Moral reasoning as a model for health promotion

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Abstract

The paper describes a model of moral reasoning used to guide the conduct of health researchers and recommends that this model be applied in health promotion. It argues that this model is a more appropriate and sound way of thinking about the means and ends of health education, with implications for both research and practice. When faced with ethical dilemmas about the most appropriate course of action in health research, investigators and bioethicists conduct normative analyses to identify good reasons for choosing one option over another. These reasons provide the grounds for determining what one should do, and for changing past practices in light of new moral considerations. Since the research community seems to think that this is a good way to guide and change their own behavior, this model of moral reasoning appears to have relevance and potential application to the field of health education, which engages in analogous processes of seeking to inform and change the behaviors of the lay public. The article sets this approach in the context of a humanistic understanding of human motivation and presents two case examples to illustrate the process of moral reasoning. The humanistic model outlined here helps to explain why health promotion has not made much progress in developing effective behavior change programs and it offers a more promising prospect for demonstrating success by identifying a broader range of relevant outcomes. The paper concludes by recommending that greater attention be paid to the ethical dimensions of human agency in order to develop a more coherent body of knowledge to advance both research and practice in health promotion.

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Introduction

Social scientific research is a peculiarly self-reflexive form of inquiry. It not only seeks to explain the behavior of other human beings, but also to provide self-understanding. By the same token, researchers can reflect on their own behavior in the effort to gain insight into the actions of others. This paper proposes that health researchers can improve their understanding of how people make health choices by examining how they attempt to change their own behavior with respect to the conduct of research.

During the course of conducting health studies, investigators are often confronted with ethical dilemmas about what they should do, which course of action is most appropriate in the situation at hand. There are competing moral principles at stake and they are not sure which should take precedence or carry greater weight. To resolve these dilemmas, the various parties involved—researchers, Institutional Review Boards (IRBs), bioethicists, research participants, and the lay public—engage in a process that philosophers formally call “normative
analysis,” which aims to identify good reasons for choosing one option over another. The research community seeks to reach free and uncoerced agreement that the particular analysis under consideration is correct; that is, they draw conclusions about which action is right in that situation based on the cogency and coherence of the reasoning put forward. To illustrate, the research community once thought that women should be excluded from participation in health research due to a perceived greater vulnerability. Later, however, they came to see and agree that it was unfair to conduct research only on men, since the benefits of the research for women would remain uncertain and justice demands that the benefits be distributed fairly. Based on analyses of the relevant moral considerations, researchers decided to change their behavior and now systematically seek to achieve gender balance in health studies (unless there are particular circumstances that indicate why it is not necessary).

The purpose of this paper is to describe a model of moral reasoning used by researchers to guide their own conduct and to suggest that this model could be applied to good advantage in health education, by re-shaping both research and practice in health promotion. The field of health education is now devoted to discovering and developing a scientific explanation of behavior. The recent surge of interest in “evidence-based public health” has put an even greater premium on testing hypotheses to determine the most effective means of changing people’s behavior. In contrast, this paper proposes that the field needs to pay greater attention to the ethical dimensions of human agency to advance its understanding of human action. The model of moral reasoning described here offers an expanded view of the human condition that will enable researchers to develop a more comprehensive body of knowledge to advance the field. The proposed model helps to explain why health promotion has not been able to make significant progress in effecting health behavior changes and it provides a promising approach for demonstrating greater success in the field by identifying a broader range of worthwhile outcomes.

The paper starts with an outline of two frameworks for describing the human condition—here called the “scientific” and “humanistic” models—and identifies several characteristics on which they can be compared and contrasted. To demonstrate the application of humanistic research methods, the article presents a synopsis of two normative analyses from the author’s own research, the Kennedy-Krieger lead abatement study and early stopping rules for reasons of efficacy in clinical trials. The purpose of introducing these case examples is: (1) to illustrate the process that the research community uses to decide what to do and whether they need to change their behavior; and (2) to indicate, by way of analogy, a model for thinking about processes of behavior change outside of the research context in the quotidian world of human health behaviors. Reflecting on the ways that researchers make decisions regarding their conduct offers a distinct, and potentially more fruitful, way of thinking about how the field could be re-oriented.

