2021

Disparities, Telemedicine, and COVID-19: Rhetorical Approaches to Health and Medicine for Positive Behavior Change in Older African American Women

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Recommended Citation

Wrenn, Audrey S., "Disparities, Telemedicine, and COVID-19: Rhetorical Approaches to Health and Medicine for Positive Behavior Change in Older African American Women" (2021). *All ETDs from UAB*. 532.
https://digitalcommons.library.uab.edu/etd-collection/532

DISPARITIES, TELEMEDICINE, AND COVID-19: RHETORICAL APPROACHES TO HEALTH AND MEDICINE FOR POSITIVE BEHAVIOR CHANGE IN OLDER AFRICAN AMERICAN WOMEN

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A THESIS

Submitted to the graduate faculty of The University of Alabama at Birmingham
in partial fulfillment of the requirements for the degree of
Master of Science

BIRMINGHAM, ALABAMA

2021

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ENGLISH

ABSTRACT

Overlapping exigencies experienced during the COVID-19 pandemic illustrate the need for adaptable and flexible public health responses that include cultural perspectives and lived experiences of specific groups. The rhetoric surrounding COVID-19 has proven to be multifocal because of the social and environmental experiences occurring simultaneously. Americans experienced periods of civil unrest, unequitable health care, overall lifestyle changes, and an immediate shift to telehealth use as the pandemic unfolded. This research examines telehealth engagement during the pandemic among African American (AA) women ages 75 and older to indicate the benefits and challenges to patient care in a virtual environment and from an ecological perspective to show the role culture plays in health care. Structured phone interviews were conducted using an eighteen-item questionnaire to gain a better understanding of how personal beliefs, experiences, and behavior impact health decision-making among women who engaged in a telehealth visit during the pandemic. Participants were asked questions pertaining to health care, technology use in the home, experience with telehealth visits and providers, and interest in electronic health information. Findings show that telehealth has been beneficial to this population of older AA women who can fully engage in it, and that technological approaches can be more effective when they address physical limitations, accessibility, and cognition barriers among older AA populations. This study also notes the need for public discourse that emergences from fluid public health crises to be adaptable, flexible, and to accommodate the cultural perspectives of targeted groups. In order for the public health response to global health crises to be effective, social influences should be a part of the public discourse.

Key words: inequities, disparities, health communication, telemedicine, telehealth

ACKNOWLEDGEMENTS

I would like to acknowledge the following people who helped me through this journey.

Dr. Cynthia Ryan, my thesis committee chair, who guided and encouraged me along every step of the way. I am grateful for the feedback, suggestions, and reassurance through each phase of this project.

Dr. Christopher Minnix who introduced me to the concept of rhetorical ecologies and provided such thoughtful feedback.

Dr. Margaret Jay Jessee whose in-depth classroom discussions on historical social issues helped me visualize this project.

My husband and biggest supporter who encouraged me during the challenging times and gave me hope.

My three children who are my biggest cheerleaders. They inspire me in more ways than they know.

My parents who taught me to reach higher heights, and my sisters who helped keep me sane.

Dr. Cathy Roche who gave me great advice at just the right time.

All others who were put in my path for purposes of this project, I appreciate the support you gave in the way that only you could.

God, who never left my side.

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CHAPTER 1

INTRODUCTION

The COVID-19 pandemic has revealed health inequities, disparities and racial biases that have exposed exigencies throughout the United States. As the pandemic unfolded in 2020, the nation simultaneously experienced periods of civil unrest that continue to arouse memories of historical periods of racism in America. According to the American Psychological Association, “racist incidents that evoke social and historical experiences of racism” cause stress for older African Americans (AA) who have had to endure repeated periods of racial encounters throughout their lifetime (American Psychological Association, n.d.). The intensity of a global health crisis compounded with racial injustice has shown the role that culture plays in health care. Similarly, the rhetoric surrounding COVID-19 has proven to be larger than the virus itself. It is multifocal, having social and environmental aspects as well. There are individual and public health consequences associated with COVID-19 that have prompted a public health crisis response, and for the response to be effective, the social influences should be a part of the public discourse. According to Angeli and Norwood, “when public health crisis communicators craft messages, they engage in rhetorical work by managing and responding to specific contexts, audiences, and purposes simultaneously” (2019, p. 215). A rhetorical point of view is beneficial because it incorporates the voice of the individual – as a patient, minority, or certain gender – into “official communication” which can be difficult considering the complex necessities of public health (Malkowski and Melonçon, 2019, p. 11). Public health guidance is “more likely to reflect... institutional policy rather than...lived experiences of targeted communities” (Hite and Carter, 2019). Communication is sometimes crafted for the improvement of overall health, but the problems within health systems and social structures can make adherence to policy challenging or nearly impossible. Public health crisis communicators should understand the unique characteristics of specific groups within a population and gain insight into their beliefs, values, and norms. This exchange of information helps people acquire knowledge about health practices, policies and prevention strategies that are designed to examine personal risk, motivate action, and determine a response to messages received (Parrot, 2004).

The 2003 Institute of Medicine Report addressed the need for an ecological approach to achieve health aims through strategic health communication, an approach that involves the “interaction of multiple determinants including biology, behavior, and the environment...unfolding over the course of the lifespan of individuals, families and communities” (Parrot, 2004, p. 752). Rhetoric and ecology are complementary in that they address issues by considering systematic approaches to humanity (Druschke et al., 2016). Jenny Edbauer argues in favor of rhetorical ecological models because they “read rhetoric both as a process of distributed emergence and an ongoing circulation process”; they build connections between people, events and history and are not situated in one isolated event (2005, p. 13). On the contrary, Lloyd Bitzer defines a rhetorical situation as the “natural context of persons, events, objects, relations, and an exigence which strongly invites utterances” (1968, p. 5). In this way, rhetoric is viewed as situational, or occurring in an isolated place and within a specific set of constraints. The problem with Bitzer’s definition as related to the pandemic is that it presents a view of “rhetoric as elemental conglomerations” or “individual parts” that ignore overlapping exigencies and the processes and encounters that are ongoing, fluid and muddled (Edbauer, 2005, p. 7). For example, individuals participating in civil rights protests during the pandemic needed to adhere to health guidance intended to reduce the spread of the virus. Airline travelers were faced with restrictions that prevented them from traveling, even to care for sick family members who may have been infected with COVID-19. These two seemingly unrelated issues (protests and airline travel) were directly connected to the pandemic (a public health crisis), and the public health response needed to address these issues and other varying situations that individuals were facing. Public discourse that emerges from an ecological view is built on interwoven threads of human interaction situated within a changing environment. Viewing the COVID-19 crisis from an "ecological approach considers the dynamics of systems, and social and material environments that people are situated in” which provides a glimpse into the way individuals read themselves into a health crisis (Rivers and Weber, 2011, p. 196).

Making health care decisions can be complex at any age regardless of whether or not an illness is present, and the addition of a global health crisis can bring about many unforeseen challenges. According to 2017 data from the National Institute on Aging (NIA), Americans are living longer and approximately 85% of those age 65 and older have at least one chronic health condition and 60% have at least two (NIA, n.d.; NIA, 2017; Guo and Albright, 2017). The unusual lifestyle changes associated with the pandemic intensified challenges already faced by older adults, especially those with chronic health conditions that make them more susceptible to COVID-19 (Hawley et al., 2020). Additionally, historical data show the strong connection of past unethical practices by government and medical researchers to present health decisions (Jacobs et al., 2006). With the expectation that the percentage of older adults will continue to increase, an important aspect of public health communication should include an understanding of the challenges associated with aging and the health disparities that exist in minority populations. This project has been conceived from the perspective of Edbauer's concept of rhetorical ecologies, including the networks and complexities in health care, to better understand the implications that historical perspectives, inequalities in health care, compounded with ageism and racism have on older AA women during a global health crisis.

The rhetoric of health and medicine (RHM) is an interdisciplinary field that combines rhetoric with research, health, medicine, and patient advocacy; and the communication surrounding public health "emphasizes how language helps to create, organize, challenge and fragment" the realities of public health crises (Malkowski and Meloncon, 2019). A "holistic understanding of public health's complexities" is necessary when rhetoric is used to influence health practices (Malkowski and Melonçon, 2019, p. 11). Medicine is rhetorical through the dissemination of scholarly knowledge, but it is also rhetorical "as a system of norms and values operating discursively in doctor-patient interviews, in conversations in hospital corridors, in public debate on health policy, and in the apparatus of disease classification" (Segal, 2008, p. 3, Linguard and Haber, 1999). Pre-existing facts, notions and conditions are separate from the speaker, but still influence the actions of the audience. Physicians, health care professionals, and patients routinely engage in medical discourse, and all assume roles as speaker and audience. Segal clearly explains the relationships between these groups:

> Patients may have to persuade physicians that they are ill and in need of care; physicians seek to persuade patients to adhere to courses of treatment; experts persuade the public to count some states and behaviors as pathological and others not; pharmaceutical companies persuade consumers to request their products, and physicians to prescribe them. (2008, p. 1)

Effective strategies used in the field of the RHM to improve health outcomes must be flexible enough to deal with everchanging environments (Campbell, 2018); and the fluidity of the pandemic proved this to be true. In a study of complex health systems and services, Greenhalgh and Papoutsi note that traditional approaches should be adaptable and evolving as "there are no universal solutions to the challenges of complex health systems," and non-traditional solutions incorporate multiple perspectives, flexibility, and focus on inter-related problems in populations (2018, p. 4).

Rhetorical Ecologies

Rhetorical strategies have been used during the COVID-19 crisis to modify or change behaviors. Effective messages persuade individuals to act by considering the physical and social environments and experiences of the audience. Christian Weisser suggests that identity "emerges not just from the internal processes of the individual, but also from a wider variety of influences: the social conventions we share with other human beings" (Dobrin and Weisser, 2002, p. 567). An "ecology" offers a framework that focuses on a sequence of events between people and ideologies as opposed to a specific event that causes exigence. Edbauer's concept of rhetorical ecologies, from which I draw most heavily in this project, goes beyond audience, exigence, and constraints as argued by Bitzer (2005). Because rhetorical situations infect each other, they are woven together and do not exist apart from each other (Rivers and Weber, 2011). Personal experiences, knowledge, attitudes, and belief systems directly affect decision-making, so individuals decide what's most important, as they have the power – to a certain degree – to change their behavior. This power, or agency, can lead to positive or negative health choices depending on the way people see themselves as part of a situation, and unconscious choices can damage the freedom people have to make their own decisions.

Using an ecological approach for this research allowed for the comparison of women of a specific race and age range, with the social and environmental differences that "contaminate" – intentionally alter or disrupt – their commonalities (Rice, 2013; Rivers and Weber, 2011, p.193). The result is a linkage between rhetoric and lived experiences centered around a rhetorical situation (Edbauer, 2005; Hite and Carter 2019). For example, during the pandemic and for a long period of time, schools were closed, and many people worked from home. Messages surrounding the closures reflected institutional policies but ignored some of the "lived experiences of the targeted community" (Hite and Carter 2019, p. 153). Older adults were urged to limit interaction with others and stay home as much as possible because they were more susceptible to getting sick from COVID-19. Yet, recognition of the universal response to the pandemic did not overshadow situational differences among individuals. Some of the women who participated in the research study described in this thesis lived with an adult child or young grandchildren. The circumstances surrounding the pandemic brought them all home at the same time. School-aged children juggled online classes through digital platforms with the assistance of their grandmother, adult children juggled remote work with caretaking responsibilities, and civil unrest was present in the nation that affected minorities in negative ways. When this happens, social and cultural components of public health messages fall short.

