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Commentary on van Poppel

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Commentary on Lotte van Poppel's "Pragma-Dialectics and Health Communication: Arguing for behavioural change in advisory health brochures"

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1. INTRODUCTION

In this paper, van Poppel argues that "the quality of argumentation in health communication needs more attention" She specifically focuses on health advisory brochures, as a distinct communicative activity in the 'consultation' genre of the medical domain, and discusses the relevance of a pragma-dialectical approach to the analysis of health communication.

For the purposes of this discussion, I shall critique her case as summarised in her conclusion that while health brochures "attempt to convince readers of the acceptability of health advice" within the constraints of "reasonableness," the public should get "the opportunity to critically assess health claims." Van Poppel states that the unequal knowledge relationship between health institution and public has required certain norms of behaviour by the institutions (such as using only justifiable and truthful claims about the risks of not changing behaviour). Yet, norms can be circumvented by strategic manoeuvring which, van Poppel implies, may become rhetorical and unjustified. The assumption of a rational public seems to be her justification for applying a pragma-dialectical approach to health advisory brochures.

Van Poppel then places a caveat on her discussion that in the end, the theory of argumentation applied to the health communication does not need to demonstrate effectiveness in order to be a useful tool to "detect possibly fallacious manoeuvres."

My commentary will focus on four aspects:

- The context of production of health advisory brochures and their role (Context)
- Whether argumentation structures are appropriate tools (Appropriateness)
- Internal evidence from pragma dialectic literature about whether the pragma-dialectic approach is a useful tool in this context (Usefulness)

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- Internal evidence from this paper about how van Poppel makes her own argument (van Poppel's argument)

2. CONTEXT

Health advisory brochures are rarely used in Australia to advise people on behaviour change without a substantial and sophisticated process of behaviour modification promotion, using both positive and negative reinforcement and at both conscious and social levels of engagement. In fact health advisory brochures have been generally found ineffective alone and are usually not used by institutions for this purpose except as part of a much larger campaign, as demonstrated below...

The Australian view on using "speech acts" to address public health issues are firmly based in social change and social marketing[1] called the "New Public Health." Print media certainly form a component of the programs, but are rather more marketing oriented "rhetoric," in the argumentation lexicon, rather than "dialectic." This is (as van Poppel acknowledges) because of the difference in knowledge levels of the protagonist and the audience and the fact (not acknowledged by van Poppel) that most social diseases are more prevalent in less educated and lower socio economic groups. In fact, many of these social lifestyle pre-disposers to diseases (smoking, obesity & diet for example) are built on social conditions that are not amenable to social marketing and behaviour change, because they require fundamental changes to the way that people live—income, education, and social opportunity and control of their future. These are political resource allocation problems that will not be solved by producing a brochure! Indeed, van Poppel recognises that a pragma-dialectic approach can only focus on how arguers might try to achieve an effect and not on the actual processes of behavioural change.

The language of health promotion discourse in the New Public Health was probably initiated by the Ottawa Charter (Goltz & Bruni[2]), who argue that social reality is constituted in the language used. In this construct, knowledge, including medical knowledge, is power used to control peoples' behaviour. The state has responsibility for disease prevention, so uses technology, including mass education programs, "to produce voluntary behaviour change and legislative, economic and fiscal initiatives designed to regulate behaviour by means of rewards or punishments" (p. 522). However, the notion of individual perversity was eventually replaced by the notion of

> individual susceptibility […] [and] […] the discursive practices of the health educator shifted from information transfer to the inoculation of individuals with self-esteem and life-skills training (p. 523).

