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# GUILT, FEAR, STIGMA AND KNOWLEDGE GAPS: ETHICAL ISSUES IN PUBLIC HEALTH COMMUNICATION INTERVENTIONS

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*ABSTRACT*

*Public health communication campaigns have been credited with helping raise awareness of risk from chronic illness and new infectious diseases and with helping promote the adoption of recommended treatment regimens. Yet many aspects of public health communication interventions have escaped the scrutiny of ethical discussions. With the transference of successful commercial marketing communication tactics to the realm of public health, consideration of ethical issues becomes an essential component in the development and application of public health strategies. Ethical issues in public health communication are explored as they relate to eight topics: 'targeting' and 'tailoring' public health messages to particular population segments; obtaining the equivalence of informed consent; the use of persuasive communication tactics; messages on responsibility and culpability; messages that apply to harm reduction; and three types of unintended adverse effects associated with public health communication activities that may label and stigmatise, expand social gaps, and promote health as a value. We suggest that an ethical analysis should be applied to each phase of the public health communication process in order to identify ethical dilemmas that may appear subtle, yet reflect important concerns regarding potential effects of public health communication interventions on individuals and society as a whole.*

## INTRODUCTION

Consider the following example: a group of Ethiopian immigrant men and women are gathered to help public health practitioners

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develop an illustrated pamphlet that explains foot care to older Ethiopian immigrants with diabetes. For this low-literacy immigrant population, diabetes is a novel illness largely unknown to them in Ethiopia. The group considers portraying a traditional scene in which an older man is helped having his foot washed in a washbasin by a woman. An argument develops. Several members of the group favour this culturally appropriate scene because it will resonate with and appeal to the older Ethiopians. However, other group participants, particularly women, disagree. They say that showing a woman washing the feet of the man will reinforce traditional gender roles. 'It is time to change the image of Ethiopian women as subservient to men', they protest. Others counter this argument: if the pamphlet depicts a woman whose feet are washed by a man it will not resonate with the intended population and its message will be rejected.

This case illustrates how even the production of a seemingly simple health message raises ethical issues. In this example, delivering a message in an *effective* way, by relying on traditional images, appears to clash with the obligation to promote gender equality, as part of a *human rights* approach. This type of dilemma often emerges in multicultural settings and can be stated as follows: should public health promotion messages respect or indeed challenge cultural norms that differ from Western conceptions of equality?

For centuries, governments and other social institutions have engaged communication strategies in the service of public health through tactics some may consider to be 'benevolent public

*Figure 1. Foot Care: Pamphlet Developed for Ethiopian Immigrants in Israel for Management of Diabetes. Courtesy of the Tene Briut Project.*

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manipulation.' These have often intended to 'sell' certain health-promoting practices, such as the early detection of high blood pressure or breast cancer, or to discourage others, such as smoking or high consumption of foods rich in saturated fats. Large-scale public health communication campaigns have been credited with helping raise awareness of chronic illness and infectious diseases, and in helping promote the adoption of recommended treatment regimens across diverse populations.

With the importation of commercial communication tactics to the realm of public health, consideration of ethical issues becomes an essential component in the development and application of public health communication strategies. We propose that the identification and analysis of ethical dilemmas embedded in public health communication interventions should be put in the forefront and become an integral part of programme development and implementation. This process should be informed by principles from bioethics literature.[1] In addition, it should also draw upon precepts that underscore the moral base of public health.[2] Further, consideration of stipulations from communication ethics should be prominent as well, to ensure that attention is given to ethical issues pertaining to message design and dissemination.[3] The task of developing ethically-derived public health communication in the 21st century also needs to include consideration of issues of diversity and pluralism amidst mounting social and economic disparities within and across nations.

We begin with four suppositions. The first pertains to the *scope* of the discussion: the parameters of ethical issues far exceed the tactical level of message design and permeate all facets of the public health communication process, including the initial focus on a particular health issue, choice of target populations, design of message appeals and assessment of effectiveness. The second pertains to *visibility*: ethical issues in public health communication are often implicit and embedded in subtle decision-making processes and some may appear as merely technical matters, such as the use of colours or font size. Often ethical issues are more

[1] T.E. Beauchamp & B. Steinbock, eds. 1999. *New Ethics for the Public's Health.* New York, NY. Oxford University Press Inc.

[2] D. Callahan & B. Jennings. Ethics and Public Health: Forging a Strong Relationship. *American Journal of Public Health* 2002; 92: 168–175. N.E. Kass. An Ethics Framework for Public Health. *American Journal of Public Health* 2001; 91: 1776–1782. B. Wolder Levin & A.R. Fleischman. Public Health and Bioethics: The Benefits of Collaboration. *American Journal of Public Health* 2002; 92: 165–168.

[3] R.L. Johannesen. 1996. *Ethics in Human Communication.* Fourth edition. Prospect Heights, IL. Waverland Press.

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explicit. For example, a common quandary is whether to use images of attractive women shown in ways that emphasise parts of their body, as a visual appeal that is likely to attract viewers' attention (see example in Figure 2). Ethical ramifications of other communication tactics are often more subtle or confounding, as discussed below.

The third supposition pertains to consideration of *unintended adverse effects*: unintended adverse effects are a potential outcome of any health communication intervention, and may ripple beyond

*Figure 2. US Centers for Disease Control and Prevention Poster for the Purpose of Preventing Smoking, Featuring a Model.*

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the official range of the intervention, whether the psychological well-being of individuals or cultural beliefs. The fourth supposition pertains to *pragmatic significance*: scrutinising public health communication strategies for ethical concerns should become a routine aspect of message design, not only because any benevolent attempt to contribute to people's well-being needs to be ethical, but also because of its pragmatic implications: communication interventions that are sensitive to ethical concerns are more likely to be better executed and to be trusted by intended populations.