Robin Jenson offers “two models for engaging a rhetorical ecology approach,” including the circulation model and the percolation model (2015, p. 523). The circulation model, or “flow model,” traces communicative “ideas, assumptions, and arguments along a largely chronological timeline” to examine the ways discourses move about over time (Jensen, 2015, p. 523-4). In the percolation model connections are made between “health rhetoric in...distinct time periods” (Meloncon and Scott, 2018; Jenson, 2015, p. 524). Jensen argues that linkages to history form a “valuable contribution” to the understanding of the health concepts of today “that may not follow a linear or rational logic” but are somehow connected to “health rhetoric of the past” (2015, p. 524). For example, the Centers for Disease Control and Prevention (CDC) has as its mission to “protect America from health, safety and security threats.” It is often viewed as an authoritative and credible source of information, but that sometimes changes depending on the threat that America is experiencing (CDC, 2019, para. 2). In 2015, one year after the Ebola outbreak, the Pew Research Center surveyed 1,504 American adults and found that 70% viewed the CDC favorably (Pew Research Center, 2020). That percentage rose to 79% in 2020 (during the COVID-19 pandemic) when 1,013 American adults were surveyed. *USA Today* reported a study conducted by the Robert Wood Johnson Foundation (RWJF) and Harvard T.H. Chan School of Public Health that revealed a decrease in overall ratings for the CDC from 59% in 2009 to 54% in 2021 (Rodriguez, 2021). The view changed during health events and after the response to them. The integration of rhetoric and ecology focuses on the “analysis of history...institutions, and publics” which help address complex and pressing...problems through improved understanding (Rivers and Weber, 2011, p. 212; Druschke and McGreavy, 2016). Historical texts that predate appeals for behavior change are inseparable from current public discourse. These connections between people, events and history further support Edbauer’s claim that situations are not based on one isolated event. Chapter four provides an example of a rhetorical ecology as told through a historic marker on race and equality, and a more recent example about the response to COVID-19 in an elderly AA community.

Federal, state, and local authorities invest significant time and money into efforts designed to create guidelines for the protection of all people and the promotion of positive health practices; however, health policy alone does not change behavior. For example, public health stakeholders who engage in discourse surrounding COVID-19 need to explain the issue, justify their response to the virus, and gain the trust of the public in order to persuade individuals to modify behaviors (Di-Miceli, 2020). Yet, social structures and systems make adherence to policy difficult when there exists a lack of accessible resources, economic hardships, a distrust of so-called credible sources and a distrust of the health care system (Murray, 2015). As Arthur Miller says in "Rhetorical Exigence," the "ultimate perceived nature of the exigence depends on the constraints of the perceiver"

(1972, p. 112). Chapters three and four provide more information on the hardships faced by AA in health care institutions and their distrust of government, research, and the health care system. Public health discourse misses the mark when it doesn't include the lived experiences of their target populations (Hite and Carter, 2019). Additionally, global health threats and national health crises are unpredictable and do not fit neatly into frameworks designed to change behavior.

Diversity and Health Inequities

Healthy People, a national initiative launched by The United States Department of Health and Human Services that focuses on ten-year objectives aimed at improving the health and well-being of all Americans, included the reduction of health disparities as part of its 2000 objectives (National Center for Health Statistics, 2021). In 2010 the objectives were expanded to eliminating health disparities and further expanded in 2020 to "achieve health equity, eliminate disparities, and improve the health of all groups" (HealthyPeople.gov, 2021a, para. 4). The Robert Wood Johnson Foundation is one organization that assists communities and stakeholders in improving the culture of health by helping Americans live longer and healthier lives. Their focus on achieving and maintaining good health includes addressing health equity which is essential to behavior change (Robert Wood Johnson Foundation, n.d.). *Healthy People 2010* also added health communication to its objectives, recognizing the need for effective public health discourse (HealthyPeople.gov, 2021b).

Health equity happens when all individuals receive the same opportunities in health care regardless of any differences that exist between them (Robert Wood Johnson Foundation, n.d.). The 2016 American Health Values Survey collected data from over 10,000 adults that focused on their beliefs and values about health as related to many factors: health consciousness, health equity, social solidarity, health care disparities, social determinants, overall health care responsibility, efficacy, and civic engagement (Bye and Ghirardelli, 2016). The data reveal the differences in how Americans handle health challenges individually and collectively. According to the survey, between 2016 and 2020, more Americans recognized the hardships associated with AA accessibility to health care, yet fewer people recognized that poor health outcomes are directly related to discrimination within the health care system (Bye and Ghirardelli, 2016).

Racial disparities exist throughout the United States and are a common problem in the health care system (Wheeler and Bryant, 2017). Eighty percent of family health care decisions are made by women, and older AA are reported to experience race-related stressors that negatively impact their health (Matoff-Stepp et al., 2014). The COVID-19 pandemic highlighted problems with institutional systems, and social and economic conditions. In 2020 virtual focus groups were conducted in five urban and rural communities in Alabama to examine the perceptions AA in under-resourced areas had regarding COVID-19 prevention, coping and testing (Bateman et al., 2021). Common themes noted by researchers include, but are not limited to, a lack of information, inadequate supplies of personal protection equipment (PPE) in neighborhood stores, medical mistrust, and lack of COVID-19 testing sites (Bateman et al., 2021). The pandemic also highlighted the uniqueness of older minority groups who are disproportionately impacted by the virus as AA have experienced higher rates of infection and death compared to Whites (CDC, 2020). This trend has occurred since the onset of the pandemic and data continue to be monitored as the pandemic continues.

In *Distant Publics: Development Rhetoric and the Subject of Crisis*, Jenny Rice carefully analyzes the public discourse surrounding urban development in Austin, Texas, arguing for the inclusion of all individuals in a community when faced with a crisis situation. This involves reaching many different groups of people in ways they can relate to and understand as a way to modify certain behaviors. Rice notes the implied relationship between public discourse and place as an entity where individual choices affect the future as well as other places that are distinctly different from an individual or community, emphasizing how patterns of discourse "help cultivate both productive and unproductive public subjects" (2012, p. 17). Public discourse surrounding the COVID-19 pandemic needs to do specific things: (1) convince the public of the seriousness of the virus, (2) convince individuals of the threat of the virus to their health, and (3) persuade the public to follow the guidance of health professionals and science (Di-Miceli, 2020). Exigency is never simplistic, and when compounded with multiple complementary and conflicting discourses occurring simultaneously it can lead to the emergence of rhetoric "already infected by the viral intensities circulating in the social field" (Edbauer, 2005, p. 14). This highlights the difficulties associated with behavior change and the need for rhetorical approaches that target specific groups.

Telemedicine

The pandemic contributed to a huge increase in telemedicine which has replaced human, in-person connectedness with virtual and digital platforms. Traditionally, health care management happens between a patient and provider in a hospital or clinic setting where providers engage in medical discourse in face-to-face environments (Majerowicz and Tracy, 2010). Yet, as the pandemic unfolded, telehealth – the use of electronic information and telecommunication technologies for health care, health education, public health, and health administration –replaced many in-person visits and provided opportunities for physicians and patients to connect digitally because of social distancing restrictions; health education and information was then provided through electronic sources. The means of obtaining health information has expanded over the years. A 2013 study by Fox and Duggan revealed that 59% of Americans used the internet as a source for health information in the previous year and an estimated one in three adults uses the internet to diagnose or learn about a health concern (2013). According to the Health Information National Trends Survey Data from 2020 (which was the first full year of COVID-19), 72.1% of the adult population used electronic means to seek health or medical information for themselves. That same year, an Alabama hospital experienced a dramatic increase in telehealth visits from an average of three visits per day to 1,400 visits in one day in a span of one month (Cole, 2020). What is not defined is the age of the patients who participated in telehealth visits, the percentage of patients who had access to technology in the home, and the number of patients who were able to participate in telehealth visits without assistance from others.

To be clear, the benefits of telehealth are not in question here as this delivery method reduces barriers for those who otherwise might not have access to in-person care and has allowed for the continuation of care during this health crisis. It is the challenges associated with using telehealth that are examined throughout this project. First, the increasing use of technology highlights inequities in diverse populations – including the digital divide that exists in America – and challenges experienced by older adults (Demiris et al., 2009). Second, technology poses significant problems for older adults who have not adopted new technological methods of communication (Hawley et al., 2020). This may be attributed to fear of learning a new skill, distrust of digital technology or lack of technology resources in the home. Third, electronic methods can overlook physical limitations and visual impairments that older Americans have (Lam et al., 2020). Fourth, the linkage to history can have a direct effect on current health decisions. My research study examined the public rhetoric surrounding telemedicine and the COVID-19 pandemic among AA women ages 75 and older to determine how the pandemic affected health decision-making and approaches to health care. This research was designed to discover how public health discourse can help improve the overall health of this population.

CHAPTER 2

METHODOLOGY

The public rhetoric surrounding COVID-19 and telemedicine indicate the benefits and challenges to patient care in a virtual environment from ecological perspectives that focus on specific groups. While digital health can reduce barriers for those without access to in-person care, it also poses significant problems for older adults who have not adopted new technological methods of communication (Hawley et al., 2020). The increasing use of technology also highlights inequities in diverse populations and challenges for older adults (Demiris et.al 2009). Specifically, negative effects of racism and ageism are often experienced by AA women. This is compounded by electronic methods of health care that overlook the digital divide in America, inexperience with technology, physical limitations, and visual impairments (Lam et al., 2020). As mentioned in the previous chapter, this project was not intended to dispute the benefits of telehealth. On the contrary, it was designed to examine the challenges associated with its use compounded by the linkage to history that impacts health decision making among older AA women who are reported to be the primary group of health decision makers in U.S. households (Matoff-Stepp et al., 2014).

Research on telemedicine during the pandemic does not always include ecological approaches. Lam et al., conducted a cross-sectional study of adults using de-identified data to examine unreadiness with telemedicine by video among older adults during the pandemic. The unreadiness was defined by physical limitations or disability, lack of devices with internet capabilities and lack of internet use in the previous month (Lam et al., 2020). Unreadiness was further assessed based on the ability of family members in the home who could provide support during the telehealth visit by video or telephone. Fifty-seven percent of participants were women, the average age was 79.6, and 21% were AA. They found unreadiness among 44% of older adults ages 75-84 and 72% age 85 and under; 38% of women; and 60% of AA. As the study was conducted without human subjects, it is limited in scope. An ecological approach could uncover in-depth information about patients' lifestyles, experiences, and approaches to health care.

Hawley et al. used an exploratory sequential mixed-methods approach to conduct a three-phase study of fifty geriatric renal patients to assess patient perceived barriers to telehealth visits using a needs assessment, telehealth pilot and post-telehealth evaluation that included semi structured interviews (2020). After completion of a needs assessment, participants received training to participate in a telehealth visit at their home, which was then evaluated using an eight-item telephone interview consisting of open-ended questions. The training removed some of the barriers that many older adults have such as inexperience with technology. Training was also provided in a clinic setting on the same day that a regularly scheduled visit occurred. These factors alone created ideal situations that will not always be available to larger populations.

The focus of this research provided a more in-depth exploration of telehealth engagement among a geriatric population by exploring the ecological perspectives of a target group of older AA women. Research indicates that in the United States, 80% of family health care decisions are made by women, and older AA are reported to experience race-related stressors that negatively impact their health (Matoff-Stepp et al., 2014). Although not a research study, the telehealth data from the Alabama hospital did not include patients' race and age, technology in the home, or physical limitations so little can be drawn from an ecological perspective. What contributed to the exigencies surrounding the pandemic was a combination of a novel virus, its immediate prompting of telehealth, and the way in which this target group viewed themselves during the crisis. My study was designed to examine AA women's experiences with health-related decisions during the COVID-19 pandemic. I sought to uncover answers to the following questions:

1. In what ways do select AA women 75 years and older living in North Central Alabama report their experience with telehealth, and related decision-making about their health during the COVID-19 crisis?
2. How do their experiences draw on historical narratives about health and illness and the rhetorical ecologies constituting unique contexts in which they encounter telemedicine?

With the expectation that Americans will continue to live longer, an understanding of the effects that ageism, racism, health inequities and history have on health care is needed to craft effective public health messages that work to improve the health of the target population.

Study Design

Participants were recruited using flyers (See Appendix C) that were distributed via email to a broad range of individuals: (1) colleagues who provide health education to older AA, (2) colleagues who work with community health advisors in local and rural settings, (3) church members, (4) family and friends. These groups were asked to further distribute the flyer to individuals who met the criteria.

A mixed methods approach was used to answer my research questions because mixed methods research (MMR) is “increasingly prominent in health services research” and the complexity surrounding telehealth intervention is part of a “health care ecosystem” that includes numerous influences (Caffery et al., 2016, p. 764). MMR helped to offer a more complete understanding of participants’ experiences with telehealth and health-related decisions. Using a qualitative and quantitative approach, a questionnaire (See Appendix D) containing eighteen items was developed. The study instrument, delivered through structured interviews, consisted of five multiple choice questions, seven open-ended questions, and six questions that were measured on a 5-point Likert scale. The interviews were designed to last less than one hour and were audio-recorded using a digital voice recorder. No videos were obtained.