In other words, there has been a shift in Australia from manipulating behaviour change to empowerment of individuals to change themselves because they could not and would not do it otherwise. Furthermore, the Ottawa Charter is founded on Milio's framework[3] that

[1] Baum, F. (2002) The New Public Health (2nd Edn) Oxford University Press, particularly Chapter 6-17: *Behavioural health promotion and its limitations.pg 323.*

[2] Goltz, K. and N. Bruni (1995) Health promotion discourse: language of change*?* In Gardner, H. *The Politics of Health: the Australian experience (2nd Edn)* Churchill Livingstone, pg 510 ff

[3] Milio, N. (1976) A framework for prevention: changing health damaging to health generating patterns, *Am Jnl Public Health* 66 (may): 435-439

is in turn based on a planned process "to achieve desired health outcomes which are constructed within a particular model of health." The Ottawa Charter is constructed on five key health promotion action slogans: healthy public policy, create supportive environments, develop personal skills, strengthen community action and reorient health services. None of these relate to rational knowledge transfer!

In order to link this paper to reality, I visited our local family practitioner clinic and took a copy of most of the brochures available in the waiting room. 15 brochures were obtained, on a variety of topics including breast awareness, obesity in women, family violence, celiac disease, organ donation, avoiding heart attacks and quitting smoking (see the attached table). Each of the 15 spent most of the pamphlet on information about the topic, which probably reflects a selection bias by the practice. National campaigns have been held on breast cancer, obesity, family violence, organ donation, quitting smoking, osteoporosis and depression. On the other hand, cervical (Pap) smears, menopause, contraceptive alternatives, celiac disease, saving drug costs and DNA parentage testing have not been part of a national campaign, although there has been considerable general publicity around the risks of HRT in the last few years and around heart disease. Of the 7 campaign topics, 5 publishers are government or community owned. The obesity pamphlet was published by a drug company as sponsor, but with an emphasis on knowledge transfer. The osteoporosis drug company has run a national awareness campaign and the brochure reinforces the message, of the other 8 conditions, 5 are published by for-profit organisations and the other 3 by not-for-profit, although all have a focus on information transfer. My conclusion is that advisory health brochures in this sample are primarily focussed on information transfer, although the sponsoring drug company may include self-promotion. However, many pamphlets are also provided by community or government sources and also aimed at knowledge transfer. Sometimes, the information is about behaviour change and is dialectical in nature (eg organ donation) although in this sample, it is linked to a national campaign.

3. APPROPRIATENESS

At my medical school, students learn about behaviour modification during their first year in hands-on experience, by engaging with real people (such as themselves) with real problems (such as obesity).

In the context of behaviour change, Rob Donovan[4] describes the underlying model to develop a communication strategy to consist of a hierarchy of beliefs, attitudes, intentions and behaviour. The process is informed by several marketing principles such as:

- The receiver is an active participant in a dialogue
- Different target audiences respond differently
- Formative research, is essential, including message pre-testing
- Comprehensive and coordinated multimodality strategies are most successful
- Multiple delivery channels are needed
- Campaigns must be long

[4] Donovan, R. Communication for change in Moodie R, and A. Hulme (2004) Hands-on Health Promotion, *IP communication Melbourne,* pg 68 ff.

- The use of a theoretical framework gives a structure to the exercise and promotes success
- Messages should be given an a mode that simulates interpersonal communication

In fact, in many ways this is a form of advertising and uses similar structures, such as that of Rossiter and Percy[5] with a sequence of tasks in the strategy of: (i) Exposure (awareness of obesity as a problem), (ii) Message processing (fat children eat too much and make fat adults), (iii) Communication effects (school tuck shops stock only healthy food), (iv) Behavioural effects (children think it un-cool to be fat), (v) Adoption of change (children eat less and exercise more), evaluated by (vi) Outcome change (reduction in diabetes).

In the context of this Commentary, it will be apparent that, while pragma-dialectics may have a role (active dialogue), brochures are not the way to achieve behaviour change. In fact, my observations of successful behaviour change campaigns in Australia, such as those focused on smoking (Quit campaign), road safety (Transport Accident Commission, Vehicle Insurance & Monash University Accident Research Centre in a virtuous cycle) and prevention of skin cancer (Slip, Slop, Slap), suggest that brochures form a minor part of the whole exercise. In my own practice as a haematologist and oncologist, brochures have proven useful for information about diseases and treatments because they can be taken away as a resource. However, in the same context, they have been less useful for discussions about behaviour, which require questions and answers in a trust relationship. In my experience in blood transfusion, many public campaigns were run to change the behaviour of non-donors to donors—where the beneficiary was the common good—and brochures played a role only in knowledge transfer, but formed only a small component in behaviour change.