The discussion that follows focuses on identifying ethical issues in public health communication as they relate to eight topics: the 'targets' of the health communication intervention, informed 'consent', persuasive tactics, messages on responsibility and culpability, 'harm-reduction', adverse unintended effects associated with labelling and stigmatisation, expanding social gaps, and the promotion of health as a value.

## THE 'TARGETS' OF THE COMMUNICATION

A recurring dilemma in public health is the tension between efficiency and considerations of equity, fair opportunity and just distribution of public goods.[4] This dilemma is epitomised in public health practitioners' adoption of the terminology and practice of commercial marketers of 'targeting' and 'segmentation.'[5] The mere decision to 'segment' and 'target' certain population groups according to certain parameters, involves a moral judgement likely to be associated with considerations of equity and utility.[6] Certain groups may be excluded from the intervention, often because they are considered 'hard to reach' or certain groups are given priority because they are considered having special needs. It could be argued that it is inefficient to 'target' populations that are not predisposed towards adopting particular health-promoting practices. Yet, such efforts may be viewed as an ethical imperative of public health, with its mandate to promote social equity.[7] Underlying large-scale intervention approaches is the assumption that resources can be maximised by 'targeting'

[4] N. Daniels. 1985. *Just Health Care*. New York. Cambridge University Press.

[5] A.R. Andreasen. 1995. *Marketing Social Change: Changing Behavior to Promote Health, Social Development, and the Environment*. San Francisco. Jossey-Bass.

[6] M.L. Rothschild. 2001. Ethical Considerations in the Use of Marketing for the Management of Public Health and Social Issues. In *Ethics in Social Marketing*. A.R. Andreasen, ed. Washington, DC. Georgetown University Press: 39–69.

[7] V.S. Freimuth & W. Mettger. Is there a Hard-to-Reach Audience? *Public Health Reports* 1990; 105: 232–238.

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relatively large segments of the population who are most likely to attend to the message and adopt its recommendation. As noted by Rose and others,[8] relatively even small changes in large populations who are at a moderate risk can result in effective public health outcomes.[9] Other moral arguments to support this approach are that urging large population segments, who are at moderate risk, to adopt risk-reducing practices, can serve to influence those who *are* at high risk and that by including broader segments of the population in the overall message, the intervention may promote values of solidarity and reduce the likelihood of stigmatisation and labelling of those considered at 'high risk.'[10]

Alternatively, it may be decided to 'target' those identified as a 'high risk' group or with particular needs, values, beliefs or communication channels. This requires 'tailoring' communication activities to the members of this group, and to customise communication tactics to fit their particular beliefs and practices.[11] The importance of 'tailoring' messages to relatively small subgroups is illustrated in findings that older American Chinese women were more likely to have undetected breast cancer because existing early-detection messages did not address their cultural values or particular concerns.[12] Tailoring messages corresponds to the communication ethical stipulation of *comprehensibility*, which requires the provision of complete and culturally-appropriate messages to diverse populations.[13] A drawback associated with the disseminating messages tailored to particular populations is that groups that are not provided with culturally-specific messages may feel excluded or short-changed.[14]

[8] G. Rose. Strategy of Prevention: Lessons from Cardiovascular Disease. *British Medical Journal* 1981; 282: 1847–1851.

[9] K.R. McLeroy, N.M. Clark, B.G. Simons-Morton, J. Forster, C.M. Connell, D. Altman & M.A. Zimmerman. Creating Capacity: Establishing a Health Education Research Agenda for Special Populations. *Health Education Quarterly* 1995; 22: 390–405.

[10] D.E. Beauchamp. 1988. *The Health of the Republic: Epidemics, Medicine, and Moralism as Challenges to Democracy*. Philadelphia, PA. Temple University Press.

[11] P. Michal-Johnson & S.P. Bowen. 1992. The Place of Culture in HIV Education. In *AIDS: A Communication Perspective*. T. Edgar, M.A. Fitzpatrick & V.S. Freimuth, eds. New Jersey. Lawrence Erlbaum Associates: 147–172.

[12] B. Mo. Modesty, Sexuality, and Breast Health in Chinese-American Women. *Western Journal of Medicine* 1992; 157: 260–264.

[13] N. Freudenberg. Community-Based Health Education for Urban Populations: An Overview. *Health Education and Behavior* 1998; 25: 11–23.

[14] B. Lalonde, P. Rabinowitz, M. Shefsky, K. Washiendo. *La Esperanza del Valle*: Alcohol Prevention Novellas for Hispanic Youth and their Families. *Health Education and Behavior* 1997; 24: 587–602.

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'Tailoring' messages may present competing demands to provide both *complete* and *accurate* information and present this information in a format that is appropriate for low-literacy audiences. Yet, for some, low literacy may be a source of embarrassment and they may want to distance themselves from materials that have an appearance of being designed for low-literacy populations.[15] This poses the challenge to develop materials that are respectful and not condescending but effective in their format.

## OBTAINING THE EQUIVALENCE OF INFORMED CONSENT

In medical care contexts, healthcare providers are legally and ethically bound to obtain the informed consent of individuals who are being asked to participate in an activity that may affect their well-being. Public health communication activities are typically mediated through various media and community settings. It should be noted that individuals and communities are exposed to a profusion of mediated commercial messages that aim to influence their beliefs and attitudes regarding commercial products and services. Aside from certain regulatory restrictions, populations exposed to commercial marketing tactics are not consulted for their consent. Is it necessary, one may ask, that all marketing initiatives that aim to 'advertise' health should pursue some kind of 'informed consent'? Should certain criteria be developed when 'consent' needs to be obtained, for example, when communication interventions that can be defined as 'invasive' such as those that challenge community norms or that address sensitive issues?