The aim was to conduct interviews with participants who engaged in a telehealth visit in the past year (between July 2020 and July 2021) in order to gain a better understanding of how personal beliefs, experiences, and behavior impact health decision-making, to determine confidence and comfort level with telehealth, and to identify perceived barriers to telehealth (access to technology and technology use). Using a rhetorical ecological approach helped to understand how experiences and beliefs directly impact choices and action. This approach provided insight on how environments and systems are interconnected to individuals.

The University of Alabama at Birmingham (UAB) Institutional Review Board for Human Use (IRB) approved this study (See Appendix A) of human subjects. Verbal consent from participants was obtained over the phone and prior to the recorded interview. Interested individuals were given the option of participating either via phone or Zoom. Prior to the start of the interview (and the recording), participants were read an Information Sheet (See Appendix B) detailing the study. Demographic information was obtained first, followed by questions pertaining to health care, technology use in the home, experience with telehealth visits and providers, and interest in electronic health information.

Considering how my position might contribute to the interpretations of the lived experiences of the research participants, I acknowledge commonalities between myself and the participants being the same race and residing in the same geographic location. I am also a research student who is employed by a public research university. I can be viewed as an insider because of the commonalities, and as an outsider because of my affiliation with a research institution.

Data Collection

The data were analyzed after interviews were completed. Audio clips were reviewed to ensure transcription of data accurately reflected phone interviews. No personal identifiers were mentioned in the interview. Questionnaires included a pre-filled alphanumeric code with no identifiable information. Through the interviews I identified technological resources used in the home, confidence with technology, comfort level with health providers, interest in electronic health information, and feelings about research. Responses (See Appendix E) were uploaded to Google Forms survey administration software for analysis and interpretation.

Limitations

This study is not without limitations. The initial goal was to interview ten subjects, but recruitment delays due to COVID-19 limited the number of participants. Study subjects are from a specific geographic location within in a certain region of Alabama. Participants were interviewed once, and no follow-up conversations took place. Health conditions of the participants are unknown as is the type and number of appointments they participated in. In acknowledgement of the small sample size, I also collected additional data from available public sources including a local online newspaper, journal articles on telehealth and aging, and local newsletters that acknowledge the growth of telehealth practices. Nonetheless, five interviews were conducted with participants ages 75-91. The next three chapters detail the findings of this research.

CHAPTER 3

HEALTH COMMUNICATION IN A DIGITAL WORLD

Communication Genres

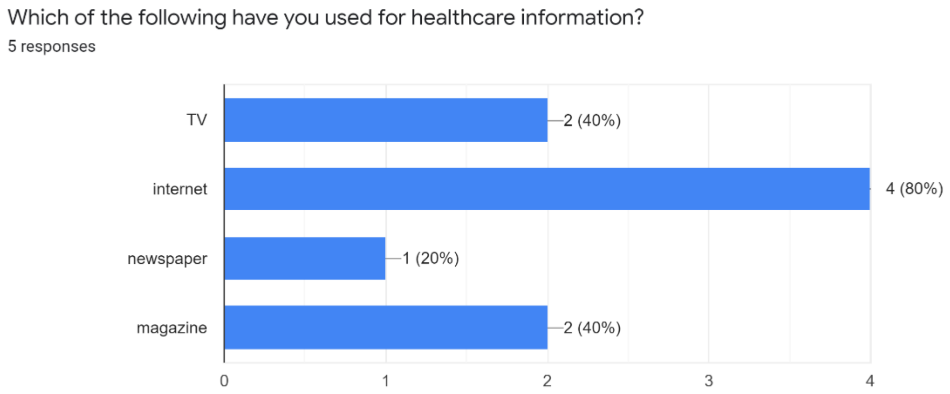
People engage in rhetorical work when they craft messages for specific audiences (Angeli and Norwood, 2019); and the public discourse that emerges is influenced by the environment that people are situated in (Rivers and Weber, 2011). Participants' reliance on various print and electronic sources indicates the need for multimodal communication. Social and environmental influences show how "texts, events and feelings" are connected to each other (Rivers and Weaver, 2011). Because the pandemic impacted the way people live, work and conduct business, it was unsurprising that businesses and other organizations contributed to public rhetoric on health and safety. These institutions took advantage of the unexpected exigence of the pandemic and adapted their messaging using logos, ethos, and pathos to increase compliance to public health mandates while advocating for continued economic support. Researchers in Italy examined the tweets of leading brands of Italian industries to determine the role rhetoric played in advertising during the pandemic. They examined how brands appealed to audiences before, during, and after the pandemic to determine if the appeal to logos, ethos, and pathos changed. Two thousand tweets were posted by seventy-six brands accessing changes made to rhetorical appeal. Among other things, findings revealed that pharmaceutical companies relied heavily on logos, which may be due to the novel opportunity to appeal to "health-concerned and health-conscious audience[s]" (Mangio et al., 2021, p. 235). In this example, the mundane or usual aspects of doing business combined with the complexities of a health crisis become a part of the discourse and was key to the message the audience received (Rivers and Weber, 2011). The intent of the text used in business relationships mirrors the intent of persuasive messages used in other public discourse, e.g., to understand the exigence and the audience, and then to work within the constraints. Edbauer (2005) explains the connection between the mundane and the complex in her concept of rhetorical ecology which we will further explore.

Communication Technologies

The 2020 data from the Health Information National Trends Survey revealed that over 70% of the adult population used electronic means to seek health or medical information for themselves. This information can also be obtained from other sources including print media and television. When participants in this research study were asked about their sources for health care information, more reported using the internet, followed by television and magazines, and newspapers. Interestingly, they reported little interest in receiving health care information on the computer (or phone) on a regular basis. On a scale of 1 to 5 with 1 being “not at all interested” and 5 being “very interested” the average rating was 2.0. Participants used the sources listed in Figure 1 to find information on prescription medications, new medications and side effects, medical conditions such as rheumatoid arthritis and high blood pressure, and statistics on COVID-19.

Figure 1

Health care Information Sources



Although the internet is used by the majority of participants, two participants stated they never used it in the past year for health information. On a scale of 1 to 5 with 1 being "never" and 5 being "always," participants' use of the internet for health care information over the past year was rated 2.6. Several conclusions can be drawn from this finding as influenced by the pandemic: (1) the focus on health shifted from maintaining regular health practices to staying safe during the pandemic; (2) usual practices were temporarily halted due to fear and anxiety about COVID-19; (3) discourse on civil unrest and racial injustice inundated the internet, shifting the focus of its users.

Staying safe during the pandemic. The research on age and racial disparities related to COVID-19 is well documented – older AA have experienced high rates of infection and death due to the virus. Women, the largest group of health care decision makers in the United States, have the additional responsibility of incorporating COVID-19 safety measures into their daily routines. These unusual lifestyle changes intensified challenges of older adults, especially those with chronic health conditions that make them more susceptible to COVID-19.

Usual practices on hold due to fear and anxiety. What is unique about the pandemic is that the public discourse surrounding it included more than the health sector; it also bled into many other areas of living and conducting business. Research participants offered some of the ongoing health care challenges that are separate from those associated with the pandemic. They were asked whether or not they receive help with ordinary routines such as scheduling appointments, getting to and from appointments, and getting prescriptions filled. One participant reported needing and receiving help from her daughter with scheduling appointments. Three receive help getting to and from appointments – either from a husband or children – and two receive help from either their husband or daughter when getting prescriptions filled. During the pandemic, these usual routines were interrupted by business closures and local, state and/or government mandates put in place for public safety. Normal routines were either put on hold or carefully planned to ensure personal safety.

Civil unrest and racial injustice. As mentioned in chapter one, public health guidance more often reflects policy rather than individual experiences (Hite and Carter, 2019). At the same time of the pandemic, there were several issues surrounding race and injustice among AA that overwhelming affected the mental, physical and emotional health of many minorities. The public health guidance about COVID-19 could have easily been overshadowed by the rise in civil unrest occurring simultaneously.

The Digital Divide

Telemedicine's dependency on technology for optimal use can also overlook the digital divide, the inequities in diverse populations, and other challenges faced by older adults (Demiris et.al 2009). Video and internet capabilities are needed for visual physical examinations; scheduling COVID-19 vaccine appointments generally require logging on to a website; tracking appointments and medications can be done by logging onto a hospital's patient portal system; and online physical activity and nutrition classes require clicking a link to participate. The increasing use of technology as a result of the pandemic "underscored the requirements for high-speed internet" so not having internet service created a health disparity (Cope, 2020). One of the five research participants reported having a "small cell phone but not a smartphone" and no internet capabilities so access to certain information and resources is limited. A second participant who has internet service uses her daughter's cell phone, yet physical limitations prevent her from using it without assistance. According to Anderson and Perrin there is a correlation between owning a smartphone and "household income and educational attainment" for older Americans which they define as 65 years and up (2017, p. 3):

> Eighty-one percent of older Americans [ages 65 and up] whose annual household income is $75,000 or more report owning a smartphone, compared with 27% of older Americans with annual household incomes less than $30,000 a year. When education level is considered the percentage of smartphone ownership for older adults with bachelor's or advanced degrees is 65%; forty-five percentage of those who attended

> college own smartphones and 27% of those with up to a high school diploma own a smartphone (p. 6).

Of the women interviewed for the research study, three report having a smartphone, three have a telephone, three have a computer, two have a laptop, and four have internet capabilities at home. Participants ranged in age from 75-91 years and economic and educational data were not obtained. Figure 2 below shows the decrease in cell phone ownership as Americans age, noted by Anderson and Perrin (2017), and the target population of the participants in this research study is among those who own cellphones the least.

Figure 2

Cellphone Ownership

Age	Cell phone ownership
65-69	59%
70-74	49%
75-79	31%
80 and older	17%

A physician and leader of telehealth practices quoted in Cope's article notes patients' preference for video appointments over telephone appointments (2020). What is missing from the article is the age of the patients and the number of patients without internet capabilities who lack the option of participating in video appointments. On a scale of 1 to 5 with 1 being "not at all confident" and 5 being "very confident", the average level of confidence participating in telehealth visits was 4.4 among research participants. This number decreased to 3.4 (on a scale of 1 to 5 with 1 being "not at all comfortable" and 5 being "very comfortable") when asked to rate their comfort level with telehealth visits on their own e.g., without any assistance from a family member or support person. In the study of telehealth visits conducted by Hawley et al., patients received training prior to participating in a telehealth visit which likely contributed to the comfort level during the visit (2020). Yet, that can be considered a luxury that not all older patients have. Additionally, a rapidly changing health crisis may not always allow for adequate time to train older patients. Barriers to technology use were identified and addressed so participants were able to engage in a pre-visit before the actual visit with a physician. It is worth noting that even with training, technical difficulties arose for a small number of patients. Also worth nothing is the fact that some patients reported the equipment used for the visit did not belong to them. What may have pushed forward an agenda to encourage more telehealth use may have disregarded the "concerns and circumstances" of specific individuals and populations (Hite and Carter, 2019). Lack of internet, hardware and software, and physical limitations are factors associated with telehealth challenges among older adults.

Telehealth and Aging

All research participants engaged in one to five telehealth visits within the previous year, and there were differences in the frequency and length of time. For one participant, telehealth visits included grandchildren who reside in her home. Although telehealth visits for herself were limited, she was fully engaged in visits for the children because of their young ages. One participant reported an increase in the number of telehealth visits; one reported that telehealth visits were shorter than in-person visits; two reported no change in telehealth visits and one reported fewer telehealth visits than usual. At the time of this research telehealth services helped people practice social distancing to help prevent the spread of COVID-19 and many physicians were called to engage in rhetoric that promoted the benefits of telemedicine to patients and providers. In addition to removing transportation barriers that prevented patients from receiving in-person care, some physicians noted the uptick in telehealth use allowed for little disruption in health care, minimal loss of staff physicians and nurses who would otherwise be unable to care for patients, and minimal use of PPE that would have been used for in-person visits (Cope, 2020). Seeing the advantages of electronic platforms for continued business practices, media outlets promoted its use and other health related businesses adopted similar methods of continuing care. Exercise instructors conducted virtual classes, dieticians provided nutritional classes online, and mental health professionals “saw” patients using video chats. Advancements in technology allowed for many health practices to continue during this public health crisis that kept people physically apart.

