

New Rules of Engagement in Public Health and Health Care Public Relations

Jennifer Vardeman-Winter, Ph.D.

This research project was funded by the Arthur W. Page Center for Integrity in Public Communication at Penn State University.

ABSTRACT

The purpose of this study was to explore ethics that are unique to public health/health care (PH/HC) public relations, as the field is an increasingly politicized, collaborative, regulated, and socially mediated communication environment. Eighteen practitioners from the PH/HC industry were interviewed about ethical dilemmas and resolutions in their jobs. Traditional ethics were confirmed, and unique ethics like sustainability, cultural accountability, and compliance emerged. As many of the ethics blur together in how they address practitioners' concerns today, the ethics were categorized according to *ethics of knowledge*, *ethics of protection*, and *ethics of engagement*. Theoretical implications are suggested, particularly around how the health context provides deeper meaning for theories of stakeholder engagement, issues management, and postmodernism. Practical and pedagogical implications are also addressed.

Keywords: engagement, ethics, health, social media, stakeholders

INTRODUCTION

Ethics in public relations has been discussed extensively among scholars and practitioners. Separately, scholars have noted the myriad ways public relations can be useful and effective in health contexts (Springston & Lariscy, 2005; Wise, 2001). However, little scholarly attention has been given to the ethics of industry-specific public relations, such as public health and health care (PH/HC).

Consider some very fundamental changes the PH/HC landscape has experienced over the past two decades: the U.S. Health Information Portability and Accountability Act (HIPAA) of 1996 required that all patient records move online and set strict requirements for providers to keep patient information private and secure; the saturation

To cite this article

Vardeman-Winter, J. (2015). New rules of engagement in public health and health care public relations. *Public Relations Journal*, 9(1). Available online: <http://www.prsa.org/Intelligence/PRJournal/Vol9/No1/>

of e-business and web-based social networks (WBSNs) now largely dictate how health consumers get information about health and health care providers (Aylott, 2011) as well as how health groups seek and obtain donations and insurance/payments; and the U.S. Patient Protection and Affordable Care Act (PPACA) of 2010 implemented significant changes in requirements for individual coverage and included an online marketplace (healthcare.gov) for individuals to sign up for insurance. These few but sweeping political and commercial changes have changed the way communication industries like public relations function.

These political trends—coupled with stagnant regulation of WBSNs and the blurred lines between medical, for-profit organizations and politicians, policy-makers, and researchers (Maher, 2012)—make the practices of PH/HC public relations ripe for ethical conflicts. Countless outcomes emerge that call to question the motivations and processes that informed them: campaigns and messages like “Save the Ta-Tas” and “Save the Boobies” use questionable rhetorical tactics that could be argued to be sexualizing women and minimizing disease; advocacy groups form that interrogate the science and widespread use of traditional medical interventions like vaccines; and more money than ever is spent by advocacy groups on healthcare and public health communication. Furthermore, questions about the ethics of conducting PH/HC public relations emerge constantly, such as how do practitioners best “sell” such policies and health behaviors to publics without violating their cultural norms, and how do practitioners tell patient success stories across multiple mediated platforms efficiently or mediate information-sharing online without violating health privacy laws? In essence, the field is ready for some inquisition on the accuracy, effectiveness, accountability, and appropriateness of our tactics, particularly in the context of how these ethics contribute to positive stakeholder engagement.

A starting frame of reference for this study is the 1943 Johnson & Johnson credo (jnj.com, n.d.). It has served as a “moral compass” among public relations practitioners and students because of its early leadership among corporations to situate its operations within an ethical environment, evidenced largely by its critically acclaimed handling of the Tylenol crisis in 1982 (Marra, 1998). Despite the beneficence and practicality of the Johnson & Johnson credo to consider all stakeholders valuable, and despite the widespread adoption of such principles by many health organizations, the current PH/HC communication environment blurs the lines between the various stakeholders that public relations practitioners must serve. Ethical principles like that from Johnson & Johnson must be contextualized in the current communication climate and expanded to help practitioners embrace new opportunities, avoid new ethical threats, and engage relevant stakeholders. To accomplish this, practitioners explained how their practices are distinct from others’ practices, how their ethics are challenged in today’s digitally- and politically-complicated environment, and what ethical guidelines they follow.

Preview of Study

The study is framed using literature about public relations ethics and health communication ethics, which highlights the need for a unique examination of ethics specific to health public relations. Two research questions guide the study, which question practitioners' perceptions of the discipline of health public relations as well as how ethics helps strategically manage their communication. In-depth qualitative interviews with practitioners were conducted to obtain data about what ethics are unique to PH/HC public relations as well as how they use these ethics to guide decisions in a digitally-mediated and increasingly politicized environment. In the discussion section, theoretical, practical, and pedagogical implications are proposed, particularly around the intersections of ethics in the context of PH/HC public relations.

LITERATURE REVIEW

Stakeholder Engagement and Public Relations

The Johnson & Johnson credo is seen as an influential mission statement in that has been called "a model for corporate America" (Abrams, 2012), largely because of its consideration for all stakeholders and not just stockholders. It adopts a stakeholder engagement approach largely like that of modern public relations theorists (e.g., Grunig & Repper, 1992; Rawlins & Bowen, 2005) and educators in recognizing that all stakeholders—including patients, doctors and nurses, employees, the surrounding community, and the environment—have consequences on the organization.

A more contemporary approach to public relations and stakeholder relationships is broadly termed, stakeholder engagement. Although lacking a widely adopted, concrete definition (Taylor & Kent, 2014), the approach recognizes that "engaging with stakeholders should be one of the most important core competencies of public relations" (de Bussy, 2010, p. 127). Despite these commitments and tangents to corporate social performance/responsibility (de Bussy, 2010; O'Byrne & Daymon, 2014), stakeholder engagement research has been critiqued as largely neglecting publics and instead, privileging organizational interests (Kang, 2014). To discuss such issues, a recent special issue of the *Journal of Public Relations Research* was dedicated to conceptualizing and elaborating on the nature of engagement. In their lead article in the issue, Taylor and Kent (2014) proposed a definition that centers stakeholder engagement on dialogue: "engagement is a part of dialogue and through engagement, organizations and publics can make decisions that create social capital" (p. 384).

Taylor and Kent (2014) explicate engagement by situating it in dialogue theory, which they argue is an orientation toward "value sharing and mutual understanding between interactants rather than as web site design features" (p. 388) that are offered readily via WBSN s like Facebook and Twitter. They proposed five requirements of engagement: interaction with stakeholders that follows secondary research of the contexts of an issue; evidence of caring about stakeholders' needs surrounding an issue; fostering of a relationship with the stakeholder outside of the current issue; seeking of input from

stakeholders about an issue; and a recognition of each group's importance to the greater community good (p. 391).

However, there are disagreements about the nature of engagement, particularly in a socially mediated communication climate (Kang, 2014; Taylor & Kent, 2014). Kang (2014) presented a succinct mapping of the confusion: some research conceptualizes engagement as the "ultimate marker or maker of a good organization-public relationship" (p. 400), whereas others have measured the engagement as "any interaction [marketers] were having with their customers," such as in evaluating the "number of clicks, bookmarking, friend requests, tweets, or subscribing without really tapping into psychological aspect of being engaged" (p. 400). Differently, other research suggests that social networking sites enable corporations to establish and enhance engagement with publics through demonstrations of transparency and authenticity online (Men & Tsai, 2014). Although researchers do not agree on definitions or specific factors and outcomes of engagement, research, dialogue, positive relationship outcomes, corporate social responsibility, and the context of social media emerge as common elements in a stakeholder engagement approach to public relations management.