Once it is established that consent is needed, a second ethical query emerges: who has the mandate to represent large and diverse populations for the purpose of informed consent, and how can this be implemented? Approaches adopted by epidemiologists and ethnographers and others who work in community settings can provide working models.[16] One approach is to engage community advisory boards whose members develop community

[15] S.K. Davis, M.A. Winkleby & J.W. Farquhar. Increasing Disparity in Knowledge of Cardiovascular Disease Risk Factors and Risk-Reduction Strategies by Socioeconomic Status: Implications for Policymakers. *American Journal of Preventive Medicine* 1995; 11: 318–323.

[16] J. Last. 1996. Professional Standards of Conduct for Epidemiologists. In *Ethics and Epidemiology*. S.S. Coughlin & T.L. Beauchamp, eds. Oxford. Oxford University Press: 53–75.

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standards that monitor the intervention.[17] This method raises ethical concerns: advisory board members may not necessarily represent the community at large and recruitment of board members may be time consuming and hinder implementation.[18]

When the intended populations for communication interventions are youth and children, additional ethical issues may emerge: parents may object to the dissemination of information or the implementation of activities on certain topics. Yet, their children would like to obtain this information and public health practitioners strongly believe it is essential to promote their health. Should the children be provided with the information, despite the objections of their parents? Can this be justified on the basis of the rights of children and youth? Can this be justified on the basis of preventing vulnerable populations from harm?[19]

Full disclosure of what the intervention is actually about also presents another ethical dilemma. In certain areas, to obtain formal consent from individuals or groups may be difficult until a level of trust is established. For example, it is a common communication strategy not to mention at the outset the overriding goal of programmes such as HIV prevention, whose intended population is difficult to reach through traditional prevention programmes. Declaring that the programme will eventually be discussing HIV prevention may jeopardise people's willingness to participate. These types of dilemmas suggest that alternative conceptualisations of informed consent may need to be developed for health communication interventions. Perhaps a model of a gradual and negotiated process would be more applicable, particularly when working on sensitive topics or with diverse populations.

## CAPTURING ATTENTION AND PRESENTING RISK INFORMATION

A pedestrian crosswalk is stained with what appears to be blood, next to it lays a body of a child and in the background a chilling

[17] R.P. Strauss, S. Sengupta, S.C. Quinn, J. Goeppinger, C. Spaulding, S.M. Kegeles & G. Millett. The Role of Community Advisory Boards: Involving Communities in the Informed Consent Process. *American Journal of Public Health* 2001; 12: 1938–1943.

[18] R. Myrick. In Search of Cultural Sensitivity and Inclusiveness: Communication Strategies used in Rural HIV Prevention Campaigns Designed for African Americans. *Health Communication* 1998; 10: 65–85.

[19] E. Eng, E. Parker & C. Harlan. Lay Advisor Intervention Strategies: A Continuum for Natural helping to Paraprofessional helping. *Health Education and Behavior* 1997; 24: 413–417.

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scream of a woman is heard. This television advertisement depicts a scene of a child killed by a careless driver. Some viewers claim it should not be shown because it lingers in their minds and thus is intrusive; others firmly believe it is important to use graphic images to deter reckless driving and potential harm. A common perception is that the use of communication strategies does not conflict with the obligation to respect people's privacy compared to public health regulatory measures. Yet, every mode of information provision is inundated with ethical concerns.[20]

In a world saturated with mediated messages, public health practitioners must vie for people's attention: this may require 'shock tactics' or strong emotional appeals. Furthermore, some believe that to convince people to adopt behaviours they are not inclined to adopt requires strong motivating appeals. From the early days of public health campaigns 'fear appeals' – vivid images or descriptions of damage that can occur – have been used to gain attention and arouse motivation to comply with health messages. More recent attempts to capture the attention of the public include the use of statistics that amplify risk. Drawing on the literature on ethics in communication, messages that misrepresent statistics or use highly charged emotional appeals may fail to meet stipulations for truthfulness and sincerity, as well as correctness and accuracy.[21] But, proponents of using inflated statistics or strong emotional appeals contend that these tactics have been proven to enhance public response. The dubious morality of certain communication tactics has been noted by ethicists, who describe preventive health campaigns as 'a marketing effort, subject to all the risks of motivational marketing-hyperbole, demagoguery, or praying upon fears and prejudices.'[22]

Public health communicators increasingly adopt sophisticated marketing methods to identify intended populations' vulnerabilities, concerns and desires, and to use effective tactics to facilitate persuasion.[23] Such marketing tactics are clearly ethically

[20] W. Paisley. 1989. Public Communication Campaigns: The American Experience. In *Public Communication Campaigns*. Second edition. R.E. Rice & C.K. Atkin, eds. Newbury Park, CA. Sage: 15–38.

[21] Johannesen, *op. cit.* note 4.

[22] L.E. Goodman & M.J. Goodman. Prevention: How Misuse of a Concept Undercuts its Worth. *Hastings Center Report* 1986; 16: 26–38, at 29.