In contrast to the standard scientific model that now dominates the field, the model of moral reasoning would reconfigure the relationship between research and practice. As proposed here, research and practice in health promotion would be redirected toward the goal of promoting autonomy and responsibility by means of enhancing people’s capacity for moral reasoning.

Two views of the human condition

Over the course of human history, two basic worldviews about the human condition—some might say competing, but perhaps they are better understood as complementary—have emerged. While this brief sketch obviously can only grossly oversimplify complex matters, these worldviews can be succinctly cast as ideal types, in Weber’s sense of the term.

In the first perspective, the scientific model views human behavior as the product of antecedent factors that cause people to act in predictable ways. Behavioral research in the scientific model is thus directed toward verifying cause-and-effect relationships. Researchers test hypotheses in experimental research designs, toward the goal of developing the capacity to interrupt the causal chain of events that results in unhealthy behaviors.

In contrast, the humanistic model sees human beings as endowed with a free will that allows them to choose between different courses of action. It is the ability to choose that provides the very foundation for ascribing moral responsibility. In this view, human action is guided by reasons, which enable people to act on felt desires—or to choose not to act—based on values and principles that they hold to be important (Frankfurt, 1971). Research in the humanistic model is thus directed toward
clarifying human values, good reasons for pursuing one course of action over another and the moral considerations that should properly guide conduct.

As Table 1 shows, these two models can be contrasted on several characteristics. While space constraints preclude a full discussion, the respective frameworks highlight different aspects of the human condition and use different rules of evidence to draw conclusions about different types of questions. Significantly, the issue of whether one model has been proven to be true, while the other patently false, has not been definitively resolved. It is an open question about whether human beings have free will, but the dismal lack of progress in the social sciences and the lived experience of feeling like one can choose suggest that human agency and moral responsibility remain viable possibilities (Kane, 2002). In general, the respective models serve as a set of background assumptions that researchers in different fields largely take for granted in conducting research.

One advantage of the scientific model, which may explain why it has become so popular in the social sciences, is that it provides more clear-cut rules for deciding whether the evidence yielded by an investigation enables one to draw certain conclusions. There can be little question that the scientific model provides a greater degree of certainty in answering certain types of questions. But it is important to acknowledge that the scientific model provides a greater degree of certainty in answering certain types of questions. But it is important to acknowledge that the questions that it can answer—questions about the direction and magnitude of cause-and-effect relationships—do not exhaust the sphere of human concerns: for example, is certain research (e.g., a natural history of syphilis in black men) socially valuable, or is it wrong? Hypothesis-testing research is incapable of answering such normative questions.

It is an unfortunate fact of our epistemological predicament that the model that seeks to address the ethical dimension of human agency simply does not provide the same degree of certainty provided by the hypothesis-testing, scientific method (Taylor, 1985). In conducting normative analyses, bio-ethicists are the first to admit that one of the most vexing problems in ethics centers on the nature and limits of justification (Daniels, 1996). One crucial issue in seeking valid answers to ethical questions is the epistemological foundation for justifying moral judgments: When is a reason a good reason for a moral judgment? What reasons count, and how much weight should they be given? In answer to these questions, bio-ethicists posit that the standards for certifying the validity of ethical claims are ultimately based on reaching reasoned agreement. There is a subtle point to emphasize here: positions are justified not by the fact that people agree with it, but because they find good reason to concur with the analysis.

Many health researchers might consider the methods of humanistic inquiry foreign and irrelevant, but such analyses invariably comprise the starting point for any research that involves human subjects, especially health research, since it frequently poses risks to the participants. Because there are significant social values at stake—the potential benefits of the research versus the potential harms to participants—researchers must rely on rigorous, sound analyses about the ethically most appropriate way to proceed. Researchers decide what to do based on their recognition and acknowledgment that there are good reasons for choosing one course of action over another. Two case examples are presented to illustrate this process; readers are referred to the original studies for complete discussions.

