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Focus: Current issues in medical ethics

Help yourself to good health?

Edward M Myer, *Department of Education, University of Manchester*

Summary

In recent years more support has been given to the idea of Health Education and there are strong reasons for believing that such schemes of prevention may receive much more financial backing from governments. It is being realised, also, that many of our 'ills' may be attributed to an over-reliance on medical technology. There is reason to believe that in years to come the emphasis will be placed on the fostering of mental health in programmes of Health Education enabling the individual to take a responsible attitude in learning how to seek out health hazards for himself without over-reliance on others.

It would be fair to say that in recent years there has been an increased interest shown by both the general public and within official circles towards the whole idea of Health Education.[1,2,3] No doubt many people are already quite familiar with the television and press 'ads' currently being put out by the government-backed Health Education Council (HEC) in its latest bid to attempt to get us all to 'look after ourselves'. This latest campaign to persuade us to exercise more and give up some of the things we now enjoy is the direct result of a million pounds bonus recently received by the HEC from the government. But this is a mere 'drop in the ocean' when it is compared with the kind of resources currently commanded by the hospital service, not to mention the social services, the general educational system and, indeed, the armed services.

Nevertheless, there are quite a few considerations worthy of mention that may lead us to believe that this is only the start of an increasing amount of support which we can expect to be given by future governments for such preventive health measures and, as a corollary to this, we may add that we can equally expect less emphasis to be placed on hospital-based curative health services.

The technological fix

A fairly obvious factor, that will be apparent to many people now working in the health and social welfare services is, the fact that we are today more aware than ever before of how far health matters are intimately connected with general social conditions and the living standards of the population at large. Indeed, there is reason to believe that there has been a fundamental change in mortality and morbidity patterns in this country over the last hundred years or so. We no longer suffer greatly from the squalid and insanitary conditions associated with nineteenth century poverty which brought about epidemics of infectious disease. Of course there will, no doubt, be some room left for improvement in such matters; but today's so-called 'affluent society' now fosters an over-reliance on labour-saving machinery, and self-indulgence itself has, with such a sedentary life-style, brought the recent increase in degenerative diseases.[4] Unfortunately, the practice of hospital-based medicine in many of its features shares many of the characteristics of a culture which tends to place great value on the idea of a 'technological fix' to patch up our past mistakes, be it by means of an artificial heart to replace our fat-clogged old one or a soporific drug as a panacea to dissolve away all the worries and cares of the economic rat-race. Our 'technology-as-a way-of-life' may encourage us to think of our having a *right* to medical treatment rather than our having moral *responsibilities* that can be seen to be attached to the ways in which we utilise expensive public services. But, furthermore, there is some evidence to suggest that traditional hospital-based medicine has been practised in a way that tends to treat people as, in a sense, similar pieces of biological material to be examined in a doctor's surgery or hospital bed in isolation from their social circumstances, 'repaired', and sent home.[5] Such an approach would seem to favour the conceptualisation of 'disease' as if it were an 'entity' actually inside a person rather than a matter of evaluation (in 'functional' terms) about how a complex individual has managed to 'adjust to' or 'come to terms with' a unique web of personal relationships amidst a socio-cultural setting.[6] Thus, we may quite reasonably claim, in the light of such considerations as these, that the emphasis in past thinking about health matters has been focused fairly sharply upon a 'disease process' in isolation

from its surrounding causes. This, in itself, has probably had a major part to play in recent concern expressed over shortage of resources in the NHS. Much money has been spent on techniques aimed at treatment of disease at the cellular or even molecular level of the human body. Not only are there serious technical problems over man's inability to, as he might hope, master nature's forces but also the potential drain on resources in the development of sophisticated techniques is tremendous. Couple this with the public's insatiable demand for better health services and the glamour of 'scientific' medicine and the potential expense becomes limitless!

Also, in a situation of economic scarcity like today, life and death decisions have to be made quickly to decide who is to have what limited treatment is available. Thus, arises the question of how we are to arrive at a *just* and fair allocation of medical resources and this question becomes even more problematic as soon as we also ask how far the individual himself has responsibilities for the care of his own health. Of course, the government has taken some of the initiative in the light of the fact of the existence of illness-producing industries such as sugar-refining, white flour, tobacco, alcohol, and the like, some of which have been supported and continue to be supported by governments in one way or another. But the important point to bear in mind is the fact that, however minimal it may be seen to be, the government *is* now beginning to take an active stand in giving financial support to such bodies as HEC. There can be little question that traditional approaches are seriously and increasingly being brought into question, and we can reasonably expect there to be further fundamental changes in the way of official policy lending more weighty support in various ways to such preventive measures that are available in the years ahead.

