A New Ethic for Health Promotion: Reflections on a Philosophy of Health Education for the 21st Century

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This article describes two models for thinking about the purposes of health education—a medical model and an education model—and traces how concerns about the validity of research have driven preference for the medical model. In the medical model, the purpose of health education is to develop effective interventions that will prevent people from adopting unhealthy behaviors. Here, health educators are expected to replicate the methods identified by researchers to effect targeted changes in health behavior. The article then describes an alternative way of thinking about the purposes of health education. In pursuing a philosophy of education, the purpose of research and practice would be to clarify basic social values and to strengthen one’s faculty for making value judgments. Practitioners here use research results as a stimulus for dialogue about the role of good health habits in living the kind of life that community members find most valuable.

Keywords: ethics; health education; health promotion; philosophy; research

What is the purpose of health education? What are we trying to accomplish? The power and the promise of the new millennium beckoned us with new possibilities. Subsequent events have only heightened the need for reexamining our goals and asking ourselves anew about the good that we seek to achieve. This article offers reflections on the ends that we now seek and the ends that we should seek, with the aim of continuing a healthy debate.

To get into these questions, I want to explore a potential tension inherent in the juxtaposition of the terms health and education. I want to describe two different models for thinking about what we are doing, a medical model and an education model, at once familiar yet with interesting contrasting characteristics. I want to suggest that the dominant metaphor for thinking about what we are doing in health education is now a kind of medical model, in the sense that the overarching goal of health education seems to be to develop more effective interventions, just like effective medical treatments. The vast bulk
of health education research is directed toward developing more powerful programs that will successfully prevent people from adopting behaviors that are harmful to their health: smoking, obesity, lack of exercise, unsafe sexual behaviors, violence, illicit drug use, teen pregnancy, alcohol abuse, low screening rates, drinking and driving, sunburn, low fruit and vegetable consumption, and so on. Just as physicians can prescribe medications that effectively control patients’ blood pressure, so too health educators want to run programs that will effectively control people’s weight.

The prod for taking up this topic stems from my uneasiness with the direction that we are now headed. My worry is this. Because there is now such tremendous institutional inertia and intellectual and financial investment in the current program of behavioral and social scientific research, I think that we have largely lost sight of the fact that telling people how we think they ought to live is a moral and political process, not a scientific problem to be solved. We need a new ethic (Buchanan, 2000). As an alternative, I want to describe a philosophy of education that might be more well suited for engaging the public in examining the way we live and how we, individually and collectively, might choose to change it. Instead of the medical model, I propose the model of higher education as a more ideal philosophy for thinking about the purposes of health education.

To set the stage for the discussion that follows, I want to start by describing briefly several strands of thought that lay out several major differences for thinking about what we are doing, as hinted by my shorthand use of the labels medical model and philosophy of education. My thinking on these issues is deeply indebted to the work of Jurgen Habermas, Charles Taylor, and the emerging field of public health ethics. The principal theme running through these works is that there are fundamental differences between scientific reasoning and ethical reasoning, which in turn have major implications for thinking about the goals and methods of health education.

### SCIENTIFIC VERSUS ETHICAL ANALYSIS

In his early work, *Knowledge and Human Interests*, the German philosopher, Jurgen Habermas, recalls Aristotle’s distinction between different types of human experiences—*theoria* and *praxis*—and the different types of knowledge corresponding to each (Aristotle, trans. 1962; Habermas, 1971; McCarthy, 1982). According to Aristotle, *theoria* refers to the experience or observation of order in the unchanging realities of the natural world, events that appear constant, universal, and eternal. The knowledge that grows out of these experiences corresponds to what we now call the natural sciences. In contrast, *praxis* refers to the experience of initiating action in the flux of ever-changing, nonrecurrent social situations. In Aristotle’s analysis, the experience of *praxis* requires an entirely different kind of knowledge because human action, at its most fundamental level, is distinguished by choice, in circumstances that require sensitivity, perceptiveness, and attentiveness to the unique morally salient features of the situation at hand. It is the kind of knowledge that we need when we must decide what we should do right here and now. As Aristotle (trans. 1962) put it, “The decision lies in the perception.... For where it is in our power to act, it is also in our power not to act, and where we can say ‘no,’ we can also say ‘yes’” (p. 65). It is this capacity for making choices that provides human beings with the unique capability for moral reasoning—for choosing on the basis of what we think is right, what we think we ought to do, and hence, our peculiar notions of moral responsibil-
ity. Because human beings can choose, Aristotle thought that human behavior could never be captured in the kinds of general laws that are found to govern cause-and-effect relationships in the natural world, the proper realm of *theoria*. In contrast, the kind of knowledge that emerges from the experience of *praxis* corresponds to what we would now call moral judgment, or wisdom.