[23] N. Guttman. 2000. *Public Health Communication Interventions: Values and Ethical Dilemmas*. Thousand Oaks, CA. Sage. R.W. Pollay. 1989. Campaigns, Change and Culture: On the Polluting Potential of Persuasion. In *Information Campaigns: Balancing Social Values and Social Change*. C.T. Salmon, ed. Newbury Park, CA. Sage: 185–196. C.T. Salmon. 1989. Campaigns for Social 'Improvement': An Overview of Values, Rationales and Impacts. In *Information Campaigns:*

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problematic. The tension between communitarian and utilitarian concerns and the infringement upon personal liberties has been noted in the larger context of public health. This tension applies to public health communication interventions as well, though the issues may be less explicit. For example, health messages with subtle appeals are less likely to attract people's attention and consequently will be ignored. This calls for strong appeals that can potentially 'break through the clutter.'[24] Advertisers thus may suggest to public health practitioners that they should use scary, sexually arousing, or crude humour as means to attract the attention of intended populations. Dilemmas surrounding whether to use such message appeals are particularly vexing when they are based on suggestions of the intervention's population. For example, messages found to be most memorable to Vietnamese and Latino smokers were graphic portrayals of cancerous tumours.[25] Messages with fear appeals may indeed increase awareness of the hazards of unhealthy practices such as smoking, thus helping to trigger smoking cessation. Yet, some people may find such illustrations offensive or too scary.[26] What confounds this dilemma further is that the utility of fear-arousing messages is contested both by researchers and practitioners. Findings suggest that even when fear appeals arouse the interest of those who are exposed to them, they often are not associated with health behaviour changes, but in other instances they have been found to generate strong responses.[27]

Ethical dilemmas in the presentation of health risk information and health recommendations to the public can be compared to dilemmas noted in the context of physician-patient communication regarding how to present information about possible treatment outcomes and potential risks. Ethical stipulations derived

*Balancing Social Values and Social Change*. C.T. Salmon, ed. Newbury Park, CA. Sage: 19–53. K. Witte. The Manipulative Nature of Health Communication Research: Ethical Issues and Guidelines. *American Behavioral Scientist* 1994; 38: 285–293.

[24] W.A. Smith. 2000. Ethics and the Social Marketer: A Framework for Practitioners. In *Ethics in Social Marketing*. A.R. Andreasen, ed. Washington, DC. Georgetown University Press: 1–16.

[25] F. Sabogal, R. Oterso-Sabogal, R. Pasick, C.N. Jenkins & E.J. Pe'rez-Stable. Printed Health Education Materials for Diverse Communities: Suggestions Learned from the Field. *Health Education Quarterly* 1996; 23: S123–S141.

[26] Ibid.

[27] J.L. Hale & J.P. Dillard. 1995. Fear Appeals in Health Promotion Campaigns: Too Much, too Little, or Just Right? In *Designing Health Messages: Approaches from Communication Theory and Public Health Practice*. E. Maibach & R.L. Parrot, eds. Thousand Oaks, CA. Sage: 65–80.

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from communication ethics specify that communicators should avoid asserting certainty when tentativeness and degrees of probability would be more accurate.[28] In public health, as in medicine, practitioners may find that certain populations resent information that is explained as tentative, and thus believe that the goal of public health is best served by messages that make a clear connection between risk and a preventive measure. Yet the information used in messages about health may be tentative or incomplete, or subject to different interpretations. A recent report found men who have sex with men who did not know that the spermicide nonoxynol-9, which in previous years was touted as a protective measure, does not offer protection against HIV infection.[29] The case of hormone replacement therapy, which had been widely advocated as nearly a panacea for women with menopausal symptoms, is currently viewed as potentially harmful.[30] How can health recommendations that are based on possibly tentative data, be presented to the public in a way that will prompt people to adopt recommended behaviours, but at the same time avoid potential inaccuracies?

Communicators are also expected to refrain from exaggerating factors such as negative consequences, the magnitude of problems or the degree of the expertise of the authorities it relies upon, even when such a presentation would be more persuasive.[31] For example, presenting a one-sided argument or selecting only favourable supporting evidence could be considered unethical.[32] Yet, from a public health perspective, presenting a two-sided argument is likely to be rejected by groups whose cultural discourse discourages tentativeness. Should ethical concerns to protect these populations from harm override the concern for complete 'truthfulness'?

## MESSAGES ON RESPONSIBILITY AND CULPABILITY

One of the most taken-for-granted messages in public health, and perhaps the most contested, is the notion of responsibility of the

[28] J.R. Marshall. Editorial: Improving Americans' Diet – Setting Public Policy with Limited Knowledge. *American Journal of Public Health* 1995; 85: 1609–1611.

[29] G. Mansergh, G. Marks, M. Rader, G.N. Colfax & S. Buchbinder. Rectal Use of Nonoxynol-9 among Gay Men who have Sex with Men. *AIDS* 2003; 17: 905–909.

[30] K. McPherson. Where are we now with Hormone Replacement Therapy? *British Medical Journal* 2004; 328: 357–358.

[31] Johannesen, *op. cit.* note 4.

[32] Johannesen, *op. cit.* note 4, p. 194.

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individual to adopt a lifestyle that society considers healthy, sensible and responsible.[33] Appeals to personal responsibility are ubiquitous in public health messages[34] and reminiscent of ancient exhortations to overcome vices such as gluttony, sloth, and lust.[35] Messages may imply that illness or disability will result from failure to adopt a 'responsible' lifestyle and that individuals who behave irresponsibly – by not adopting health messages – will become a burden to their family or society.[36]

Linking responsibility messages to health outcomes raises several ethical issues: the first concerns conceptions of culpability. Implied in messages that make a causal link between a person's behaviour and their health, is an assumption that people's behaviour can significantly affect their health and therefore they can be held responsible for detrimental health outcomes. Whereas such messages resonate with the notion of human agency, they may be ethically problematic because they do not take into consideration that individuals may have limited impact on social factors that affect their behaviour.[37] Critics also note that health messages that emphasise the importance of personal responsibility are politically compatible with the 'ideology of individualism'; the paradigm that considers the individual, rather than social structure, as the appropriate focus of public health efforts.[38]

This corresponds with the critique that an emphasis on culpability may lead to what has been articulated as 'blaming the victim' that is, locating the causes of social problems within the individual, rather than in social and environmental forces.[39] Messages that emphasise individual responsibility may de-emphasise the

[33] Callahan & Jennings, *op. cit.* note 2.