Of course, the 'engineering' approach to health matters has seldom been found entirely acceptable to community workers such as, say, health visitors or district nurses who, all too often, have seen patients returned home 'fit' from hospital but into conditions entirely unsuitable to prevent a further period of hospitalisation. Such patients may well have been 'doing quite nicely' in the protective surroundings of a hospital ward with staff on hand for emergencies. Indeed, we should not forget the fact that long before a potential 'patient' sees a doctor he or she will have experienced all kinds of social pressures and a certain amount of (quite literally!) self-examination before reaching the difficult decision concerning the advisability of consulting a medical practitioner.[8]

Fostering a sense of responsibility

This brings us back to the crucial question of how far the enterprise of Health Education may be able to offer real help to the individual. This help may be needed either in his attempts to prevent the actual occurrence of disease or in knowing when and how to seek help in a morally responsible manner with confidence in his own powers of judgement. In the latter case, it is preferable that he need not be influenced by no doubt well-meaning social pressure from friends, relatives, or neighbours who may persuade him to seek treatment at an advanced stage in the disease process when the 'symptoms' are only too obvious to everyone. In the past, it would seem, many programmes of Health Education may have tended to rely heavily on the 'engineering' approach. Although this may not have been apparent at the time, much of the so-called 'teaching' may have been better conceptualised or thought of as 'instruction' in the 'facts' about the phyical workings of the human body and concentrating on 'hygiene', 'fitness', 'diet', 'exercise' with quite a lot of effort being given over the last two. Moreover, such a programme of instruction could fairly be regarded as essentially concerned with the dissemination of 'information' or 'facts' and 'Do's' and 'Don'ts', (with less 'Do's' than 'Don'ts') and little or no real positive guidance concerning what to do with such information once it was handed on, apart from the question of what to do when 'something goes wrong'.[9,10]

Such an attitude is to some extent understandable in the light of the fact that, particularly when it comes to the teaching of such apparently 'sensitive' topics as, say, human reproduction or venereal disease, there is a great temptation on the part of the teacher to avoid 'moralising' by remaining 'neutral', just giving the 'plain facts', so that he does not stand the risk of being accused of 'brain-washing' or 'indoctrinating' the children rather than the seemingly more socially respectable activity of 'teaching'.[11] But there is no obvious reason why a teacher cannot remain 'neutral' whilst, at the same time, *intervening* in a classroom discussion by presenting a *valid argument* in the impartial pursuit of the truth about health matters. 'Neutrality' is not the same as 'non-intervention'. It does not mean standing back and never pointing out to children (and adults) just when they are wrong about health matters! In summary, what was missing in the past was the crucial connection between knowledge about health 'facts' and *understanding* in terms of relevance. There was a need to be told what to do with all those bits of information concerning bodily workings. An 'expert' such as a doctor, nurse, or health visitor may have told the learners what was an 'appropriate' diet but not what was an appropriate diet for any *particular* individual.

Indeed, the kind of diet and exercise, especially the latter, that would be appropriate for, say, diabetic, epileptic, or blind children and all their associated physical conditions, could hardly be expected to be exactly the same for apparently 'normal' children. Add to this developmental

changes at different ages under different sets of social circumstances and life at once appears to be very complicated indeed! As for 'normal growth and development', such 'growth points' as we may choose to study in our child development charts are always highly selective and are probably indicative of the kinds of values held by child psychologists working within a particular culture at a particular time.[12] If we are going to talk in terms of 'developmental progress' it would seem to be important for us to try to make our assumptions clear to ourselves and others by indicating into *what* it is we wish to get our children to develop! Of course, teachers of physical 'training' and 'fitness' have long appreciated the fact that there are special problems of an emotional nature associated with the idea of 'fitness training' for disabled and handicapped children.[13] Such children will obviously need extra special care and individual attention so that their courage and confidence may be gained in overcoming personal weaknesses in, say, athletics or swimming. Indeed, even top-line athletes are daily in the headlines as a result of being withdrawn from an important sports event due to injury during training. But they, themselves, may have taken many years to build up their own courage and confidence to push themselves to the limit of their abilities in an effort to overcome personal weakness as was, indeed, the case when, after many unsuccessful years of trying hard Virginia Wade finally won Wimbledon. What about the rest of us who are warned not to do *too much* exercise at once when we finally decide to get out of our armchairs and give our creaking joints the airing they have never had since the day we learnt to drive? Of course, there can be little doubt that many degenerative and orthopaedic conditions could be prevented by a more active life-style but we must also recognise the very real dangers that may arise from our forgetting, in our new found enthusiasm for *bodily* fitness, the close connection that exists between the 'mental' and the 'physical'. Indeed, it would be absurd to put everyone through his paces in the gymnasium in the name of 'health' at the cost of great mental stress for those who lack stamina.