Building on Aristotle’s original distinctions, in his *Theory of Communicative Action*, Habermas (1981/1987) traces how these different kinds of knowledge come down to us today in terms of what he calls communicative (moral-practical) versus instrumental (scientific-technical) reasoning (Habermas, 1990, 1991/1993; Passerin d’Entreves & Benthalib, 1997; White, 1995). Communicative rationality is consent oriented, that is, it is oriented toward gaining mutual understanding and agreement about the validity (moral rightness) of norms of behavior. In his analysis, communicative rationality is characteristic of the world of everyday human existence, a sphere he refers to as (following Husserl and Schutz) “lifeworld,” which is described as that implicit “taken-for-granted” background of shared understandings, values, and routine ways of life in which one’s social identity develops. In contrast, instrumental rationality is goal oriented or success oriented. The logic of this type of reasoning is organized around determining the most effective means to achieve set goals, goals that are themselves determined by the structure of impersonal economic and administrative systems geared to profit maximization and bureaucratic efficiency. On the basis of these distinctions, Habermas is deeply troubled by what he sees as the inappropriate imposition of instrumental thinking on the sphere of lifeworld affairs.

The process of “rationalization” is the extension of instrumental reasoning to ever more arenas of social life. In Habermas’s analysis, the distinct logic of instrumental rationality is gradually displacing communicatively oriented modes of socialization and social integration. Instrumental patterns of communication are strategic and manifest in the attempt to get others to conform to goals given by the economic system or administrative state; instrumental communication stands in contrast to communicative rationality, which is expressed in a mutually open, reciprocal, two-way process of seeking consensus on appropriate norms of living in society. In response to pressures generated by economic and bureaucratic systems, consent-oriented patterns of communication and interaction are being progressively squeezed out and replaced by the instrumental modes of reasoning. As this process of rationalization is extended into new domains, consensus becomes secondary to efficiency. Ultimately, Habermas traces the origins of various social pathologies in modern society to these systematically distorted patterns of communication, a process Habermas dramatically refers to as the “colonization of the lifeworld.” According to Habermas, social ailments such as anomie, hedonism, drug use, cynicism, apathy, violence, the withdrawal from responsible citizenship into a private world of pleasure seeking and the maximization of self-interests, and so on result from the erosion of social consensus about the norms and conditions of a just society. Our unique human capacity for autonomous moral reasoning is being increasingly threatened and impoverished by the increasingly predominant recourse to instrumental rationality, which is steadily encroaching on the way we think about issues that are more appropriately resolved through the consent-oriented moral reasoning processes of the lifeworld domain.

Based on a related yet independent line of analysis, the Canadian philosopher, Charles Taylor (1992), sees the growing recourse to “instrumental reason” as a “massively important phenomenon” underlying the perplexing sense of loss, malaise, and disintegration
widely felt in modern culture (Weber, 1921/1978). Succinctly stated, instrumental reason is the intellectual tendency to give precedence to thinking about means, rather than ends. Coined by the great German sociologist, Max Weber, the term instrumental reason refers to a pattern of thinking dedicated to the methodical expansion of human control and domination “by means of an increasingly precise calculation of adequate means.” Weber used the term to characterize the modern preoccupation with determining the most effective means to a given end, to the neglect of the evaluation of the ends themselves. As the sociologist Philip Selznick (1992) stated, “Reason is instrumental when it abdicates responsibility for determining ends and restricts itself to ways and means” (p. 56).

In contrast to instrumental reasoning, Weber described another type of reasoning process that he called “value rationality” or “practical reason.” Building on Weber’s work, Taylor (1995) saw a compelling need for reviving the exercise of “practical reason” to counterbalance the growing prominence and hegemony of instrumental reason. Practical reason addresses questions about the good for human beings. It is reflection on the goals, values, and purposes of human action. It is the thinking process involved in evaluating the quality of the ideals that we seek to realize in this life. Practical reason is the exercise of one’s critical faculty of judgment in making qualitative distinctions of worth among different goals and choosing one course of action over another in light of the highest good people hope to realize.