[34] N. Guttman & W.H. Ressler. On being Responsible: Ethical Issues in Appeals to Personal Responsibility in Health Campaigns. *Journal of Health Communication* 2001; 6: 117–136. W.G. Kirkwood & D. Brown. Public Communication about the Causes of Disease: The Rhetoric of Responsibility. *Journal of Communication* 1995; 45: 55–76.

[35] L. Berkman & L. Breslow. 1983. *Health and Ways of Living*. New York. Oxford University Press.

[36] Guttman, *op. cit.* note 23.

[37] M.H. Becker. A Medical Sociologist looks at Health Promotion. *Journal of Health and Social Behavior* 1993; 34: 1–6; D. Callahan. 1990. *What Kind of Life: The Limits of Medical Progress*. New York. Simon & Schuster. D. Wikler. Who should be Blamed for being Sick? *Health Education Quarterly* 1987; 14: 11–25.

[38] S.N. Tesh. 1988. *Hidden Arguments: Political Ideology and Disease Prevention Policy*. New Brunswick, NJ. Rutgers University Press. M. Minkler. Personal Responsibility for Health? A Review of the Arguments and the Evidence at Century's End. *Health Education and Behavior* 1999; 26: 121–140.

[39] P.R. Marantz. Blaming the Victim: The Negative Consequence of Preventive Medicine. *American Journal of Public Health* 1990; 80: 1186–1187.

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role of structural factors such as limited resources to purchase nutritious foods, disadvantaged work conditions, limited access to healthcare, that contribute to the aetiology of health problems.[40]

Linking health with personal responsibility may, by implication, characterise those who do not adopt recommended health-related practices as weak of character and at fault for certain medical conditions. This can lead to the conclusion that people should be held morally, and perhaps legally, accountable for their behaviour,[41] thus exempting society from paying for certain healthcare costs, or requiring certain individuals to pay higher premiums.[42] Survey findings from several countries indicate there is willingness in the public to impose higher health insurance premiums on individuals who engage in behaviours such as smoking or high consumption of alcohol.[43] Such public sentiments raise ethicists' concerns regarding potential impact of conceptions of individual culpability on healthcare policies, rather than of social values related to equity and solidarity.

Sociologists and anthropologists note that conceptions of risk and responsibility assigned to risk-taking are socially constructed.[44] Certain risk-taking actions may be socially sanctioned and even admired (e.g., risks taken in sports or by fire-fighters) whereas others are deemed irresponsible (e.g., not wearing a motorcycle helmet, smoking cigarettes, not using condoms in sexual relations). Certain risk-taking is praised because it is perceived as carried out for others' benefit, or it may be criticised because it is interpreted as merely fulfilling personal gratification.[45] Yet, there

[40] D. Blane. Editorial: Social Determinants of Health – Socioeconomic Status, Social Class, and Ethnicity. *American Journal of Public Health* 1995; 85: 903–905.

[41] L. Sachs. Causality, Responsibility and Blame – Core Issues in the Cultural Construction and Subtext of Prevention. *Sociology of Health and Illness* 1996; 18: 632–652.

[42] H.V. McLachlan. Smokers, Virgins, Equity and Health Care Costs. *Journal of Medical Ethics* 1995; 21: 209–213. Daniels, *op. cit.* note 4.

[43] R. Blendon, Hyams Stelzer & J.M. Benson. Bridging the Gap between Expert and Public Views on Health Care Reform. *Journal of the American Medical Association* 1993; 269: 2573–2578. A. Bowling. Health care Rationing: The Public's Debate. *British Medical Journal* 1996; 312: 670–674.

[44] Douglas explains how the language of danger has turned in the 20th century into the language of risk and liability, and how the discourse of risk in society is politicised. M. Douglas. 1994. *Risk and Blame: Essays in Cultural Theory.* London. Routledge. Lupton, from a critical perspective, argues that the rhetoric or risk is similar to the one used previously regarding 'sin.' D. Lupton. Risk as Moral Danger: The Social and Political Functions of Risk Discourse in Public Health. *International Journal of Health Services* 1993; 23: 425–435.

[45] R.L. Keeney. Decisions about Life-Threatening Risks. *New England Journal of Medicine* 1994; 331: 193–196.

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may be diverse conceptions of what serves the public good, or of which ('risky') personal gratifications are socially sanctioned. When disseminating health messages that imply that risk-taking has a moral dimension, it may be important to consider the following: what is the moral basis for promoting risk avoidance and how do persuasive appeals, based on certain moral claims, resonate with social mores and ideals?