Health promotion communications may have one or more of several objectives[6], such as Medical or Preventive information, Behaviour change, Educational, Empowerment or Social change. In my experience, brochures are primarily used for education, not to establish a dialogue. Others have described different approaches to behaviour change. For example: Caplan & Holland[7] describe a continuum of approach from expert-led to self-help networks, with individual or societal dimensions as well, such as demonstrated by the successful Quit (smoking) campaign in Australia. Beattie[8] proposes four paradigms: Persuasion, legislation (coercion), personal counselling and community development, a combination used in managing the threat of HIV/AIDS in Australia. On the other hand, Tones[9] considers that education for health informs discussion at various levels including the professional, leading to political advocacy, which promotes a healthy environment and the road safety virtuous cycle is an example.

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[5] Rossiter, J.R and L. Percy (1997) *Advertising communications and promotion management* 2nd Edn McGraw Hill New York

[6] Naidoo, J. and J. Wills (2000) *Health promotion: foundations for practice* 2nd Edn Bailliere Tindall Sydney pg 91ff

[7] Caplan R and R. Holland (1990) Rethinking health education theory, *Health Education Journal*;49:10-12

[8] Beattie, A. The changing boundaries of health. In: Beattie A, Gott M, Jones L, Sidell M (Eds)(1993) *Health and Wellbeing : a reader Macmillan/* Open University, Basingstoke

[9] Tones, K. and S. Tilford (1994), *Health Education: effectiveness, efficiency, equity* 2nd Edn, Chapman & Hall: London

Ewles and Simnett[10] describe a seven stage process to plan and evaluate health promotion, including: Identify needs & priorities, set aims, decide how to achieve those aims, indentify resources, plan evaluation, set an action plan and implement the plan. Wright[11] underscores the importance of understanding how information presentation needs to be targeted to the particular audience in order to ensure effective communication.

4. USEFULNESS OF THE PRAGMA DIALECTICAL PROPOSITION

Lacking a background in argumentation, I have had to reference my arguments to key authors in pragma dialectics such as Frans H. van Eemeren and his collaborator Rob Grootendorst[12]. These authors state very early (p. 2) that there is an implicit appeal to reasonableness in the reader, otherwise there is no point in argumentation. As discussed above, I would argue that for behaviour change in public health, the intellectual reasonable argument is rarely and perhaps never effective alone.

In other words I would argue that the tool of pragma dialectics is inappropriate to public health behaviour change programs, at least in Australia. When a bureaucracy is being persuaded to spend money on a campaign—say against smoking or obesity or risky acts for HIV/AIDS- then argumentation theory and practice will certainly be relevant, but not particularly in behaviour change of individuals in the public arena! The government bureaucracy is expected to be knowledgeable and to want value for spending public money when requested to do so by a lobby group such as doctors.

However, in a different article[13] the authors consider that "argumentative discourse should be judged not only in its success in gaining the audience's assent, but also in terms of its problem solving capacity." This would support my contention that the argument must be practically useful.

In fact van Eemeren and Grootendorst propose four stages of argument: confrontation, opening, argumentation and concluding stages and the construct should cover all forms of "speech acts," exactly as outlined in a total program to convince bureaucrats to spend money on a public health problem. The authors accept that the pure, Aristotelean, definitions of dialectic and rhetoric need to be combined in reality and the dialectic effectiveness of the argument can be enhanced by rhetoric. This supports Toulmin's comment that rhetoric was until recently seen by many logicians as no more than the "deceptive peddling of falsehoods"[14]. However, it is apparent that pragma-dialectic theory, even expanded to include multimedia and the flourishes of rhetoric, cannot be applied to the context of a behaviour change program because of the anonymity of the target audiences and their lack of power and education relative to the protagonists.