What constitutes a successful telehealth visit for older AA women is dependent on numerous factors from an “ecological” perspective on health, aging, and the environment (Edbauer, 2005, p. 13). Inexperience with technology, physical limitations and visual impairments can easily be overlooked when electronic methods of care are being used (Lam et al., 2020). While some older adults embrace telehealth, others find it challenging to navigate. It is convenient for those who are capable of engaging in it, yet burdensome for those who have personal or physical challenges. All five participants in the research study reported that they make their own health care decisions and are more comfortable talking to health care providers in person instead of over the phone. Participants were asked to rate their comfort level with talking to health care providers during a telehealth visit on a scale of 1 to 5 with 1 being “not at all comfortable” and 5 being “very comfortable”. The average scores was 4. Using the same scale participants were asked to rate their comfort level with talking to health care providers in person, and the average score increased to 5. Favorable comments regarding telehealth visits included feeling “more comfortable” in one’s own setting without having to “contend with others” during the pandemic, the simplicity of the visit and the ease with which health care providers can be contacted. One participant “couldn’t get out and was immobilized after surgery” so telehealth visits eliminated hardships associated with traveling to a clinic or hospital.

On the other hand, challenges associated with telehealth include the inability to comprehend “what’s being told,” having to rely on others to “make the call and help answer questions,” and visual impairment, “even with glasses,” as a barrier to using a computer. A participant who relies heavily on her daughter for assistance with health care and mobility issues has internet capabilities but would have needed her daughter to “set everything up” for a Zoom interview. One out of five participants reported problems in all four areas accessed: poor vision, problems typing, physical pain and hearing loss. The rapid changes related to COVID-19 contributed to the influx of telehealth visits even though the practice was not a new model of care. Addressing the needs of target populations prior to its implementation might help to alleviate many of the challenges experienced by older adults. Because the aging population is expected to grow and advances in technology continue to increase, breaking down economic, social, and cultural barriers would help bridge the gap between technology and aging so older adults can thrive in a technologically advanced world.

Does Telehealth Remove "the Medical Gaze"?

Segal (2008) explores the physician-patient relationship from a rhetorical perspective. Physicians and patients engage in discourse that provides the physician with information on which to draw conclusions for a medical diagnosis. The in-person clinical encounter usually begins with a question that starts the discourse. As mentioned in chapter one, both the physician and the patient – at some point – occupy roles as speaker and audience. In the case of telehealth, it is the patient who first takes the role as rhetorician, persuading the physician (the audience) that a problem does or does not exist. If a problem exists, the roles are reversed and the physician attempts to persuade the patient of a proper diagnosis and valid treatment option. When patients are seen for well visits and no problems exist, the patient, as rhetorician, persuades the physician (the audience) that they are indeed well by society's definition of wellness. From a biomedical point of view, telehealth visits limit the interaction between physician and patient that include a medical diagnosis based on observations and tests. One research participant acknowledged the "difference on screen than in person" when stating her preference for in-person visits because they allow the patient "to look at him or her and he or she can look at me." Physicians "see" patients through a medical lens that allows them to treat illness and disease. This study of the human body is called biomedicine which combines biology with physiology as a way to treat symptoms and promote healing through physically viewing the body and having knowledge of the body’s processes (Segal, 2008). The body is considered to be universal. Moreover, the focus is on the disease or illness and not on the patient as a whole.

Another way physicians view the body is through what Michel Foucault calls “the medical gaze” – the power physicians have historically been granted as they observe, diagnose and treat patients based on their medical knowledge and experience (Misselbrook, 2013, p. 312; Sinha, 2000). According to Sinha, “the health care system has found the ultimate expression of Foucault's medical gaze in telemedicine” (2000, p. 294). The gaze, as described by Foucault, explains how physicians visually inspect the body from a position of power (Sinha, 2000) and those who utilize telehealth use videos to perform physical examinations (Cope, 2020), thereby extending the “gaze”. The inspection of the body is conducted through a digital screen. Those who study patients through a digital lens should also listen to what is being said and what is not being said in order to engage in medical discourse with the patient. When videos are not used, telehealth appointments are conducted over the phone (not a smartphone) and without visual contact. Self-reported data becomes important because neither the traditional nor digital physical examination occurs. The question then becomes: does telehealth remove the medical gaze? On one hand, patients without video capabilities are denied a “gaze” by their physician because there is no visual contact. Subsequently, these patients cannot be studied or inspected in the way Foucault describes. On the other hand, even without visual contact, the physician is still in a position of power as an expert in the field of medicine.

Patients have been studied, inspected and visually examined for centuries, yet not all physicians engaged in this practice using ethical and human methods. The next chapter focuses on some of the unethical and inhumane medical practices and research performed on AA women and men that has continued to negatively affect their view of research, the government, physicians, and other health care providers.

CHAPTER 4

HISTORY AND HEALTH CARE

> Why would you create a movie for black people if you don't understand the history and perspective of the people you are doing it for? You need historical perspective to make sound decisions.
>
> - Tim Reid, Actor

Ethics in Medical Research

The literature is filled with examples of medical research that was routinely performed on slaves and poor AA who were denied ethical consideration that was reserved for white Americans (Scharff et al., 2010). As a result, older (and even younger) AA today are sometimes hesitant to participate in research for fear of being taken advantage of; and their suspicions cause them to question the credibility of the researcher and accuracy of information they are given (Scharff et al., 2010). As a female AA researcher living in the same geographic region as the study participants, I observed hesitation among subjects when asked to participate in the study. Some needed reassurance that they would not have to take any medication, use their name, or show their face on a video screen. None of the participants opted for Zoom interviews, choosing phone interviews instead. Their guardedness regarding research was evident in their hesitation to speak on record even though some were acquainted with me in some way. One participant wanted reassurance that her answers to the question about methods of receiving health care in the future would not dictate how she will actually receive health information as a result of her participation in the study. Another participant revealed that she provided an incorrect birthdate during the recorded interview. Although within the age criteria, she never gives her “real birthday” opting instead to provide a fake one, “even on Facebook”. Prior to the interview, specific questions about the research were asked to ensure answers would be kept private and not linked directly to her. At the conclusion of the interview, that participant offered to tell her friends about the study if more participants were needed. This level of distrust explains the strong connection of past unethical practices to present health decisions (Jacobs et al., 2006), and can contribute to the influences of others when deciding whether or not one should engage in research.

Numerous examples exist of unethical practices in research that illustrate how advances in health care were made at the expense of powerless AA women, and how AA men were denied humane treatment for decades. Dr. James Marion Sims is often called the “Father of Modern Gynecology” because of his contributions to women’s reproductive health (Wall, 2006). In addition to performing research on black slaves without their consent, the procedures were done without anesthesia because he, along with many other white people at the time, thought black people didn’t experience pain (Wall, 2006). Sims, a slave owner, had access to black slaves who likely could not refuse to be a part of his research experiments. In the mid-1800s, he performed numerous operations on young AA women. After years of perfecting the procedure through torturing these women, he successfully performed it on white women using anesthesia.

The infamous Tuskegee Study of Untreated Syphilis in the Negro Male continued for over forty years and involved hundreds of AA men, mainly sharecroppers, who were told they were being treated for bad blood. None of the men consented to the study and none were treated for their disease (CDC, 2021). Instead, from 1932-1972 medical workers withheld treatment for black men who were infected with syphilis in exchange for free medical exams, free meals and burial insurance (CDC, 2021). By the time the study was shut down many participants had already died.

Henrietta Lacks was a black tobacco farmer who began treatment for cervical cancer at John Hopkins Hospital in 1951. Neither Lacks nor her family were aware of the medical research that was being conducted, illegally, using her cells, called "HeLa cells," to advance science (Skloot, 2010). The research was beneficial to the development of drugs to treat many diseases and conditions, yet Lacks did not consent to it; and the role she played in the advancement of science was unknown to her family for over twenty years (Skloot, 2010).

Not everyone starts from the same place given the historical legacies of discrimination which impact current realities. What results is a population of people who don't trust research, the government, or data; and the rhetoric surrounding COVID-19 and vaccines was not exempt from suspicion. The following example is relating to frequent research conducted with residents of a poor Alabama town with a large AA population: Uniontown, a rural community in Perry County, Alabama. In 2019 the population of Perry County was estimated at 8,923 of which 67.9% were AA; less than 60% of households had computers and 53.9% of households had internet subscriptions (Siebenthaler, 2020). According to the U.S. Census, the 2019 population in Uniontown was 1,880, 51.2% of residents were living in poverty, and the median household income was $17,000. Local residents in this community reported that researchers often visited for data collection, but not to solve a problem, and as a result, many of them “distrust big government and are wary of strangers” (Whites-Koditsche, 2021, ‘We’re just going to use you’). The founder of a community organization in the town says it this way:

> So often, people come into the community to get information and people feel like they’ve been taken advantage of. For so long in our culture, that’s happened. ‘We’re just going to use you as a number.’ And we sense that, and so we won’t allow you to use us as a number. We will just kind of keep our space and our distance and say ‘no’. (Whites-Koditsche, 2021, ‘We’re just going to use you’).

There is a direct link to race and health care because the “legacy of mistrust of the health care system…lingers” among AA (Wheeler and Bryant, 2017, p.4; Jacobs et al., 2006). When older AA women relive the injustices of the past, they may pass on their views to children or grandchildren creating generational cycles of mistrust (Wheeler and Bryant, 2017). These cultural differences are key to solving the problems associated with health inequity.

Cultural Competencies and Health Equity

Public health communication influences health care decision-making, and health messages often assume that most people value their health and are motivated to make positive changes. Pre-existing facts, notions, and conditions are separate from the speaker, but still influence the actions of the audience. To understand the role that culture places in health care, a look at culturally competencies is warranted. Healthy People 2020 defines health equity as the “attainment of the highest level of health for all people [which] requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities" (HealthyPeople.gov, 2021b, para. 4). It further defines a health disparity in the following way:

> a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage [that] adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. (HealthyPeople.gov, 2021b, para. 5)

How does race and age intersect with health care? Clearly stated, health equity happens when all individuals receive the same opportunities in health care regardless of any differences that exist between them. Health equity is problematic in the assumption that the same opportunities are available to everyone. Racial disparities exist throughout the United States and are a common problem in the health care system (Wheeler and Bryant, 2016). As evidenced by the pandemic, barriers exist that clearly display health disparities and racial biases throughout the nation (Farley et.al 2020).

Inequalities in Health care

Public health discourse viewed from an ecological standpoint does not occur from isolated incidents (Rivers and Weber, 2011). Whites-Koditsche's article describes the perceptions surrounding COVID-19 vaccinations among the residents of Uniontown where public discourse about the pandemic included vaccine hesitancy, disparities, and misinformation (2021). Studies have shown that AA have more underlying health conditions that increase the risk for severe illness with COVID -19 infection than other racial groups. However, the belief exists that many AA choose not to be vaccinated. Some AA feel the rhetoric surrounding vaccine hesitancy among them is exaggerated and ill-linked to the Tuskegee Syphilis Study. In the article, Tuskegee University Professor Vivian Carter states the following:

> [The] Tuskegee Study, has become too easy of a shorthand for understanding hesitancy towards COVID-19 vaccines. It's not just that, because I can tell you, numbers of people can tell you, how they've been treated when they go into health care systems. (Whites-Koditsche, 2021)

Also noted in the article is the opinion of former Tuskegee Mayor, Dr. Lucenia Dunn, who is AA. Dunn points to well-documented inequalities in health care of AA and the distrust among AA patients that negatively affects their health care management. She states the following about health inequalities:

> We have been abused, medically and scientifically, for centuries, and if you want to put a date on it, 1619, when they brought the first African slaves here. We had to endure the message that we didn't feel pain, so you could do whatever it was to our bodies. We had to go around the back door to the doctors' office and they refused to even touch us. (Whites-Koditsche, 2021)

The inequalities in health care for AA are well documented, and the distrust among AA patients negatively affects their health care management. Medical recommendations may be viewed with skepticism because patients feel that providers are being dishonest which "creates the perception "that there is something to hide" (Scharff et al., 2010, p. 8). There are systems of supremacy, power, and privilege that infect the minds of AA that influence their health care decisions. Since women represent the largest group of health decision makers in America, their opinions and experiences with health care providers can directly affect the health of their families.

