe nerves that release adrenaline (epinephrine for US readers) from their terminals [1].

When neurotransmitters were first being discovered and identified in the 1930s, adrenaline was thought to be the principal neurotransmitter in peripheral sympathetic nerves (nerves involved in controlling such things as blood pressure over which we have no voluntary control). However, it was eventually shown (1945) that the neurotransmitter in these peripheral nerves is *nor*adrenaline (norepinephrine in the US), rather than adrenaline, whereas adrenaline is the hormone released from the adrenal medulla in response to shock, fear or excitement. Nerves that have noradrenaline as their neurotransmitter should therefore be referred to as *noradrenergic*, although they seldom are—old habits die hard.

IUPHAR recommends that receptors on end-organs that respond to noradrenaline should be referred to as *adrenoceptors*, not *adrenergic* receptors [1]. Similarly, IUPHAR recommends that receptors that respond to the neurotransmitter acetylcholine should be called *acetylcholine* receptors rather than *cholinergic* receptors.

The recommendations of the Nomenclature Committee of IUPHAR are published in the journal *Pharmacological Reviews*. For a regular update of internationally agreed names of receptors and channels see The British Pharmacological Society's Guide to Receptors and Channels [2].

Finally, there is no such chemical as adrenalin.

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2. Alexander SPH, Mathie A, Peters JA. Guide to receptors and channels (GRAC), 3rd Edition. *Br J Pharmacol* 2008; 153((Supple. 2)):S1-S209.