Health Promotion and Professional Ethics

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Preface

The primary audience for this book is health professionals on pre-service or in-service education programmes. These days health professionals and would-be professionals are required to have thought about, and take an active interest in, a wide range of issues which extend far beyond clinical knowledge and skills. As a result both health promotion and ethics have become common currency in health professional education, and there are a number of accessible introductions available to both of these fields. A further text, which links the two fields, requires some justification.

Perhaps we should first stress what this book is not meant to be. It is not a more specialised or esoteric discussion which focuses on some relatively obscure overlap between health promotion and ethics. It is first and foremost designed to be accessible and to introduce the reader to both fields of study. The two fields are linked together in the book simply because, we argue, the two fields are linked together in practice. And this linkage, we suggest, is far from obscure but something quite basic and of widespread relevance. This argument is what we hope makes the book original, and hence worth producing and reading. The full argument for the linkage is set out in the text (particularly the first two chapters) – but it can also be signalled here. The point is that as health workers bring the idea of 'promoting health' within their remit they thereby re-orient the ends, the means, and the dilemmas associated with their work. To take up health promotion is, in part, to take up a 'new professional ethics'.

We have deliberately chosen the label 'professional ethics' for our theme rather than a label such as 'bioethics', and it is worth briefly setting out why. By 'professional ethics' we mean to refer to the routine, day-to-day, value judgements inherent in, or deliberately made within, professional activity. To think about professional ethics, in this sense, requires us to be self-conscious about the values built into policies and practices, the different ways in which our choices and actions impact upon others, the standards of conduct expected from people working in our occupational field, and the need to be able to explain and defend our practice to managers and clients. None of this is an abstract, academic or theoretical activity – it is, as we say, routine stuff. Nevertheless it is necessary to stress this foundation here because (as will be discussed more fully later) there is no established 'professional ethics' in the field of health promotion.

We have also shied away from the label 'bioethics' because much of the book is not about bioethics in the widely accepted sense of moral philosophy about health care. Bioethics or health care ethics is a hugely important tradition of academic work which provides both an analytical and a critical perspective on professional ethics. We cannot pretend to do this tradition of work justice in this context but we have included it as one of the threads in our discussion, and have hopefully provided some pointers to those who feel the need to go beyond the 'common sense' of professional ethics to a more philosophically reflective stance on health care ethics. A feature of this emphasis on professional ethics rather than bioethics is our choice of deliberately mundane and non-dramatic examples of health promotion work. Whereas moral philosophy texts often embrace 'science fiction' examples or life and death dramas we have chosen to explore some of the issues through 'bread and butter' cases. Our choice here is certainly not meant to imply that the more dramatic examples are not valuable or practically important; it is merely to highlight the pervasiveness of value judgements in occupational practice.

Hopefully the organisation of the book is straightforward. The three sections each have a different role which is explained by their titles – *Why health promotion ethics?; Values and ethics in health promotion practice*; and *Towards ethically defensible health promotion*. The first and last sections serve respectively to introduce and 'take forward' the issues. Their job is adequately summarised by the synopsis contained in this Preface. The middle section has broadly the same aspirations but seeks to address these through a more careful and concrete consideration of issues in practice. We have added an introduction to Section Two to explain and illustrate this further.

We will be delighted if readers leave the text with a heightened sense of the need for a revised approach to professional ethics in an era of health promotion. But we also hope that they will be persuaded of the value of more theoretical and critical reflection on both health promotion and ethics.

Section One
Why Health Promotion Ethics?

Chapter 1
Values and Health Promotion: Some Fundamentals

Premise and purpose

The premise of this book is that health promotion represents a challenge to the values and ethics of health professionals. The purpose of the book is to illustrate the nature of this challenge in practical terms and, we hope, to help meet it. Section One – this chapter and the following one – form an introduction to these issues and to the rest of the book. At this stage we might be expected to run into a series of definitions and clarifications: 'What is health promotion? What, for that matter, is health? What do we mean by "the values and ethics of health professionals"?' All of these questions are important and we will consider them, but we prefer to begin by approaching things indirectly.

For now we will rely on the fact that everyone reading this book must already have a notion of what is meant by health promotion. Presumably very few people would buy or borrow a book on health promotion if the term meant nothing to them! At the very least, it might be expected that you associate the term with certain kinds of activities (perhaps, for example, smoking cessation programmes). Different people may associate it with a rather different range of activities but presumably it has some such associations for everyone.