**Kennedy-Krieger Institute Lead Abatement Trial**

The first research project concerns the controversial Kennedy-Krieger Institute (KKI) Lead Abate-

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ment Trial (Buchanan & Miller, 2006; Buchanan & Miller, Chapter 18; 2006). The purpose of the KKI research was to determine whether less expensive lead abatement procedures could prevent lead poisoning in children living in high-risk environments. In 2000–2001, CDC data showed that 2.2% of all children 1–5 years old in the US, and 9.6% of African-American children, had blood lead levels above the recommended 10 μg (Centers for Disease Control, 2003). According to the Alliance to End Childhood Lead Poisoning, an estimated 5 million preschool children in the US still live in houses with significant lead hazards. When the KKI study was being conceived, 95% of low-income housing in identified neighborhoods in Baltimore was contaminated by lead-based paint. Studies at the time showed that 40–50% of the predominantly African-American children living in these high-risk neighborhoods had elevated blood lead levels over 20 μg, deemed “moderate” blood lead elevation by CDC standards. But because of the high costs of standard lead abatement (~$20,000 per house), little was being done about the problem (Barltrop, 1974; Needleman, 1998).

To address these conditions, researchers at the KKI, a pediatric research facility affiliated with Johns Hopkins University, developed low-cost lead abatement procedures that effectively reduced ambient lead paint dust levels by 80% or more. The researchers then wanted to test whether these low-cost methods would effectively reduce blood lead levels in children living in houses that had been so abated.

The study included 108 houses in five comparison groups: three treatment groups that used the new lead abatement procedures, costing $1650, $3500, and $6500, respectively; and, two comparison conditions, composed of housing abated by the city of Baltimore and housing built after 1978, which were presumably lead paint-free (Environmental Protection Agency, 1997; Farfel & Chisolm, 1991). By design, the researchers chose not to include a control comparison of existing housing that had received no abatement procedures, because they thought that it would be unethical to follow children being exposed to a known health hazard without remediation, despite the fact that this was the condition of the majority of children living in these neighborhoods. The study was designed to collect blood samples at baseline, 6 and 24 months; children whose blood lead level exceeded 20 μg or whose blood level increased by 5 μg or more were referred for medical and environmental attention. The results showed significant reductions in lead dust in all five study conditions. Overall, the blood lead levels of children residing in the KKI-treated homes stayed constant or went down, although there were a few cases of increases.

Shortly after the trial was completed, two families sued KKI, stating that they were not fully informed of the trial purposes and that KKI had failed to inform them in a timely manner of the results of their children’s blood tests. The case was thrown out by the lower courts, but the families appealed and in August 2001, in Grimes vs. Kennedy Krieger Institute, the Court of Appeals (Maryland’s highest court) issued a scathing 96-page ruling comparing the research to the Tuskegee syphilis study and Nazi research on prisoners (Maryland Court of Appeals, 2001). The judges called it a “callous scientific experiment that put children in harm’s way,” saying the children were being used merely as “measuring tools.”

The judges’ decision made national headlines, and in the ensuing controversy, numerous articles analyzing the case have appeared in public health, legal, medical, and bioethics journals (Glantz, 2002; Hoffmann & Rothenberg, Mastroianni & Kahn, 2002; Ross, 2002; Spriggs, 2004). Critics have questioned the value of the research, and going even further, whether a such research might undermine efforts to enforce just social policies. Moreover, they claim that the research is unfair, because it treats different population groups unequally, by providing participants with an intervention that is less effective than the best known treatment available. Finally, they contend that the research exploits the participants, by sacrificing their welfare to accomplishing the goals of the research.

