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ETHICAL ISSUES IN HEALTH COMMUNICATION IN CLINICAL AND DIGITAL SETTINGS AND IN HEALTH COMMUNICATION CAMPAIGNS

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Communicating about health inherently raises ethical issues because it concerns people's private lives and what they should know or do in order to avoid health-related risks or adopt health-related practices. The main purpose of this chapter is to present ethical issues as they emerge in health communication in various settings. The first section provides an overview of several ethical approaches and guiding precepts that can direct our thinking on ethical issues in health communication. The second presents several ethical issues in clinical settings. Because health communication increasingly takes place through the Internet and digital information technologies, the third section concentrates on ethical issues associated with health communication in digital and social media contexts. The fourth section focuses on ethics in health communication campaigns and social marketing. The chapter concludes by underscoring the importance of identifying and attending to ethical issues in various health communication contexts and noting implications for advocacy.

Ethical Approaches and Guiding Precepts

The consideration of ethical issues in health communication can be informed by international declarations of human rights. In particular, the United Nation's Universal Declaration of Human Rights provides a basis to argue that pro-health interventions must promote autonomy and equity (Gordon et al., 2016). Discussions regarding ethics in healthcare are often guided by ethical obligations as articulated by bioethicists, most notably Beauchamp and Childress (2009), drawing on a principlist approach. These principles refer to fundamental ethical obligations, beginning with the obligation to avoid doing harm, whether physical, psychological, or social, and the basic tenet of the helping professions to "do good" (*beneficence*). By implication, communicating about health should aim to help people promote their health and avoid health-related risks, but it is also imperative to consider how this communication could cause unintended harm (e.g., raising anxieties or stigmatizing).

Another central obligation is *respect for autonomy*, based on the premise that people have an intrinsic right to exercise their free will to make decisions for themselves on matters that affect them, so far as such decisions do not harm others. This obligation is rooted in a liberal Western tradition and democratic theory that places high importance on individual choice in political life and personal development. It is also the basis for the obligation to respect people's privacy and is the foundation

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for medical care codes such as patients' rights, informed consent, and confidentiality rules. Respecting autonomy is also the basis for the obligation to be truthful and to refrain from deceptive or manipulative persuasive tactics when communicating about health. However, the prominent emphasis on autonomy has also been criticized as based on Western assumptions of individualism and as not reflecting cultural diversity in moral reasoning (Carrese & Rhodes, 1995). Different conceptions of autonomy or fairness can be found in collectivist cultures (Cortese, 1990), according to which people are interdependent, a person is a person through others, and one's well-being is connected with one's family and community (Metz, 2010). An emphasis on connectedness and caring can also be found in the ethics of care in feminist literature (Tong, 1998) and in the communitarian approach, which stress a sense of common purpose and tradition and prioritize values such as generosity, compassion, solidarity, sympathy, and reciprocity (Bouman & Brown, 2010). Therefore, messages that mainly focus on personal autonomy could be perceived as inappropriate in cultures that emphasize communal obligations.

An additional central precept refers to *equity* and the obligations to promote a just and fair distribution of resources, access, opportunities, benefits, and risks within and across populations. This principle includes the obligation to provide for those who are disadvantaged, vulnerable, marginalized, or have special needs. A contentious issue associated with equity is the debate regarding moral relativism versus the obligation to adhere to universal principles. For example, should one respect cultural values regarding gender-role norms when communicating about health-related issues and consequently avoid using messages or images that challenge these norms? That is, when targeting members of societies with traditional gender roles, should health communicators disseminate materials that refrain from gender equity and depict only women practicing behaviors associated with traditional female gender roles (e.g., cooking or childcare) and show only men in roles associated with male gender roles? Another guiding precept is associated with *utility* and effectiveness, according to which the approach should be chosen to maximize the greatest benefit to the largest number of people, especially when resources are limited. For example, should one choose a specific digital platform to disseminate health information because of its popularity, although it is not accessible to certain groups?

The communication ethics literature presents guiding ethical precepts associated with respect for autonomy that specify communicators' obligations to truthfulness, correctness, reliability, sincerity, and comprehensibility of the information provided. They also add the obligation to include relevant individuals and groups in the process of developing and disseminating information aimed to influence and persuade them (Johannesen et al., 2008), which can be associated with both autonomy and equity. Similar precepts can be found in the advertising literature, as may be seen in a framework called TARES, which underscores obligations to *truthfulness* of the message, *authenticity* of the persuader, *respect* for the people whom one intends to persuade, *equity* of the persuasive appeal, and *social responsibility* for the common good (Baker & Martinson, 2001). The literature on ethics in social marketing adds the obligations not to model inappropriate or undesirable behavior, not to be offensive, and to avoid stereotyping (Donovan & Henley, 2010; Smith, 2001). These precepts and obligations can help health communicators identify ethical concerns when communicating in clinical settings or digital platforms and when developing persuasive appeals for the purpose of information campaigns.