Stakeholder engagement and ethics in PH/HC. Despite the abundance of stakeholder engagement research in public relations, there are no studies to date that investigate the unique ethics of stakeholder engagement in PH/HC public relations. Rather, stakeholder engagement and ethics are largely discussed in public health research, particularly as health organizations have recognized that community relations are vital to the success of health/risk interventions and therefore, the lowering of epidemics like HIV/AIDS (Koen et al., 2013). In fact, UNAIDS-AVAC published revised "Good Participatory Practices" in 2011 around establishing and maintaining significant stakeholder relationships when working toward community health. The group defined stakeholder engagement as "processes through which trial funders, sponsors, and implementers build transparent, meaningful, collaborative, and mutually beneficial relationships with interested or affected individuals, groups of individuals, or organisations, with the ultimate goal of shaping research collectively" (p. 16). The "Good Participatory Practices" includes values of respect, mutual understanding, integrity, transparency, accountability, and community stakeholder autonomy.

More specifically, Koen et al. (2013) found that representatives from HIV/AIDS civil society organizations in South Africa believed ethics like "meaningful engagement," sincere interest in the program, stakeholder input in decision-making, ongoing dialogue, honesty, respect, and transparency were required for interventions to meet their goals. In a similar public health setting in Jamaica, researchers found that "the use of a relational public health research ethics framework that considers relational personhood, social justice, relational autonomy, and relational solidarity" is useful for engaging communities in research (Davison et al., 2013, p. 63). Findings among public health scholars demonstrate that while some ethics are consistent with public relations ethics, ethics unique to PH/HC seem to center around community orientation to publics and commitment to social well-being.

PH/HC Public Relations and Ethics

As noted earlier, research that explores the intersection of public relations/stakeholder engagement, PH/HC contexts, and ethics has not yet been conducted. Some studies conducted in PH/HC settings have mentioned ethics peripherally; but the purpose of such research was to elaborate theories like contingency theory (e.g., Lumpkins, Baeb, & Cameron, 2010), relationship management theory (e.g., Seltzer, Gardner, Bichard, & Callison, 2012), framing theory (e.g., Park & Reber, 2010) using health topics and contexts. To this point, such studies elaborate public relations theories about media and relationships rather than offer ethical guidelines for conducting public relations practitioners in health contexts. In other words, we have yet to learn, describe, analyze, and predict how the health system—as a political, legal, economic, and social context—affects the value-rich practice of public relations.

General public relations ethics. Ethics as a theory and practice has been well-researched among public relations scholars (e.g., Fitzpatrick & Bronstein, 2006; Heath, 2001; see Bowen, 2010, for a recent review of definitions and models of ethics in public relations). In practice, although practitioners are not required to abide to a particular set of ethics, several associations and research bodies have proposed ethical guides for which scholars, students, and practitioners can follow. For example, the Public Relations Society of America's (PRSA) code of ethics are advocacy, honesty, expertise, independence, loyalty, and fairness, and their "provisions of conduct" are free flow of information, competition, disclosure of information, safeguarding confidences, conflicts of interest, and enhancing the profession (PRSA, n.d.). Although numerous typologies and models for public relations ethics have emerged—such as PRSA's—the purpose of this study was to determine ethics that are new and unique to health contexts. Therefore, practitioners defined ethics themselves and gave examples of dilemmas and strategies they face in their job that may be different from the ethical challenges facing their counterparts in other (non-health) industries. Finally, although the definitions of ethics for health public relations is purposefully kept broad for this study, it is important to review some ethical questions broached in PH/HC contexts in public relations.

Ethical Issues in Health Communication

Some public relations research suggests contradictions between the goals of PH/HC organizations and the actual communication efforts conducted by those organizations (Aldoory, 2009; Curtin & Gaither, 2007; Vardeman-Winter, Jiang, & Tindall, 2013). These contradictions take the forms of marketing PH/HC problems and solutions to some publics who are not the publics most susceptible to public health disparities (Tindall & Vardeman-Winter, 2011); conducting process-oriented campaigns instead of outcome-oriented campaigns (Dutta, 2010); excluding publics from decision-making about communication goals and efforts (Lupton, 1994); and employing rhetorical tactics like pinkwashing, which is the use of pink ribbon symbols on products to gain attention and improve sales of products (Breast Cancer Action, n.d.). Finally, despite the "enthusiastic acceptance" of fact-based programming and evidence-based practices

(EBPs) by medical professionals, public health administrators, and communicators, Lee et al. (2013) highlighted that “health disparities among racial/ethnic minorities are persistent in spite of the adoption of standardized care based on evidence” (p. 263) for the continued problem of culturally inadequate program design and implementation:

The problems with current EBPs focused on reducing health disparities may stem from an overemphasis on research knowledge, that does not equally emphasize the patient's values and preference and the sociocultural situation in which the care is delivered as well as the clinicians' expertise. (p. 264)

These contradictions beg investigation about the autonomy of publics and the reality of ethical PH/HC public relations: Who determines what is a PH/HC problem, and how does public relations contribute to these definitions of problematic public health? To what extent do PH/HC practitioners have an ethical obligation to help public health victims versus to assist their stakeholders? These blurred lines between advocacy and education, politics and public health often result in ethical conflicts and “cultural misses” in communication (Vardeman-Winter et al., 2013). Those who miss out, often, are consumers of necessary, factual PH/HC information.

Furthermore, several scholars in the ‘health communication’ field (Dutta, 2010; Guttman, 2003; Guttman & Salmon, 2004; Lupton, 1994) have exposed ethical issues like “assumptions of universality” (Dutta, 2010), the misappropriation of cultural symbols in campaign materials (Lupton, 1994), and messages that stigmatize already marginalized populations (Guttman & Salmon, 2004). However, ‘health communication’ is somewhat different from ‘public relations’, mainly in the emphasis public relations puts on the strategic management of communication via considerations for professionalism, issues management, policy-making, codes of ethics, boundary-spanning, and industrial diversity, to name a few. Furthermore, public relations relies heavily on media relations as a tool, whereas health communication tends toward community-based, grassroots tactics (Vardeman-Winter, 2014).

RESEARCH QUESTIONS

This study will highlight the distinct role public relations plays in the strategic management of ethical PH/HC communication. Thus, the first RQ asked, *why is PH/HC public relations significant as a strategically managed practice, and how is it practiced differently from the widespread discipline, health communication?* Also, to identify how public relations practitioners see themselves facing ethical dilemmas and employing ethical frames in their decision-making, the second RQ asked, *What are the basic ethical problems confronting PH/HC public relations, and what are the ethical resolution strategies used by PH/HC public relations practitioners?* These RQs contribute to the goals of public relations scholars and educators to continue questioning ethics.

METHOD

Overview

Qualitative inquiry was the most appropriate form of data collection and analysis to answer the RQs because of the exploratory nature of the study. Practitioners in the health field were recruited and interviewed using a semi-structured interview guide. Grounded, thematic analysis was used to let themes autonomously emerge from the data. The interview method, sample, procedures, and data analysis are discussed next.

Interview Method

Sample. To explore this rather uncharted topic, a total of 18 qualitative, individual interviews were conducted with PH/HC public relations practitioners. Practitioners provided useful data upon which to evaluate ethics in the field because they serve in the capacity of counselors, teaching and coaching ethics to dominant coalitions and organizations at-large (Bowen, 2010).