In our analysis, the KKI case raises the broader question of whether research designed to test less costly interventions that might not be as effective as existing treatments can ever be ethically justified. In seeking to resolve whether such research should be allowed to proceed, we have determined that this type of research can be ethically justified only under carefully circumscribed conditions. To justify research aimed at developing less expensive yet less effective interventions, four conditions must be met: (1) a large population in need; (2) the existence of a treatment that is more effective yet substantially more expensive than a lower standard that would be cheaper but still significantly effective; (3) economic or political constraints that prohibit extensive
provision of the higher standard; and, (4) a high likelihood that the less costly intervention will be implemented on a wide scale.

In response to arguments that such research should never be allowed, we identified the following reasons for permitting research on less expensive treatments to go forward, under the conditions enumerated above. The value of this research lies in developing an intervention that can provide relief to potentially millions of children in their lifetime. Indeed, the failure to conduct such research causes the greater harm, because it limits health interventions to the status quo of those who can afford currently available options and deprives disadvantaged populations of the benefits of imminent incremental improvements in health conditions. Such research represents a fair contract with the participants, where the risks to subjects are reasonable and proportionately balanced in relation to the prospective health benefits to them and the value of the knowledge to be gained. Contrary to the misplaced charges of exploitation, all of the participants in KKI study stood to benefit from reduced exposure to lead effected by the research intervention. Thus, the KKI study offered a favorable risk-benefit ratio both in terms of potential benefits to the participating children by living in safer housing, and in terms of the knowledge to be gained about cost-effective means of lead abatement.

**Early stopping rules for reasons of efficacy**

The second case example focuses on early stopping rules for clinical trials (Buchanan & Miller, 2005; Buchanan, Dunn, Slutsman & Miller, 2004). Data and safety monitoring boards (DSMBs) are responsible for reviewing emerging data from clinical trials and recommending that trials be stopped for reasons of toxicity, efficacy, or futility (Ellenberg, Fleming, & DeMets, 2002; Food and Drug Administration, 2001). While it is obvious that trials should be stopped as soon as firm evidence emerges indicating that a new treatment is harmful, it is less clear when trials should be stopped when data indicate that a new drug appears to be beneficial. Given that valuable data will be lost, a critical question that researchers must answer is, when should clinical trials be stopped for reasons of efficacy?

The issue has received considerable attention recently because three major national breast cancer treatment trials were stopped early for reasons of efficacy within the last two years (Baum et al., 2002; Coombes et al., 2004; Goss et al., 2003). The decision to stop these trials has provoked heated controversies. While many researchers have decried the loss of data, more surprisingly, the decisions were also criticized by the National Breast Cancer Coalition, the nation’s largest breast cancer patient advocacy group, and the New York Times editorial board, who declared the decision to stop one trial an exercise in “ethical overkill” (Bryant & Wolmark, 2003; Cannistra, 2004; New York Times Editors, 2003; Twombly, 2003).

Currently, decisions about when to start and stop trials are founded on the concepts of equipoise and the therapeutic obligation. The therapeutic obligation derives from the Hippocratic Oath. In swearing allegiance to this Oath, physicians make a commitment to do everything in their power to benefit the patient. Once physicians assume this obligation, however, it creates a potential ethical dilemma in conducting research, as research participants will inevitably be exposed to a treatment found to be inferior to the other trial arm.

To resolve this dilemma, Fried (1974) developed the concept of “equipoise”. Based on the concept of equipoise, it is ethical start trials only when clinicians are in genuine doubt about the benefits of a new treatment. The reason that a clinician must be in a state of equipoise is that, if a physician knew that one therapy was worse than another, then it would be unethical for the physician to randomize patients to the inferior condition, because it would violate their therapeutic obligation to provide the best treatment possible patients. Following this line of thinking, in landmark papers, Marquis (1983) claimed that, due to the therapeutic obligation, it is “ethically mandatory” to stop a trial as soon as it is “more probable” that one treatment regimen is better than another. Likewise, Freedman (1987) re-affirmed that trials should be stopped as soon as one discovers that one treatment is superior: “Should the investigator discover that one treatment is of superior therapeutic merit, he or she is ethically obliged to offer that treatment. This may occur well short of the original schedule for the termination of the trial.”

