years and varies with patient characteristics. The American Heart Association blood pressure classifications (Table) represent general guidelines for normal, borderline, and elevated values, and the Eighth Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure recommends that clinicians initiate therapy in patients who (A) are older than 60 years of age with a blood pressure of 150/90 mm Hg or higher, (B) are younger than 60 years with a blood pressure of 140/90 mm Hg or higher, or (C) have diabetes and a blood pressure of 140/90 mm Hg or higher.

### Table. American Heart Association Blood Pressure Classification

<table>
<thead>
<tr>
<th>Level</th>
<th>Systolic</th>
<th>Diastolic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>&lt;120 mm Hg</td>
<td>&lt;80 mm Hg</td>
</tr>
<tr>
<td>Prehypertension</td>
<td>120-139 mm Hg</td>
<td>80-89 mm Hg</td>
</tr>
<tr>
<td>Hypertension</td>
<td>≥140 mm Hg</td>
<td>≥90 mm Hg</td>
</tr>
</tbody>
</table>

In discussing treatment options, Erlich listed the primary classes of blood pressure medications and their mechanisms of action.

**Coronary Heart Disease**

With a grounding in the basics of the circulatory system and hypertension, the discussion transitioned comfortably to coronary heart disease, a condition marked by the accumulation of plaque (consisting of cholesterol, fat, cellular waste, fibrin, and calcium) in the coronary arteries that causes approximately 16% of deaths in the United States, according to Erlich. Potential outcomes include ischemia (ie, insufficient blood flow to the heart muscle), angina (ie, chest pain), atherosclerosis (ie, hardening of the arteries), blood clots, stroke, and heart attack. She went on to explain that although some coronary heart disease risk factors, such as age, sex, and family history, cannot be modified, there are several factors that people can control. These include poor diet, obesity, lack of exercise, smoking, and elevated cholesterol.

**Cholesterol**

After noting that cholesterol is produced in the liver and is needed for digestion and hormone production, Erlich explained that this fatty substance circulates in the blood in 2 forms: low-density lipoprotein (LDL), or “bad” cholesterol, and high-density lipoprotein (HDL), or “good” cholesterol. Excess LDL accumulates within the arteries and narrows them, whereas HDL acts as a scavenger to sweep LDL back to the liver for recycling. This portion of the presentation included an image of test tubes containing blood collected after a fatty meal, which was disturbing enough to cause at least one audience member to opt for a vegetarian dinner that night. Erlich summarized other cholesterol-management options, particularly the statin medications.

**Arrhythmias**

The talk concluded with an overview of arrhythmias, which the American Heart Association defines as changes in the sequence of electrical impulses through the heart. These can cause the heart to beat too rapidly (tachycardia), too slowly (bradyarrhythmia), or irregularly. Erlich characterized arrhythmias as generally harmless but potentially damaging for organs that do not receive an adequate blood supply. Treatments she discussed included medications, pacemakers, and ablation.

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ARE YOU PICKING UP WHAT I’M PUTTING DOWN? THE COMMUNICATION CONUNDRUM

**Speaker**
Robin Whitsell
*Founder and President, Whitsell Innovations, Inc., Chapel Hill, NC*

**By Kirby Snell**

As professional writers and editors, we depend on our excellent listening and communication skills, with our clients as well as our coworkers—but are we as good at listening and communicating as we think we are?

**Design versus User Experience**

Good communication is a challenge of design versus user experience, Robin Whitsell explained: “We think we’re going down one path, while our listener is going down another path…. It’s not as straightforward as we think it is.” To illustrate the difference between speaker and audience perception, Whitsell replicated an uncomfortable experience from a conference she attended. She played a video of a supposed “listening exercise,” but when she asked questions about the rapid-talking video, the questions covered not only the spoken dialogue but also details of what the characters were wearing, props visible in the scene, and other visual details. What was introduced to us as “an exercise in listening” required, in reality, a different level of engagement than we were told to expect. She asked the audience to consider how they felt following this experience, recognizing that the likely perception was unfavorable.

The audience gleaned 2 lessons from this exercise: first, as listeners we should be prepared to engage with our full envi-
ronment; and second, as communicators providing information to others, we need to make sure the rules are both the same for—and clearly understood by—everyone.

**What Great Listeners Actually Do**

Whitsell then introduced a study from the *Harvard Business Review* that identified 4 main qualities that define great listeners:

1. People listen better when engaged and periodically asking questions, not just listening in silence.
2. Good listeners build up the self-esteem of the person they’re listening to, allowing him or her to feel supported.
3. Good listeners are cooperative; they are trying to help, not simply win an argument.
4. Good listeners make suggestions, based on the respect already established with the speaker.

**Communication Styles**

The idea of communication styles also came into play. Whitsell highlighted one particularly valuable theory, the Process Communication Model developed by Dr Taibi Kahler, which presents 6 communication styles, or “perceptual languages” (see Box). While being aware of your own primary “language” is valuable, it is also important to recognize other people's styles. “We hear people based on our communication style,” Whitsell emphasized, “not their communication style.” If you can identify the style of the people you are speaking to, you can adapt your approach to better connect with and influence them.

**Box. Six Perceptual Languages**

- **Thoughts:** Talks about facts, details, logic; asks about who, what, where, and why; wants things to make sense
- **Opinions:** Guided by values and judgment; “we ought to be doing...”; “this is what we believe in/this is our goal”
- **Feelings:** Uses the heart as a moral compass; is perceptive and empathic; is sometimes bullied over because they’re more concerned about others
- **Reactions:** Jumps in without much forethought; low filter; gut-based, and maybe more honest
- **Action:** Verb-based; focused on tasks, taking charge, and getting things done
- **Reflection:** Open and uncontrolled thought process; doesn’t speak much; likes to reflect on things

Whitsell invited the audience to put this in practice by first identifying our own primary languages and then partnering with a neighbor with the assignment of convincing each other of specific arguments (whether climate change is real, New York- vs Chicago-style pizza, our favorite books) while targeting each other’s perceptual languages. The added factor of heightened emotions around the assigned topics emphasized both the challenges and the value of meeting a colleague or conversation partner on their own territory.

**Conclusion**

Some final takeaways included knowing that at some point in our professional lives, all of us will likely have to convince others of something we ourselves are not excited about (eg, when upper management has made a decision and you have to get your own team on board), being able to recognize when you need to change mediums, and remembering to check in with your listener to make sure you’re going in the right direction. The value of knowing your audience—and knowing tools that can guide that understanding, such as the Process Communication Model—has great application for medical communicators in the workplace, as well as in all areas of our professional and personal lives.

**References**


**TRASH TALK: DRUG WASTE IN THE 21ST CENTURY**

**Speaker**

Ashley Khan, PharmD

Medical Writer and Consultant, Whitsell Innovations, Inc., Chapel Hill, NC

**By Callie Rainosek**

As Ashley Khan put it, “[Pharmaceutical waste] is not something you think about in your day-to-day routine.” However, thousands of metric tons of pharmaceutical waste are produced annually, which may be harming both humans and the environment.

**What is Pharmaceutical Waste?**

Khan defined pharmaceutical waste as “any drug product that is no longer used for its intended purpose.” Medication may be considered waste because the product is expired, discontinued, or damaged. Drug waste also includes vials, syringes, and even materials such as tubing used to administer chemotherapy treatments. Drug waste can be in solid, liquid, or gas form.