Sampling strategies. Purposive and convenience sampling strategies (Rubin & Rubin, 1995) were used to recruit people in positions at organizations that reach local, city, county, and state regions. Snowball sampling was also used because some participants referred the researchers to people in similar positions.

Recruiting. The researchers recruited PH/HC public relations practitioners by reaching out to the local Public Relations Society of America (PRSA) chapter. The researchers asked personal contacts to forward the solicitation email to people they think would be interested in participating. The solicitation email stated: "We are conducting interviews with public relations practitioners in the health care and public health fields to learn about how you use ethics in your job." If the potential participant self-identified as a practitioner in these fields, the researchers then followed up with questions about the types of tasks s/he performs on a daily basis and his/her job title. Tasks included media relations, crisis communication, issues management, client communication, research, event planning, social media strategy, etc. If the potential participant fulfilled one of these roles and had contact with the organization's external publics, s/he was invited to participate in the study.

Procedures

Once participants expressed interest in being interviewed, a mutually beneficial time and place to meet were decided. Most of the interviews were conducted in participants' offices, and the rest were conducted in local coffee shops. A trained research assistant (RA) helped in recruiting and conducting interviews: the principal investigator (PI) conducted five interviews, and the RA conducted 13 interviews. The RA was a former undergraduate student who took a research-intensive public relations course from the researcher. In the course, students learned how to conduct qualitative interviews with individuals, and they were required to interview four individuals for a final project. For

this study, the RA read the literature gathered to inform the study design as well as select method readings about qualitative interviews (e.g., Lindlof & Taylor, 2002; Rubin & Rubin, 1995). The RA was also trained in ethical conduct in data collection and analysis during her Institutional Review Board training. The RA attended the first three interviews with the PI and observed her conducting the interviews. Debriefing meetings followed the interviews to allow for reflections on the methods and findings of the interviews. Finally, the PI met with the RA three times throughout data collection to discuss her observations and provide feedback about the flow of the interviews.

At the start of the interviews, the interviewer asked participants to read the informed consent form, which was approved by the university's Institutional Review Board. Any questions participants had about the interview process or the study were answered. Participants also filled out a voluntary information sheet, which asked for their official title, the type of public health or health care their organization performs, how many years they had been in communication/public relations, the highest level of formal education they obtained, and the top three communication tasks they perform on a regular basis. Before proceeding through the interview guide, participants received a \$25 gift card to Target to thank them for their time. All participants gave permission for the interviews to be audio-recorded, and a professional service transcribed all the interviews. The interviews lasted between 15 and 60 minutes, with an average length of 35 minutes.

Interview guide. A semi-structured interview guide was used that included broad questions to elicit practitioners' experiences; specific questions to explore concepts in ethical public relations such as honesty, transparency, and advocacy; and probes to delve deeper into participants' motives and barriers for why they do/not make ethical decisions in their practices. Sample questions included, "how do you define ethics?" "how do you resolve ethical dilemmas in your job?" and "when you think about ethics in your job, what values are unique to a communication job in public health/health care?" Participants were also asked for specific examples of ethical dilemmas they faced and resolution strategies they employed in their jobs.

Summary of participants. Eighteen participants were interviewed, representing 16 local organizations. (See Appendix for participant profiles.) The majority of the participants were in managerial roles, indicated by the use of words like director, chief, manager, or senior in their titles. All participants signed a voluntary participant information sheet. The participants worked in public relations for a health care or public health entity for an average of 13 years. All participants were women except for three men. Six participants held a bachelor's degree, ten held a master's degree, two had a doctoral degrees, and one was APR. All participants worked within the same county and city within the United States. Eleven were White, five were African American, and two were Southeast Asian. This lack of racial diversity is a limitation to this study, particularly as no Hispanic practitioners were recruited.

Data Analysis

The most appropriate way to allow new ethics to arise from the data was to use a grounded theory approach to analysis. Inductive data analysis was performed (Miles & Huberman, 1994). Analytical techniques derived from grounded theory allowed themes to emerge autonomously from the data, and the methods of constant comparison and integration enabled the PI to identify patterns and relationships between the concepts (Glaser & Strauss, 1967). The PI used the qualitative software program, HyperResearch, to conduct axial coding and data reduction. Themes were then connected to the research questions (Miles & Huberman, 1994).

RESULTS

Variations of Health Public Relations Defined

In the past two-and-a-half decades, health communication as a term and discipline has gained significant popularity, particularly in academic settings (Kim, Park, Yoo, & Shen, 2010; Parrott, 2004). The U.S. Centers for Disease Control and Prevention defines health communication as, “the study and use of communication strategies to inform and influence individual decisions that enhance health. Health communication can take many forms, both written and verbal” (2011). Sometimes used synonymously with ‘health promotion,’ “the breadth of the scope of health communication implicitly acknowledges that strategic communication to achieve health aims” (Parrott, 2004, p. 752). Finally, the study of health communication encompasses macro-level dynamics—like how social norms, cultural patterns, and ecological conditions affect community health—as well as micro-level interactions, like the interpersonal patient-provider interaction, individual beliefs about efficacy and health benefits/costs, and knowledge of risk (Rimal & Lapinski, 2009).

Differently, many articles about the health care industry in public relations journals investigate the role of media relations in affecting coverage of health topics (e.g., see Cho & Cameron, 2007, for a short review). Researchers also suggest that the tools and techniques of public relations communicators—such as brochures, campaigns, events, public service announcements, and news releases, among others—“are essential to effectively inform the public about healthy behaviors and persuade them to adopt those behaviors” (Springston & Champion, 2004, p. 484). In essence, health public relations as a research field seems to be limited to the primary task of informing publics about a health risk via the use of media tools and processes. However, to establish the standpoint from which participants understood ethics in their communication tasks, the first research question sought to find out whether practitioners think PH/HC public relations is significant as a strategically managed practice, and how it may be applied differently than health communication.

All practitioners said they performed health communication, public health information communication, or some form of public relations in the health industry. To this point, on the voluntary participant information sheet (which all participants filled out), 12 out of 18

participants listed media relations as one of their major tasks they performed regularly. Other tasks reported most often were coordination of events, client communication, issues management, fund-raising, or specific-public communication (e.g., doctors' relations, board relations).

Most practitioners interviewed believed there is a difference between PH/HC public relations and health communication: public relations consists more of working with the media and promoting an organization or a product, whereas health communication involves educating the community about a general health topic. Kinsey explained her role in doing health communication: "The words that come to my mind in relation to my job is community education...which is taking the information to the streets...That's different, I think, than PR. PR is the media relations side of things." These two perspectives were made distinct by Eloise, a public affairs head for a municipal health department, who sees herself in the public health communication role, and Stacy, who sees herself in the health care public relations role because she works for a hospital. For example, Eloise is more concerned with health messages than with the organizational reputation:

As a government communicator, I'm not selling a product, and my primary goal is helping a household, a family, the viewer, the listener, or the reader to make good decisions about their health and the health of their family. I'm not trying to sell a product, I'm not trying to make government look great. The government will look great if we do a good job to public health.

Differently, Stacy emphasized the hospital's brand that she is trying to permeate through media and ultimately potential consumers:

Underlying everything—whether it's education that we're trying to push out or letting people know of new programs that we have—ties back into our brand...Whereas I feel like public health, it's not about letting you know where that information comes from and not a specific place has that information. It's just making sure that the right people get the right information to help them.