Finally, there is a standard distinction in philosophy between empirical and normative analyses. Empirical analysis is directed toward informing beliefs, whereas normative analysis aims at guiding action. As the distinguished bioethicist and author of the Belmont Report, Tom Beauchamp (1980), stated,

If science is inquiry into general causal laws and explanation, ethics is inquiry into non-causal justification and general action-guiding reasons. . . . The foundations of normative ethics will be prescriptive (or at least non-descriptive), for ethics is an action-guiding discipline that provides reasons for human action and that attempts justifications of moral claims (which are ultimate justifications at the level of the foundations of morals). Science, by contrast, deals with the causes of events and with causal explanations of phenomena. The statements in the two domains thus display an unbridgeable logical difference: one is based ultimately on non-descriptive sentences, and the other on descriptive sentences. It is, therefore, logically impossible that the foundations of ethics find their roots (premises) in the foundations of science. Those familiar with modern ethical theory will recognize that this argument is merely a corollary of one use of the fact/value distinction. (p. 263, 268)

It is the difference between “knowing” and “valuing.”

Filling out the discussion, the philosopher Anthony Kenny (1992) wrote,

Practical reasoning is reasoning which reasons out the good, as theoretical [scientific] reasoning is reasoning which reasons out the truth. The conclusion of a piece of theoretical reasoning is a truth to be believed; the conclusion of a piece of practical reasoning is a good to be brought about. By setting out my theoretical reasoning I may explain why I believe a certain proposition; by setting out my practical reasoning I may explain why I am performing a certain action. The point of practical reasoning is the achievement of good, just as the point of theoretical reasoning is the acquisition of truth. (pp. 1-2)

With that as background, let us now take a closer look at two models for thinking about the purposes of health education.
THE MEDICAL MODEL

The metaphor of the medical model is quite familiar to those of us in health education, commonly encountered, for example, in the notion of making an “educational diagnosis” using the popular PRECEDE model (Green & Kreuter, 1991). Although there can be little question that this framework has made an important contribution to the field, especially in its systematic approach to conducting a needs assessment, it is worth remembering that this is not the only way that we have thought about our work. One of the founders of the field, Godfrey Hochbaum (1976), noted a historical shift in the field dating to a time around 1950. Following in the wake of huge increases in funding for social scientific research after World War II, he observed that the field began to move away from its earlier goal of providing factual information toward “the need to influence these [social-psychological] factors if behavior is to be effectively modified.” By 1960, another giant in the field, Mayhew Derryberry, made perhaps the earliest reference to the metaphor of the medical model: “The processes [of health education] are almost completely analogous to those used by physicians in the practice of medicine,” and “the steps that the two groups go through in applying their respective sciences are almost identical” (p. 6). Following this train of thinking, Lawrence Green, the developer of the PRECEDE model, thus could write in 1978: “Health education is found to be highly interwoven with the complementary and overlapping technologies of motivational and behavioral control such as mass communication and behavior modification” (p. 49). These days, with major funding from the National Institutes of Health, a research agenda that emulates the medical model is rarely questioned.

The reason that health education bought into the medical model (in the sense outlined here) has everything to do with the awesome success of modern medical science, in particular, and the natural sciences, in general. Because of their undeniable success, many, if not most, researchers argue today that the best—or even more strongly, the only—way to gain valid knowledge about human behavior is to use the exact same research methods that researchers in the natural and medical sciences use, namely, an experimental, hypothesis-testing model. Researchers have opted for the scientific, hypothesis-testing model, by and large, because it provides clear and powerful criteria for determining the validity of claims about how the world works. But these very same criteria for assessing the validity of truth claims have a built-in bias: The power to effect change is inherent in the use of hypothesis-testing methods. One significant and inextricable by-product of the use of the criteria of prediction and control is that the confirmation of hypotheses can be demonstrated only by wielding instrumental power over the events being investigated: the dependent variable changes, as predicted, as a result of the experimentally induced changes in the hypothesized independent variable(s). Based on this singular understanding of how one establishes the truth of propositions (what positivists call the verification principle), the scientific method has proven remarkably successful in extending man’s power to control the course of events occurring in the natural world. Caught up in the larger cultural awe and wonder with scientific success, the historical shift in orientation in the field of health education was set in motion by this particular understanding of what makes research valid, which over time has resulted in a reformulation of the goals and methods of the field. As the experimental, hypothesis-testing model of behavioral research has become dominant, the practice of health education has consequently come to be identified with developing effective interventions, as I will now try to explain.