Clinical Settings

Communication between healthcare providers and patients in clinical settings elicits a host of ethical issues. This section focuses on dilemmas regarding truth telling and conveying uncertainty in diagnosis, communication about sensitive issues (see also Chapter 13, this volume), crossing boundaries of professional roles, and whistleblowing.

Truth Telling and Communicating About Diagnostic Uncertainty

Being truthful as a central moral tenet in communication ethics is associated with the obligation to respect people's autonomy and to provide people with information that is as truthful as possible (Johannesen et al., 2008). However, the obligation to be truthful raises ethical dilemmas in the healthcare context, for example, when healthcare providers do not feel it is morally right to provide patients with complete information. One such dilemma is whether to disclose costly treatment options that are not covered by the patient's insurance in order to protect the feelings of those with limited income who might possibly feel shame or frustration from not being able to afford these treatments (Iezzoni et al., 2012; Marcus, 2007). Another dilemma concerns disclosing an unfavorable diagnosis. Contemporary "patient rights" bills emphasize individuals' right to know their diagnosis and prognosis, in contrast to the past when physicians decided what to disclose. Concealing or misrepresenting what is known about a diagnosis, even when healthcare providers believe this is for a good cause (e.g., not wanting to upset patients), infringes on respecting their autonomy. Yet, critics propose that the preoccupation with patients' autonomy indicates a cultural bias of Western medicine and contradicts the values of certain patients and their families (Blackhall et al., 1995). For example, some people do not want to hear a negative prognosis, and in some cultures it is not customary to disclose a negative prognosis to elderly members of the family. Consequently, in certain situations healthcare providers face the dilemma of whether it is their moral obligation to disclose the prognosis to their patients or to respect their families' preference not to (Rising, 2017).

A related dilemma is how to communicate to patients about an uncertain diagnosis. Uncertainty is an integral part of illness. Diagnostic uncertainty can result from undeveloped symptoms or insufficient information about the progression of the illness. However, disclosing diagnostic uncertainty could distress and overwhelm patients coming to seek reassurance that the condition is not serious (for example, a persistent headache). Healthcare providers need to decide how to communicate and acknowledge diagnostic uncertainty without risking harm to the patient by creating anxiety (Heritage & McArthur, 2019). A related concern is that some patients might be inclined to request various diagnostic tests to reduce the uncertainty, and such tests could be costly, invasive, or produce worrisome "false positive" responses. To address such dilemmas, it is recommended that healthcare providers receive training and tools to discuss diagnostic uncertainty with their patients (Stacey et al., 2017).

Communication About Sensitive Topics

Discussions about health issues necessarily raise sensitive topics because they refer to people's bodies and private and intimate practices. Some topics (e.g., mental illness, domestic and intimate partner violence, death) are considered highly sensitive or even taboo and difficult to discuss (Ferdous et al., 2018). Providers face the dilemma of how to engage in discussions about such sensitive topics with members of diverse populations when they believe discussing them is part of their obligation to promote the welfare of their patients. Yet, if they attempt to do so, this could result in causing discomfort or even resistance on the part of their patients. One example is initiating discussions on preferences for end-of-life medical treatments (see Chapter 9, this volume). Due to the use of invasive medical technologies that prolong life but do not necessarily enhance its quality, patients are accorded the right to express their preferences about the use of such technologies in end-of-life situations. As people might be unable to voice their preferences when the actual decision needs to be made, their autonomous decision needs to be established in advance by completing an "advance directive" or naming a proxy. Because this topic is considered difficult to discuss, it is infrequently raised in medical encounters. Consequently, many patients in end-of-life situations are deprived of the opportunity to realize their preferences. This poses a dilemma to healthcare providers: if, when, and how to raise the issue of preferences for end-of-life treatments, even if people want to avoid thinking and talking about death-related issues (Olson et al., 2020).

