Clackamas County Public Health Advisory Council

December 11, 2023 minutes

In attendance: Ruth Adkins, Mike Foley, Rebecca Stavenjord, Ryan Hassan, Gianou Knox, Pamela Bonner, Mitchell Doig

Excused Absences: Kelly Streit, Christina Bodamer, Yvonne Smith, Missy Albrich, Darcee Kilsdonk

Unexcused Absences: Annie LaVerdure-Weller, Beto Contreras

Others in Attendance: Philip Mason-Joyner, Armando Jimenez, Dr. Sarah Present, Kevin Dirksen, Sara Kolmes, Malley Nason, Kim LaCroix, Irvin Jacobo, Jenny Masculine, Maeve Connor, Elizabeth Federici

Facilitator notes on Dec. 2023 PHAC deliberation on responding to health misinformation.

Deliberation SWOT* analysis:

S – Already-existing ties to community health workers and other community trust brokers to provide education for communities in which medical misinformation exists, already-existing training programs for motivational interviewing and other forms of communication which identify differences in values in a neutral way to find common ground, strong dedication to working towards justice and long-term outlook on education and community building.

W – limited resources for outreach, a political climate that has fostered misinformation, lack of access to the actual sources of misinformation in many cases (e.g., media environments, algorithms pushing misinformation via social media, historical harms by medical establishment causing generalized medical mistrust)

O – public health organizations can partner with communities to combat misinformation and deepen ability to provide care for marginalized or underserved communities using the same strategies

T – failure to successfully outreach to these communities could result in misinformation problems becoming work, recent experienced with covid have revealed that addressing health misinformation is difficult.

*strengths, weaknesses, opportunities, threats

Deliberation question:

What is the impact of health misinformation, stigma, and community pushback on the delivery of public health services and resources? What is the role of public health in responding to instances of misinformation, stigma, and community pushback?

Summary / Takeaways:

The discussion was framed using a set of case studies demonstrating where medical misinformation prevented individuals and communities from accessing health-related resources. Participants appreciated that misinformation is not the same as disinformation and the nature of the false information and intent of those who are spreading it ought to be considered in terms of determining how public health responds.

Participants of the deliberation identified a distinction between responding to mistrust of a given person, on the one hand, and responding to medical misinformation on a community level, on the other. It was recognized that efforts to respond to medical misinformation on a community level – for example, timely messaging by a public health department to counter false claims about vaccine injury – would lead to a reduced occurrence of and need for individual responses to mistrust manifesting from specific persons. We noted that theoretical questions about standards of medical information and values may be less salient for those facing economic and material hardship; a focus only on this kind of communication would represent a justice issue and fail to outreach our community's most vulnerable.

Furthermore, participants reviewed the difficulty represented by larger political and societal forces that drive medical misinformation and its appeal. It was discussed that combatting medical misinformation may not feel 'apolitical' as medical misinformation is, regrettably, often politicized today. While public health organizations may not be able to quell such tides or avoid the political nature of these broader trends, the health-related benefits to be gained by even incremental progress may be substantial. The group noted that harm reduction is a great example where the evidence of programs like syringe exchange services are substantial yet are an increasing target of politically-motivated defunding efforts. It may be worthwhile to examine how such programs and the broader philosophy of harm reduction can be justified using discourse that other sectors of the public may find compelling such as: promoting public safety, representing a fiscally conservative strategy to decrease poor health outcomes that are extremely costly to taxpayers, about recognizing freedom and rights without ignoring the problems on our streets, etc.

The group discussed various strategies which might assist in engaging with communities who have been subject to medical misinformation. Potential resources to address this may include but are not limited to: i) training public health staff in motivational interviewing or MI (which is less forceful that overt communication strategies and can allow identification of shared values and value differences which can be distinct from disagreements about facts), ii) considering how formal communication efforts can model a philosophy of MI in formal messaging campaigns, and iii) further develop and leverage imbedded community health workers who are familiar with and trusted by the community.

To close, this is a perennial issue whose importance has only become more salient following Covid-19, and slow careful trust-building combined with humility was recognized as the most important force in combatting misinformation in the long term. The immediate goal is not merely to counter misinformation, but to work to become a trustworthy health partner for those we serve. This issue will not be solved immediately, but some strategies can begin to chip away at the problem.