

CHAPTER 1

TOWARD A SEAMLESS SALUTOLOGY

Reconciling Subjectivity and Health Professionalism

"...recipes for a healthier society must be clear about what they mean by 'health',
and what aspect of health they are directed at." (Mildred Blaxter, 1990)

INTRODUCTION

"Health" is a word which represents different things to different people at different times and in different situations. This empirically well-documented fact contrasts dramatically with the professional desire to standardize health among all people, across time, and in any situation. Perhaps for this very reason, little has been done to provide for the explicit accommodation of diverse conceptualizations of health and health etiology within theories of health professionalism. This chapter attempts to address this gap by providing a model for classifying varying levels of subjectivity in health goals and the means employed to pursue them. Since subjectivity is a theme of importance to any field seeking to enhance health, the model is illustrated in relation to three archetypal professional health fields.

In the first section of the chapter, I present insights from empirical science, theory, and practice which have revealed important limitations to the positivist tradition in health professionalism and the resulting need for the accommodation of subjectivity in health theory. In the second section, I attempt to develop a working vocabulary for the discussion of subjectivity in relation to health and health professionalism. This vocabulary is then employed to further specify the nature of the challenges which subjectivity poses for health professionalism. In the third section, I build on the work of Aaron Antonovsky and René Dubos to construct a model for grounding the abstract conceptualization of "health" in the more concrete currency of health etiological resources. Finally, in the fourth section of the chapter, I suggest how Habermas' Theory of Communicative Action might be used as a means of theorizing the ongoing negotiation between health professionals and the public regarding health goals and means. This is then carried into a discussion of the meaning and dynamics of "salutology."

1 THE CHALLENGE OF SUBJECTIVITY FOR HEALTH PROFESSIONALISM

The Positivist Tradition in Health Professionalism

The so-called "biomedical paradigm," today constitutes the dominant tradition within health professionalism. Though clinical medicine and epidemiology are quite distinct disciplines, they share key epistemological assumptions which have led to their mutual classification as "biomedical." The epidemiologist's concern, by definition, with the incidence and prevalence of disease in populations leads to the operationalization of health in practice as lower morbidity and mortality in a population. Implicit, therefore, is an epidemiological definition of health as freedom from measurable disease and longevity. Such a definition coincides nicely with the world view of clinical medicine, which as a field seeks to cure disease and extend life in individuals. By defining health as the absence of measurable morbidity and premature mortality, both clinical medicine and epidemiology limit health to an empirically observable – and therefore highly reliable – epistemological realm. It is the relatively high reliability of knowledge produced within such narrow epistemological confines which has earned for medicine and epidemiology a dominant status within health professionalism. This dominant status, then, *presupposes* the privilege of defining which health goals are encompassed by the label "health" and the best means for pursuing these.

Despite its widespread employment, we should perhaps question the wisdom of using the expression "biomedical paradigm." The word "biomedical" has come in some health professional circles to be synonymous with curative medical care. Yet one finds at least some examples of other types of care even within medicine itself, such as palliative care for the terminal ill. Inversely, one finds a great deal of epidemiology even in fields such as health education and policy-based health promotion, which have sought explicitly to distance themselves from "biomedical" disciplines. Thus "biomedical" seems a less adequate term than "positivist." "Paradigm," on the other hand, is a term developed by Kuhn (1968:11) to describe "models from which spring particular coherent traditions of scientific research." The expression "biomedical *paradigm*" has often been employed to call attention to the hegemonic manner in which, as Starr (1988) has documented, medicine has endeavored to undermine the legitimacy of all other types of health professionalism, especially those which portend to cure. However, the term "paradigm" implies very strongly, in Kuhn's original sense, that the essence of a dominant paradigm must be discredited before the ascendancy of a new paradigm can begin (1968:77). Most professional health fields which would not identify themselves as "biomedical" would also not, however, wish to claim a falsification of biomedical epistemology; they would assert the *incompleteness* rather than the *inaccuracy* of that model. Therefore, in this chapter, I will refer to the "positivist tradition" within health professionalism. This expression, unlike "biomedical paradigm", accommodates the fact that empirical science is employed quite universally within professional health disciplines. It also allows for the possibility that such employment might coexist, rather than be replaced by, professional actions for health which fall outside the boundaries of the epistemology or practice of positivism.

