# *Reconsidering the Moralization of Health: Practices Versus Concepts, and What We Can Learn from Evidence-based Research*

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**Abstract:** This article aims to do two things. First, it argues that moralization of health occurs not only at the practical level of individual healthcare choices and health states, but also at the conceptual level of health itself. This is most evident in cases where the concept of health is presumed to possess the property of "overridingness" when compared to competing values and norms, that is, when it is treated as taking precedence over other values and norms it may come into conflict with. Second, the article makes a case for being critically skeptical of specific deployments of the concept of health when it has been moralized in this way. In such cases, what typically results is that some other personal value/norm, or set of values/norms, held by the individual is treated as intrinsically at odds with the concept of health, which is presumed, uncritically, to be superior, often because it is taken to be free-standing and self-justifying. Yet, a growing body of evidence-based research suggests that the role played by dimensions of personal meaningfulness in the quality of individuals' overall health is quite underappreciated. It is useful to think of these dimensions of personal meaning and significance as representing the individual's values. Thus, taking these data more seriously ought to lead to a reevaluation of the moralization of health at the conceptual level. In the first place, it is not obvious that if the concept of health runs afoul of other values/norms held by an individual, the latter should automatically yield. In the second place, they suggest that other values/norms held by an individual are not necessarily intrinsically opposed to the concept of health, but in fact may go a good distance in support of it.

**Keywords:** conceptual moralization of health; overrdingness; medical values; cultural values; moralization of health; responsibilization; evidence-based medicine

This article aims to do two things. First, it argues that moralization of health occurs not only at the practical level of individual healthcare choices and health states, but also at the conceptual level of health itself. This is most evident in cases where the concept of health is presumed to possess the property of "overridingness" when compared to competing values and norms, that is, when it is treated as taking precedence over other values and norms it may come into conflict with. Second, the article makes a case for being critically skeptical of specific deployments of the concept of health when it has been moralized in this way. In such cases, what typically results is that some other personal value/norm, or set of values/norms, held by the individual is treated as intrinsically at odds with the concept of health, which is presumed, uncritically, to be superior, often because it is taken to be free-standing and self-justifying. Yet, a growing body of evidence-based research suggests that the role played by dimensions of personal meaningfulness in the quality of individuals' overall health is quite underappreciated. It is useful to think of these dimensions of personal meaning and significance as representing the individual's values. Thus, taking these data more seriously ought to lead to a reevaluation of the moralization of health at the conceptual level. In the first place, it is not obvious that if the concept of health runs afoul of other values/norms held by an individual, the latter should automatically yield. In the second place, they suggest

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**Moralization of Health: Standard-Type Examples**

Useful examples of moralization of health are not difficult to come by, and it will be helpful to begin by considering one or two standard-type examples before turning to an example that helps us see what I'm referring to as "conceptual" moralization. Let us start by considering Paul Rozin's classic example of the moralization of cigarette smoking.[1]

In the middle of the last century, cigarette smoking was considered "a mere preference . . . [but] it is now a morally laden act."[2] According to Rozin's analysis, the shift from the perception of cigarette smoking as a morally neutral personal preference, to a behavior incurring the moral censure of others occurred in connection with efforts to show the negative health effects of secondhand smoke.[3] Causing harm to others is clearly immoral. Thus, by demonstrating the negative health consequences to passive bystanders of secondhand smoke, the collective perception of the relevant moral principles involved in cigarette smoking effectively shifted away from the principle of autonomy toward the harm principle. The principle of autonomy suggests that rational agents are free to direct their lives as they see fit, while the harm principle holds that the rational agent's autonomy is limited by the harm her freely directed actions may cause to others. To the extent that secondhand smoke represents a serious danger to the health of passive bystanders, it falls clearly under the scope of the harm principle, and the moralization of cigarette smoking on these grounds is easily understandable.