The medical model is based on the assumption that it is only by conducting experiments that one can verify claims about the nature and direction of relationships among
observed events. Or rather, somewhat more tediously but more accurately, the medical model has developed a codified set of standards regarding levels of evidence that has established that prospective tests of hypotheses in experimental research designs provide the highest level of certainty about the truth of a given claim (Elwood, 1988; Ferreira et al., 2002). Thus, while there are many other types of social scientific research, such as descriptive or correlational studies, the quality of evidence in these types of research is considered inferior and less trustworthy, and hence, these types of studies are generally regarded preliminary steps along the way to the most robust test of science, experimental research designs. Researchers conduct experiments to test hypotheses about the nature and magnitude of suspected cause-and-effect relationships between identified independent and dependent variables. In the health field, these experiments are called randomized controlled trials (RCTs). Although there are many other types of nonexperimental health studies, RCTs are the gold standard toward which all other lines of research are directed. As anyone who has ever submitted a grant application to the National Institutes of Health knows, RCTs are the research design that all other lines of research are ideally expected to attain in order to meet the highest standards of credibility, proof, and validity. RCTs enable researchers to determine whether a change in an independent variable will or will not effect a change, as predicted, in the dependent variable of interest.

To cite one example that illustrates this hierarchy of knowledge, epidemiologists had observed an inverse correlation between levels of beta-carotene and the severity of lung cancer. On the basis of these observations, epidemiologists thought that beta-carotene reduced lung cancer risk. However, to meet the standards of evidence prescribed by the medical/scientific model, these observations were recast as a hypothesis—if serum beta-carotene levels are increased, then we predict that lung cancer mortality rates will decrease—which was then tested in an experimental research design. As we know, the results of the RCT, in fact, proved the hypothesis to be false; contrary to their prediction, the researchers found that if beta-carotene levels are increased, then lung cancer mortality rates increase too (Omenn et al., 1996). As this example demonstrates, many researchers today thus believe that it is only by conducting experiments that one can draw valid conclusions about the true relationships among various phenomena of interest. Whether it is in testing new drugs to treat AIDS or cancer, or new behavioral interventions to prevent overeating or promote exercise, it is the ability to effect change as predicted in testing hypotheses that is considered the most critical test for establishing valid knowledge in the medical/scientific model. By testing hypotheses, social scientists assume that they can identify the causes of people’s behaviors (e.g., interest these days focuses on what causes people to eat too much). Drawing on the well-known canon of health behavior theories, theories such as social learning theory, the health belief model, the theory of reasoned action, and so forth, behavioral scientists formulate hypotheses about the relationship between various independent variables (e.g., self-efficacy, perceived susceptibility, attitudes, etc.) and the dependent variable of interest (e.g., overeating), which they then test by conducting experiments.

When the criteria that are used to assess the validity of claims are set by an experimental, hypothesis-testing paradigm, then the goals and methods of the practice of health education follow directly. After researchers have tested and verified the relationships among the different variables in their theory, practitioners are expected to use the exact same methods to achieve the exact same results as researchers. Just as lab scientists know precisely how to control electromagnetic currents, or split atoms to make nuclear energy, or mix up a batch of pure unadulterated aspirin, or medical doctors know how to cure bacterial infections, health educators are supposed to design programs to effect changes in a set
of specified independent variables, which will then cause changes in the dependent variable, health behavior. So, in response to the current epidemic of obesity, health educators are supposed to increase the target population’s sense of susceptibility to the ill effects of being overweight, their perception of the severity of diabetes, and so on. This point needs to be emphasized: In the medical model, intervening to change theoretically specified independent variables to bring about targeted changes in the dependent variable is the ideal and expected relationship between research and practice, a link technically referred to as “fidelity in implementation.”

To sum up, in the medical model, the goals are identified by a bureaucratic system set up to maximize the most efficient use of resources by ranking the leading causes of morbidity and mortality (heart disease, cancer) and their causes (smoking, obesity), and then, the methods to achieve these goals are determined by discovering through scientific research the most effective way to interrupt the causal chain of events that causes people to eat too much or to start smoking. Health education practitioners are expected to replicate the methods identified by researchers to be the most effective in achieving the goals set by the administrative apparatus of the state. An “effective” program is one that consistently results in people behaving in accordance with these given goals.