Limitations to the Positivist Tradition in Health Professionalism

Over the past quarter century, limitations inherent to the positivist tradition in health professionalism have become apparent at empirical, theoretical, and applied levels. Researchers, theoreticians, and practitioners have asserted that notions of "health" held by individuals and social groups extend well beyond the realm of empirically observable phenomena. Such voices have further described individual and social values as critical factors in determining which goals should be pursued in the name of "health" and which means should be used to do so. This implies, of course, that individual and group understandings of health may conflict with the notions of health embodied by empirical operationalizations of health within the positivist tradition.

At least three areas in the health literature reveal an empirical confirmation of social and individual diversity in understandings of health.

Exhaustive studies have concluded, for instance, that conceptions of health or the origins of health differ markedly by socioeconomic status (Herzlich, 1973; Cornwell, 1984; D'Houtaud and Field, 1984; Calnan, 1987, 1989; Blaxter, 1990; Calnan, 1990), gender (Van der Heuvel, 1989; Blaxter, 1990), age (Van der Heuvel, 1989; Blaxter, 1990), status as a smoker (Dijkstra, Bakker and De Vries, 1997) or patient (Tsevat, Cook, Green, Matchar *et al.*, 1995), and (sub-) cultural membership (Dubos 1959; Curren 1989; Joosten 1989; Anderson, Blue and Lau, 1991; Scheper-Hughes, 1992; Helman, 1994; Curtis and Taket, 1996; Bergsma and Commers, 1997), and this remains a partial list. The work of Stainton Rogers (Stainton Rogers, 1991) deserves special mention, because it describes at both detailed and more abstracted levels the myriad concepts which individuals identify as "health".

Second, though longevity (i.e. relatively lower mortality) is the world's number one measure of population health, there is evidence which questions whether populations agree with this operationalization of "health". Joosten (1989) found that among a sample of 764 Dutch respondents, "long life" ranked 17th on a list of 21 possible completions to the leader, "Health is..." D'Houtaud and Field (1984) found that only 0.4% of 4000 respondents spontaneously mentioned the theme "long life" as an answer to the question, "What is, according to you, the best definition of health?" Donald "Dax" Cowart became an emblem of patients' autonomy discourse in bioethics when he consciously and coherently asserted his right to refuse life-saving medical care after being burned severely in the early 1970's (Cavalier, Covey, and Anderson, 1999; McGee, 1997). In Dax's case, the patient felt that health was death, whereas the law compelled doctors to preserve his life. This pitting of legal versus personal health goals is mimicked, of course, when the issue of "active" euthanasia is at hand. Finally, Tsevat, *et al.* (1995) found that seriously ill patients have radically different desires from one another in regards to their wishes for medical treatment to extend life or relieve pain.

In addition to empirical studies, a number of influential theoreticians have challenged the moral legitimacy of the positivist tradition in health professionalism. Parsons'

(1964:274) defined health as "the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialized." This functionalist approach to health opened the way for a tradition of analysis which emphasized that what is called "health" is a product of social structure and therefore of power relations. Illich (1976) asserted that the reduction of the human being to a "machine" (and even to the notion of a system) resulted in multiple forms of "iatrogenesis," a term he employs for biomedically-induced health loss. For Illich, the positivism of biomedicine was irreconcilable with the ideal of allowing health to be constructed on democratic (1976:128) or individual (1976:273) grounds. Navarro (1981) asserted that biomedicine is designed merely to support the conditions which facilitate the extraction of capital. Navarro understands positivism within medicine and epidemiology to be a powerful tool for the legitimization of existing power relations. He decries the portrayal of science within the positivist tradition as neutral, as well as the corresponding necessity of professional expertise for interpreting all aspects of reality which have a bearing on health. In protest of biomedicine, Navarro expresses the need for the massive democratic participation of workers in decisions relating to social structure and hence to health.