In practice, the decision about when there is sufficient evidence to conclude that one treatment is superior is based on rejecting the null hypothesis (Freedman, Glass, & Weijer, 1996). As Fig. 1 illustrates, there are various early stopping rules,
such as the O’Brien-Fleming boundary, that define when this point has been reached (Jennison & Turnbull, 2000). It is important to note that these rules are all based on strict extrapolations of the $p < 0.05$ cut-off point for rejecting the null hypothesis, merely adjusted for taking serial peaks at the data. If the DSMB plans to look at the data every 6 months, then they need to adjust the $p$ value to take into account the repeated looks, such that the final $p$ value works out to the standard $p < 0.05$ convention for ruling out Type 1 errors. As soon as the data indicate that the magnitude of difference between the arms has crossed the designated boundary, the DSMB recommends the trial be stopped. In accordance with such rules, the letrozole trial, for example, was stopped after 2.4 years, instead of the original 5 years for which the trial was planned (Goss et al, 2003).

There are many problems, however, associated with the loss of data that results from stopping early. Physicians and patients are left floundering with respect to the proper dose and length of treatment for the new drug. Other trials may be stopped, as the standard of care gets recalibrated, thus setting in motion a domino effect of toppling trials and losing even more information. Early stopping may lead to the need to conduct further trials to resolve unanswered questions, exposing even more subjects to research risks in the long run. Most importantly, stopping trials early may result in a therapy coming into practice that ultimately has an unfavorable risk-benefit ratio. As the results of the hormone replacement therapy and cox-2 inhibitor trials demonstrate, a new therapy may demonstrate immediate relief for hot flashes or pain, but cause higher mortality rates with long-term administration (Rossouw et al., 2002; Horton, 2004).

In examining the basis for setting early stopping rules, we have proposed that the rules should be changed. In our analysis, the key question is when should continuing a trial in the face of emerging evidence of benefit for the intervention group be considered morally equivalent to harming or exploiting participants in the control group due to the withholding of superior treatment? Based on the principle of non-exploitation (Wertheimer, 1996), we posit that the stringency of the stopping guideline should be proportional to the gravity of the harm incurred by withholding an efficacious treatment. In this framework, we delineate different types of primary outcomes, whether mortality, major morbidity, or minor symptom, and adjust the early stopping rules accordingly. The lesser the
harm of the primary endpoint, the greater the amount of evidence it should take to stop a trial (see Fig. 2).

The alternative framework reflects the moral significance of the difference between practicing medicine and conducting research. In a medical setting, it may be morally acceptable for a physician to use any evidence (personal experience, rules of thumb, case studies, etc.) as the basis for trying a new treatment regimen with a particular patient. Sometimes, these “experiments” turn out to be ill-advised and the patient’s condition aggravated, but the effects of individualized medical decisions have no ramifications beyond that single patient. However, in the context of randomized controlled trials, the decisions of DSMBs have implications for the whole of society. Since FDA approval and standards of practice often hang in the balance, the moral consequences of being wrong—of recommending a treatment that may turn out to increase the risk of serious morbidities or death—are more severe than individual clinical decisions. Therefore, it is appropriate to require a greater amount of evidence regarding the decision about when to stop a clinical trial than physicians in clinical practice may need to disturb equipoise. Under these more conservative rules, the decision to continue a trial is morally warranted because it is in both the participants’ and the public’s interest to establish greater certainty about the safety of the new drug, provided that this knowledge can be gained without exposing participants to undue risks.