Another sensitive issue related to end of life is communicating with families regarding organ donations from the deceased. Organ transplantation can substantially benefit individuals with serious medical conditions and can literally save lives, but across nations fewer organs are available for transplantations than the patients who need them. In order to maximize the availability of organs for transplantation, it is customary that trained medical staff approach close family members of the recently deceased and ask them if they would agree to donate the organs of the deceased and convey to them the urgency of this difficult decision. This request is typically made when the loss is relatively sudden and families are grieving, and therefore it raises ethical concerns. First, some families welcome the organ donation request because it corresponds to their values or to the wishes of the deceased; others would feel it adds to their distress or is disrespectful of their beliefs (Siminoff et al., 2011). Further, in order to help other patients, the staff is trained to employ persuasive communication to encourage families to agree to the donation, and a persuasive approach raises ethical concerns. Staff training needs to include attending to ethical concerns associated with discussing organ donation with grieving families from diverse backgrounds.

Sensitivities regarding health-related topics vary across individuals, age groups, and cultures, each raising ethical concerns. For example, talking about issues related to sexuality could be difficult for many people, especially for individuals living in traditional cultures, adolescents, the elderly, or individuals who are gay, lesbian, bisexual, or transgender. Some of these individuals would find talking about sexuality offensive or an invasion of their privacy. This is illustrated in a study that found that in a traditional culture some unmarried women avoid consulting their doctors about urinary tract infections (which can be associated with sexuality) because they fear they will be judged as immoral (Khazen & Guttman, 2021). Studies find similar hesitation among transgender populations because healthcare providers may not know how to address trans issues, such as checking with trans patients about preferences to be treated as a male or a female or how they want to talk about their body (Vincent, 2020). Meanwhile, providers face the dilemma of how to encourage individuals belonging to diverse groups to talk about sensitive topics while respecting their privacy and how to manage the challenge of overcoming cultural taboos that associate the topics with fear or shame (Alexander et al., 2020).

Boundary Crossing in Clinical Settings

The imbalance in relationships in clinical settings is strongly tilted toward the healthcare provider due to their professional expertise. It is also perpetuated by the organizational structure of healthcare facilities and the legal or administrative authority accorded to practitioners as gatekeepers of medical treatments and medications. Yet, practitioners find themselves in situations that blur professional boundaries when communicating with patients and therefore elicit ethical dilemmas. Choosing to express empathy to patients by self-disclosing their own personal health experiences would be one such example (Arroll & Allen, 2015). Thus, professionals can face dilemmas about whether their communication with their patients should be guided by professional norms or by their personal beliefs about how they can help their patients.

Blurring personal and professional boundaries can also be found in community settings in societies with a collectivist orientation that prioritize connectedness and values of loyalty to other members. Practitioners who are part of this society and have personal ties with their patients/clients report that they feel the pressure of conflicting obligations (professional versus connectedness) to accede to their customers' requests for medications and treatments (e.g., the provision by community pharmacists of antibiotics without a prescription; Khazen, 2019). To address ethical dilemmas associated with professional boundaries, scholars recommend that practitioners be provided with training and tools (Chen et al., 2018).

Whistleblowing

Invariably, unsafe, unethical, or illegal acts take place in healthcare organizations (Gagnon & Perron, 2020). Although professional ethical standards typically require that such practices be reported, healthcare providers face the dilemma of whether to report them: They do not want to betray the trust of their colleagues or fear negative consequences to themselves. Hence, even when healthcare professionals believe it is their moral duty to expose misconduct in their workplace, many refrain from communicating about it. But many also believe it is important to expose misconduct. Such reporting on misconduct in organizational settings is referred to as "whistleblowing." Whistleblowing requires moral courage and strength to do the right thing because whistleblowers may be victimized or portrayed as troublemakers; indeed, they face considerable stress in such situations (Mannion & Davies, 2015). Recommendations to encourage the reporting of misconduct include providing support and protection to those who do report about the misconduct of someone in a higher position, offering support to the healthcare provider under investigation, and emphasizing the positive outcomes of such reporting to patients and organizations (Gagnon & Perron, 2020).

Ethical Issues in Health Communication in Digital Media and Social Media Platforms

The Internet and digital communication platforms increasingly serve as a central and significant resource for health information (Millar et al., 2020), and they have become an integral part of healthcare practice and delivery (referred to as eHealth; for a review see Chapter 26, this volume). These platforms include information "search engines" that can help reach vast sources of health-related information; telemedicine, which enables remote communication between providers and patients; a proliferation of health-related smartphone applications that encompass various purposes (e.g., illness monitoring, offering motivational support; Tokgöz et al., 2019); and digital social media, which can serve a wide range of health-related functions (e.g., peer support; Partridge et al., 2018). These technologies offer opportunities to enhance communication between providers and patients, increase the effectiveness of healthcare service delivery, and personalize health-promoting messages. They also raise a wide range of ethical concerns. The following section focuses on concerns related to equity, autonomy and privacy, and healthcare quality and potential harm.