There are significant questions about whether this model works on its own terms (i.e., I think it is an open question about whether we are making any progress in identifying more effective weight control programs or smoking prevention programs), but setting aside the epistemological question about why this model has not been more successful in identifying the causes of human behavior, the question that I want to pursue here is the ethical one: Are there other ways of thinking about the goals and methods (the means and ends) of health education that we might find more commendable than physical fitness and behavior modification? I am going to come back to some of the limitations of the medical model in the concluding section and some of the worthwhile parts that might be salvaged in light of a different interpretation. But if this is a fair representation of how the field presently operates, then we can turn now to consider another way of thinking about our purposes, one that should be very familiar to readers of this journal, the model of higher education.

**THE EDUCATION MODEL**

There are, of course, many different ideas about the purposes of education, so let me start by saying that the model that I have in mind is neither simple information transmission nor vocational skills training (such as auto mechanic school). It is, instead, the model of a broad liberal arts education, where the goal is to develop a cultivated “well-educated” mind. Five common purposes of a liberal education cited in the literature are (a) to enhance one’s faculty of critical judgment; (b) to gain deeper self-understanding; (c) to liberate, or free people from narrow, distorted, or prejudiced views of the world; (d) to refine moral sensibilities, by challenging and strengthening one’s convictions and sense of obligation to advance justice in this world; and (e) to build respect for the diversity of understandings of the good life for human beings and a commitment to reaching reasoned agreement about how we can best share a more decent and humane world (Anderson, 1993; de Nicolas, 1989; Frankena, 1965; Oakeshott, 1989). These purposes, I think, provide a better analogy for thinking about aims of health education. It is exactly what we do, in our best moments, as faculty members and graduate students.
Critical Judgment

In *The Republic*, Plato argues that the purpose of education is to develop one’s capacity to distinguish the good life from the bad life and to form those habits of mind always to choose the better alternative from among all that are possible. It is a process of becoming more self-conscious about how one lives; to reflect at length about what one had previously just taken for granted; and to develop one’s ability to justify and defend which courses of action and ways of life, as individuals and as a society, one considers most worthwhile and fulfilling. It is a matter of developing one’s aptitude in determining when information must be acted on and when it is irrelevant. Education seeks to expand one’s horizons in order to enrich and improve the process of making well-reasoned choices from among a wider range of envisioned alternatives. It is sustained inquiry into the good life for human beings. It aims to hone one’s skills at discerning about what is best, a reasoning process that can never be fully captured by algorithms or computer-like rules for rank-ordering decisions.

Self-Understanding

Oakeshott (1989) defined education as “an encounter with self-understanding” (p. 3). Etymologically, *education* signifies a leading out, from darkness into light. Education is a process of comprehensive engagement in which we come to know ourselves and our place in the world more clearly. As Anderson (1993) wrote,

> To be fully human is to be acutely conscious of purpose. Only when we think through our aims and objectives—when we ask probing questions about the “good” we seek, about the *telos* of our acts—do we act as humans are capable of acting” (p. 5)

It is gaining greater insight into areas of one’s life that were formally opaque, obscured, and poorly understood. We study good literature in order to be better able to discriminate among feelings that were previously confused; as DeBotton (1997) wrote,

> The value of a novel is not limited to its depiction of emotions and people akin to those in our own life; it stretches to an ability to describe these *far better* than we would have been able, to put a finger on perceptions that we recognize as our own, but could not have formulated on our own. (p. 28)

Greater self-understanding makes it possible to live a life that one can call “one’s own.” It is finding a way to be at home in the world and face it with more or less grace. Education begins with the idea that, in Socrates’ most famous words, “The unexamined life is not worth living.”

Liberation

The ideal of a liberal education is the realization of a certain sort of freedom, the capacity to think for oneself (Giroux, 2001; Giroux & Myrsiades, 2001). Its opposite is acquiescence or acceptance of dogmatism and bigotry. The goal of education emerges out of the recognition that ignorance is a form of slavery and dependence, of being blind to new possibilities. It is opening one’s mind to see different paths and imagine what might be
otherwise. It is becoming better able to formulate one’s life plan and foresee the steps to pursue it. It is expanding one’s ability to respond to situations with new and fresh interpretations, in lieu of thoughtless knee-jerk reactions.

Justice

The value of education lies in its capacity to make us better people. We trust that educated people will be better able to recognize injustices, identify what must be done to correct them, and know how to make a more convincing case for taking action. A good education seeks to deepen one’s commitment to advancing justice, “which means, above all, unflagging concern for those who have gained least from modern prosperity, education and democracy. A concern for justice takes seriously the rightful claims of all persons to life, health, dignity, and hope,” as Selznick (2002) explained (p. 12). One purpose of education is to create more intelligent, wiser people who can figure out how to make our political and economic systems more responsive to the needs of all people.