In the light of such considerations as these it would be reasonable to claim that there has been in recent years a recognisable and marked trend in the field of Health Education towards placing an increasing amount of emphasis on the idea of the fundamental importance of *mental* health in the context of normal personal relationships.[9] Much more emphasis is now being given to the idea of fostering healthy attitudes involving not just holding individuals accountable to others for their actions but inculcating a sense of responsibility in which people become aware of their own powers and possibilities.[14] This is close to the idea of fostering, also, a degree of *personal automony* .Thus, we may expect a 'responsible' person to 'take care' of himself by activily looking for hazards by himself. This is not just a passive 'watching' or 'looking' but would involve the acquisition of skills of recognition involved in searching one's self and one's environment for actual and potential threats to one's health and well-being.[15] In this way 'taking care' is seen in adverbial terms rather than dispositional terms; it refers to the manner in which more or less 'risky' things are done and, more particularly, it refers to the kinds of precautions that go with the things we are disposed to or 'care' to do.[16] The kinds of standards involved in searching for hazards involve *thoroughness*, *completeness* and *success*. 'Thoroughness' refers to the amount of detail involved in, say, palpating a breast or keeping an eye open for road hazards, 'completeness' refers to the amount of the task covered such as, say, the number of bodily systems examined in a medical examination, and 'success' refers to the kinds of results achieved in the search for hazards. Above all, the kinds of powers or skills involved in fostering a sense of responsibility in health matters would seem to be those involved in 'heeding' or paying attention. We might wonder how far a person, in cultivating such skills may become something of a 'connoisseur' of health hazards able to appreciate the dangers and peculiar risks attached to each situation he comes across. As a result of all kinds of uncertainties and ambiguities involved in our relying on immediate sensory impressions a crucial part of Health Education may be expected to be that of utilising the 'autonomous' mental imagery that goes with the conventional set of 'warnings' and 'advice' that is to be found in any linguistic community. The role of *language*, then, can be seen to be crucial in helping an individual to identify successfully particular objects in the world, especially a changing world that may offer themselves as an immediate threat to our health and well-being.[18,19,20]

The ethics of the counselling approach

Those who tend to favour thinking of Health Education as less of a distinct and separate curriculum subject and more as a way of showing concern for the individual learner may also see the whole enterprise as something like 'counselling' or 'therapy' and may, indeed, see these activities as not of an essentially 'academic' nature.[21,22] The idea of 'school counselling' is gaining in popularity in many countries but is especially popular in the United States.[23] One of the difficulties with this idea is that it may tend to foster the notion of 'children-as-problems', pigeon-holing them, so that instead of being concerned with their 'problems', the counsellor, as an agent of the school, may come to think of the learner as one of the 'school's problems'. No child can be reasonably expected to learn how to form healthy personal relationships with someone that cannot be entirely trusted and confided in with

confidence.[24] Thus, it becomes an important matter that, if the counsellor is to be of genuine help and assistance to children he does not give them any reason to believe that he is continually spying on them and assessing their every deed or misdeed. Of course, there will be the need for early detection and treatment of 'pathological conditions' if and when they arise. But, rather than maintaining a constant surveillance, on the look out for every possible 'sign' of abnormality and judging everything the child does, there is also the possibilty of being selective. What the counsellor can do is to only 'judge' (if necessary) each child by his best performance and, in letting each child know about this, the inhibiting fear of blotting one's copybook will, hopefully, be much reduced.[25] Similarly, we might say that when an individual is on the look out for 'danger signs' he is most sensible if he has priorities. He looks for *short-range strong signs* such as fire and haemorrhage to deal with first before he tackles *long-range weak signs* such as, say, a small bruise.[26] Any competent first-aider, of course, knows this! By concentrating on 'priorities' in this way some room will, hopefully, be left for intellectual, emotional, and social experimentation and the possibility of each learner giving what he has to offer confidently knowing that he can learn from his mistakes without them being 'held against him' except, of course, if his life involves little more than just 'mistakes'. Such an approach that allows for human error also might encourage the attitude of humility that may have been sadly lacking in the past. Indeed, we must remember how fallible we all are.

Finally, 'health educators' may be regarded in some quarters as 'busy-bodies', 'paternalistic do-gooders', and generally 'interfering' people who take all the fun out of life by arrogantly telling us not to do all the things we really enjoy doing. 'But it's for your own good,' they say. This kind of response only seems to worsen matters for those who already claim to 'know' what is for their 'own good'. However, I have already suggested that Health Education can be taught with a degree of humility if the learner is allowed some freedom to experiment. But this only really makes sound sense if he truly knows what is a reasonable risk to take and is able to weigh up all the advantages and disadvantages in the light of the evidence, say, about such things as alcohol or cigarette smoking. Not all of us, and certainly not very young children, are in a position really to be able to make a valid claim to the effect that we actually know (have a true belief with evidential backing) what is in our own best interest in the long run. A more fundamental point may be, however, that made by those liberals who also argue that we are not really entirely justified in freely doing as we please where, by that very action, we would be denying someone else a similar freedom to so act. To deny this would be, in effect, to place ourselves in a privileged position over and above others; unless we are able to say in exactly what relevant respect we differ from others and, if so, why such a difference allows us to be treated differently, then our claim to privilege, if made, must fall down.[27] In this respect, *liberty* to make decisions about health matters for ourselves must be conceptually distinguished from the notion of a *licence* to do as we so please.

Thus, we might come to see Health Education as one way of attempting to liberate individuals from life's uncertainties. But such a 'liberal' approach that we might advocate must also be seen to take in the idea that by paying attention to danger, by learning how to look out for health hazards such a cautious person that avoids being negligent [16] in such matters also learns to fulfil certain responsibilities to the rest of the community, not to mention the nursing and medical personnel who have in the past been taken for granted as always present to repair our 'mistakes' for us.

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