Equity Concerns

A prominent concern regarding the health-related opportunities afforded by digital technologies is digital inequality, which is primarily associated with access to various digital platforms and digital literacy skills (see Chapter 29, this volume, for a discussion of health equity and the digital divide). The Internet contributes to health inequities because even in high-income countries certain populations (e.g., people living in rural areas, the elderly, linguistic and cultural minorities, disadvantaged or marginalized populations) suffer from "digital exclusion" by not being able to utilize the Internet and digital information and healthcare-related resources due to myriad technological, economic, cognitive, language, social, and cultural issues (Hargittai & Hsieh, 2013; Watts, 2020). The opportunities afforded by these technologies (e.g., obtaining relevant health information, communicating remotely with healthcare experts, customized resources on how to stay healthy or manage diseases), which can help assist in making informed healthcare decisions (Kreps, 2020), are less available to them. In addition, biases that privilege those with certain sociocultural backgrounds could be incorporated in the development of the technology, and these biases are unlikely to be transparent (Terrasse et al., 2019).

The increasing use of telemedicine exemplifies how the use of digital technologies exacerbates concerns regarding health communication and inequity. Telemedicine has become a prominent phenomenon in healthcare, and recent pandemics such as H1N1 and COVID-19 served to accelerate this trend. Healthcare organizations responded to social distancing requirements by increasing and encouraging use of telehealth services (Olayiwola et al., 2020). Telemedicine has the potential to increase remote access to general and specialized healthcare services to people living in remote geographical areas, and it can offer greater flexibility in scheduling appointments, save travel time, and reduce costs (Kruse et al., 2018). However, it also raises concerns regarding equity. It is less accessible to populations with limited Internet connectivity and linguistic and digital literacy (Kaplan, 2020). In addition, it limits face-to-face interaction, which could be particularly important for members of diverse cultural groups for whom such a connectedness is important to maintain trust and enable the communication of their concerns. To address equity concerns it is important to ensure that technologies used to communicate with patients respect their needs, do not exclude those who feel uncomfortable using them (Skär & Söderberg, 2018), and that alternative means to communicate with the healthcare system are provided for those who are reluctant to use them (Terrasse et al., 2019).

The use of health-related smartphone applications (apps) similarly raises concerns regarding equity. Apps have proven benefits (e.g., related to nutrition, physical activity, medication management, coping skills) but are less available to people without easy access to the expensive technology needed to use them (see Chapter 25, this volume, on social media-based interventions). Apart from the costs of the smartphones themselves, many of the apps are not free of charge, are unavailable for fair and equal usage (Tokgöz et al., 2019), and have content less suitable to the sociocultural needs of marginalized populations (Denecke et al., 2015). Researchers propose that to address health-related inequities associated with digital information technologies, their design should not require that potential users have specialized knowledge or skills to benefit from them. If certain skills are needed, those persons needing them should be provided with training and assistance or alternative venues such as printed materials or phone helplines.

Autonomy and Privacy Concerns

The use of digital platforms in health communication raises ethical issues regarding the extent to which such use infringes on people's ability to make health-related autonomous, informed choices and threatens their privacy. This is true across platforms. For example, a central tenet in healthcare provision is that patients be given the opportunity for informed consent. Using telemedicine technologies can jeopardize this because the digital platform is likely to limit certain nonverbal signals that could convey their hesitancy or some patients might feel less comfortable expressing themselves through the technology. Consequently, important patient concerns could go unnoticed or their values could be misunderstood, thus impairing the process of informed consent. Scholars add that communication through telemedicine channels raises ethical concerns regarding differences in the decision-making process when the communication between patients and healthcare providers is conducted at a distance. They propose that the clinical encounter enables the development of relationships, which allow healthcare providers and patients to partner in medical decision-making that involves moral considerations. This occurs through dialogue, body language, and touch. In this process, providers can learn about the patient's personal values, concerns, anxieties, and preferences (Cheshire, 2017). Researchers cite the philosopher Lévinas (2005), who proposes that a human meeting is necessary to elicit ethical aspects such as respect, responsibility, and trust. These are considered to be critical for making moral decisions in healthcare. Since provider-patient face-to-face interactions are more limited in telehealth, this could affect the process of informed consent and decision-making (Skär & Söderberg, 2018). Researchers are also concerned that with the increasingly complex information structures involved in eHealth or telemedicine, patients could find it more difficult to make informed decisions. Ethical issues are also associated with teleconsultations conducted in crowded spaces with limited options for privacy. This raises concerns regarding infringement on autonomy, in that patients have to resort to using a less preferable communication channel with their healthcare providers because of administrative or economic considerations. These concerns are also associated with equity because lack of privacy when using teleconsultations is more likely to happen with individuals from vulnerable populations whose access to private surroundings is more limited (Kruse et al., 2018).