The antivaccination phenomenon provides a more recent, and a particularly fascinating case, since moralization can be seen to be at work on both sides of the issue. Interestingly, the harm principle is at work here, too, but in complex and competing ways. A long since discredited case series published in the *Lancet* in 1998 by Andrew Wakefield and twelve colleagues, purported to show a link between the measles, mumps, and rubella (MMR) vaccine and behavioral regression and pervasive developmental disorder in children.[4] Despite a retraction of the original article by the *Lancet* nearly a decade ago, and the subsequent revelation that Wakefield, *et al.* were guilty of deliberate fraud[5], "anti-vaxxers" (as they are called) continue to cling to the belief that vaccinations are connected to an increased risk of autism and other neurological disorders in children. As a result, anti-vaxxers refuse to have their children vaccinated. However, anti-vaxxers' hesitancy is not merely a function of these perceived practical harms, but also driven by underlying moral beliefs. A 2010 review of anti-vaccination web content found that 38% of such websites mentioned immoral acts in connection with vaccination programs, linking vaccines to things such as "viruses being cultured in the tissue of aborted fetuses; animals being tortured in the process of vaccine manufacturing; and experimenting on children in developing countries when testing vaccines."[6] A more recent study has shown that anti-vaxxers emphasize the moral values of liberty and purity over fairness and prevention of harm.[7] Liberty in this case is associated with freedom, personal responsibility, property rights, and resistance to state intervention, whereas purity reflects a concern with boundaries and avoidance of contamination. Thus, anti-vaxxers have condemned public health efforts to ensure widespread vaccination as unwarranted paternalism, not only on the basis of

misguided practical beliefs about the safety of vaccines, but also on the basis of strongly held moral beliefs, particularly those focused around the sanctity of freedom of choice and bodily integrity.

However, despite their attempts to frame mandatory vaccination as immoral, anti-vaxxers are widely viewed with moral disapproval not only by the scientific-medical community, but by mainstream society as well, who see them as irresponsibly and selfishly risking not only the health of their own children, but also, and more importantly, compromising the "herd immunity" of the general population. In this regard, the anti-vaxxer's actions are routinely moralized in a manner analogous to those of the smoker; they are not generally treated as morally neutral preferences. In some cases, responses have gone well beyond mere feelings of disapprobation. According to a review published in *Pediatria Polska*, some pediatricians have reported dismissing families who refuse to vaccinate.[8] Meanwhile, others have made the case that there may be legal grounds for holding anti-vaxxers accountable for their choices, which put significant numbers of others at risk.[9]

In contrast to these two examples, consider the processes of moralization common in instances of overweight and obesity. In this context, at least in mainstream American culture if not in other settings as well, moralization tends to function by linking an individual's body weight to that individual's moral character. The poor health of overweight or obese individuals is often taken as a sign of a preexisting moral defect-–gluttony, weakness of will, lack of self-control, or sheer laziness–which ultimately manifests in being overweight or obese. What is interesting about this sort of case, and part of what differentiates it from the first two examples, is that although the individual's poor health marks her for moral judgment, the *moral* judgment is not aimed at her obesity as such, but rather at her personal character.

It is not surprising, then, to find that obese and overweight individuals tend to be treated in workplace settings in ways suggestive of a kind of moral suspicion. For instance, studies show that obese people are less likely to be hired than "thin" people, and are perceived as less competent, lazier, and less self-disciplined than their thin co-workers, and that overweight employees are disciplined much more harshly for work-related infractions than normal weight employees.[10,11,12] Tacit moral judgments about the character of overweight and obese individuals seem to be an important part of what enable these forms of discrimination. Despite the fact that overweight and obesity commonly entail a variety of concrete harms for the individual's health, it is not this fact that typically grounds moralization in such cases.

The differences between these three examples notwithstanding, each represents a token of standard-type moralization. By this I mean that, although the specific process differs in notable respects from one example to the next, each intrinsically embodies a process of moralization at the practical level of healthcare choices or health states. It might be suggested that the third example, of the moralization of overweight or obesity fails to fit this claim, since it was argued that the target of the moral judgment is the individual's personal character, rather than her state of health or specific healthcare choices. However, the moralization operative in this particular case "reads backwards," as it were, from the individual's observable physical condition, which is taken as evidence of an otherwise undetectable personal moral defect. In other words, were these same individuals not overweight or obese, it is unlikely that the same moral judgments

would be directed at their character. This suggests that the moralization hinges on the state of their health, even while it targets their character.

