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The Sociological Practitioner in Organizational Health Promotion Programming

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ABSTRACT

In this paper, the roles of the sociological practitioner will be investigated as they apply to the rapidly growing field of organizational health promotion. Health promotion programs include a combination of educational, organizational, and environmental activities designed to support health-conducive behavior within the work setting. Such programs usually include weight reduction programs, aerobic exercise classes, blood pressure monitoring and so on. Theoretically, the ideas of Mead and Becker are investigated as one approach to the understanding of health behaviors. Methodologically, the utilization of needs assessment and evaluation tools provide integral information for the development of a program specifically tailored to meet the needs of an organization. Finally, the clinical sociologist, as a practitioner, can work to design successful programmatic interventions for the worksite. The field of helath promotion provides a number of roles within which sociologists could find viable employment.

Introduction

The advent of organizational interest in promoting the health of employees provides sociological practitioners with an opportunity to utilize theoretical, analytical, and interventionist skills in an emergent job market. Wellness programming centers around health promotion rather than disease prevention. As one founder of health promotion ideas, Dunn (1961) attempted to devise a

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new way of thinking about health by differentiating the disease process, which is dominated by medical practitioners, from the process of health promotion, which is dominated by social scientists, educators, and others. Conrad (1988) defined health promotion as a combination of educational, organizational, and environmental activities designed to support behavior conducive to the health of employees and their families. Health promotion activities traditionally include the provision of exercise facilities, the addressing of specific health problems such as hypertension, the assessment of overall health status, and the investment in comprehensive health promotion programs (Breslow, Fielding, Herrman, and Wilbur, 1990). Weight reduction programs, aerobic exercise classes, blood pressure monitoring, general health education, nutrition programs, and stress management programs, are examples of typical health promotion programs at the work site.

Employers have become increasingly involved in health promotion activities. Hollander and Lengermann (1988) have indicated that two-thirds of the Fortune 500 companies have wellness programs; the other third have plans to start programs. In addition, two-thirds of worksites with over 50 employees and one-fifth of companies having between 50 and 100 employees have reported involvement in one or more areas of health promotion (Fielding and Breslow, 1983; Davis, Rosenberg, Iverson, Vernon, and Bauer, 1984; Fielding and Piserchia, 1989). In one study, 78 percent of all companies in California were reported to have at least one health promotion program (Fielding and Breslow, 1983). Participation rates of employees for on site programs range from 20 to 90 percent (Fielding, 1984; Kiefhaber and Goldbeck, 1986).

Escalating health care costs and employee absenteeism are two motivating forces behind organizational involvement in health programming. Tenneco reported that the average claim for nonexercising females was $1,535, compared to $639 for exercising females, with a similar differential reported for males (Stockel, 1988). Smokers cost employers an annual estimated $624 to $4,611 more than nonsmokers in increased medical costs, absenteeism, replacement costs, maintenance, property damage, other insurance increases, and lower productivity (Kristein, 1980; Weis, 1981). Cardiovascular disease and hypertension result in an estimated 26 million work days lost annually (LaRosa, 1983). Finally, excessive drinking has resulted in an estimated 19 billion work days lost per year (Cunningham, 1982).

Within this paper, the primary roles of the sociological practitioner as a theoretician, as a researcher, and as an interventionist will be applied to the health promotion setting. The intent of this overview is to provide sociological practitioners who are new to this field with some basic information about the nature of health promotion and the possible roles available for their adoption.

The author's comments are derived from experiences working with a small city government in the southeastern United States while developing a health promotion program for its municipal employees.

The Sociologist as Theoretician

Sociological practitioners with training in classical and contemporary theory can provide an appropriate integrative conceptual basis for the coherent introduction, testing, and revision of health promotion ideas. The philosophical underpinnings of wellness programming, which tend to emphasize individual action and self-responsibility, can be expounded on utilizing a micro-level perspective. In this section, emphasis will be placed on micro-oriented theoretical approaches utilized by this author, including Mead's (1934) symbolic interactionist perspective and the health belief model.