Privacy is a central issue in the use of digital platforms for health communication-related purposes. One important issue is that these platforms (e.g., websites, applications) obtain users' consent to monitor their activities and collect and utilize their personal information. Although users are often asked to agree to these privacy policies, some of which are mandated by law, these policies are generally difficult for most users to comprehend. This raises ethical concerns regarding both autonomy and privacy because individuals are likely to be unaware of the way organizations or companies gather, use, or sell data for purposes related or unrelated to healthcare (Kaplan, 2020). Further, there is a risk that despite companies' declarations, personal health data could be exposed to other individuals or third parties that provide services such as advertising (Parker et al., 2019). To address these concerns, potential users need to receive clear and relevant information about the process, possible alternatives, and any risks to their personal data when they use digital platforms for health-related purposes (Stanberry, 2001). This information should be adapted to meet various cultural and linguistic differences (Skär & Söderberg, 2018).

Concerns regarding autonomy and privacy are also central in social media platforms because many individuals share health-related information on these platforms (Denecke et al., 2015). This is encouraged by the very design of the social media platform (e.g., Facebook), which is intended to motivate users to disclose and share personal information and content. Although users often believe that the privacy of the information they share is protected within the groups, rules guiding the online activity of presumably closed groups cannot guarantee that personal or health information disclosed within an online group will not be shared outside of it (Miller et al., 2016). Healthcare providers may also infringe on patients' privacy even when they describe anonymous medical cases online on social media platforms because if enough details are shared, even though anonymized, patients could identify themselves or others (Terrasse et al., 2019).

Healthcare Quality and Potential Harm Concerns

The increasing use of digital health-related technologies in patient-provider communication, accelerated as a result of the COVID19 pandemic (Watts, 2020), raises concerns regarding missing out on relevant signals, which can reduce the quality of healthcare delivery (Cheshire, 2017) and erode healthcare providers' therapeutic relationships with patients (Terrasse et al., 2019). A related concern is that greater use of digital applications in healthcare service delivery means less human social interaction, which can contribute to the social isolation of patients, especially the more vulnerable (Denecke et al., 2015).

Concerns regarding quality and accuracy also are associated with the widespread availability of health information from a variety of online sources. Internet users often have limited skills to detect the poor quality of online sources and content, which puts them at risk for using incorrect or incomplete information (Linn et al., 2020). Further, the Internet, including popular social media, is a fertile ground for health-related online disinformation (Smaldone et al., 2020) or "fake news" disseminated by individuals or groups who spread false facts or statements (Klein & Wueller, 2017; see also Chapter 22, this volume). This can be exacerbated by social media platforms' methods that automatically recommend content similar to users' presumed interests in order to promote engagement that serves the commercial goals of their paying advertisers. Such recommendations can result in giving disproportionate visibility to anti-health claims (Terrasse et al., 2019). Exposure to inaccurate or incomplete information, or to misinformation and disinformation, which present biased or distorted facts, can cause negative outcomes, including distress, incorrect self-treatment (Tan & Goonawardene, 2017), vaccination avoidance, or non-adoption of mitigating practices (e.g., not wearing protective facemasks during a pandemic). To address the challenge of potentially harmful health-related information disseminated in digital channels, scholars recommend helping people to develop eHealth literacy skills that can enable them to critically evaluate online health information and make appropriate health decisions (Quinn et al., 2017; see also Chapter 28, this volume).

Ethics in Information Campaigns and Social Marketing

Health communication campaigns are persuasive communicative initiatives that aim to influence people's health-related choices and behaviors (see Chapter 23, this volume). As such, they elicit ethical concerns associated with infringing on people's autonomy and equity. Further, by employing social marketing approaches that draw on commercial marketing strategies, which include targeting specific segments of the intended populations and identifying costs, barriers, and benefits associated with adopting the health-related practice, these strategies also prompt ethical concerns (Lee & Kotler, 2015). Attending to ethical concerns in health campaigns also has utilitarian implications because messages scrutinized for ethical concerns are more consistent with people's values, less likely to be rejected as offensive, and more likely to have a long-term impact (ten Have et al., 2011). The sections that follow illustrate how ethical issues can be found in different facets and approaches of health communication campaigns.