**Conceptual Moralization of Health**

With this in view, I want to introduce a fourth example that shows a different type of moralization of health, namely, moralization at the level of the concept of health itself. To help draw out what is distinctive about *conceptual moralization of health*, as I'm referring to it, let us consider a case of noncompliance that differs from the anti-vaxxer scenario.

A recent female Haitian émigré to America, who has settled in the greater Boston area, has been receiving nutritional counseling through a local community health alliance, which provides healthcare services to underserved communities. She is overweight, with a body mass index (BMI) of just under 28. She is being seen because she has high cholesterol (over 250 mg/dL), but, as a black woman, she is also at a higher risk for heart disease and diabetes, among other things, and given the fact that she has maintained her traditional Haitian diet, these risks may develop into actual disease unless she takes preventive steps. The nutritionist overseeing her case is sensitive to a range of relevant issues, such as:

- Patients' eating habits and behaviors and their reasons for them;
- Self-assessments of what potential interventions are realistically achievable, given patients' circumstances (i.e., income, access to affordable nutritious foods, ability to prepare nutritious meals, access to safe available space for exercise, free time to prepare foods or exercise, and so on);
- Accounts of patients' general living situations, focused on social and infrastructural features that support or undermine potential courses of action; and
- The various meanings and significances patients attribute to certain foods and food behaviors.

Given the various factors that are in play, rather than recommend that the patient eliminate all traditional Haitian cuisine, the nutritionist has recommended introducing modest and easily adhered-to dietary adjustments, designed to promote improvements noticeable to the patient herself, with the idea that these gains will then motivate further healthy modifications, in a gradual stage-wise manner. Despite this moderate approach, however, the patient has remained noncompliant for several months. The nutritionist suspects health literacy challenges may be the source of the problem—that the noncompliance may be a function of the patient's failure to adequately comprehend the health risks involved in her case—or, perhaps, that the patient simply does not want to give up any of her traditional eating habits, no matter how seemingly minor the concession. Through conversation, however, the nutritionist is finally able to ascertain that neither of these assumptions is correct. In fact, the patient has a clear understanding of the health risks involved in maintaining her current dietary habits, and, moreover, is not unwilling to try adjusting them. Instead, it turns out that her noncompliance is rooted in her strong desire to maintain her current body weight. Her reason is that a fuller figure for a woman is considered beautiful in the context of her home culture and values, and this matters more to her than improving the health markers she associates with weight loss.

Although there are likely to be moral judgments directed at the woman's character in the manner typical of overweight and obese patients more generally—the usual attributions of laziness, gluttony, and so on—cases such as this may activate an impulse to make moral judgments at another level as well. For many, the patient's noncompliance is seen as particularly transgressive and morally irresponsible precisely because it defies medical-scientific values that the patient clearly understands, in deference to cultural values that, viewed from the outside, may seem comparatively trivial, or even vain. Thus, there is a perceived problem of responsibilization, insofar as the patient fails to recognize and yield to the presumed hegemony of medical-scientific values over her home cultural values. To the extent this is the case, it suggests that scientific-medical values are effectively treated as possessing the property of *overridingness*, a property commonly attributed to moral norms.

Overridingness refers to the thesis that moral norms take rightful precedence over the norms of other normative domains whenever they come into conflict.[13] In addition to morality, we also rely on other normative domains to assess our actions. For example, we routinely utilize legal norms, norms of prudence, and norms of etiquette, to guide our daily conduct. However, it is not the case that the normative demands of these different domains cleanly coincide. For example, abiding by the rules of etiquette may be imprudent in certain situations. Or, to take an example more to the point, from time to time laws are perceived to be immoral, and in such cases the morally-appropriate response may well require us to carry out illegal activities.