Implications for health promotion

The purpose of presenting these case examples is to highlight the decision-making processes used by health researchers regarding their own behavior in conducting research. Against this model, however, health researchers start from the assumption that the behavior of the people that they are studying is driven by antecedent factors that cause them to act in predictable ways, and thus, their behavior can be modified by manipulating these precursor social and psychological variables. If, however, health researchers act on the belief that their own behavior is guided by moral reasoning, then it may be worthwhile to consider the implications of normative analyses as a model for understanding the decision-making processes used by the lay public in deciding what they should do with respect to their health. In the situations described, the researchers must decide what to do, and the way that they do that is to look for good reasons for proceeding in one direction versus another. I want to propose that the way that researchers decide about whether to go forward with their research or not is no different from the way that people in general decide how to conduct their lives: human beings look for good reasons for choosing one course of action over another.

Several characteristics of the action-guiding model described here are worth highlighting. First, contrary to the claims of some epistemologists, the conclusions drawn in these types of analyses are rational, defensible, and valid, even if no hypotheses have been tested. Perhaps the most striking aspect of the analyses presented above is that they immediately raise questions and invite a response. The reader seeks clarification of points before deciding whether she agrees. One wants to raise objections, hear rebuttals and strive to reach common ground that may, and often does, entail shifting one’s original position in response to points that uncover flaws in one’s initial reasoning. Anderson (1993) describes this reasoning process as follows:

Like most of the elemental notions—justice, integrity—that guide our moral life, we do not have a sharply discriminating, operational definition ready at hand. Rather, we proceed by mutually intelligible intimations, affirming this, denying that, each claim suggesting an aspect of the whole that we vaguely discern but cannot readily grasp. This is what makes reasoned argument possible. We persist in trying to persuade our antagonists that there is some crucial element of the matter at hand that their case neglects, and we proceed in the good faith that, if we show them this perceptively, if we illuminate them, they may change their minds. And for our part, we presume that we may learn from the deliberation, which is to say, we keep open, and positively, the prospect that the case we are now earnestly making we will come to recognize as inadequate, because we will see a more significant, a larger truth in the matter.

Second, it appears that the researchers’ decisions are based on free choice. While the possibility of free will remains an open question, it certainly seems like nothing causes or determines the outcome in advance; researchers must choose whether to continue the trial, or not. The grounds for justification
and the validity of decisions are based on judgments about the strength of the arguments; researchers choose based on what they consider the more coherent case for one position over another. Third, as consumers of these analyses, researchers would consider it inappropriate if someone tried to manipulate their decision to adopt one pre-determined position over another; it is critically important to the ethical integrity of the researchers that they provide their free assent based on what they have determined is the right course of action.

Adopting an expanded view of the human condition that included the ethical dimensions of human agency would have major implications for both research and practice in health promotion. For researchers, it would mean opening important new vistas concerning both the means and ends of health promotion. In embracing a humanistic orientation, an important part of researchers’ work could focus on conducting normative analyses to identify more compelling reasons why people should take up behaviors that promote physical fitness. It would also require researchers to think more deeply about the goals that the field seeks to achieve. For example, it would be important to address the question of the degree to which developing the technologies of behavior control is more important and should override the goal of promoting human autonomy and responsibility in seeking to realize human well-being (Buchanan, 2000).

Reflection on the ends of health promotion would open new avenues for empirical investigation. Rather than uncritically accepting pre-determined goals (largely set by bureaucratic imperatives for cost-efficiency), researchers might consider the extent to which human beings achieve a sense of well-being through living lives of personal integrity and pursuing life projects that connect them to transcendent values that bring meaning to their lives. For example, many studies have shown that physical health does not bring happiness, while conversely, finding a sense of purpose leads to better physical health (Diener, 2000; Ostir, Markides, Black, & Goodwin, 2000; Ostir, Markides, Peek, & Goodwin, 2001; Segerstrom, Taylor, Kemeny, & Fahey, 1998). Likewise, it appears that those people in our society who can now exercise the greatest degree of individual autonomy also enjoy the best health. If these findings hold up, then it would seem that promoting autonomy, rather than attempting to control and restrict choice, offers the more promising prospect of promoting physical health.