Mead's Symbolic Interactionism

Mead's (1934) symbolic interactionist perspective, as expanded by Turner (1987) into a general interactionist model of motivation, can be used to provide one understanding of health promotion activities at the worksite. At the basis of this approach are the ideas of self-directed action, identity, and the definition of the situation; the relationship of these variables is depicted in Figure 1. Each of these ideas will be further developed, below.

The self-directed act.

Mead's emphasis on the self-directed act, the basis of Turner's (1987) interactionist model of motivation, is based on the concept of reflexive thinking which entails the ability of the self to be viewed as an object. As such, one can observe one's self, can engage in an assessment of one's actions in relationship to the actions of others, and can form a response (Mead, 1934). Together, these abilities form the self-directed act.

How is the self-directed act important in health promotion? If the individual develops the ability to view the health component of one's self, to be referred to as the health self in this article, then the individual will engage in activities which reflect the assessment of self as determined by others. If the assessment by others is negative, the individual may choose to act in such a way to reverse this assessment in order to achieve a more ideal or "fit" conception of self. The health self is manifested in and influenced by the physical body, for it is this body that others are reacting to in social interactions such as group exercising (Glassner, 1989; Freedman, 1986). If the health arena is extended to the organizational

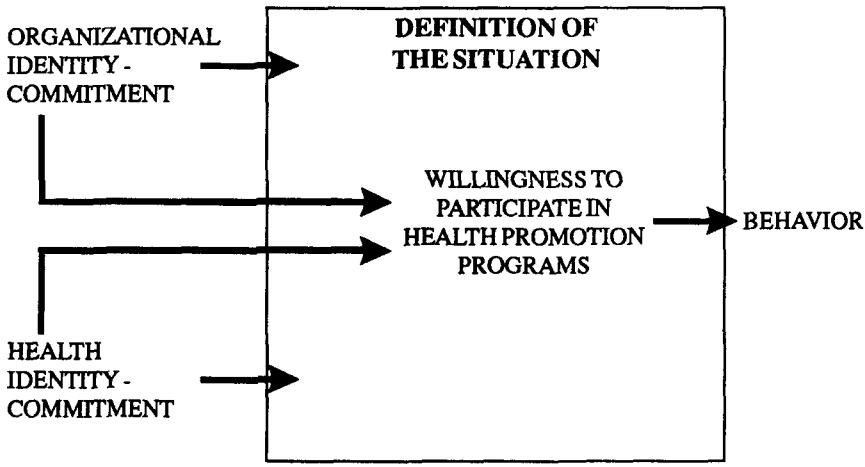

Figure 1. The relationship between identity and behavior

role, as is the case within organizational health promotion programming, then organizational responses to the individual's health state can also be expected to become important in determining both one's health self—that part of the self which corresponds to one's organizational role—that is, the organizational self.

Identity.

Identity is the content of the self-concept. The Iowa School of structural interactionists defines identity as internalized roles (Gecas, 1982). Role identities are not all equal, but differ in prominence and in importance. Therefore, the self-concept can be viewed as a hierarchical arrangement of role identities (McCall and Simmons, 1978; Stryker, 1968).

The extent to which an identity influences behavior is signified by commitment. Cheney and Tompkins (1987) assert that the "degree" of commitment refers to how closely behavior is "tied to self" or incorporated into the self. Thus, the extent to which an organizational identity is incorporated into the self determines the extent to which behaviors are congruent with the stance of the organization. Likewise, the extent to which a health identity is incorporated into the self determines the extent to which behaviors emerge that are congruent with significant others in the individual's health arena. Within the situation under analysis, the stance of the organization and the stance of significant others

within the individual's health arena can usually be defined as supportive of individual participation in health promotion activities.

The definition of the situation.

The definition of the situation influences behavior. W. I. Thomas expressed the belief that "preliminary to any self-determined act of behavior there is always a stage of examination and deliberation that we may call the definition of the situation" (1931:47). When one defines a situation, one represents the situation to the self symbolically and then makes a self-directed response. Thus, the subjective rather than the objective factors of a situation are the primary determinants of behavior. One's identity, as the conglomeration of values, roles, and behaviors that the actor believes to be authentic, serves as a filter through which selective perception and recall occur. Hence, the definition of the situation is influenced by one's identity.