Civility

Finally, the goal of a liberal education is to foster mutual respect and more civilized discourse about how we can best share this space on earth. It aims to promote the value of reaching reasoned agreement about the core constituent elements that define the common good of community life, the full extent of areas of cooperation, and the boundaries of private space where people are free to pursue their own vision of the good life (Havel, 1997; Shils, 1991). A well-educated person is invested in dialogue. Through a good education, we become more open to the possibility that we may be persuaded by other points of view and change our minds about what is valuable and worth realizing.

To wrap up, one critical difference between the medical model and a philosophy of education is their respective constructions of the relationship between means and ends. In the medical model, the goals are seen to be independent of the means, both in how they are determined and in how they can be achieved. In the medical model, goals are prioritized based on concerns for efficiency; smoking is the number one preventable public health problem not because people in the community are clamoring for smoking cessation programs but because statistical calculations have determined that it is the largest contributor to the leading cause of death, heart disease. Likewise, the methods for reducing smoking are seen to be unrelated to the process of goal setting. After a goal has been independently determined, the methods of achieving a given goal are considered largely interchangeable (e.g., counseling, prescription drug medications [e.g., buproprion], aversive conditioning, hypnosis, acupuncture, etc.) and to be selected virtually exclusively on the basis of which is shown to be most effective.

In contrast, the model of liberal education has always had difficulty in settling on precise operational definitions of what it means to be educated and appropriate ways to measure the outcomes of an education. We find it awkward to speak of, let alone measure, an “effective” college education. It takes a good education to appreciate the value of a good education. And the methods of education are inextricably linked to the outcomes; it is only through engaging in the process of education (encounters with the thinking of others, self-reflection, and dialogue) that one becomes educated. To conclude this discussion, the sociologist and great American scholar, Robert Bellah (1983), succinctly captured one critical difference between these two models:
The purpose [of practical reasoning] . . . is not to produce or control anything but to discover through mutual discussion and reflection between free citizens the most appropriate ways, under present conditions, of living the ethically good life. . . . It is precisely the point about praxis that it has no extraneous product. It has an end, namely, the good of human beings, but that end is attained through itself, that is, through action or practice that is ethical and political. . . . For “helping professionals,” this will involve toleration of high levels of uncertainty in trying to aid people to improve their own skills of practical autonomy, rather than categorizing them in terms of preconceived theories with resulting automatic formulas for treatment. (pp. 35, 43)

In an ironic commentary on differences described here, written early in the evolution of the field of health education, Mendelsohn (as cited in Faden & Faden, 1978) describes the difference between education and persuasion:

Education seeks to expand the intellectual horizons to facilitate rational choice from among alternatives; it does not seek to change behavior per se. Persuasion, on the other hand, is concerned with limiting choices and controlling perceptions to facilitate adoption of those behaviors promoted by communicator. (p. 10)

Based on these distinctions, he therefore concludes, “We must drop the euphemistic ‘education’ mantle. Educators do not make for effective persuasive communicators” (p. 10).

Fortunately, there is a long and proud tradition in health education that has not treated people as a means to the field’s ends. This philosophy of health education has worked to strengthen individual autonomy and social solidarity through practices centered on caring and fulfilling our collective responsibility for creating more humane living conditions for all people (Minkler, 1989; Nyswander, 1967). Change and growth are possible when community members connect with one another as human beings in caring relationships characterized by trust and mutual support. It is a type of health education practice that is fully accountable yet not dependent on exercising instrumental power to accomplish predetermined outcome objectives. It is based on the knowledge that, with a modicum of trust and institutional support, many good things can happen—many we may never have even considered before listening to, learning from, and engaging with fellow community members (Minkler & Wallerstein, 2003; Wallerstein & Bernstein, 1994).