Overridingness can be understood in more than one way, and not everyone devoting philosophical attention to the matter is in agreement that moral norms or reasons automatically override nonmoral norms or reasons, or that when they do, it is because of the specifically moral features involved.[14,15,16,17] For the purposes of my hypothesis, however, I am not concerned with the well-groomed technical accounts of professional philosophers, but rather with the typical responses of ordinary individuals in situations when moral norms and nonmoral norms are perceived to clash. The overridingness thesis explains the commonly held intuition that in such situations, the relevant moral norm takes rightful priority over the relevant nonmoral norm. Of course, even in ordinary cases of this sort, recognizing the priority of a moral norm over a nonmoral norm in a given situation, on its own does not necessarily make it clear what a morally appropriate response to the situation is, even though it may be adequate to surface one's moral judgments. Identifying a law as immoral is one thing; carrying out a moral response to an immoral law is another thing altogether.

Although a fascinating question, it lies beyond the scope of this article to explore the possible reasons why medical-scientific values are often treated as overriding other norms and values. In terms of the case at hand, however, a plausible hypothesis is that medical-scientific values and norms are presumed to be abstract, objective, nonrelative (i.e., universal), and value-free. As such, they are believed to be detached from the entanglement of contingencies characteristic of individuals' various cultural home-values, which are viewed, by contrast, as nonobjective, relative, or perhaps even crudely subjective. Because objectivity is consistently linked with rationality in the Western consciousness, the cultural home-values of the Haitian patient in our example appear irrational in the face of the competing medical-scientific values. This interpretation treats the moral verdict in something like the

rational standpoint sense of moral verdicts. Paul Hurley describes the rational standpoint sense of moral verdicts thus:

> To claim that we are *rational standpoint morally required* to perform actions of a certain type, e.g., to keep our promises, is to claim that we have decisive reasons simpliciter to keep our promises that are in some sense distinctively moral, at least ceteris paribus. It is to claim that we ought to keep our promises in the standard decisive reasons sense of ought, and that the reasons why we should do so are in some sense distinctively moral reasons . . . On the rational standpoint sense, claims of moral requirement are claims of rational requirement simpliciter.[18]

To help clarify my position, it is worth comparing the case of the Haitian woman to the case of the anti-vaxxer. There are, of course, elements of the anti-vaccination movement given to fringe conspiracy theories, but many anti-vaxxers are simply confused about the data, doubtless in good part because the fringe group has successfully muddied the waters. The conspiracy-theorist fringe can, I think, safely be judged to be anti-scientific, at least with respect to medical matters. Many anti-vaxxers, however, remain committed to medical-scientific values; they have simply been confused by the prevalence of misinformation. Our Haitian patient differs both from the antiscientific anti-vaxxer, and the pro-science, misinformed anti-vaxxer. Unlike the latter, she clearly understands the medical science, and unlike the former, she respects medical-scientific values. At a minimum, this is evident by her commitment to maintain meetings with her nutritionist. The crucial difference in her case is that she holds medical-scientific values lower in her personal hierarchy of values. Unlike many, who take it as obvious that the medical-scientific values involved rightfully override the patient's cultural home values, for her, the same conclusion is not straightforward or self-evident.

To the extent we are inclined to see her prioritization of her home cultural values as a problem of responsibilization, this suggests we are moralizing the concept of health. For it suggests that we have, at least tacitly, taken medical-scientific values as rightfully overriding her competing cultural values, in the same way that moral norms are ordinarily taken to override other norms when they conflict with one another.

**What We Can Learn From Evidence-Based Research**

Against the grain of this impulse to moralize the concept of health (and apart from the question of whether medical-scientific values are culturally-neutral) results from evidence-based research, particularly systematic reviews and meta-analyses, increasingly suggest that the role played by dimensions of personal meaningfulness in the overall quality of individuals' health is underappreciated.