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[10] Ewles, L. and I. Simnett (1999) Promoting Health: a practical guide, 4th Edn Bailliere Tindall, Edinburgh In: Naidoo, J. and J. Wills (2000) *Health promotion: foundations for practice 2nd Edn*, Bailliere Tindall Sydney

[11] Wright, P. Writing and information design of health care materials. In: Wright, P. (1999) *Writing, texts, processes and practices*. Longman.

[12] Eemeren, F.H. van and R. Grootendorst (2004). A Systematic Theory of Argumentation: the pragma-dialectical approach, Cambridge Univ Press.

[13] Eemeren, F. H. van and P. Houtlosser (2002). Strategic manoeuvring; Maintaining a delicate balance. In: Eemeren, F.H. van and P. Houtlosser (Eds), *Dialectic & rhetoric*, Kluwer, Netherlands.

[14] Toulmin, S.E. (2001). Return to reason. Cambridge Massachusetts: Harvard University Press.

Van Eemeren and Grootendorst attempt to refute my argument by using a hypothetical rabbi[15] to describe pragma dialectic as "an ideal model of critical discussion and a procedure […]" In the real world, of course, all models are wrong, but some models are useful[16], meaning that slavish attachment to any model should not be allowed to get in the way of understanding the real world—but may on occasion be useful to that understanding. The theory of pragma dialectics is based around the (useful) belief "that argumentation is an attempt to overcome doubt regarding acceptability (of a point of view)" (p. 53). The authors are comfortable with the position that the antagonist position in the dialogue may be silent or implicit, as required by van Poppel. However, I would argue that the model does not apply in the case of advisory health brochures to change behaviour because the assumption that the audience is rational is inaccurate and not useful.

Van Eemeren and Grootendorst use an example of behaviour change literature from the HIV/ AIDS campaigns (p. 115ff). While they are able to demonstrate that the authors of the (presumably Dutch) posters have made quite complex assumptions of comprehension by their audiences there is no demonstration that the posters have been effective in changing behaviour. The authors assume enough knowledge in their audience of young people about sexually transmitted disease and pragmatic beliefs about the uniqueness of the current sexual relationship as isolated from real life behaviours of the sexual partners that they can use irony. However, in the real world of Australia (as distinct perhaps from the Netherlands) most young people at the time (mid 1980's) had limited knowledge about sexually transmitted disease, about male to male sex, about sex education in general and about the risks of drug taking and were driven by more primary instincts of sexual gratification. However, the government undertook a very large behaviour change program over many years that included legalisation of brothels, needle exchange programs, changing blood services, education about male to male sex and decriminalising drug use (though not drug pushers), which has resulted in a different society by the mid-90's. Brochures were used to provide information to back up multi-media slogans.

In summary, while the protagonists for pragma-dialects repeatedly emphasise requirement for a rational and reasonable audience (p. 124 ff), I am sceptical that such an audience exists when behaviour change is required in non-rational acts such as sex or eating or smoking. Instead, I believe that rational argument is only one aspect of such a health campaign, and then often as a justification with the bureaucrats who pay the marketers and legislators who use more emotive or coercive means of communication.

5. VAN POPPEL'S ARGUMENT

As a scientist, I am used to evidence being provided to support sweeping statements and I have been disconcerted to find no examples of health brochures in the paper to support the author's arguments.

Often the sweeping statements in the paper form the springboard for the subsequent argument such as "Since many modern-day health risks can be avoided or

[15] Eemeren, F. H. van and R. Grootendorst R (2004). A Systematic Theory of Argumentation: The pragma-dialectical approach. Cambridge Univ Press.