Broadening perspectives on health care

Arguably, the rise of health promotion is best understood as both a reflection and an expression of changing perspectives in health care. These changes can be seen, for example, in the broadening of curricula for the education and training of health care professionals (English National Board 1987, General Medical Council 1993). Students training to be health professionals are likely to be introduced to a wide range of disciplines, themes and topics. In addition to biological and clinical knowledge and 'hands-on' skills, they might also cover issues in psychology and sociology, aspects of law and public policy, and topics in communication as well as in ethics and in health promotion. This broadening of curricula is no doubt partly inspired by a conviction that health professionals

should have a broad education for their own personal and professional development; but it is mainly a consequence of evolving ideas about health and health care. Three linked trends are discernible: first, an increasing emphasis on client-centred or person-centred health care; second, an increasing emphasis on the social and environmental determinants of health; and third an increasing emphasis upon broader and more flexible notions of health and well-being.

This list of trends is clearly something of a generalisation and simplification, but in broad terms we believe it to be a reasonable summary. The trends are all elements of a reaction to what is often called, perhaps unfairly, the 'medical model'. Respectively they each provide a counterbalance to a comparatively narrow focus on 'professional authority and judgement': the nature of 'the diseased body'; and 'measures of morbidity and mortality'. In turn these health care trends are themselves a reflection of a much wider and deeper set of social trends. Although it is not within the scope of this book directly to examine these in historical or sociological detail, we can briefly remark on them. First, professional authority – and in particular professional medical authority – has been subject to fundamental critique and scepticism in many spheres. (See, for just one example, Illich 1977.) This has resulted in it being increasingly subject to influence and control from both 'below' (e.g. consumer pressures) and above (e.g. managerial pressures). Second, social and environmental sciences have increased our understanding and self-consciousness about the things which shape our lives. As a result we are likely to be more cautious about the scope for professional work alone to produce substantial changes. Third, in modern societies there is a scepticism about generalised criteria of professional success. A high priority has come to be attached to people themselves deciding what they want out of life, and what they see as contributing to their own well-being, rather than professionals attempting to decide for them.

To say that there is an increasing emphasis on these broader perspectives on health is not to suggest that they have replaced the narrower focus – merely that in many areas these counterbalances have been growing. It is arguable that there are many aspects of health care where a narrow focus still largely predominates. Furthermore, it may seem that certain important currents in health policy (e.g. evidence-based health care) amount in some respects, to a reinforcement of these narrower models. But in general, the counterbalancing trends we have identified are significant; and it is possible to see the growth of health promotion as one important reflection and expression of them.

Perhaps the fundamental point to note is that health care and the values associated with it evolve and change over time. The changing institutions and practices of health care not only represent changes in procedures and techniques; they also represent changes in values. Let us briefly consider an example – the case of the hospice movement.

Hospices are institutions which serve specific functions; i.e. providing good quality respite and terminal care for families affected by life-threatening chronic

diseases. Simply to express their role in these stark terms, though, is to miss out such a lot about them. What hospices stand for, first and foremost, is a set of values. They are one answer to the question, 'How can patients and families facing life-threatening diseases, or living through the process of dying, be cared for in a way that meets their needs, respects their dignity and wishes, and does justice to all of the different forms of pain and disruption these experiences entail?'. In short, they are one institutional expression of the attempt to give 'care' a place of equal importance to 'cure' within health services. Models of good palliative care have now spread far beyond hospices themselves – indeed, many people would argue that palliative care may often be better provided for outside of specialist institutions. In many ways the legacy of hospices to health care lies in the values they represent rather than their institutional form. They are one example of the evolution of values in health care, and they highlight the tensions between 'care' and 'cure'.

The rise of the hospice movement also connects with the three trends we have just mentioned. Good palliative care aims to be centred on the patient's agenda and not that of the health professionals: it is mindful of the patient's social and cultural context, and it considers dimensions of the quality of life much broader than those defined by clinical medicine. Hospices and palliative care are of course, not just abstract 'value movements'. They also involve people undertaking different sorts of work, delivering new practices and interventions – whether it is new techniques of pharmacological pain relief, 'talking therapy', complementary approaches to health care, peer support, or many other initiatives. It is important to see that these various new practices and interventions can be subject to ethical scrutiny. We might ask, for example, about the extent to which life ought to be prolonged if it is a life which has ceased to be valued by its owner; or connected to this we might ask about how and when it is appropriate for family members to give proxy consent to the withdrawal of life sustaining treatment. Just because hospice care is performed in the name of certain 'values' it does not mean it is immune to criticism or critical examination. It is quite common for human beings to reform institutions and practices with the aim of putting an end to one set of 'evils', merely to replace them with an alternative set.