Consider the following handful of examples. A 2008 study established a basis for determining patient competency in cancer contexts, pointed to related health effects of competence, and suggested the fruitfulness for future investigations into other mechanisms for coping with life-threatening disease, like optimism, hope, sense of coherence, empowerment, and self-advocacy.[19] A meta-analysis published in 2009 found that patient-centered cancer care that engages patients as complex selves through "patient-centered communication" and "affective behavior" (including physicians' displays of approval, concern, empathy, worry, reassurance,

positive affect, and informal physician-patient talk) more strongly correlated with a variety of patient benefits, including, but not limited to patients' adherence to treatment and post-treatment quality of life, than did "instrumental behavior" (such as basic question-asking and direction-giving).[20] Similarly, a 2007 study showed benefits among advanced cancer patients whose oncologists communicated about emotions during visits.[21]

Atul Gawande cites another study that followed 4,493 Medicare patients with either terminal cancer or congestive heart failure, which found that among patients with breast cancer, prostate cancer, and colon cancer, there was no improvement in survival for those choosing aggressive, standard therapy over those choosing hospice. And "[c]uriously, hospice care seemed to extend survival for some patients; those with pancreatic cancer gained an average of three weeks, those with lung cancer gained six weeks, and those with congestive heart failure gained three months."[22] A 2014 systematic review found that having a purpose in life correlates to improved mortality, even when controlling for age, culture, and other psychosocial factors.[23] Another study, published in 2007, suggested health benefits for workers whose working conditions allow for creativity.[24] A longitudinal study published in 2007 demonstrated the benefits to the elderly of volunteering.[25] And, finally, a prospective study of mortality rates published in 2003 suggested that providing social support was even more beneficial than receiving it.[26]

Taken in isolation, no single one of these studies offers much insight. But taken collectively, they suggest the plausible, if broad, hypothesis that systems of meaningfulness and significance are relevant to the health of individuals. This is helpful, for a useful way of understanding systems of personal meaningfulness and significance is that they are represented or embodied in an individual's personal values. This is not to say that there is a one-to-one correlation, however. Meaning and significance are fluid, often very subtle, and in some cases, may exist below the level of an individual's conscious awareness. Nevertheless, insofar as values are beliefs and commitments that individuals use to guide their conduct, one's values will at least be a general reflection of her more stable sources of meaning and significance.

For instance, it seems to go without saying that whatever one's purpose in life may be, it represents or embodies some value, or set of values held by that individual. If volunteering or being a reliable social support for others is a source of meaningfulness or personal significance, then one likely holds something like generosity, benevolence, and/or kindness as personal values. Thus, while we should not expect one's systems of meaning and significance to be coextensive with one's set of values, we may reasonably anticipate that they will overlap with and reinforce one another.

These and similar data exhibiting the same basic pattern are open to more than one interpretation. Among the interpretive frames worth foregrounding is that these data suggest that an individual's personal values are relevant to her health states. To the extent that this hypothesis is plausible, it represents reasoned empirical grounds for curbing the impulse to moralize the concept of health, particularly in cases where medical-scientific values initially appear to be at odds with an individual's personal values.

## Conclusion

I have argued that moralization of health occurs not only at the practical level of healthcare choices and health states, which has been the prevailing focus in the

literature on the moralization of health. Moralization also occurs at the conceptual level of our very concept of health itself. This happens when medical-scientific values and norms are viewed as overriding competing values and norms in much the same way that moral norms are taken to override nonmoral norms in cases where they conflict. I have also argued that a growing body of recent evidence-based research suggests the merit of reevaluating our impulses toward conceptual moralization of health.

At a minimum, I think such a reevaluation would involve checking the often-unquestioned assumption that medical-scientific values ought automatically to override other competing values. This assumption should be guarded against particularly in intercultural situations, but also in intracultural situations when the competing values are vital to an individual's most central systems of meaningfulness and significance, since these will be at the core of her understanding of what makes for a full and flourishing life and consequently may represent deep resources potentially to be tapped into for healthy benefit. If we were to begin to regularly and honestly question whether medical-scientific values ought automatically to override other values, I suspect we would frequently be unable to demonstrate that they should.

What is more, I suspect that when we begin to take that question seriously, and assess the relative merits of medical-scientific values compared to other value sets, it will become less clear that there is such a rigid distinction to be drawn between them in the first place. In the case of the female Haitian patient, for example, prioritizing medical-scientific values seems to amount to valuing certain physiological markers over everything else. Yet little effort is required to see that the concerns embedded in the woman's home cultural values at the very least connect directly to matters of her psycho-social and sexual health. This pair of health concerns seems to be at least as pressing in light of her circumstances as a single woman in a foreign setting as the concerns targeted by the medical-scientific values, which it is worth noting are risk factors, not disease states.