[16] Box. G.E.P. and N.R. Draper (1987). Empirical Model-Building and Response Surfaces. Wiley. pp. 424.

diminished by making different lifestyle choices (see e.g. Buchanan 2008), a common (relatively cheap) way for institutions to advise a large amount of people is the distribution of health brochures." This refers to knowledge transfer with the intention of initiating behaviour change. A discussion ensues, that concludes with the statement "Every reader (of a brochure) determines whether the argumentation is convincing or not and whether he will adjust his behaviour." This reinforces my interpretation of van Poppel's thesis that the purpose of the brochure is to change behaviour rather than to inform in a dialectic argument.

This is indeed van Poppel's thesis—that the reader of a health brochure is the subject of a purposive speech act designed to change their behaviour. For example "You should eat 5 portions of fruit per day" and "It is good to exercise every day." Although she subsequently seeks to de-link the dialectic of the speech act from its success or failure in public health terms, linking it only to acceptance of the argument by the reader. She then quotes authority that the three main determinants of intention are one's attitude, the perceived norms and one's perceived capability of performing the behaviour and finally that the advice is beneficial. I would also agree that "The various ways in which institutions try to implement such theoretical assumptions in practice (see e.g. O'Keefe 2002), can be explained in pragma-dialectical terms." However, I would contrast the all-encompassing terms used in this quote (and my earlier discussion) with the narrow focus on health advisory brochures in this paper. Obviously, to be effective, the target audience should be well characterised in marketing terms to ensure the strategy and tactics used will be effective—for example in Australia, the recipients of information about male to male sex in the HIV/AIDS campaigns were given very different information and in different modalities from the users of a needle exchange program. However, again, the modalities used were much more than just advisory brochures.

I would agree with Van Poppel that the "disparity in knowledge and power between sender and receiver of the (health) message." And I would argue that the discrepancy is so great that often the state uses non-rational means to persuade behaviour change in the interests of the greater good (for example, costs of public health care, or herd immunity) as well as the personal good (avoiding diabetes through obesity, or avoiding whooping cough).

The issue of informed consent is really only relevant if it can be transferred from an individual circumstance to the concept of public consent. The nature of public consent to behaviour change campaigns has not been debated in Australia because it is perceived that our democratic institutions of the press, the judiciary and the next election cope well enough with perceived and real invasions of personal privacy, but may be of issue in more authoritarian societies. This is the democratic mechanism for dealing with Van Poppel's statement that

> when medical institutions […] have to take financial or political interests into account, it will become much harder to (believe) that the advice is indeed beneficial for the individual reader.

This is fair criticism for drug companies and has been seen in some totalitarian regimes in Europe. It has also been imputed in race-specific campaigns—such as screening for sickle cell disease in Afro Americans.

Van Poppel then returns to her underlying assumption that the audience for an advisory brochure is rational and reasonable and that the brochure is a useful way of changing behaviour. As demonstrated, I would refute these assumptions and therefore her case, if it is limited to the brochure as a stand-alone media tool.

6. CONCLUSION

The nub of van Poppel's belief structure appears to be

> In health communication, it is of special importance that the public gets the opportunity to critically assess health claims and their justification, because of the unequal position of institutions and the public and the possibly far-reaching consequences of accepting or not accepting an advice.

However, in this statement, the "public" interest can be interpreted as the individual good or the general population good. In Australian society, the general population interest is served through democratic systems of politics, lobby groups, a free press and an independent judiciary to enable the dialogue to occur. This dialogue, which can be termed pragma-dialectical as I understand the term, occurs between the protagonist institutions (a government or other community agency or a drug company) and is not conducted through the medium of a health advisory brochure. The private person is usually (as van Poppel says) at a knowledge and power disadvantage that precludes application of the pragma-dialectic model to any health advisory brochure on its own, but can be conducted as described campaign of which an information brochure may form a part. However, I would contend that a health advisory brochure is rarely intended to or able to function as a dialogue on its own to convince an anonymous public person to change their ways.

Link to paper