In short, health care is evolving and there are certain 'broadening' trends discernible in this evolution. We suggest that health promotion needs to be seen in this context. It connects with a set of value changes in society and is part of a range of challenges to the values of health professionals. It is also – just like the hospice movement – associated with a set of practices and interventions which again, can and should be subject to ethical scrutiny in their own right.

In the rest of this chapter, we will concentrate on exploring some of the ambiguities surrounding the idea of health promotion. This exploration involves, among other things, considering some concepts and meanings, but this concern with language is not an end in itself. In order to investigate values and ethics in health care it is essential to think about the ways in which health care is under-

stood – at a conceptual as well as a practical level. As we have seen, changes in values represent themselves in changes in the ways things are talked about. Part of the spirit of the hospice movement, as we have mentioned, is represented by talking about the importance of 'care' and not simply 'cure'. Connected with this emphasis on care are a lot of other ideas, such as 'respect', 'compassion' or 'holism'. These can be used to develop and complement the central idea of 'care'. Similarly, the changes in perspectives and the health policy trends embodied in the health promotion movement can only be explored by looking at the ideas associated with health promotion. Unless we have a relatively clear picture of what a supporter of health promotion is actually advocating, we cannot begin to evaluate it ethically; nor are we in a position to decide whether or not a particular intervention qualifies as health promotion at all, let alone 'good' health promotion.

A tricky question: What is health promotion?

Let us now turn to the business of describing the nature of health promotion and to discussing some of the difficulties involved in doing this. The starting point for this discussion is to accept that there is no single, clear and uncontroversial account of what is meant by 'health promotion'. The term has caused, and continues to cause, considerable uncertainty and debate. (The literature of this debate is very broad, but a sense of its contentiousness can be found in Seedhouse (1997).) There are a number of approaches we could take to try and make progress in understanding: 'conceptual approaches'; 'empirical approaches'; and a combination of the two.

By a 'conceptual approach', we mean one which analyses the expression 'health promotion' and in doing so attempts to map out some coherent and circumscribed account of the meaning of the expression. Ideally, such an approach would enable us to identify some 'core sense' of the term and would help us decide to what actual processes or activities it properly applies. More realistically we would probably find that there is not simply one sense of the term, but that it can be used in rather different ways. Nevertheless, this would still help us to circumscribe the several 'core senses' of health promotion.

By an 'empirical approach', we mean one which concentrates on exploring the practices themselves (processes or activities) that people happen to call 'health promotion'. What sorts of things do people refer to as health promotion? When is the term used?

In practice, some combination of these approaches will probably be needed. This is because, on the one hand, it would seem bizarre to suppose that the 'real' (conceptual) meaning of the term was completely different from the way it was used in practice. On the other hand, if we only look at the ways in which the term is used in practice it might reveal such a variety of contradictory and confusing

examples that we are left with no sense of how to 'pin down' what is meant by 'health promotion'.

We will begin by exploring a conceptual approach to answering the question. This might seem a rather abstract place to start and, as we will soon see, it is fraught with the danger of getting bogged down with rather vague-sounding concerns and debates. But despite these disadvantages, it may help us make a little progress. A purely conceptual approach might go something like this:

> *Health promotion is, by definition, the promotion of health. To promote something is to encourage or increase it, so anything which encourages or increases health must be an example of health promotion. Health has a number of meanings (let us leave these on one side for now) but given any one of these meanings we are able to gain a picture of health promotion. For example, if we take health to be something like 'the absence of disease', then health promotion refers to anything which works to reduce the amount of disease in the world.*

This obviously still leaves the need for some further basic clarification. Should we think of health promotion as referring only to activities (which here we understand as things that are deliberately done); or to both activities and processes (by which we mean things that might happen without deliberate action)? Just to explore this point, take an absurd example. Suppose some freak astronomical event happened next year which somehow had the effect of wiping out malaria (just as an asteroid might have wiped out the dinosaurs). Would this be an example of health promotion? Or are we inclined to think that health promotion is something that people have 'to do', not just something which happens? For the purposes of this particular exercise let us confine health promotion to activities only.

Now there is a further piece of clarification needed. We must ask about the intention of activities. If we say health promotion refers to a set of activities: then as well as being deliberately done, must these activities be conducted with the deliberate aim of promoting health; or is what matters that an activity has the consequence of promoting health? Of course, something can be done deliberately and have consequences other than intended. Indeed, in relation to this discussion, we can imagine four kinds of activities:

(i) activities which have the aim of promoting health and do in fact promote health;
(ii) activities which do not have the aim of promoting health but actually do promote health;
(iii) activities which have the aim of promoting health but do not promote health, and
(iv) activities which do not have the aim of promoting health and do not promote health.