A synthesis of the definitions of both the work situation and the health situation results in a definition of the health situation at the work site. The theme or attitude of importance within this definition is the willingness of the individual to participate in a wellness program. The behavior of importance to the clinical sociologist is that of participation in the health promotion program.

The Health Belief Model

The Health Belief Model (HBM) is another approach to the understanding of the practice of preventive health behaviors. Initially formulated by Rosenstock and his associates (Rosenstock, 1966) and revised by Becker and his associates (Becker, 1974; Becker, Drachman and Kirscht 1974; Becker, Haefner, Kasl, Kirscht, Maiman, and Rosenstock, 1977; Becker and Maiman, 1975; Becker, Maiman, Kirscht, Haefner and Drachman, 1977), the health belief model currently proposes that health preventive behaviors are associated with the following factors: (a) a general tendency to engage in health behaviors, (b) the level of susceptibility of the particular illness or condition, (c) the level of severity of the consequences of the disease on biological or social functioning, (d) the potential benefit of the health directives in preventing or reducing susceptibility and/or illness, and (e) the existence of physical, psychological or social barriers that might affect initiating and/or continuing the health directive. Studies have demonstrated the utility of knowing the health beliefs of clients when attempting to predict health behaviors, especially compliance (Haynes, Taylor and Sackett, 1981). In addition, health beliefs have been shown to be moderately associated with the adoption and maintenance of physical activity (Sallis, Haskell,

Fortmann, Vranizan, Taylor and Solomon, 1986) and the practice of protective health behaviors (Harris and Guten, 1979).

The health belief model and the identity model may be related. Identity, as stated, appears to be an important factor in the formation of attitudes/beliefs. The identity model encompasses beliefs/attitudes within the definition of the situation. Within interactionist theorizing, beliefs logically emerge from identity. Thus, the proposed identity model and the HBM may be complementary components of a larger model which better explains health behaviors.

The Sociologist as a Researcher

The sociological practitioner brings valuable research skills to the organizational setting. The utility of needs assessment skills and evaluation skills in health promotion programming will be presented in this section.

Needs Assessment

In order to develop programs that adequately address the needs of employees, organizations must go through an initial information collection stage. Information which represents the present health status of employee, the at-risk status of employees, the type of programs in which the employees are willing to participate, and potential organizational barriers to health-conducive behaviors is needed.

The health status of employees.

An overall definition of health includes physical, mental, and social components. According to the World Health Organization (WHO), health is "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (1948). Physical health includes both physiological dimensions (e.g., blood pressure) and physical components (e.g., the ability to walk), mental health refers to the individual's state of mind, and social health refers to the quantity and quality of social contacts. The emphasis on an overall state of well-being makes the WHO definition of health complementary to the orientation of wellness programming.

Due to the problematic nature of objective health status measures and the nonexistence of measures of the physical health status of the general population (Patrick, Bush, and Chen, 1973; Sackett, Chambers, MacPherson, Goldsmith and Mcauley, 1977), this researcher utilized a subjective measure of health. Subjective measures of health complement the interactionist approach by emphasizing the individual's perception of his/her health. Although self-reported indices of

health are widely used, a controversy does exist over the validity of these measures in comparison with objective measures. However, a number of researchers support the reliability, predictability and validity of subjective measures (Singer, Garfinkel, Cohen, et al., 1976; Mossey and Shapiro, 1982; Goldstein, Siegel and Boyer, 1984).

In addition to this measure of physical health status, this researcher, after reviewing innumerable measures of mental health status, chose to use a 28-question version of the General Health Questionnaire that assesses anxiety, somatization, social dysfunction, and severe depression (Goldberg and Hillier, 1979). In his study of the different forms of the General Health Questionnaire, Banks (1983) concluded that the 28-question version had superior performance concerning misclassification rate (15%), sensitivity (100%) and specificity (84.5%) using a cut-off point of 5/6.

The "at-risk" status of employees.