The potential effects of responsibility messages on individuals also raise ethical concerns. People may react to them with feelings of guilt, shame or frustration when they feel they cannot adopt the recommended practices. For example, a single parent may feel guilty and frustrated after viewing a recent US television advertisement on drug abuse prevention. The advertisement (titled 'the enforcer') depicts an assertive African American mother who successfully manages to influence the behaviour of her adolescent son, who is shown to be experimenting with drugs with his friends. The mother effectively 'grounds' him. This advertisement may serve to inspire some parents, but others may feel that they are unable to use it as a model because of their life circumstances (e.g., they work outside the home when their kids return from school) or personal capacities. This type of message may reinforce self-blame and helplessness if it does not also provide an appropriate support. Findings from a study in a low-income population on attitudes towards breastfeeding suggest that feelings of guilt and shame were prevalent among mothers who did not breastfeed. These mothers were well aware of the benefits of breastfeeding. As one exclaimed, 'If I could, I would, but it was impossible', referring to her difficult life circumstances.[46] A recent British study reveals how individuals with lung cancer said they were ashamed of having the illness because it is associated with the culpability of smokers, and some even reported hiding their illness or not seeking support.[47]

Appeals that stress moral obligations to others represent another type of personal responsibility messages. One such message is the obligation to stay healthy: for example, women are told to care for their health because others depend on them.[48]

[46] N. Guttman & D. Zimmerman. Low Income Mothers' Views of Breastfeeding. *Social Science and Medicine* 2000; 50: 1457–1473.

[47] A. Chapple, S. Ziebland & A. McPherson. Stigma, Shame, and Blame Experienced by Patients with Lung Cancer: Qualitative Study. *British Medical Journal* 2004; 328: 1470–1473.

[48] J.A. Earp, C.I. Viadro, A.A. Vincus, M. Altpeter, V. Flax, L. Mayne & E. Eng. Lay Health Advisors: A Strategy for getting the Word out about Breast Cancer. *Health Education and Behavior* 1997; 24: 432–451, at 441.

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Another appeals to the obligation to promote the health of significant others. For example, a wife should help her spouse maintain a healthy diet, parents should insist kids use seatbelts, and families should support the father's attempts to quit smoking. Such messages can serve to reinforce a moral commitment to others' needs, kindness, and solidarity.[49] A prominent example are campaigns seeking to prevent automobile crashes caused by drunk drivers, that state that 'Friends don't let friends drive drunk' implying that people have a moral commitment to protect their friends from harm: this raises ethical issues regarding the extent to which one is responsible for adverse outcomes when the other person refuses to comply, and whether the campaign also needs to include messages that one is obligated to stop their friend from drinking large amounts of alcohol, to prevent harm to their health in general.

## MESSAGES TO REDUCE HARM

A photonovella published by a public health agency features a story about the activities of young adults living in a city apartment. It appears that some of them are using drugs; one of the characters explains to the others how, if you use drugs through injection, you should not share needles, and how you should disinfect the needles you use. The explanation is accompanied by photographs. A comic book, published by anther public health agency and entitled 'Captain Condom', is about a group of young people. It contains explicit illustrations on how to properly put on a condom. A series of postcards produced by a US health organisation that aims to promote the health of gay men presents young men who describe how they like to party and have casual sex. These are examples of materials 'tailored' towards specific populations. However, members of certain groups may find these and other materials or activities offensive and even immoral. Others may not condone the practices they address, but accept them as part of a 'harm reduction' intervention strategy. For example, members of certain groups who believe that sexual relations should only take place among married adults may object to providing youth with information about contraceptives and safer sex practices. They would argue that the mere provision of information implies that sexual relations among youth are sanctioned and normative. Yet, even members of these groups

[49] E.D. Pellegrino. The Metamorphosis of Medical Ethics: A 30-year Retrospective. *Journal of the American Medical Association* 1993; 269: 1158–1162.

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may agree to provide youth with risk-reduction information if they believe that these youth will not refrain from sexual relations and that they need to be protected from potentially debilitating diseases.

The harm-reduction approach prioritises the obligation to protect people from greater harm while they may be engaging in other potentially harmful practices.[50] It justifies proffering information and services to help individuals avoid certain risks even if this appears to condone practices judged by society as anti-social or even immoral. Proponents of this approach often refer not only to the obligation to help people with special needs to avoid serious harm, but also to the utility of this approach. For example, syringe-exchange programmes for injection drug users can serve as delivery sites for other health services, and help gain the trust of this under-served population.[51] Research findings indicate that youth interventions that included discussions of contraceptives were not found to be associated with higher reports of sexual behaviour, whereas youth were more likely to drop out of programmes that only focused on abstinence.[52] Despite these justifications, messages intended as 'harm-reduction' raise strong emotional responses and continue to be challenged on a moral basis by opponents.

## UNINTENDED ADVERSE EFFECTS

The prospect of iatrogenesis – harm inflicted on the patient from the treatment itself that may turn out to be more detrimental than the condition for which the patient was treated – is a central consideration in clinical medicine, but one that has received relatively little attention in discussions of social interventions.[53] Perhaps it is presumed that since public health communication mainly relies on information-dissemination strategies, there is little risk of causing significant harm. Nevertheless, unintended effects can have adverse consequences on individuals and

[50] R. Elovich. Staying Negative – It's not Automatic: A Harm Reduction Approach to Substance Use and Sex. *AIDS and Public Policy Journal* 1996; 11: 66–77; W. Odets. AIDS Education and Harm Reduction for Gay Men: Psychological Approaches for the 21st Century. *AIDS and Public Policy* 1994; 9: 1–5.

[51] D.C. De Jarlais, N.S. Padian & W. Winkelstein. Targeted HIV-Prevention Programs. *New England Journal of Medicine* 1994; 331: 1451–1453.

[52] C.S. Haignere, R. Gold & H.J. McDanel. Adolescent Abstinence and Condom Use: Are we Sure we are Really Teaching what is Safe? *Health Education and Behavior* 1999; 26: 43–54.