Finally, several practitioners said there really isn't a difference because both disciplines are promoting some aspect of health.

Health Public Relations Ethics Defined

All practitioners said ethics are important to their jobs. Also, despite their somewhat varied opinions on disciplinary definitions, overall, the large majority of participants said there are ethics that are unique to PH/HC public relations as compared to public relations in other industries like oil, manufacturing, retail, etc. The main reason cited was that PH/HC practitioners are dealing with people's lives rather than a product, and therein lies a greater responsibility than to stakeholders or a product's reputation. For example, Joyce said:

I think working in the health field, there is a greater good; we have a purpose in what we're doing. We're trying to make people aware of our mission, and so I think when someone brushes off what we're trying to do it's hard because we're trying to save lives.

To this point, many of the participants talked about the type of person or the skills that makes an ethical communicator in health unique from other public relations people, as demonstrated in Ellen's comment: "... you're dealing with people's livelihood. You always have to be able to put yourself in their shoes and...realize that how would you want to be treated as a patient, how would you want your information to be private?"

Furthermore, practitioners defined ethics fairly consistently with the use of words like "doing what is right," and "the greater good." Several talked about ethics being a framework, policy, or as Danny put it, "a code that a communicator commits to." Many participants also brought up honesty and privacy of clients/patients in their definitions of ethics. Finally, several practitioners suggested that ethics help a practitioner obtain, "personal confidence that you've treated people fairly in a way that you would not be ashamed to have known publicly."

Ethical Dilemmas in New Contexts

Not only did the practitioners define ethics consistently, but they also reported fairly similar dilemmas and strategies. Some of the ethics they found important are ethics discussed and highlighted in many public relations codes and texts, such as ethics like honesty, advocacy, and free flow of information found in the PRSA Code of Ethics. Other ethics are health-context specific. Furthermore, the ethics discussed emerged as so intricately intertwined with one another that it would be difficult to report them singularly. Therefore—as a matter of understanding the realistic contexts within which students, scholars, and practitioners will encounter these ethics—they are reported as clusters. Understanding the ethics as intersecting illuminates the complex nature of ethics in PH/HC public relations, as dilemmas emerge when two or more obligations contrast, and a practitioner has to parse out the consequences of each. Ethical intersections discussed are *ethics of knowledge* (honesty, advocacy, and expertise); *ethics of protection* (free flow of information, privacy, compliance, and transparency); and *ethics of engagement* (cultural accountability, sustainability, and loyalty).

Ethics of Knowledge

Honesty. *Honesty* was the most often cited ethic by participants. Practitioners also mentioned *expertise* and *advocacy* as highly relevant to their jobs. These ethics work together because many practitioners felt that to be honest to their constituents, the information they sent had to be fact-based, which requires expertise in the field.

Complications occur for many of these practitioners because of the strategic reasons to consider whether whole truths must be revealed or if lies of omission are acceptable. Some practitioners, like Stacy, waver between legal obligations and ethics:

When you have like, lies of omission, are those really lies? You're not telling the complete truth, "Well I didn't say I didn't do that." I think that comes up quite a bit here, and in health care, in general, because we have to be so selective of the information that we're allowed to tell. Sometimes I feel the desire to omit information even though we're not legally obligated to protect. It comes up often.

Others, like Lorraine, believed that complete fact-based information is important to communicate:

Factual data is very important...the way we message public health is very important, so we are very clear about what we're saying. Yes, there is a chance that if a child is vaccinated, that it's going to have some downside. There's a chance when they get on a bicycle, there's a downside too. So, I think we've got to be very clear on what the data shows as opposed to just the ideology.

Advocacy. As advocates of health, some practitioners ran into dilemmas where fact-based honesty and advocacy conflict with legality. Tricia faced this challenge, for she could be criticized for being dishonest because she may not be legally allowed to share health information with minors if their parents have not given consent:

Sometimes we're not allowed to give all the information like when we're working with young girls, there's a waiver that the parents have to fill-out before they can participate in class. So based on what the parents are allowing us to say about controversial topics then we're not allowed to provide all the information. So while we're not being dishonest, there might be like a lack of information which some people may say is dishonesty.

A few practitioners discussed the fine line between advocacy and honesty in revealing research findings, medical breakthroughs, and clinical trial results produced in their organizations because, as Keith put it, "you don't want to oversell the story." For example, Mark gave an example of a particular test being done by an external company that he believes is "lead[ing] people to false hope" about a health threat:

[The test] will catch a certain percentage of these things...but the bottom line is, are you giving parents a full sense of security? Then go and say, "Well my child's been tested. Here she had an EKG in this program."...[an advocate] asked us to participate with him in that lobbying. We declined because...for us to lend our reputation to an effort to test people...using one test that can only pick up a portion of these conditions would be

unethical...it would be unethical to give parents this false sense of security and policymakers.

Expertise. In these cases, practitioners are using expertise to determine the honesty of the health claim, and in turn, determining whether they will advocate for that organization or health intervention. However, advocacy is multi-layered: some practitioners took it to mean they may be the dissenting voice in the decision-making process who speaks up for the community, as Alexandra expressed: "I have to be their voice. They're not in the meeting. It might be a hard conversation sometimes...but you have to advocate for what the public wants at the end of the day." Others, like Kinsey, said she had to be the advocate for both donors and recipients in her role. Finally, some practitioners said they are obligated to their external as well as internal stakeholders, which often conflict in the values they want honored by the organization.

In an outlying perspective, Keith pointed out that many of the ethical questions are not problems if an organizational communicator has the adequate resources and expertise to do his/her job. In essence, he perceived ethics more like benchmarks for competence to do the job rather than value-based issues: "I don't see that ethics is a big issue, I see it as doing your job, presenting accurate information...we're pretty much just sharing information with the public."

Ethics of Protection

Nearly all practitioners discussed the ethics of protection, which consisted of the *free flow of information, privacy, compliance, and transparency*. Furthermore, practitioners told about continual compromises they had to make in their communication tasks in order to negotiate conflicts among these ethics. Many practitioners felt the responsibilities to a free flow of information but concurrently, they knew they had legal and moral obligations to protect patient privacy.

Free flow of information. Most practitioners mentioned their obligation to not just provide information to publics about a health topic or risk, but to also not obscure or hide any unfavorable information about the organization or health topic. Practitioners felt a strong sense of the importance of the "public right to know"; however, some felt this loyalty complicates the transparency ethic by suggesting that there are limits to the ethic of a free flow of information. Stacy commented that "mini-hysteria" could result from her hospital releasing information about a new public health threat without strategic planning:

We've done some media interviews about it...But we're not doing a big push right now because we're also part of a study that's looking at if we have one of the first cases. The minute we have the first cases, if we were to let that information go out...without having a plan around it, it could cause a mini-hysteria in our community. So I think it's free flow of information can be very, very dangerous...So I think that giving information and disclosing information is vital to what we do but

understanding that that is not the same as just allowing messages to run freely.

Social media has further complicated such issues of confidentiality and transparency. As a social media manager for a large, privately owned network of health clinics, Ellen balanced how to address an upset customer's concern on Twitter with not revealing the customer's medical background:

A lady tweeted us and said, "I'm never going back to [the organization] again. Y'all are a bunch of joke!" She was letting us have it... because she wasn't able to get her medication. She called our office, and nobody is picking up the phone, they were putting her on hold. She specifically described what type of medication she needed and what her condition was on this Twitter platform. So that's where the ethics comes in...what's the best way to respond to it, and also trying to figure out how do I get this woman's medication so she can stop complaining on Twitter?