Choice of Topics and Segmentation

The very choice of the health topic is fraught with ethical concerns because it could serve to moralize practices associated with the particular topic. For example, regular physical activity can be associated with virtue and good character, and not engaging in exercise can be characterized as being lazy (this is further elaborated in the later section on appeals to responsibility). Topic choice also raises concerns regarding equity because certain topics are more relevant or beneficial to certain groups. For example, choosing to focus on promoting physical activity could be more beneficial to individuals who have the means and time to engage in physical activity (e.g., have safe and lit paths or exercise facilities). Ethical concerns also emerge regarding selecting groups with specific characteristics as the campaign's intended population (referred to as segmentation). This approach is based on the assumption that being attuned to specific groups' cultural values and norms is more effective than targeting the larger population. Adopting this utility-based (cost-effectiveness) rationale, which involves choosing to target the segments most likely to adopt the recommended practice (e.g., smokers planning to quit smoking rather than all smokers), raises concerns regarding equity (other groups are less likely to benefit from the campaign). A related concern is when the campaign aims to target those least likely to adopt the recommendations (e.g., low-income heavy smokers who do not intend to quit smoking). Although that decision is based on considerations of helping those most in need, it raises concerns regarding spending public resources inefficiently. Lee and Kotler (2015) propose that one way to address the segmentation dilemma is to have a long-range plan to reach groups not included in the first stages of the communication/social marketing initiative.

Labeling and Stigmatizing

The strategy of targeting certain groups also raises concerns regarding stereotyping and stigmatizing when the health issue is associated with a negative stereotype or a behavior considered morally unacceptable (see also Chapter 6, this volume). One example is a study of fathers who smoke, who reported having internalized a negative image of themselves as parents (Greaves et al., 2010). Although stigmatization raises ethical concerns, some argue it can be an effective and morally justified approach by "de-normalizing" unhealthy/risky practices (e.g., depicting smoking as "deviant behavior" or shaming drunk driving). Opponents contend that not only is it immoral to purposely stigmatize people but from a utilitarian perspective it is likely to be ineffective. First, those whose behavior is stigmatized will reject the message (Bayer & Fairchild, 2016; Thompson & Kumar, 2011). Second, stigmatizing messages do not address the conditions that contribute to the health/risk problem (Puhl et al., 2013). For example, men who consume alcoholic beverages and do not refrain from driving do so because their culture encourages heavy drinking among "buddies" when they go out. This is reinforced by the alcohol industry's advertising. Thus, stigmatizing messages of men who drink and drive that do not address sociocultural and economic factors are unlikely to be effective.

Risk Messages, "Fear Appeals," and Provocation Tactics

Disseminating information about a health hazard (e.g., from smoking, lack of physical activity, a pandemic) involves the moral obligations to inform people about its risks in order to ensure they understand its gravity and to motivate them to adopt protective measures. The obligation to convey the gravity of the risk involves ethical concerns associated with autonomy and avoiding doing harm. One dilemma is how to get people to take seriously or to fear potential dire outcomes of a health-related hazard without being manipulative, which can occur when the appeal emphasizes emotional arousal. There is an ongoing debate about the ethics and effectiveness of using communication tactics that aim to evoke strong negative emotional responses (e.g., anxiety, horror, distress, disgust) to meet these obligations. Proponents argue it is essential to use strong threats or negative emotional appeals to motivate those at risk to change their behavior (Bayer & Fairchild, 2016). Critics contend that although such tactics gain attention and are memorable, they have a limited long-term impact. Additionally, many people react by dismissing the threatening message, arguing that the threatened outcome will not happen to them (Ruiter et al., 2003). Such threatening risk messages can also have negative unintended outcomes when people exposed to them, especially vulnerable populations, experience anxiety and distress, a sense of helplessness, or even fatalism (Hastings et al., 2004). However, there are different approaches for presenting risks, though they might be referred to under the general term of "fear appeals." Thus, alternative approaches can be used to explain damage to the lungs from smoking. For example, one approach utilizes graphic images of diseased lungs, whereas another utilizes abstract illustrations that show potential damage, as well as the fact that the lungs can undergo a repair process when one quits smoking. As information about the risk is likely to distress people, scholars contend it is ethically imperative that risk messages avoid exaggerations; furthermore, such messages should include elements on how to successfully cope with the threat and should strengthen intended populations' conceptions of self- or collective efficacy (Stolow et al., 2020).