Another factor that merits inclusion in the health needs assessment is an indicator of the health risk status of employees. Health risk assessments (HRAs), which have been developed for this specific purpose, are tools utilized to describe an individual's chances of dying or of acquiring specific diseases within a specific period of time (usually ten years). Currently, HRAs emphasize the measurement of risk for the development of cardiovascular disease. A risk score is calculated based on measures that may include weight, height, age, smoking, cholesterol levels, lifestyle issues and so on. Risk assessment indicators are distinctly different than health status indicators. HRAs are based on probabilities derived from epidemiological studies, rather than diagnoses. For example, a cardiac risk indicator score may conclude that an individual is at high risk for developing coronary artery disease within ten years, while the individual's present coronary status may be excellent, good, fair, or poor.

The HRA has both organizational and individual uses. From the organizational perspective, the HRA can gauge the risk of the population for some defined preventable disease. In addition, the HRA can be used in combination with morbidity and mortality statistics to provide a basis for a health program specifically tailored to meet the needs of the organization.

The HRA utilized should be chosen to reflect targeted programming areas. A list of health risk assessment tools can be ordered from the Center for Disease Control, Bureau of Health Education, 1600 Clifton Road, N.E., Atlanta, Georgia 30333. When choosing an HRA, the researcher should be aware of the following: (1) the validity of the instrument is closely related to estimation procedures with mortality risk, morbidity risk, overall heart disease risk, life expectancy, and general health status in order of decreasing validity, (2) the validity of an HRA

increases with the number of questions used to assess risk, (3) the adjustment of risk scores for age renders them more valid (Smith, McKinlay, and Thorington, 1987), (4) the charges for questionnaires range from zero to $40, (5) the HRAs can be self-scored or computer-scored, and (6) the investment in a computer package is cost-efficient for an organization which plans on long-term use.

The assessment tool utilized by this researcher measured the risk for the development of cardiovascular disease. The American Heart Association's RISKO instrument was chosen due to its low cost and its apparent reliability as tested by researchers in the assessment of HRAs. Measures of height, weight, cholesterol level, age, cigarette smoking and systolic blood pressure are the components of this health assessment tool.

In terms of its applicability to individuals, the HRA can be referred to at will by an individual, discussed with the family, and used to monitor progress (Fielding, 1984). The theory behind the HRA complements the interactionist schemata previously detailed due to the provision of a tool to aid the individual in incorporating the health self. The ability to do this will lead to a further ability to reflexively view this health in an accurate manner (Glassner, 1989). When an individual realizes how his/her self is viewed by others (e.g., the health care community), actions that confirm or disconfirm this self-concept should be forthcoming.

Program interest.

The initial identification stage of planned organizational change provides an opportunity to investigate the nature of programs that are of interest to employees, features that would prevent participation, and times that would be convenient for optimal usage. Through this needs analysis, the following information should emerge:

- those programs that are of no interest to employees;
- those programs with which the organization could reach a large target audience; and
- avenues for intervention that would encourage greater involvement.

Together, proper utilization of the information provided by the employee will lead to a program specifically tailored to meet the needs of employees.

This researcher assessed willingness to participate in blood pressure monitoring, weight reduction programming, aerobic exercise programming, nutrition awareness seminars, mental health sessions, stress management classes, first aid classes, on-site nursing services, and personal growth and development programs. Through such an assessment, this researcher was able to initially target

mental health, weight reduction, smoking cessation, and aerobic exercise within this worksite.

Occupational safety and health.

The organizational environment is often related to the occurrence of accidents and the appearance of illnesses among employees. As such, an assessment of existing and potential occupational hazards provides some important information for the developers of a health promotion plan. Work accidents account for an estimated 5 million injuries, with 2.2 million of these accidents being permanently disabling and 13,000 resulting in death (Hills, 1987). In addition, approximately 100,000 Americans die each year from occupation-related diseases with 390,000 new cases being diagnosed each year (Elling, 1986). Although often ignored, workers' self-report of health hazards has tended to be highly reliable (Nelkin and Brown, 1984).