Privacy. Privacy was mentioned almost as often as honesty as important to practitioners' jobs, despite it being a complicated ethic to continually uphold. For example, some said they wanted to be open and transparent by revealing details of a health intervention, organizational process, patient story, or research finding, but that they either could not legally share details or they felt they should not because of the need to make patients/consumers feel safe. In fact, many participants talked about experiences in which the media would call the practitioner for a comment on allegations made about bad experiences at the hospital/clinic/association, but the practitioner could not even comment about whether the patient/client had been a former or current patient. Some practitioners felt a sense of loss of professionalism as well as competition because of complying with HIPAA or related laws. For examples, a few practitioners experienced upset stakeholders—like media and doctors—because of their inability to provide valuable content to media stories about patient and provider experiences.

Because communicators manage relationships among multiple publics simultaneously, conflicts naturally arise around whose privacy matters more. For example, Eloise, a government communicator, explained that a case of tuberculosis broke out at a local high school, but she could only report that it was "a school" where the outbreak occurred, because of a confidentiality agreement. But, she felt that tension between the "public right to know" and "free flow of information" with the need to respect the privacy of the school's attendees and administrators and comply with privacy laws.

Compliance. A unique quality of PH/HC public relations practitioners' work is the extreme value they place on the patient's experience or the population's need for quality health information. Because of the increased pressure for engagement online, practitioners discussed how they have to respond readily to complaints, with the publics' needs as a top priority. Stacy expressed that privacy, transparency, and compliance intersect in a particularly challenging way in the health context because of practitioners'

nature to conduct genuinely customer-oriented communication and concurrent timely responses to media inquiries:

When the rare times come up that there's an upset family...we pretty much have a standard protocol that we're never going to talk about a family in the media...So that's a challenging part...if somebody in the media calls, that we pick up the phone or we call them back within five minutes...We try to be as accommodating as we can and sometimes because of federal guidelines, HIPAA, we can't get them the information they want. We can't get them information that maybe will tell the other side of the story...then the reporter or the producer gets upset with us, and it's out of our hands at that point.

In a similar story, Veronica was faced with a difficult situation in which the ethics of privacy, compliance, and patient-centered care conflicted with her organization's desire to get high-level publicity about a serious health risk:

Swine flu, the first death in the United States was at our hospital. So we had international media and, of course, all the community of international and national [media] just swarming at us. Yeah it was our chance to get on all these top programs but at the same time, this family is grieving the loss of their child. So this media is just hounding you, and they're yelling at you, and especially it's hard for the ones that you worked so hard to build relationships with. Like they're threatening to never work with you again. How do you balance that?

Veronica also discussed her dilemmas between taking opportunities to gather information for mission-relevant patient stories with sensitivity to publics' emotional needs:

I think the hardest was when I was doing PR for the newborn center. And there's these parents sitting bedside next to their teeny, teeny pretty baby. How do you approach them without being kind of sleazy like, "Oh, hey, I know you're grieving right now, and your child's really, really sick, but will you help me up with the story?" It's different how we position...you have to have a softer side. There's been so many stories that will be great on paper, great on television, but it's just not appropriate... So we have to let them pass.

Stacy's strategy for dealing with protection issues like this was to help reporters develop their story without giving them specific details about the patient:

So we'll go back and we'll get the background from our team's side obviously knowing that we won't be able to share most of it with the reporter. We've actually had the discussions, what's ethical to do? Are there questions that we can post to the reporter? Have you thought about

this?...Things where we're not giving them information but it may trigger questions that perhaps you should ask the family...Is that ethical? Is it ethical to post those questions to a reporter?

Transparency. Finally, ethics of protection involved transparency in communication, particularly around profit-raising and use of funds, misperceptions of partnerships, and conflicts of interest. For example, Mark expressed that he felt conflicts naturally arise because of the need for philanthropic groups to form corporate partnerships. Furthermore, several participants talked about misperceptions by publics about how their organization uses their money. Gracie explained the debate happening around whether groups like hers should spend donor dollars on ads to raise awareness or on research about the health issue:

I think we constantly have to ride that ethical line of how much, as non-profits, how much is too much when you're not devoting some of your dollars to the actual mission of the organization...It's part of your job to bring awareness especially when it comes to prevention. If you don't spend the money, you can't make the money in terms of donations, and you can't ultimately achieve your goals. So you're always walking that ethical line of how much money is too much money to spend on marketing and advertising when you're in a non-profit healthcare organization.

Ethics of Engagement

Cultural accountability. Most practitioners said they considered culture to be a strong ethical consideration in their job. For example, several participants explained how they faced dilemmas in outreaching to groups that they consider racially diverse or culturally different from themselves (and other personnel in their organization). For example, Kinsey described that she is challenged by the reality that African Americans and Hispanics comprise between one-third and one-half of organ donation wait lists, although as racial/ethnic groups, they have cultural and religious reasons for not registering as donors. She perceives this as an ethical dilemma:

Because when we have somebody that's African-American or Hispanic that needs a transplant, the better outcome for them is to receive that organ from somebody from their ethnical background for matching purposes. So the perception could be that you're saving all these people we're talking about, and you're letting all these people that are Hispanics or African-American die. That, to me, is a huge ethical dilemma.

To this point, a few practitioners talked about the need for communicators to have relatable backgrounds to their publics. Alexandra, for example, questions the backgrounds and motivations of the people who develop and implement campaigns she perceives are culturally inappropriate for the populations with which she works. In fact, she believed that to have a "relatable relationship with the community" should be an ethic: "It's really hard for people who come from a drastically different background to

gain that inspiration from the public because there can be a perspective that's pretty dismal. But there could be a perspective that's hopeful in these communities."

Similarly, Gracie addressed cultural differences often in her role in communicating preventive health to populations who have historically practiced risk-averse behaviors. She described an opportunity her organization had to work with a high-profile celebrity who, while on the track to becoming healthier, had a past of multiple unhealthy behaviors that the organization did not want to align itself with. Internally, Gracie's team had to determine the ethical and strategic implications of working with this celebrity:

So you have the communications team going, "This is not a good decision, for not just the fact that [s/he's] a smoker but because of everything that [s/he] stands for... it is not in alignment with our brand, with our mission and with our organization." We had another group that was saying, "Yes, but you have to meet people where they are. You're not going to rid the world of [health topic] if you only work with health junkies. You have to branch out, and you have to work with individuals who are not healthy."...Ultimately there was a compromise.

Sustainability. The need for sustainable programming and communication is related to the ethic of cultural alignment. This arises largely because of the difference between the culture of granting organizations and communication programmers, and the cultures of publics that are targeted (by organizations) for health change. Marion explained that these "cultural barriers" result in recruitment and retention for their education programs: "There's also an issue with a lot of programs coming into low-income communities and wanting to do things and after the program ends, they just kind of leave... So the biggest challenge has been recruitment and retention in on-going programs." Alexandra explained that the publics she works with are often targeted to test the efficacy of intervention programs and therefore, the publics are over-researched and have become distrustful of researchers and communicators. She described the challenges she faces with going into a community to teach about health and being faced with "a lot of heartache and disappointment":

A lot of people target them to do programs. They're typically grant-funded, and they're typically short-lived....communities don't change or aren't able to truly evolve with the limited amount of time. So I feel like it's like building participants up, and then you're gone and letting them down. I feel like it's our duty as professionals to keep that connection. If you can't do the project, find a partner.