If health behavior research was re-directed toward identifying good reasons for choosing one course of action over another, it would open the field to the possibility that a broader range of outcomes for evaluating health promotion programs might be relevant and important. By ignoring the possibility of free choice, the field has set itself up for failure. Currently, researchers have declared that the success of health promotion efforts can best be measured—and to many researchers, only be measured—by the degree to which programs change people’s behavior. Based on a research agenda restricted to identifying the causes of human behavior, the field has promised to deliver programs that are as effective in making people lose weight as physicians are in reducing blood pressure with prescription medications. Yet, it is difficult to make a convincing case that the field is making even remotely comparable progress in controlling people’s behavior. The reason that the field of health promotion has not been able to make greater progress is largely because it has overlooked the ethical dimensions of human agency. One major concern is that, in light of the field’s evident lack of progress to date in developing effective behavior change programs, policymakers and funding agencies may conclude that health behavior research does not hold the same scientific promise as other avenues, and therefore, should be afforded lower priority in funding allocation decisions.

In contrast, the humanistic model provides a more realistic possibility for demonstrating the success of health education programs. Rather than narrowly focusing on behavior change, the field could consider the possibility of helping people to develop their own capacity for exercising autonomy and responsibility (Bellah, 1983). At an individual level, humanistic criteria of evaluating health promotion programs might focus on evidence of informed decision-making; for example, (1) awareness of alternative courses of action; (2) the ability to enumerate the advantages and disadvantages of the major alternatives; (3) greater self-understanding of one’s reasons for choosing one course of action over another; (4) greater satisfaction with one’s decision; and, (5) greater reassurance that one’s decision better advances one’s own life projects. At the community level, humanistic criteria could include: (1) the degree to which the community provides input and exercises control over research and community programs; (2) the degree to which community members feel their
advice is respected; (3) the degree to which participants feel their concerns have been addressed; and finally, (4) the degree to which community members trust the researchers (Emanuel, Wendler, Killen, & Grady, 2004).

In terms of practice, a humanistic orientation would require health educators to be open to the idea that, however they might think people should behave, they could be persuaded that community members have good reason for pursuing other courses of action and making choices that are valuable to them. For example, health promoters could be convinced that people are right in stating that they have more important things to do, like taking care of their children, developing their skills, or helping out in the community, than spending 90 min a day exercising at the gym, or that they would rather focus their attention on more worthwhile projects than losing 10 pounds. Similarly, while public health has declared smoking as the number one public health problem, health promoters could better appreciate why certain communities might see drugs and violence as having higher priority. The field of health promotion could even be persuaded that it might be equally if not more important to recommend that community members devote 30 min a day to promote social justice, as a valued effort necessary to achieve the goal of reducing health disparities.

Emanuel and Emanuel (1992) provide an apt description of a humanistic orientation to health promotion, contrasting their “deliberative” model with the more traditional paternalistic process of seeking patient compliance:

The aim of physician–patient interaction is to help the patient determine and choose the best health-related values that can be realized in the clinical situation. To this end, the physician must delineate information on the patient’s clinical situation and then help elucidate the types of values embodied in the available options. The physician’s objectives include suggesting why certain health-related values are more worthy and should be aspired to. The physician aims at no more than moral suasion; ultimately coercion is avoided and the patient must define his or her life and select the ordering of values to be espoused.

As these authors make clear, adopting a model of moral reasoning would in no way mean that health promoters would simply nod their heads in passive acquiescence to any nonsense that anyone put forward about why they plan to go living a self-destructive lifestyle. It is dialogical. It aims at reaching reasoned agreement about the good life for human beings (Bellah, 1983).