Rhetorical Ecologies – Past and Present

The Past. Rivers and Weber provide an example of the rhetorical analysis of the 1955-1956 Montgomery Bus Boycott as told from an ecological point of view (2011). The boycott began four days after the arrest of Rosa Parks, an AA woman who refused to give up her bus seat to a white man and lasted 381 days as AA refused to ride buses in Montgomery, Alabama. This "incredibly organized and rhetorically savvy movement" was formed by a cadre of community leaders, professionals and advocates who created texts that proved crucial to the success of the boycott (Rivers and Weber, 2011, p. 201). Oftentimes, texts are overshadowed by public acts – not because of their insignificance but because there is a tendency to overlook the huge role they play in shaping behavior (Rivers and Weber, 2011). In the Montgomery Bus Boycott example, Rosa Parks' arrest seemed to be the sole act that put the bus boycott in motion. However, between the time of her arrest and the start of the boycott, the "institutional structures that predate appeals to change" were taken into account with the launch of "logistical and organizational texts to keep the boycott going, informational and motivational texts to inspire the boycotters, and advocacy, public relations, ally building, fundraising and legal texts to represent the movement to other publics" (Rivers and Weber, 2011, p. 205,200). The exigence of the movement was more than it appeared to be as the rhetorical situation bled into other elements (Edbauer, 2005).

Though the utilization of systems already in place, leaders of the movement recognized the social, professional and religious networks at work in the community. Collectively, texts in the form of handwritten signs, verbiage for phone calls, and meeting minutes helped to coordinate a process "within shared structures of feelings" (Rivers and Weber, 2011, p. 200). When communities are involved in the process, results can happen more easily. Churches were key as pastors engaged in public rhetoric from the pulpit; and nonviolence experts used rhetorical appeals to conduct workshops on protests. Druschke and McGreavy note the importance of workshops as "informed by rhetoric...[to] help people pay attention to context and develop approaches" that work for the people and align with their shared values (2016, p. 49). In this way, workshop participants are able to craft their own verbiage for the specific situation within the parameters set by the organizers. Black mail carriers organized carpool systems because of their knowledge of the area. Meetings were also organized. A volunteer phone committee used specific and consistent messaging to increase meeting attendance, meeting minutes were taken, and songs with uplifting messages of pride and community were played. River and Weber (2011) suggest that "the rhetoric that gets an audience to a speech and motivates them afterward must be considered as important as the speech itself" (p. 197). Documents with persuasive messages were developed and distributed throughout black communities urging people not to ride buses. Conversations permeated through homes, salons, businesses and grocery stores. Rhetoric became a verb – an “ongoing circulation process” – as well as an emergence (Edbauer, 2005, p.13).

Setbacks were addressed as counter rhetorics resisted the original exigence of the boycott. Lies, violence and other efforts to stop the movement surfaced. Word-of-mouth campaigns were designed to defy misinformation intended to negatively affect the movement. Cars used in carpools that were organized to transport boycotters were refused insurance by White owned insurance companies. As a result, another insurance company was used, and money was collected to cover carpool and other related costs. Organizers carefully selected their words, calling the movement a “protest” instead of a “boycott” to avoid legal action since boycotts were outlawed. Attorneys were involved in court cases surrounding the integration of public buses. The changing dynamics of the rhetorical action were experienced as documents developed in support of the boycott were also used as evidence against Martin Luther King Jr. who was accused of leading a boycott. The lasting protest came with burdens as people walked long distances and faced violence and intimidation. At the conclusion of the bus boycott and in the wake of the bus integration system, a document comprised of seventeen explicit recommendations for courteous and nonviolent behavior emerged emphasizing the following:

> [The] bus integration places upon all of us a tremendous responsibility of maintaining, in the face of what could be some unpleasantness, a calm hand of loving dignity befitting good citizens of our Race. If there is violence in word or deed, it must not be our people who commit it. (Rivers and Weber, 2001, p. 201)

The document is “both internal and public because it realizes that within the social flux of Montgomery, and because of previous public-building work, the actions of bus-riding AA have rhetorical and legal consequences” (Rivers and Weber, 2011, p. 201).

The Present. Africatown - located in Mobile, Alabama – is a community with a rich heritage that dates back to 1860 when Africans landed on the Gulf Coast. The response to vaccinations in Africatown - described as an “elderly community” with residents who “don’t get to travel” often (Whites-Koditschek, 2021, “High turnout in Africatown”) provides an example of an approach to a rhetorical ecology, showing the importance of texts as documents that prepare groups for public rhetorical action, and social ties as relational networks that advocate on behalf or communities. Taking transportation barriers into account and using interpersonal networks, a local pastor solicited the help of the nearby University of South Alabama to assist with a vaccination clinic at the church – an effort that resulted in 400 people being vaccinated in February 2021 (Whites-Koditschek, 2021). The pastor used a robocall service, a computerized autodialer with a recorded message, to connect with local residents and provided transportation to and from the church vaccination site. Once vaccinated, many residents encouraged others to get vaccinated and returned to the site with them. Johnson notes the importance for community members to be involved in the rhetorical process so they will become “more invested in the outcomes” (2021). Although readers are not privy to the conversation between the pastor and the university, it seems obvious that it contained appropriate messaging that led to a partnership between the two groups. Readers are not informed of the language used for the robocall, yet the message was effective because it led to 400 people being receiving vaccinations. Oftentimes the result of the public rhetorical action receives the most attention, yet, in ecological approaches mundane texts are key to focusing on specific groups (Rivers and Weber, 2011).

Both examples show the importance of community advocacy and flexibility in addressing the changing dynamics that accompany public rhetoric. Shared values and cultural knowledge provide perspectives that may be unknown to those outside the community or those who are unfamiliar with it. Well-crafted messages that address social and environmental aspects can move individuals to engage in practices that are intended to benefit both themselves and their communities.

CHAPTER 5

CONCLUSION

As the pandemic seemed to shut down the world, many people faced challenges that affected them physically, mentally, and emotionally, and older AA women grappled with additional health-related and societal issues that impacted their response to public health messages and their health care decisions. With the expectation that Americans will continue to live longer (Mullen, 2015), an increased understanding of the effects that ageism, racism, health inequities and history have on health care and longevity expectations is needed. Unique experiences among this population should be addressed when crafting health messages and mandating public policy, and the unique needs of this population should be considered when engaging in telehealth as an option for long term health care.

Findings

This study notes that telehealth has been beneficial to a select population of older AA women during the pandemic as it has been a great resource for those who can fully engage in it, and positive experiences with telehealth may make them more likely to continue telehealth visits in the future – with or without the presence of a health crisis. Findings also suggest that technological approaches can be more effective when they address physical limitations, accessibility, and cognition barriers among older AA populations. Participants with internet capabilities were willing to participate in telehealth when comfortable with technology or with assistance from a supportive family member, as were women who viewed telemedicine favorably because it limited their exposure to COVID-19 and allowed for the continuance of care when immobile. Further research is needed to address physical limitations (i.e., difficulty with touchscreens or assistance with navigating a mouse), cognitive challenges, or audio and/or visual difficulties that may prevent older populations and other individuals from completing a telehealth visit on their own.

This study also notes that past unethical practices in research cause hesitation with present participation in research. Dialogue with study participants prior to and immediately after recorded interviews revealed a level of distrust in research. Participants did not wish to be identified or provide any information that may somehow alter the way they would receive health information in the future. They also wanted to be sure no medication was involved before participating in the study. For research findings to assist Americans in attaining health equity, older AA must be comfortable enough to participate in research studies, especially those that directly affect their health. Historical perspectives continue to plague older AA women who may easily influence the perceptions of younger generations who they care for and live with which shows the influential role of AA women in families as revealed by Matoff-Stepp (2014) and Scharff et al. (2010). Further studies should be conducted on the connection between historical perspectives, repeated incidences of racism and health care management, furthering studies by Jacobs et al. (2006), Murray (2015), and Scharff et al. (2010). In-depth case studies on AA perceptions during times of crises may also help researchers to gain a better understanding of the needs of this population. Identifying problems more quickly can lead to improved health outcomes because individual experiences play a key role in the way older AA women manage their health.

The overlapping exigencies experienced during the pandemic have proven that health communication messages must change when public health crisis intervention overlaps with normal routines. Since public health crises are unpredictable and fluid, the response to them must be adaptable and flexible, while accommodating the cultural perspectives of targeted groups.

Limitations

This study is not without limitations. As mentioned in chapter two, the initial goal of the study was to recruit ten subjects, but recruitment delays due to COVID-19 limited the number of participants. Findings are based on the interviews of five participants who live in the same geographic area of North Central Alabama. Their experiences may not necessarily reflect the views of all older AA women or women who reside in other areas. Health conditions of the participants are unknown as is the type and number of appointments they participated in.

Forging Ahead

I argue for sensitivity towards older AA populations, especially women who either rely on supportive family members or are primary caretakers in the home, and who have unique needs that don’t fit into prescribed methods of care. Incorporating the voices of these individuals into policy will help meet their individual needs. This may be accomplished with the help of community leaders or on-the-ground advocates who have influence in and knowledge of the policymaking process. There is also a need for further research in this area with a larger population of older African American women to examine the difference in family structures that impact health care decisions. Caretakers of young children have additional telehealth exposure that is different from their own telehealth visits. This can become problematic when there are barriers to technology or physical/cognitive challenges as these can affect the health of family members as well. Effective public health rhetoric and health education materials can teach this population how to manage their health in times of crisis; and people who engage in public health rhetoric should listen to the values and language of the target audience in order to influence positive changes in behavior (Rivers and Weber, 205). Acknowledging that health issues are different for different populations, public health communicators can plan approaches that are personally relevant to individuals and communities.

REFERENCES

American Psychological Association. (n.d.). *African American older adults and race-related stress – how aging and health-care providers can help.* https://www.apa.org/pi/aging/resources/african-american-stress.pdf

Anderson, M., & Perrin, A. (2020, May 30). *Tech adoption climbs among older Americans*. Pew Research Center: Internet, Science & Tech. https://www.pewresearch.org/internet/2017/05/17/tech-adoption-climbs-among-older-adults/

Angeli, E.L., & Norwood, C.D. (2019). The internal rhetorical work of a public health crisis response. *Rhetoric of Health & Medicine 2*(2), 208-231. https://www.muse.jhu.edu/article/729143

Bateman, L. B., Schoenberger, Y. M., Hansen, B., Osborne, T. N., Okoro, G. C., Speights, K. M., & Fouad, M. N. (2021). Confronting COVID-19 in under-resourced, African American neighborhoods: a qualitative study examining community member and stakeholders' perceptions. *Ethnicity & Health*, *26*(1), 49–67. https://doi.org/10.1080/13557858.2021.1873250

Bitzer, L. F. (1968). The rhetorical situation. *Philosophy & Rhetoric*, *1*(1), 1–14. http://www.jstor.org/stable/40236733

Bye L., & Ghirardelli, A. (2016, June 30). *American health values survey*. Robert Wood Johnson Foundation. https://www.rwjf.org/en/library/research/2016/06/american-health-values-survey-topline-report.html

Caffery, L. J., Martin-Khan, M., & Wade, V. (2017). Mixed methods for telehealth research. *Journal of Telemedicine and Telecare*, *23*(9), 764–769. https://doi.org/10.1177/1357633X16665684

Campbell, L. (2018). The Rhetoric of Health and medicine as a “teaching subject”: Lessons from the medical humanities and simulation pedagogy. *Technical Communication Quarterly*, *27*(1), 7–20. https://doi.org/10.1080/10572252.2018.1401348

Centers for Disease Control and Prevention. (2019, May 13). *Mission, role and pledge*. U.S. Department of Health and Human Services https://www.cdc.gov/about/organization/mission.htm

Centers for Disease Control and Prevention (2020, Dec 10). *Disparities in COVID-19 illness*. U.S. Department of Health and Human Services. https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/racial-ethnic-disparities/increased-risk-illness.html

Centers for Disease Control and Prevention. (2021, April 22). *The U.S. public health service syphilis study at Tuskegee.* U.S. Department of Health and Human Services. https://www.cdc.gov/tuskegee/timeline.htm