As a strategy, Alexandra believed that sustainability is an ethic that communicators must follow: "Sustainability is a huge thing. I feel that is a very ethical part of what I have to do because it's not just my job, it's their lives."

Loyalty. Related to the discussions of sustainability and cultural connectedness was the idea of loyalty to communities/publics. Participants talked about this in terms of working

with the community, even after a program has ended (and in Alexandra's case, sometimes working for free for the community when it asks for a health presentation when she is "off-the-clock") as well as in terms of a communicator being authentically interested in the community and passionate about the cause. As such, passion and compassion emerged in multiple interviews. For example, Kinsey's organization recently rebranded itself and included passion and compassion as two of its three core values. Similarly, Lorna hires people based on their demonstrations of compassion and passion for the cause because it can help or undermine the organizational mission:

...if you can't relate to what my clients or patients or members are feeling, then they're going to see right through that. So you have to have some connection to my cause...everybody has to be a face for the organization, right? So if we're going to raise funds or increase awareness or communicate effectively, then they have to see your passion, or people see right through that. I mean I'm not going to donate or take part in an organization where I feel like they're not engaged, right?

Finally, Eloise introduced an interesting potential factor of loyalty she called "walk the talk": "I always try to walk the talk of public health. I try to encourage my people I work around to walk the talk also because how can we expect the public to watch their weight when we have donuts everyday?"

DISCUSSION

This study uncovered some unique dynamics of ethics in PH/HC public relations. First, ethics are difficult to isolate and thus, they exist within intersections. Second, ethics of knowledge, protection, and engagement emerged as most salient for the practitioners interviewed. Third, new ethics like sustainability and cultural accountability suggest that the field of PH/HC public relations is requiring practitioners to engage more deeply with their stakeholders. These "new rules of engagement" suggest a unique site of stakeholder engagement, one that reflects some more postmodern characteristics than some traditional definitions cited earlier in the study. Propositions about PH/HC ethics are provided to extend theory about stakeholder engagement in the PH/HC fields.

Theoretical Implications

Although no specific ethical theory in public relations framed this study, general principles of ethics in public relations—particularly those that are used by professional associations like PRSA and organizations like Johnson & Johnson—were confirmed in this study. Ethics like honesty, expertise, advocacy, and safeguarding confidences continue to be among the most important values that shape practitioners' decisions. The strength of traditional ethics suggests that perhaps some generic ethics exist in U.S. practice.

Proposition: Ethics like honesty, expertise, advocacy and safeguarding confidences are generic ethics in U.S. public relations practice, through time and across industries.

However, ethics unique to public health and health care organizations emerged as important as well. Participants believed ethics like sustainability of programs/information, authenticity/passion about the cause/public, cultural accountability, and compliance (particularly with HIPAA laws) were distinctive ethics that practitioners from other industries may not need to consider. Almost every participant said the reason for these unique characteristics is because their work deals with people's lives and experiences with health. To this point, Levins (2000) argued that, "PR agencies must ensure that the experts and the people living with the disease drive their communication approach" ("Evidence-based approach," para. 2). The emergence of ethics like sustainability, authenticity/passion, and cultural accountability echo a similar shift in public relations theorizing away from a corporate/organizational tradition to a stakeholder approach, as the new ethics seemed to largely emerge from practitioners' senses of loyalty to the patients/consumers/publics.

Proposition: Ethics like sustainability of programming, authenticity/passion about patients/communities, and cultural accountability are ethics that characterize PH/HC public relations practice.

Proposition: The PH/HC public relations industry requires public-centric communicative behaviors above organizationally-driven decisions, and the industry's unique ethics drive these decisions.

This fragmented, messy, multi-faceted communication environment in which practitioners must negotiate ethical decisions can be considered postmodern. As postmodernism has been defined as a rejection of metanarratives and normative practices as well as an ease in navigating multiple, often conflicting interests within a discourse (Holtzhausen, 2011), some practitioners exhibited postmodern values underlying their ethics. For example, many participants said that avoiding conflict is unethical, particularly in times when the publics' voice needs to be heard within the organization. Furthermore, several PH/HC practitioners worked constantly within a tension between compliance with laws prohibiting the release of privileged information, advocacy on behalf of patients, and honesty about health organizations. Thus, contemporary ethics for PH/HC public relations advances not only a general theory of public relations, but it helps us better understand that working in the health industry requires some deeper understandings of the nature of truth and science and the variable ways humans will come to make meaning about health.

Proposition: Negotiating ethical conflicts is a reality of PH/HC public relations work, and as such, practitioners exhibit postmodern strategies in managing their moral and organizational obligations.

Finally, this study adds to our understanding of stakeholder engagement in some important ways. Overall, the participants affirmed public relations, health communication, and PH/HC literature in their collective foci on engagement as central to positive organization-public relationship outcomes (de Bussy, 2010). Furthermore, most

participants discussed the need for dialogue, the need for communicators to be passionate about the project/cause/community, and inclusion of stakeholders' input in decision-making, which map closely to the requirements of engagement proposed by Taylor and Kent (2014).

However, differently than set forth by stakeholder engagement literature, many participants suggested that culture was an important basis for engagement. Culture accountability/sensitivity/competency is a context that health communication scholars have long argued as vital (Dutta, 2010; Lupton, 2003). However, the foundation of culture as a starting point for engagement has not yet permeated ethical decision-making within public relations engagement research.

Proposition: PH/HC public relations exemplifies many requirements of positive stakeholder engagement, including an additional imperative for cultural accountability as fundamental to establishing positive relations with a community/public.

However, the cultural accountability ethic participants discussed complicates the current debate of the nature of engagement somewhat: whereas scholars have disagreed about how dialogue manifests into engagement (Taylor & Kent, 2014) – whether in approach or in actual measures of social media interactions – PH/HC public relations practitioners face a nuanced challenge of engagement: if the cultural group they need to engage with seeks information largely via WBSNs, not only must these practitioners learn the dynamics of engagement online, but they must also negotiate between the ethics of privacy (of individual health data) and the ethics of compliance (with corporate policies and government laws). PH/HC practitioners do not enjoy some luxuries other industries do regarding compliance and need for sustainable programs; furthermore, differently from in previous decades, complying with policy and enacting grant/funding requests were not perceived by publics and practitioners as questionable ethical realms; now, practitioners now are under scrutiny to enact PH/HC communication not just for organizational purposes but for the larger social wellbeing.

Proposition: PH/HC public relations offers opportunities to expand stakeholder engagement research by exploring the cultural context(s) of engagement, the factors and outcomes of engagement when multiple ethics conflict, and the consideration for aligning government/legal imperatives with sustainable programming.

Practical Implications

The tenets in the Johnson & Johnson credo still stand solid, 70+ years after it was created: to doctors, nurses, patients, families, vendors, employees, communities, and stockholders, the organization pledges good service, accuracy, fairness, dignity, security, freedom of expression, equality, competence, good citizenry, compliance with taxes, environmental protection, experimentation and innovation, research advancement, and profits. The study's participants confirmed virtually every one of these publics and ethics to be important today. This study furthers this ethical

discussion by updating the contexts within which these publics' interests can conflict and new iterations of how these ethics are applied.