As indicated by its name, provocation tactics are also employed to elicit strong negative emotional responses. Justifications for using such tactics include raising an issue that does not get sufficient attention in the public agenda, forcefully presenting an alternative point of view on an issue, or gaining attention in a "saturated" media environment (Vezina & Paul, 1997). For this purpose, campaigns use graphic images or language considered obscene or offensive in order to shock or create a sense of outrage by challenging people's moral sense or social norms and taboos. By definition, provocative messages raise ethical concerns because they endeavor to make people feel uncomfortable (e.g., by using images that elicit disgust or graphic images of death). Further, people could respond to provocation with anger, retreat, guilt, and despondency rather than feeling empowered to adopt pro-health practices (Lupton, 2015). Another concern is that the strong emotional impression created by provocation could overshadow a more in-depth discourse about social norms and values and what is needed to create a meaningful change to promote the health practice (Brown et al., 2010). Thus, using risk messages, fear appeals, or provocative tactics needs to be carefully scrutinized because doing so can infringe on people's autonomy (e.g., be emotionally manipulative), equity (e.g., mainly scaring the vulnerable), and utility (e.g., having only short-term effectiveness) and cause harm (e.g., be offensive, raising anxiety).

Narratives and Entertainment Strategies

Some campaigns employ entertaining narratives (e.g., stories, drama, comedy) to influence people's pro-health beliefs and practices. The success of such a strategy is largely based on people's enjoyment and the ability of narratives to captivate their interest by drawing them into the storyline (Singhal et al., 2004). This approach can get people to think about a health-related issue about which they were not inclined to think (e.g., cancer, sexuality, mental health, family planning, and domestic violence) and present them with a different perspective about it (Moyer-Guse, 2008). For example, it could get them to consider that it is one's responsibility to try to stop a friend from drinking and driving. As this approach is based on eliciting emotional involvement, it raises ethical concerns about being manipulative. Proponents maintain that narratives could elicit moral thinking by depicting various characters, perspectives, and dilemmas true to the lives of the intended population and could enhance self-efficacy by depicting positive role models. The production of narratives as a strategic communication approach requires careful consideration of ethical concerns, including providing misleading information (e.g., when depicting medical conditions or treatments) and use of stereotypes (Asbeek et al., 2015). Scholars recommend employing a participative approach when developing the narratives to help ensure that their content reflects issues that are relevant to the intended population, which can help address autonomy and equity concerns (for an elaboration of ethical concerns in health-communication entertainment approaches see Bouman & Brown, 2010).

Appeals to Responsibility

Appeals to personal responsibility are often used as a means to encourage people to adopt health-promoting and risk-mitigating practices. A common message emphasizes that people should take the responsibility for their own health (e.g., eat healthier foods, have an early-detection test). This can contribute to one's sense of autonomy and corresponds to the notion of "agency," or people's ability to make choices that have an impact on their lives. Yet, it also elicits the concern that people will be held accountable (it is "their fault") if they do not succeed in adopting the recommended practices and get ill, when in fact other factors prevent them from doing so (e.g., psychological, logistical, socioeconomic). A focus on personal responsibility could also cause harm by exacerbating people's feelings of self-blame, helplessness, and low self-image among those unable to make recommended changes (e.g., lose weight; Carter et al., 2011). It can also serve to blame, shame, or stigmatize groups as a whole, especially members of vulnerable groups who do not have the social support or resources to adopt recommended practices. Research indicates that people from disadvantaged populations feel more pronounced self-blame for their illness (Chapple et al., 2004). Appeals to personal responsibility could also reinforce gender roles or cultural stereotypes. Examples would include women urged to cook healthier foods for their families or young women in road safety campaigns encouraged to act as "angels" by keeping male drivers from taking risks (Guttman, 2014). Thus, even when appeals to positive social norms are employed, they should be scrutinized to avoid placing the sole responsibility on individuals and eschew gender-role stereotypes.

Another concern associated with the emphasis on personal responsibility in health campaigns is that a discourse emphasizing personal responsibility makes it appear that individuals have control over their health outcomes. This can be seen when campaigns emphasize the responsibility to adopt a healthier lifestyle by choosing healthier foods and engaging in physical activity. This shifts the focus away from structural, environmental, and social conditions that have a major impact on people's health-related practices. Holding people morally accountable for their health condition could also serve policies using this argument to avoid providing insurance coverage for health conditions which some consider caused by people's voluntary behaviors (Voigt, 2013) or to reduce funding for healthcare resources (Gordon et al., 2016). Thus, employing appeals to personal responsibility as a motivator in health communication needs to be accompanied by resources ensuring that the intended populations have fair opportunities to pursue healthier practices and the capacity to make informed choices.