Cope, D. (2020, May 8). UAB doctors post 1,400 telehealth patient visits in just one day, underscoring Alabama's broadband needs. *Alabama News Center*. https://alabamanewscenter.com/2020/05/08/uab-doctors-post-1400-telehealth-patient-visits-in-just-one-day-underscoring-alabamas-broadband-needs/

Demiris, G., Doorenbos, A. Z., & Towle, C. (2009). Ethical considerations regarding the use of technology for older adults. The case of telehealth. *Research in Gerontological Nursing*, *2*(2), 128–136. https://doi.org/10.3928/19404921-20090401-02

Demiris, G., Thompson, H., Boquet, J., Le, T., Chaudhuri, S., & Chung, J. (2013). Older adults' acceptance of a community-based telehealth wellness system. *Informatics for Health & Social Care*, *38*(1), 27–36. https://doi.org/10.3109/17538157.2011.647938

Di-Miceli, A. (2021, February 7). Rhetoric in the Time of Covid-19: The Art of Compliance [web log]. Retrieved July 8, 2021, from https://blogs.lse.ac.uk/psychologylse/2021/02/07/social-rhetoric-in-the-time-of-covid-19-the-art-of-compliance/

Dobrin, S. I., & Weisser, C. R. (2002). Breaking ground in ecocomposition: Exploring relationships between discourse and environment. *College English*, *64*(5), 566–589. https://doi.org/10.2307/3250754

Druschke, C. G., & McGreavy, B. (2016). Why rhetoric matters for ecology. *Frontiers in Ecology and the Environment*, *14*(1), 46–52. http://www.jstor.org/stable/44000934

Edbauer, J. (2005). Unframing models of public distribution: From rhetorical situation to rhetorical ecologies. *Rhetoric Society Quarterly*, *35*(4), 5–24. http://www.jstor.org/stable/40232607

Farley, J. H., Hines, J., Lee, N. K., Brooks, S. E., Nair, N., Brown, C. L., Doll, K. M., Sullivan, E. J., & Chapman-Davis, E. (2020). Promoting health equity in the era of COVID-19. *Gynecologic Oncology*, *158*(1), 25–31. https://doi.org/10.1016/j.ygyno.2020.05.023

Fox, S., & Duggan, M. (2020, August 14). *Health online 2013*. Pew Research Center: Internet, Science & Tech. Retrieved August 24, 2021, from http://www.pewinternet.org/2013/01/15/health-online-2013

Greenhalgh, T., & Papoutsi, C. (2018). Studying complexity in health services research: Desperately seeking an overdue paradigm shift. *BMC Medicine.* 16 (85), 1-10. https://doi.org/10.1186/s12916-018-1089-4

Guo, Y., & Albright, D. (2018). The effectiveness of telehealth on self-management for older adults with a chronic condition: A comprehensive narrative review of the literature. *Journal of telemedicine and telecare*, *24*(6), 392–403. https://doi.org/10.1177/1357633X17706285

Hawley, C. E., Genovese, N., Owsiany, M. T., Triantafylidis, L. K., Moo, L. R., Linsky, A. M., Sullivan, J. L., & Paik, J. M. (2020). Rapid Integration of home telehealth visits amidst COVID-19: What do older adults need to succeed? *Journal of the American Geriatrics Society*, *68*(11), 2431–2439. https://doi.org/10.1111/jgs.16845

HealthyPeople.gov. (2021a, October 27). *Disparities*. Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

HealthyPeople.gov. (2021b, October 27). *Health communication and health information technology*. Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services. https://www.healthypeople.gov/2020/about/foundation-health-measures/Disparities

Hite, A., & Carter, A. (2019). Examining assumptions in science-based policy: Critical health communication, stasis theory, and public health nutrition guidance. *Rhetoric of Health & Medicine*, *2*(2), 147–175. https://doi.org/10.5744/rhm.2019.1009

Jacobs, E. A., Rolle, I., Ferrans, C. E., Whitaker, E. E., & Warnecke, R. B. (2006). Understanding African Americans' views of the trustworthiness of physicians. *Journal of general internal medicine*, *21*(6), 642–647. https://doi.org/10.1111/j.1525-1497.2006.00485.x

Jensen, R.E. (2015) An ecological turn in rhetoric of health scholarship: Attending to the historical flow and percolation of ideas, assumptions, and arguments. *Communication Quarterly*, 63:5, 522-526, DOI: 10.1080/01463373.2015.1103600

Lam, K., Lu, A. D., Shi, Y., & Covinsky, K. E. (2020). Assessing telemedicine Unreadiness among older adults in the United States during the COVID-19 pandemic. *JAMA Internal Medicine*, *180*(10), 1389–1391. https://doi.org/10.1001/jamainternmed.2020.2671

Lingard, L., & Haber, R. J. (1999). Teaching and learning communication in medicine: a rhetorical approach. *Academic Medicine: Journal of the Association of American Medical Colleges*, *74*(5), 507–510. https://doi.org/10.1097/00001888-199905000-00015

Majerowicz, A., & Tracy, S. (2010). Telemedicine. Bridging gaps in health care delivery. *Journal of AHIMA*, *81*(5), 52–58. http://library.ahima.org/doc?oid=100028#.YB3E5OhKiUl

Malkowski, J., & Melonçon, L. (2019). The rhetoric of public health for RHM scholarship and beyond. *Rhetoric of Health & Medicine*, *2*(2), iii-xiii. https://doi.org/10.5744/rhm.2019.1010

Mangiò, F., Pedeliento, G., & Andreini, D. (2021). Branding rhetoric in times of a global pandemic: A text-mining analysis. *Journal of Advertising*, *50*(3), 240–252. https://doi.org/10.1080/00913367.2021.1927912

Matoff-Stepp, S., Applebaum, B., Pooler, J., & Kavanagh, E. (2014). women as health care decision-makers: Implications for health care coverage in the United States. *Journal of Health Care for the Poor and Underserved*, *25*(4), 1507-1513. doi:10.1353/hpu.2014.0154.

Meloncon, L., & Scott, B.J. (2018). *Methodologies for the Rhetoric of Health and Medicine*. New York: Taylor & Francis.

Miller, A. B. (1972). Rhetorical exigence. *Philosophy & Rhetoric*, *5*(2), 111–118. http://www.jstor.org/stable/40236794

Misselbrook, D. (2013). Foucault. *British Journal of General Practice*, 63(611), 312. DOI: 10.3399/bjgp13X668249

Mullen J. (2015). Living longer better: A call to action to promote the health of older adults and their communities. *Journal of Public Health Management and Practice: JPHMP*, *21*(4), 410–412. https://doi.org/10.1097/PHH.0000000000000280

Murray T. M. (2015). Trust in African Americans' health care experiences. *Nursing Forum*, *50*(4), 285–292. https://doi.org/10.1111/nuf.12120

National Center for Health Statistics. (2021). May 25). *Healthy people.* Centers for Disease Control and Prevention, U.S. Department of Health and Human Services. https://www.cdc.gov/nchs/healthy_people/index.htm

National Institute on Aging. (2017, May 17). *Supporting older patients with chronic conditions*. U.S. Department of Health and Human Services. https://www.nia.nih.gov/health/supporting-older-patients-chronic-conditions

National Institute on Aging. (n.d.). *Living longer. living healthier? tips for better aging infographic*. U.S. Department of Health and Human Services. https://www.nia.nih.gov/health/infographics/living-longer-living-healthier-tips-better-aging-infographic

Parrott, R. (2004). Emphasizing “communication” in health communication. *Journal of Communication*, *54*(4), 751–787. https://doi.org/10.1111/j.1460-2466.2004.tb02653.x

Pew Research Center. (2020, May 30). *Most view the CDC favorably; VA's image slips*. Pew Research Center - U.S. Politics & Policy. http://www.pewresearch.org/politics/2015/01/22/most-view-the-cdc-favorably-vas-image-slips/

Rice, J. (2012). *Distant publics*: *development rhetoric and the subject of crisis*. (1 ed.). Pittsburgh: University of Pittsburgh Press.

Rivers, N. A., & Weber, R. P. (2011). Ecological, pedagogical, public rhetoric. *College Composition and Communication*, *63*(2), 187–218. http://www.jstor.org/stable/23131582

Robert Wood Johnson Foundation. (n.d.) *Building a culture of health*. https://www.rwjf.org/en/how-we-work/building-a-culture-of-health.html

Rodriguez, A. (2021, May 13). *Many Americans don't trust their public health system during COVID-19 pandemic, survey shows*. USA Today. http://www.usatoday.com/story/news/health/2021/05/13/cdc-fda-american-opinion-public-health-system-suffers-amid-covid/5054439001

Scharff, D.P., Mathews, K.J., Jackson, P., Hoffsuemmer, J., Martin, E., & Edwards, D. (2010). more than Tuskegee: Understanding mistrust about research participation. *Journal of Health Care for the Poor and Underserved 21*(3), 879-897. doi:10.1353/hpu.0.0323

Segal, J.Z. (2008). *Health and the rhetoric of medicine*. Carbondale: Southern Illinois University Press.

Siebenthaler, D.J. (2020, December 3). *Perry County*. Encyclopedia of Alabama. http://encyclopediaofalabama.org/ARTICLE/h-1292

Sinha, A. (2000). An overview of telemedicine: the virtual gaze of health care in the next century. *Medical Anthropology Quarterly*, *14*(3), 291–309. http://www.jstor.org/stable/649500

Skloot, R. (2010). *The immortal life of Henrietta Lacks*. Nzew York: Crown Publishers.

U.S. Census Bureau. (n.d.). *Census profile: Uniontown, AL*. Census Reporter. https://censusreporter.org/profiles/16000US0177904-uniontown-al/

Wall L. L. (2006). The medical ethics of Dr J Marion Sims: A fresh look at the historical record. *Journal of Medical Ethics*, *32*(6), 346–350. https://doi.org/10.1136/jme.2005.012559

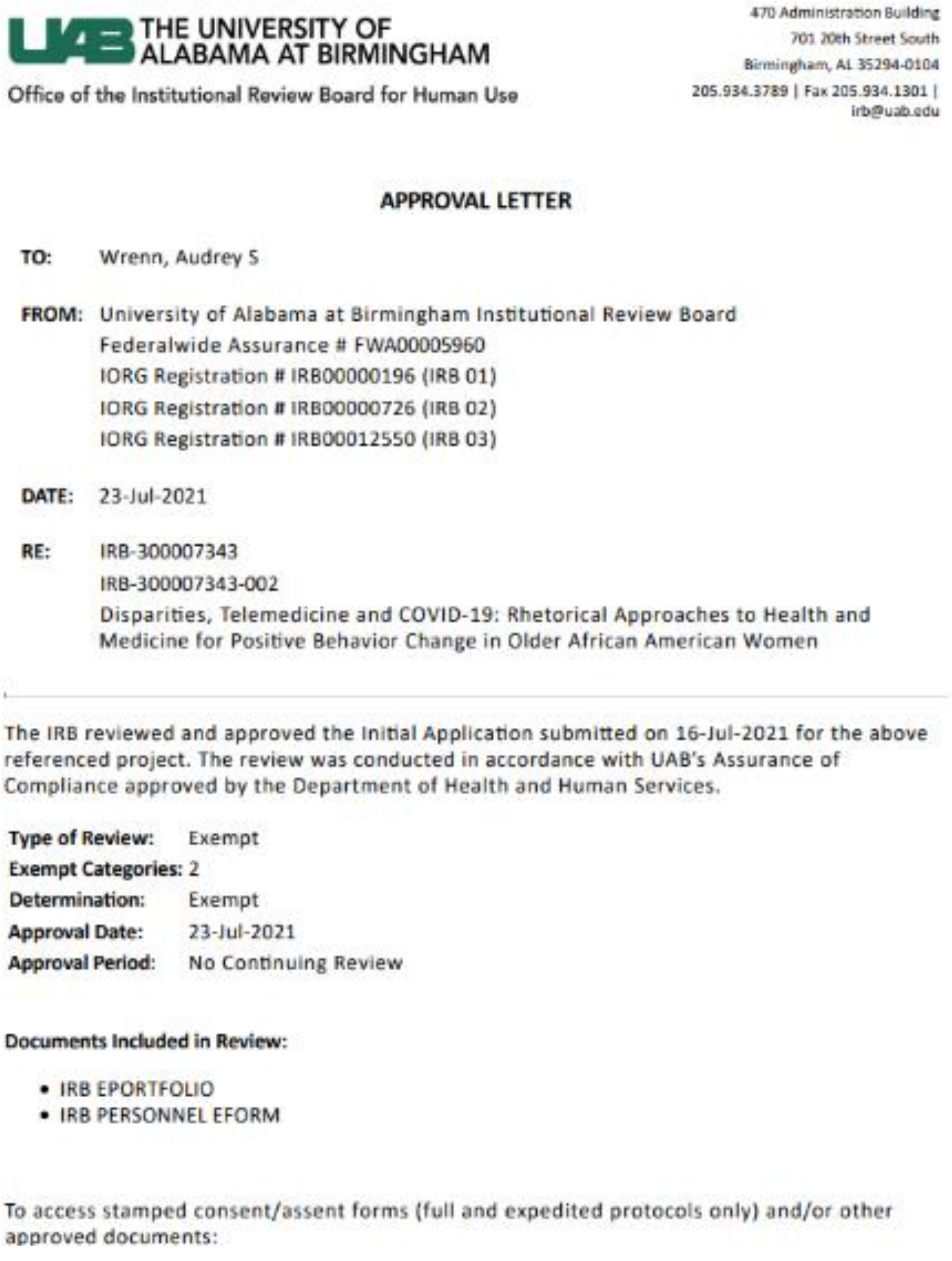
Weisser, C.R., & Dobrin, S.I. (2001). *Ecocomposition*: *Theoretical and pedagogical approaches*. Albany: State University of New York Press.