[53] E. Seidman & J. Rappaport. 1986. Framing the Issues. In *Redefining Social Problems*. E. Seidman & J. Rappaport, eds. New York. Plenum Press: 1–8.

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society as a whole.[54] In this section we will discuss several subtle, yet potentially harmful effects of public health communication messages. We begin with the rather common phenomenon of messages that actually elicit the opposite behaviour that the health message was trying to instil: examples include anti-drug messages that are known to heighten interest in illegal drugs and encourage experimentation rather than avoidance among adolescent sensation seekers; anti-smoking messages that trigger an urge to light up a cigarette among smokers who are attempting to quit;[55] and messages regarding weight control that prompt women with eating disorders to eat even less.

*Messages that label and stigmatise*

How does one reconcile the use of persuasive appeals that on the one hand scare people regarding potential hazards, and thus raise their motivation to avoid it, but on the other hand may present a negative image of those who have the disease? This is the essence of the stigmatisation effect, which has long been a concern with HIV/AIDS interventions in particular. Who – in terms of race, gender, age and sexual orientation – is depicted as having HIV/AIDS in televised public service ads, posters and brochures? How are individuals shown living with the disease: as victims or as empowered? The 'faces' of HIV/AIDS has become the raw materials for stereotypes, labels and potential social stigma. Once stereotypes and stigmas are established, they can result in individuals being feared, avoided, regarded as deviant, and even blamed for engaging in the immoral behaviours that must have elicited the 'punishment' of their affliction. In general, this type of social climate can be devastating to members of vulnerable populations who suffer from stigmatised medical conditions since it can result in the internalisation of self-blame and destruction of self-esteem.[56] Even school-based weight loss programmes may serve to stigmatise overweight children.[57] Similarly, messages depicting

[54] C.T. Salmon & L. Murray-Johnson. 2001. Campaign Effectiveness: Some Critical Distinctions. In *Public Communication Campaigns*. Ronald Rice & Charles Atkin, eds. Third edition. Newbury Park, CA. Sage.

[55] D.W. Stewart & I.M. Martin. Intended and Unintended Consequences of Warning Messages: A Review and Synthesis of Empirical Research. *Journal of Public Policy and Marketing* 1994; 13: 1–19.

[56] J.W. Dourard. AIDS, Stigma, and Privacy. *AIDS and Public Policy Journal* 1990; 5: 37–41; N. Glick Schiller, S. Crystal, & D. Lewellen. Risky Business: The Cultural Construction of AIDS Risk Groups. *Social Science and Medicine* 1994; 38: 1337–1346.

[57] McLeroy et al., *op. cit.* note 9.

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*Figure 3. 'AIDS makes no distinctions among people.' Courtesy of Israel AIDS Task Force.*

the horror of being confined to a wheelchair because of drunk driving were perceived by individuals with mobility disabilities as devaluing them and attacking their self-esteem and dignity.[58]

Images intended to show that diseases such as cancer or AIDS can affect anyone may also serve to perpetuate negative stereotypes. An example is a pamphlet developed to dispel the conception among religious minority women that breast cancer risk is mainly associated with what they considered 'loose' or promiscuous behaviour. For this purpose it showed women in different lifestyles, including a woman in clerical robes and one in a tight-fitting low-cut dress.[59] The portrayal of the 'loose' woman may further entrench negative stereotypes of women who choose to dress in a non-traditional way. Similarly, two postcards produced in Israel for the purpose of HIV prevention each show a presumably 'respectable' character paired with a 'not-respectable' character. The copy reads: 'AIDS hits [people] without making any distinctions' (Figure 3). A recent example of a different type of

[58] C. Wang. Portraying Stigmatizing Conditions: Disabling Images in Public Health. *Journal of Health Communication* 1998; 3: 149–159.

[59] C.S. Skinner, R.K. Sykes, B.S. Monsees, D.A. Andriole, C.L. Arfken & E.B. Fisher. Learn, Share and Live: Breast Cancer Education for Older, Urban Minority Women. *Health Education and Behavior* 1998; 25: 60–78.

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stereotyping is a US radio advertisement sponsored by a state health department that says that sexually active teenage girls are often dumped by their boyfriends and wind up feeling 'dirty and cheap.' Critics of this advertisement are quoted as saying that 'There's nothing wrong with encouraging teens to be abstinent, but the harshness of using "dirty and cheap" is unhelpful, especially for adolescents who may already be feeling stigmatized.'

*Health messages and social gaps*

Health communication interventions, particularly those that are successful, may reinforce, rather than reduce, existing social disparities.[60] Research findings indicate that, following the dissemination of health information, populations from higher socioeconomic groups were more likely to have increased knowledge relevant to the health issue and more likely to adopt recommended practices, though motivation to do so may have been similar across different populations. This phenomenon is called the 'knowledge gap' and it may not be ethically problematic in commercial contexts, but is an ethical problem in public health.[61]

Another phenomenon less documented but still associated with social gaps is that certain recommendations presented persuasively in health messages may deprive disadvantaged populations of practices they enjoy, or that have become part of their identity or daily routine. These practices, though unhealthy, may have cultural significance or emotional importance. Certain practices, such as smoking, might offer members of vulnerable groups not only pleasure, but also important coping mechanisms[62] or serve social functions that are not easily replaced. The less privileged economically are also likely to have fewer options for healthier substitutions for practices they enjoy that are considered unhealthy. Their quality of life may in fact suffer from what critics

[60] J.F. Aruffo, J.H. Coverdale & C. Vallbona. AIDS Knowledge in Low-Income and Minority Populations. *Public Health Reports* 1991; 106: 115–119.