In arguing that we ought to guard against uncritical conceptual moralizations of health, I am not arguing that medical-scientific values ought never to override cultural or other deeply held value sets. Recognizing that medical-scientific values do not always override other non-medical-scientific values does not, on its own, clarify in a given case whether medical-scientific values should yield or prevail. For instance, perhaps there is a tipping point at which it becomes apparent that the relevant medical-scientific values ought to override the relevant home cultural values of the Haitian patient, given sufficient deterioration in her health markers. Even granting that, at least in principle, such a point may exist, it nevertheless remains difficult to determine where to draw the line, and by what criteria. Assuming a scenario in which that determination was relatively uncontroversial, conceptual moralization of health may be warranted. Even so, it would be considerably more ambiguous than other "positive" forms of moralization, such as the moralization of public smokers' and anti-vaxxers' behaviors. In both of these cases, moralization is grounded straightforwardly in the harm principle. By contrast, the Haitian patient's behaviors do not violate the harm principle. Thus, to hold that conceptual moralization of health is warranted in her case, would be to contend that her health states are so severe as to warrant curbing her autonomous decision to prioritize her relevant home cultural values over the relevant medical scientific values. It is challenging at best to imagine a relevant scenario that would

not run afoul of our commitment to the principle of autonomy, which, it should be noted, extends all the way to a patient's right of refusal of even lifesaving interventions.

Notice, however, that the relevant home cultural values and medical-scientific values may very well overlap before reaching such a theoretical tipping point. Medically, her risk factors may develop into diseases, while culturally, she may become too full-figured to remain attractive to potential partners in her community. One of the merits of sensitizing ourselves to the uncritical habit of moralizing the concept of health is that doing so is a valuable check on the impulse to binary, either/or forms of thinking; it opens space for recognizing fruitful overlaps in value sets when they exist.

In this connection, there is a helpful insight to be gained from the hedonistic paradox. According to the hedonistic paradox, the direct pursuit of pleasure may actually undermine one's ability to experience and maximize pleasure, whereas engaging in other activities not directly aimed at pleasure, such as meaningful pursuits reflective of one's values, commonly yields pleasure. Consider volunteering. One does not typically volunteer because volunteering is a direct route to pleasure, that is, because it is intrinsically pleasurable. Rather, one volunteers because volunteering expresses one's values. The pleasure one experiences from volunteering is indirect, a function of one's values finding a satisfactory outlet. For the individual whose values are not thus reflected, volunteering will seem burdensome.

A similar, counterintuitive logic appears to be at work with respect to health. An obsessive focus on the pursuit of health (conceived abstractly as a state of normal variation of statistical ranges) may actually be less effective at achieving the desired outcomes in many cases than focusing on a broader scope of patient concerns that, *prima facie*, appear unrelated to health. In a case such as that of the Haitian patient, appealing strictly to the presumed overridingness of the medical-scientific values is likely to prove counterproductive, particularly, if as seems likely, doing so will be perceived as an assault on her other, more central values. Appealing to the more deeply held, overlapping home cultural values is likely to better promote the desired medical outcomes. So much the better if this proves to be the case. However, if it does not, the conclusion cannot be drawn, apart from careful and critical assessment, that the conflicting values must yield to the medical-scientific values. Regardless of whether these values promote a patient's health, they are deserving of respect in their own right.

Part of what this investigation has suggested is that a given individual may be subject to different levels, degrees, or kinds of moralization simultaneously, across or between different health conditions, depending on how views about these conditions intersect with prevailing cultural assumptions about medical-scientific values, broader cultural expectations and norms, and so forth. In any case, a growing body of evidence helps us see why the distinction between medical-scientific and other values may be less straightforward than it seems, and consequently why assessing trade-offs between them needs to be handled with greater care than is commonly done. More robustly, however, I think this discussion should prompt us to begin to reevaluate our very concept of health, which will become increasingly inadequate as this body of evidence continues to grow, demanding a more broadly integrative theory.

## Notes


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