Wheeler, S. M., & Bryant, A. S. (2017). Racial and ethnic disparities in health and health care. *Obstetrics and Gynecology Clinics of North America*, *44*(1), 1–11. https://doi.org/10.1016/j.ogc.2016.10.001

Whites-Koditsche, S. (2021, March 16). *The next battle in Alabama: Equalizing the vaccine.* AL.com. www.al.com/coronavirus/2021/03/the-next-battle-convincing-alabamians-to-get-the-vaccine.html

APPENDIX A

INSTITUTIONAL REVIEW BOARD APPROVAL



THE UNIVERSITY OF
ALABAMA AT BIRMINGHAM
Office of the Institutional Review Board for Human Use

470 Administration Building
701 20th Street South
Birmingham, AL 35294-0104
205.934.3789 | Fax 205.934.1301 |
irb@uab.edu

APPROVAL LETTER

TO: Wrenn, Audrey S

FROM: University of Alabama at Birmingham Institutional Review Board
Federalwide Assurance # FWA00005960
IORG Registration # IRB00000196 (IRB 01)
IORG Registration # IRB00000726 (IRB 02)
IORG Registration # IRB00012550 (IRB 03)

DATE: 23-Jul-2021

RE: IRB-300007343
IRB-300007343-002
Disparities, Telemedicine and COVID-19: Rhetorical Approaches to Health and Medicine for Positive Behavior Change in Older African American Women

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The IRB reviewed and approved the Initial Application submitted on 16-Jul-2021 for the above referenced project. The review was conducted in accordance with UAB's Assurance of Compliance approved by the Department of Health and Human Services.

Type of Review: Exempt
Exempt Categories: 2
Determination: Exempt
Approval Date: 23-Jul-2021
Approval Period: No Continuing Review

Documents Included in Review:

- IRB EPORTFOLIO
- IRB PERSONNEL EFORM

To access stamped consent/assent forms (full and expedited protocols only) and/or other approved documents:

APPENDIX B

INFORMATION SHEET TO BE A PART OF A RESEARCH STUDY

INFORMATION SHEET TO BE PART OF A RESEARCH STUDY

Title of Research:	Disparities, telemedicine, and COVID-19: Rhetorical approaches to health and medicine for positive behavior change in older African American women
UAB IRB Protocol #:	IRB-300007343
Principal Investigator:	Audrey Wrenn, M.A.Ed.

The purpose of this research study is to find out from African American women ages 75 years and older what their experiences have been with telehealth appointments during the COVID-19 pandemic, and how the COVID-19 pandemic has affected decision-making about their health.

If you agree to be a part of this research, you will be asked to participate in a phone or Zoom interview, which will take no more than one hour. With your consent, the researcher will audio record the interview. The recording will be used for transcription purposes only and will not be accessible to anyone else.

Participation in this research is voluntary and you can choose to withdraw at any time. If you choose to do this, none of the data collected from you will be used for the research.

Information obtained during the course of the interview will be kept confidential and only the principal investigator will have access to this information. The data collected from you will be coded to ensure that the information cannot be traceable to you. Your name will not be recorded or used, so you are encouraged to use a pseudonym. These data will be stored in a secure place and will be destroyed after a period of six months.

By completing the interview you are consenting to allow your responses to be used in this research study.

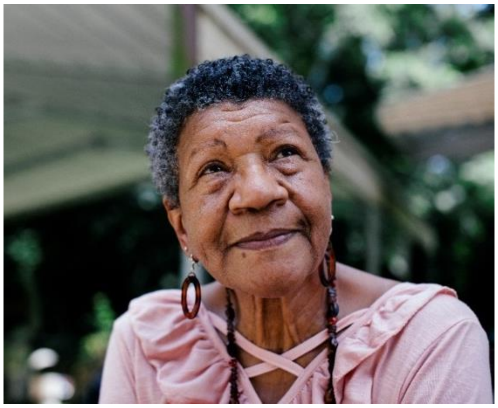
There are no known risks to participating in this research. There are no direct benefits to you for participating in this study, but your participation may contribute information that may improve health messages for older African American women.

If you have any questions, concerns, or complaints about the research please contact the Principal Investigator, Audrey Wrenn, at 205-578-8983. If you have questions about your rights as a research participant, or concerns or complaints about the research, you may contact the UAB Office of the IRB (OIRB) at (205) 934-3789 or toll free at 1-855-860-3789. Regular hours for the OIRB are 8:00 a.m. to 5:00 p.m. CT, Monday through Friday.

APPENDIX C

RECRUITMENT FLYER

PARTICIPANTS NEEDED TO SHARE THEIR TELEMEDICINE EXPERIENCE



WHO:

- ✓ African American women
- ✓ 75 years or older
- ✓ Must have participated in a telehealth appointment (medical appointment over the telephone or computer) over the past year

If you are interested in participating, please call or email
Audrey Wrenn, M.A.Ed.
205.578.8983 or awrenn@uab.edu

This study is being conducted for thesis research at The University of Alabama at Birmingham (UAB). There is no monetary compensation for your participation in this study.

This study will examine experiences with telehealth and other health-related decisions during the COVID-19 pandemic.

UAB THE UNIVERSITY OF ALABAMA AT BIRMINGHAM

APPENDIX D

PARTICPANT QUESTIONNAIRE

PARTICPANT QUESTIONNAIRE

	QUESTION	ANSWER CHOICES
1.	What is your date of birth?	
2.	What is your race?	
3.	Tell me about your living environment. (Who do you live with? Alone? Home? Residential? Facility?)	
4.	What motivated you to want to participate in this research study? How did you find out about it?	
5.	Who makes important decisions about your health care?	
6.	Do you receive help from someone in the following areas:	scheduling appointments? getting to and from appointments? getting prescriptions filled?
7.	Which of the following items do you have that are needed to participate in a telehealth visit/appointment?	Smartphone, phone, computer, laptop, internet
8.	How confident are you that you can participate in a telehealth visit/appointment? Tell me more about that.	1 - Not at all confident 2 - Slightly confident 3 - Somewhat confident 4 - Confident 5 - Very confident
9.	How comfortable are you with telehealth visits/appointments on your own? Tell me more about that.	1 - Not at all comfortable 2 - Slightly comfortable 3 - Somewhat comfortable 4- Comfortable 5 - Very comfortable
10.	How many telehealth visits/appointments have you had in the past year? In what ways, if any, did they change because of the pandemic? (frequency, time, technology)	1-5 6-10 11 or more
11.	Which of the following make it hard for you to use a computer or phone?	Poor vision, problems typing, physical pain, hearing loss, other, none
12.	Which of the following do you use for health care information? What kinds of information might that be?	TV, internet, newspaper, magazines, other

	QUESTION	ANSWER CHOICES
13.	How often have you used the internet for health care information in the past year?	1 - Never 2 - Rarely 3 - Occasionally 4 - Very Often 5 – Always
14.	How comfortable are you with talking to your health care provider in person?	1 - Not at all comfortable 2 - Slightly comfortable 3 - Somewhat comfortable 4 - Comfortable 5 - Very Comfortable
15.	How comfortable are you with talking to your health care provider as part of a telehealth visit/appointment?	1 - Not at all comfortable 2 - Slightly comfortable 3 - Somewhat comfortable 4 - Comfortable 5 - Very comfortable
16.	How interested are you in receiving health care information on the computer or phone on a regular basis?	1 - Not at all interested 2 - Slightly interested 3 - Somewhat interested 4 - Interested 5 - Very interested
17.	What has been the biggest challenge (or obstacle) with telehealth during the past year?	
18.	What has been the greatest success (or surprise) with telehealth during the past year?	

APPENDIX E

PARTICPANT RESPONSES

PARTICIPANT RESPONSES

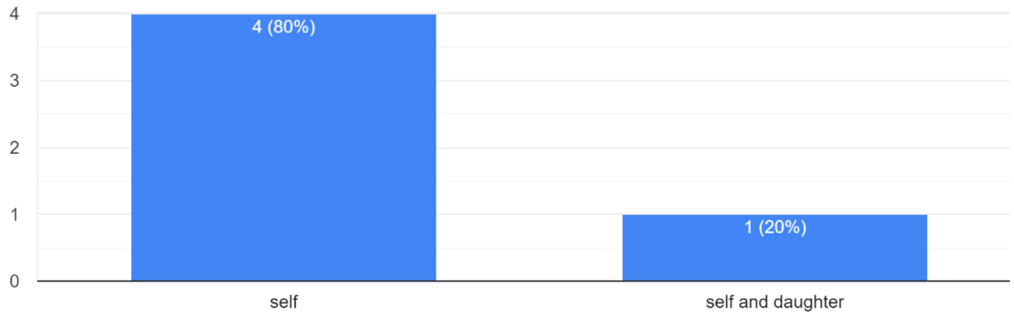
DEMOGRAPHICS	
Age Range	75-91
Living Environment	Home with husband Home with 4 grandkids Home alone Lives with adult daughter

RESPONSES TO OPEN-ENDED QUESTIONS	
Reasons for participating	Was asked to participate (4/5) Likes to help
Kinds of information sought	Rheumatoid arthritis High blood pressure Medication Information on new medications Side effects COVID statistics Contact numbers for information on issues Prescription medication (2/5)
Challenges with telehealth	Making doctor's appointments Getting in to see a doctor Preference for in person visits Ability to comprehend what's being told Having to rely on daughter to assist with tele-health and help answer questions No problems or challenges
Successes with telehealth	Uses telehealth for kids' appointments but not for self Comfortable in own setting No concerns about exposure to COVID since at home Simple Easy to contact health provider No surprises

PARTICIPANT RESPONSES CONT.

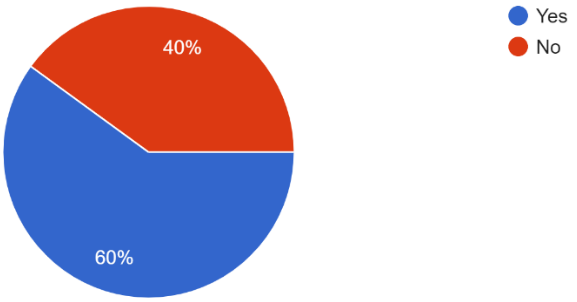
Who makes important decisions about your health?

5 responses



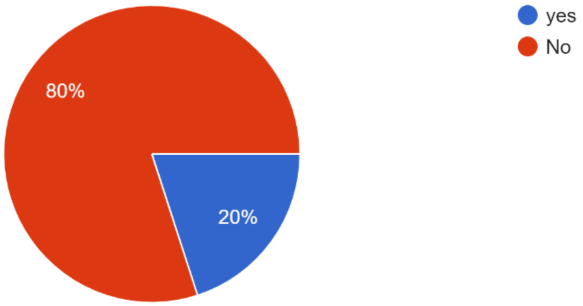
Do you receive help from someone getting to and from appointments?