Appeals to Positive Social Values

Related to appeals to responsibility are appeals to people's positive social values. These include appeals to solidarity, reciprocity, and caring for others. Such appeals have been used to encourage people to help others in situations of crisis, such as pandemics (e.g., to wear a face mask in order to protect others from contracting a virus; Dawson & Verwij, 2012), or to engage in prosocial behaviors, such as blood or organ donation (Siminoff et al., 2011). Their use can be justified by representing basic human values. Researchers studying social values cross-culturally have found that people consistently consider benevolence among the most important human values (Schwartz & Bardi, 2001). Yet, employing appeals to positive social values raises ethical concerns. Although proponents argue that they reflect the kind of society in which people strive to live, some consider prosocial appeals as less effective than self-benefit appeals (e.g., reducing consumption to help the environment). Another concern is that an emphasis on solidarity (e.g., people helping others in need during a pandemic), similar to an emphasis on personal responsibility, can serve to reduce an emphasis on the authorities' obligation to ensure health-promoting policies and resources.

Depriving

An ethical issue often overlooked in health communication campaigns is that the behavior being discouraged may be important to members of the audience in some significant way. For example, perhaps the behavior gives members of the target population one of the few pleasures readily available to them in their lives (e.g., consumption of alcoholic drinks after a long day of work with buddies and then driving home), or perhaps it serves an important sociocultural function (e.g., food with high caloric fat and sugar content prepared as traditional holiday dishes; sweets given to children as part of holiday traditions). Therefore, trying to influence practices of socially and economically marginalized communities raises concerns regarding equity and unintended harm. For example, the recommendation to avoid the consumption of foods with low nutritional value may require relinquishing food consumption practices considered culturally significant or highly pleasurable among certain populations. Often these practices are part of people's daily routine and social relations, and the practices may provide them with emotional satisfaction and social cohesion or serve as a means for coping with stress (for example, smoking when meeting others as part of a social encounter). But people with limited economic means cannot easily find ways to replace such practices (MacAskill et al., 2002). Consequently, health communication campaigns could have an inadvertently negative impact on disadvantaged groups by urging individuals to eliminate a practice without offering ways to replace it with pro-health alternatives. This poses a moral challenge in that health communication professionals should provide satisfying alternatives to the unhealthy practices people are asked to give up.

Conclusions and Challenges

Each setting of health communication presents challenges associated with ethical issues—whether it is meeting the obligation to respect people's autonomy and refrain from manipulative tactics, avoiding causing harm, avoiding increasing social and health inequities, or efficiently utilizing healthcare resources for the public good. Therefore, it behooves health communicators to scrutinize each stage of the health communication process for ethical concerns. This requires engaging relevant stakeholders in the process, including healthcare providers, patients and their family members, and members of the community, with a special effort to include the most vulnerable and disadvantaged. This obligation corresponds to the oft-cited theme that health communication should be carried out as a dialogical process rather than a one-directional approach. A participative and deliberative approach can also help address ethical concerns about paternalism and concerns regarding equity by identifying and focusing on issues and values that are important to patients or intended populations. To avoid causing unintended harm when targeting populations, communication initiatives that aim to promote pro-health practices need to consider barriers to their adoption, propose ways to address the barriers, and advocate for policy solutions (e.g., policies to reduce the detrimental impact of a media environment saturated with messages from commercial sources that promote the consumption of unhealthy products).

Health communicators also have to be attuned to ethical challenges associated with healthcare's increasing reliance on digital communication technologies because digital inequities can be found within and across countries. Advocacy is needed to ensure that these technologies can be effectively used by diverse populations, especially those hindered by economic, cultural, social, and language barriers. The accelerated developments of health-related technologies and the popularity of the Internet as a health information resource have preceded the development of ethical codes of conduct for providers, users, and organizations. Recent pandemics illustrate the importance of attending to ethical concerns associated with privacy and autonomy because various nations employed unprecedented surveillance (Eck & Hatz, 2020) and a host of persuasive tactics as part of their national mitigation efforts (Stolow et al., 2020). By implication, health communicators should be part of advocacy efforts to identify and address the nuances and complexities of ethical dilemmas and challenges in digital and non-digital contexts from a health communication perspective.

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