It seems reasonably clear that health promotion does not refer to group (iv); and that group (i) activities are good candidates for the health promotion label, but what about group (ii) and (iii) activities? If we stress the importance of the activities' *aim* then (i) and (iii) become the salient set. If we stress the importance of the activities' *consequences* then (i) and (ii) are salient.

One of the difficulties in exploring examples to illustrate these points is that there are so many other confounding factors. Not only do we have different intuitions about what counts as health, but we have different intuitions about the likely effects of different activities. Furthermore the effects of activities are typically complex. The same activity may promote health in some respects, or to some degree, whilst failing to promote health in other respects or to a different degree. These kinds of complications will become important in the detailed discussions we have about activity in Section Two. For the moment, we can use a couple of examples to explore the relevance of the broad distinction between an activity having as its *aim* the promotion of health; and an activity having this as its *consequence*. These examples will help us to recognise that this issue contains still further complications.

(1) Suppose you are lucky enough to be able to find a plumber to install new plumbing in a house you are having modernised. She arrives one Monday morning and by Friday evening she has put in a new toilet system, a central heating system and hot and cold running water. Imagine that she spends a whole year doing this in different properties (perhaps she has a contract with a local authority or housing association to modernise its stock). It is quite possible that this activity would contribute to disease reduction and therefore (according to a model where health is understood as the absence of disease) it would be an example of health promotion. We are using it as an example of group (ii) activities above because we are supposing that the plumber does not have the aim of promoting health, and certainly does not think of what she has been doing as 'health promotion'. She sees herself as attempting to install the right equipment in technically (and perhaps aesthetically) the best way, as earning a living, as developing her competence and craft, but not as promoting health.

(2) Suppose a hospital employee becomes privately convinced that his own 'medicinal concoction' has strong and far-reaching curative powers. As a result, he decides to add his concoction regularly (but secretly) to the hospital food whilst it is under preparation. His intention, let us imagine, is pure. He does not wish to make money or become famous. He simply wishes to make his contribution to improving the health of the hospital's patients. Unfortunately, as a consequence of this activity several patients take a serious turn for the worse having been effectively poisoned by a substance that was meant to help. This is an example of group (iii) activities. The intention is to promote health but the consequence is rather different.

Now which, if either, of these two examples should be called health promotion? To many people it will seem odd to apply the term to either. The plumbing may happen to promote health in some sense but it is not health promotion. The hospital employee may want to promote health but he is not practising health promotion. (Furthermore many people would say the same thing even if the concoction had achieved the desired effect.) Why do we suggest this? One of the reasons is that many people think of health promotion as more than the name for an abstract set of activities. They see it as the name of a specific kind of practice, like marketing or nursing. Of course, we could run into similar difficulties to those discussed above in trying to identify whether a very specific activity counted as an example of marketing or nursing – but we know in broad terms what these practices are. In following this line of thought we are, to some extent, starting to incorporate what we earlier called the 'empirical approach' – that is to say, we are reflecting on how the term 'health promotion' is used in practice.

If we think of health promotion as an occupation, like marketing or nursing, we can perhaps dismiss the above two examples fairly easily. Neither of the two protagonists has the occupation of health promotion. What is more if health promotion, like nursing, has certain conventions and standards built into it, then the hospital employee is falling short of these standards in any case. Imagine that the employee in the example is a nurse. Would we describe their activity of supplementing the food as nursing? We think not. Of course, it would be different if they were asked to do something similar as a deliberate and open feature of hospital food policy.

Now we can extend this way of thinking to health promotion. If we think of health promotion as a kind of occupational practice, then we need not get bogged down by vague hypothetical puzzles about whether or not specific isolated activities count as health promotion. Instead we need to map out the sphere of the occupational practice. We need to ask '*Who are the people who work in health promotion, and what, broadly speaking, do they do?*' So it will be possible to identify the things falling within this sphere, by virtue of being part of the occupational practice, as health promotion. (Suggesting this does not, of course, exclude the possibility of disagreements about what is 'authentic' or 'worthwhile' health promotion activity between those engaged in the overall occupational practice. Even though both sides in such disputes may argue about the specific worth of an activity being undertaken by 'the other side', they may nevertheless agree that both activities could be called 'health promotion'; their disagreement may be evaluative rather than descriptive.)