DISCUSSION AND CONCLUSION

In a famous debate that appeared in Science in 1956 titled “Some Issues Concerning the Control of Human Behavior,” B. F. Skinner and Carl Rogers agreed that the science of behavior control was both imminent and inevitable, and the only question worth debating was who would have control over determining the goals to which the new technology would be put to use. The stock response of those committed to the medical model of health education is that any qualms about manipulation will be absolved by securing voluntary and informed consent. Just as surgeons must obtain the patient’s informed consent before removing a tumor, so too the practice of health education can be ethically redeemed by gaining voluntary and informed consent before subjecting clients to the procedures that will effectively alter their behavior. And if we stick strictly to the question of whether such procedures would meet current ethical standards for clinical care, there can be little question that such a program would not only pass ethical scrutiny but would prob-
ably be warmly welcomed by all of us who have ever struggled with losing weight or freeing ourselves from our favorite addiction.²

If these technologies were ever developed, however, we would have to confront the profound implications for our understanding of the meaning of the human condition, letting go of any pretensions to human autonomy, integrity, dignity, and moral responsibility. Even though we might lose weight, we would not gain the integrity and dignity that comes from becoming a self-disciplined agent capable of self-control. More concretely, if the medical model of health education ever were successful, we would need to address gravely serious questions about who would control these interventions, especially in a public health context when they are intended to be applied on a population basis. (Case in point, in the COMMIT trial, did every single citizen in all 22 cities sign an informed consent form volunteering to participate in the experiment? [COMMIT Research Group, 1995a, 1995b]) As Huxley’s nightmarish Brave New World vividly illustrates, we might all be made happy (with Body Mass Indexes of 25!), but we would no longer be living lives of our own choosing. Let me conclude with some final comments on the implications of a new ethic for research and practice.

First, it seems to me that the choice of models has been driven largely by what we think makes research valid. Most social scientific researchers have opted for the hypothesis-testing model because it provides such clear-cut criteria for assessing the validity of factual claims. If our choice of models turns on this concern, then it may be time to consider whether there are other grounds for establishing the validity of claims besides testing hypotheses. One way of approaching the question of what makes research valid is to ask ourselves whether we have any grounds for claiming that statements about values are true or not. How do we know if some way of living is good or not? Or if some course of action that we are considering is the right thing to do? To the extent that one thinks that value claims can be reasonably debated and one can arrive at rational conclusions about their validity, then an alternative research framework to be considered is normative analysis, the type of research that goes on in bioethics all the time. It is research that aims at the clarification of basic human values. Research in ethics seeks to articulate more clearly and comprehensively the reasons and justifications that support one course of action over another.

Although space constraints preclude a full discussion, the criteria for establishing the validity of value claims are based on reaching reasoned agreement. We gain confidence in the validity of normative propositions to the extent that others exercise their considered judgment and find good reasons to concur with the analysis. Anderson (1993) provides a good illustration of this reasoning process:

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. (p. 11)
Based on these criteria, it is clear that the validity of value claims will never attain the same level of certainty as factual claims verified by the scientific method. (As Taylor [1985] noted, unfortunately, “such uncertainty is an ineradicable part of our epistemological predicament” [p. 18].) But here is where I part company with colleagues invested in the medical model: The certainty granted by the power to predict and control outcomes is not the only measure of the value of research. In the alternative model outlined here, the goal of the research—the good to be achieved—is to gain clarity, not to claim certainty.

In getting back to our roots in education, the field would return to its role as disseminators of factual information—what is known about the causes of death and disability—and facilitators of rational choice. People have a right to this information, whether or not they choose to act on it. But rather than expecting people to change their behavior based on this information (or feeling frustrated when they do not), the more interesting challenge for the field would be to help people make critical value judgments about their priorities, the steps they want to take in pursuing their life plans, the place of “good” health habits in their vision of the kind of person they want to be, and the kind of society they want to live in. In this model, the quality of a health educator’s work would be evaluated not by its effectiveness in changing people’s behavior but by whether audiences find the dialogue valuable in helping them think about how they want to live their lives, the impact of their behaviors on the pursuit of their life goals, and the kinds of environmental conditions that community members find most conducive to living healthy and fulfilling lives.

For example, there is growing interest in the field of health education in advancing public policy initiatives designed to change the environment to support healthier living habits. In the education model outlined here, one critical role for health educators would be to stimulate discussions in public forums about whether community members think any changes need to be made in the organization of society, for example, regarding the role of large corporations in manipulating the content, cost, and availability of foods that are bad for people’s health. Schlosser (2001), for example, provided a thought-provoking analysis of the impact of the food industry in shaping our eating habits that could be used as a stepping-off point for dialogue and deliberation. Building public support for policy initiatives aimed at redressing the vast inequities in the distribution of power in our society through educational forums is critical to the successful passage of such policy proposals. With democratic support from the majority of society, it becomes morally acceptable and politically feasible to use the instrumental power of the state to change the physical and social environment (e.g., passing more progressive tax policies to reduce inequalities in wealth, which have been associated with inequalities in health) in line with more people’s vision of the good society.