5 responses



Do you receive help from someone scheduling appointments?

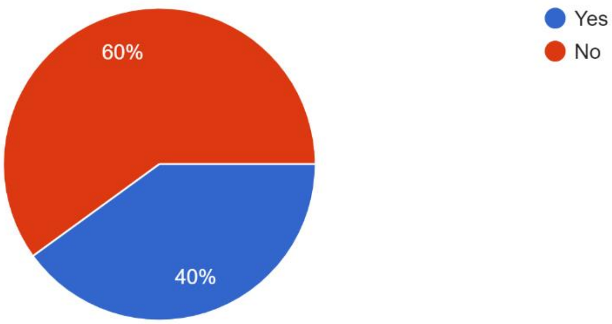
5 responses



PARTICIPANT RESPONSES CONT.

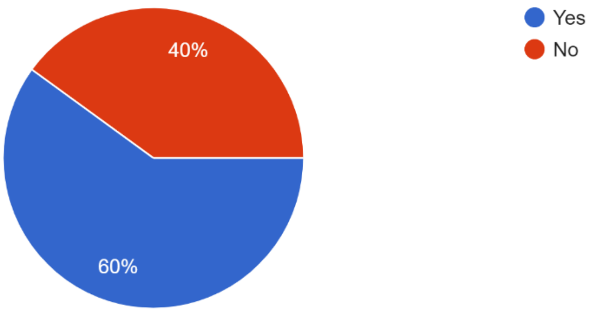
Do you receive help from someone getting prescriptions filled?

5 responses



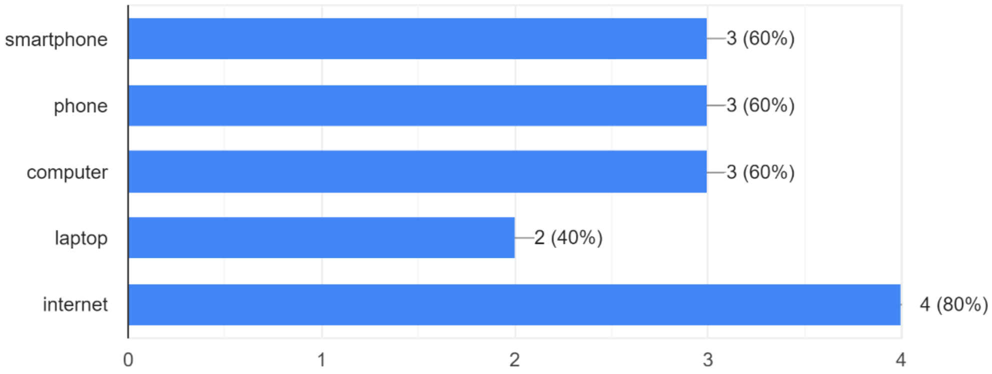
Do you receive help from someone getting to and from appointments?

5 responses



Which of the following items do you have that are needed to participate in a telehealth appointment?

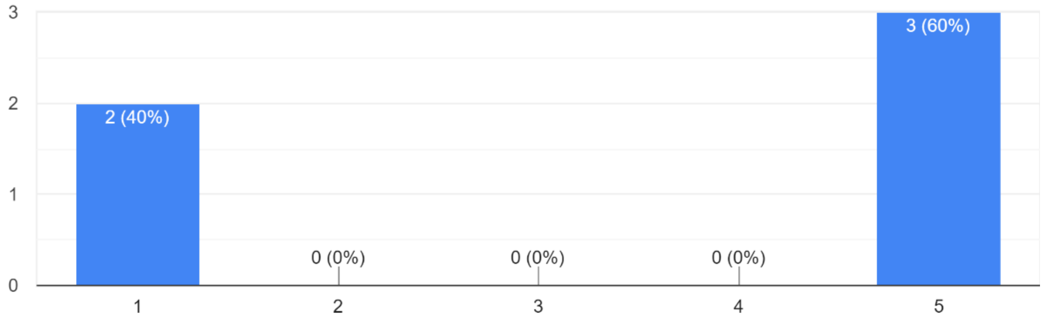
5 responses



PARTICIPANT RESPONSES CONT.

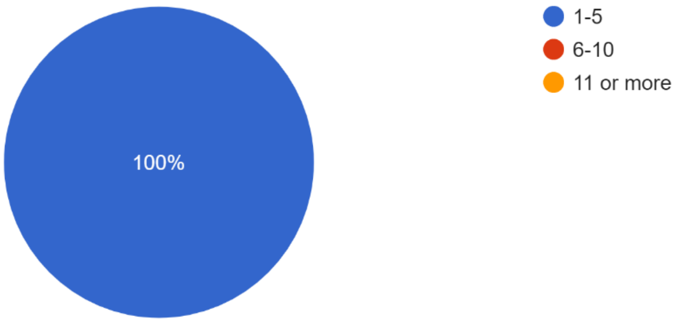
How confident are you with telehealth visits/appointments on your own?

5 responses



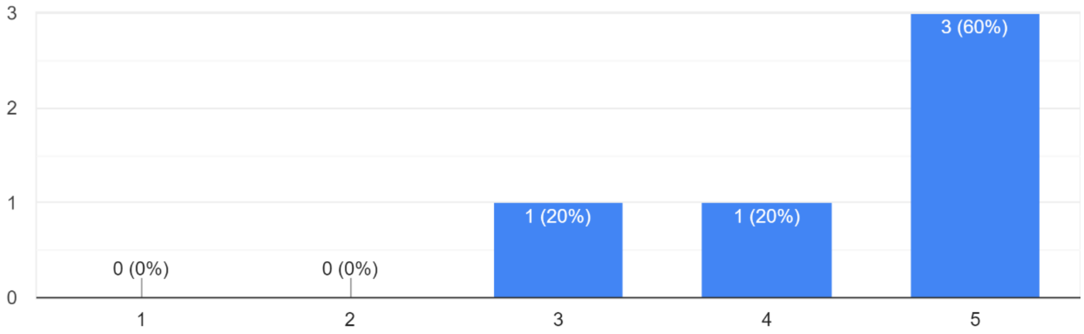
How many telehealth visits/appointments have you had in the past year?

5 responses



How confident are you that you can participate in a telehealth visit/appointment?

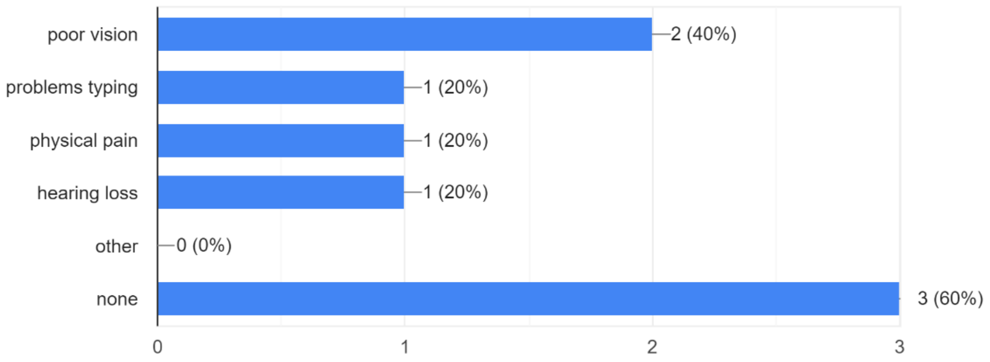
5 responses



PARTICIPANT RESPONSES CONT.

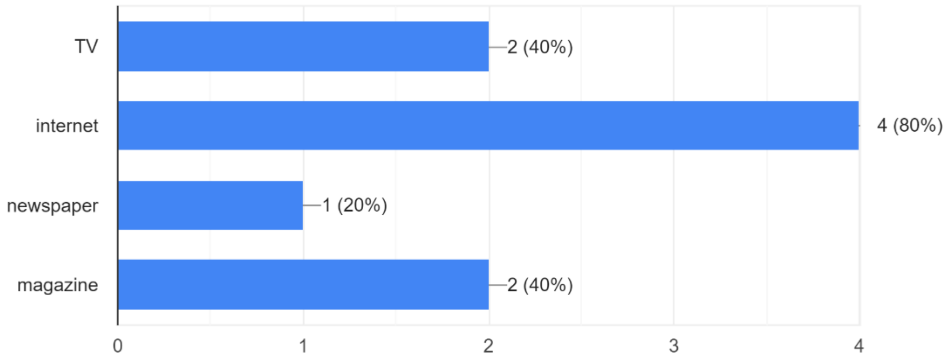
Which of the following make it hard for you to use a computer or phone?

5 responses



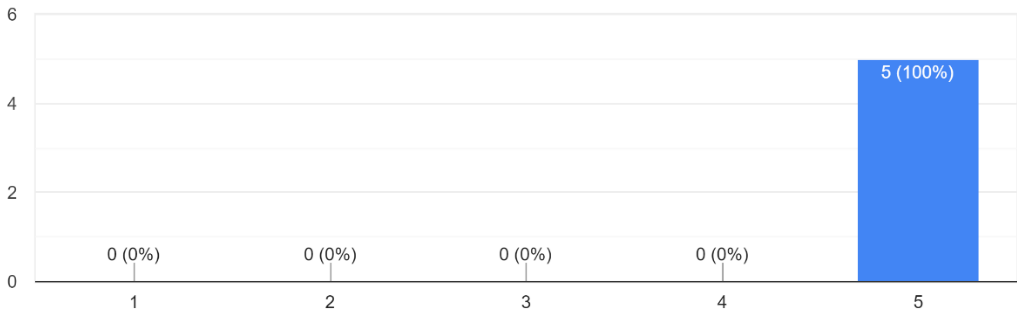
Which of the following have you used for healthcare information?

5 responses



How comfortable are you with talking to your health care provider in person?

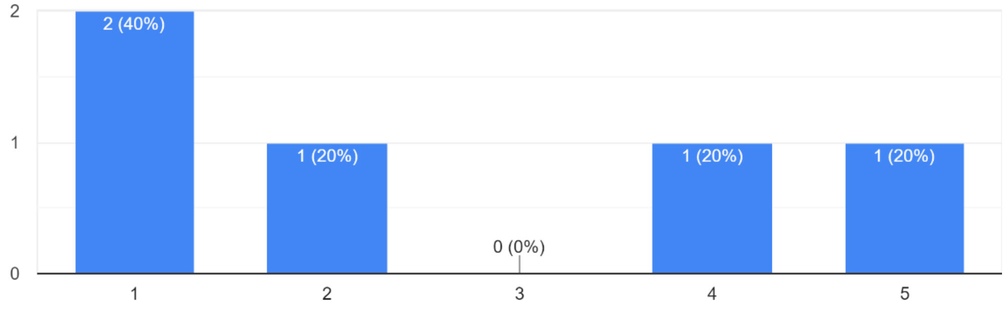
5 responses



PARTICIPANT RESPONSES CONT.

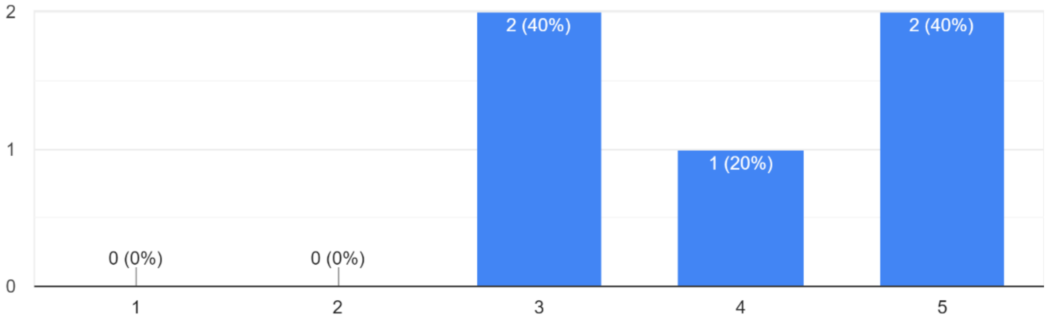
How often have you used the internet for health care information in the past year?

5 responses



How comfortable are you with talking to your health care provider as part of a telehealth visit/appointment?

5 responses



How interested are you in receiving healthcare information on the computer or phone on a regular basis?

5 responses