Practice, rather than health research or theory, has also shown the necessity of respect for "lay" opinions on health goals and the means employed to achieve them. The ubiquitous call for "participation," from clinical medicine to policy-based health promotion, has emerged more from the failure of top-down programming than empirical or moral insight. In medicine, doctors have conceded a steadily larger – albeit still subordinate – role for the patient in medical decisionmaking due to demands for such among patients and ethicists. Concern with informed consent and living wills is a symptom of this shift. Patient participation has also been shown to harbor potential benefits for the coping (and thus survival) ability of persons with chronic conditions (Bergsma and Commers, 1997). Still being debated in most of the world are the issues of whether patients should have the right to refuse life-saving care (McGee, 1997) or to receive assistance in dying (Houtepen, 1998). In health education, recommended practice presupposes the participation of those whose health is in question. Green and Kreuter's (1991) *Precede-Proceed Model*, perhaps the most widely employed planning schema in Western health education interventions, emphasizes community participation. The authors contend that if a community is not involved in goal-setting, it is unlikely to trust, support, or internalize the goals of an initiative. Finally, experience has shown the necessity and advantage of involving populations in the development and implementation of policy-based or "structural" health promotion efforts. This insight has been institutionalized in the *Ottawa Charter for and Jakarta Declaration of health promotion* (WHO, 1986, 1997).

The empirical, theoretical, and applied insights described above all emphasize either the reality or necessity of lay participation in the defining of health goals and the choosing of appropriate means for pursuing them. Such emphases thereby reveal the inherent limitations of the positivist tradition within health professionalism. The positivist tradition, as we have seen, presupposes professionals' ability to operationalize health in universally applicable and empirically observable terms, and to scientifically identify appro-

appropriate means for the promotion of those operationalizations. The acknowledgement of a lay role in these processes overwhelms the capacities of the dominant positivist tradition in health professionalism. This is demonstrated by that fact that none of the insights referred to in this section (empirical, theoretical, applied) are widely integrated into health professionalism. Diversity in notions of health, ideological skepticism of biomedicine, and participation are all themes which, while they are increasingly demanding attention, remain at the fringe of health professionalism. One reason for this marginalization is the lack of overarching theory which acknowledges both the "objectivity" suggested by the narrow yet reliable epistemological standards of the positivist tradition, while at the same time ascribes a legitimate place to the "subjectivity" implied by lay evaluation of health goals and the means employed in pursuit of them.

2 A VOCABULARY OF RELATIVE SUBJECTIVITY FOR HEALTH GOALS AND DETERMINANTS

Much ambiguity exists in the way words are used to deal with subjectivity in professional health literature. Perhaps the best example of this problem is the expression "subjective health" itself. In health-related literature, "subjective health" has most often been employed as one "subjective" variable among a number of "objective" variables in studies seeking to document the "overall" health status of a population or the effects of risk factors upon that status (e.g. Mackenbach, Van den Bos, Joung, Van de Mheen, and Stronks, 1994). However, such employment of "subjective health" leaves no room for the kind of subjectivity involved in a terminally-ill cancer patient's decision about whether "fighting it out in the hospital" or "dying at home with my family" constitutes health. As I hope to make clear, the kind of "subjectivity" I am addressing in this chapter encompasses both of these examples, since both involve the lay evaluation of health goals and the means to them. Nonetheless, to prevent confusion, I will try in this section to briefly develop an operational vocabulary for dealing with the issues of subjectivity and health professionalism I address in the final two sections.

Phenomena-Labeled-As-Health

As the actions of any health professional confirm, any action in the interest of health demands an operationalization of health. For example, when a physician sets a cast on a broken leg, health is operationalized as an intact leg bone. When a health educator distributes materials urging people not to eat excessive fat, health is implicitly depicted as a life free of disease induced by excessive dietary fat (and perhaps a longer life because of it). When a psychologist speaks with a patient, health may be represented as greater self-esteem, or less experienced anger. In other words, it is only through the embodiments which are labeled as "health" *in situ* that we can "see the ideal" in its incarnate form. It is in fact this labeling, conducted at individual and social levels, which constitutes the locus of relative subjectivity within health discourse. I will therefore employ the expression "phenomena-labeled-as-health" to acknowledge both the variety of phe-



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