If the field were to restore and renew a philosophy of education, the lines between research and practice would become blurred. The project recommended here is a “public reasons” approach, similar to the framework put forward by John Rawls (1971; Brock, 1996; Daniels, 1996). It is based on the cooperative search for moral rightness, which is determined solely on the basis of good reasons, in which nothing but the force of better argument prevails. As Habermas (1981/1987) argued, we have a right not to be bound to norms other than those to which we give our uncoerced rational consent, and it is only by engaging in dialogue with others that one can become convinced of the validity of any proposed norm. The participants themselves are ultimately the only ones competent to judge the merit of various proposed justifications for a particular course of action (e.g.,
losing weight, stopping smoking, regulating industry), for it is the consequences to their needs and interests that constitute the relevant reasons in terms of which the issue of normative validity must be decided. In Habermas’s view, justice consists in permitting all persons to participate freely and equally in conversations aimed at reaching consensus on norms regulating conduct.

This new direction would thus entail building health education programs around the notion of an argument, that is, a particular form of conversation in which something is at stake. Why should people spend 30 minutes a day exercising? Why is this more valuable than the other ways that they now choose to spend their time? In answer to these questions, I think that we as a field have been largely mute, mumbling something about living longer, saving the government money on Medicare, and making corporations more profitable by reducing absenteeism and paying less for health insurance. Let me point out, however, that, when viewed in a more positive light, what many health education theories seem to do is to provide reasons for particular courses of action, except that they have become misunderstood by the imposition of a scientific cause-and-effect framework. Telling people how serious diabetes is, how susceptible they are, and discussing the values that they might attach to different outcomes (à la Ajzen’s [1988] breakdown of the component parts of “attitudes”) is truly offering reasons they might want to change their behavior, ones that most of us remain genuinely convinced are important. One crucial difference in the approach recommended here, though, is that we would remain open to the possibility—indeed, we could become convinced—that there may be more important issues in people’s lives on which they are focusing their attention. Frankly, I cannot wait for the time when public health recommends that each and every one of us spend 30 to 45 minutes a day, 4 or more days per week, working for social justice, for which a much better case can be made.

In conclusion, instead of devoting all of our time and energy to creating the technologies of behavior control, I think that we should be moving in precisely the opposite direction: We should be doing everything in our power to increase human autonomy. Instead of seeking to develop programs that are more effective in altering people’s behavior, we should focus on aiding people to make their own choices about how they want to live in light of their best understanding of the good life for themselves (Haan & Bellah, 1983). As far as I can tell, it is precisely those people in our society who can now exercise the greatest degree of individual autonomy who also enjoy the best health. If this is true, then we should shift the emphasis in the field from the rather narrow focus on producing specimens of physical fitness, to a broader concern for human well-being, here understood in terms of enhancing moral judgment, promoting greater self-understanding, liberating people from scientistic assumptions (perpetuating the belief that human behavior is determined by antecedent causes that only highly trained scientists can divine), advancing the cause of social justice, and promoting respect for the diversity of understandings of the good life for human beings.

At bottom, it is the dominance of this instrumental mind-set that concerns me most. The medical model frames how we think about our relationship to others, dictating the development of more effective behavior change programs and the unquestioned pursuit of the power to make others behave the way we think they should behave as the overriding purpose of health education. We seem to have placed higher priority on the pursuit of scientific, technical expertise over the advance of moral propriety. If the medical model is a fair characterization of the current direction and purposes of the field, then we have banked on the power of science and technology over democratic processes of engaging fellow citizens in forging a just society. But at the end of the day, figuring out how we
should live, individually and collectively, is a moral and political process, not a scientific problem to be solved.

Notes

1. Lifeworld is “the intuitively present, in this sense familiar and transparent, and at the same time vast and incalculable web of presuppositions that have to be satisfied if an actual utterance is to be at all meaningful” (Habermas, 1981/1987).

2. I am not quite sure what such a program would look like, but probably some combination of (a) genetic testing to determine genotypic predispositions and responsiveness to alternative therapies, (b) psychotropic medications to regulate targeted reward pathways, (c) cognitive therapy to reprogram those internal tapes with positive messages, and (d) environmental contingency management (e.g., restrictions on what one can buy with food stamps).

References