[61] C.T. Salmon, K. Wooten, E. Gentry, G. Cole & F. Kroger. AIDS Knowledge Gaps in the First Decade of the Epidemic. *Journal of Health Communication* 1996; 1: 141–155; K. Viswanath, J.R. Finnegan, P. Hannan & R.V. Luepker. Health and Knowledge Gaps: Some Lessons from the Minnesota Heart Health Program. *American Behavioral Scientist* 1991; 34: 727–741; C. Farley, S. Haddad & B. Brown. The Effects of a 4-year Program Promoting Bicycle Helmet use among Children in Quebec. *American Journal of Public Health* 1996; 86: 46–51; M.A. Winkleby, B. Taylor, D. Jatulis & S.P. Fortmann. The Long-Term Effects of a Cardiovascular Disease Prevention Trial: The Stanford Five-City Project. *American Journal of Public Health* 1996; 86: 1773–1779.

[62] Odets, *op. cit.* note 50.

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have labelled 'forceful, evangelistic health propaganda.'[63] One example can be found in an anti-smoking programme developed for American-Vietnamese men who commonly carry a pack of cigarettes, which they offer to a friend in social encounters. This sharing of cigarettes is an important social practice that serves to reinforce social ties and solidarity in this immigrant community. Other minority communities, for example, Arab men in Israel, appear to share this practice as well. The well-intentioned messages 'tailored' for these immigrants stated that to offer someone a cigarette is like offering cancer. It emphasised by implication the obligation to help protect others from dangers associated with smoking. Considering the low rates of smoking cessation, its main effect, however, may have been to make these men feel guilty. If these men were not given the opportunity to adopt an alternative practice, they were likely to continue offering cigarettes to each other. Is it the obligation of those who create health messages to include suggestions for alternative practices that can express social solidarity, generosity, kinship, friendship, and bonding?

*Health as a value*

With a continuous barrage of health messages aimed to promote the health of the public, disseminated by government agencies and numerous health organisations, the public is inundated with messages on the importance of health. It may be difficult to conceive what kind of diffuse cultural effects are likely to occur as a result of the accumulation of benevolent public health communication activities. Yet, already a decade ago, a prominent public health researcher raised concerns about the adverse impact a greater emphasis on the importance of health as an overriding value might have on individuals and society. Furthermore, some experts predict that health promotion may turn the pursuit of health into a crusade with moral overtones that may do more harm than good.[64]

On the individual level, people are increasingly preoccupied with their health, and even when they are not ill, many are the 'worried-well',[65] constantly seeking how to improve their health,

[63] T. Strasser, O. Jeanneret & L. Raymond. 1987. Ethical Aspects of Prevention Trials. In *Ethical Dilemmas in Health Promotion.* S. Doxiadis, ed. New York. Wiley & Sons: 183–193, at 190.

[64] M.H. Becker. A Medical Sociologist looks at Health Promotion. *Journal of Health and Social Behavior* 1993; 34: 1–6.

[65] A.J. Barsky. 1988. *Worried Sick: Our Troubled Quest for Wellness.* Boston. Little Brown.

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and worrying that they are not doing enough. As good health increasingly signifies virtue, those who are unhealthy may be made to feel that they are unworthy.[66] On the societal level there is the obligation to promote equity. Emphasis on health as a value may reinforce the notion of individual needs as the basis for healthcare, and thus contribute to escalating public expectations. Only the more powerful groups, critics maintain, will be able to place demands that the healthcare system meet their escalating needs, while members of vulnerable groups will continue to receive relatively fewer services and benefits.[67]

## CONCLUDING REMARKS

Public health communication campaigns have been credited with helping raise awareness regarding risks from chronic illness or new infectious diseases. They have been a tremendous factor in helping to promote the adoption of recommended treatment regimens and helping de-stigmatise populations that suffer from new and old medical conditions. The production of messages to promote public health is a creative enterprise, embraced by public health practitioners who aim to exploit the wide range communication strategies in order to achieve public health goals. Even television entertainment programmes such as soap operas and sitcoms have health messages strategically infused into their plots or scenery, for the purpose of influencing viewers.[68] Messages about how to improve health may not appear as ethically problematic to many public health practitioners. Although both practitioners and scholars have pointed out ethical dilemmas associated with communication for the purpose of public health,[69] many aspects of public health communication interventions often have escaped the scrutiny of ethical discussions. Perhaps this is because communication activities have been viewed, compared to more coercive methods in public health that involve regulations and sanctions, as rather benign. Ethical dilemmas may appear to be subtle, yet reflect important concerns regarding potential effects of public health communication interventions

[66] Callahan, *op. cit.* note 37; F.T. Fitzgerald. The Tyranny of Health. *New England Journal of Medicine* 1994; 331: 196–198.

[67] Daniels, *op. cit.* note 4.

[68] A. Singhal & E.M. Rogers. 1999. *Entertainment-Education: A Communication Strategy for Social Change*. Mahwah. Lawrence Erlbaum.

[69] D.R. Buchanan. 2000. *An Ethic for Health Promotion: Rethinking the Sources of Human Well-Being*. New York. Oxford University Press; S. Doxiadis, ed. 1987. *Ethical Dilemmas in Health Promotion*. New York. Wiley-Liss.

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on individuals and society as a whole. Therefore we suggest that an ethical analysis be applied to each phase of the communication process. This analysis may need to enlist different ethical approaches and imaginative thinking to help elucidate value considerations and to point out ethical dilemmas that should be taken into consideration in activities that aim to promote the good of the public through communication.

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