Evaluation

A few scientific evaluations of worksite health promotion programs have emerged. The Johnson and Johnson "Live for Life" program, which includes annual blood screening, nutrition programs, weight control, stress management, and blood pressure controls, conducted an evaluation by comparing sites with comprehensive programming (e.g., the experimental group) with sites that had only performed a health risk assessment (e.g., the control group) (Breslow, Fielding, Herrman, and Wilbur, 1990). With respect to vigorous exercise, the experimental group demonstrated a 20 to 30 percent increase in employees reported participating in regular vigorous exercise after the initiation of the program compared to 0 percent prior to the program implementation. In addition, people who participated in one or more sessions of the smoking cessation program reported a quit rate of 31.6 percent at the two year follow-up, as compared to 17.4 percent in the control group. A 9 percent reduction in reported sick days was reported for the experimental group, as compared to a 14 percent increase for the control group. Finally, the annual return on the investment was reported to be approximately 30 percent, as reflected in the stemming of increases in inpatient costs to a twofold increase for the experimental group as compared to a fourfold increase for the control group during the five-year study period.

Control Data's "Staywell" program has also been evaluated. Health care benefit payment reductions have been confirmed within the Staywell program (Naditch, 1984). Compared to nonsmokers and those who quit smoking more than five years ago, smokers claimed 25 percent more benefit payments and

utilized twice the number of hospital days. In addition, sedentary individuals' claims averaged $436.92, with .57 hospital days, as compared to active individuals' claims of $321.01 with .31 hospital days.

Sociological practitioners can assist the organization in evaluating the overall health promotion program. Within this section, a brief overview of systems-oriented evaluation is provided as it applies to health promotion programming. An in-depth presentation of the evaluation process will not be attempted, since many excellent books on evaluation exist (Suchman, 1967; Attkisson, Hargreaves, Horowitz and Sorensen, 1978).

Systems evaluation focuses on the analysis of input, process, and output units. A level of effort or input involves the amount and distribution of resources into programs; examples of such measures include the sources of income, sources of expenditure, number of clients, and type of clients.

An output or performance approach involves an assessment of the program's outcomes and the effectiveness of the program in obtaining its specified goals. Potential organizational and client goals are usually reflected in the needs assessment data. At the organizational level, these goals may be a decrease in health insurance monies paid out, an increase in job satisfaction, a decrease in job turnover, a decrease in absenteeism, and so on. Goals at the client level should also be assessed; if clients are not reaching personally defined goals for participating in the health promotion program, then participation may cease. At the client level, goals may include decreasing health risk status, improving health status, and facilitating of mobility within the organizational setting. Obviously, organizational goals and client goals may overlap, as is hoped in the case of an increase in health status.

The process approach emphasizes the means utilized to obtain a goal. Focus is placed on the process itself, rather than on the outcomes of such a process—for example, an employer's utilization of money and staff (input) to train individuals in weight-reduction technique (process) to decrease health risk status (outcome). Within this scenario, training in weight-reduction technique would be assessed to see its effectiveness (i.e., actual weight lost). Process approaches may also include policy approaches (e.g., a no-smoking policy at the worksite); the effectiveness of a policy can be assessed through monitoring of compliance at the worksite.

Once the concern or focus of the evaluation has been delineated, it is possible to outline specific evaluation questions. Questions that encompass concrete measurable phenomena are better able to be used as measurements of goal attainment. For example, general questions geared to evaluate changes in employee health risk status could include the following:

1. At the input level: How many clients are presently at risk?
2. At the process level: Have clients stopped smoking, lost weight, etc.?
3. At the outcome level: Do clients have a lower risk status after programming?

The Sociologist as an Interventionist

The clinical sociologist, whose primary emphasis is intervention, can aid the organization in its attempt to develop and implement a health-promotion plan. The sociologist, in conjunction with a committee of employees representing both management and labor, is a viable guide for the change process. According to Felix, Stunkard, Cohen, and Cooley (1985), the selection of enthusiastic employees is the key to the successful establishment of a health-promotion program.

Designing and Structuring the Change Effort

The direction that a change effort takes is an important factor in determining its success. In designing and structuring a change effort, making a distinction between a policy and a program approach becomes important. Designing a change effort "includes defining the purpose and nature of the change intended, creating a delivery system, and specifying their relationships to each other" (Kettner, Daly, and Nichols, 1985:141).

The purpose of the change effort is reflected in the goals and the objectives. Common goals for a work-site health-promotion program might include a reduction in health expenditures for employees and an increase in the health status of employees. Organizations may relate these goals by inferring that an increase in the health status will ultimately result in a decrease in health expenditures. For example, the goal for the health-promotion plan devised for municipal employees by this interventionist was "to create a positive atmosphere that promotes the physical, social, and emotional well-being of the city employees while stemming the increase in health-care costs to the city."