As the data suggest, the new contexts are the rise of digital communication and social media (media), the rise of health-related advocacy groups (activism), insurance-related and privacy-related legislation that communicators have to consider in their programming (legal), and inter-organizational relationships that call interests into question (political, economic). Ethics salient to practice, now, are culture, compliance, protection, and the nature of information. To effectively navigate these new ethics, Levins (2000) recommended that public relations in health care should be, "evidence-based, expert-driven, micro-focused, issue-oriented, patient-empowering and noncommercial" ("Good Healthcare PR," para. 1).

Pedagogical Implications

This study has direct implications for scholars and students. As the field PH/HC public relations grows, it will increasingly become important for students to know the types of ethical dilemmas they are likely to face and be armed with strategies for resolving them. Also, as indicated by Stacy, students may enter the field insecure about the definition, manifestation, and consequences of ethical situations:

I think it plays a much bigger role than kind of taught in school. I think there's a lot of things that are kept left out of our curriculums. You know, I feel like you get your little discussion on ethics... You talk about it for six weeks, and then you're done when really, weekly, there are topics that we're having discussions about which, they may be easy ethical questions but they're ethical questions. I think especially in a healthcare setting, it comes up way more often than I ever anticipated it would.

Thus, discussing ethics—particularly about those that are unique to the largest industries like health, energy, sports/entertainment, and retail—with students is important early and often in their public relations education.

Limitations and Future Research

As this study explored new ethics in the PH/HC industries, the findings are anecdotal and cannot be generalized. Furthermore, the data were limited to descriptions of new ethics and practical outcomes of them rather than suggestions of how ethics are predicted to emerge in different contexts. To this point, future research can examine some specific relationships between variables in the health context. For example, some practitioners interviewed had little contact with patients and others affected by disease, whereas some—like those in hospitals—had daily interactions with people suffering from conditions. A potential relationship to investigate could be between frequency of interaction with patients and the ethics of protection. Specifically, a hypothesis could predict that the closer practitioners are to working with patients, the more likely they are to report that "safeguarding confidences" and "privacy" as the most important ethics in

their jobs. Other relationships to be tested could be the higher likelihood that most salient ethics would be advocacy and expertise if practitioners spent most of their time conducting media relations; and whether the size of the organization orients practitioners more to a “health communication” or a “public relations” role.

Finally, due to the lack of representation of the sample by some racioethnic minority groups, it may be important in future research to explore whether PH/HC practitioners from different cultural backgrounds rank ethical considerations differently. This is particularly important, as cultural identifications of practitioners and publics is an important theoretical topic in the health communication and public relations disciplines alike (e.g., Dutta, 2010; Guttman, 2003; Lupton, 2003). There is some evidence across other industries to suggest that ethics are influenced by cultural background (e.g., El-Astal, 2005; Hickson, 2004) However, the link across race/ethnicity, ethics, and HC/PH public relations has not been deeply explored but should be according to how cultural relativism and ethical imperatives are affected by or influence quickly changing PH/HC contexts.

CONCLUSION

The contexts within which the health system operates are constantly changing; therefore, the health system is dynamic. Likewise, how stakeholder engagement and public relations are practiced today is vastly different than how they were not even 10 years ago. Finally, because of the dearth of guidance from scholars about industry-specific ethical practice, this study provided a timely, meaningful opportunity to conduct grounded research about how practitioners are doing their work in unique ways from their counterparts in other industries. The research found that PH/HC communicators engage their stakeholders in ways that focus on ethics of culture, compliance, and sustainability in addition to traditional ethics like honesty and transparency.

ACKNOWLEDGMENTS

This study was funded by the Arthur W. Page Center for Integrity in Public Communication at Penn State College of Communications. The author thanks the Page Center for the support and opportunity. The author also thanks her very competent research assistant, Kait Dineen, for help with recruiting participants and conducting interviews.

REFERENCES

- Abrams, P. (2012, Feb. 1). "The J&J Credo -- A Model for Corporate America That Would Make America Work." Retrieved on January 23, 2015, from http://www.huffingtonpost.com/paul-abrams/responsible-capitalism_b_1125597.html
- Aldoory, L. (2009). The ecological perspective and other ways to (re)consider cultural factors in risk communication. In R. L. Heath and H. D. O'Hair (Eds.), *Handbook of risk and crisis communication* (pp. 227-246). New York: Routledge.
- Aylott, M. (2011). Blurring the boundaries: technology and the nurse-patient relationship. *British Journal Of Nursing*, 20, 810-816.
- Bowen, S. A. (2010). The nature of good in public relations: What should be its normative ethic? In R. L. Heath (Ed.) *Handbook of Public Relations* (2nd ed.) (pp. 569-583). Thousand Oaks, CA: Sage.
- Breast Cancer Action. (n.d.). *Think Before You Pink*. Retrieved on August 2, 2014, from <http://thinkbeforeyoupink.org/>
- Cho, S., & Cameron, G. T. (2007). Power to the people—health PR people that is! *Public Relations Review*, 33, 175–183.
- Curtin, P. A., & Gaither, T. K. (2007). *International public relations: Negotiating culture, identity, and power*. Thousand Oaks, CA: Sage Publications.
- Davison, C. M., Kahwa, E., Edwards, N., Atkinson, U., Roelofs, S., Hepburn-Brown, C., Aiken, J., Dawkins, P., Rae T., & MacFarlane, D. (2013). Ethical challenges and opportunities for nurses in HIV and AIDS community-based participatory research in Jamaica. *Journal Of Empirical Research On Human Research Ethics*, 8(1), 55-67. doi:10.1525/jer.2013.8.1.55
- de Bussy, N. M. (2010). Dialogue as a basis for stakeholder engagement: Defining and measuring the core competencies. In R. L. Heath (Ed.) *Handbook of Public Relations* (2nd ed.) (pp. 127-144). Thousand Oaks, CA: Sage.
- Dutta, M. J. (2010). The critical cultural turn in health communication: Reflexivity, solidarity, and praxis. *Health Communication*, 25, 534–539.
- El-Astal, M. A. S. (2005). Culture influence on educational public relations officers' ethical judgments: A cross-national study. *Public Relations Review*, 31, 362–375.

- Fitzpatrick, K. & Bronstein, C. (Eds.) (2006). *Ethics in public relations: Responsible advocacy*. Thousand Oaks, CA: Sage.
- Grunig, J. E., & Repper, F. C. (1992). Strategic management, publics, and issues. In J. E. Grunig (Ed.), *Excellence in Public Relations and Communication Management* (pp. 117-157). Hillsdale, NJ: Lawrence Erlbaum Associates.
- Guttman, N. (2003). Ethics in health communication interventions. In T. L. Thompson, A. M. Dorsey, K. I. Miller, & R. Parrott (Eds.), *Handbook of Health Communication* (pp. 651-679). Mahwah, NJ: Lawrence Erlbaum Associates.
- Guttman, N., & Salmon, C. (2004). Guilt, fear, stigma and knowledge gaps: Ethical issues in public health communication intervention. *Bioethics*, 18, 531-552.
- Heath, R. L. (2001). A rhetorical enactment rationale for public relations: The good organization communicating well. In R. L. Heath (Ed.), *Handbook of Public Relations* (pp. 31-50). Thousand Oaks, CA: Sage.
- Hickson, K. (2004). Ethical issues in practising public relations in Asia. *Journal of Communication Management*, 8, 345 – 353.
- Holtshausen, D. (2011). The need for the postmodern turn in global public relations. In N. Bardhan and C. K. Weaver (Eds.) *Public Relations in Global Cultural Contexts: Multi-Paradigmatic Perspectives* (pp. 140-166). New York: Routledge.
- Jnj.com. (n.d.). "Our Credo." Johnson & Johnson. Retrieved on August 1, 2014, from http://www.jnj.com/sites/default/files/pdf/jnj_ourcredo_english_us_8.5x11_cm_yk.pdf
- Kang, M. (2014). Understanding public engagement: Conceptualizing and measuring its influence on supportive behavioral intentions. *Journal of Public Relations Research*, 26, 399-416.
- Kim, J.-N., Park, S.-C., Yoo, S.-W., & Shen, H. (2010). Mapping health communication scholarship: Breadth, depth, and agenda of published research in *Health Communication*. *Health Communication*, 25: 487–503.
- Koen, J., Essack, Z., Slack, C., Lindegger, G., & Newman, P. A. (2013). "It looks like you just want them when things get rough": Civil society perspectives on negative trial results and stakeholder engagement in HIV prevention trials. *Developing World Bioethics*, 13(3), 138-148. doi:10.1111/j.1471-8847.2012.00338.x
- Lee, H., Fitzpatrick, J. J., & Baik, S. - Y. (2013). Why isn't evidence based practice improving health care for minorities in the United States? *Applied Nursing*