Discussion

Two possible objections to the proposed model might be that it is too rationalistic or too individualistic. Health education has found its raison d’être in the fact that people frequently appear to act irrationally, take up self-destructive activities (such as smoking), and fail to change their behavior when informed of the dangers. Since giving people information is apparently insufficient to effect change, so the thinking goes, then the field must conduct research to uncover the “true,” deeper, and presumed hidden and pathological causes of behavior. Based on the expert knowledge produced by such research, skilled professionals are supposed to design and implement programs that are effective in getting people to adopt predetermined health behaviors, irrespective of whether such programs help people to gain insight into their own motivations.

In contrast to promoting physical fitness, the humanistic model described here seeks to achieve the goal of helping people to gain greater self-understanding and greater self-control—precisely, in that sense, of becoming more rational—even if it means that people decide they have more important things to do besides going to the gym 3–4 times per week. In the moral reasoning model outlined here, the purpose of both research and practice is to gain clarity about the reasons why people might consider the (“unhealthy”) choices that they have made as acceptable and consistent with the kind of person that they want to be and life projects that they want to pursue at this point in their life. To the extent that health promoters are convinced that good physical health is important, then their practice would become directed toward articulating more compelling reasons for adopting certain health behaviors. Such programs, however, would be built around the notion of an argument. In this model, health promoters would (continue to) offer people various considerations about why they might want to change their behavior, reasons that most health promoters remain genuinely convinced are important (e.g., disease and disability restrict the range of opportunities open to individuals, and therefore,
maintaining healthy functioning is helpful in pursuing valuable life projects), yet the measure of success would not necessarily be restricted to behavior change, but rather might include the degree to which people understand the implications of their decision and can explain why such a decision is right for them at this point in their lives. As Habermas (1984) reminds us, the goal of the enlightenment project is to realize the ideal of human rationality, not to develop ever more powerful technologies to force people to adopt regimens of physical fitness.

Second, a model of health promotion based on moral reasoning might appear to be too individualistic, directed at the decision-making processes of the individual, in contrast to the social determinants of health. This claim is a red herring. There is nothing inconsistent between the model outlined here and the goal of making changes in the social and physical environments to make them more conducive to healthy behaviors. On the contrary, the only way to gain support for public policies that would change environmental conditions is to convince people that proposed policies are more valuable than the current direction in which society is headed. For example, it appears that a broadly libertarian conception of justice now prevails in the US. To achieve the goal of reducing health disparities, the field of public health must do a better job of convincing people that a more egalitarian conception of justice is the kind of society that all citizens would find more consistent with the values they wish to uphold. Making the case for revising public convictions about the justice of extant social conditions can only be accomplished by improving people’s capacity for moral reasoning (while the field would need to remain open to the possibility that other theories of justice might prevail).

Finally, the moral reasoning model is more consistent with the goals of public health. One of the two overarching goals identified in Healthy People 2010 is to improve the quality of life. Brock (1993) defined quality of life as: “What is central to quality of life is the capacity to exercise choice in forming and pursuing an integrated and coherent life plan.” Thus, if the field is truly interested in improving quality of life, then its primary mission must be to improve people’s capacity for exercising autonomy and responsibility (Buchanan, 2000).

In his famous Two Cultures essay written more than 40 years ago, C. P. Snow (1964) lamented: I believe the intellectual life of the whole of western society is increasingly being split into two polar groups … Between the two, a gulf of mutual incomprehension—sometimes (particularly among the young) hostility and dislike, but most of all, a lack of understanding … It is all destructive. Much of it rests on misinterpretations, which are dangerous. The degree of incomprehension on both sides is a kind of joke which has gone sour … For the moment, I want to concentrate on the intellectual loss … When those two senses have grown apart, then no society is going to be able to think with wisdom.

Reflecting Snow’s concerns, the field of health promotion currently seems obsessed with establishing its scientific credentials, to the neglect of the ethical dimensions of human agency. This position is perilously shortsighted. To develop a more coherent body of knowledge, the field of health promotion must broaden its intellectual horizons, embrace a humanistic understanding of human motivation, and reject the destructive misinterpretations and intellectual loss that comes from too narrow a view of what constitutes valuable research and practice.

References