Each goal has enabling factors or processes through which objectives may be met; these processes may include a program and/or policy approach. For example, the implementation of a weight reduction program, an aerobic exercise program, and so on may be the means through which an increase in health status can be achieved. Together, these programs will enable the organization to achieve its objective of increasing the health status of employees.

Policy approaches establish the principles and guidelines utilized during the change effort (Kettner, Daley, and Nichols, 1985). Policy design requires

consideration of the population to be affected, the provisions of the policy, the method of implementing the policy, and the funding of the policy initiatives. For example, the municipal organization that was studied proposed restructuring its absenteeism policy in order to provide one incentive for health promotion. One policy provision was that one paid vacation day would be given as a bonus to employees who were not absent from work for six months. The implementation of the program was made the responsibility of the personnel department. Either existing resources or special organizational fund-raising events would provide funding for this initiative.

The program approach, in contrast, includes program designing, job designing, and program structuring (Kettner, Daley, and Nichols, 1985). The designation of inputs, process, and outputs make up the program design. Inputs include resources and needs necessary to program implementation. Process includes the means utilized to achieve an outcome such as services to be provided, and methods of intervention may be emphasized here. Finally, outputs include the change or the quality of life desired for the organization and/or individuals involved. For example, in the designing of a stress-management program, the money to hire a stress-management counselor and space for stress-management classes must first be accessed. One crucial decision is whether and how organizational change should be included as part of a stress-reduction program. The goal of a reduction in anxiety for city employees could be achieved through both organizational and individual changes.

Patton, Corry, Gettman, and Graf (1986) suggest a number of roles that have evolved in health promotion, such as managers, planners, supervisors, educators, exercise leaders, motivators, counselors, promoters, assessors, and evaluators. The trained sociologist may find employment in any of these roles or as an organizational change agent. For example, clinical sociologists have worked as family therapists and as individual therapists (Glassner and Freedman, 1979). Given that one sociologist can not do everything, the creation of an interdisciplinary team to provide services is a necessary outcome in health promotion.

After the program design has been completed, a job design can then be created while taking into account the amount of socialization required for an individual to be effective in the task at hand. One position created for the city was that of mental health counselor. As a one-fifth time position, the primary responsibility of this counselor was the provision of on-site, short-term mental health services in the form of stress-reduction classes for labor, management, police and fire departments. A master's degree in social psychology and/or counseling, experience in management of caseloads, experience in running stress-reduction

classes, and knowledge of police and fire department employee stress areas were the minimum qualifications.

Program structuring is the final phase in the development of a change effort. What is the relationship between specific jobs? Where does the program fall in relationship to the organization as a whole? Who or what department will be responsible for overseeing the programs? Will that department oversee all of the program, or just part of them? Organizational charts developed around these relationships, which reveal linkages to other departments or corporate officials, are one way of organizing the structure of a health-promotion program. Within the city being studied, it was decided to develop a wellness department whose director would report to the city council. The decision to not include the wellness department in the personnel department was a political one. Within this city, the personnel department head and the health coordinator were housed in separate departments. The health coordinator had voiced opposition to anything but the curative approach of the current health insurance policy. As such, it was crucial to keep the health coordinator from exercising control over the health-promotion plan.

Once the process issues have been delineated, the creation of a service-delivery system becomes feasible. The service delivery system incorporates those services that will be provided and by whom. Within the city studied by this researcher, the city hospital, skilled municipal employees, and contracted workers could provide the needed services. The services would be provided on-site with funds allocated by the city government.

A Note on Ethics

As with any change effort, ethical issues must be taken into consideration. Many of these ethical questions surround the tendency to focus on the individual as a source of change rather than the organization (Castillo-Salgrado, 1984). Allegrante and Sloan (1986) present four dilemmas that confront workers in health promotion. Each of these dilemmas will be discussed, below.