According to our first, conceptual, approach to the question, 'What is health promotion?', the answer is that it is equated, somewhat abstractly, with 'the promotion of health'. According to our second, empirical approach, health promotion is equated with a domain of occupational practice. This second approach is certainly not purely hypothetical; there are people who work in the field of health promotion and think of it as an occupation – or part of their

occupation. Some of these people have health promotion in their title, and more still have the expression in their job description. The biggest group of workers unambiguously working in the field of health promotion are those whose full-time occupation is the promotion of health. Such people often (but not always) work in health promotion units attached to the health service or local authorities. In this book we will refer to these individuals as 'health promotion specialists'. Other workers who have health promotion in their job description, or who are otherwise thought of by their occupational group as practising health promotion as a significant part of their occupational role, we will refer to by the generic label 'health promoters'. A by no means exhaustive list of such workers would include nurses, midwives, health visitors, environmental health officers, teachers and doctors. (When we wish to differentiate these two groups we will use both labels; but a lot of the time we will simply use 'health promoters' to include both. There are of course many others on a possible list of occupational groups concerned with health promotion.) If we look at what is done within the occupational domain referred to as health promotion (work done by health promotion specialists and health promoters and described as health promotion), we will get a practical picture of health promotion. It includes, among other things, such activities as public health campaigns, face-to-face health education, community development work, health-related policy lobbying and planning. These are all planned activities intended to contribute to the health of groups of individuals or wider populations. But it is important to emphasise that they are a set of activities defined by their place in occupational practices and not merely the total set of activities that happen to promote health.

By and large the focus of this book will be upon health promotion as the name for the occupational practices of health promoters. We will consider the value questions faced by these groups of workers through some indicative examples. To some extent we will deliberately leave behind the conceptual issues raised in defining health promotion by taking the pragmatic solution of equating health promotion with the work most typically *called* health promotion in this field of occupations (the occupations of health promoters and health promotion specialists). This is a practical solution for what we intend to be a practical book.

Health promotion: open field or occupational field?

However, if we want to understand the nature of health promotion, it is important not to abandon the conceptual approach entirely. Part of the influence of the health promotion movement has been precisely to direct our attention to *all* the determinants of health. This is why it is properly included in, and arguably exemplifies, what we have called broadening perspectives on health care. One of the functions of the language of health promotion is to direct our attention beyond narrow health care services, and towards the myriad sets of causes and

choices which shape people's experiences of health and illness. In this sense health promotion refers to an 'open field' and not merely to a set of practices and activities undertaken by occupational groups within health care and related fields alone. All activities and social and environmental processes may contribute towards the promotion of health (World Health Organisation 1986). None of them can be easily omitted from consideration.

It is for this reason that the purview of health promotion encompasses so much including: every kind of public policy – such as economic, legal, housing, transport and so on; the activities of private companies and voluntary organisations; global issues about environmental change, population growth, international capitalism; local issues about, for example, road safety or social isolation; the work and side-effects of all professional and occupational groups, and all leisure activities; and the material construction, organisation and policies of specific settings like schools and hospitals. Indeed, it encompasses just about anything you can think of! Given that all of these – and more – can have an impact on peoples' health status and experiences: and that it is therefore possible, in principle, that any of them should be taken into account as we attempt to shape and improve health; then they become worthy of the interest and attention of 'health promotion'.

Health promotion, therefore, cannot be owned by any single occupational or professional group. Anyone and everyone could be charged with some responsibility for promoting health. On the other hand there are relatively few people who would see health promotion as comprising all – or almost all – of their job description. These workers – health promotion specialists, according to our distinction – have to take into account the open field of health determinants, and consequently have to think in terms of partnerships with other individuals, organisations and sectors. However, they will also think of themselves as working at the centre of the occupational field of health promotion (other occupational fields such as nursing and medicine 'overlap' with the occupational field of health promotion) (Society of Health Education and Health Promotion Specialists 1997a).

It is characteristic of health promotion that it possesses this duality of being both a part of health care work and at the same time transcending it. Health promotion is seen as something which extends beyond, complements and perhaps even critiques, traditional health care; yet at the same time health promoters are often working in, or are closely allied to, existing health services. Indeed, as we will explore further in a later section, health promotion is increasingly seen by many as a current within health care, and as an important part of well-established health professional roles in medicine and nursing. Here again we can see the elasticity of the meaning of the term 'health promotion'. It is applied to a wide range of, sometimes contradictory, things. One of its uses seems to be simply to refer to work aimed at health which transcends narrow models of health care, even though there are some very different kinds of work which fall into this