- Research*, 26, 263–268.
- Levins, I. (2000). Good healthcare PR mirrors the practice of good medicine. *Healthcare PR and Marketing News*, 9, 1–3.
- Lindlof, T. R., & Taylor, B. C. (2002). *Qualitative communication research methods* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Lumpkins, C. Y., Baeb, J., & Cameron, G. T. (2010). Generating conflict for greater good: Utilizing contingency theory to assess Black and mainstream newspapers as public relations vehicles to promote better health among African Americans. *Public Relations Review*, 36, 73-77.
- Lupton, D. (1994). Toward the development of critical health communication praxis. *Health Communication*, 6, 55-67.
- Lupton, D. (2003). *Medicine as culture* (2nd ed.). Sage Press.
- Maher, J. N. (2012). The corporate profit motive and questionable public relations practices during the lead-up to the Affordable Care Act. *Journal of Law & Health*, 25(1), 1-39.
- Marra, F. J. (1998). Crisis communication plans: Poor predictors of excellent crisis public relations. *Public Relations Review*, 24, 461-474.
- Men, L. R., & Tsai, W.-H. S. (2014). Perceptual, attitudinal, and behavioral outcomes of organization-public engagement on corporate social networking sites. *Journal of Public Relations Research*, 26, 417-535.
- Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- O’Byrne, S., & Daymon, C. (2014) Irresponsible engagement and the citizen investor. *Journal of Public Relations Research*, 26, 455-473.
- PRSA.org. (n.d.). Public Relations Society of America (PRSA) Member Code of Ethic. Public Relations Society of America. Retrieved on August 1, 2014, from <http://www.prsa.org/aboutprsa/ethics/codeenglish/>
- Park, H., & Reber, B. H. (2010). Using public relations to promote health: A framing analyses of public relations strategies among health associations. *Journal of Health Communication: International Perspectives*, 15, 39-54.
- Parrott, R. (2004). Emphasizing “communication” in health communication. *Journal of Communication*, 54, 751-787.

- Rawlins, B. L., & Bowen, S. A. (2005). Publics. In R. L. Heath (Ed.), *Encyclopedia of Public Relations* (pp. 718-721). Thousand Oaks, CA: Sage Publications.
- Rimal, R. N., & Lapinski, M. K. (2009). Why health communication is important in public health. *Bulletin of the World Health Organization*, 87, 247. Retrieved on January 23, 2015, from <http://www.who.int/bulletin/volumes/87/4/08-056713/en/>
- Rubin, H. J., & Rubin, I. S. (1995). *Qualitative interviewing: The art of hearing data*. Thousand Oaks, CA: Sage.
- Seltzer, T., Gardner, E., Bichard, S., & Callison, C. (2012). PR in the ER: Managing internal organization–public relationships in a hospital emergency department. *Public Relations Review*, 38, 128–136.
- Springston, J. K., & Champion, V. L. (2004). Public relations and cultural aesthetics: Designing health brochures. *Public Relations Review*, 30, 483-491.
- Springston, J. K., & Lariscy, R. A. W. (2005). Public relations effectiveness in public health institutions. *Journal of Health and Human Services Administration*, 28, 218–245.
- Taylor, M., & Kent, M. L. (2014). Dialogic engagement: Clarifying foundational concepts. *Journal of Public Relations Research*, 26, 384-398.
- Tindall, N. T. J., & Vardeman-Winter, J. (2011). Complications in segmenting campaign publics: Women of color explain their problems, involvement, and constraints in reading heart disease communication. *Howard Journal of Communication*, 22, 280-301.
<http://dx.doi.org/10.1080/10646175.2011.590407>
- UNAIDS-AVAC: Joint United Nations Programme on HIV/AIDS. (2011). Good participatory practice: Guidelines for biomedical HIV prevention trials. Retrieved on January 28, 2015, from http://www.avac.org/sites/default/files/resource-files/Good%20Participatory%20Practice%20guidelines_June_2011.pdf
- U.S. Centers for Disease Control and Prevention. (2011). Gateway to Health Communication & Social Marketing Practice: What is Health Communications? Retrieved on January 23, 2015, from <http://www.cdc.gov/healthcommunication/healthbasics/whatishc.html>

- Vardeman-Winter, J. (2014). Navigation and grounded communication: Grassroots strategies for public relations practitioners working with underserved communities. In R. Waters (Ed.), *Public Relations in the Nonprofit Sector: Theory and Practice* (pp. 124-140). Routledge New Directions in Public Relations and Communication Research series.
- Vardeman-Winter, J., Jiang, H., & Tindall, N. T. J. (2013). Information-seeking outcomes of representational, structural, and political intersectionality among health media consumers. *Journal of Applied Communication Research*, 41(4), 389-411.
- Wise, K. (2001). Opportunities for public relations research in public health. *Public Relations Review*, 27, 475–487.

Appendix: Profiles of Participants

Participant name	Role in organization/Title	Type of public health/health care
Kinsey	Director of communication	Government/public administration (specific health topic)
Mark	Director of public affairs	Research and education (specific health topic)
Stacy	Manager, public relations	Hospital
Veronica	Senior public relations specialist	Hospital (disease specific)
Joyce	Senior specialist, media advocacy	Government/public administration (specific health topic)
Eloise	Chief of public affairs	Government/public administration
Danny	Communication specialist, external communication	Hospital (disease specific)
Keith	Senior media relations specialist	Hospital
Chris	Director	Government/public administration (disease-specific, population-specific, insurance, retail)
Ellen	Digital marketing specialist	Network of health clinics (disease-specific, population-specific, insurance)
Alexandra	Health educator	Large county hospital system with specific outreach programs around specific risks
Tricia	Executive director	Organization providing education to low-income women and girls about health
Lorraine	Executive director	Organization working to change health policy (population-specific, insurance)
Iris	Community relations specialist	Government/public administration (population-specific)
Gracie	Senior director of communication	Non-profit advocacy group (disease-specific)
Lorna	Executive director	Coalition of organizations increasing healthcare access to women for a specific health risk
Marion	Senior health educator	Large county hospital system with specific outreach programs around specific risks
Ali	Communication consultant	Advocacy group (disease-specific, population-specific)

JENNIFER VARDEMAN-WINTER, PH.D. is an assistant professor of public relations at the University of Houston. Email: jvardeman@uh.edu