The Dilemma of Conflicting Loyalties

Organizational goals may conflict with the health needs of employees. The professional thus may become caught between focusing effort either on individual change or organizational change. While individual change efforts may not fully address the cause or nature of the problem, organizational change efforts may offend the authority or structural values of the employer. Obviously, focusing change efforts solely on employees will result in the unnecessary

development of employee resentment. As such, change efforts could be geared to include change at both the organizational and individual level; Lovato and Lawrence (1990) suggested that both individual and organizational issues should be addressed in the optimal health-promotion arena. However, organizational change may be more difficult to enact than individual change. For example, the researcher was invited by management to initiate the investigation into the feasibility of developing a health-promotion plan. Although the researcher focused on the employee as a predominant source of change, organizational/ environmental issues were also addressed by focusing on both policy changes and nonthreatening environmental changes, such as a no-smoking policy and removal of cigarette machines, respectively. As the change effort becomes more accepted and supported, hazardous work conditions may then be better addressed.

The Dilemma of Blaming the Victim

Health promotion programs, which tend to focus on the reduction of risk behaviors, imply that the individual is responsible for his/her illness. Thus, the individual is blamed for something that may or may not be his/her responsibility. Even health care workers would not claim that they are positive about the origins of disease. In a situation where individuals do not have complete control, blame should not be easily assigned. However, given the tendency to assign blame, the manifestation of blame in punishment (i.e., refusal to promote someone who is in ill health) should be avoided. Although this researcher did not confront such a problem, the potential legal ramifications of discrimination of this sort appear to warrant discouragement from adopting this approach.

The Dilemma of Voluntariness or Coercion

The circumstances under which an organization can become ethically or morally justified in using coercion to bring about organizational change are ambiguous. Minkler (1978) proposed that coercive means are justified if a harmful situation exists and noncoercive means have been unsuccessful in rectifying the situation. Since the structure of work organizations and the economy are conducive to ill health, coercive means that focus on individual change are difficult to justify. Overall, the health promotion program devised by this researcher was based on voluntary participation, with the exception of the no-smoking policy. Given the documentation of the ill effects of passive smoking, this restriction did not seem unjustified.

The Dilemma of Unintended Consequences

Health-promotion program philosophies have resulted in a reduction of health benefits in some organizations. In addition, screening technologies have created a potential for abuse and/or misuse of information. For example, employees with health problems may not be hired or may be fired by the organization. These detrimental consequences were never intended to become a part of health-promotion programming. For example, the researcher had to confront the role that drug testing would play in the health-promotion program. The researcher decided not to include illegal drug use/abuse issues in both the needs assessment and the health-promotion plan in order to avoid the stigma of implied coercion being applied to the health-promotion program.

Researcher versus Interventionist

This researcher proposes an additional ethical dilemma of particular concern for the sociological practitioner: the dilemma of researcher versus interventionist. During the needs assessment, some potential problems of an individual (e.g., mental health problems) may surface. The researcher ethic is to be objective and not to analyze data as it is being collected. On the other hand, the interventionist ethic, especially if the researcher is also a counselor, mandates that the researcher/clinician intervene and assist the individual. In so doing, would the researcher/clinician violate either his/her role as a researcher and/or the individual's right to privacy?

This researcher/clinician chose to finish the interview and then asked the individual whether s/he had problems s/he would like to discuss. One method used to approach the topic (e.g., depression) was with a general question, such as, "It looks like you've been feeling pretty down lately. Would you like to talk about it?" If the individual expressed interest in discussing the issue, the researcher/clinician proceeded to assess the crisis nature of the situation and refer the individual to appropriate services.

Conclusion

Health-promotion programming is an emergent field in which sociological practitioners can utilize theoretical, research, and interventionist skills. The application of theoretical initiatives provides one basis for the introduction, testing and revision of health program ideas. Needs assessment, health risk appraisal, health status measurements, and evaluation tools are an integral part of developing and maintaining adequate programming specifically targeted to meet the

needs of employees. The sociological practitioner could be a valuable resource in the development of health promotion programs at the worksite. However, given the uncertainty of medical criteria for "fitness," the prevalence of organizationally and environmentally linked health hazards, the tendency to focus on individual change, and the existence of opportunities for the violation of the employee's rights, the health-promotion field provides some ethical challenges for the practitioner who is willing to get involved.

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